Delivering hegemony: contemporary childbirth discourses and obstetric hegemony in Australia

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Abbreviations

- ACOG: American College of Obstetricians and Gynaecologists
- ALP: Australian Labor Party
- AMA: Australian Medical Association
- ACM: Australian College of Midwives
- ASA: Australian Society of Anaesthetists
- CDA: Critical Discourse Analysis
- EBM: Evidence Based Medicine
- GP: General Practitioner
- LNP: Liberal National Party
- MJA: Medical Journal of Australia
- MSR: The Maternity Services Review
- NASOG: National Association of Obstetricians and Gynaecologists
- NHI: National Health Institute (United States).
- NHMRC: National Health and Medical Research Council
- PHI: Private Health Insurance
- RACGP: Royal Australian College of General Practitioners
- RANZCOG: Royal Australian College of Obstetricians and Gynaecologists
- RCOG: Royal College of Obstetricians and Gynaecologists (United Kingdom).
- RDA: Rural Doctors Association
- RDAQ: Rural Doctors Association Queensland
- VBAC: Vaginal Birth After Caesarean

Abstract

Utilising a feminist critical discourse analysis framework, this thesis examines contemporary Australian childbirth debates in order to understand how knowledge about childbirth is produced and contested through discourse. The thesis builds on previous feminist analyses of childbirth knowledge and obstetric hegemony but concentrates specifically on the contemporary Australian discursive landscape with a wide-ranging analysis which includes obstetric textbooks used in Australian universities, media, policy debates and processes, as well as women's experiences. In this thesis, I argue that obstetric conceptualisations of childbirth dominate public knowledge of childbirth in Australia, and that obstetric hegemony is created, maintained, and reinforced yet also contested throughout various discursive sites. Anthropological and feminist post-structuralist historical analyses have demonstrated that childbirth practices and understandings in modern Western nations are particular to the cultural values of the West. They arose out of the Enlightenment era of scientific rationalism and the privileging of mind over body, science over nature and male over female. More recently, scholars have theorised that modern childbirth and maternity care discourse and practice should be understood from within a risk society framework. The shift from industrial to risk-averse post-industrial societies in the late 20th and early 21st century coincides with the shift from a social model to a medical model of childbirth; risk management has thus become a central tenet of maternity care and one that obstetrics has been able to socially shape. This analysis finds that in Australian debates around rates of caesarean birth, access to homebirth, the role of midwives in maternity care, and in discussions of women's experiences with their obstetricians, dominant cultural discourses of risk-management and consumer individual choice were employed to rationalise ongoing obstetric control of childbirth knowledge and maternity services. Thus, the intersection of obstetric discourse with a prevailing Western ideology that privileges personal autonomy and obligates the individual to appropriately manage risk, maintained and even strengthened obstetric hegemony in Australian public discourse.

Statement of Authorship

Except where reference is made in the text of this thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person's work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis were approved by the relevant Ethics Committee February 8th 2008, HREC 07-132.

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Introduction

Childbirth is a site of contested knowledge. Struggles over who should 'own' birth continue to shape public and professional discourses as well as policy decisions around pregnancy and childbirth. These struggles represent historical conflict between medical and alternative constructions of reproduction (Reiger 1999). For decades now, feminists, social scientists, midwives and childbirth advocates have brought to our attention the way in which a biomedical paradigm of reproduction has come to dominate birthing practices and knowledge about childbirth (Oakley 1980; Rothman 1982, 2007; Davis-Floyd 1994; Kahn 1995; Lane 1996; Davis-Floyd and Sargent 1997; Jordon 1997; Reiger 2001). This has meant that knowledge about women's bodies and birth is produced by the medical profession which understands birth as inherently pathological and risky and therefore needing medical management. In contrast, what is described as the women-centred or 'normal birth' model promotes normal, physiological birth (Romano and Lothian 2007; Reiger and Morton 2012) and conceptualises it as a 'manifestation of health' rather than illness (Lane 1996). The way a culture understands and constructs childbirth is important to how women experience it (Jordan 1993, 1997), thus 'medical' birth and women-centred, 'normal birth' are not just conceptual models but are connected to specific practices that have different health, psychological and social outcomes for mothers and babies, including outcomes for the way women interpret and experience their bodies through birth (Maher 2003; Beckett 2005; Romano and Lothian 2007).

By closely analysing key Australian debates around caesarean section, midwifery-led care, and access to homebirth, in addition to women's experiences of obstetric care, this thesis examines the ways in which knowledge of childbirth in Australia has been produced, disseminated and reproduced during the first decade of the 2000s. The histories, knowledges, politics and practices surrounding childbirth have been extensively researched by feminists, social scientists, midwifery researchers and historians, and while different theoretical perspectives have been applied, there are unifying themes across the literature. Firstly, it is now understood that childbirth is bio-cultural; a physiological process that is always mediated by cultural norms, ideologies and systems of power relations, particularly gendered relations of power (Jordan 1993; Davis-Floyd

& Sargent 1997). Secondly, in Western culture, it is recognised that patriarchal and biomedical frameworks dominate understandings and practices of childbirth. Thus, the epistemological basis for childbirth knowledge is based upon the 'body-as-machine' paradigm of Western, patriarchal, Cartesian scientific thought (Davis-Floyd 1994, 2001; Kahn 1995; Murphy-Lawless 1998; Rothman 1982, 2007; Edwards 2005). Furthermore, biomedical knowledge about childbirth is seen as hegemonic and as espousing a particular world-view, arising out of 19th century medicine and gendered relations of power (Murphy-Lawless 1998), which serves the interests of the obstetric profession.

This thesis builds on existing feminist analyses of childbirth knowledge and experiences by examining the contemporary Australian discursive landscape. Utilising a feminist critical discourse analysis (CDA) framework, I examine a number of sites in this landscape, including obstetric textbooks currently used in Australian universities, media discourses, policy debates and processes, as well as the experiences of women reflecting on childbirth. The thesis seeks to reveal the discursive processes through which obstetric hegemony is created, maintained, reinforced and contested in early twenty-first century Australia. In this light, then, each chapter in the thesis focuses on a specific discursive site where childbirth knowledge, practices and relationships are produced and particular views are sustained and contested; and where, I argue, meanings are made about contemporary childbirth practices and beliefs.

Chapter One critically examines and summarises the theoretical foundations of feminist and midwifery analyses of medically-dominated childbirth. I critically review historical analyses that outline the history of the medicalisation of childbirth and the subordination of midwifery and examine the work of scholars who theorise the epistemological basis for obstetric knowledge demonstrating that contemporary obstetric knowledge arose from, and reflects, the specific cultural values of the West, including scientific rationalism and the privileging of mind over body, science over nature, male over female. I then examine the work that investigates the effects that the epistemological basis of modern obstetrics has had on contemporary maternity care and women's experiences of childbirth. I examine each of these areas of scholarship, but posit that further analysis of the cultural power of the obstetric conceptualisation of childbirth is needed in order to understand contemporary practices, debates and discourses evident in Australian society

and the prevalence of obstetric ideology in maternity services and policy. I also examine recent analyses of obstetric discourse that have drawn on sociological theories of risk society, in order to explain the role these discourses have in shaping maternity care and practices. Finally, I outline a theory of hegemony, ideology and the methodological framework of Critical Discourse Analysis (CDA), which I employ in this thesis in order to reveal the maintenance of obstetric hegemony in contemporary childbirth discourses in Australia.

Chapter Two re-examines the epistemological basis of obstetric knowledge. Through an analysis of current obstetric textbooks used in Australian universities, I examine the construction of obstetric power through the material process of obstetric education. Previous analyses of obstetric textbooks (Martin 1989; Kahn 1992; Murphy-Lawless 1998) have shown us that they are steeped in a Cartesian metaphysics of the 'body-as-machine'—where birth is understood as a series of perfunctory processes that occur to passive bodies and the birthing body is understood as abject and fragmented, rather than active and embodied. This chapter argues that, while contemporary textbooks acknowledge women's subjectivity more so than in the past, obstetric knowledge continues to construct birth in a mechanical way, thus risking a misunderstanding of the birth process. The absence of attention to the subjective, embodied, lived experience of childbirth helps to make sense of the explanations and justifications for caesarean birth in medical discourse, as the following chapters will show.

Chapter Three illustrates the cultural dimension of hegemony through media representations. This chapter examines the influence of print media in maintaining and contesting obstetric hegemony in debates around caesarean sections. I argue that, in response to increasing concerns over escalating caesarean rates, a narrative of 'choice' emerged in Australia. The rapidly rising rates of caesareans were constructed in the media as being the result of women 'demanding' surgery, either for non-medical or 'lifestyle' factors or through a desire to minimise vaginal and pelvic floor damage. The capacity to choose a caesarean was identified as a woman's 'right' by both members of the obstetric community and women. In this way, obstetric and public discourse drew on the language of the consumer-led normal childbirth movement (choice in childbirth) as well as a neoliberal notion of autonomy. Rising caesarean rates were also constructed as being a problem of an ageing maternal population and increasing rates of obesity, thus, ostensibly, the

result of the pathology of women's bodies. The combined public focus on women's choice and pathology conveniently deflected attention away from elements of obstetric practice that might otherwise be recognised as contributing to the increase in caesarean rates.

Another dimension of knowledge construction and the maintenance of obstetric hegemony is produced through political activity and policy formation. Drawing on theorists using a policy as discourse analysis (Bacchi 2005), in Chapter Three I critically examine the 2008 Federal Government's Maternity Services Review (MSR). Historically, medical and obstetric professions have been influential in shaping maternity care policy in Australia, ensuring that policies align with the interests of their own material and political interests (Willis 1989; Schofield 1995). The Maternity Services Review represented an important moment, appearing at first to be a meaningful attempt at institutionalising midwife-led care and thus a direct challenge to obstetric hegemony. However, I argue that the outcome of the process, a policy of 'collaboration', served to re-entrench and cement obstetric-led care. The obstetric profession effectively used the policy process to reinforce obstetric control over childbirth practices by firstly taking credit for Australia's 'record of safety' in childbirth outcomes and, secondly, by framing birth as always risky, unpredictable and thus necessarily requiring obstetric supervision. Obstetricians were able to convince the government that they are better than midwives at managing risk (see also Lane 2012). The now legislated policy of 'collaboration' resulted in doctors having veto power over midwifery practice and decision-making. The MSR had particular ramifications for independent midwifery and women choosing to birth at home, as independent midwives were excluded from a government professional indemnity scheme.

Following the MSR, public debates around homebirth in Australia intensified. Despite increasing international research demonstrating the safety of homebirth for healthy low risk women, women who choose homebirth in Australia were constructed by the media and obstetric profession as selfish risk-takers, motivated by ideology rather than the best interests of their babies. While the obstetric community vigorously argued for women's right to choose a caesarean without medical indication, choosing to birth outside the obstetric-led maternity system was not an option supported in the same way. In fact, it was aggressively opposed; some members of the profession called for 'banning' homebirth. Policy developments arising from the MSR failed to make

effective provision for independent homebirth midwives who practice outside of a hospital, leading some commentators to argue that there was an increase in 'freebirthing' (birthing at home without a qualified attendant). I argue that the ideology of intensive mothering (Hays 1996), with its key obligation to 'manage' risk, intersects with the powerful obstetric ideology that conflates homebirth with danger and irresponsibility. Popular media discourse during this time constructed homebirth women and midwives as inadequate 'risk managers' who act selfishly and recklessly in defiance of common-sense. Moreover, several high profile coronial inquests into deaths of babies born at home produced a moral panic around homebirth in the period 2009-2012.

The final chapter examines the operation of hegemony at a personal, internalised level. Using qualitative data from interviews with 13 pregnant women using private obstetric care, I demonstrate that the women participating in this study enter into a relationship of trust with their obstetrician based both on their class positioning and their belief and entrenchment within the hegemonic biomedical model of birth. Second, I demonstrate that their confidence and trust in their own ability to birth without medical expertise is subtly eroded in the medical encounter, as well as through cultural fears surrounding birth. I use this evidence to make a wider claim regarding the limits of choice and agency within the obstetric encounter. I do not suggest that women in medical systems of maternity care are 'passive dupes' of obstetric hegemony. However, I do argue that their autonomy is nonetheless constrained by their relationship with their obstetrician and an increasing normalisation of medical birth.

Through this examination of the production and distribution of childbirth knowledge in Australia, I argue that dominant discourses repeated in media, policy and everyday interactions, become hegemonic as other discourses are neglected or deliberately repressed and become marginalised (Laclau and Mouffe 1985). Obstetric discourse marginalises other ways of understanding childbirth because it works with other powerful contemporary discourses, such as neoliberal discourse, consumerist notions of free-choice, and risk-society discourses. Obstetric ways of understanding childbirth thus become common sense and seemingly unquestionable. The central argument of this thesis is that, in contemporary Australian debates, obstetric discourse intersects with other cultural discourses in reinforcing the biomedical ideology of birth as a dangerous process best managed, or at least overseen, by obstetricians.

Chapter One

Theorising Power and Knowledge in Childbirth

This chapter examines the key sociological and feminist theoretical perspectives employed to understand obstetric hegemony in childbirth, including those offered by previous scholars whose analyses of the epistemological basis for obstetric knowledge and historical analyses of the obstetric profession I build upon. Historical analyses of the medicalisation of childbirth—the shift from a familial process in the home, to a medically-controlled event in a hospital—have been well researched, and there are existing succinct reviews of this literature (e.g. Schofield 1995; Edwards 2005). Three key areas of analysis are pertinent in understanding modern childbirth and inform the basis of this thesis. Firstly, the professionalisation project that organised medicine embarked upon between the 16th to the 19th century implicitly involved the subordination of midwifery; thus the continuing power struggles between midwifery and obstetrics are rooted in longstanding, deeply gendered relations of power. Secondly, anthropological and historical analyses have demonstrated that childbirth practices in modern Western nations are particular to the cultural values of the West and arose out of the Enlightenment era of scientific rationalism and the privileging of mind over body, science over nature, male over female. Thirdly, the history and epistemological basis of modern obstetrics has major, and ongoing, implications for the ways in which women experience childbirth, as well as for the practices of contemporary maternity services and hospitals. I examine each of these areas of scholarship, but posit that further analysis of the cultural power of the obstetric conceptualisation of childbirth is needed in order to understand contemporary practices, debates and discourses evident in Australian society, including the prevalence of obstetric ideology in maternity services and policy. I also examine recent analyses of obstetric discourse that have drawn on sociological theories of risk society, in order to explain the role these discourses have in shaping maternity care and practices. Finally, I outline an approach to theorising hegemony, ideology and the methodological framework of critical discourse analysis (CDA), which I employ in this thesis in order to understand how hegemony works in contemporary childbirth discourses.

1.1. The appropriation of childbirth: feminist perspectives

The feminist critique of childbirth practices and maternity care arose from within the women's health movement and second wave feminism of the 1970s. It sought to reinstate women's autonomy and power in childbirth, and advocated for midwife-led 'natural' birth (Pringle 1998). Material practices, discourses and social processes surrounding childbirth and the care of women and babies were understood to have been co-opted by a patriarchal medical fraternity. Birth was redefined from a 'natural' and familial life event that occurred in the home, to a 'disease state' requiring medical and surgical expertise, stripping women of agency in the process (Ehrenreich and English 1973; Rothman 1982, 2007; Oakley 1984). The historical appropriation of childbirth, feminist scholars argued, meant that knowledge about both women's bodies and birth came to be produced by the medical profession, which perceived women's bodies and reproductive processes as pathological (Rothman 1982, 2007). Birth, therefore, has come to be understood as a risky medical event rather than a 'natural' process. This viewpoint relies on what Pringle (1998) calls a 'foundational story' about the male conquest of childbirth, in which the emergence of obstetrics is understood as a 'victory' for patriarchy and capitalism to the detriment of women and children (Pringle 1998: 44).

Though different locations gave rise to specific experiences, the trajectory that saw childbirth move from homes to hospitals and become redefined from a normal state, to an illness, followed a similar path in most of the Western world. Between the 17th and 19th centuries across Western Europe, North America, New Zealand and Australia, male physicians saw that there was profitable income to be made from delivering babies and embarked on a strategic project to displace women healers and midwives from the domain of childbirth (Ehrenreich and English 1973; Haire, 1978; Corea 1977; Scully 1980; Arney 1982; Rothman 1982, 2007; Oakley 1984; Willis 1989; Witz 1992; Murphy-Lawless 1998). As an organised profession, doctors were able to do this firstly by constructing a division between normal and abnormal births and staking a claim on abnormality, but eventually blurring those boundaries and taking charge of all births (Edwards 2005:74). Constructing all births as pathological allowed doctors to claim that only they had the expertise and necessary instruments to ensure the safety of mothers and babies. The invention of obstetric forceps greatly aided physicians' campaigns, as they were able to deliver

live babies in cases where previously either mother or baby would have died (Scully 1980: 25; Rothman 1982, 2007). In England, the earliest encroachment on the work of midwives came from 'barber-surgeons', initially only called upon to extract a dead foetus from the mother, which involved a crushing of the foetal skull and dismemberment or extraction via caesarean (Rothman 1983, 2007). As Rothman (2007: 10) writes, 'it was not within the technology of the barber-surgeon to deliver a live baby from a live mother'. However, that changed with the invention of the obstetric forceps. As laws in Europe prohibited midwives from using forceps, they were increasingly pressured to call on barber-surgeons in cases of difficult labours, not just after the foetus or mother had died (Rothman 2007: 11).

This 'bitter war' on midwives (Scully 1980: 25) did not occur without resistance; doctors were met with strong challenges from midwives, who for many years resisted the pressure to cease practice and actively attacked doctors' 'instrument aided childbirth' as dangerous and 'meddlesome' (Scully 1980: 28; see also Arney 1982; Murphy-Lawless 1997; Rothman 2007). Challenges also came from within their own ranks, with some doctors holding the view that men had no place in childbirth as it was perceived immodest and unchaste for women to expose their genitals and pregnant state to men (Scully 1980: 26).

The cultural elevation of scientific medicine in the 19th Century eventually led to medical knowledge being valorised over traditional midwifery knowledge, and midwives came to be associated with witchcraft and superstition (Ehrenreich and English 1973; Scully 1980). Men formed professional organisations (the earliest incarnations in Europe being the barber-surgeons' guilds) and had the social and economic means to disseminate, legitimise and eventually *institutionalise* their knowledge, eventually leading to the creation of the discipline of obstetrics (Scully 1980; Arney 1982; Rothman 1982). By comparison, midwives were mainly sole-operators and not professionally organised. Thus, lacking institutional power, they eventually became subordinated to the medical profession or completely eradicated, as was the case in North America (Rothman 1982, 2007). As sociologist Diana Scully notes, traditional midwives 'were unable to compete with the growing power of organised medicine' (1980:34).

Concerns over low population growth and high infant mortality rates in Europe and Australia in the 19th century and early 20th century supported the obstetric profession's authority, as it was

able to argue that medical care would lower the rates of infant and maternal mortality (Willis 1983; Reiger 1985; Tew 1998; Weir 2009; Edwards 2005; 73). In the United Kingdom, for instance, concern that the British race 'was in a state of deterioration' following the Boer Wars in 1899-1902, led the state to become involved in childbirth and maternity care where previously it had not been a matter of state interest (Edwards 2005: 73). Similarly, in Australia concerns over population growth and maintaining racial purity led governments to support the hospitalisation of childbirth overseen by medical specialists (Reiger 1985; Willis 1989; Fahy 2006). In the biomedical, obstetric version of childbirth history, it is argued that maternal and infant death rates were reduced as a result of the shift from midwife care at home to physician care in hospital (c.f. De Costa 2008). This claim, however, has been critiqued by historians and feminists, who suggest that records reveal maternal mortality actually *increased* during this period as a result of the spread of sepsis leading to 'childbirth fever', due to doctors not washing their hands and using unsterilised instruments between patients (Rothman 1982, 2007; Tew 1995; Murphy-Lawless 1998; Weir 2006).

Feminist analyses of obstetric and childbirth history hold that the obstetric profession was driven by a 'structural matrix' (Witz 1992: 66) of patriarchy and capitalism (see also Arney 1982: 7; Willis 1989; Rothman 1982; Kahn 1995; Pringle 1998). Thus, the medicalisation of childbirth is understood as representing, firstly, the desire of men to appropriate women's reproductive powers in an extension of their aspiration to control and dominate nature (Ehrenreich and English 1973; Corea 1977; Daly 1978; Rothman 1982; Oakley 1984; Kahn 1995), and secondly, loyalty to the economic and professional advancement of their field, rather than to the well-being of women and babies (Scully 1980; Arney 1982; Willis 1989; Witz 1992). Scully (1980) undertook hundreds of hours of field research and interviews over three years, within delivery suites, surgical suites, clinics and classes as well as in obstetric residencies in two American hospitals and argues that obstetricians and gynaecologists undergo a process of professional enculturation where their professional goals come to be unevenly matched and even clash with the needs the of pregnant women. She refers in particular to their surgical training, in which the gaining of surgical expertise is considered the highest priority of becoming an obstetrician, leading to a 'surgical mentality':

> Although training in obstetrics and gynaecology focuses on surgery and other forms of treatment for acute pathological conditions, the majority of problems that women bring to their physicians do not require these treatments. Still, residents were mainly interested in learning and doing surgery and had professional identities closely linked to the surgeon's role…a career orientated toward preventive or well-care was viewed as having less potential for advancement, profit and satisfaction than a surgical or superspeciality career (1980: 139).

Scully goes on to argue that, historically, the focus on developing the speciality of technical/surgical skills within the profession was in response to the low status held by obstetricians—or 'baby catchers and uterus snatchers' as they were dubbed—within medicine. In focusing heavily on surgery, obstetricians were not being trained in other important areas and thus not meeting the needs of women (Scully 1980: 140). Scully also noted a distinct lack of empathy and often contempt expressed by obstetricians toward the women they cared for (see also Oakley 1980), noting that most were motivated by profit and personal advancement. More recently, McCallum's (2005) anthropological fieldwork in Brazil also found that obstetricians feel more comfortable performing surgery and view it as more profitable.

Within feminist scholarship, the rise of the obstetric profession is understood as not just a matter of market monopolisation, but also a form of social control of women (Oakley 1980, 1984; Kahn 1995). The redefinition of childbirth, from a social or 'natural' event to a medical one, was aided by gendered ideology, for example, perceptions of women's bodies as being inherently pathological and dangerous, and the emerging ideology of technology (Rothman 2007) and biomedicine, as I discuss further below. The subordination of midwives mirrored patriarchal sexual relations of power in broader society (Willis 1989). Therefore, many feminist scholars argue that underlying the co-option of the birth process lay a desire to subordinate not just midwives, but women as a group (Oakley 1980, 1984; Willis 1989; Pringle 1998: 46; Edwards 2005). As Oakley argues; male obstetrics rose to prominence just when women's social positions were changing and there were 'important parallels between medical and social ideologies of womanhood' (1980: 16).

1.2. Problems with the feminist medicalisation critique

There are however, divergent views within feminist scholarship regarding the extent of medical power in the history of childbirth, with some scholars arguing that the medicalisation perspective over-simplifies the patterns of power and denies women's agency (Michie and Cahn 199l; Annandale and Clarke 1996; Papps and Olsen 1997; Pringle 1998; Zadoroznyj 2001; Beckett 2005; Frost et al. 2006). As Pringle notes, the reality of the relationship between the medical profession and women is 'a great deal more complex' than the simplistic notion of doctors set on enhancing their own economic power and controlling women as a group (1998: 43). For example, some have argued that women contributed to the medicalisation of childbirth, by demanding access to analgesia in 19th and early 20th Century America (Leavitt 1986; Beckett 2005) and by advocating for hospital birth in the late 1940s in Australia (Reiger 1985). Moreover, some feminists argue that technology in birth is not 'bad' per se, nor does technology always have to be inherently contrary to women's interests; therefore, women should have the right to control the resources of medicalised childbirth to their own benefit (Annandale and Clarke 1996; Pringle 1998).

Empirical research in the 1970s, 1980s and 1990s in North America and the United Kingdom suggests that women experienced a paternalistic and dehumanised system of medicalised birth which was highly controlled/managed and reliant on technology such as epidurals, episiotomies, forceps and caesareans, and where women apparently lacked any agency or control (Shaw 1974; Oakley 1980; Martin 1989). Practices during labour, such as birth position and routine enemas, often reflected obstetricians' preferences or convenience and not what was best for women and babies. Maternity care focused on ensuring a live baby, while mothers' experience of the childbirth process was considered inconsequential (Oakley 1980; Lane 1996). Qualitative studies undertaken in the 1970s and 1980s were influential in the Women's Health movement and Natural Childbirth movements, contributing to improvements in maternity services and the eradication of some dehumanising, routine practices such as enemas and shaving of the pubic area (Reiger 2001).

However, during the 1990s and 2000s, qualitative research contradicted aspects of the dominant feminist view of medicalised childbirth. While childbirth advocates, including consumers, feminists and midwives believed that a model of 'natural' or 'holistic' midwife-led model of childbirth with minimal intervention best met women's needs, research suggested that some women actively engaged with, and sought out medical birth (Sargent and Stark 1989; Lazarus 1994; Davis-Floyd 1998; Zadoroznyj 1999, 2001; Martin 2003; Edwards 2005). This research described ways in which women in some Western countries negotiated medical hegemony in order to exercise agency and control during labour and birth. This research acknowledges the socially constructed nature of women's subjectivity and suggests that women use the practices of medicalised birth to maintain a feeling of being in control, especially to remain physically distant from bodily sensations. For example, Sargent and Stark's (1989) research found that the middle-class American women they interviewed were primarily concerned with control of bodily sensation, emotion and behaviour during birth and technologies such as epidural analgesia were used in order to remain in command of their bodies and emotions. Karin Martin's (2003) interviews, again with middle class American women, suggest that medical technology is sometimes used in order to meet gendered expectations of 'lady-like' behaviour and maintain 'control' of bodily processes and emotions in the presence of family and spouses. Anthropologist Robbie Davis-Floyd (1992) explored the experiences of different social groups of American women, finding a dissonance between the feminist critique of childbirth and the beliefs and desires of women. The majority of the women Davis-Floyd interviewed did not question the 'American way of birth' (highly medicalised, doctor-led), but rather spoke in accord with it. Davis-Floyd sought to understand their choices 'as embedded in the hegemonic cultural model of reality that most of us to some degree embrace' (1998: 5), arguing that American birth reflects the founding tenets of Western culture and that obstetric practices initiate birthing women into the core values of our society. The majority of women in Davis-Floyd's study accepted the medical, 'technocratic' model of birth and many actively sought it. Lazarus (1994) and Zadoroznji (1999, 2001) also argue, from their research data, that women, particularly middle-class women who share the same class values as obstetricians, are active 'consumers' of obstetric maternity care, speaking in accord with the values of medical childbirth.

These studies indicate that women may use medical technology in birth in apparently empowering ways and can be active *participants* in the process of medicalisation, even if the underlying reasons for desiring medical technology are linked to gender and class expectations. Gange and McGaughey's (2002) understanding of cultural hegemony, power and women's agency is useful for understanding women's participation in the medicalisation of childbirth. In their analysis of women's decisions to undergo cosmetic surgery, they argue that power is not something that can be divided into 'haves and have nots'; it is much more complex than this. Women are not necessarily *coerced* but rather are guided by norms, beliefs and ideologies that are internalised as 'natural' and 'normal'. Gagne and McGaughey (2002: 819) recognise women's agency in their decision to undergo cosmetic surgery, but hold that those decisions are made in the context of 'hegemonic gender norms' that become internalised. Similarly, women are culturally embedded in the values of medical birth, but are still able to hold power within that system.

Feminist analyses and understandings of the ways in which capitalism, patriarchy and obstetric ideology are intertwined remain pertinent in understanding the machinations of the hegemony of obstetric-led birth and should not be discarded. However, feminist commentators also point to the limitations of this approach. For example, it is argued that some perspectives uncritically use the idea of the 'natural', which is entrenched in other discourses and cultural systems that have 'historically [been] oppressive to women' (Michie and Cahn 1991: 55). The positing of women-centred, midwife-attended 'natural' birth as the idyllic alternative to patriarchal medical birth, as is often done within critiques of medical birth, problematically ties women to nature and to the cultural norms of femininity and heterosexuality (Michie and Cahn 1991: 55; see also Annandale and Clarke 1996; Beckett 2005). The dichotomy between medical birth and women-centred, 'natural' or holistic birth has also been questioned. For example, the dichotomy fails to see the way in which 'natural' birth is just as much a social construct as 'medical birth' (Annandale and Clark 1996; Pringle 1998; Akirch and Pasveer 2004; Beckett 2005; Frost et al. 2006) as birth is *always* a culturally mediated event. Akirch and Pasveer (2004) oppose the medical/natural model dichotomy itself. They argue that there is already a 'contamination' between the two models as women's bodily experience is already shaped by medical knowledge:

> Obstetric knowledge comes to be part of women's world, shaping their perceptions, suggesting behaviours and models of action, proposing patterns for expression and verbalization, and thus forms part of bodily childbirth experience (Akirch and Pasveer 2004: 81).

Murphy-Lawless (1998) further argues that, as women's experiences are constructed through obstetrics' theories and practices, the 'obstetric viewpoint becomes part of our experience' (1998: 32). This is not to say that as a *practice* woman-centred birth cannot exist. As Beckett (2005) and Maher (2003) point out, 'medical' birth and 'natural' birth are not only two sets of knowledge about childbirth, but the practices formed by these knowledges and ideologies have very different outcomes for mothers and babies, including outcomes for the way women interpret and experience their bodies through birth.

Van Teijlingen (2005) provides an important distinction between using the different models of birth as analytical tools as opposed to using them to describe practices. As analytic tools, the two models of birth allow us to interpret social phenomena. They can be used to analyse the dominant taken-for-granted approach to birth in society and to study those who have internalised a specific ideological outlook (2005: 15.2). In this thesis, I understand medical birth both as an 'internalised specific outlook' as well as a practice. However, I am particularly interested in the manner in which this internalised outlook or view is formed; how medical knowledge about birth is produced, perpetuated and how women accept or contest it; that is, how and why it is hegemonic. Whilst early feminist interpretations used the dichotomy natural/medical to understand the ways in which birth in Western society is viewed and managed, they have also uncritically used the models as ideological value judgements with inherent presumptions about 'true', 'real' or 'natural' birth as existing somewhere outside of culture or in some pre-capitalist, pre-industrialised era.

1.3. The epistemology of medical birth

In order to understand medical birth as an ideology, feminist analyses of obstetric history examine the complexity and dispersal of power and explore the underlying cultural belief systems or epistemologies forming the fundamental basis of modern medicine, shaping social and

professional relationships and medical practices (Papps and Olsen 1997; Murphy-Lawless 1998; Edwards 2005) as well as, importantly, the subjectivity of women. These critiques challenge the epistemological basis of obstetric hegemony and contest the neutrality of science and medicine. In examining the interweaving factors contributing to the rise of obstetric power; particularly the links between scientific ideology, the Cartesian understanding of the body, and the control of childbirth, these analyses of obstetric discourse reveal associations between obstetric hegemony and the production and dissemination of knowledge.

Anthropologists Robbie Davis-Floyd (1992, 1997, 1998) and Brigettte Jordan (1993) use the concept of 'authoritative knowledge' to describe the way in which a 'technocratic' model of birth acts as a 'cohesive and hegemonic mythology' shaping beliefs, practices, and behaviours. Authoritative knowledge develops over time and reflects power relations and material practices. It acts to marginalise and silence alternative knowledge and gains legitimacy because it seems normal, reasonable and common sense. We come to accept authoritative knowledge because it is prevalent, but we also actively and passively engage in its construction (Davis-Floyd 1997). Davis-Floyd (1998: 259-60; see also Jordan 1993) argues that contemporary obstetrics is a system created by both obstetricians *and* women, 'each of whom have much to gain from deconstructing organic childbirth and reconstructing it as technological production'.

In Western societies, authoritative knowledge regarding birth is primarily constructed by the obstetric profession; however, it reflects the fundamental doctrines of our culture. Thus, the *practices* involved in medical childbirth are ritualistic in that they symbolically reinforce the core values of Western 'technocratic' culture (Davis-Floyd 1992). These core values include: a Cartesian mind/body dualism; the enshrinement of 'rational' science; and the dependence on patriarchal institutions (Davis-Floyd 1992, 2001). As Davis-Floyd (1998: 257) explains:

> The intravenous drips commonly attached to the hands or arms of birthing women make a powerful symbolic statement: they are umbilical cords to the hospital. The cord connecting her body to the fluid-filled bottle places the woman in the same relation to the hospital as the baby in her womb is to her. By making her dependent on the institution for her life, the IV conveys to her one of the most profound messages of her initiation experience: in American

> society, we are all dependent on institutions for our lives. The message is even more compelling in her case, for she is the real giver of life. Society and its institutions cannot exist unless women give birth, yet the birthing woman in the hospital is shown, not that she gives life, but rather that the institution does.

Utilising the theoretical framework of symbolic anthropologist Peter Reynolds (1991), Davis-Floyd argues that technocratic culture privileges science and rationality. Technological 'progress' is therefore the ritual process of replacing 'nature', conceptualised as feminine, unsafe and primitive, with culture, conceptualised as 'advanced', 'safe' and 'male' (Davis-Floyd 1992; Fenwick 2009, see also Ortner 1972). This is described as the 'one two punch theory'. The basic premise, as Fenwick (2009; 107) explains, is that:

> The first punch destroys the natural process and then the second punch seeks to replace it with a culturally fabricated process. The new, supposedly improved process, becomes a representation of technocratic society's 'supervaluation' of science and technology over nature.

Childbirth is understood, then, as just one of the many 'natural' processes that technology can 'improve' upon. Moreover, as a rite of passage, childbirth indoctrinates society's newest members into this dominant culture and obstetricians act as the 'policemen' for this indoctrination (Davis-Floyd 1994). The technocratic model of birth, and the obstetric control of knowledge production and management of childbirth, persists because its fundamental principles are so closely intertwined with dominant Western cultural values. Thus, as Davis-Floyd's research with middle-class American women found, most birthing women speak in accord with, and have faith in, technocratic birth and authoritative medical knowledge. The production of obstetric knowledge and the maintenance of hegemony succeed because they intersect with and are reinforced by cultural factors.

Historians and social scientists have documented the historical evolution of obstetric knowledge and childbirth practices via discursive analyses of medical journals, government documents and other historical artefacts. This body of research lays out the inextricable link between obstetric hegemony and the rise of science and rational thought in the West (Rothman 1982; Martin 1989;

Papps and Olsen 1997; Murphy-Lawless 1998). This literature argues that obstetrics is a positivist science and thus, like other sciences, it aims to find objective, measurable facts in nature in order to 'tell the truth' – in this case about women's bodies (Murphy-Lawless 1998: 17). As Papps and Olsen (1997: 140) argue, medical knowledge incorporates only a *small* scope of knowledge about women's bodies and childbirth, yet monopolises and controls the 'social institution of childbirth'. It is able to do this because 'the power of medicine is still essentially linked to the systems of cultural belief a society has about what counts as valid knowledge'.

Analyses of the obstetric professions by sociologists Papps and Olsen (1997) in New Zealand and Murphy-Lawless' (1998) in the United Kingdom, argue that obstetric technical expertise superseded the older midwifery tradition of 'being with woman' through a complex milieu of discourses and practices closely following the Enlightenment era scientific revolution. They argue that doctors, later obstetricians, were able to claim sole responsibility for holding the specialised scientific knowledge constructed as being absolutely required for safely delivering babies. They were able to make this claim as a result of the status and authority associated with scientific knowledge, the construction of birth as inherently risky, and, as discussed earlier, the practical use of obstetric tools such as forceps. Papps and Olsen (1997) and Murphy–Lawless (1998) argue that the systematic campaign to gain control of childbirth relied on several *pre-existing* discourses, in addition to the medical profession's privileged gender and racial positions. Thus, the systematic discrediting of midwives, their knowledge, and their place in the arena of childbirth was made possible through the use of gendered ideology, for example the depiction of midwives as backward, 'incompetent' and dangerous compared to 'rational, modern men of science' (see also Rothman 1983, 2007). Simultaneously, birthing women were depicted as weak, unreliable and unable to give birth without medical assistance. The discursive formation of obstetric science, argues Murphy-Lawless (1998: 101), helped male midwives and physicians 'become the principle knowledge brokers of women's bodies'. However, ideologies readily existed at this time within society that legitimated their claims:

> …obstetrics interpreted and imbued the body with a set of significances that worked because there was ready legitimation for those meanings, the legitimation itself coming from a wider patriarchal order, which was working with newly emerging economic and political significances about the reproductive body (Murphy-Lawless 1998: 101-2).

Thus, as Papps and Olsen (1997: 150) argue, medical 'expertise', technological knowledge and gendered ideology 'produced a historically specific monopolisation of competence where the structures of disciplined knowledge, of power and of gender came to overlap and coincide'. Analyses of the history of obstetric hegemony demonstrate the significance of obstetric ideology's connection to wider cultural discourse and relations of power. Moreover, they demonstrate the way that construction of risk was crucial to the legitimisation of medical control; midwife-attended birth was constructed through medical and popular discourse as unsafe and risky (Papps and Olsen 1997: 153), a claim, as this thesis will demonstrate, that continues to be utilised by the obstetric profession today. In addition to the conceptualisation of risk, scholars argue that the production of scientific knowledge (which was ideological) about women's bodies and childbirth relied on dichotomised or binary thinking and the conceptualisation of the body-as-machine (Rothman 1983, 2007; Martin 1989; Papps and Olsen 1997; Murphy-Lawless 1998).

1.4. Cartesian metaphysics and the body-as-machine

Many theorists and philosophers have made clear the far-reaching and profound impact of Cartesian dualism on medical discourse and practice (Scheper-Hughes and Lock 1987; Martin 1989; Leder 1992; Williams and Bendelow 1998; Goldberg 2002). These theorisations argue that Descartes' distinction between soulless machine-like body and rational mind—'I think, therefore I am'—led to radically materialist thinking within most strands of Western medicine. Mechanistic conceptions of the body and its functions contributed to a failure to attribute 'mindful causations' to physical states (Scheper-Hughes and Lock 1987: 9). Medical philosopher Drew Leder argues that behind the development of modern medicine lies the 'epistemological primacy' of the 'dead Cartesian body' (Leder 1992: 21). Leder argues that Descartes' fixation with corpses and a conceptualisation of the body-as-machine during the scientific Enlightenment allowed nature to be philosophically reconceived as lifeless mechanism. The body, argues Leder (1992: 21), 'devoid of intrinsic subjectivity', could therefore be reshaped in a limitless fashion, facilitating the growth of medical technology. Technologies such as the stethoscope, x-ray and blood tests 'allow[ed] a kind of dissection of the living body, analysing it into its component parts, exposing what life ordinarily conceals' (Leder 1992: 22). The body of Western Cartesian medicine came to be interpreted, then, as merely an assemblage of material matter and

mechanical systems composed of cells, tissues and biochemistry (Goldberg 2002: 447). The metaphor of mechanical corpse permeates modern medicine as a 'methodological tool and regulative ideal' (Leder 1992: 22). In medical encounters, Leder argues, the living patient is treated as a cadaver, impassive and dehumanised, while the doctor has the role of explorer calling on the body to respond in mechanistic ways and using means that will alter the body 'as one would a mechanical thing, substituting parts, altering inputs and outputs, and regulating processes' (1992: 23; see also Armstrong 1983).

This Cartesian metaphysics had specific consequences for the development of obstetric knowledge, practices and contemporary maternity care. Feminist scholars of diverse backgrounds have made clear the ways in which medicine and science (re)produce cultural assumptions about women's bodies and sexuality, but present these assumptions as scientific 'facts'. Thus, socio-cultural meanings about women are 'inextricably linked' to medical and scientific discourses (Braun 2003: 7; Scully and Bart 1973; Jordanova 1989; Martin 1989; Jacobus et al. 1990; Shildrick 1997; Murphy-Lawless 1998; Braun 2003; Maher 2003; Edwards 2005). Western understandings about women's bodies have relied on the Cartesian philosophy in which the world is dichotomised into hierarchical binary oppositions; women are associated with nature, disorder and pathology, while the male body represents the machine-like, ordered, 'norm'. Obstetric science, like other sciences, placed women's bodies in the domain of the 'natural'. As part of nature, women's bodies were viewed as objects fit for discovery and, while all human bodies were likened to machines, the *female* body was perceived as a faulty and inherently inferior machine as a result of being 'irretrievably tied' to its reproductive functions (Shildrick 1999). Childbirth, therefore, was understood as both pathological and mechanical; as a failure of the machine (Martin 1989; Khan 1998).

1.5. The institutionalisation of obstetric knowledge: industrial childbirth

The epistemology of the body-as-machine, has informed the basis of obstetric practice historically (Oakley 1984; Martin 1989; Kahn 1998; Davis-Floyd 1992) and, according to several commentators, continues to do so today (Goldberg 2002; Kitzinger 2005; Goldberg 2008; Rothman 2007; Plante 2009). Anthropologist Emily Martin (1989) compared American maternity care to a Fordist production line; birth, she argued, is constructed in metaphors that reflect

production, using terms such as ‘efficiency’ or ‘inefficiency’. Labour, like factory work, is subdivided into many stages and each stage is supposed to progress according to pre-defined times; deviation from the assigned statistical rates can produce a ‘variety of disorders’ such as prolonged or arrested labours, which are then treated with pharmacological interventions aimed at enhancing productivity (Martin 1989: 59). The doctor is given the role of a ‘supervisor’ or ‘foreman’ who manages the labour and birth. According to Martin, the focus on the *product* of birth, takes focus away from the *experience* of the mother. Martin’s interviews with American women revealed birth experiences that were severely disrupted and highly controlled. More recently, obstetrician and social scientist Lauren Plante (2009), in her commentary on the rising caesarean rate in the United States, similarly makes a case that contemporary maternity care has become increasingly ‘industrialised’ as a result of the standardisation of obstetric practice. Industrialised obstetrics she argues, ‘strips the locus of power definitively away from women’ as

> .the definition of normal becomes narrower and narrower and toleration of deviance, ever lower. The final stage of this philosophy takes the process of birth away from the woman entirely and turns it into a surgical procedure performed by the doctor. Childbirth becomes a manufactured experience shorn of any real risk and any real power… (Plante 2009: 144).

Goldberg (2002) argues that modern hospital maternity wards inevitably reinforce a Cartesian model of the body and birth, in which the labouring woman is an object belonging to the health care expert (2002: 446). The extensive use of electronic foetal monitoring, oxytocic inductions, and epidural anaesthesia reduces women to the status of object ‘by enforcing a birth that is continually monitored by machines’ (2002: 448). For example, electronic foetal monitors centralise monitoring to computer screens in the nurses’ station, thus care providers no longer need to be with the labouring woman and she is increasingly viewed as merely a ‘body in which the foetus resides’ (Goldberg 2002: 448, see also Mitchell and Georges 1998; Kitzinger 2005; Wagner 2006). The caesarean is the ‘quintessential Cartesian act’ in which the pregnant woman is viewed as:

> [N]othing more than a body, to which an intravenous (IV) infusion is attached, a Foley catheter is inserted, and anaesthesia is administered. The operating

> room, no different than a morgue, is cold, sterile, and mechanistic. There is a machine that cuts, a machine that sews, and a machine that directs the procedures. (Goldberg 2002: 448).

Goldberg, a perinatal nurse, questions how as a health professional she is to connect to women as *embodied human beings*, rather than as merely the 'res extensa' (Descartes' corporeal matter) that women are invariably reduced to by birthing within the industrial techno model (2002: 449). The Cartesian schema separates not just body from mind, but mother from baby, reflecting contemporary discourses that separate the subjectivity of mother and child and puts foetus' rights ahead of mothers' rights (Beckett 2005; Davis and Walker 2008).

While the mechanical body has been the basis for obstetric conceptualisations and practices in regard to birth, there are critical alternatives to understanding the birthing body offered by feminist theorists, midwifery academics and other scholars (Marshall 1999; Goldberg 2002; Young 2002; Odent 2002; Gaskin 2002; Buckley 2005; Blythe 2005; Reiger and Dempsey 2006; Davis and Walker 2008; Foureur 2008; Down 2010; Lokugamage 2012). Rejecting the Cartesian schema and using evidence from neurobiology and emerging hormonal science, this alternative offers a humanist, embodied version of the birthing body that emphasises the complexity of the interaction between the social, emotional and physiological processes in childbirth (Reiger and Morton 2012). These alternative discourses have existed alongside and even within the obstetric system, sometimes stronger, sometimes more muted. I discuss this in more detail in the next chapter, but draw attention to this model of knowledge here to highlight the fact that the hegemonic construction of the birthing body does not go completely uncontested. Midwifery knowledge in particular draws on the ancient art of 'being with woman'.

1.6. Risk society and contemporary maternity care

Recently, scholars in the maternity care arena have argued that conceptualisations of risk play an increasingly pertinent role in discourses and material practices of childbirth, sustaining and strengthening obstetric hegemony (Possamai- Inesedy 2006; Weir 2006; Rothman 2007b; Benoit and Zadoroznyj 2010; Bryers and van Teijlingen 2010; Lane 2012; Coxon et al. 2012). The concept of a 'risk society', developed in the 1990s by sociologists including Ulrich Beck (1992),

Anthony Giddens (1991) and Zygmunt Bauman (1992) hold that late post-industrial modernities have given rise to increasingly risk-orientated societies. Risk society is the product of diminishing traditional social structures/institutions such as the nuclear family and the Church, which were previously able to mediate risk for us (Giddens 1991; Beck 1992; Bauman 1992). Innovations in science and technology, ostensibly meant to improve our lives, paradoxically led to new and increased risks and hazards as side effects — for example, climate change and increased carcinogens and pollutions in our environment. While science produces risk, it is also seen as the only legitimate definer of risks (Zinn 2008; Lane 2012). As Zinn articulates, the risks are real in the sense that they have real impacts, but the knowledge surrounding those risks are socially constructed through scientific discourse and then interpreted, mediated and regulated by governments, policy-makers, insurers and health-care professionals. At an internal level, risk society is transformative; guiding our actions, beliefs and social relationships (Beck 1992; Zinn 2008; Lane 2012). In risk societies, it is the responsibility of individuals to adequately mediate or negotiate risks by utilising 'rational' science-based, positivist thought and actions (Zinn 2008). As such, risk theorists such as Beck (1994, 1996), argue that the central 'problem' of post-industrial societies is not the production and distribution of goods, as Marxists held, but rather the prevention and minimisation of risk (Possamai-Inesedy 2006: 406).

In regards to childbirth and maternity-care, recent challenges and international struggles (c.f. De Vries et al. 2001) have centred on different interpretations of risk and safety, such as those evident in the 2008 Maternity Service Review in Australia, which I examine in Chapter Four. Modern obstetric-led maternity care classifies women as either high or low risk (never no risk) and these categories have shifted over the years so that the high risk category incorporates a larger and larger array of not only physiological factors, such as presence of gestational diabetes, but also social and other characteristics of individual women, such as age (Rothman 2007b: 30-31). For example, in the 1970s amniocentesis was only recommended for women over the age of 40, but is now recommended for women 33 and over (Rothman 2007b: 31).

The shift from industrial to risk-averse post-industrial societies coincides with the shift from a social model to a medical model of birth; risk management has thus become a 'central tenet' of maternity care (Bryers and van Teijlingen 2010; see also Coxon et al. 2012) and one that

obstetrics has been able to socially shape (Weir 2006; Bryers and van Teijlingen 2010; Benoit and Zadoroznyj 2010; Lane 2012). Scholars using a risk society analysis of maternity care and childbirth argue that, while in the early 20th Century risk management in childbirth was seen as a state responsibility (the focus was on population growth and reducing infant mortality), in contemporary societies, risk management has become individualised as responsibility has shifted from governments to consumers of maternity care (Weir 2006; Benoit and Zadoroznyj 2010; Bryers and van Teijlingen 2010; Lane 2012). For instance, empirical research examining decision-making around caesareans in Australian hospitals suggests that decisions by women and care-givers are based on the neoliberal obligation to manage risk and 'choose' what is (medically constructed) as the safest, most sensible option — caesarean (Bryant et al. 2007). The transformative nature of risk society means that women incorporate risk management as part of their pregnancy and birth experiences and must negotiate the anxieties constructed by risk culture, by making 'rational' decisions based on the 'evidence' provided to them by their caregivers (Weir 2006; Downe and McCourt 2008).

Lane (2012) and Lane and Reiger (2013), using Crook's (1999) thesis, argue that there are different risk regimes or 'dreams of order' present in contemporary maternity care practices and policies: modernist, hyper-reflexive, and neo-traditional. While arising from different historical eras, these risk regimes exist and compete simultaneously. A modernist risk regime reflects the Fordist, mechanical model of birth as described by feminist scholars (Oakley 1980; Martin 1989; Kahn 1995 for instance), where risk is seen as residing in women's bodies which are always in danger of 'malfunctioning' (Lane and Reiger 2013:8). Historically, these risks were managed paternalistically by obstetricians who were able to use their specialised knowledge, based in rational and objective science, to mitigate the inherent risk associated with childbirth. Modernist hospitals were overly bureaucratic, patriarchal and everyone 'knew their place' (Lane and Reiger 2013:8). A 'hyper-reflexive' risk regime of childbirth reflects neoliberal market principles and the dispersal of power and responsibility; there is a greater emphasis on self-monitoring and on the role of consumers in responsibly negotiating and managing risk, and subsequently modifying their behaviour in accordance with expert advice.

Lane and Reiger (2013) argue that hospital management under hyper-reflexive risk regimes is more dispersed and less hierarchical, but medical hegemony has nonetheless been able to continue. For instance, several scholars point to the recent restructuring of maternity services in Canada, the United Kingdom and Australia as having challenged ingrained medical hegemony by placing emphasis on alternative midwifery models of care and the 'normalisation' of childbirth. However, the structural 'embeddedness' of medical hegemony in the maternity system has been hard to shift and has largely remained intact (Benoit and Zadoroznyj 2010: 480; Bryers and van Teijlingen 2010; Lane and Reiger 2013). Lane (2012) argues that this is because, over the course of the last century, Australian obstetricians have been better able to convince governments that they are superior 'risk managers' compared to midwives (see also Schofield 1995). In the contemporary era of 'hyper-reflexive' risk management, care-givers must utilise 'evidence-based medical and technological practices to manage the intensified demands of accountability common to neoliberal regimes' (Lane and Reiger 2013: 9).

Evidence-based medicine (EBM) emerged in the early 1970s and the field of obstetrics was, famously, the last of the medical disciplines to incorporate it into their practices after being awarded the 'wooden spoon' for being the worst health care discipline in terms of evaluating their practices (Enkin 2006; Downe 2010). The *Cochrane Collaborative Database*, a summary of all existing evidence in a field, was designed to help health care professionals decide on the best and most effective treatment. It was developed in the mid-1980s and these summaries eventually became protocols and guidelines for 'effective care' (Enkin et al. 2000). Governments and hospitals saw EBM as a way to effectively minimise and protect against litigation risk, while some consumer advocates, midwives and even medical critics saw its potential to challenge routinised obstetric practices that were harmful to women (Goer 2005; Enkin 2006; Wagner 2006; Akirch et al. 2012). However, Reiger and Morton (2012) argue that there is now growing contention about the use of EBM as a method of improving maternity care, particularly in the way evidence is produced and interpreted and the way in which practices are implemented, such that the EBM appears merely to reflect the interests of the obstetric profession. Moreover, there are concerns that what constitutes 'good' evidence remains linked to positivist, biomedical forms of knowledge, thus reinforcing obstetric hegemony (Wendland 2007; Plante 2009; Downe 2010; Reiger and Morton 2012). Although perceived as objective, critics argue that EBM is socially

constructed knowledge and, as a product of positivist Western scientific knowledge, it assumes authoritativeness and neutrality and claims to establish the 'truth'. EBM privileges scientific knowledge and scientific methods (predominantly the randomised controlled trial) and applies population-based responses not suited to the complexity and individuality of the needs of birthing mothers (Downe 2010). Moreover, as Wendland (2007: 219), a practising obstetrician and anthropologist, argues in relation to caesarean and breech birth debates, the production of 'evidence' itself is inherently flawed and fails to see the biases and vested interests at stake in the way that data is chosen, collected analysed, published and selected for public consumption (see also Goer 2002).

1.7. Contemporary challenges to obstetric knowledge and practice

Loosely comprising of consumers, researchers, midwives and other health care professionals, the 'normal birth movement', as it is now commonly called (De Vries et al. 2001; Reiger 2001; Romano and Lothian 2007; Reiger and Morton 2012), promotes normal physiological birth, contests the obstetric knowledge base, calls into question routine maternity-care practices seen as being harmful to women and babies, and draws attention to the material interests and professional conduct of the obstetric profession. Akirch et al. (2012: 1) reviewed and analysed the activities of childbirth advocacy and activist organisations in four countries (the United Kingdom, Ireland, France and Portugal) and concluded that 'knowledge-related activities are central' to the activism of these groups. Producing evidence to counter the normative claims of medicalised births in the way of surveys and statistics, and using scientific evidence to destabilise obstetric practices (Akirch et al. 2012), are some of the ways the normal birth movement is able to challenge obstetric hegemony in childbirth. This social movement has made considerable progress in 'normalising' childbirth and providing alternatives to the 'industrialised' (Plante 2009), highly controlled, obstetric-dominated maternity systems, gaining the support of governments in the United Kingdom and Australia, particularly as they are recognised as cheaper and safer models (De Vries et al. 2001; Hatam et al. 2008; Davis-Floyd et al. 2008; Reiger and Morton 2012; Akirch et al. 2012). Moreover, in several countries, including the United States, New Zealand, Canada and Australia, midwifery as a profession has become more politicised over the last 20

years, staking a claim on normal birth by arguing that their professional expertise should allow them, rather than obstetricians, 'autonomy over physiological normal birth' (Reiger 2010: 6; see also Bourgeault et al.2004).

Over the last decade, the emerging critique of obstetric hegemony has centred on the rapid rise of caesarean rates in the Western world. Mounting evidence shows caesareans being linked to higher maternal mortality rates (Romano and Lothian 2007), as I will discuss in Chapter Three. Obstetric organisations worldwide justify the increase by holding middle class women responsible for supposedly frivolously requesting caesareans in the absence of medical necessity, or, in arguing that contemporary women *need* caesareans more than ever before due to increasing maternal age and pathology (May et al. 2007; McCourt et al. 2007). However, research suggests a more complex set of cultural and professional factors are at play; a combination of risk-averse obstetrics, fear of litigation, the 'cascade of intervention' (Wagner 2006; Romano and Lothian 2007), low rates of vaginal birth after caesarean (VBAC) and a fear of vaginal birth all contribute to higher rates of caesarean births (Declercq et al. 2004; Declercq and Norsigian 2006; Gwande 2006; O'Leary et al. 2007; Savage 2007; Goldberg 2008; Bourgeault et al. 2008; Bryant et al. 2007; Weaver et al. 2007; Kalstrom et al. 2010; Mazzonni et al. 2010; Miller et al. 2011). However, the obstetric profession is reluctant to take any responsibility for the increases, some even arguing that caesarean birth is superior to vaginal birth (Douché 2007).

Attention has also been drawn to the profession's 'tribe mentality' (Wagner 2006) in which loyalty to the profession can sometimes outweigh loyalty to caring for mothers and babies (Goer 2002; Perkins 2003; Wagner 2006; Savage 2007; Reiger 2010). Reiger (2010) examined obstetric controversies in Ireland and Australia, arguing that while individual doctors might hold commitment to caring for women and babies, 'obstetrics is clearly about more than what individual obstetricians *do* in their clinical roles and professional practice' (2010: 7) According to Reiger, while the obstetric profession has carefully constructed itself as 'knights on white charges responsible for saving women and babies from the intrinsic dangers of childbirth' (2010: 7), in recent years important critics either within or close to the profession have begun to dispute this 'heroic' narrative of medical achievement, arguing that the profession has been slow to respond to evidence based practice and has operated with a tribe mentality that sometimes even puts

women's lives in danger (Reiger 2010; see also Perkins 2003; Wagner 2006; Savage 2007). Marsden Wagner, advocate and non-practicing medical doctor, similarly suggests the profession is self-interested and does not always have the best interests of women and babies in mind. He refers particularly to the Cytotec scandal that was responsible for the death and injury of many mothers and babies in the 1990s (Wagner 2006).

Epidemiologist and birth activist Henci Goer (2002) argues that American obstetricians reacted to the internal and external criticisms aimed at them during the 1980s and 1990s by way of an organised public relations campaign, analogous to the tactics of cigarette companies in the 60s. The American College of Obstetricians and Gynaecologists (ACOG), according to Goer, sold the American public 'the idea that obstetricians are heroes, selflessly doing their best against difficult odds to safeguard the health and wellbeing and protect the interest of women and babies' (2002: 1). She asserts that the profession has been able to control the research and publications in medical journals to their own interests. In particular, editorial of the prominent and prestigious *New England Journal of Medicine* has been controlled by members of ACOG who interpreted medical research — especially in regard to the safety of VBAC (vaginal birth after caesarean) versus elective caesarean — according to their own professional interests (Goer 2002; see also Michal et al. 2011; Olsen 2011; Leeman and Plante 2006; Plante 2009). In Australia, too, it has been shown that the national medical union (the Australian Medical Association) presented data on the safety of homebirth in a way that would support their point of view (Sweet 2010; Homer and Broome 2011), as will be discussed in Chapter Five.

To sum up, early feminist analyses show that the medical 'co-option' of childbirth was strategically motivated by both financial incentive and as a reflection of broader cultural values regarding women's roles and reproductive processes. The 'redefinition' of childbirth into a dangerous, pathological event has ensured the continuing control of childbirth beliefs and practices by the medical profession. This has been viewed as detrimental to women , producing maternity care akin to a 'production line' in which women have little agency or control (even if some women feel they are able to negotiate obstetric hegemony to their own benefit). Historical analyses of obstetric discourse and practice reveal that the fundamental core of the obstetric profession, and thus its knowledge, is based on a Western, patriarchal, Cartesian epistemology

based on binary oppositions that position women as inferior, is reliant on 'rational science' and assumes an understanding of the body-as-machine. The construction of risk has been pertinent to the continuing power of obstetric knowledge, particularly recently in the context of an increasingly risk-orientated society and neoliberal governance of maternity-care at a state and hospital level (Possamai-Inesedy 2006; Reiger 2006; Weir 2006; Lane and Reiger 2013). The intersection of obstetric discourse with notions of risk, and of neoliberal consumer choice in the Australian context needs further examination and analysis, and this is what I set out to do in this thesis. The concept of hegemony is crucial to my interpretation of the Australian, and broader, system of medical power in childbirth. As such, I now turn to examine the concept of hegemony more closely.

1.8. Theorising obstetric power and hegemony

Hegemony refers to a process of power relations that occur not by force, but through political and ideological leadership (Gramsci 1971; Hall 1977; Simon 1982). Hegemonic rule, therefore, refers to the way a group is able to gain and maintain the consent of another group by way of political and ideological struggle. The concept of hegemony arose within the Marxist tradition of political theory, developed by Italian political theorist Antonio Gramsci (1971) in his *Prison Notebooks*, and further developed by Marxist theorists such as Stuart Hall (1977) and Laclau and Mouffe (1985). In recent years, some theorists have questioned the continued relevance of a concept of hegemony to the analysis of contemporary social and political relations, favouring instead a post-structuralist conceptualisation of power (Lash 2007). However, I shall argue that a concept of hegemony is vital to the understanding of continued obstetric dominance and control of maternity services and childbirth discourses, at least in Australia. I draw particularly on Laclau and Mouffe's concept of hegemonic articulation (1985) and contemporary re-workings of the concept of hegemony in discourse by scholars such as Howarth (2010), Mumby (1997) Fontana (2008) and Waitzkin (1989).

The concept of hegemony can be used as a tool through which to understand society 'in order to change it' (Simon 1982: 22). For example, Mumby describes hegemony as 'a means to

understand the processes through which certain conceptions of reality come to hold sway over competing worldviews' (1997: 343). While Gramsci's focus was on class struggle, it is now understood that there is no monocultural notion of hegemony;

> The usefulness of a concept of hegemony is not strictly dependent on Gramscian economic class-based cultural economics…but on how the concept can reform or be reformed in theoretical practice (Hearn 2004: 65).

Thus the theoretical framework has been applied to other areas of sociological inquiry in order to understand how a group or alliance of groups is able to dominate practices, beliefs and discourses through ideological hegemony (Waitzkin 1989; Gange and McGaughey 2004; Hearn 2004). Hearn, for example, puts forth a framework for using hegemony to understand masculinity; here hegemony is understood as the 'political techniques of a patriarchal social order' (2004: 57) as opposed to the capitalist social order. These operate through mass media, advertising, laws, as well as material practices. Hegemony is further understood as a continuing process or 'historical situation': a dominant group must already hold ideological leadership before gaining power, but in order to preserve 'institutionalised power' it must always maintain this leadership through the process of knowledge production and dissemination (Hearn 2004; Fontana 2008; Howson and Smith 2008). Thus, hegemony is a process of struggle 'over systems of meanings' (Mumby 1997: 364) that is always unfinished (Stoddart 2007: 202). Fontana (2008: 100) describes hegemony as being

> …directly related to the mechanisms and processes by which knowledge and beliefs are first produced, and second, disseminated. Here is the crux of the formation of a 'conception of the world' and its dissemination throughout the people. A conception of the world (an ideological system of beliefs) is always opposed to different conceptions of the world. Thus, these are constantly in conflict, in a 'battle' against each other, and the hegemonic conception is one that has become the 'common-sense' of the people. But a counter conception is constantly generated even if only embryonically, to challenge the prevailing common-sense.

Hegemony is therefore always contested and challenged and, although it appears stable (Hearn 2004; 58), it 'embodies simultaneously processes of *domination and resistance'* (Mumby 1997: 356, my italics). Thus, the theory overcomes the problem of 'false consciousness' inherent in a Marxist concept of power (Purvis and Hunt 1993; Mumby 1997). This is because, as Mumby articulates, it 'recognises *both* the possibilities for change *and* the tenacity of the dominant hegemony that resists such change' (1997: 366, original italics).

According to Gramsci (1971), the manufacture of consent largely occurs in the realm of civic society; through churches, schools, mass media, and family and so on. Hegemony is a powerful form of social control because of the subtle nature of the ways in which dominant ideologies appear as 'common sense' or popular views of the world (Gramsci 1971; Hall 1977). These common sense views (ideologies in disguise) represent *and* legitimate existing social relations (Hall 1977; Waitzkin 1989; Purvis and Hunt 1993; Fontana 2008). For example, as Waitzkin points out, science is 'ideology par excellence precisely because it claims to be above ideology' — neutral, objective and universal (1993: 224; see also Willis 1981; Purvis and Hunt 1996). Gender norms can also be seen as ideological because they appear to be commonsensical and natural, but actually legitimise existing relations of power and dominance (Weedon 1999; Hearn 2004). Thus, hegemony is not just a theory of dominance of one group over another; rather, it is a:

> … reading of the dialectical struggles over meaning that occur in the various realms of civil society and therefore every social actor engages in this process, if only at the level of 'common-sense' (Mumby 1997: 364).

Gramsci insisted that hegemony had a material dimension and was not only a cultural system or structure. It is lived and produced via everyday experiences and social interactions. Thus, as Stoddart writes, 'this illustrates how hegemony works as a sort of common sense, rather than as coherent body of thought, such as we would associate with [a Marxist concept] of ideology' (2007: 202).

Throughout this thesis, ideology is used in terms of a system of thought, while discourse refers to discussion that surrounds it or legitimises certain ideologies. To simplify, discourse is ideology

expressed (van Dijk 2006: 118), and ideology is therefore an effect of discourse (Stoddart 2007: 193). I do not use the term ideology in the Marxist sense, in that there are no 'true' or 'false' ideologies, and I do not suppose that ideologies are born (solely) of the relations of production and economic structures (Laclau and Mouffe 1985; van Dijk 1996: 245; Purvis and Hunt 1993). As Stoddart (2007: 200) explains, the use of the concept 'ideology' was reinterpreted by Gramsci, who rejected the totalising model of ideology used by Marxists. I use Gramsci's (1971) Laclau and Mouffe's (1985), Purvis and Hunt's (1993), van Dijk's (1995, 2006) and Stoddard's (2007) interpretation and explication of the terms ideology and discourse. These scholars identify ideology as shared belief systems or 'socially shared interpretive frameworks' (van Dijk 1995: 245) that define the basis of a social group, community, profession, organisation or culture's identity, discourses and practices. Van Dijk claims that ideologies are socio-cognitive; that is, they are the interface between the social and the cognitive. Ideologies are social in that they are politically related to social structures and social relations of power, and cognitive, in the way they relate to thoughts, values, beliefs and ideas. Moreover, ideologies have several social functions; predominantly, they organise social representations and are the basis of the discourses and practices of a social group, community, profession etcetera. However, members of an ideological group, community or profession assume themselves to be non-ideological, and thus their knowledge is taken for granted (van Dijk 2006: 122). Ideologies may function to legitimate domination, but can also define resistance or contestation to power (van Dijk 1996, 2006). In terms of childbirth then, ideologies of medicine and science have both informed the discourses and practices surrounding maternity care and childbirth knowledge. Other, less dominant ideologies arising from feminists, midwives, consumers also shape discourses around childbirth.

1.9. Post-Structuralist understandings of knowledge and power

A Foucauldian perspective similarly understands power as relational, invisible and as being constituted through the production and dissemination of knowledge (Weedon 1999). Power is undetectable, insidious and is not held by any one group but rather operates through discourses and practices usually attached to institutional knowledges, and are always contested by alternative knowledges. Discourses not only produce knowledge and power but also constitute subject positions and give meaning to bodies and social relations (Foucault 1975; Armstrong

1983; McNay 1992). For Foucault, the body is site of political and ideological control and surveillance; medicine is just one social institution through which meaning about bodies is created and defined (Foucault 1975; Lupton 2003: 25). The development of medical practices and technology in the late 18th century, such as routine physical examination and use of the stethoscope, the microscope and post-mortems, 'all served to increasingly exert power upon the body' (Lupton 2003: 26). Simultaneous with these innovations in practices was the increasing surveillance and regulation of bodies via other social institutions, such as schools and prisons. Foucauldians reject the idea that power is coercive, or exerted by one dominant group over less dominant groups. Rather, power is everywhere and enforced by all in a society, not just those in positions of authority. So, for example, in the medical encounter, doctors and patients share the same faith or belief in the necessity of invasive techniques and constant monitoring because that is what 'people have been socialised to expect' (Lupton 2003).

Both a theory of hegemony and a Foucauldian understanding of power challenge the idea that power is achieved through coercion or force. Instead, power is understood as operating through ideologies or discourses which become 'commonsensical' and therefore invisible. Both theories give prominence to semiotics and understand that subjects are constituted through ideology and expressed in discourse (Purvis and Hunt 1993). Discourses, according to Purvis and Hunt, have ideological *effects*, by reinforcing, re-enacting and reproducing, unequal power relations. Discourse is ideological through its 'connection to systems of domination' (Purvis and Hunt 1993: 497). While Foucauldian analyses of medical power have been pervasive in the sociology of medicine field, Gramscian accounts have been less so (Waitzkin 1989). However, some theorists point out that Gramsci's concept of hegemony and a post-structuralist, Foucauldian concept of power can intersect and complement each other (Smart 1983; Purvis and Hunt 1993; Gange and McGaughey 2004; Matsuda and Ohana 2008; Fontana 2008; Eckers 2008). As such, in the following analysis I utilise both Foucaldian and Gramsican frameworks to understand elements of obstetric power.

1.10. Studying hegemony and discourse

In relation to the medical domination/control of childbirth, the concept of hegemony seems appropriate to understand the manner in which medical constructions of childbirth came to be

accepted as ‘common-sense’ as well as providing an understanding of how this ‘worldview’ is maintained through the production and dissemination of knowledge shaping contemporary discourses. This thesis attempts to understand how consent is ‘manufactured’ or, as Kitizinger et al. (2006) asked, ‘why do women go along with this stuff?’ The obstetric conception of childbirth is never stable—it is continually contested and competes with alternative understandings, in particular with midwifery knowledge and practice. In light of the above, obstetric hegemony can be viewed as existing alongside competing ideological frameworks and discourses. Feminist and midwifery bodies of knowledge both strongly contest the obstetric viewpoint. Laclau and Mouffe (1985; Laclau et al. 1999) describe the process of hegemonic articulation as competing discourses functioning to give meaning to and achieve dominance in a discursive field. Dominant discourses repeated in media, policy and every day interactions become hegemonic as other discourses are neglected or deliberately repressed and become marginalised. Hegemony, they argue, involves competition between different ‘political forces’ to gain maximum support for their ways of making meaning (Laclau and Mouffe 1985).This thesis, then, argues that obstetric discourse marginalises other ways of understanding childbirth because it works with other powerful contemporary discourses, such as neoliberal discourse, consumerist notions of free-choice, and risk-society discourses. Obstetric ways of understanding childbirth thus become common- sense and seemingly unquestionable.

The methodological framework employed in this thesis is critical discourse analysis (CDA). Wodak and Meyers (2009: 27) note that CDA does not have “well-defined empirical method but rather [it is] a bulk of approaches with theoretical similarities”. However, it usually includes strategies that involve an analysis of common texts such as media and political discourse. A CDA framework focuses on the ‘role of discourse in the (re)production and challenge of dominance’ (van Dijk, 1993) and seeks to make transparent the workings of power and ideology in discourse (Wodak and Meyer, 2009). According to a CDA framework, dominance is achieved through the reproduction of discourse in strategic ways in order to both maintain hegemony and influence common thought processes, opinions and actions. CDA offers a framework for highlighting the covert ways in which power and ideology operate through discourse in complex and nuanced ways to uphold hegemonic social relations. Unlike other forms of discourse analysis, it has a specifically emancipatory component in that it aims to transform inequality and power relations

by ‘critical[ly] linking language, ideology and social change’ (Marston 2000: 351). As Lazar (2005) points out, CDA is not textual deconstruction for the ‘sake of it’ but covertly aims to affect social transformation (2005:5).The central precept to a CDA analysis is the role of ideology or ‘common-sense assumptions’ (Fairclough, 2001) and their link to power. Discourses have simultaneous functions as texts and as producing social practices (see also Foucault 1975). Therefore, as Fairclough (2001: 19) educes, language activity is not just a ‘reflection or expression of social processes and practices, it is *part* of those processes and practices’. Textual analysis is therefore only part of the discursive analysis in CDA; also important are the *processes* of production and interpretation and the *contexts* in which they are produced and interpreted. Van Dijk (1993: 255) suggests, ‘power elites’ like doctors have greater access to institutional power and knowledge and to ‘symbolic power’ linked to their social status, have more access to discourse, including the popular media, and therefore literally ‘have more say’. For example, obstetricians have symbolic power which is related to their privileged social position as doctors, to their historical dominance over maternity care provision and birth knowledge, as well as institutional power through their powerful professional organisations.

After having established the theoretical and analytical framework, in the following chapters, this thesis examines the production of discourse by the obstetric profession, paying particular attention to the way in which other institutions (such as the media) interpret these discourses, but also the way they are contested/challenged. In the next chapter, this examination begins with a focus on the production of obstetric knowledge in the context of the production of obstetricians, by analysing the content of obstetrics textbooks currently used in Australian universities.

Chapter Two

Delivering Knowledge: Re-visiting obstetric textbooks

Previous feminist analyses of obstetric textbooks drew attention to an understanding of childbirth based on the conceptualisation of the body-as-machine, which obscured women's subjectivity and constructed childbirth as a medical event (Martin 1989; Kahn 1992). Other analyses additionally argued that there was a hidden ideology of paternalism, sexism and biological-determinism in obstetric and gynaecological textbooks of the 1970s to 1990s (Scully and Bart 1973; Koutroulis 1990; Kahn 1992). The following chapter critically examines contemporary obstetric textbooks used in Australian universities and recommended by the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG). The goal is to determine whether there are any similarities or differences from previous feminist enquiries of obstetric texts (Scully and Bart 1973; Martin 1989; Koutroulis 1990; Kahn 1992). Like Koutroulis (1990: 74), the analysis aims to 'produce a reading of the hidden ideology' within the textbooks. However, I do not wish to imply any 'conspiracy' on behalf of the individual authors involved in the writing of the text books. As Koutroulis (1990: 75) points out, the authors' work is 'a product of their social location within society' as well as being a product of their professional habitus. Moreover, while textbooks are not the only site in which obstetricians gain knowledge and enculturation of the obstetric field, the texts do nevertheless give an insight into the manner in which obstetric knowledge is produced. Thus, this analysis is not a critique of the technical aspects of the profession per se, nor an attack on obstetric expertise. Rather, it is a challenge and critique to the *epistemological foundation* of contemporary obstetrics.

The analysis is based on an examination of 15 obstetric textbooks currently used in Australian universities. The books were published between 1996 and 2007 and are drawn from the recommended reading lists at a sample of Australia medical schools, including at Monash University, Flinders University, The University of Melbourne and the University of New South Wales, for the year 2007. The most recent edition of each text was used. The text books are also recommended and advertised through the RANZCOG online bookshop. This analysis was conducted in 2007/2008, and in 2012 I confirmed that the same texts books remained in use. Six of the texts were written and published in Australia, five in the United Kingdom and four the

United States. The texts varied in style and content; some were solely obstetric-based and focused on labour and birth, others on pregnancy, labour, birth and the post-partum period, and 9 books were for both obstetrics and gynaecology students and therefore included the entire female reproductive spectrum. I specifically examined the chapters on labour and birth, but also, where appropriate, other sections such as the chapters on anatomy and prenatal care. I did not examine sections on gynaecology where the text was an obstetric and gynaecological book. I did not examine the content on caesarean or abnormal birth, as I was primarily interested in understanding how normal labour and birth are constructed. A content analysis utilising a critical discourse analysis framework was undertaken by looking for the language and metaphors used, in order to make apparent the contemporary obstetric understanding of childbirth. I argue that, in comparison to previous analyses of obstetrics and gynaecology texts (Koutroulis 1990), there is now *some* attention given to the role of socio-cultural factors in the experience of childbirth. There is an awareness and respect of women's autonomy, choice and 'comfort' in the current books that was missing from earlier texts. However, the subjectivity of women and experiences of birth remain largely absent, and mechanical metaphors of childbirth and women's bodies prevail.

2.1. Are current textbooks sexist?

While the primary aim of this analysis is to demonstrate the obstetric conceptualisation of childbirth and the birthing body, it is worth taking some time to explore the texts' representations of women more generally. Scully and Bart's (1973) analysis and Koutroulis' (1990) replication of their study, found that obstetrics and gynaecology text books had a 'hidden curriculum of sexist, patriarchal ideology' (Koutroulis 1990: 81 see also Kahn 1995) and biological determinism. There was some evidence in the current texts of similarly sexist stereotypes and heteronormative assumptions about women's sexuality and anatomy.

In illustrations of reproductive anatomy, for example, the genitals and the vulva/pubic areas were always white, pubescent and hairless and three textbooks did not include the clitoris in illustrations of the reproductive organs. Four books describe the female reproductive organs and genitals in a heteronormative, masculinised framework. For instance; the labia majora and clitoris are described as being 'homologous' to the male scrotum and the penis, respectively. The clitoris

is described as 'rarely exceeding 2 cm in length' and its capacity for pleasure or orgasm is omitted in all but one book (Symonds and Symonds (2003) *Essentials in Obstetrics and Gynaecology*, herein referred to as *Essentials*). The vagina's 'primary purpose' according to *Obstetrics and the Newborn: an Illustrated Textbook* (Beischer 1997, herein referred to as *Obstetrics and the Newborn)* is as a 'receptacle for the male penis during coitus' (1997: 20). This description of the vagina was present in Koutroulis' (1990) analysis of an older edition of the same textbook. As Koutroulis (1990: 79) points out, the vagina's function as a passage for menstrual blood and its vital function as a birth passage is not mentioned: this is a particularly striking omission given it is an obstetric text book.

Gendered stereotypes of women are also a feature of *Obstetrics and the Newborn.* For example, women were always presented as married and heterosexual (one other text also makes this assumption) and its pre-natal section on doctors' advice to women about what to bring to hospital when in labour included such items as 'make-up' and a 'sewing kit'. Moreover, a degree of paternalism is apparent; the author frequently implies that pregnant women are passive, vulnerable, indecisive, unreliable and prone to hysteria (c.f. Oakley 1980). For example, in the section on pre-natal care, it states that an obstetric history must be ascertained, however 'in many cases the woman is vague about the history, not having been told the details or understood the explanation provided' (Beischer 1997: 59). Paternalism and moralism is also expressed in the text's emphasis on the importance of imparting pre-natal care to women, including 'proper' hygiene, diet and sleep, and the advice that the obstetrician should 'critically review' the obstetric history to assess the woman's 'health consciousness' and ascertain her level of 'risk' (Beischer 1997: 63). This is indicated by 'diet, exercise, social risk-taking (sex, drugs), medical and dental preventative treatment including immunisations' (Beischer 1997: 63-64).

For the most part, unlike earlier analyses, the contemporary textbooks I examined do not have a 'hidden' sexist agenda nor are they wholly paternalistic or steeped in biological essentialism (Koutroulis 1990). On the contrary, the majority of books emphasise the importance of recognising women's autonomy, the importance of treating women with compassion, and understanding and respecting socio-cultural, sexual, and ethnic diversity. Some texts devote more space to these issues than others though; while two of the Australian textbooks (Finn et al. (2005)

Women's Health: a Core Curriculum and O'Connor and Kovacs (2003) *Obstetrics, Gynaecology, and Women's Health*) had entire chapters on the social aspects of providing women's health care, including attention to gender, other texts had but a single sentence. These issues are discussed further below. The acknowledgement of women's autonomy and differences does not mean, however, that the textbooks are women-centred. As I will now demonstrate, women as *embodied, active subjects* are almost entirely missing.

2.2. The 'powers, the passages and the passenger': the mechanics of birth

Like previous analyses of obstetric text books (Martin 1989; Kahn 1995) current textbooks continue to use mechanical metaphors and analytical language to describe both the processes of labour and birth as well as the birthing body itself. All texts have a heading in the labour and birth section titled 'the mechanisms of normal labour and birth' describing the foetus' movements through the birth canal. Eleven of the 15 books described the birth process as a matter of automatic mechanical interaction between three autonomous functions: the 'powers'— the uterine contractions; the 'passages'—the pelvis and vaginal canal; and the 'passenger'—the baby/foetus:

> The ability of the fetus to successfully negotiate the pelvis during labour and delivery is dependent on the complex interaction of three variables: the powers, the passenger and the passages.
> *Obstetrics: Normal and Problem Pregnancies* (Gabbe et al. 2002: 181)

> The uterus and cervix are an active unit of muscular power providing the force by which the fetus (passenger) is pushed through the pelvis (passage). Secondary powers in labour… put pressure on the rectum [producing] a sensation that results in the expulsive bearing down exertion.
> *Handbook of Obstetrics and Gynaecology* (Leader et al. 1996: 155)

> There is interplay between the 'powers' of the uterus (the contractions), the 'passages' of the birth canal (the bony pelvis and soft tissues of the pelvic floor and perineum) and the 'passenger' (the fetus).
> *Obstetrics by Ten Teachers* (Baker 2006: 220)

> Factors that can delay or prevent [the foetus' journey through the birth canal] are the shape of the pelvis (passages), the size of the fetus (passenger) or the quality and frequency of the uterine contractions (powers)
> *Fundamentals of Obstetrics and Gynaecology* (Oats and Abraham 2004: 55)

Mechanical words such as expel, expulsion, propel, forces, surges and efficiency feature frequently in the majority of texts. Thus, labour and birth are described as seemingly automated processes occurring in order to 'expel' the 'product' of pregnancy, and without any subjective involvement of the mother:

> Labour is the expulsion of the fetus and placenta from the uterus…the fetus is propelled down the birth canal by the action of the myometrium
> *Lecture Notes Obstetrics and Gynaecology (*Hamilton-Fairly 2004: 157)

> Labour is defined as the process in which the fetus, placenta and secundines are expelled from the birth canal. The process of labour is to some extent a matter of mechanics- the negotiation of the birth canal by the foetus, the propulsive force being the myometrial motor
> *Obstetrics and the Newborn: An Illustrated Text* (Beischer 1997: 391)

> Labour and Childbirth is the process whereby the fetus and placenta are expelled from the uterus by coordinating myometrial contractions….uterine contractions propel the baby downwards through the dilated vagina and overcomes the resistance of perineal muscles …at the height of each bearing down effort the total force exerted in the fetus is approximately 2kg/cm …a force propelling the head downward.
> *Llewellyn -Jones' Fundamentals of Obstetrics and Gynaecology* (Oats and Abraham 2004: 55).

Echoing Emily Martin's 1989 analysis, *Essentials* (Symonds and Symonds 2003: 150) uses Fordist metaphors of production in referring to the baby as a product; '….products of conception are expelled from the uterine cavity'. The uterus, cervix, and pelvis are the central subjects in the

description of labour and birth; women are largely absent as active participants in the birth process while the foetus is but a passive 'passenger'.

Other areas of medicine have moved on from mechanical paradigms, for instance in the area of immunology, Emily Martin has pointed to the use of alternative metaphors that invoke a post-modern sense of the body as flexible and interactive, as a system of networks (Martin 1992). There was some evidence of the flexible, post-modern body metaphor in contemporary obstetric textbooks, particularly in two descriptions of how labour is initiated. *Women's Health: a Core Curriculum* (Finn et al. 2005, herein referred to as *Women's Health*) an Australian book for medical students and midwives and written in collaboration between eleven Australian medical schools; and *Dewhurst's Textbook of Obstetrics and Gynaecology* (Edmonds 2007, herein *Dewhurst's*), a British book. Vollenhaven and Finn, in *Women's Health*, define labour as:

> . [R]egular uterine activity that results in progressive cervical dilation. The anticipated outcome of a normal labour is the vaginal birth of a full-term, healthy infant to a healthy mother… Giving birth is a most significant event in a woman's life. As health practitioners, we must respect the significance of labour and birth for the woman and her partner (Vollenhaven and Finn in Finn et al. 2005: 146)

While *Women's Health* still has a heading titled 'mechanisms', Vollenhaven and Finn's (2005) description of what the uterus does is fluid or—in Martin's (1992) framework—'flexible' and post-modern, rather than mechanical:

> Coordinated waves of contractility begin in the uterine fundus, sweeping towards the lower segment, drawing the lower segment up over the presenting part and guiding the foetus into the pelvis (Vollenhaven and Finn in Finn et al. 2005: 146).

Dewhurst's has an interesting analogy for the process of uterine contractions that differs from the mechanical descriptions in other textbooks:

> This process is usefully compared to pulling on a woollen jumper with a tight polo neck, where the action of the arms represent the contractions of the myometrium, while the changes in the neck of the garment replicate the effacement of the cervix (Edmonds 2007: 89)

Like the description in *Women's Health,* the analogy in *Dewhurst's* is 'flexible', fluid and connected and, although the birthing woman herself is still utterly absent, it points perhaps to a changing understanding of the birthing body.

If labour is seen as mechanical and disembodied, the second stage of labour (the pushing contractions and birth of the baby) are constructed as an opportunity for the doctor/mechanic (Martin 1989) to instruct, control and guide the passenger through this last perilous stage through the 'passages':

> The accoucheur now controls the delivery and the woman is encouraged to breathe from a mask providing nitrous oxide/oxygen—uncontrolled expulsive efforts at this stage may result in some perineal tearing and cerebral damage to the baby.
> *Obstetrics and the Newborn* (Beischer 1997: 432).

Here, the texts often rendered women's presence entirely unnecessary. *Obstetrics and the Newborn*, for instance, asserts that the process of labour and birth is 'largely an autonomous one' and thus 'voluntary efforts [during the second stage of labour] are not essential; paraplegic women and those with epidural analgesia have normal deliveries' (Beischer 1997: 434). *William's Obstetrics* also suggests 'efforts' during the second stage of labour are not 'necessary' although 'the expulsion of the fetus [is] accomplished more readily when the woman is instructed to bear down' (Cunningham et al. 2005: 157).

In comparison, *Llewellyn-Jones' Fundamentals of Obstetrics and Gynaecology (*herein *Fundamentals)* centres on what the *woman* is doing during birth rather than what the doctor/care-giver or her uterus is doing:

> .simultaneously with the uterine contraction the patient holds her breath, closes her glottis, braces her feet and, taking a breath, holds it, grunts and contracts her diaphragm and her abdominal muscles to force the fetus lower in her pelvis. The energy expended causes her pulse to rise, and she sweats…the active cooperation of the expectant mother is needed to add the voluntary muscle contractions of her diaphragm and abdominal muscles, to the involuntary uterine contractions (Oats and Abraham 2004: 76)

The majority of texts advocate that women be able to choose their own birth position in the second stage but, somewhat contradictorily, also emphasise the importance of the doctor/mechanic being able to have access to the vagina for episiotomy or if complications arise:

> The patient should be prepared for a well-controlled delivery of the fetal head …the supine lithotomy position [is the most] …common and convenient… [for delivery and repair]…and the preference of physicians who are commonly trained in delivery techniques in this position.
> *Obstetrics and Gynaecology* (Beckmann et al. 2006: 90)

William's Obstetrics claims that there is 'no evidence' to suggest that squatting or upright positions are advantageous and that 'the most satisfactory position [for mother and doctor] is the dorsal lithotomy position' (Cunningham et al. 2005: 437). It then goes on to recommend leg stirrups for 'better exposure'. Conversely, *Fundamentals* advises against stirrups but stresses that birth is 'easier to manage' if the woman is 'reclining' (Oats and Abraham 2004: 78). *Obstetrics and the Newborn* states:

> [the] lithotomy position has the advantage that the woman does not need to be moved for repair of an episiotomy. Also the position is more suitable for a forceps delivery… [standing or vertical positions] are more difficult for the operator (Beischer 1997: 446)

Essentials states that women prefer to lie down at this stage of the labour (Symonds and Symonds 2004: 162). Finally, *Handbook of Obstetrics and Gynaecology* acknowledges that while squatting is a more 'effective' birth position, 'it is usually more convenient for the

accoucheur to assist or manipulate during delivery if the mother is in the dorsal or lateral position' (Leader et al. 1996: 171). The authors then go on to argue that in modern developed countries the relationship between foetal skull and pelvis is not critical for normal delivery. This, in short, justifies the medically supine position, which makes it easier for doctors to *manage* delivery, and reinforces the inactive, passive machine/corpse body as well as working against gravity, making it much more difficult for women to birth without intervention. Some texts, such as *Williams* (Cunningham et al. 2005), referred to the *Cochrane* meta-analysis of birth position, which found that there was no evidence to support upright positions in labour (Gupta et al. 2004, 2012). However, as Downe and McCourt (2008) argue, the *Cochrane* analysis included any position that was not 'supine' as being upright. Thus 'the physiological variability between trials using lateral position and those squatting is not explored in the analysis' (2008: 8). The trials also did not consider women's *preference* or any of the other external and complex variables involved in childbirth, which Downe and McCourt argue is a common problem with randomised controlled trials in the area of labour and birth. In regard to birthing position, it would seem that obstetric protocol is to recommend supine positions despite what women prefer or common sense would dictate, simply because it is the obstetric preference. Another justification for the supine position was that it was the most appropriate position to be in in case of emergency or complication. This, clearly, reflects the medical view of birth as inevitable pathological and an impending emergency.

In sum, then, like Khan's (1992) earlier investigation obstetric textbooks, descriptions of labour and birth contain scant reference to women's subjective experience. Labour processes are described in abstract, analytical and mechanical language and the birth of the baby itself is an opportunity for the doctor to use his/her mechanical skills. Thus obstetric discourse continues to construct birth as something that happens to women and therefore something medicine can control, rather than something women *do* (Rothman 1993). The obliterating of women's role in labour and birth is synonymous with Cartesian thought — in which the labouring woman is merely a body working independently of the mind. As Downe and McCourt (2008: 8) point out, in the medical paradigm of childbirth it is assumed that there are 'straight forth cause-effect relationship[s] in the physiology of birth' and that therefore birth can be reduced to its 'essential

components and systematically examined'. The mechanical conceptualisation of childbirth renders it a process that *needs* medical management and control.

2.3. Dissection of the body

Another way women's active and embodied subjectivity is obliterated in the current text books is through the fragmentation and systematic dissection of the birthing body. Consistent with previous analyses, current texts continue to present women as a series of fragmented parts (Scully and Bart 1973; Martin 1989; Jordonova 1989; Koutroulis 1990; Kahn 1992; Murphy-Lawless 1998). Medical philosopher Drew Leder (1992) also argues that medicine in general has difficulty seeing people as a whole. Obviously a working knowledge of anatomy is an essential element of medical training and diagrammatic illustrations are a necessary educative tool. However, the lack of illustrations or photographic depictions of *whole* labouring or birthing women is problematic and contributes to disjuncture between seeing birth as a mechanical process that happens to women, and seeing birth as biocultural event that women perform/experience. Obstetric science has traditionally endeavoured to 'discover' and 'master' the maternal body (Kahn 1992; Murphy-Lawless 1998). Indeed, the preface in *William's Obstetrics* declares that, while obstetric medicine has made many advances, there is 'still much to discover and define' (Cunningham et al. 2005np) The dissection of the female body continues the work of obstetrics to name, control and 'know' the maternal body (Khan 1992; Murphy-Lawless 1998).

Although not all books include a specific section on anatomy, all devote a significant proportion to describing the anatomy of pelvis, uterus and cervix. Diagrams and measurements of pelvises that are not connected either pictorially or descriptively to women presuppose positivist preoccupation with measurement. The classification of pelvic shapes is said to be important to understanding the 'mechanism' of labour; various pelvic shapes and sizes are identified as either 'normal' or 'abnormal' with the 'gyneocoid' pelvis categorized as being the most favourable to giving birth. While most textbooks acknowledge that the practice of pelvic measurement is no longer considered useful and is therefore not necessary, three books do however recommend

pelvic measurement during pregnancy. *William's* (Cunningham et al. 2005), for example, gives a distressing description of how this examination should take place:

> Two fingers are introduced into the vagina. The mobility of the coccyx is first evaluated….in order to reach the sacral promontory, the examiners elbow must be flexed and the perineum forcibly indented by the knuckles of the third and fourth fingers…by deeply inserting the wrist, the promontory may be felt…the vaginal hand is elevated until it contacts the pubic arch (Cunningham et al. 2005: 354).

Murphy-Lawless argues that, in early 18th and 19th century obstetric textbooks, the female body was often presented as sexualised, passive and open to penetration 'at physical and ideological levels in ways that suggest nothing less than eroticised violence' (1998: 94). Jordonova (1989) also identifies sexually violent imagery in an early obstetric textbook, particularly in relation to the unnecessary detail in the dissection of the reproductive organs. She argues that this was vital to the ideological work the profession was accomplishing in this early period. There were many examples of this kind of violent and grotesque imagery present in *Obstetrics and the Newborn* (Beischer 1997). The photographic plates in the book resemble a kind of obstetric 'freak' show; ghastly and gruesome images of diseased vaginas, deformed babies, abnormal cervixes, disorders of pregnancy, ruptured uteri and so forth giving a generally pathologic impression of women's bodies and childbirth. *Obstetrics and the Newborn* appeared on every medical school's list of recommended texts. When I checked again in 2012, the book remained a key text and there had not been an updated edition published.

The uterus, like the pelvis, is also dissected, discussed, measured and analysed piece by piece. This is not surprising, as it is the main organ of childbirth; however, the descriptions— particularly in regard to understandings of what causes labour to commence — are significant. As discussed in the previous chapter, historically, the foremost purpose of obstetric science was to discover, 'know' and master the maternal body. But, as Khan explains, despite its scrutiny, obstetrics has made few 'discoveries' and there is still a great deal it does not understand. Each textbook I examined points out that the initiation of labour and the process that leads to the 'ripening' of the cervix remain 'unknown'. Many theories are advanced though, and these

descriptions diverge from the mechanical language used to describe the process of birth. For instance:

> At the cellular level… the formation of gap junctions between myoctoes allows communication between the cells and thus the production of coordinated contractions
> *Essentials in Obstetrics and Gynecology* (Symonds and Symonds 2004: 152)

> There is cell to cell communication by means of gap junctions, which facilitate the passage of various products of metabolism and electrical current between cells…interactions between collagen, fibrocenctin and dermatan sulphate...
> *Obstetrics by Ten Teachers* (Baker 2006: 229)

This imagery is somewhat different to that of a 1980s textbook, which likened the initiation of labour to 'ripe fruit' falling from the tree (Kahn 1992). Again, Emily Martin's (1992) notion of the 'flexible' body is valuable here; metaphors of mass communication analogous to advanced post-modern society are utilised rather than mechanical metaphors, perhaps reflecting a shift in understanding of birth that more accurately reflects the physiological ebbs and flow of labour. However, the uterus is given its own essence or purpose, at the expense of outside psychosocial factors. Emerging research on the importance of hormones, particularly oxytocins, to the initiation of labour are not mentioned (c.f. Odent 2002; Foureur 2008 and discussed in detail below), nor are psychosocial factors relating to labour initiation.

While many pages of the texts scrutinise and dissect components of the maternal body, images of complete, active women in labour, or birthing a baby, are scarce. More often than not, birth is presented in illustrations rather than photos. These images pictorially depict the 'mechanics' of 'flexion, rotation and extension' or illustrate a forceps delivery. Thus we see only torsos, pelvises, vaginas and foetal heads, but no faces. Only two texts have photographic images, but the view presented is nearly always the medicalised, de-personalised, supine position, we do not see the mother, only the authoritative medical gaze between her spread legs and the doctor's hands guiding the baby out or removing the baby with forceps. The few images of complete women in labour are found in *Obstetrics and the newborn* (Beischer 2007)*:* a black and white

photo of a naked woman from the Trobriand Islands, squatting and surrounded by female helpers; a reprint from Dr Michel Odent's famed water-birth clinic in France showing naked woman squatting and pushing her baby out; and finally another black and white photo of a smiling woman reclining on a hospital bed, legs bent and raised apparently in the second stage of labour, while a midwife/nurse in white nurse's hat looks on. The first two pictures appeared in a small section about birth position and they are quite clearly presented as an alternative, as 'other' and perhaps even as primitive in comparison to the more common clinical and disembodied images of birth in the remainder of the text. The photo of the Trobriand Islander woman is juxtaposed with photos of a fully clothed Western woman demonstrating various birthing positions; it is unclear whether the woman is actually in labour, or even whether she is pregnant.

The itemisation and dissection of the body in conjunction with the absence of complete women contributes to a prevailing paradigm of birth as a clinical and mechanical process that apparently only involves the uterus, pelvis, vagina and the doctors' analytical skills. In contemporary textbooks, then, women's subjectivity in labour and birth is obscured, deemed unnecessary, even ignored. Instead, a passive and sometimes sexualised view of women synonymous with a patriarchal and Cartesian epistemology and authoritative medical knowledge, triumphs. One could argue that trainee obstetricians encounter many real women and witness many births in their education and as such the lack of photographic images in textbooks is inconsequential. However, high rates of caesareans (in Australia 1 in 3 births (Li et al. 2011)) and concerns from within the profession that trainee obstetricians are losing skill and rarely witnessing spontaneous normal birth (Gwande 2006; De Costa, in Hall 2008; Lokugamage 2012; Klein 2012) may contribute significantly to trainee obstetricians overall lack of understanding of normal birth.

Many textbooks *did* acknowledge, albeit often inadequately, that childbirth is an emotional as well as physiological process and emphasised the importance of recognising pregnant women's choices, subjective experiences and differences. As mentioned above, the texts differed in how much attention was given to these issues. The Australian-published *Obstetrics, Gynaecology, and Women's Health* (O'Connor and Kovacs 2003) and another Australian text, *Women's Health: a Core Curriculum* (Finn et al. 2005), are exceptions among the textbooks in that they include entire chapters on the social, political and cultural aspects of providing healthcare to women,

including a small discussion of the Women's Healthcare movement. It is worth noting that all of the authors of both these books are women.

Obstetrics, Gynaecology, and Women's Health begins with a chapter on 'woman-centred care' and makes a concerted effort to move away from traditional patriarchal, medical views of women. It gives emphasis to recognition of women as 'subjective persons' as opposed to 'objectifiable patients' comprised merely of body parts (O'Connor and Kovacs 2003: 5). Moreover, it adopts a midwifery-style philosophy of working 'with' women as 'partners with equal but different expertise' (O'Connor and Kovacs 2003: 6). The second chapter examines the complexity of gender and healthcare provision, describes gender inequities both past and present in the healthcare system and highlights the value and necessity in understanding the differences among women and the intersection of race, class and gender. The text places significant emphasis on informed choice and providing women with 'safe' options tailored to each individual woman's needs. Subsequently, women more frequently feature as subjects, rather than body-parts, in descriptions of labour and birth in this book too.

Women's Health a Core Curriculum (Finn et al. 2005) is similarly women-focused and conscious of the problems with traditional obstetric epistemology. For example, in the introduction the authors assert that 'each woman occupies a unique subject position' and that medicine must 'move away from' a neutral, genderless, objective approach. *Women's Health* is woman-centred throughout all sections of the book; women are actively present in most explanations and guidelines, for instance in the pre-natal-care section the authors highlight the importance of supporting women to 'explore the changes occurring in her body and her life during pregnancy' and it is the only text that encourages the use of a birth plan (Finn et al. 2005: 87). Moreover, in striking contrast to the other texts, *Women's Health* defines the beginning of labour as when the *woman* 'reports uterine activity' (Vollenhaven and Finn 2005: 146), whereas every other textbook asserts that labour can only ever be determined by a vaginal examination upon the woman's admission to hospital.

Fundamentals (Oats and Abraham 2004) is also generally more women-centred and aware of psychosocial and cultural aspects of childbirth. Oats and Abraham acknowledge the criticism directed toward medicalised birth and outline the recommendations from the World Health

Organisation's guidelines for effective care in labour and birth (e.g. access to continual support by a birth attendant, ensuring women can find the best position in labour by allowing mobility). Furthermore, the importance of treating pregnant/labouring women with respect is given prominence:

> The discomfort and pain of childbirth are reduced if the attending nursing and medical staff treat the woman as an intelligent individual, who has needs and who can make choices, and who is perceived as a woman having a baby rather than as a patient requiring medical attention (Oats and Abraham 2004: 51)

All textbooks paid at least passing attention to issues of autonomy and respect—one or two sentences, a paragraph at the most—sometimes while also conflictingly referring to women as 'patients' elsewhere. Yet, discussions of choice and the importance of viewing pregnant women as people, rather than patients, are little more than empty rhetoric when viewed in light of the practices outlined in the texts' sections on the 'management' of labour and birth.

2.4 The 'Active Management' of birth

All textbooks recommend the Active Management of labour system, developed at the National Maternity Hospital, Dublin in the 1960s by Dr Kieran O'Driscoll (O'Driscoll et al. 1973). The active management 'package' is, according to midwifery researchers Downe and McCourt (2008), the 'epitome of positivist, linear and reductionist science applied to childbirth' and powerfully illustrates the obstetric pursuit to control and standardise birth. According to O'Driscoll and colleagues (the inventors of the technique) the Active Management package was an attempt at standardising and controlling the length of labour:

> [I]t is only in recent years that a systematic attempt has been made to curtail the duration of labour. Obstetricians previously accepted labour as subject to wide natural variation and largely outside medical control…there has been a complete break with tradition at the National Maternity Hospital where the passive concept of labour has been replaced by an intensive care situation in which every patient has a personal nurse and every labour is controlled…the policy of active management has proved so successful that expectant mothers

> are now informed of the change of outlook and are given a firm assurance that the duration of labour will not exceed 12 hours (O'Driscoll et al. 1973: 135).

Active Management of labour standardises childbirth so that it fits into a convenient twelve hour timeframe. Labour is considered abnormal if it does not progress at a rate of 1 cm dilation per hour, in which case artificial rupture of the membranes (amniotomy) would commence and oxytocic drugs would be administered in order to make an 'inefficient' uterus more efficient. Critics have pointed out, though, that O'Driscoll and colleagues never quantified uterine (myometrical) activity and, as such, an understanding of 'normal' was never established in the first place and thus 'efficient' and 'inefficient' activity are both utterly arbitrary (Keirse 1993: 159). Recurrent measurement and observation, including two hourly vaginal examinations and foetal monitoring, are integral to Active Management, restricting women's movements during labour. If induction fails and delivery has not occurred within 12 hours, a caesarean is recommended (O'Driscoll et al. 1973). O'Driscoll and colleagues argued that, by making labour efficient and systematic, they were able to give each labouring woman a 'personal nurse'; thus, a crucial and controversial element of the Active Management package was continual support during labour.

Despite criticisms that the practice was unproven, that it increased risk of infection and foetal hypoxaemia, and that many women actually resented the interventions, the Active Management system 'rapidly moved into routine use' in Western English-speaking countries (Thornton and Lilford 1994: 366). However, its continual labour support aspect was not given as much attention as its technical aspects. While proponents of the Active Management package attested that the system would lower caesarean rates, a 1994 review published in the *British Journal of Medicine,* found that it was this final aspect of the system — constant midwifery care — that originally contributed to fewer caesareans in the *National Maternity Hospital,* and not the procedural aspects of the practice (Thornton and Lilford 1994). Downe and McCourt (2008) argue that the tendency for obstetricians to have emphasised the technical aspects of the package, rather than the social, explains why instead of lowering the caesarean rate, rates have increased all over the Western world, including at the *National Maternity Hospital Dublin* (2008: 8; see also Rothman 1993; Wagner 2008). For example, as Rothman explains, the diagnosis of 'dystocia' increased

and changed in meaning following the introduction of the Active Management system — from a 'mechanical failure to fit' to a 'time bound failure to progress' — therefore increasing the number of caesareans performed for this diagnosis (1993: 158). Moreover, augmentation of labour results in much more painful and intense contractions, requiring administration of epidural anaesthesia, slowing or stalling the labour and resulting in increased operative deliveries including caesareans (Alexander et al. 1998; Kotaska et al. 2005; McCarthy et al.; 2007; Grivel et al. 2012). Thus, despite the original claims that Active Management would lower caesarean rates, there is increasing evidence suggesting the opposite is true. O'Driscoll responded to the criticism put forward by Thornton and Lilford in the *British Journal of Medicine* (1994: 309) by insisting that the technique's 'true purpose' was to 'enhance the experience of mothers' by shortening the labour length and providing a 'sympathetic' support person. However, as satisfaction surveys were never undertaken, women's perspectives were absent from any evaluation of this form of care.

These debates are absent from the contemporary obstetric textbooks I examined, and the Active Management system is, for the most part, indiscriminately advanced in each text. Active Management of labour fits with a mechanical model of the birthing body. Women's bodies are expected to perform like machines at a specific rate. If they fail to, they are considered abnormal or inefficient, thus 'necessitating' medical intervention. Active Management is the standard mode of care-giving in every textbook and, while some textbooks question aspects of the technique, there is no consideration of alternative birth management. For example, *Women's Health* (2005) questions the appropriateness of an approach which 'defines 45% of nulliparous women as abnormal' and therefore requiring augmentation (Vollenhaven and Finn 2005: 153). However, the authors then assert that since the method is 'safe' and 'effective' it should be applied regardless. *William's* acknowledges that there are 'wide variations' in length of labour and that 'interventions other than caesarean delivery should be considered before resorting to this method of delivery for failure to progress' (Cunningham et al. 2005: 424). *William's* also suggests that there may be other causes for stalled or prolonged labour, especially the use of analgesia and/or sedation. *Dewhurst's* (2007) points out that the timing used in the Active Management system may be viewed with 'some scepticism' (Calder 2007: 51) and that there is 'no compelling argument for aminotomy' if mother and foetus are not experiencing any other problems (Calder

2007: 53). The American-published *Obstetrics and Gynaecology* (Beckmann et al. 2006: 2013) stands alone in rejecting O'Driscoll's timeframes completely, arguing that as long mother and baby are doing well there is 'no reason to intervene' and labour does not have conclude within any specific time frame, although over twenty hours can be considered 'abnormal'. At the opposite end of the spectrum, *The Oxford Handbook of Obstetrics and Gynaecology* (Arulkmaran et al. 2004) shortens the second stage to one hour (the Active Management technique recommends two hours).

In nearly all of the textbooks, there is scant discussion of the social, environmental and psychological effects on the progression of labour, despite these factors being perceived as important among midwives, birth activists and some obstetricians. Obstetric practices such as Active Management are based on the body-as-machine and may prevent obstetricians from viewing birth as a social, emotional and psychological as well as physiological process. Drew Leder argues that, as long as patients are modelled on mechanistic automatons, the 'living person with wishes, pains and fears, can all too easily be overlooked' (1992: 24). The Cartesian framework thus demands of doctors an almost 'schizophrenic shift' between at the one moment examining the machine-body and at the next acknowledging the person to whom it belongs. In relation to nursing and midwifery, Goldberg argues that the Cartesian paradigm of the birthing body makes it impossible for healthcare workers to actually acknowledge women as human beings (2002: 448). The construction of the birthing body as mechanical and the inattention to women's subjectivity renders birth as a process that necessitates control. Despite the lack of evidence and criticisms of the Active Management technique, it remains the standard method of care in labour and birth. Alternative methods of pain relief and support during labour are sometimes acknowledged in the textbooks but are prefaced with warnings as to their ineffectiveness and assertions that they are unproven or even dangerous (for example, immersion in water as a form of pain relief was constructed as risky and advised against in several of the text books). While the texts acknowledge women's autonomy and right to decision-making, this is purely rhetorical as women can have no real choice or autonomy in labour and birth when it is managed according to timelines, protocols and practices which work against the processes of physiological, normal birth.

2.5. An alternative model of childbirth and the birthing body

While the mechanical body has been the basis for obstetric conceptualisations and practices in regard to birth, alternative understandings, arising from midwifery knowledge and sometimes referred to as 'undisturbed birth' (Foureur 2008), 'normal birth' or ' physiological birth' (Reiger and Morton 2012), reject the Cartesian schema. This alternative paradigm of birth offers a humanist vision of the birthing body, recognising the complexity of the interaction between the social, emotional and physiological processes in childbirth (Reiger and Dempsey 2006; Davis and Walker 2008; Down 2010). The concept of the 'lived body', based on Merleau-Ponty's (1962) theory, is employed to offer an alternative to the Cartesian separation of mind and body. In this paradigm, the complexity of social and physiological processes and the continuum between self, other, culture and biology involved in childbirth is emphasised (Marshall 1999; Young 2002; Goldberg 2002; Reiger and Dempsey 2006; Davis and Walker 2008; Down 2010). Embodiment is understood as a unification between mind and body, 'in which one lives in her body, not separated from it… as a vehicle by which we experience the world, and participate in relatedness with others' (Goldberg 2002: 449).

Reiger and Dempsey (2006) use the theoretical framework offered by feminist philosophers of the body to argue for a re-conceptualisation of birth as the interaction between physiological processes and cultural contexts. Birth is not an automatic biological function that 'just happens' to women, yet nor is the experience purely cultural. Bodies and physiological processes are the site of interaction between culture and biology. Birth, then, can be seen in terms of the intersection of cultural discourses, local practices and 'embodied, psychological realities' (Reiger and Dempsey 2006).

Midwife Jenny Blyth (2005) calls this 'dynamic anatomy in action'. Drawing on neurological research, normal childbirth advocates such as Blyth argue that the body is a dynamic, changeable system always in interaction with its environment (Reiger and Dempsey 2006; Buckley 2003; Odent 2002; Blyth 2005; Foureur 2008; Lokugamage 2011) not the Cartesian dead/mechanical/abject body. As such, any unnecessary interference with the normal processes of childbirth has negative impacts on maternal and infant physiology and psychology (Lokugamage 2011; Dahlen 2011). British midwifery academic Soo Down (2010) argues that pregnancy and

childbirth are not linear, measurable processes. Rather, they are examples of 'complex adaptive systems' and pregnant and labouring bodies 'adapt dynamically to a range of hormonal and physiological inputs' with interconnections between biochemical, cellular and muscular signals and responses (2010: 233). As a consequence, linear monitoring of labour (such as measuring the length of active labour and use of the partogram) can be misinterpreted as lack of progression, leading to 'erroneous decision-making' by caregivers (2010: 234).

If birth is understood as a dynamic 'interconnectivity between maternal and fetal physical and psychological' factors' (Down, 2010: 234), then all kinds of external and internal factors can impact on the process of birth (see also Reiger and Dempsey 2006; Buckley 2003; Gaskin 2003; Lokugamage 2011). American midwife Ina May Gaskin refers to 'sphincter law' and posits that labours that are stalled or do not progress according to a obstetric time line are not the result of a faulty body or inefficient uterus or cervix, but rather may become stalled due to lack of privacy, fear, and stimulation of the wrong part of the labouring woman's brain, which inhibits the sphincter properties of the cervix (Gaskin 2003). Emerging neurological and hormonal research helps explain the important connection between the brain, hormones and the physiology of birth (Odent 2002; Uvnäs-Moberg 2003; Foureur 2008). When examining the role of hormones in birth, researchers argue that birth requires the use of our primitive brain, which, among other things, governs the release of hormones essential to the birth process. However, stimulation of the neo-cortex, the 'newer' part of the brain, inhibits the release of the birth hormone, oxytocin. Social/emotional and environmental factors thought to stimulate the neo-cortex and inhibit the release of oxytocin include being asked to answer a question that requires thought, feeling self-conscious, fearful, threatened or stressed, and being in a foreign environment or under bright lights (Odent 2002; Buckley 2002; Uvnäs-Moberg 2003; Foureur 2008). Adrenaline, released in the 'flight or fight' response when a woman is stressed or afraid, stalls the release of oxytocin and, thus, of labour. This explains why many women's labours often stall upon admission to hospital but begins again once women have 'settled in' (Foureur 2008: 60). Epidural anaesthesia is also thought to interfere with the release of birth hormones (Uvnäs-Moberg 2003). Factors that stimulate oxytocin production include touch, feeling loved, breastfeeding, massage, immersion in water, sexual activity, warmth and eye-to-eye contact (Foureur 2008: 71). Many of these techniques and practices have been part of midwifery knowledge and practice for thousands of

years. Numerous studies show that midwifery models of care are effective, safe and have lower rates of interventions and higher rates of satisfaction (c.f. Hatem et al. 2009; Waldenström 2000).When this research is taken into account, it becomes clear that women labouring in hospitals must contend with factors which actually inhibit the birth process. Contemporary obstetric-led maternity care in Australia may thus be ill-suited to the needs of birthing women.

This chapter has demonstrated that Cartesian metaphysics arising from Enlightenment era science continue to dominate obstetric conceptualisations of childbirth and women's bodies forming the epistemological basis of obstetric practice. Obstetric knowledge remains wed to mechanical constructions of birth and positivist preoccupations with measurement and linear time, particularly the Active Management technique, which enforces birth practices that are systematically timed and controlled. There was some evidence of the flexible, post-modern body metaphor in contemporary obstetric textbooks, particularly in descriptions of how labour is initiated. However, the dominant metaphor in obstetric medicine continues to be based in a Cartesian schema in which the body is viewed as corpse-like and mechanical. The notion of a 'lived body' was not present and there was no mention of promoting normal birth or any reference to the growing body of research examining the complex interplay between hormones and childbirth (Foureur 2008). The paternalism, sexism and biological-determinism apparent in earlier obstetric/gynaecological texts (Scully and Bart 1973; Koutroulis 1990, Kahn 1992) are not as overt or as frequent. In comparison to previous analyses of obstetrics and gynaecology texts (Koutroulis 1990), there is now *some* attention given to the role of the socio-cultural factors in the experience of childbirth — although this varied from book to book. Moreover, I have argued that the Active Management of labour system (O'Driscoll et al. 1973) promoted by all text books examined makes it very difficult for women to exercise any autonomy over the birth experience and, according to recent neurobiological research and midwifery experience and knowledge, may actually inhibit the birth process.

Chapter Three

Delivering 'choice': obstetric hegemony and contemporary media debates around caesarean birth

Since the early 2000s the rates of caesarean births have been a widespread topic of heated discussion, debate and analysis within mainstream and alternative Australian media by academics, state and federal politicians, policy-makers, consumers, birth activists and health professionals alike. Australia , like other Western countries, has experienced an seemingly inexorable increase in caesarean birth rates over the last 10 years; increasing from 23.3% nationally in 2000 to a peak of 31.5% in 2009 (and an average of 42.5% in private hospitals) (Li et al. 2011). This means one in every three babies born now in Australia is likely to be surgically delivered. The largest increase in caesarean surgery has been among the healthiest and most socially advantaged group of women who birth in private hospitals (Laws et al. 2010; Miller, Thompson et al. 2010; Miller et al. 2012). This is somewhat of an anomaly as this demographic of women are the *least* likely to need medical assistance in birth (Baker 2005). Policy makers, health professionals, midwives, consumers and academics express concern regarding higher rates of caesarean births since evidence suggests that increases in caesarean do not correspond with better outcomes for mothers and babies (MacDorman et al. 2006; Villar et al. 2006; Romano and Lothian 2008; Amnesty International 2009) and are not cost-effective (Gibbons et al. 2010). Since at least the late 1990s rising rates of caesareans have been a cause for concern for Australian governments too; a Senate Inquiry into maternity services in 1999 by the opposition Labor government for example, found higher incidence of obstetric intervention and caesarean in Australia compared to similar countries. The recommendation from the inquiry, though not taken up by the Coalition government of the time, was that a target rate for caesarean sections be implemented, moving towards the target of 15% recommended by the World Health Organisation in 1985 (WHO 1985; Senate Community Affairs Reference Committee 1999). The New South Wales Labour government introduced policy guidelines in 2007 aimed at reducing the number of

elective caesarean births in the public hospital system, suggesting that the matter had become a matter of public health concern.

Australian debates around caesareans are emotionally charged and highly polarised. In one camp are those who argue that the caesarean rate is too high, does not correspond with need, that it is obstetrician-led, a result of the medicalisation of childbirth, particularly the over-use of intervention and the loss of obstetric skill and motivated by fear of litigation as well as convenience and financial incentive. In the other are those, usually doctors, and to a lesser extent, some women, arguing that the rate of caesareans is medically and socially justified, caused by an aging population of first time mothers, obesity and 'maternal choice'.

In this chapter, I argue that obstetric constructions of caesareans dominate public debates but explore the interweaving discourses around risk, and 'free choice' synonymous with a neoliberal consumer ideology. I examine the influence of the media in maintaining and contesting obstetric hegemony and consider the narrative of 'choice' and blame that is evident in public debates about caesarean birth in Australia. As the choice for caesareans came to be justified as a woman's 'right', discourse drew on both the language of the consumer led normal childbirth movement (choice in childbirth) as well as a neoliberal notion of autonomy. In addition to 'maternal choice', rising caesarean rates were also constructed however, as being a problem of an ageing maternal population and growing rates of obesity and other illnesses , thus caesareans were constructed as being a result of the increasing *pathology* of women's bodies; again reflecting an underlying epistemology that understands birth and women's bodies in mechanical ways. This has deflected attention away from obstetric features that may be attributable to the increase in caesarean rates.

3.1. Caesarean birth: medical and sociological perspectives

Caesarean birth has been a concern of feminist academics and birth activists since the late 1970s. As the procedure became safer, and thus more common, doctors were accused of performing the operation unnecessarily out of convenience and financial incentive (Cohen and Estner 1983; Wendland 2007). Until the late 1960s, a caesarean was a procedure with a very high mortality rate, undertaken primarily to save the mother but not as commonly to save a foetus (Wendland 2007; Douché 2007; De Costa 2008). With decreased mortality, the indications for caesarean

widened; particularly with the advent of electronic foetal monitoring in the 1970s and 80s along with an increase in malpractice suits. While the rate seemed to plateau in the 1980s, by the late 1990s concerns about the procedure's overuse were again voiced by birth activists and by some within the obstetric profession (Wendland 2007; Douché 2007). The 1990s saw a proliferation of indications for caesarean in the medical literature, including for the first time the prophylactic caesarean or caesarean by 'maternal request' (Gawande 2006; Douché 2007; Wendland 2007; De Costa 2008; Plante 2009).

Debates around the ethics of maternal request caesarean have raged in the medical literature and spilled into the public domain. In 1996 a letter was published in the *Lancet* and then in the following year as an article in the *European Journal of Obstetrics, Gynaecology and Reproductive Health* which discussed the results of a survey of obstetricians in London ostensibly suggesting 33% of obstetricians would choose elective caesarean as their preferred mode of birth (for their spouses or for themselves) (Al Mufti et al. 1996, 1997). This survey was used by Al Mufti and colleagues as justification for offering elective caesarean as a legitimate alternative birth choice for 'well-informed' women. As Douché (2007: 126) explains, the letter and survey were re-published and widely cited (often incorrectly) over the next few years as maternal choice caesarean increasingly gained support among the profession (c.f. Steer 1998; Paterson-Brown and Fisk 2000; Fisk 2001; Cotzias et.al 2001; De Costa 2002, 2005; Dietz and Peek 2004; Gonen et al. 2004; Paterson-Brown 2004; Queenan 2004; Robson 2004; Molloy 2005; NIH 2006). While only 33% of respondents (of 206 in total) said they would choose a caesarean, according to some commentators, the survey and a subsequent survey in 2001 with similar results (Cotzias et al. 2001) were used as promotional material by individual obstetricians who endorsed caesarean as a valid alternative to vaginal birth (Douché 2007:125-126; Bourgeault et al. 2008). These views were not met without controversy and sometimes condemnation within the profession. The main reason for not supporting maternal request caesarean was that there were was insufficient evidence regarding the risks versus benefits, contradicting the medical obligation to 'first do no harm', and questions regarding whether elective caesarean was a good choice in the long-term (c.f Castro 1999; Christilaw 2006; Husslein 2001; Kierse 2002; Klein 2004; FIGO 1999). However, as Douché argues, by the mid-2000s, the dissenters in the profession had been silenced and the dominant discourse in the medical literature, and increasingly in the media was—in a

clever co-option of the natural childbirth movement's rhetoric of choice— that women had a 'right to choose' caesarean in the absence of medical need. Bourgeault et al. (2008) argue that the risks caesareans involved were acknowledged by some in the obstetric community, however in pro-caesarean by choice discourse, the perceived benefits of caesarean were assumed to be evenly balanced with the risks, thus caesarean by choice was deemed a valid birth option. Moreover, Douché argues that the 'safety of the norm' rule protected obstetricians from malpractice; the more the procedure became 'routine' the more it became acceptable practice (2007: 133).

Since the 1990s, caesarean birth rates have risen dramatically to well over 30% in many Western Nations. As outlined in Chapter Two, the obstetric management of birth, particularly the active management of labour resulting in a 'cascade of interventions' along with the tendency to define 'normal' birth within increasingly smaller parameters, has had the effect of steadily increasing caesarean rates in Western maternity settings (Beckett 2005; Romano and Lothian 2008; Kotaska et al. 2005; Wagner 2006; Wendland 2007; Plante 2009). Other non-clinical factors such as loss of obstetric skill, obstetricians' fear of litigation, and obstetricians' assessments of risk, and the standardisation of maternity care have also been explored as causes of the worldwide increase in occurrence of caesarean births (Declercq et al. 2004; Declercq and Norsigian 2006; Gwande 2006; O'Leary et al. 2007; Savage 2007; Goldberg 2008; Bourgeault et al. 2008; Kalstrom et al. 2010; Klein 2012). Douché (2007: 39-42) reviewed the literature and succinctly outlined the clinical and non-clinical reasons given in the medical literature for caesareans:

Clinical reasons	**Non-clinical reasons**
• Repeat caesarean	• Increasing age of maternal population
• Dystocia (the baby becomes stuck in the birth canal).	• Maternal 'choice'
• Failure to progress /prolonged labour	• Obstetrician factors such as fear of litigation, convenience
• Breech birth or multiple birth	• Place of birth and caregiver (for e.g. obstetric-led care associated with higher

	rates of caesarean; private hospitals have higher rates of caesarean

Variance in caesarean rates across locations, however, has more to do with personal preference and practice of individual obstetricians, than it has with maternal populations '[signalling] a shift of indications beyond biology' as the main cause for increased rates (Douché 2007: 40). Douché (2007 c.f Baker 2004; Miller et al. 2012) points out that the largest increases have been among populations who were previously seen as least likely to experience complications in childbirth.

A significant portion of the (late 1990s to mid-2000s) medical literature on caesarean however, focussed on *one* aspect of the increase; non-medically indicated 'maternal request' or elective caesarean (McCourt et al. 2007; Declercq 2010; Bourgeault et al. 2008). In 2006 the *National Institute of Health* (NIH) in the United States held a three day *State of the Science* conference on 'Caesarean Delivery on Maternal Request' (NIH 2006) on the unfounded or as Young (2006) argues, 'faulty' premise that maternal request caesarean was driving up rates in the North America. Critics of the NIH conference claim that it ignored significant other factors related to rising caesarean rates by framing the debate in terms of women's 'choice' (Young 2006; Bourgeault et al. 2008). The conference was internationally influential in the meaning-making that surrounded rising caesarean rates. In 2007 McCourt et al. conducted a systematic review of medical articles relating to caesarean on request. From 200 articles identified, only minority were based on empirical research; most were opinion-based or epidemiologically focused on statistically ascertaining how many women were 'demanding' caesarean births. Some empirical studies do indicate maternal request as a factor in the increase in caesarean births (Edwards and Davies 2001; Marx et al. 2001; Lo 2003; Lapeyre et al. 2004; Bettes et al. 2007; Robson 2009; Stavrou et al. 2011), but conclusions drawn from these studies are questionable as they have either relied on routine records with no way of ascertaining women's true preferences or have focused on *obstetrician's* perceptions of women's preferences, and have not asked women themselves (Declercq and Norsigian 2006; McCourt et al. 2007; Bourgeault et al. 2008; DeClercq 2010). When women's opinions *are* sought, the research shows only a small number of women in Australia and elsewhere choose caesarean without medical reason. Qualitative research with

women in Brazil, Italy, Australia, the United States, the United Kingdom, South Korea, China and other countries where the high caesarean rate is attributed to women's requests, reveal that the majority of women would prefer to birth vaginally and the decision to undergo caesarean , elective or emergency, is influenced by *doctor's* preferences and women's perception that the caesarean was necessary and safer for the baby (Liamputtong and Naksook 1998; Hopkins 2000; Murray 2000; Gamble and Creedy 2001; Potter et al. 2001; Donati et al. 2003; Lee et al. 2004; Declercq 2006; Bryant et al. 2007; Green and Baston 2007; Moffat et al. 2007; Weaver et al. 2007; Mazzonni et al. 2010; Miller et al. 2011). For example, interviews conducted in United Kingdom with 105 women, 24 obstetric registrars or consultants, and questionnaires with a further 408 postnatal women and 785 obstetric consultants concluded that

> We did not find women making requests for caesarean in the absence of what they perceived to be clinical indications, but the perceptions of women and doctors as to what constituted indication were not always similar. The only women who made requests for caesarean did so in the light of anxiety or fear about the safety and well-being of themselves or their baby. Similarly, few obstetricians …reported requests from women in their personal practice. However….many obstetricians also reported in the questionnaire that maternal request was an important contributor to rising caesarean rates in the United Kingdom (Weaver et al. 2007: 38).

Moreover, the authors suggest that the manner in which the risks and benefits of vaginal birth versus caesarean birth are presented by health professionals and in the birth stories in media and of friends and relatives, may play an important part in women's perception of risk and fear of birth, leading to the belief that elective caesarean was a safer option.

Recently a Queensland survey of new mothers found that a majority of women who underwent caesarean did not have the opportunity to make a fully informed decision regarding their birth;

> Even among women who had a C-section that was scheduled in advance (i.e., major abdominal surgery in non-emergency conditions), only half had made an informed decision about having the surgery' (Miller et al. 2011: 137).

Several qualitative researchers have linked decisions around caesareans to wider social discourses in contemporary post-modern societies. Bryant et al. (2007) posit that the existing medical and health literature/research reduces the 'complex phenomenon' of rising caesarean rates to fixed explanations located within the individual (women or obstetricians) and ignores social contexts. Their qualitative research in an Australian maternity ward examined decision-making around caesarean births and concluded that consumerist identities, the belief systems of midwives, obstetricians and women, as well as a culturally pervasive neoliberal ideology, shape the context of decision-making around caesarean. The authors argue that women view themselves as self-determining individuals and consumers with full agency over their bodies, albeit with the guidance of medical experts. However, women's decisions around caesarean were informed by discourses of their caregivers and by powerful obligations to manage risk. For example, within the discourse of risk and safety, doctors are 'engendered with the authority' to limit women's choices by suggesting caesarean is the correct/ safest option (Bryant et al. 2007:36). Similarly, ethnographic research in an obstetric unit in the United Kingdom, suggested that doctors sometimes use 'discursive tactics' which provide 'the illusion of client choice' but actually 'ensures the choice being discussed is the choice or outcome that is supported by the obstetricians' (Simpson 2004: 216). The 'discursive tactic' used was to present labour and vaginal delivery as possibly difficult and caesarean as controlled and problem-free. Anthropological research in Brazil, which has some of the highest rates of caesareans in the world, exposed an obstetric culture that dominates public discourse and encourages surgical birth (Hopkins 2000; Murray 2000; McCallum 2005). Several ethnographies describe a privatised obstetric-led maternity system (there are no midwives and very few childbirth educators) that is heavily motivated by profit in a culture where class differences and cultural beliefs about birth, femininity, sexuality and technology, as well as obstetric dominance of public discourse have led to a perception of vaginal birth as disfiguring and primitive and caesareans as desirable (Hopkins 2000; McCallum 2005). For example, McCallum's (2005) Brazilian ethnography found strong cultural associations between vaginal birth and poverty, low status and primitiveness, whereas caesareans were associated with modernity, technology, high-status and wealth. These perceptions reflect the real stratifications between the birthing experiences and places of rich and poor women. The cultural assumptions are also portrayed in popular movies, books and TV.

McCallum analyses Brazilian beliefs about the female body, sexuality and motherhood, showing how vaginal birth is thought to not only physically disfigure a woman's body but also taint her with the 'natural' and 'primitive' associations which are undesirable compared to the modern associations of caesarean (2005:227). Importantly, McCallum points out the 'discursive silence' in regard to birth in Brazil. The lack of an organised and active birth movement 'strengthens medical hegemony' and when calls are made to naturalise birth, it holds no appeal (2005: 230). McCallum argues that the notion that Brazilian women choose and desire surgery may 'simply be a compliance born in absence of both a coherent, culturally appropriate critique of existing practices and women's knowledge about vaginal delivery' (2005:230).

When researchers have sought to discover women's reasons for electing caesarean without medical indication, tokophobia (fear of childbirth), previous traumatic birth, *perceived* safety and ease of a caesarean for the baby emerge as the main reasons for women's choices (Edwards and Davies 2001; Gamble and Creedy 2001; Gamble et al. 2007; Arthur and Payne 2005; Kealy et al. 2006; Staff 2006; Wiklund 2007; McGrath et al. 2009; Fenwick et al. 2010). Women who request a caesarean may perceive vaginal birth as dangerous, disfiguring, unpredictable and potentially harmful to either themselves or their babies while a caesarean is perceived as safe, predictable, controlled and as guaranteeing a healthy baby. Australian midwifery researcher, Lyn Staff's Masters dissertation (2006) suggests that women who opt for non-medically indicated caesareans did so because they felt that undergoing a caesarean gave them greater control of the birth process (see also McGrath et al. 2009). Respondents in Staff's research did not place great importance on the birth, only on 'getting the baby out'. They also expressed seeing childbirth in passive terms; as something that was done to them, not something they needed to actively participate in. Echoing previous research (Davis-Floyd 1995; Zadoroznyj 1999, 2000) participants in Staff's study desired 'expert' care and trusted their doctors to do the work for. Very few women in the study were aware of the risks involved in caesarean birth or mentally 'switched off' to risk and reassigned the responsibility of risk back to their doctors. Additionally, when complications arose from the surgery, women tended to dismiss or trivialise them (2006; see also Fenwick et al. 2009; Kealy et al. 2006). What women hear from their obstetricians is therefore crucially important to decisions around caesareans.

Sociological and Anthropological empirical research thus suggests that there are complexities in decisions made around caesarean birth; fear of birth, that wider cultural influences and dominant discourse, and relations of power play a part in 'maternal request' caesarean. However, in the Australian media discourse, women's individual choices are cited as the main reasons increases to caesarean rates.

3.2. 'Asking for it': examining maternal choice in the Australian media

In order to assess the Australian cultural context and discourses shaping the caesarean debates, I examined major Australian newspapers from 2005 to 2012 for articles on caesarean birth in the *Factiva* database using the search terms 'Caesarean Section', 'Caesarean', 'C-Section' or 'Cesarean'. Of over 400 print articles identified, 91 were chosen for closer analysis. Articles were included in the analysis if they met the following criteria:

- comment, opinion, debate on Australia's increasing rates of caesarean births;
- comment, opinion, debate on elective /maternal choice caesarean;
- news /factual stories reporting on social and medical issues relating to caesarean births (e.g. stories reporting on risks associated with caesareans, reasons for increases, demographic data relating to women who undergo caesareans etc.);
- feature stories /investigative stories about caesareans;
- personal accounts /human interest stories about caesarean birth; and
- letters to the editor commenting on caesarean birth.

Additionally, I examined the online versions of selected articles and analysed the reader comments made in response to newspaper and online web articles. Television and radio segments examining the phenomenon of increased caesarean rates were also included in my analysis. A total of five television programs and two radio programs were included. Additionally, I undertook a search of opinion articles and letters in medical journals; particularly the *Australian Medical Journal*, *British Medical Journal*, *The Lancet* and the professional magazine of RANZCOG, *O& G.* Over the course of my research I subscribed to and followed several blogs, Facebook pages, maternity care email lists, and online communities (such as *Essentialbaby.com.au*), through

which I explored the most significant debates. Given the nature of online material, for example the many comments to blog posts and online articles, forum posts replies, it is difficult to quantify the online material I examined. For a selection of online sites I examined in this analysis, refer to Appendix 3. I applied a thematic analysis using NVivo software to identify recurrent and key themes, however I specifically employed a CDA framework by looking for tacit ideological discourses. The media I have examined is thus not comprehensive; rather it is a selection of the key debates on the issue of caesarean births in the Australian context.

As discussed in Chapter One, hegemony is a process of struggle 'over systems of meanings' (Mumby 1997: 364) between competing political forces and meaning- making occurs through the process of hegemonic articulation (Laclau and Mouffe 1985; Laclau et al. 1999) where competing discourses function to give meaning to and achieve dominance in a discursive field and are repeated in media, policy and everyday interactions. Online and print current affairs media in addition to forums, radio and television became key cites in which public meaning-making over rising caesarean rates occurred. As discussed above, the obstetric profession had already been debating the merits and ethics of caesarean on demand in the medical literature from the late 1990s. The early 2000s saw this discourse spill over to the public sphere where it became, for obstetricians, a 'new surface of emergence for making statements about caesarean' (Douché 2007: 135; see also Goer 2002). Obstetricians, as the accepted 'experts' in birth were able to dominate the discourse around caesareans, however competing meanings about caesareans challenged the dominant discourse too.

The early to mid-2000s saw a proliferation of investigative journalism pieces seeking to uncover the reasons for Australia's increasing rates of surgical birth. Obstetricians and their organisations, were given prominent coverage as experts in birth although not all in the medical profession were in consensus. The most recurring reason cited for the increase in surgical births, was elective or 'maternal request' caesareans, consistent with previous research in Australia and New Zealand (Douché 2007; May et al. 2009) and North America (Bourgeault et al. 2008). Articles, commentary and public discussion from 2004 onward reported that more women were choosing elective caesareans for what was termed 'life-style' reasons or fear of vaginal birth; a view widely supported in the media by obstetricians and others in the medical profession as well

individual women. The phenomena of maternal request caesarean was internationally dubbed ‘too posh to push’, said to have arisen from celebrity Victoria Beckham’s preferred mode of birth. ‘Too posh to push’ became a part of the popular lexicon in the Australian media often with reference to ‘career’ women who did not have time in their busy lives for the unpredictability of vaginal birth.

> Older mothers and career women are forcing a jump in the number of caesarean births, with an almost 10 per cent increase in the past decade. A third of all children are now born using elective caesarean procedures, with women -- especially those admitted to private hospitals -- seeking the convenience of knowing what day their child will arrive…’The woman of the 21st century gets what she wants,’ said Professor Chapman, an obstetrician and IVF specialist. ‘She has her career, at 35 when she's the manager of a human resources company, she decides it's time to have a baby. She gets pregnant, but wants to continue to work until the last moment. And to avoid the uncertainty of wondering if it is going to be a week early or late -- because she's got work to do -- it's a caesarean for her. ‘She puts it in the diary and has her hair appointment the day before, as one lady said.’
>
> Nicolette Burke, ‘Career women drive up caesarean surge’, *Hobart Mercury*, 10 December 2005.
>
> There’s also this perception that women are juggling now, they’re working, they're single parents and women really have to schedule the caesarean in and so does the doctor, that everybody sort of wants everything to happen when they want it to happen and then caesarean works for them.
>
> Dr Louise Messara in ‘Birth Wars’, *Today Show*, Channel 9, 10 September 2008.
>
> The biggest reason for the increase in caesarean sections is patient choice…It's becoming more common for modern women who (want to be) organised and know exactly when they are having their baby…

> Dr David Molloy in Mathew Fynes-Clinton and Sophie Elsworth, 'More mums hail Caesar', *Courier Mail*, 14 October 2007

Doctor Molloy, former president of National Association of Specialist Obstetricians and Gynaecologists and outspoken proponent of caesarean by choice (all 3 of his own children were born by elective caesarean (personal communication, October 2009) featured frequently in various media formats as the voice of pro-caesarean by choice. On the SBS *Insight* program he again referred to the spectre of 'modern' woman who chooses technology in birth in the same way she takes out a bank loan or buys a car

> It suits the modern woman. Miranda is like so many intelligent, incisive patients I have, they are used to making life decisions, they have work, they take out loans, they buy cars, they make decisions about everyday life in their jobs and they make decisions about birthing now. They want a defined outcome .
>
> Dr David Molloy, in 'Why are more women having caesarean sections'? *Insight*, SBS, 10 March 2009.

Along with the convenience factors, the other most common reason given in the media for women requesting caesareans was preservation of the pelvic floor. In a 2004 *60 Minutes* story, reporter Liz Hayes interviews fellow reporter Tracey Curo about her caesarean birth;

> Liz Hayes: Why did you decide on caesarean births?
>
> Tracey Curo: There was some compelling medical reasons why it was a good thing for me. But I had to be convinced that it was also going to be the safest for my baby.
>
> Liz Hayes: And am I able to ask what your compelling medical reasons were?
>
> Tracey Curo: Oh, absolutely. Preservation of the pelvic floor. I certainly think that this is like the last no-go zone in a vast territory of secret women's business. Women don't readily discuss pelvic floor dysfunction. And it's quite ghastly, really.

In Mortlock and Gaitz, ‘Mothers Choice’, *60 Minutes, 30* May 2004.

Four years later, *60 Minutes* again reported on maternal request caesarean. Reporter Tara Brown asks a woman why she has chosen an elective caesarean;

> Di Baker: In order to keep everything intact, um, I wanted to have a great sex life, I wanted to enjoy intimacy with my husband and have total fulfilment.
>
> Tara Brown: Well so when you say ‘keeping everything intact’, what do you mean exactly?
>
> Di Baker: It is like the unspoken myth, women don't want to talk about it. Things certainly have to open up for baby to have to pass through and things don't necessarily remain intact down below.
>
> In Thompson and Taylor, ‘Mothers Choice’ *60 Minutes,* 8 June 2008.

A special feature on caesareans in *The Weekend Australian* in 2005 (Horsburgh), featured several women who stated their choice of birth as being a precautionary measure for keeping their pelvic floors intact. One woman, Lisa Tarabay told the reporter that:

> She and husband Teddy are expecting their fourth child in April and the caesarean is already booked. ‘I hate being pregnant,’ says the 36-year-old Brisbane PR consultant. ‘I would bond just as readily if I went to the hospital and was handed a baby. I'm 5'4’ [163cm] and 52kg wringing wet. There's no way you're going to get an eight-pounder out of there - and I really don't want to try.’ … ‘I had done the classes and read the books and I had no desire to huff and puff.’… Women request caesareans for any number of reasons: concern for their baby's safety, fear of labour pain or even just for convenience; others want to avoid pelvic floor injuries that may lead to urinary or faecal incontinence.
>
> Susan Horsburgh, *Weekend Australian,* February 19-20th 2005

On a popular Australian online parenting forum *Essential Baby*, there are countless threads discussing the positive benefits of elective caesarean (though these assertions do not go unchallenged) including that caesarean birth prevents damage to the pelvic floor and vagina. For example, 'Nic-jaylas_mum' who says 'the knowledge of knowing I didn't have to push my big bubba out and destroy the down stairs area', was the 'best thing' about her elective caesarean (*Essential Baby*, February 15th 2009). Jane Ashcroft, interviewed for an *Age* article says she was 'relieved' when her obstetrician informed her that her baby was too big and would have to be born by caesarean, as she was 'happy to avoid the stretching and mauling' that she perceived as going hand in hand with vaginal birth (Hamer 2007a).

Obstetricians confirmed that preservation of the pelvic floor was a common indication for maternal request caesarean, for example;

> When asked about the spiralling caesarean rate, almost every privately practising Brisbane obstetrician *QWeekend* contacted mentioned maternal request in their opening gambit. The three main reasons were: fear of labour and childbirth; alarm about short-term incontinence, sexual dysfunction (loss of muscle tone) and other pelvic floor stress, as well as the prospect of pelvic prolapse, or sagging of the womb, in later years; and the convenience of scheduling a caesarean into hectic lives… [Dr John Howland] says one-third of his primary caesarean requests are sparked by fear of pain, while the majority are a response to worries about injury to the sling of pelvic muscles supporting the bladder, rectum, uterus and other organs…
>
> Matthew Fynes-Clinton, 'The Other 'C' Word', *QWeekend*, 13 October 2007.

The author of the *QWeekend* article above, clarifies that research acknowledges that pregnancy rather than birth itself cause pelvic instability and incontinence. At RANZCOG conference in 2005, Professor of obstetrics, Dr Michael Chapman, gave a paper on maternal request caesarean claiming that 'fear of pelvic injury and the desire for "a pristine vagina"' were reasons driving up the caesarean rate (in Konkes 2005), which was widely reported in the daily newspapers at the time (Darby 2005; Konkes 2005; McKimmie 2005; The Age 2005). The notion that vaginal birth

was potentially damaging to the pelvic floor was sometimes challenged in the media, however medical professionals often reiterated the popular notion. For example in 2008, *The Age*, *Sydney Morning Herald* and Channel 7's *Morning* show reported on British research debunking the myths of pelvic floor dysfunction, but asked doctors to comment on the findings:

> Tim Wilson, a colorectal surgeon at Sydney Hospital and Mona Vale Hospital, said vaginal birth caused serious problems for women that were often only unmasked later in life. 'I see sphincter disruption after vaginal delivery as well as tears in the immediate post-partum period, but most commonly we see the effects of that damage … when women are in their 50s and 60s.'The most common thing we see is symptoms related to a tear … in the muscles between the anus and the vagina.'
>
> Ruth Pollard, 'Caesareans unlikely to spare mothers' grief of incontinence', *The Sydney Morning Herald*, 16 January 2008.
>
> After hearing about the pain and suspense entailed in a normal vaginal delivery, it is not surprising some people start to look on caesarean as an easy way out! After all, why do hard labour, apparently attempting to squeeze a watermelon out of a teapot spout, if you can just lie back and let the experts escort your baby out of an exit hole cut specifically for the purpose?
>
> Dr Cindy Pan, celebrity doctor, on the *Morning Show* Channel 7 Network, 13 March 2008.
>
> Hans Peter Dietz, an obstetrician at Nepean Hospital, said there was little risk of incontinence through vaginal birth but fears of future organ prolapse were realistic. Avulsion injury, in which the pelvic floor muscle is torn away at its edge, was much more common than previously recognised, affecting 20 per cent of vaginal births and 40 per cent in first-time mothers aged 38 and older, he said.

> Julia Robotham, 'Mothers, push for baby's sake', *Sydney Morning Herald*, 25 September 2008.

There was some public space given to alternative views of maternal request and not all in the profession agreed that maternal request was the main cause for increased rates of caesareans. On several occasions, professor of obstetrics, David Ellwood , discounted the belief that caesareans would prevent pelvic floor damage , but also that the women who ask for caesareans on these grounds, are pushing up the overall rate, for example:

> Professor David Ellwood, from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, said it was important these women [who chose caesareans] were properly counselled. For instance, if they had made their choice for pelvic floor protection, a caesarean might reduce risk to a degree but did not offer complete protection. 'But these are not the women driving up Australia's caesarean rates' he said.
>
> Marnie McKimmie, 'Caesarean: to intervene or not second time', *The West Australian*, 13 Ju1y 2005.
>
> Others will say that they have the right to protect their pelvic floor and perineum from labour and birth, although the evidence is lacking that caesarean is completely protective against prolapse and incontinence
>
> David Ellwood, 'The folly in blindly turning women away from natural birth', The *Sydney Morning Herald*, 15 January 2008.

Obstetrician and then president of RANZCOG, Dr Ted Weaver told the *Age* that it 'was difficult to speculate' on what was driving up the caesarean rate and that while 'life-style factors' and fear of vaginal damage *might* account for some caesareans, the majority of caesareans being performed in Australian hospitals were actually repeat surgeries (Medew 2008).

Women journalists and commentators also disputed the idea that fear of vaginal damage was driving up caesarean rates. Writer and journalist Emma Tom, was highly critical of the media's

focus on women who had chosen caesarean for vaginal preservation reasons (although Tom, elsewhere applauds the medical profession and expounds a medical view of birth).

> ‘Tra la la la la,’ the nation's lady folk are supposedly trilling as one. ``We're such feckless floozies, we can't wait to accidentally conceive so we can join feminism's secret campaign to scourge the world of all unborn babies. And when we do get pregnant on purpose, we can't wait to endanger our infants' lives with flamboyant abdominal surgery because all we care about is keeping our treasure boxes teeny-bopper taut.
>
> Emma Tom, ‘Let’s cut (or push) out this claptrap’, *The Australian*, 18 December 2008.

Meredith Nash, a feminist academic, also questioned the widespread narrative of maternal request, arguing that fear of birth was on the rise, and that ‘horror’ birth stories reported in the media were partially responsible, therefore women were not ‘too posh’ but possibly ‘too scared’ to push (Nash 2008). Bianca Nogrady, writing for *The Australian,* also counters the popular view:

> Research suggests that most women who undergo elective C-section do so out of concern for their baby's safety, contrary to the popular notion they are ‘too posh to push’. But they make that choice on the advice of medical experts working in a highly litigious, pro-interventionist and, some would say, overly fearful environment.
>
> Bianca Nogrady, *The Australian* March 7th 2009.

In the media coverage, there was also some attention given to research citing fear of birth and concerns about baby’s safety as the main reasons for women choosing caesarean, not pelvic floor preservation or scheduling purposes (Buckley 2007; O’Brien 2010). However, the ‘too posh to push’ discourse was prevalent and often supported and proffered by obstetricians and other medical specialists as reasons why women were electing birth by caesareans, supposedly pushing up the rates to record highs. Surveys of obstetricians in Australia and the United Kingdom suggest that many believe increasing caesarean rates were due to non-medically indicated

maternal request (Kiran and Jayawickrama 2002; Simpson 2004; Handfield et al. 2006; Bettes et al. 2007; Weaver et al. 2007; Robson et al. 2009) even when they admit to only receiving a small number of requests themselves (Weaver et al. 2007). These opinions have a strong presence in peer-reviewed medical journals where a discourse of maternal request echoes (or predates) the media discourse (Douché 2007; Bourgeault et al. 2008). As discussed above, in the international medical literature in the late 1990s to mid-2000s, caesarean without medical indication was promoted and supported as valid birth choice available to all women (Douché 2007). In this literature, caesarean was often presented in terms of being what all women would desire if they were properly informed of the supposed 'dangers' of vaginal birth (Steer 1998; Farrell 2002; Fisk and Paterson-Brown 2004; Molloy 2004; Robson 2004; Rozenberg, 2004; Dietz and Peek 2004). For example, British professor of obstetrics, Philip Steer, suggested that if women knew that vaginal birth might result in such 'disabling complications' as incontinence, most women would choose caesarean and the 'unpredictable risks' of labour would no longer be justified (1998: 1053). In a letter to the Guardian newspaper in the United Kingdom, obstetricians Nicholas Fisk and Sarah Paterson-Brown likened vaginal birth to drink driving or riding a bike without a helmet; arguing that as a society we are no longer willing to take such risks and as such, women should not have to endure vaginal birth (2004). In Australia, Dr David Molloy described caesarean delivery as 'vaginal bypass surgery' which he said would reduce the incidence of vaginal 'injuries'. He argued that as more women become aware of these problems they would increasingly choose caesarean (2004: 187). Writing in the *Australian and New Zealand Journal of Medicine* in 2004 Dietz and Peek endorse elective caesarean (citing the British survey of obstetricians' birth preferences discussed above) primarily on the basis of pelvic floor preservation:

> The second reason for the ongoing shift in attitudes, both among doctors and their patients, is our increasing knowledge of pelvic floor physiology. There has been an inexorable accumulation of evidence suggesting that, for some women, vaginal delivery (or even the attempt at vaginal delivery) may not be a good idea. Neurophysiological investigations imaging, urethral pressure measurements, and clinical data all indicate that vaginal delivery, in particular vaginal operative delivery, is associated with impairment of fascial pelvic organ

> support and levator antructure and function, anal sphincter damage, as well as pudendal nerve trauma. (2004: 103).

In the United States, the influential National Institute of Health, *State of the Science* conference on maternal request caesarean in 2006 heard from several panellists claiming the primary rationale for advancing caesarean by request was pelvic floor preservation (NIH 2006; Bourgeault et al. 2008). The final panel statement from the conference conservatively stated that evidence either for or against elective caesarean 'on demand' was inconclusive, yet as Bourgeault et al. (2008) point out, the accompanying press release and surrounding media at the time did not dispel the notion that caesarean would protect against pelvic floor dysfunction and damage (see also Young 2006). The medical construction of caesarean as a preventative surgery endorses women's fear of vaginal birth and covertly appeals to heteronormative notions of the vagina. Feminist political scientist, Naomi Wolf, wrote in 2001 of North American magazines describing a new trend of obstetricians who recommend caesarean in order to enhance their patients' sex appeal—dubbed the 'honeymoon vagina'(Wolf 2001; see also Beckett 2005). In the Australian media, obstetrician Dr Andrew Childs, also referred to women desiring a 'honey moon fresh' vagina, as a reason for choosing caesarean

> There is the fear factor but it's also for cosmetic reasons -- in Chile, they say the high rate of caesareans there is linked to women wanting to stay honeymoon fresh so there is a probably a bit of that here, too.
>
> Linda Simalis, *Sunday Telegraph*, 6 March 2007.

Discourses around vaginal disfiguration and women's insecurities with their bodies and the culturally created, heteronormative desire to keep the vagina toned and 'honeymoon fresh' for a male sexual partner (Beckett 2005) need to be placed in the context of a culture that places significant worth on women's aesthetic qualities above anything else (Bewley and Cockburn 2002a; Bordo 1993). Indeed, labioplasty is the fastest growing area of cosmetic surgery in Western countries (Braun 2009). As cosmetic surgery is increasingly targeted toward the vagina —the 'new frontier' of 'corrective' surgery—the vulva and labia are yet another area of women's bodies to fall prey to Western culture's obsession with 'perfect' bodies (Kessler 1998). Davis

(1995) has argued that cosmetic surgeons, like obstetricians, are quick to defend a woman's right to undergo such surgery. Braun (2009) identifies a strong rhetoric of patient choice in British debates about genital cosmetic surgery. In Brazil, ethnographic data suggests that fear of vaginal birth and the centrality of aesthetics to women's identity is quite openly exploited by the obstetric profession and often marketed as 'preventative surgery' (Hopkins 2000; McCallum 2005). Other studies show that women's fears about vaginal birth may be compounded by doctors who do not discourage women's decisions or counsel them about their fears, but instead reiterate the alleged 'dangers' of vaginal birth (De Mello E Souza 1994; Hopkins 2000; McCallum 2005; Staff 2006; Simpson, 2005; Bewley and Cockburn 2002b; Fenwick et al. 2009).

The Active Management of labour technique is associated with operative interventions such as forceps and episiotomies which can cause vaginal trauma and pelvic instability (Bewley and Cockburn 2002; Homer and Dahlen 2007; Romano and Lothian 2008). Midwives contend that preventing against vaginal damage might thus be as simple as opting for midwifery-led care which is associated with lower rates of operative deliveries and therefore lower incidences of vaginal damage. Moreover, recent research shows that the only way to prevent pelvic floor instability and incontinence is to not be pregnant in the first place (Homer and Dahlen 2007; Lavy et al. 2012). Pregnancy, rather than mode of birth, can contribute to pelvic instability and incontinence, though forceps delivery and episiotomy are associated with higher rates of problems (Homer and Dahlen 2007; Lavy et al. 2012). Using surgery to overcome the iatrogenic effects of medicalised birth seems a case in point of the 'one two punch theory' described in Chapter One ; punch one: take a highly successful natural process, render it dysfunctional with technology and, punch two: fix the created problem with technology (Davis-Floyd 1994; Fenwick 2009). Reporter Tracey Curo's description, above, of the preservation of the pelvic floor as 'compelling medical evidence' for the justification for a caesarean, suggests that like Brazil, fear of vaginal birth would appear to have been intensified and the solution for fear is perceived as being more technology.

As discussed above, there is little empirical evidence to suggest maternal request is the cause for increases in caesareans. The small minority of women who do choose caesarean in the absence of medical reasons, mostly do so because of an underlying fear of vaginal birth, or because they are

convinced this is the best option for themselves or their baby. Yet the Australian media discourse emphasises women's request as primary reason for the increase. Similar media discourses have been reported elsewhere such as the United Kingdom and North America (Weaver et al. 2007; Declercq and Norsigian 2006; Douché 2007; Bourgeault et al. 2008). Declercq and Norsigian (2006) and Bourgeault et al. 2008 make the point that the 'too posh to push' narrative makes for a good news story, however it gives a skewed impression of reasons for high rates of caesarean section, particularly obscuring obstetric practice as a cause. Moreover, if women *are* choosing caesarean in order to preserve their pelvic floor, then this needs to be understood in the context of hegemonic understandings regarding childbirth as dangerous and disfiguring. The biomedical view of childbirth constructs birth as a medical event that is always fraught with danger and risk. Combined with the strong cultural emphasis on women's heterosexual desirability (Bordo 1993) and the increasing cultural fear around vaginal birth (Reiger and Dempsey 2006) and it is not surprising that some women may opt to 'preserve' their vaginas via elective caesarean birth. As Gagne and McGaughey (2002:819) argue in relation to cosmetic surgery, decisions are made in the context of internalised 'hegemonic gender norms'.

3.3. 'My body, my choice': autonomy in the context of hegemony

Regardless of *why* or *if* women were choosing caesareans, the overarching narrative that women were behind the increase of caesarean birth was framed in terms of a neoliberal discourse of consumer choice. The right of women to choose a caesarean was vigorously defended by the many in medical/obstetric profession. Before turning to the public media discussion, I will briefly overview the arguments that emerged from within the medical literature expounding women's right to choose, as this predated the debates that surfaced in the media.

Douché (2007) argues that the underlying message in the pro-caesarean medical literature in is framed in terms of women's rights. Choosing caesarean, it is argued in the medical literature, is an emancipatory decision. The narrative of supposed emancipation is utilised to justify caesarean on request, by comparing it to a host of other reproductive choices such as contraception, abortion and IVF that improved and changed the lives of women in the 20th century (c.f. Quinlivan et al. 1999; De Costa 2000; De Costa and Robson 2004; Molloy 2004). Dr David

Molloy for example, argues that caesarean is a 'logical endpoint in female reproductive emancipation' after years of being 'limited by their reproductive systems' (2004: 188). British obstetrician, Dr Sarah Paterson-Brown (also stating the dangers of vaginal birth and drawing on the discourse of risk) argues that

> We are at a turning point in obstetric thinking, brought about not only by the advances that have made C-sections safe and the evidence that vaginal delivery can be associated with substantial morbidity but also by the attitudes of our society, which reflect intolerance to risk. We encourage 'family planning' and pre-pregnancy counselling, we routinely perform antenatal screening, and we offer prenatal diagnosis—all of which are 'unnatural' and promote a concept of the 'designer baby.' Can we do all this and then refuse a woman a safe mode of delivery (caesarean section) that removes the gambles associated with labour and which she personally finds unacceptable? (Paterson-Brown 1998).

Advocates of caesarean by request in the medical literature, draw on the legacy of feminists such as Shulamith Firestone (1970) and Simone De Beauvoir (1952), who understood women's biology, especially their childbearing capacities, as oppressive and reproductive technologies as liberating. Thus, the decision to opt for a caesarean is constructed as being the choice of enlightened, modern women. Opinion writers in the medical literature refer to 'educated' and 'informed' women using logical reason to choose caesarean (Paterson-Brown 1998; Steer 1998; De Costa 2000). The pro-caesarean discourse claims that since educated, informed and emancipated women choose (or would choose) caesarean, it is a childbirth option that all women should have. There is much rhetoric, for example, around 'respecting' and 'protecting' women's choices (Paterson-Brown and Fisk 1997; Paterson-Brown 1998; Molloy 2004; NIH 2006). A neoliberal narrative is employed, where women's emancipation is equated with individual success and freedom of choice or consumption (Braidotti 2005; Bulbeck 2005).

At the same time, the natural childbirth movement is discredited and misrepresented as constraining or limiting women's choices. For example, Paterson-Brown (1998) believes the natural childbirth movement wants to limit women's choices by 'dictating' to women what they should and should not want. Likewise, Molloy (2004) argues that the 'natural birth lobby'

attempts to take away women's choices or 'coerce' them into choosing natural birth (2004: 188). Others argue that natural childbirth midwifery-led care is dangerous (Steer 1998; De Costa and Robson 2004; Hankins 2006). Thus, the obstetric profession is able to make the point that *they alone* are giving women what they want, keeping childbirth safe and respecting women's 'rights'.

In the mid to late 2000s these perspectives about women's right to choose a caesarean in the absence of medical need, were given prominent space in the popular Australian media:

> If we assume that a woman is an intelligent, capable person prior to them getting pregnant I don't see why that needs to change after they get pregnant…I don't think that it's up to an obstetrician to tell the woman what to do. I don't think it's up to a midwife or a policy maker to tell a woman what to do. I think that it's important that we respect that woman's wishes. Our responsibility is to educate her and to make sure that she is fully informed and that she makes a fully informed decision.
>
> Dr Vijay Roach in *ABC Radio National Health Report*, 9 December 2009.
>
> Women have good contraception, access to good contraception…They can choose whether they want to have children at all, how many they want to have, when they want to have them, spacing and so on and so control over what happens to you in a planned pregnancy, or even an unplanned but wanted pregnancy is now regarded almost as a women's right. Part of that right is the ability to choose caesarean or to agree to caesarean, or to suggest caesarean to your doctor if that's what you think should be happening to you.
>
> Dr Caroline De Costa in *ABC Radio National Health Report,* 9 December 2009.
>
> Dr John Howland, a specialist consultant at the North West Private Hospital in Everton Park, agrees that caesarean requests are 'certainly something gathering speed' and believes it's medically and ethically appropriate to support women's right to choose.
>
> Matthew Fynes-Clinton, 'The Other 'C' Word', *QWeekend*, 13 October 2007.

In 2007, in response to consumer and midwifery pressure, the NSW government introduced a policy in public maternity hospitals to lower the rate of caesareans by making it harder to request an elective caesarean without medical cause (Gallego 2007). In the same year, then Western Australia state health minister, Jim McGinty, suggested a similar policy for his state, and in a direct challenge to the dominant obstetric discourse argued that he had he had 'no doubt' some obstetricians were motivated by 'convenience and medical liability'(in Knowles 2007). His suggestion was met with strong resistance from the West Australian branch of RANZCOG

> I think that women should be allowed to have autonomy in decisions and I think that as long they're given the full and accurate information, if they should choose to make the decision they want to be delivered that way, I believe they should be allowed to.
>
> Dr Louise Farrell, quoted in *ABC News Online,* 4 April 2007.

The language of the natural childbirth movement— the rhetoric of choice— is thus co-opted by doctors as a 'discursive strategy to remain in control' (Douché 2007: 134) of the construction of caesarean debate in the Australian media thereby, supporting obstetric hegemony. It needs pointing out that the endorsement of choice in childbirth only extends to women's choices that correspond with biomedical ideology (Leeman and Plante 2006; Wagner 2006; Douché 2007: 134). As I will discuss in Chapter Five, obstetricians are not so quick to defend a women's right to choose to birth at home and in fact actively and aggressively oppose it. Similarly, obstetricians generally do not champion women's right to a VBAC (vaginal birth after previous caesarean) or vaginal breech birth (Leeman and Plante 2006). Historical analyses of the politics of childbirth show that the obstetric profession has been quick to, reformulate its field of power in reaction to challenges from the natural childbirth movement, in this way co-opting a marginalised discourse and incorporating it into the hegemonic norm (Arney and Neil 1982) For example, childbirth education classes in Australia, previously run by independent advocacy groups or midwives, were eventually taken over by the hospital system. In this way, medicine retained control over information being disseminated to women (Reiger 2001: 212). In the caesarean by choice discourse, the notion of autonomy in childbirth, introduced into public consciousness by the

natural childbirth movement in the 1970s, has been reformulated to suit the professional needs and motives of modern obstetrics practitioners.

In modern maternity care, women are often discursively constructed/positioned as consumers (Zadoroznyj 1999, 2001; Lupton 2003; Maher 2004; Bryant et al. 2007; Bourgeault et al. 2008). The consumer challenge to medicine in the late 1970s and into the 1980s has been characterised by medical sociologists as a movement that successfully destabilised traditional paternalistic medical authority calling for more input by patients (now consumers) in medical decision-making (Henderson and Peterson 2002; Lupton 2003). The demand for autonomy and equal participation in decision-making formed a crucial part of the alternative or 'natural' childbirth movement (Bourgeault et al. 2008 see also Reiger 2001). Advocacy for greater participation and choice in maternity continue to be the basis of consumer challenges to obstetric–led maternity care (such as The Maternity Coalition in Australia (Newman et al. 2011). Choice in childbirth, as imagined by advocates, is for the freedom to choose *less* medical intervention (Bourgeault et al. 2008: 107), yet obstetricians increasingly use the discourse of choice to advocate for *more* intervention, including for caesarean birth without medical indication.

In the Australian media, women letter-writers/commentators, participants in online blogs and online forums, journalists, writers, media personalities, and even academics drew on the 'my body my choice' mantra of the 1970s Women's Health Care movement (e.g. Boston Women's Health Collective 1998) to justify elective caesarean as a mode of birth. Many are defensive in their tone; tired of being cast as ill-informed and flippant by the 'natural birth Nazis' they draw on consumerist liberal rights discourse and present a medicalised understanding of birth, to make their point:

> I am sick and tired of hearing people whinge (sic) about the amount of c sections being performed. My husband and I have private health insurance and we both chose to have our son by c section. I didn't suffer any medical complications luckily I simply chose to have a C-section. My obstetrician advised the pros and cons of both delivery methods to us and we made a choice. I am a firm believer that everyone has a right to decide how they deliver their

> baby and not be brown beaten into defending yourself because your choice is not according to some people ‘the right one’.
>
> Fiona of Brisbane, letter to the editor, *Courier Mail*, 31 October 2007.
>
> And if women choose to have a c/section because they want to avoid the pain of childbirth - that's fine too. As a previous poster said - it's all about choices - and aren't we lucky to live in a society where we are able to choose?
>
> ‘Saffi’ *Essential Baby* forums, 16 August 2007.
>
> We have medical technology now that gives us choices and women should feel free to make those choices. We don't say to someone who's had a heart problem, `Just see how you go, just diet and run and if you die in the meantime then we're really sorry but you should try naturally to de-clog your arteries'. No, we don't, we say, `Go on and have your open-heart surgery'.
>
> Cath Leary in ‘When birth becomes a matter of opinion’, Erica Watson, *The Daily Telegraph*, 16 March 2009.

Writer and feminist commentator Melanie La’Brooy wrote

> If a woman chooses to have an elective caesarean, in the same way that another woman might choose to have a non-medicated home birth, then why can't we just leave both of them the hell alone?. Assuming that women are being conned by the medical profession into having unnecessary caesareans also implies that women are passive, ill-informed and unintelligent when it comes to making decisions about their own bodies and their child's welfare. All of the mothers and pregnant women that I know are the exact opposite.
>
> Melanie La’Brooy, ‘Even those mothers who drive 4WDs deserve our thanks’, *The Age*, 11 May 2007.

Conservative opinion columnist, Miranda Devine, also decried the idea that women who chose elective caesareans were ill-informed or irrational:

> But such evidence will never sway a militant minority of midwife activists who continue to demonise obstetric intervention as a patriarchal insult which disempowers mothers, rather than seeing it as a legitimate choice by rational women.
>
> Miranda Devine, 'Caesarean scare mongers should zip it', *The Sydney Morning Herald*, 21February 2009.

A participant in online community *Essential Baby*, 'Maerska' draws on the surveys of obstetricians preferences for caesarean, discussed above, as justification for her choice, in addition to fears about pelvic dysfunction and damage:

> I am tired of reading and hearing the criticism of women choosing to have elective CS. When I was pregnant, I had not really considered 'how' I was going to have my daughter- I just expected that I would go into labour and check into the birthing suite at my nominated hospital. Until about week 32, that was my expectation. I never had a 'birth plan' such as those you read about in the books you buy during your pregnancy. I did however, recruit an excellent obstetrician who discussed the available options when I shared this with him. I never felt any fear of pain and I had no fear of going into labour. I researched statistics on vaginal birth vs an elective caesarean and the issues that relate to damage to the pelvic floor later in life, prolapse, and unpleasant complications during vaginal birth that may ultimately lead to an emergency caesarean delivery. I also recognised that of those females in the medical profession that where surveyed, 69% would choose to have an elective caesarean over vaginal delivery. It is not always about woman being 'too posh to push' or taking the easy way... It is a very personal choice and I am really pleased that I made the choice to go this way.
>
> 'Maerska', *Essential Baby* forums, 7 September 2007.

‘Maerska’s’ careful construction of herself as informed consumer choosing an elective caesarean demonstrates the operation of obstetric hegemony at the personal level; repeated are the discourses around pelvic floor damage, the idea that obstetricians choose caesarean for themselves (therefore it *must* be safe and valid), and the notion that choosing a caesarean is her ‘personal’ choice. Yet she also states her recruitment of her ‘excellent obstetrician’ whom she consulted and discussed options with. Many critics question whether women are truly able to make informed decisions about caesareans in the context of medicalised maternity systems and obstetric hegemony (Wagner 2000, 2006; Bewley and Cockburn 2004; Weeks 2005; Douché 2007; Bourgeault et al. 2008; McAra-Couper et al. 2012).

Consumerism in medical/maternity care is not just a discursive subject position, but also linked to wider ideologies and discourses associated with neoliberalism. In neoliberal societies, individuals are expected to be economically productive and make rational ‘free’ choices that align and conform to society’s values (Bryant et al. 2007; Douché 2007; Braun 2009). Autonomy is trait highly valued in neoliberal ideology, and is the hallmark of civil, legal and political movements, including feminism (Braun 2009). In the context of birthing options, women’s and obstetricians’ expression of women's right to choose reflects their entitlement as consumers, to choose the birthing services and commodities that best suit their needs/desires (Maher 2004; Bryant et al. 2007). More broadly, the consumerist ‘my body, my choice’ mantra is one that is used to justify other choices women make about their bodies, for instance in the case of genital cosmetic surgery or women’s decisions to partake in sex work (Braun 2009; McAra-Couper et al. 2012). However, as many scholars suggest, informed decision-making is difficult within the confines of obstetric hegemony, and women’s decisions are influenced by broader cultural discourses as well as directly through their doctors (McCallum 2005; Weeks 2005; Crossley 2007; McAra-Couper et al. 2012). McAra-Couper et al. (2012: 82) argue that choice is always limited and ‘shaped by hegemonic discursive orders and social practices that often privilege the interests of one particular group over those of the individual’.

Thus while a rights based discourse implies absolute autonomy of the birthing mother, decisions takes place within larger structures of power and knowledge. For example, information given to women about caesareans may be ‘…presented from within a particular paradigm that venerates

technology….above any other way of knowing' (Weeks 2005: 22; see also Bryant et al. 2007; McAra-Couper et al. 2012). Critics of obstetric practice, maintain that women are being misinformed about the risks involved in caesareans and are being given biased and 'Dr friendly' information (Wagner 2000; Goer 2001; Bewley and Cockburn 2002a; McFarlin 2004; Weaver 2004; Beckett 2005; Weeks 2005; Bergeron 2007). Moreover, they argue that the tendency of obstetrics to offer choice within the confines of perceived risks does not give women any confidence in their ability to birth and taints the information given to women in hospital settings (Bewley and Cockburn 2004: 197; Bryant et al. 2007). Bergeron (2007) asserts that true autonomy and informed decision- making in maternity care can only happen when there is an equality of resources; when the facilitation of normal birth receives the same money and resources as surgical birth and when maternity care professionals are trained in normal and abnormal birth procedures.

Other cultural and societal factors also need to be taken into account when understanding decisions around birth. Journalist and writer Michele Hamer, for instance, argues that our culture's intolerance of risk, our desire to control, manage and standardise the birth experience is leading to a culture of 'Mc Mothering' (Hamer 2007b: 19). She argues that the 'baby-stakes' are high in Australia; having a baby is an event to planned, managed, controlled and perfectly timed to fit into an appropriately allocated spot between travelling and buying a house (Hamer 2007b). Caesarean birth gives the illusion of control that many women seek (Davis-Floyd 1992; Staff 2006; Fenwick et al. 2009; Robson 2009; McAra-Couper et al. 2012). Caesarean birth may also seem a more preferable and 'civilised' option in a society so far removed from the 'natural' (Handfield 2006). In a culture obsessed with the lean, disciplined body and where the pregnant and birthing body is perceived as fat, out of control, leaky, unpredictable, and primal (Nash 2012) and caesarean birth can appear more preferable. Women who choose caesarean speak of their desire to remain separate from the birth process and to retain a sense of control over their bodies (Staff 2006; McAra-Couper et al. 2012). For instance, McAra-Couper et al. (2012) interviewed 33 women in New Zealand who had recently given birth and found that among their participants, there was a preoccupation with retaining bodily control; women feared defecating or making too much noise during birth, as one women said 'I'm not going to be the grunting, pooing, foul

woman during birth' (McAra-Couper et al. 2012: 89 see also Martin 2003). Normal birth, as Handfield (2006) argues, is now considered by some as 'too noisy, too bloody, too fleshy'.

'Choice' then is a great deal more complex than merely a matter of women 'storming' into their doctors' offices demanding surgery for convenience and other 'life-style' factors. While the experiences of women requesting non-medical caesareans needs more research, particularly the decision-making processes between doctors and women, this represents a very small number of the overall caesareans being performed in Australia each year. The claim that women demand surgery has nonetheless become the dominant narrative in the public and professional debates around caesarean birth. These media debates highlight the way in which medical knowledge is produced, and obstetric hegemony is maintained, through the intersection of medical discourses and commonly held cultural values, such as heteronormative preoccupations with vaginal perfection and the belief in women's autonomy and individual rights.

3.4. 'Killer scars': constructing risk in the caesarean debates

Between 2006 and 2009 several large-scale studies from North America, France, Canada, the United Kingdom and Latin America, were published suggesting that there are increased risks for mother and baby with caesarean birth (Kolas et al. 2006; MacDorman et al. 2006; Villar et al. 2006; Gray et al. 2007; Liu et al. 2007). In short, mothers and babies are more likely to die following a caesarean, women are more likely to require rehospitalisation for infections, have a greater risk of requiring a hysterectomy and babies are more likely to require resuscitation for respiratory distress regardless of whether the surgery was emergency or elective. Most concerning, was the research suggesting that the risk of placenta previa and placenta acreta in subsequent pregnancies following a caesarean (Yang et al. 2007). This was dubbed the 'killer scar' by some media outlets (Benson 2008). These studies received considerable media coverage (Knowles 2008; Benson 2008; Pollard 2008b) and contributed to the New South Wales government decision to introduce policies aimed at limiting women's option for elective caesareans without medical indication (Gallego 2008; Pollard 2008b).

Newspaper reporting of the New South Wales policy initiatives and the risks of caesarean, cautioned women to reconsider non- medically indicated caesarean. The discourse became

paternalistic, with many doctors, politicians and concerned commentators warning women of the risks involved in caesarean:

> …this widely embraced medical procedure is becoming more dangerous. There are increased chances of immediate and long-term complications; babies are at greater risk of respiratory problems; still birth is more common; it has been deemed internationally to be often unnecessarily invasive and the whole process is now putting a strain on the health system generally..It is time for women who choose caesarean for no medical reason, or who quickly agree to it when a doctor suggests the possibility without exploring all their options, to take a long hard look at themselves.
>
> Jane Fynes-Clinton, 'The slice and serve childbirth', *News.com.au*, 17 January 2008.
>
> Some media reports indicate a trend towards elective caesareans - in the absence of medical need - and this is very concerning,' Pike said. 'I would strongly caution any woman or doctor against making such a choice. There are times when caesareans are required and doctors need to make those judgements.
>
> Bronwyn Pike, (former) Victorian Health Minister, in Michelle Hamer, 'The great Caesar debate', *The Age*, 10 May 2007.
>
> Women who have caesarean births have double the risk of death and illness to themselves and their baby, a study has found .As caesarean rates in many of Melbourne's hospitals hit 30 per cent, doctors are urging women to give birth naturally if they can. Doctors say most women who choose caesarean sections do so for medical and psychological reasons, but some just want to avoid a vaginal birth.
>
> Susie O'Brien, 'Caesarean mums may face health risks,' *The Age*, 31 October 2007.

Evident in the media discourse here is the ongoing narrative that women are choosing to give birth surgically with no good reason; however the rhetoric shifted from one of 'choice' to one of blame. As epitomised most clearly in the Fynes-Clinton newspaper article above (2008), the responsibility of blame was being placed on women. Obstetricians quoted in the media during this time began to strongly promote the view that caesareans were caused by an ageing population of first time mothers, the 'obesity crisis', and the higher incidence of multiple births due to increase use of assisted reproductive technology. For instance:

> Professor Alistair MacLennan, head of Obstetrics and Gynaecology at Adelaide University, said there was a complex range of reasons for the increase, including the older average age of first-time mothers, and called for women to be given better information about their choices. The mean age of women giving birth has increased from about 26.5 in 1981 to just over 30 in 2006. Professor MacLennan said this age increase could cause more complications and increase the need for caesarean sections.
>
> Tory Shepard, Australians set a poor example as caesarean rates skyrocket, *Adelaide Advertiser*, 26 December 2007.

This shift in discourse was cemented during 2008/2009, when the Federal Labor government carried out a major review of maternity services (Department of Health and Aging 2008), which I examine in detail in the following chapter. Submissions to the review from obstetricians and professional obstetric organisations almost unanimously reinforced the narrative that increased caesarean rates were now seen to be caused by the aging maternal population, obesity and multiple births, and some by maternal request. The shift away from the narrative of maternal request coincided with the new research suggesting that risks of caesareans could be outweighing the perceived benefits, but also came at a time when there was increasing public scrutiny placed on obstetric practices.

The view that rising caesarean rates might be attributable to factors relating to obstetric-led childbirth received considerable media coverage. For example, in 2009 a SBS *Insight* Program ran a discussion panel on caesarean birth featuring midwifery representatives, consumers and

obstetricians. Considerable space was given to the view that over use of intervention and obstetricians' risk-averse approach might be contributing to higher rates of caesarean birth. Dr Andrew Bisits, a well-known advocate of normal birth, asserted that constructions of risk had a role to play in the use of intervention in private obstetric practice:

> Well I think we're totally over obsessed with risk, at our peril. There is a lack of emphasis on what can go right in hospitals all the emphasis is on what went wrong and what may go wrong and not so much what may go right. As far as the comment … about midwives skating over risk, I think the truth is they have a different way of presenting the risk and I find it fascinating, particularly say when we're talking about breeches and VBACS, they all present the same figures but there's this different slant and I suppose it's a more optimistic slant rather than often the obstetrics stereotype is one of doom and gloom.
>
> Why are more women having caesarean sections? *Insight*, SBS, 10 March 2009.

Dr David Ellwood, professor of obstetrics at Australian National University, pointed to a culture of fear; fear of litigation among obstetricians and fear of birth and desire for control and perfection among women were factors to consider in the debate:

> Litigation and the fact that people expect perfection in everything they do these days has driven people to think that the more intervention the better, and maybe that isn't true. There is a climate of fear that has been generated about childbirth, and for things to switch around it will require some real champions, who are obstetricians, to come out and say, 'We do not have to do it this way; there are safe alternatives without intervention'.
>
> In Ruth Pollard, Fatal flaws in steady rise of caesareans, *The Sydney Morning Herald*, 14 January 2008.

Bisits' and Ellwood 's opinions represented a minority view from within the obstetric profession and it's notable that both doctors work within the public hospital system. Other obstetricians

however, used the media to diffuse any idea that rising caesareans had anything to do with them, or with obstetric culture. For example, when the *Sunday Age* reported on a study suggesting association between induction of labour and emergency caesarean the response from 'leading obstetrician' and chairman of the Victorian Maternity Services Advisory Committee, Professor Euan Wallace, was dismissive of the link, stating that 'finding a relationship between inductions and caesareans was a complex issue' (Switzer 2007). Others used the media to reject that caesareans were unsafe, or as risky as recent studies suggested. For example Dr Andrew Pesce, then chairman of the National Association of obstetrics and Gynaecologists (NASOG) and later president of the Australian Medical Association (AMA), wrote a letter to the *Sydney Morning Herald*, criticising a report citing evidence from the North America that death was 'twice as likely' for newborns born via caesarean:

> When planned vaginal births go wrong babies are most often delivered by caesarean. It is easy to see that even with the best intentions, neonatal mortality can be incorrectly attributed to a planned caesarean delivery, rather than a planned vaginal birth gone wrong. Given that mortality rates in low-risk pregnancies are two to three per thousand births, it would take only one incorrectly recorded or interpreted birth certificate per thousand births to lead to an erroneous conclusion that planned caesarean delivery is more dangerous for babies than planned vaginal birth. Whether a woman chooses to give birth naturally or by caesarean, far and away the most likely outcome is a healthy baby and mother. There are many reasons why we should encourage women to give birth naturally when all is going well in their pregnancies, but not because caesareans kill otherwise healthy babies. They don't. 'Caesareans don't kill otherwise healthy babies'.
>
> Dr Andrew Pesce, *Sydney Morning Herald,* 8 April 2008.

Dr Christine Tippett, then president of RANZCOG told the Herald Sun that caesareans had risks, but 'not at the level the studies suggested'; 'there is some evidence to suggest an increased

maternal mortality risk and greater risks to the baby, but Australia is one of the safest places to have a baby in the world' (in O'Brien 2007). Thus while minority views within the profession were sometimes heard in the media, these views were quickly shut down by organised medical organisations such as RANZCOG and the AMA who strategically deflected blame away from obstetric practices towards women's individual pathology or individual 'choices'.

In conclusion, in the Australian media during the first decade of the 2000s, rising caesarean rates were constructed as being the result of women's individual choice, or pathology. The media narratives represented doctors as the 'experts' in the caesarean epidemic and women as the culprits. In the hegemonic struggle to make meaning of rising caesarean debates, media discourse thus contributed to strengthening of the dominant obstetric viewpoint.

Chapter Four

Delivering safety: The Maternity Services Review 2008-2009

The discursive field of childbirth knowledge is shaped not only in professional texts and public debates, but also through policy formation. Several theorists (Gaspar and Apthorpe 1996; Motion and Leitch 2009; Shaw 2010) but particularly Bacchi (2000, 2002, 2005) argue that policy-making and political reform processes act as a sites of discursive 'meaning making'. Rather than viewing policy formation in terms of responses to particular social problems, Bacchi (2000: 48) argues that policy constitutes a discourse process through which both problems and solutions are constructed. Moreover, policy issues are often constructed in a way that 'mystifies' power relations and emphasises individual responsibility thus drawing attention away from structures and institutions. The ways that policy issues are represented have effects 'that limit the impact of reform gestures' and 'subvert' their progressive intent (Bacchi, 2000:48). The aim of a 'policy as discourse' approach to analysis of policy then, is to 'demystify' the power relations and to bring to the fore the 'silences hidden in discourse' (Bacchi 2000: 48). The field known as Critical Discourse Analysis also aims to make transparent the workings of power in discourse, to as Wodak and Meyer (2009: 3) put it 'analyse opaque and sometimes transparent structural relationships of dominance, discrimination, power and control as manifested in language (or discourse)'. In line with Salter's (2006) account of medical politics in the United Kingdom, Australian professional medical and obstetric organisations such as the AMA, RANZCOG and NASOG are able to gain ready media coverage and access to politicians (see also Goer 2005). How they then define the issues or represent what Bacchi (2002) calls the 'policy problem' is a crucial dimension of professional strategy. In this chapter I firstly outline a brief history of maternity care policy in Australia, before turning to examine the federal Labor Government's Review of Maternity Services, including submissions to the Review and associated media debates. I argue that the Maternity Services Review (MSR) in 2008/9 became a key discursive site as medical organisations mobilised their professional agenda in response to proposals to reform provision of Australian maternity care, moves which seemed to threaten the entrenched dominance of the obstetric profession. This mobilisation process is not new—the Australian obstetric profession

has a long history of working with governments to protect and promote their material interests and ideologies.

4.1. Maternity care policy in Australia

Historically, Australian governments at both State and Commonwealth levels have been integral to obstetric domination and control of maternity services. Several scholars have provided analyses of the relationship between government policy, the medical profession, consumers and the midwifery profession in Australia (Reiger 1985, 2000, 2005; Willis 1989; Schofield 1995; Summer 1999; Fahy 2006). As Willis (1983), Crichton (1990), Gillespie (1991) and Schofield (1995) have argued, Australian doctors have been powerful political actors, with a long legacy of resisting what they perceive to be state control over the profession. While the different colonies, and later states, had their own policies and legislation around maternity care provision, generalisations can be made from the existing research – particularly Schofield's (1995) work on NSW policy, Willis' (1989) Victorian research and Sumner's (1999) examination of midwifery legislation and history in South Australia.

As in other Western nations, the rise of obstetric control of birth and the subordination of midwifery in Australia was due in part to the ability of the medical profession to enact their ideologies through government legislation, particularly legislation which limited the extent of midwifery practice. Australian obstetricians, like those in Europe, North America and the United Kingdom, were successful in constructing childbirth in technical, medical terms; privileging the specialised, 'scientific expertise' of obstetricians and favouring a fee-for-service model of maternity care (Schofield 1995). The move from midwife-attended childbirth in small birthing cottages and women's homes, to obstetrician–supervised childbirth in hospitals was largely a result of the material interests of the medical profession and their ability to influence governments to legislate in their favour (Willis 1989). Unlike New Zealand or the United Kingdom, birth in Australia was never seen as 'automatically deserving of public financial support' (Reiger 2000: 56); government policies supporting fee-for-service medical practice in both the private and public sectors were fundamental to the medical control of childbirth service provision in Australia.

Willis' Marxist analysis of medical hegemony in Australia claims the alliance between the State and doctors is at the 'root' of medical dominance in Australia (1989: 27). What he terms the 'division of labour in health care' is an ongoing struggle for occupational territory in the context of the systems of power in a capitalist society, including gender and class relations. While the relationship between knowledge, power and science is fundamental to medical power, providing the *ideological* basis for control, the continuing division of labour in the health care system, Willis argues, is more to do with the preservation of control of medical care by doctors (1989: 5). Governments and medicine, Willis argues, both represent the interest of the dominant class and are thus closely aligned in interests. However, Reiger (1985) emphasises that women too, were agents in this process; often advocating to governments for better outcomes for mothers and babies through hospitalised antenatal and childbirth care.

Prior to the 1890s, community-based midwives, some but not all with formal training, practised largely unhindered in the new colonies of Australia. However, in the period between the late 1890s and the 1930s major changes occurred as the newly formed disciplinary field of obstetrics and gynaecology emerged and nursing professionalised. The number of general practitioners expanded in the late 19th century and they were keen to carve out a market for themselves in family medicine. Midwives were 'increasingly seen as a problem' (Fahy 2006: 27) as they potentially limited doctors' incomes (Willis 1989; Fahy, 2006). The United Kingdom's medical act of 1858, which was similarly duplicated in Australia, gave medical practitioners the right to 'define and control medical practice and limit other workers from practising medicine' (Fahy 2006: 26). Fahy (2006) and Summers (1999) point out that both doctors' organisations and the emerging nursing 'societies' opposed the training of independent midwives proposed by NSW and Victorian governments in the late 1880s in an effort to improve birth outcomes. The Diploma of Midwifery (the first of its kind) offered at the Women's Hospital in Melbourne in 1888, for example, could only be taken by students who had completed general nursing training (Willis 1989; Summers 1999). This was to be the beginning of midwifery's subordination under the umbrella of nursing (see also Gamble and Vernon 2007). By 1915, Victoria, South Australia and Tasmania had enacted *Midwife Registration Acts* requiring midwives to be registered/licensed in order to practise their trade. Registration however, required midwives to be trained foremost as nurses under medical

supervision in hospitals, a process heavily dominated by medical interests (Reiger 1985; Willis 1989: 120; Schofield 1995). Reiger documents that while some medical advocates opposed midwifery training, many supported it if only to ensure that 'the nurse was only a nurse and never an independent practitioner' (1985: 91).

It was during the early years of the 20th century, and then those following WW2, that medical control of birth services in Australia became entrenched with the support of the state. Wider contextual issues were crucial in this period. Racist anxieties regarding the newly federated nation's population and high levels of infant mortality, led to the initiation of the 'baby- bonus' by the federal government in 1916. This baby-bonus, aimed at boosting the nation's white, Anglo population (it was not paid to Indigenous mothers) was eventually only paid only to women who saw a doctor in the antenatal period (Reiger, 1985; Willis, 1989: 113). Although doctors initially opposed this payment, preferring it to be paid directly to medical providers, by World War 2, Australian maternity care was based on the premise that individual *families* would be responsible for financing their own maternity care (Crichton 1990:31). Any efforts by the federal government to provide a socialised system of universal healthcare (including maternity care) were strongly opposed by doctors' advocates and organisations (Gillespie 1991). At the time, midwives were blamed for the high infant and maternal mortality rates. As was the case internationally, Australian doctors portrayed midwives as dangerous, ignorant, and lacking in hygiene standards (Willis 1989; Reiger 1985; Murphy-Lawless 1998). However, there was no change in the rates of Puerperal Fever (or 'Childbed Fever' as it was also termed) following the decrease of midwife attended births, and it is now thought that infection was spread through doctors' not washing their hands after seeing sick patients (Willis 1989: 111; Schofield 1995; Fahy 2006). As Willis argues, in the early 20th century the newly formed specialist obstetric profession was concerned about the competition midwives posed, as they were at the time, 'cheap and popular' especially for poorer families and women in rural areas. The solution for doctors, as Willis sees it, was to encourage poorer women to come to state-subsidised 'lying-in' hospitals by arguing that women would be safer in their hands—despite evidence to the contrary. However Reiger argues that while medical discourse and popular advice literature increasingly emphasised birth as a medical event, women were not entirely resistant to more medical control. As some had suffered in the care of both midwives and

doctors at home (1985: 92), many women also advocated for 'modern' hospital birth under medical supervision.

By the 1950s through to the 1970s, the Australian obstetric specialty became established and professionally organised, for example through the Australian branches of the British Royal College of Obstetricians and Gynaecologists (which became the Royal Australian and New Zealand College in 1972), which were keen to 'raise the status and standards of obstetrics and gynaecology' (McDonald et al. 1981). As Schofield's (1995) detailed historical research has demonstrated, doctors worked closely with the governments of the time to define birth in 'specialist-therapeutic' terms (Schofield 1995). They emphasised the clinical safety afforded by hospitals and reiterated the importance of a high level of specialist medical expertise. The general practitioners or family physicians who had formerly provided a large proportion of maternity-care were marginalised and the economic and social capital of the specialist obstetric profession increasingly underpinned by policies supporting their role in both the private and public sectors. While still administered by state governments, in the 1950s and 1960s maternity policy and funding were largely financed by the Federal government. The conservative Liberal (Menzies) government of the 1950s/1960s catered to the interests of a middle class clientele by institutionalising a voluntary health insurance scheme that cemented medical power (Crichton 1990:43; Schofield 1995). Government policy in this era was thus integral to the medicalisation of childbirth in Australia and to increasing specialist obstetric control within the medical profession.

The policy balance between encouraging public and private provision, including through a network of private hospitals, has continued with conservative governments stressing self-provision whereas reformist Labour governments have emphasised equity and universality. Private Health Insurance (PHI) memberships declined significantly following the introduction of the national health insurance scheme, Medicare, in 1984 and the obstetric profession started to express serious concerns over the possible demise of their private sector work, lobbying to reverse the trend to public health care (Benoit et al. 2007). In 1999/2000 the conservative Coalition (Howard) government, under health minister Tony Abbott, sought to boost PHI (ostensibly to reduce the 'strain' on the public health system) by introducing subsidies for

individuals and families purchasing PHI Schemes. A 30% government rebate for new members resulted in a dramatic increase in numbers of privately insured patients – from just 31% of the population in 1997 to 45% of the Australian population in 2000, a rate much higher than in similar countries (Hindle and McAuley 2004). As the rebate was offered and encouraged (through a proliferation of government sponsored advertising campaigns) to consumers under the age of 30, many (mainly high-income earning) women of childbearing age entered the private maternity system (Shorten and Shorten 2002; Benoit et al. 2010). Currently 30% of Australian mothers are privately insured and using a private model of obstetric-led care (Li et al. 2009). As Benoit et al. (2010: 478) point out, the reforms did little to reduce public hospital waiting lists or to 'improve the accessibility or equity in health care'; they benefited medical reproductive specialists and women in high income brackets. The other significant effect was that rates of intervention into births increased for privately insured maternity consumers, despite women with PHI being one of the healthiest groups in society and therefore the least likely to actually require medical attention (Shorten and Shorten 2002; Miller et al. 2011).

From 2004, many privately practising obstetricians again benefited from state-subsidised medical indemnity insurance and from general financial incentives offered to families to lessen private medical costs (Benoit et al. 2010). The new Medicare 'Safety-Net', which was developed following negotiations between the Australian Medical Association and the federal government was aimed at ensuring privately insured patients did not incur more than $1000 in 'out of cost' expenses (Glasson 2004). This allowed obstetricians to charge highly exorbitant fees by using inventive fee structuring; separating claims for (expensive) pregnancy planning, for each antenatal visit, and for intrapartum/postnatal care. With a rising birth rate, more women with private insurance and with 'Safety Net' support, costs to the public purse tripled for private births from 1997 to 2007; in 2007, 31% ($98.6 million) of total safety net expenditure went to obstetric services (Menzies Health Policy Centre 2008). Moreover, the earnings of private specialist obstetricians reportedly increased by 285 per cent from 2004-7 (Menzies Health Policy Centre 2008; Benoit et al. 2010). Dissenting Sydney public hospital obstetrician Daniel Challis (2008a), in a submission to the Health and Hospitals Reform Commission, stated that:

> [the] result of the Safety Net is that obstetricians in private practice can virtually write their own cheque and charge as much as they want. In some parts of Sydney it is not uncommon for obstetricians to charge over $10,000 for a delivery, and Medicare will pay up to 80% of this. It is not difficult for an obstetrician in private practice to earn over $1,000,000.

4.2. Consumer driven policy since the 1980s

During the 1980s, the consumer driven birth reform movement (Reiger 2001, 2005) produced a process of liberalisation of many routinised, but not evidence-based birth management practices associated with hospitalised birth in preceding decades. Midwives also became professionally and politically organised and have strongly advocated for professional autonomy and recognition (Reiger 2000; Gamble and Vernon 2007). The dominance of Australian maternity policy by doctors has been significantly challenged by consumers as well as by midwives working in alliance with bureaucrats in promoting reform of maternity services (Regier 1999, 2000, 2006). In the last 20 years there have been several state and federal inquiries or reviews into maternity services (c.f. NHMRC 1987; Victorian Department of Human Services 1988; Department of Health Victoria 1990; Ministerial Task Force 1989; Senate Legislative Committee 1999; Victorian Government 2004; QLD Government 2005; Northern Territory Government 2007; South Australian Government 2007) . As outlined by Reiger (1999, 2000, 2006) and Newhman (2010) these largely consumer-driven inquiries and policy formations have directly challenged obstetric-led practice and facilitated the articulation of women-centred maternity care emphasising women's rights to 'choice, continuity and control' in childbirth, and the normalcy of pregnancy and birth. The *Birthing Services Review* in Victoria for example resulted in policy that recommends primary care by midwives and stresses the normalcy of pregnancy and childbirth (Department of Health Victoria 1990; Reiger 1999). At a federal level, the Senate Inquiry *Rocking the Cradle* (1999), strongly critiqued the growing reliance on technology in birth and the increase in caesarean rates, making a case for greater provision of midwifery care and a loosening of obstetric dominance. The (independent) National Health and Medical Research Council's (NHMRC) 1996 research paper *Options for Effective Care in Childbirth* made similar recommendations to the state reviews; even going as

far as offering guidelines for the provision of publically funded homebirth. However, as Gosden and Noble (2000) have explicated, these initial recommendations by the NHMRC emphasising women's 'right' to homebirth were later qualified and situated within medically defined boundaries following pressure from medical groups.

In the last two decades, a range of alternative models of care, including more family birthing centres and some *limited* home birth provision, notably in Western Australia and more recently South Australia and Victoria has been supported at the policy level but not at a fiscal level. However, a prevailing neoliberal context has constrained effective resourcing of these alternatives and thus changes has been slow (Reiger 2006). The combination of government support for PHI, and lack of *financial* support for midwife-led maternity care has, as Benoit et al. (2010; 478) put it 'cemented obstetricians' dominance and increased the medicalisation of childbirth'.

In sum then, doctors have been strongly influential in shaping public policy around health insurance and maternity care in Australia. In constructing childbirth in 'specialist therapeutic terms' (Schofield 1995) the obstetric profession sought to protect their domain and ensure that maternity care remained obstetric-led. Governments throughout Australian history have accepted biomedical ideology and largely supported the profession through policy. Moreover, health insurance policies and a medical system that has historically favoured a fee-for-service model, significantly advantages the obstetric profession. Obstetricians' resistance to maternity care reform (Reiger 1999; Schofield 1995), including in response to the 2008/9 Maternity Services Review that I will now discuss, must be seen in light of their strong material interest in maintaining the status quo.

4.3. The Maternity Services Review 2008-2009

The role, and indeed power, of obstetricians emerged as particularly contentious in the context of the MSR, which was the first federal government review conducted by a party currently in power. Auspiced by a reformist Labor government elected in late 2007, the MSR was responding to several pressures for reform of the maternity system— those from midwives and childbirth advocacy groups such as the Maternity Coalition, public concern over the Medicare

safety-net ‘rorts’ by obstetricians, and the escalating cost of maternity care in the private sector (Newman et al. 2011). The Maternity Coalition’s *National Maternity Action Plan*, released in 2002, called for greater access to midwife-led care and received widespread media coverage and support from politicians from all the major parties (Newman et al. 2011). Government lobbying from the Maternity Coalition intensified during the 2007 election campaign, especially that directed at the shadow health minister, Nicola Roxon, a new mother herself. The concerns expressed by the Maternity Coalition included claims that the hospital maternity system was ‘broken’ and harmful to women and their babies, declining access to women-centred care in rural areas, workforce shortages, escalating intervention rates—particularly increasing rates of caesareans—continued obstetric dominance of maternity services, and lack of adequate access to continuity of midwifery care, particularly homebirth services for many women (Newman et al. 2011). Several birth centres and rural maternity services around Australia had closed down in the two years leading up to the Review and women in these areas were forced to travel long distances to obtain obstetric-led quality maternity care.

After their election in 2007, as part of their National Health Reform agenda, the Labor government established The Maternity Services Advisory Group (MSAG) chaired by former Commonwealth Chief Medical Officer, John Horvath and Commonwealth Chief Nurse and Midwifery Officer, Rosemary Bryant (Department of Health and Aging 2009). The group included representatives from a wide range of stakeholders including consumer organisations, non-government organisations, academics, doctors’ organisations, and other health professionals. Their role was to ‘collegially’ provide ‘cross-disciplinary’ advice to the government on maternity policy (Department of Health and Ageing 2009). In 2008, the government facilitated a series of six round table forums to discuss key issues relevant to maternity services in Australia. Participation was by invitation only and representatives were largely drawn from the previously established MSAG (Department of Health and Ageing 2009). Consumer reports from the round table discussions were positive; attendees from the Maternity Coalition for instance, felt that their views and concerns were well received, that there was respect for women to be at the centre of maternity care, and there was real optimism for reform (Teakle and Arnott 2008). Consumer advocate, Leslie Arnott wrote that many obstetricians present on the day were genuinely supportive of women-centred care and

collaboration between midwives and obstetricians, while others seemed 'scared' of change and only able to understand the perspective of women who use private obstetric services, claiming that the views of 'minority' of women drowned out the 'moderate' views of 'most' childbearing women (*Birth Matters* 2008).

Following the round table forums, a discussion paper *Improving Maternity Services in Australia* (Commonwealth of Australia 2008), was released, calling for submissions into a national review of maternity services. Submissions were asked to address four areas or questions about current maternity services: access to maternity services in rural and remote areas; aspects driving high rates of medical intervention and ways to address this; funding models; and infrastructure and workplace organisation of maternity services (Commonwealth of Australia 2008). Over 900 submissions were received; the majority from consumer advocates, particularly women seeking better access and support for homebirth and independent midwifery. The overwhelming majority were actually from individual women (and sometimes men) who articulated dissatisfaction with current maternity care provision, in particular the escalating intervention rates and their perceived mistreatment and trauma experienced in the hospital system. Submissions from midwives, midwifery organisations and consumer advocacy groups called for better access to continuity of care, more autonomy for midwives, indemnity insurance for independent midwives and improved choice of services, including homebirth provision for women. The final report of the MSR was released in early 2009, recommending legislative change to facilitate greater provision of midwifery care (Commonwealth of Australia 2009).

The MSR eventually resulted in legislation and a National Maternity Services Action Plan to facilitate new arrangements for midwives and nurse practitioners—the *Health Legislation Amendment Act (Midwives and Nurse Practitioners) 2010;* the *Midwife Professional Indemnity (Commonwealth Contribution) Act 2010;* and the *Midwife Professional Indemnity (Run-off cover support payment) Act 2010.* The reforms and associated legislation, it was claimed, would 'improve the choice for Australian women seeking high-quality, safe maternity care, as well as providing support for midwives' (Department of Health and Ageing 2009: np). According to the government, midwives would now have the ability to 'exercise their skills to

their full potential'. The acts were designed, it was claimed, to enable 'eligible' midwives and nurse practitioners to gain access to Medicare Benefits Schedule MBS rebates and Pharmaceutical Benefits Scheme (PBS) prescriptions from July 2010 and government sponsored indemnity insurance. 'Eligible' midwives and nurse practitioners however, had to demonstrate that they worked in 'collaborative arrangements' with medical professionals. Such 'collaborative' care, however, was viewed as problematic by midwives, consumer groups and many academics in the field as it failed to acknowledge the professional autonomy and responsibility of midwives. As Newnham argues, 'collaborative care' reinforces a medical model of birth 'while simply incorporating midwives' role within it' (Newnham 2010: 6 also Reiger and Lane 2012).

While the review and subsequent legislation appeared to be a positive step forward for midwives and women, and seemed to be driven by genuine impetus for reform, closer examination reveals 'caveats that may not be cause for celebration' (Newnham 2010: 5) as I will discuss below. Midwives' professional indemnity insurance provision and Medicare benefits for birthing at home were not included in the reforms although antenatal and postnatal visits by independent midwives were supported. In the policy-formation context of a moderately reforming government, the MSR became a key discursive site, one in which, I argue, key players in the Australian obstetric profession were able to attempt to reinstate or maintain professional dominance over maternity services in the face of increasing criticism and challenges from government, consumers and midwives.

The submissions to the MSR therefore, provide ripe ground for analysing the relations of power in the context of managing contemporary childbirth. Some 832 submissions were tended to the review (the majority, 450, written by consumers of maternity services) but for the purposes of this analysis, only submissions from medical/obstetric organisations or individual doctors/obstetricians or anaesthetists were examined, although submissions from midwifery organisations and consumers are used for comparison. I also draw on McIntyre's (2011, 2012) and Dahlen et al.'s (2011a) analyses of consumer and midwifery submissions. There were twenty-four submissions from obstetric organisations and medical professionals. Nine medical organisations made submissions: the Royal Australian and new Zealand College of

Obstetricians and Gynaecologists, Royal Australian and new Zealand College of Obstetricians and Gynaecologists NT and SA committee, The Royal Australian College of General Practitioners, the Rural Doctors' Association, the Rural Doctors' Association QLD, the Australian Society of Anaesthetists, the Australian College of Anaesthetists, the Australian Medical Association and the National Association of Specialist Obstetricians and Gynaecologists. There were a further 13 submissions from individuals or groups of individual practising obstetricians, GP-obstetricians and anaesthetists. A further two submissions were from academic obstetricians. The submissions varied in length and format; some such as the RANZCOG document, were lengthy and detailed, while others were just a paragraph or sentence. In addition to the submissions, I examined online and print media debates surrounding the Review.

In order to more fully assess obstetricians' role in the Review process and in order to understand their professional (though not always individual) opposition to maternity care reform, I also sought to interview key stakeholders in the obstetric profession. Ethics approval was granted via La Trobe University Human Ethics Committee to approach professionals through their place of work. I approached seven key obstetric representatives via telephone or email. Four obstetricians — Dr David Molloy, then president of NASOG, Dr Andrew Pesce, who became president of the AMA halfway through the MSR, Dr Caroline de Costa, a high-profile academic obstetrician, and Dr Ted Weaver, then president of RANZCOG—agreed to be interviewed in person. The remaining three obstetricians approached for interviews were not able to participate due to time restraints or did not respond to my attempts to contact them. Notably, the three who could not participate were obstetricians employed in the public hospital system, and who had previously spoken out against the obstetric status quo. Interviews were recorded and transcribed verbatim. Obstetricians were given the option of reading the interview transcripts prior to research publication.

The submissions, interviews and media were coded manually at first but then themed using NVivo software. A CDA analysis was then used as described in previous chapters. In many regards, the themes emerging from the MSR discourse reflect the wider themes of this thesis; obstetric hegemony is maintained through the prevailing discourses of risk, safety and

neoliberal notion of consumer /individual 'choice'. Paramount to these discourses is a biomedical and technological imperative— that is, medical control of childbirth is seen as always necessary and justified because medicine is responsible for 'saving' women and babies from the 'dangers' of childbirth. Implicit in this understanding is the obstetric view of risk/safety, an ostensibly neutral view based in scientific rationality, and, as previously discussed, a mechanical understanding of the body that obscures the subjectivity of women.

4.4. Constructing the policy problem: Australia is a 'safe' place to give birth

From the outset, even before the discussion paper was made public, Health Minister Nicola Roxon emphasised in a press release that Australia was 'one of the safest places to give birth or to be born' (Roxon 2008). This axiom was then reiterated throughout the initial discussion paper, and used by Roxon in various media appearances between 2008 and the end of 2009. The policy issue then, as Bacchi argues, had already been constructed – 'Australia was a safe place to birth'. The medical responses to the MSR repeatedly drew on this statement, taking responsibility for this safety record. More importantly, the safety axiom allowed the medical profession to argue effectively that since medicine/doctors were *responsible* for such good outcomes, there was no sound reason to reform maternity services or alter the status quo. In fact, any changes, they argued, would indeed compromise Australia's safety record and put mothers and children in danger. For example, in a media release titled 'Medical supervision the key to safe maternity services', which was quoted in various daily newspapers around the country, Dr Rosanna Capolingua, the then president of the AMA stated:

> Australia has seen a 35 per cent decrease in perinatal deaths over the past 35 years as a result of the excellent maternity care provided in this country under medical supervision. It is important that these good health outcomes are not compromised as a result of any changes to maternity services (AMA 2008a).

She went on to argue that midwife-led care was risky and it was 'essential' that a doctor be available at all times (2008a: 2). RANZCOG's immediate media release in 2008 following the release of the initial MSR discussion paper, stated that:

> Today Australia is one of the safest countries in which to give birth and for some time has recorded lower maternal and perinatal mortality rates than similar countries. It is crucial that any reforms to the delivery of maternity services are carefully evaluated to ensure that they do not have any adverse effect on mothers and babies in Australia (RANZCOG 2008a).

These press releases received wide coverage in the initial media surrounding the MSR discussion paper, weakening the claim by activist groups that Australia's maternity service provision was in crisis. In the medical submissions to the MSR, the message regarding safety was further emphasised and there were more emphatic warnings about ensuring that these high standards of mortality and morbidity rates were not compromised. All the peak medical organisations (AMA, RANZCOG, and RANZCOG state branches, NASOG, RACGP and ASA) stressed that Australia's infant and maternal mortality rates had decreased due to medically-led maternity care, rather than to improvements in the population's health:

> Australia is one of the safest countries in the world to be born and to give birth. The Australian Institute of Health and Welfare 2008 report shows a further 10% reduction in the national perinatal mortality rate between 1995 and 2005…and a maternal mortality rate of 8.5/100,000 compared to an average ratio for developed countries of 20/100,000. This continuing improvement cannot merely be attributed to improvements in the general health of the population…It is fundamental that any changes being contemplated do not risk these excellent outcomes. None of this should be taken for granted and NASOG believes that these excellent outcomes are due to a high quality overall maternity service which has historically been medically led (NASOG 2008:1).

> Currently in Australia we have high quality maternity service that deliver infant and maternal morbidity and mortality statistics that are the envy of many

> countries. Our mothers and neonates are safe, and our babies are given the best possible start to life….This is the result of a lot of hard work and dedication by the medical profession and close to perfect results are now an expectation of the Australian community (AMA 2008b: np).

RANZCOG SA and NT regional committee assert that 'Australia already offers women and their babies safe, effective maternity care' and that they would therefore be 'distressed' to see Australia's safety record compromised due to a shift from medically-led maternity care (RANZCOG SA and NT Regional committee 2008:1). Individual obstetricians' submissions repeated the same adage and media in the year following the MSR also echoed the prevailing political and medical discourse. For example, in a radio interview in 2009, the newly elected president of NASOG, Dr Hilary Joyce, reiterated that childbirth is only safe in Australia because birth is medically supervised and to reverse this situation would result in increases in death, returning us to the dark ages:

> …our women enjoy the safest services in the world and we really mustn't be looking at turning the clock back in any way, to more so called natural childbirth which would take us back to the risks that were involved for mothers and babies at the turn of the century which were extraordinary. Maternal death rates of 1 in every 30 women dying as a result of childbirth. So we've made extraordinary advances over a century and particularly in the last 25 years and we must see those maintained.
>
> ABC Radio National, *Life Matters*, July 1 2009.

The notion that that the MSR recommendations would 'turn back the clock', reversing the medical advances of the 20th century was echoed by opinion columnists. For example, *Sydney Morning Herald* conservative columnist and outspoken supporter of medically-led birth, Miranda Devine, took the opportunity to lambast the 'militant' midwifery and birth advocacy groups who she felt had pressured the government to reform maternity care unduly:

> And a review of maternity health services ordered by the Health Minister, Nicola Roxon, and due to report in the next few weeks, is expected to place more pressure on

> women to reject the so-called "medicalisation" of childbirth. The review is expected to pave the way for a midwife takeover…You just have to look in any cemetery for the truth about our obstetric past, when women and their babies used to die regularly in childbirth, when brain damage for the child and catastrophic injury for the mother was not uncommon. One estimate of life in 18th-century England holds that mothers died in 25 of every 1000 births; in Roman times, infant mortality may have been as high as 30 per cent. There cannot be much wrong with our obstetrics system, generally, since Australia remains one of the safest places in the world to be born and to give birth
> Miranda Devine, 'Caesarean scare mongers should zip it', *Sydney Morning Herald* February *21* 2009.

This view did not go entirely unchallenged in the Australian media however; there was also significant press reports between 2008 and 2009 that were critical of escalating intervention rates and obstetric-led care especially in relation to caesareans, as described in the previous chapter (e.g. SBS Insight Program 2009; ABC Radio National *Health Report,* 2009). Midwifery academics Lesley Barclay, Sally Tracy and Sue Kildea strongly disputed the safety discourse. Writing in the news and current affairs blog, *Crikey,* they argued that the previous Howard government's push to private health insurance had led to a 'boon for obstetricians' but had *harmed* women with excessive rates of dangerous and unnecessary operative deliveries with associated physical and emotional risks such as post-traumatic stress disorder (Barclay, Tracey et al. 2008). Then president of RANZCOG, Dr Ted Weaver, responded to their opinion piece with annoyance:

> [the authors'] lament the supposed adverse outcomes associated with taxpayer supported private obstetric care in Australia and quite outrageously suggest the system currently in place has increased suffering and injury to women and infants and led to obstetricians earning millions of dollars a year from women who do not need their (obstetricians') care. These comments cannot go unchallenged because they are wrong. Despite the claims made by Barclay et. al., current maternity care consistently provides good outcomes…As referred to in Health Minister Roxon's recent 'Improving Maternity Services in Australia'

> document…the high standards of professional care provided by obstetricians working in both the public and private system is a major contributor to our current enviable safety record. Without the provision of obstetric care provided by obstetricians working in both private and public practice, Australia would not be the safe place it now is for pregnancy and birth.
>
> Ted Weaver, Safety needs to be the focus of any changes to maternity services, *Crikey*, November 21 2008.

The government's message regarding safety is here utilised to the medical profession's advantage in order to negate criticisms of obstetric practices and reinforce their own responsibility for Australia's maternal and infant safety record. During this time period, the president of the AMA obstetrician Andrew Pesce, president of NASOG, Hilary Joyce and then president of RANZCOG, Ted Weaver, made several media appearances disputing the claims of midwives and birth activists/organisations.

Holding the obstetric profession accountable for excessive intervention rates, including rates of caesarean, has provided the impetus for groups of midwifery advocates and childbirth activists, consumers, as well as others working within maternity services to mobilise and challenge and contest obstetric dominance (Akirch et al. 2012). As argued in Chapter One, increasing pressure on obstetricians to take responsibility for these statistics has led to attempts by the obstetric profession to reinstate their authority in maternity care in Western countries across the world (McIntyre et al. 2010). During the MSR process, obstetric and medical representatives and organisations largely presented a united front against the challenge to their professional boundaries and authority and their appearances or interviews in the media reinforced /emphasised the same message; that obstetric-led care was safe, that intervention rates were linked to women's age and pathology, not to anything inherent in the obstetric model of care.

As an extension to the argument that Australia was safe place to birth with enviable mortality and morbidity rates, medical professionals and obstetric organisations argued that intervention rates were not problematic and did not pose a risk to women .The MSR discussion paper stated that:

> There is no consensus as to whether rising rates of caesarean reflect the increasing risks associated with older mothers, decreasing procedural skills or defensive medical practice amongst clinicians, or increasing rates of women electing to give birth by caesarean when it is not medically required. Although differences can sometimes be explained by demographic and other differences, the degree of some of this inconsistency suggests a need for further consideration. There has also been some evidence of poorer health outcomes for both mother and baby from planned caesarean at term, and further research in this area is required (Commonwealth of Australia 2008:5).

Submissions from midwives, women, academics and activists claimed that increasing intervention was physiologically and psychologically harmful to mothers and babies:

> Rising rates of caesarean birth with associated increased morbidity for mothers and babies. High rates of caesarean section have normalised surgical birth. The flow on costs for the wide spread use of interventions in labour are high—both for women and their babies who are then exposed to risks of major surgery and recovering from it, and for the health services that are using more and more scarce resources on preventable surgery (Australian College of Midwives 2008: 14).

There were also some counter-hegemonic views evident within the medical profession itself however. For instance obstetrician Dr David Ellwood's submission expressed concerns that increasing rates of caesarean were reaching a 'tipping point' where we would begin to see many more negative outcomes of high rates of surgical birth, therefore safety outcomes would begin to decline (Ellwood 2008b:1). The Queensland Rural Doctors Association also expressed a more reserved view regarding safety:

> It is generally agreed that intervention rates are too high. Reassessing the evidence base for some interventions or related practices, for example those related to breech delivery, epidural analgesia or vaginal birth after caesarean

> section could lead to a re-estimation of both the risks of normal labour and the risks of intervention (RDAQ 2008:20).

Nonetheless this view was strongly opposed in the majority of medical submissions that were highly defensive of rates of intervention. They claimed that while rates may be higher than in the past, and higher in comparison to similar countries, medical intervention was nonetheless *always* justified, safe and necessary because women were older, more obese, sicker, and rates of caesarean by maternal request were rapidly rising:

> The Australian intervention rates for caesarean seem high by international standards. We do not know for certain but intervention rates in Australia are largely driven by safety and quality considerations and patient choice, and by maternal aging (AMA 2008b np).

> Australian women are choosing to defer childbearing until later in their lives. The percentage of Australian women with obesity/raised BMI and accompanying diabetes, cardiac disease and hypertension complicating their pregnancies is increasing. There are more survivors of congenital, chronic and degenerative diseases who will choose and be able to reproduce. Many of these women will not have low risk pregnancies. If we don't train and utilise the appropriate professionals to look after these women maternal and neonatal outcomes will not be maintained (RANZCOG SA and NT regional committee 2008: 3)

In an interview with Dr Andrew Pesce, then president of the AMA, I asked him to comment on the contention in the MSR and media, that intervention rates were too high, especially in private hospitals. Pesce, reiterated that the rhetoric of 'safe' outcomes and assured that there was 'no need to be concerned' about intervention rates in Australia:

> …but we've got good outcomes despite that and overall we've done really, really well and it's not just because people have healthier diets and whatever now, perinatal mortality rates have continued to improve in the last 20-30 years and it's not just a healthier society, our perinatal mortality rates are actually

> much better than our infant mortality rates so kids dying later in infancy is higher than babies dying at birth…our argument has always been 'we've got nothing to be ashamed of' because of our focus which is safety, we argue that we've done really well and although it's not the only indicator of safety we believe it's the most important indicator of safety. We start off with that position of strength because we believe it's the survival, survival rates are the most important thing.
>
> Andrew Pesce, Interview, October 2009.

Australia's peak obstetric organisation, RANZCOG, claimed that although 'much has been written about the increase in obstetric intervention throughout the OECD that many have found alarming' the reasons were perfectly logical and not 'mysterious' in anyway, rather they simply reflected the 'changes in the characteristics of obstetric population' (2008b: 44) (i.e. mothers were older, more obese, sicker and using reproductive technologies at increasing rates). RANZCOG also warned that the 'consequences' of not intervening in birth would be increases in maternal and infant morbidity and mortality, comparing Australia's current statistics with those of 'third world' countries with minimal obstetric care and higher rates of illness and death (2008b: 45). Moreover, RANZCOG again credited the medical profession with being responsible for the current 'excellent' birth outcomes – 'marked reductions have occurred in the perinatal mortality rate over the same time period that the intervention rates have increased' (RANZCOG 2008: 51).

Individual respondents were more outspoken and defensive in their submissions:

> There is reference [in the MSR discussion paper] to obstetric intervention as if it is in itself a bad thing. Any number of measures such as oxytocin augmentation of labour, operative vaginal delivery, active management of third stage of labour, regional anaesthesia…caesareans are proven to prevent morbidity and mortality… Do our colleagues in cardiology constantly defend themselves [against critiques of their practices]? (Gannon 2008: np).

One submission, from academic obstetricians Peter Howatt and Carolina De Costa claimed that caesareans were comparable to vaginal birth and were much 'safer' now than in the past:

> We have also seen great increases in the safety of caesarean section, in particular with regard to the use of regional rather than general anaesthesia. This increased safety means that the operation has become a legitimate medical alternative to a vaginal birth… (De Costa and Howatt 2008: 7).

The significant recent research findings on the negative outcomes of caesareans, as discussed in the previous chapter, are completely omitted, ignored and/or dismissed in the submissions, Moreover, despite wide spread public concern and debate around rising caesarean rates (as discussed in the previous chapter) medical submissions to the MSR generally constructed caesarean birth as safe; therefore concerns about increasing rates were construed as being misplaced, overblown or even 'hysterical' as the AMA put it (2008np). The medical consensus, reflecting the medical model of birth as pathology, seemed to be then, that while rates of intervention and surgical birth had indeed risen, this was wholly due to increases in the deficiencies in women's bodies and not at all a result of a medically managed maternity care. Moreover, since Australia's maternal and infant morbidity and mortality rates were 'excellent', rates of intervention were of no or low concern. Again, the hegemonic message that Australia was a safe place to birth was strategically used to make a common-sense argument that defended obstetric practices and control of maternity care.

Despite being challenged, the hegemonic message of the medical profession remained that Australia's maternity care system was *already* working well, it was therefore crucial to maintain the status quo of obstetric-led maternity care as any changes could potentially jeopardise the safety of Australia's mothers and babies. The *Final Report of the Maternity Services Review* (2009) recommended legislative changes to support an 'expanded role for skilled' and 'appropriately trained' midwives and its recommendations were enacted in the 2009 and 2010 budgets. The policy makers were still careful to point out that 'the Government's moves to improve choice in maternity services in Australia [were not] jeopardising our *excellent record of safety* and quality' (my italics, Commonwealth of Australia 2009: 1).

As examined in Chapter Three, decisions around caesarean birth are made within a neoliberal context in which individuals are obligated to 'manage risk' and choose the safest option – this is especially relevant when discursively connected to the risking of life itself (Bryant et al. 2007; Beckett 2005). Similarly, in relation to policy formation, it can be argued that as the policy discourse during the MSR was framed in terms of (a medically constructed) ubiquitous notion of safety, to argue counter to this view would be seen as promoting unsafe practices, potentially risking the lives of women and babies. The scientific/medical, authoritative construction of safety was never seriously disputed, but instead taken as a given. However scholars argue that the medical understating of risk and safety with its emphasis on short term measures of morbidity and mortality is flawed because it assesses only immediate cause and effect outcomes. Long term outcomes such as urinary incontinence due to forceps delivery, or back pain due to epidural, adhesions from caesarean scars, as well as social, psychological and emotional issues such as depression, anxiety, trauma, and problems affecting the mother/infant dyad such breastfeeding difficulties or bonding, are not considered (Wendland, 2007; Downe and McCourt, 2008; Walsh et al. 2008). As Dr Pesce, quoted above, stated 'survival rates are the most important thing'.

The Australian College of Midwives West Australian branch raised this issue in their submission, arguing that safety is 'narrowly defined as a live mother and baby' which 'belies the level of emotional distress and physical morbidity of either mother or baby' (ACM WA 2008: 4). A live baby and physically-well mother are considered the epitome of a safe and good outcome. However, as Wendland (2007) argues, this conceptualisation of 'safety' is premised on the obstetric perspective of complications rather than the maternal, and hence maternal subjectivity is completely absent in the measurement of 'safe' outcomes. The 'body as machine' paradigm overrides any alternative understanding of childbirth. There is no consideration, for example, of the emotional and long-term consequences of poorly managed birth. Recent research for instance, found that up to 30% of Australia women suffer some kind of birth trauma and 8% will develop post-traumatic stress disorder (Boorman et al. 2014). The majority of women's submissions to the MSR described dissatisfaction with hospital maternity services and overuse of medical interventions, particularly caesareans. Many midwives' submissions posited medically-led birth as being often unsafe and harmful to women and

babies (Australian College of Midwives 2008; Barclay, Farrington et al. 2008; Maternity Coalition 2008; McIntyre et al. 2011). Yet the prevailing medical construction of 'safe outcomes' effectively undermined the position of the women and midwives contributing to the MSR process. Instead the strategically-driven axiom that Australia was a 'safe place to give birth' because birth was medically managed, became ubiquitous and obstetricians drew on their privileged position as a 'power elite' (van Dijk 2006) to impose their own professional agenda, the maintenance of medically–led care.

4.5. Necessitating obstetric-led care

While interventions including caesareans were constructed as 'safe' in the MSR medical submissions and surrounding media commentary, vaginal birth was framed, predictably, within the paradigm of risk and pathology. Similar to previous maternity services policy documents, the discussion paper for the MSR reflected a social model of birth, that of a 'normal physiological process, not an illness or disease' and one in which midwives should have a greater role (Commonwealth of Australia 2008). However, medical submissions to the MSR countered claims that birth was 'natural' and instead constructed childbirth as unpredictable, risky and potentially deadly;

> Yes birthing is a natural process. Maternal death and infant mortality are also natural processes. It is medical intervention that interrupts these natural processes and save lives (RANZCOG SA and NT Regional Committee 2008:3).

Many of the medical submissions were critical of 'risk' assessment categories commonly used for assigning women to different types of maternity care. The dismissal in most of the medical submissions of the categories of 'high' or 'low' risk could be viewed as a new strategic mechanism to counter the possibility that categorising/assessing women as 'low-risk' potentially exempted women from obstetric care. For example, RANZCOG argued that: 'labelling women as 'low risk' or 'high risk' may have the consequence of determining the care model as either 'Midwifery' or 'Medical'- thereby denying women the benefits of both professions.' (2008:45). Others argued that there was no way to either accurately assess who was low risk, nor guarantee a low risk birth, as things could always go wrong:

> It is not at all helpful to state that 'pregnancy and childbirth are normal physiological processes, not an illness or disease'. Childbirth has always been a risky process, in the past horrifically so. It is all very well to talk about 'assessed level of risk'. Risk cannot be assessed as very low in any circumstance….No one can make delivery risk free but avoidable risk should be avoided (Dr Peter G. Beahan, 2008:1)

> Again and again it is touted that birth is a 'natural process' and that most women should be able to deliver without medical support… [but] there is currently no effective means of determining who is likely to deliver normally before the event…the absence of 'risk factors' in no way ensures or even predicts the ability of a first time mother to deliver normally (Dr Peter Kell 2008 np).

> The assessment of risk throughout pregnancy is problematic. While pregnancy and birth are clearly natural processes, so too are death and disability…intervention in these natural processes…can help to deliver the very low levels of maternal and perinatal morbidity and mortality that Australia currently enjoys (RANZCOG 2008b:47)

Dr Vijay Roach was more overt in the argument that since levels or risk in birth were impossible to predict, 'childbirth and postnatal care always requires the involvement of an obstetrician' (Dr Vijay Roach 2008:1).

One exception to the dominant medical discourse on risk was a submission from the Clinical Director of Obstetrics and Maternal and Foetal Medicine at Royal Hospital for Women, Sydney (Challis 2008b). Dr Daniel Challis agreed that the risk categories were problematic because 'some pregnancies may start off as "low risk" subsequently develop major complications, and some pregnancies which are initially "high risk" turn out to be problem free'. Challis however, does not use this to affirm obstetric-led care, but to instead promote midwifery models of care:

> In the former it is vital that timely specialist referral be facilitated, and for the latter group the women should not miss out on the involvement of a midwife. It

> is also important that a woman's enjoyment of her pregnancy not be overshadowed by her medical risk factor (Challis 2008b: np).

Challis goes on to recommend multidisciplinary midwifery continuity of care models. It is notable however, that Challis is *not* a private obstetrician but works in this very care model. Indeed his submission to the MSR is mostly critical of current funding to maternity services that privilege private obstetric care such as the Medicare Safety Net arrangements that result in private obstetricians charging exorbitant amounts.

The ideological construction of risk, synonymous with concept of the 'body as machine' and the technocratic model of childbirth, is readily apparent in the medical submissions to the MSR. The medical profession, as argued earlier, understands labour and birth as 'risky unless proven otherwise' (Walsh, El-Nemer and Downe, 2008: 118; Rothman 2007b) or as only 'normal' in retrospect. Thus, while the submissions from women and midwives perceived risk in the overuse of medical intervention—what has been described as the 'cascade of intervention'—with associated iatrogenic outcomes including unnecessary caesareans (Wagner 2006), conversely, obstetricians construct risk as originating inherently within the birth process and birthing body itself. However, as Newnham (2010) points out, the assessment of risk and danger 'are not straightforward but linked to dominant conceptions of the 'truth' of a situation' (2010: 3). In keeping with a critical discourse analysis perspective, reliance on the risk paradigm and, by default, the necessity of specialised technical supervision necessitates the obstetrician's role – this is what makes discourse ideological. As I discussed above, in the past the construction of birth as risk-laden and requiring specialist skills was strategically utilised by the medical profession to ensure government policies and legislation aligned with the interests of the profession (Willis 1989; Schofield 1995). To construct birth as always or inevitably risky justifies and maintains obstetric dominance of maternity services. The government's suggestion of a more autonomous role for midwives was responded to with assertions that obstetricians (or other medical professionals such as GPs in rural areas) must always be 'kept in the loop' (Molloy 2009, interview). Therefore the categorisation of low and high risk previously regarded as useful was now being dismissed because it may give the impetus for midwives to work independently - a notion that was strongly rejected by every medical submission to the MSR. In order to make the

overall argument that obstetricians must always oversee childbirth due to its inherent unpredictability and riskiness, the profession had to also undermine the skills and expertise of midwives.

4.6. Midwives and 'collaborative care': obstetric dominance disguised?

Both midwifery representatives and obstetricians advocated for a 'collaborative' model of maternity care. However, the way collaborative care was perceived by these groups differed considerably. Drawing on research linking midwifery care with better outcomes, lower intervention rates, cost-effectiveness and higher rates of satisfaction, midwifery groups advocated for funding of a continuity of care model with a known midwife in both private and public systems (ACM 2008). In this model, midwives would be autonomous but would 'consult with obstetricians' regularly and when needed:

> All midwives who provide continuity of care [would] work collaboratively with either GP or specialist obstetricians. Sometimes the medical practitioners are employees of the same service, sometimes they are private obstetricians with visiting rights. For some services the medical practitioners are on site, for others they work in referral service to which women are transferred if necessary (ACM 2008: 11).

Midwives positioned themselves as experts in normal birth and argued that the 'longstanding tradition in Australia of channelling all women into medical care must be discontinued' (ACM 2008: 9). Obstetricians, however, saw any suggestion of giving midwives more autonomy as a threat and, instead, advocated collaborative care under their own supervision. Supervision, it was argued, was necessary because midwives did not have adequate skills for assessing risk. The opening line in the AMA's submission (2008) featured a quote from a previous nurse, now obstetrician, suggesting that nurses and presumably by default, midwives, did not have the same skills, knowledge and expertise and doctors:

> There is a big difference between the knowledge, skills and abilities of doctors and nurses…I trained as a state registered nurse/registered sick children's nurse (SRN/RSCN) for four years and worked as staff nurse, research nurse, and ward sister for the following seven years… I then went to medical school and found I knew about 10% of the course already…As a GP I still believe that the knowledge and diagnostic skills I have now are not possessed by nurses (Elaine R Carter cited in AMA 2008:np).

The medical submissions argued that as midwives did not have necessary skill or expertise, had not undergone the same specialist training as doctors, and did not understand 'impending risks' (Searle 2008: np), they should not work as autonomous practitioners. When asked about midwifery-led care, Dr David Molloy, then president of NASOG felt that there were significant differences in the way midwives and doctors were educated that rendered midwives inferior at 'problem solving':

> Now there's a huge educational difference between those 2 levels and there's a difference between how that learning is done. With medical schools a high learning component is problem solving, midwifery learning and nursing learning is more manual based and protocol based and if you move outside the protocol, you haven't often in that 3 years at uni been taught to cope with the problem solving required in those kinds of situations.
>
> David Molloy, interview 2009.

In most obstetric submissions, support for autonomy of midwifery was strongly opposed, with the words 'independent practitioner' as used in the MSR discussion paper (2008), taken to mean rejection of any medical input or consultation. Accordingly, independent midwifery practice and midwife-led care should not, it was argued, be endorsed by the government. NASOG (2008) for instance, stated that it:

> Does not support the concept of independent midwifery led care for women in labour…NASOG believes that a single individual carer take

> overall responsibility for the care of a woman in labour and the obstetrician is the most appropriate choice for such a role.

RANZCOG (2008) stated that:

> To provide for the best possible outcomes and in regard to safety for mothers and babies, 'Independent' professional practice, where one particular professional group or individual works in isolation, does not have a place in modern maternity care. Independent practice has significant potential for an adverse impact on outcomes for mother and baby.

While in the past medical discourse had represented midwives as incompetent, dangerous and 'backward', based on their gender and lack of 'scientific understanding' (Willis 1989; Murphy-Lawless 1998), most submissions here were careful to note that doctors had considerable *respect* for their midwifery colleagues but did not believe midwives should be the lead carers in maternity care. For example, Dr Vijay Roach stressed that he 'value[s] and respect[s]' his midwifery colleagues and does 'does not challenge their experience and expertise' but he was 'concerned' that the push for midwife-led care would put 'patients at risk' (2008:1). Midwives were never blatantly criticised by obstetricians, but the standard and level of care received by women in situations where midwives are the lead carers (homebirths and birth centres) was constructed as less safe than medically-led care. For instance, Dr Andrew Pesce explained in an interview that midwives tend to take 'safety as given', whereas it could not be.

Medical submissions drew on published research that apparently 'proved' (Gannon 2008) that midwifery-led care was not safe, and in fact was dangerous (NASOG 2008; AMA 2008). Yet numerous studies cited by midwives and consumers that indicate that midwifery models care are safe, cost-effective, have lower rates of intervention and higher rates of consumer satisfaction, were either omitted or dismissed. Instead specific, and often outdated and widely criticised research such as the 'Bastian' homebirth study and the term breech trial, which support the view of birth as risky and necessitating medical care are continually cited. Dr Beahan (2008), an anaesthetist from Western Australia, seems to try to undermine the MSR

discussion paper's reference to evidence that midwife-led birth centres and homebirth provide equivalent levels of care as hospitals, as 'in need of careful interpretation' – presumably by medical specialists who are best equipped to understand the research. Like its ridicule of the caesarean research, the medical profession implied that only medical professionals are able to understand the data (RANZCOG 2008). The established affirmation that Australia was one of the safest places to birth once again benefited the profession in their discursive position; since medically-led care was safe, then the common-sense assumption was that midwifery-led care was not.

Some submissions were defensive in their tone and argued not just that midwifery-led care was unsafe but also that it was an insult to the hard work and dedication of the obstetric work force. This is perhaps best expressed by Dr Kell, a private obstetrician from Western Australia, who felt that 'medical opinion' is often ignored in governments' maternity policies:

> …for a doctor working at the coalface within an obstetric workforce crisis the [MSR] document is disappointing and demoralising. It is plain the federal government's agenda is to…undermine us and push the barrow of midwifery-led care… (Kell 2008: 1)

Similarly, Dr David Molloy strongly expressed the view that midwifery-led care was an affront or assault to the work of obstetricians and felt indeed that the MSR was 'politically biased' and the whole impetus for the MSR was driven by a 'huge political push by the midwives to have a more independent role' (Molloy, Interview 2009). Kell's and Molloy's complaint is not just that obstetricians are apparently marginalised by policy makers, but also reflect fear that midwifery-led care will supersede the control of maternity care provision that obstetricians currently enjoy. Several submissions argued that a shift to midwifery-let care would result in obstetricians being marginalised from maternity care and relegated to only practising 'fire engine obstetrics';

> Distancing obstetricians from the majority of birthing women will also have effects on our professional job satisfaction. It will make obstetric medical practice 'fire-engine' obstetrics, Doctors will always be 'on the back foot'

> dealing with a woman and family whom they don't know, whose particular preferences and needs they can't appreciate, as the only time he/she is involved is to deliver 'bad news', to 'medicalise' their natural experience and 'interfere'…We will end up only ever doing those things that the minority of our midwifery colleagues feel is all we do (RANZCOG SA and NT Committee 2008: 2).

> As doctors, most of us do not want to work in a system where pregnancy and labour is 'managed' by personnel of far less training and expertise only to be called in at the last minute to potentially very difficult situations, where women have been misled to believe that if they are healthy and strong enough to put up with the pain and risks of childbirth on their own, 'trusting in their bodies' they should *expect* to deliver normally! It is absurd to even propose such a scheme (Kell 2008: 1).

Molloy drew on the historical succession of midwifery by obstetrics as evidence that a return to midwife-led care, where obstetricians were only called in emergencies, would result in higher rates of mortality:

> The model of care we've developed has happened only in the late 20th century essentially and we don't want to go back to the old model where we were at the top of the tree and only called in when there was a disaster. We call that fire engine obstetrics and the reason is, is that it's all changed, and the reason is, part of what's driving the C-section rates, we see patterns and problems developing and the whole trick now is to intervene *before* problems are developing.
>
> David Molloy, interview, October 2009.

Midwifery-led care was thus almost unanimously rejected, seen as threat and constructed as less safe. Instead, there was widespread consensus that a 'collaborative care' model under medical supervision, was the ideal model of maternity care. Collaborative care was the catch cry of the Review as well as the main legislative outcome of the Review process. In this model, no maternity care provider would ever work independently from others; instead midwives,

general practitioners and obstetricians would 'work together' in their own specified roles in providing safe, cost-effective and woman-centred care.

> I strongly believe that the path to providing women a better service is through the development of effective functioning women's healthcare teams, and that this should be supported from both an educational perspective and a business model that rewards a collaborative model of care. I believe that overemphasis of who the leader of the care is (be it either GP-led, midwifery-led or obstetric-led) is unhelpful and only reinforces public perceptions professional silos. Please can we change this to collaborative care? (Searle 2008 np).

> … all models of maternity care must be collaborative both in structure and implementation. Lack of collaboration or poor communication will adversely impact on maternity care. No model should be described as, or endorse, independent practice. All practitioners will work better in collaborative models (RANZCOG 2008).

In both the MSR submissions and surrounding media discussion, collaborative care was promoted as the panacea for the problems of the 'turf war' between obstetricians and midwives (SBS *Insight* 2009; McColl 2009). The submissions asserted that collaborative care would overcome professional antagonisms, place women at the centre of maternity care and offer them more choice and control. The ensuing National Health and Research Council draft guidelines for collaborative care (2009) (recommended following the report of the MSR in February 2009) also framed collaborative care as an overwhelmingly positive step for women, midwives and obstetricians. However academics and midwives have raised major concerns with the concept of collaborative care in a medically dominated system.

Sociologist Karen Lane argues that move to collaborative care in contemporary maternity services, which have historically rested on medical dominance, represents a 'radical shift in professional relations' (2006:346) and a potential destabilisation of obstetric hegemony. However research in a Victorian maternity hospital where a collaborative care model had been emphasised in light of Victorian policy shifts, found that while boundaries shifted slightly, they

still tended to be 'fortified along old divisions' and thus hierarchical structures were resilient (2006:347). For instance, doctors still had veto powers of decision-making and were unable to accept midwifery knowledge as an alternative to 'techno-rational knowledge' (2006: 348; see also Reiger 2008; Reiger and Lane 2009). In their response to the NHMRC draft guidelines for collaborative care (2010) academics Reiger and Lane argue that there are major barriers to '*effective and genuine'* collaborative care, not least because in maternity care:

> The taken-for-granted authority on the part of medical professionals flies in the face of the distinctive claims of midwifery to its own body of knowledge as the basis of professional practice (2010:2).

Collaboration is thus seen as merely 'working together' harmoniously but with historical power structures and doctors' privileged place in the hierarchy of knowledge and practice, still intact (Reiger and Lane 2010). In a Canadian review of a policy program aimed at facilitating collaborative care (Medves et al. 2006) researchers found that while all health professionals believed there was no place for hierarchy in collaborative care, doctors nonetheless saw themselves as supervisors. As Medves et el. argue, 'a key component of medical practice …recognises that physicians have within their roles as manager the element of 'supervising others' (2006: 12). Midwives, understandably, saw themselves as accountable to their own craft and their own ethical guidelines, and thus felt they had no need for the supervision of other disciplines.

In the MSR submissions, it was clear that doctors felt that they should supervise maternity care while still working in a 'collaborative' model:

> The AMA would support expanded funding arrangements for midwives provided this is available within a medically supervised model. In this model, there is a team based approach but the highest trained practitioner, the medical practitioner, *supervises* the overall care of the patient and can delegate aspects of a patient's care to a midwife (AMA 2008 np).

> Problems can always arise in any delivery. Therefore, every mother deserves the overarching supervision and care of an ob. Such an arrangement does not

> devalue or limit the role of the midwife. It simply describes a logical hierarchy of responsibility. Specialist support and back-up is to everyone's advantage and is regarded positively where working relationships and communication are good (Beahan 2008).
>
> We must work together in collaborative models, not competitive models, to ensure safe and sustainable maternity services. Midwives are a huge asset to maternity care and good care could not be delivered without them. Too often their expertise and experience is not acknowledged by many of my colleagues and I am deeply disappointed by this when I see it. But midwives should NOT be the lead managers in maternity care; they should work collaboratively with us, under our supervision (Kell 2008).

Dr Ted Weaver, breaking from the standard line, had a slightly more incisive perspective on collaborative care. Though at the time of the MSR he was the president of RANZCOG, Weaver had been a practising obstetrician at a private hospital in Queensland which was at the time well known for having a liberal and collaborative model of care. Weaver's private views, and indeed his reputed practice, seemed to be in conflict with the official position of RANZCOG. Weaver acknowledged that 'tensions' exist in collaborative care due to different professional paradigms but that collaborative care was ultimately a partnership:

> So I think there has historically been…distrust that has built up. The only way to get out of that is by sitting down and looking at your practice, looking at what you're doing, auditing you're outcomes. Why did you do this? That was clearly a stupid thing to do. Why did you let that woman sit in second stage for 8 hours, where the fetal heart was 60?- look at this And likewise a midwife needs to be able to say to a doctor – why did you go and do a caesar on that one- foetal heart rate looks okay, labour was progressing okay, why did you intervene? That's the only the way you can break down these problems. You need to be able to get together so that the other side can, so that each group understands why people do what they do, in a nonjudgmental way. And it's silly to stand and belittle in your little tent and say well 'them over there, they're bad and we don't like

> them' and visa versa. That is nonprofessional, non-helpful and not good for women. So I think the only way you're going to be able to do it is by getting the groups talking and there's any number of example of this good practice all over Australia.
>
> Ted Weaver, interview, November 2009.

However, the other key obstetric informants I interviewed all endorsed collaborative care under *medical supervision*. This view was perhaps best summed up in an interview with the then president of the AMA and practising private obstetrician, Dr Andrew Pesce, who stated emphatically that:

> The midwives I work with in public and private systems, we *do* have a collaborative model, we work well, but at the end of the day it's quite clear who has the final say and that's me because I'm the doctor…
>
> Andrew Pesce, interview, October 2009.

Given these pervasive views and the ingrained hierarchical structures of maternity care, based on centuries of ideological hegemony—reflecting in turn the privileged class and gender position of doctors, their alignment with rational science, and the antagonism between the midwifery and obstetric profession—the notion that collaborative care be instigated in policy without addressing these power relations is clearly simplistic and naïve. Thus, as Newnham argues, the 'seemingly inclusive' notion of collaborative care in the Maternity Services Review and ensuing legislation is simply an endorsement of the medical model of childbirth (Newnham 2010: 6). Moreover, national registration of 'eligible' midwives, an outcome of the MSR, and implemented nationally in July 2010, includes a clause that such midwives need to *prove* they are working in 'collaborative arrangements' in order to receive public indemnity insurance and, for their clients, access to Medicare benefits. Underpinning this legislation is an underlying assumption that 'midwives are not to be trusted to collaborate and thus must be legislated to do so' (Reiger and Lane 2010: 3). Obstetricians however, have no such obligation to prove they are in collaborative care arrangements with midwives. This was the crux of the Review's outcomes: the resulting legislation was testament to the power of the obstetric construction of

the policy problem. Obstetricians had succeeded in convincing policy-makers that there really wasn't a problem, that our mortality rates were excellent and that they should remain in supervisory roles. There was widespread disappointment with the MSR expressed by many who had hoped for change – particularly in regard to homebirth (Dahlen et al. 2011). Yet the legislation following the Review deliberately omitted coverage of births at home, though not private antenatal care, from a National Insurance Scheme for midwives. The impacts of the MSR on homebirth provision in Australia are discussed in the following chapter.

This chapter began by outlining the history of maternity care policy in Australia, demonstrating the way in which obstetricians in Australia have been integral to the development of policy and practice and have been able to ideologically shape policy discussions and debates. Though consumer lobbying has been strong over the years and contributed to State government policies promoting midwife-led, women-centred care, change to practice has been slow, especially outside the major public hospitals. Accordingly, expressions of dissatisfaction with public maternity care were high leading up to the MSR and midwifery and consumer groups had strong expectations of reform. The MSR process, like the policies and legislation that came before it, offered a meaningful attempt at enacting change in Australian maternity care and the consultation process yielded significant response. Though women made up the majority of respondents to the consultation process, the power of the obstetric profession emerged in full force and was able to dominate and shape public debates. In utilising the axiom that 'Australia was a safe place to give birth', obstetric responses to the MSR were able to persuade the Australian government and, it would seem, the Australian public, that changes to the status quo, that is, removing obstetric–led maternity and allowing midwife-led care, would jeopardise Australia's safe birthing record. In both the MSR submissions and the Australian media, obstetricians and their representative organisations argued that birth was inherently risky and that increases in intervention were not due to obstetric practices but to increase in women's pathology and risk factors such as age and obesity. Although the MSR process resulted in some very positive steps forward for midwives who now have access to the Pharmaceutical Benefit Scheme and a National Indemnity Scheme (for hospital births only), this was predicated on the condition that midwives prove they work collaboratively with medical professionals. By reinforcing obstetricians' power over the professional practice of another profession, the MSR

cemented obstetric power in Australia and maintained prevailing obstetric hegemony in public understandings and debate. It also however destabilised the status quo and provided opportunity for widespread contestation.

Chapter Five

Delivering risk: Moral panic and the homebirth debates

> The debates about homebirth are not just about place of birth but the right of women to have control over their bodies, rejection of the medical model of birth, including the belief that society has an investment in the product of childbirth and should therefore determine what is considered safe, the culture of childbirth, women's status in society . Homebirth represents the different philosophical paradigms of medicine and midwifery, therefore the debate is ideological, contested, longstanding and circumscribed by relations of power (Dahlen et. al 2010: 48).

Homebirth is an 'ambiguous and contested site' (Edwards 2005:19). Homebirth discourse in the Australia media somewhat mirrors the discourse around caesarean. Intertwining, complex and sometimes contradictory themes of risk, safety, choice and women's rights are at the forefront of public debates and discussions around out of hospital birthing. This chapter examines the Australian debates around homebirth as another key discursive site where obstetric hegemony is both contested and re-instated. As I have observed in preceding chapters, the obstetric profession in Australia strongly promotes women's 'choice' in relation to medical intervention and caesarean. Autonomy in birthing decisions is also strongly endorsed by women and commentators in the Australian media and is a key tenet of consumer–orientated neoliberal society. However, autonomy is not valued when it comes to women choosing to birth outside mainstream maternity systems, or in their own homes. In this chapter, I seek to make sense of the prevailing hostility to homebirth in contemporary Australian public discourse. I argue that the ideology of intensive mothering (Hays 1996) with its key obligation to 'manage' risk intersects with the powerful obstetric ideology that conflates homebirth with danger and irresponsibility. Popular media discourse constructs homebirth women and midwives as inadequate 'risk managers' acting selfishly and recklessly in defiance of commonsense. Moreover, in the context of several high profile coronial inquests into deaths of babies born at home, and the publication

and dissemination of studies into the safety of homebirth, I argue that for a period, in 2009-2012, there was what sociologists refer to as a 'moral panic' around homebirth.

The concept of a moral panic (Cohen 1972) refers to an episode or group of people who become defined as deviant and as a threat to societal values or social order and come to be represented by mass media in a stereotypical and stylised fashion (Cohen 1972; Hall et al. 1978; Krinsky 2013). Episodes of moral panic are usually triggered by alarming media stories and by public anxiety or concern which are out of proportion to the 'actual threat offered' (Hall et al. 1978: 16) and reinforced by reactive laws and public policies (Krinsky 2013). Moral panics gain momentum as concerned citizens, 'experts' politicians, mass media and policy makers join forces in condemning a particular group of people as deviant (Krinsky 2013: 5). I draw on the theorisation of moral panics in a risk society (Ungar 2001; Miller 2006; Miller 2013) to consider the way several competing discourses interact to reiterate and compound medical opposition to homebirth. Firstly, however I examine the politics of the production and dissemination of knowledge in regard to homebirth safety and risk.

5.1. Homebirth in Australia

The United Kingdom, the Netherlands, New Zealand and several Canadian provinces offer homebirth as a publicaly funded maternity care option. In the United Kingdom, the Royal College of Obstetricians and Gynaecologists (RCOG) accepts homebirth, stating that 'there is no reason why homebirth should not be offered to women at low risk of complications and that it may offer considerable benefits for them and their families' (RCOG, 2007: 1). Worldwide, midwifery organisations and childbirth advocacy groups and some international public health organisations endorse homebirth as a safe and even superior maternity care option for most healthy women and indeed support it as basic human right (Freeze 20l0; Dahlen 2011; Olsen and Clausen 2012). Yet, in Australia and the United States, where maternity care is dominated by medicine and a characterised by a privatised obstetric system as discussed in the previous chapter, medical organisations and individual obstetricians have a deep-seated and longstanding opposition to the practice (Gosden and Noble 2000; AMA 2008; Young 2008; Dahlen 2011; Lokugamage 2011; RANZCOG 2011; Pesce 2011; NASOG 2010). The number of women birthing at home in Australia is small at just 0.9% of all births in 2011, doubling from 0.4% in

2010 (Li et al. 2012), compared to other comparable Western countries such as the New Zealand with 11% of all births and the United Kingdom with 2.6 %. There are few publically funded options in Australia and families who chose this option usually pay for independent midwives who until recently were not covered by Medicare (independent or privately practising midwives are currently still not covered for the birth but can claim antenatal and post-natal costs). Some public hospitals offer homebirth services, but often limit this option to a small percentage of women fitting the narrow profile of 'low risk'. Western Australia and the Northern Territory offer Community Midwifery programs which includes the option of homebirth, however, again these services are generally only available to a small number of women. While there is some evidence to suggest increasing numbers of women are opting to homebirth following a previous traumatic or unsatisfactory hospital birth (Dahlen et al. 2011; Dannaway 2013) numbers of Australian women choosing or even wanting homebirth remain low, yet public interest is high and debate is emotionally charged and highly polarised.

Medical opposition to homebirth in Australia has intensified in the last decade (Dahlen et al. 2010). This has partly been in response to the MSR in 2008/2009 and the direct challenge it was perceived to present to obstetric-led care, as discussed in the previous chapter. Women advocating for more access to homebirth made up the majority of submissions to the MSR consultation process and were increasingly vocal during this period. They're mobilisation included the organisation of a 5000 strong protest at Parliament House, Canberra in 2009 to demand insurance for independent midwifery to cover homebirth (Metherell 2009). However, significant negative publicity also featured prominently at this time with three high-profile coronial inquests into deaths of babies born at home and the strong media promotion by the AMA of an Australian homebirth study linking higher neonatal mortality rates with homebirth (Sweet 2010). In 2009 leading homebirth advocate, feminist writer and founder of the online homebirth community, *Joyous Birth*, Janet Fraser, made headlines when her baby was stillborn following an unassisted 'freebirth' (the practice of birthing at home without medical or midwifery assistance) at her home in Sydney after 3 days of labour. Days earlier she was mid-interview with *The Age* regarding insurance issue for homebirth midwives when her labour began. She stated to journalist John Elder that 'I could do this for days. My daughter's birth was 50-something hours. You just do it — it's just birth, a normal physiological process' (Elder 2009). In 2012 a coronial inquest

found that the death of Fraser's baby could have been avoided had a midwife been present, and that Fraser's 'ideological beliefs' contributed to the baby's death (Mitchell 2012). The death and the subsequent coronial inquiry received significant news coverage, often tending to the gleeful, vindictive and hateful (Bolt 2009; Freeman 2009; Devine 2009). Though this incident was a freebirth, not a homebirth with a midwife, this was rarely distinguished in the media.

In 2012, a coronial inquest was held into the deaths of 3 babies born at home in South Australia over a period of three years, under the care of an unregistered midwife, Lisa Barrett. All three births would be considered high risk by many midwives. In Barrett's case, the inquest found that all three babies would have 'with certainty' lived had the mothers had a caesarean (Schapel 2012). The first case investigated a VBAC with a known macrocosmic (larger than average) baby who died due to intrapartum hypoxia after becoming stuck during the second stage of labour; the second birth investigated, involved breech birth with the baby's cause of death again found to be intrapartum hypoxia; the third birth involved a twin pregnancy where the first twin was born alive and healthy, the second twin died in-utero on route to hospital after Barrett established foetal distress. The coroner established that the baby had died as a result of hypoxic ischaemic encephalopathy due to separation from the placenta and that Barrett had waited too long before transferring the mother to hospital (Schapel 2012). In each of the babies' deaths, the coroner found that Barrett and the families involved were aware of the potential risks. A formal complaint about Barrett was also lodged to the South Australian Health and Community Services Complaints Commission (Tully 2012). When Barrett appealed the coronial inquiry to the High Court on the grounds that one of babies, the twin, was not born alive (a coroner only has jurisdiction over the death of a baby born alive, not a stillborn), her appeal was dismissed. Barrett reports being sent threatening hate mail and news crews following her as she attended births (Barrett 2011). In 2012 another high-risk homebirth, this time a VBAC, resulted in the death of baby Joseph Thurgood-Gates nine days after his birth (Parkinson 2013). The Victorian Coroners' Court ruled that Joseph Thurgood-Gates was brought to hospital with hypoxic brain injury resulting from asphyxia as an outcome of uterine rupture (Parkinson 2013). Coroner Parkinson found that a delay in transferring the mother to hospital and poor judgement and management of risk were factors in Joseph's death.

These incidents led the West Australian AMA, and tabloid journalists, to call for a ban on homebirth (O'Leary 2012; O'Brien 2012; Puddy 2012). In South Australia, legislative changes were brought into place that makes it a crime for an unregistered midwife or birth attendant to attend a homebirth. Reports of television news crews following homebirth midwives and waiting outside the homes of birthing mothers (Owen 2012) and of a police visit to a New South Wales woman who failed to turn up for an induction in hospital after telling the hospital she was planning a homebirth (Sikora 2010), suggest a climate of heightened public anxiety around homebirth. The Australian incidents and debates have also occurred in the context of what has been described as an international 'backlash against independent midwives' and homebirth (Dahlen, 2011). In Hungary, the Czech Republic, and the North America midwives have been jailed and or are facing criminal charges for assisting women to birth at home (Eggermont 2012; c.f. humanrightsinchildbirth.com).

In the previous chapter, I outlined the way in which the Labor government's Maternity Services Review failed to provide indemnity cover for independent midwives who support women to birth at home, or make any provision for publically funded home birth, and the final legislative changes enshrined medical power of veto by requiring independent midwives to enter into 'collaborative arrangements' with a doctor to be eligible for the Medicare rebate. According to those in the profession, (Dahlen et al. 2011) scrutiny placed on homebirth midwives since the MSR has had significant ramifications. The Australian College of Midwives claims that since the legislation, 100 independent midwives have withdrawn their registration and some are now practicing as unregistered 'birth attendants' (Puddy 2012; Homebirth Australia 2012). Increasing dissatisfaction with hospital maternity services, and the inflexibility of hospital protocols regarding high risk pregnancies (for example VBACS and vaginal breech births are not supported in many Australian hospitals) has led more women to birth 'underground' in unassisted 'free births' (Dannaway 2013; Jackson et al. 2012; Homebirth Australia 2012) According to an unpublished Homebirth Australia survey of its members, 67% of over 1000 respondents said they would birth unassisted at home if they did not have access to the services of a midwife (Homebirth Australia 2012). In response to these concerns, the obstetric profession reasons that women have the option of using 'home-like' birth centres attached to hospitals (RANZOG 2011, NASOG 2011). But these are also far and few between with limitations on eligibility of use.

Moreover, as Professor of Midwifery, Hannah Dahlen notes: '…some women just don't want to birth in a birth centre…they are not the whole answer and will not take away the issue of homebirth' (in Puddy 2012). They are also diminishing in number and being integrated into mainstream services (Hagan 2013).

5.2. The construction of knowledge in homebirth

The basis of the Australian medical and obstetric opposition to homebirth is the view that birth at home without medical supervision carries unacceptable risks for mothers and babies. RANZCOG for example states that 'planned homebirth is not endorsed as it is associated with an unacceptably high rate of adverse outcomes' (2011: 3). NASSOG (2011: np) also claims that 'due to the inherent risks of labour and birth for both the mother and baby NASOG does not recommend home birth or standalone birth centre birth'. The Australian Medical Association (AMA) does not have an official position statement on homebirth but has demonstrated its opposition to homebirth and independent midwifery via various media releases and submissions to the MSR and other inquiries over the last 5 years (AMA 2008). Under the leadership of obstetrician, Dr Andrew Pesce (also a former president of NASOG) the AMA vigorously used the popular media to promote its anti-homebirth stance during the MSR process; indeed Dr Pesce cited as his 'greatest achievement' his successful lobbying to have homebirth midwives excluded from a National Insurance Scheme (Stark 2009).

While medical opposition to homebirth is framed in terms of safety, many commentators, including within the profession, note that that opposition to homebirth is based not in evidence, but in politics and ideology (Keirse 2010; Homer and Broome 2012; De Melo-Martin and Intemann 2012; Dahlen et al. 2010; Lokugamage 2011; Dahlen 2011) and 'circumscribed by relations of power '(Dahlen et al. 2010). As De Melo-Martin and Intemann argue; the debate about home birth is a telling example of the failure of science and medicine to attribute values or bias in the construction of knowledge (2012). The medical opposition to homebirth has little to do with place of birth; rather it symbolises the 'fundamental differences' (Homer and Broom, 2012: 166) in the management and philosophy of childbirth, differences historically rooted in the longstanding political, ideological and economic dominance of maternity services by obstetrics. Obstetrician Amali Lokugamage (2001: 263) argues that doctors fear birth outside medical

parameters because they rarely see normal physiological birth; their perception of birth is thus skewed and they hold a deep-seated belief that all birth is potentially life-threatening (see also Klein 2005).

In maternity care, as argued in the preceding chapters, biomedical knowledge is taken for granted as legitimate, while elements of midwifery knowledge that are viewed as experiential and 'non-scientific' are devalued or not recognised at all. The use of evidence in maternity care is highly contentious and there are disparities in views of what constitutes 'legitimate' evidence and the construction of risk and safety. The 'ammunition' (Lokugamage 2011: 265) for an anti-homebirth stance is largely derived from the paucity of 'gold standard' research. In obstetrics, like all medicine, a Randomised Controlled Trial (RCT) is the 'gold standard' of research evidence (Keirse et al. 2009; Reiger and Morton 2012). However, as very few (if any) pregnant women would opt to randomise such an important life event, there are to date, no RCTs on homebirth, or likely to ever be (Keirse et al. 2009; De Melo-Martin and Intemann 2012; Homer and Broome 2012). Thus, existing studies assessing the safety of homebirth are based on observational studies, retrospective analyses of birth data, or meta-analyses, and are open to methodological disagreement and scrutiny from those supportive of homebirth *and* those who oppose it (Homer and Broome 2012; De Melo-Martin and Intemann 2012). Those opposed to homebirth however, have no problem utilising studies that apparently demonstrate higher mortality or morbidity associated with homebirth to make their case (Homer and Broome, 2012; De Melo Martin and Intemann 2012; c.f Pesce 2010).

I argued in the previous chapter that representative medical organisations used dated and flawed research in their submissions to the MSR to argue their case against homebirth. For example, what has been dubbed as the 'Bastian Study' (Bastian et al. 1998) continues to be used in Australia as 'strong evidence' (RANZCOG 2011: 1) that birth at home carries higher perinatal morbidity and mortality rates. However as several critics show, the retrospective analysis of birth data included births attended by unregistered midwives, high risk births such as twins, and the authors used unconventional methods such as searching newspapers for death notices (Homer and Broome 2012). The authors themselves noted these shortcomings. In fact, the study shows

that for women with no known risk factors, homebirth is a safe option (Homer and Broome 2012).

In 2010, an American meta-analysis published in the *American Journal of Obstetrics and Gynaecology* (Wax et al. 2010) gained extensive media coverage in North America and Australia. The study concluded that 'less medical intervention in homebirth is associated with a tripling of the neonatal mortality rate' (2010: 152). However this study too, has been critiqued from a methodological standpoint, primarily in regard to the questionable inclusion of data and incorrect extraction of statistics (Gyte et al. 2010; Sandal 2011; Zahar and De Vries 2011; Keirse 2010; Michal et al. 2011; Olsen 2011). Michal et al. found that;

> The statistical analysis upon which this conclusion was based was deeply flawed, containing many numerical errors, improper inclusion and exclusion of studies, mischaracterization of cited works, and logical impossibilities (Michal et al. 2011: 1).

The Wax study also omitted in its meta-analysis, a Dutch analysis of over half a million homebirths showing that neonatal outcomes in homebirth are comparable in to that of hospital births (Olsen 2011). The Wax et al. study was not only widely reported in the popular media, but also uncritically reported in prestigious medical journals, *The Lancet* and *The British Medical Journal* and used by medical organisations in Australia and in North America to justify opposition to homebirth. Sandall (2011) argues that this was 'unethical' and called for the journal's peer review guidelines to be reviewed (2011). Olsen (2011: 83), a medical statistician, argues that the Wax study and the ensuing medical dissemination of it, demonstrated a 'willingness [by obstetricians] to distort science' for their own gain.

Similarly, an Australian analysis of South Australian birth statistics, published in the *Medical Journal of Australia* (MJA) (Kennare et al. 2010) , received significant media coverage and was used by medical organisations in Australia as 'evidence' that homebirth was dangerous and deadly (AMA 2010; NASOG 2011; Owens 2010; Pesce 2010a; Svigos 2011). The study found that over a 16 year period in South Australia, there were 9 perinatal deaths of babies in planned home births (compared to 2440 in hospital). The study, like the Wax study, has been vigorously

criticised (Sweet 2010; Homer and Broome 2011; Lokugamage 2011; Dahlen and Homer n.d.). Critics highlight that seven of the deaths occurred in hospitals following transfers, the remaining two deaths occurred at home, and one baby had congenital abnormalities. Once the statistics were adjusted to take into account congenital abnormalities, the rates of perinatal death for planned home birth versus planned hospital births were statistically similar. The authors of the study in fact noted that:

> There were only three perinatal deaths for which one can reasonably assume that a different choice of care provider, location of birth or timing of transfer to hospital might have made a difference to the outcome' (Kennare et al. 2010: 79).

One of these three deaths occurred in what was accepted as a 'high risk' twin pregnancy. The study reported that there was a seven times greater risk of death for babies born at home and 27 times greater risk of asphyxia during labour; yet again, the authors point out that 'small numbers and large confidence intervals limit the interpretation of these data' and 'urge caution in the findings' (2010: 79). These important qualifications to the study however, were not mentioned in the media reporting of it (Sweet 2010; Homer and Broome 2011). The article was accompanied by an editorial in the *Medical Journal of Australia* written by Dr Andrew Pesce (2010a), then president of the AMA, and a media release by the AMA (2010). Medical journalist, Melissa Sweet, reported that journalists had relied only on the accompanying media release from the AMA and the editorial by Pesce rather than reading the study itself (Sweet 2010). Sweet argues that in the context of 'the intense politicking that has surrounded home-birth policy in the context of maternity services reform', the MJA's decision to have Pesce, president of the AMA, write the accompanying editorial gave the AMA another 'platform' from which to espouse their anti-homebirth stance. In the MJA editorial, Pesce argued that the study justified the government's decision in not insuring independent midwives given the 'accumulated evidence from Australia spanning 30 years' (he cites the discredited Bastian study) show that homebirth would 'contradict evidence-based care principles' (2010: 60). He also warns that 'science, not politics' should inform maternity policy. In response to Sweet's criticisms of Pesce, the AMA and media reporting of the study, Pesce claimed that Sweet (and others) were 'shooting the messenger'

(Pesce 2010b). Pesce claimed that the evidence spoke for itself, that he there was no conflict of interest in reinforcing the AMA's position

The obstetric profession's misrepresentation, and deliberate distortion of statistics and research, is not limited to homebirth research however. There are several areas of maternity care where statistics are used by obstetricians in unethical or incorrect manner; research on use of ultrasounds, VBAC, breech birth and use of syntocin to induce labour for example are other areas where study findings have been misrepresented (Olsen 2011; Wendland 2007; Plante 2009; Goer 2002; Wagner 2006). A recent review of the research studies used in the American College of Obstetricians and Gynaecologists' position statements found that only 30% of their recommendations were based on 'level A' evidence, 38% based on 'limited or inconsistent evidence' while 32% were based solely on 'expert opinion and practice consensus' (Wright et al. 2011).

There is a growing body of research suggesting that birth at home in *low risk* pregnancies, with the support of qualified midwives, is comparable, and sometimes superior in outcomes, to hospital birth (Johnson and Davis 2005; de Jonge et al. 2009; Romano and Lothian 2007; Hutton et al. 2009; Janssen et al. 2009; Birthplace in England Collaborative Group 2011; Olsen and Clausen 2012). Yet these studies are never or rarely cited or acknowledged by medical organisations. Professor of Midwifery and spokeswoman for the ACM, Professor Hannah Dahlen, writes that 'when the dominant paradigm is determined for homebirth to be eradicated, there is little chance for science to project an informed and balanced voice into the debate' (2011: 259). The dissemination of research into homebirth demonstrates the dominance of authoritative medical knowledge – it is taken for granted as neutral, unbiased fact. As I will discuss below, the media discourse around homebirth overwhelmingly reflects this dominant paradigm, despite the efforts of many researchers, mothers, midwives, obstetricians and epidemiologists to present an alternative viewpoint. Thus, while Dr Pesce contends that science not ideology should inform maternity policy (2010a), it is clear from the examples above, that ideology and politics, not science forms the rationale behind the obstetric profession's opposition to homebirth and independent midwifery.

5.3. Homebirth, risk society and 'intensive motherhood'

Lee et al. (2010) argue that in the context of a risk society, collective anxieties about the safety of babies and children form the core of the surveillance of parents designed to ensure that potential hazards involved in birth and childrearing are managed adequately and responsibly. In this context parents are increasingly constructed as 'inadequate risk managers':

> …the parent is represented as central to the evolution and development of danger. In other words, the imperative at the individual level to become a risk manager weighs especially heavily when the message is communicated that the child is at risk. The drive to protect children 'at risk' and to increase the safety of children in general is, for these reasons, among the most powerful of contemporary cultural and policy norms (Lee et al. 2010: 299).

Coxon et al. (2012: 506) elaborate on this hypothesis, arguing that risk is a 'key element' in the contestation over hegemony within maternity care (2012: 506). The obligation to assess and manage risk responsibly is central to decisions surrounding pregnancy and birth (Gregg 1995; Coxon et al. 2012) and this obligation is 'intensified by the intersection of the discourse of risk with that of motherhood' (Murphy 2004: 204) as mothers are increasingly positioned as 'risk managers' (Knaak 2010). In 1996, feminist theorist Sharon Hays argued that the dominant ideology shaping late modern motherhood was that of 'intensive mothering' (1996). Intensive mothering is defined by the key characteristics reflective of a risk-orientated neoliberal society, and requires mothers to be utterly selfless and child–centred, relying on professional expert advice to make the right choices, avoiding risk, in regards to child rearing (Hays 1996; Lee 2008). More recently, Song et al. (2012) posit that pregnant middle –class women must perform a role as 'informed patients' but also negotiate the prevailing ideology of intensive motherhood; thus their 'consumer choices in pregnancy and birth are laden with moral responsibilities to make the best choice for one's child' (2012 see also Knaak 2010; Bryant et al. 2007). Since homebirth is viewed, both popularly and professionally, women who chose to homebirth, seen as a dangerous, risky practice, are constructed as negligent, ignorant and deviant (Miller 2012), and, as, I will argue, as failing to adequately minimise risk.

5.4. Moral panic in a risk society

The sociological concept of a moral panic refers to episodes of public anxiety in regard to particular groups of people or practices who come to be perceived as deviant and as a threat to social order. Moral panics are spurred on by mass media and then taken up by the State, various 'experts' and moral crusaders, however, in general, the reaction to the perceived risks is highly disproportionate to the actual threat posed (Critcher 2006; Goode and Ben-Yehuda 2009; Krinsky 2013). Moral panics are defined by five criteria or stages; concern, hostility, consensus, volatility and disproportion. Young (2009: 13) describes a moral panic as:

> A moral disturbance centring on claims that direct interests have been violated – an act of othering sometimes expressed in terms of demonisation, sometimes with humanitarian undertones that are grossly disproportionate to the event or the activities of the individuals concerned. It is presented in stereotypical terms. In the modern period, this involves the focusing of the mass media, buttressed by scientific experts and other moral entrepreneurs, and the mobilisation of the police and the courts, and other agencies of social control.

Miller (2006: 306) argues that risk society is 'abetted and indexed' through media-created moral panics. Media reactions to perceived cases of riskiness, argues Miller, are played out in 'highly exaggerated ways', often with clear scapegoats or what Cohen (1972) labelled, 'folk devils'. Folk devils are seen as responsible for the risk posed to society and come to be viewed with hostility and resentment (Good and Ben-Yehude 2009). In early theorising about moral panics, folk devils were usually seen marginalised members of society, however de Young (1998) argues that this is not always the case, and with access to resources, folk devils are able to 'resist their demonisation' and 'shape public discourse and challenge the efforts of social control' (1998: 289). Ungar (2001) differentiates the concepts of moral panic and risk society 'anxieties'. The locus of public anxieties in risk society is much broader (for example environmental concerns), making it harder to locate the problem in any one group or behaviour. Corporations and governments are more likely to be seen as the locus of a risk society crisis or anxiety, and there is lesser element of morality (Ungar 2001). Moral panics, on the other hand, have easily identifiable culprits who are seen to be the locus of risk. While Ungar argues that the concept of moral panic

is less useful to contemporary research agendas, other scholars have applied the concept to diverse contemporary social phenomena; sole mothers on welfare (Ajzenstadt 2008), ethnic youth and gang rape (Dagistanli 2007), internet sexual predators (Molloy 2013) to name a just a few (see also Krinsky 2013; Poynting and Morgan 2007; Critcher 2006). Moreover, as Critcher points out, moral panics can, and have been, theorised from 'almost any established framework in sociology' (2006: 2). Social phenomena and social problems can be classed as moral panics when they have specific attributes or processes (described above), but in particular when they induce a reaction that is out of proportion with the said cause, and when 'emotion rules over reason' (Critcher 2006: 3).

Hall et al.'s (1978) and Jock Young's (2009) discussions of moral panics and hegemony are of particular relevance to this analysis of homebirth debates. Hall et al. (1978) located the moral panic over 'muggings' in Britain in the late 1970s in the context of political struggle over hegemony and a conservative government's desire to introduce a widespread law and order campaign. Moral panics, they argued were a conscious response to disturbance of the social order and social values and part of an ideological struggle in the context of a rapidly changing society. Hall et al. (1978: 41) argue that the mass media 'provides one key terrain where 'consent' is won or lost'. Young (2009:13) also argues that moral panics occur when 'hegemony is in crisis' and in the context of larger social concerns.

In the next section, I examine Australian media articles, blogs and other online content to demonstrate the way obstetric hegemony operates and intersects with prevalent cultural discourses around 'good motherhood' and the obligation to manage risk, in providing the background for the moral panic that ensued around homebirth. I examined major Australian newspapers and news and opinion websites from 2009 to 2012 for articles on homebirth. Using the Factiva database, I identified 102 relevant news articles, opinion pieces, feature stories, debates, and letters to the editors where homebirth was the topic of discussion. I also examined the online versions and analysed the reader comments made in response to news articles. I further draw on content from online forums, blogs, and news /opinion websites. As described in Chapter 3, the nature of online content is fluid and difficult to quantify due to the 'live' nature of comments and replies to online articles, blog posts and forum posts. For a full list of online

sources examined, refer to Appendix 3. I also refer to State Coroner's reports (described above) on the deaths of babies born at home. Newspaper articles and online content were thematically analysed via NVivo software using a CDA framework to reveal underlying ideologies and recurrent discursive themes.

5.5. Folk devils: The construction of homebirth women as inadequate risk managers

It is evident that the practice of homebirth challenges the dominant organisation of childbirth. Birth outside of hospital resists medical hegemony in childbirth and signifies an outright rejection of the authoritative, scientific knowledge of experts and institutions (Davis-Floyd 1992; Gosden and Noble 2000; Edwards 2005; Cheyney 2008; Dahlen 2011; Moore 2011; Lokugamage 2011). Women who birth at home place their trust instead in the intuitive and embodied knowledge of women and the expertise of midwives (Davis-Floyd and Davis 1996; Cheney 2008; Moore 2011; Dahlen 2011). Mothers and midwives describe homebirth as transformative, empowering, confidence-building, as a rejection of patriarchal, technocratic culture and a mechanistic view of the body, as embracing intuition and inner strength, and importantly, as placing trust women's bodies (Davis-Floyd 1998; Edwards 2007; Cheyney 2008, Boucher et al. 2009; Moore 2011; Lokugamage 2011; Lemay 2011). Cheyney (2008:537) argues that Homebirth practices as well as being evidence-based models of care, are 'intentionally manipulated ritual[s] of technocratic subversion designed to reinscribe pregnant bodies and to re-territorialise childbirth spaces and authorities' in which participants deliberately appropriate and modify new meanings of childbirth. The mobilisation of homebirth women has, at various points in history, successfully challenged the power of medical hegemony (Beckett and Hoffman 2005; Miller 2009; Reiger 2001). In Australia homebirth activism was able to impact on policy and discourse in positive ways during the 1970s and 1980s; for instance recognition by governing bodies and various state health departments of the women's desire for 'home-like' maternity settings (Schofield 1995; Gosden and Noble 2000; Reiger 2001) and women's right to birth at home (Gosden and Noble

2000), even if these policies are rarely actually implemented. Moreover, it is often home birthing families who volunteer for activist groups such as the Maternity Coalition in Australia as well as specific lobby groups like Homebirth Australia. These mobilisations challenge medical dominance of maternity services, and consumers become involved in policy formation and implementation at state and federal levels (Reiger 1999; Newman et al. 2012).

During the period 2008-2012, biomedical knowledge and the dominance of obstetric-led maternity care was significantly challenged. As discussed above, over half of the 800 MSR submissions were from women advocating birth at home (McIntyre et al. 2011). McIntyre et al.'s (2011) analysis of the MSR submissions, suggests that the majority of submissions to the MSR overwhelming advocated a move away from obstetric-led maternity care. They represented a powerful challenge to the authority of doctors' roles in maternity care (2011: 7). In 2009, nearly 5000 women protested at Parliament House, Canberra in response to the MSR's failure to provide insurance for independent midwifery (Metherell 2009). Moreover, the internet has meant that communities of homebirth women across Australia and the world are able to connect, organise and reframe maternal subjectivity, and contest the biomedical paradigm. The ability to disseminate knowledge via blogs, *Facebook* groups and pages, email lists and via birth videos on YouTube, mean that the homebirth movement is able to publically and visibly challenge medical monopoly and hegemonic discourse around childbirth. For instance, websites such *Science and Sensibility*, *Feminist Breeder*, *Hoyden about Town*, *The Unnessecarean*, *Joyous Birth* and others challenge the expertise and authority of medicine—though recent research suggests that the internet while providing space for contestation and subversion, can also reinforce biomedical hegemony (Song et al. 2011).

In the context of this perceived challenge to hegemony, the news coverage of homebirth deaths and subsequent coronial inquests, and South Australian and North American studies into homebirth safety, were reported in the media in a highly sensationalist manner. In keeping with a moral panic framework, 'alarming media stories' (Krinsky 2013) are often the trigger for a moral panic episode and occur at time when hegemony is challenged or in crisis (Young 2009). Newspaper headlines such 'Four dead in home birth tragedies' (Lawrence and Dunlevy 2009), 'Natural Born Thriller' (Jean 2011), 'State 'in Denial' over Home-birth Risks'(Guest 2010),

‘Homebirths multiply death risk by seven’ (Owens 2010), ‘Doctors warn of homebirth danger’ (McArthur and Byrne 2010) and ‘Homebirth killed three babies’ (Freeman 2012) abounded. These headlines reiterate the dominant narrative of risk and the imagery of dead babies is a powerful emotional and moral motive. Obstetricians and their peak bodies were given prominent voice in the media during this time, consistent with Miller’s (2006) claim that during a moral panic, the ‘dual role of experts and media critics’ is crucial to the construction of a moral problem.

Obstetricians largely presented a united front with the view that home birth was never or rarely a safe birthing option:

> If you look at all the data, there’s just no doubt that the risk in particular of mortality, of the needless death of an otherwise healthy baby in a homebirth setting is higher, and we can’t imagine other specialities advocating for modes of treatment that increase the risk of death, and that’s been uppermost in our mind.
>
> Dr Steve Robson, Vice President of RANZCOG, *Radio National Law Report*, October 16 2010.
>
> All studies done on homebirth confirm there are three times more complications for the mother and baby…Complications and avoidable disasters from women classified as low-risk are seen almost every week in the major maternity units…The argument for increased homebirth must be resisted. I care if a baby is dead and I care more if the baby is brain-damaged, which is a cost on the community. The government has a responsibility to educate the public that the safest place to have a baby is in hospital where the woman is received and monitored by qualified midwives.
>
> Dr Pieter Mourik in McWirther, ‘Homebirthing a mother of a dispute’ *Daily Telegraph*, 11 September 2009.

> We do not know how much home birth risks severe, avoidable long-term disability because there aren't good figures. To take an extreme example, home birth might result in quadriplegia. Now what risk could/should a couple take to have "a really lovely spontaneous birth at home" that justifies quadriplegia? One in 1000? One in 1 million? Anything? We contend that the choice to have "a really, lovely spontaneous birth at home" is only justified if it exposes the future child to the lowest possible risk of avoidable disability. And this is just never the case at home. Why else would modern obstetrics have been developed?
>
> Lachlan de Crespigny (obstetrician), 'No mother or unborn child deserves the risk of homebirth', *The Age*, 9 September 2012.

In a 'for and against' home birth feature in the *Adelaide Advertiser* Dr Andrew Lavender, president of the South Australian Branch of the AMA emphasises the unpredictability and inherent danger of birth to justify birth within a medical setting;

> Birthing itself is an inherently dangerous event in the lives of both baby and mother. Over the last 100 years there has been a significant decrease in mortality and morbidity associated with birthing due to advances in medical treatment helping reduce the risks that are inherent in the birthing process. Some adverse events during birthing are predictable. There is also a significant risk of adverse events even in what would be anticipated to be safe and low-risk births. Complications that may occur may pose a significant and immediate threat to the life of a foetus and baby. Other potential complications are also life threatening to the mother… Where this occurs death or significant brain damage may result within minutes, and it is for this reason that the Australian Medical Association and the medical profession as a whole, is strongly supportive of birthing, where possible, within a safe environment where full medical support facilities are available.
>
> Dr Andrew Lavender, President of the South Australian branch of the AMA, *Adelaide Advertiser*, 6 June 2009.

Several articles position obstetricians as benevolent saviours of at-risk babies:

> Obstetricians regularly see cases of avoidable poor outcomes where women with significant risk factors choose to give birth at home, and warning signs of impending complications have not been acted upon'.
>
> Dr Andrew Pesce, 'Mother and baby are doing well', *The Drum*, 8 April 2009.

As with the caesarean debates examined in Chapter Three, obstetricians as experts in birth, have ready access to media on the issue of homebirth and are able to sway public discussion and maintain a united front in their opposition to the practice. Like the discourse around caesareans, the tone of many of these medical responses is paternalistic; chastising misguided women, and irresponsible midwives for putting babies lives at risk; risks that could have been avoided had they birthed in hospital.

For example, Dr Rupert Sherwood, then president of RANZCOG in an opinion piece for the *Herald Sun* addressed the attempted homebirth of singer/entertainer Danni Minogue's son, implying that women make flippant or poorly researched choices based on the cult of celebrity:

> We are well aware of well-known women trying to have babies at home. Because of the glamour of celebrity, it can be difficult for women and their families to understand the level of risk.
>
> Rupert Sherwood, 'Hospitals are the safe option for both mother and baby', *The Herald Sun*, 1 February 2012.

Obstetrician John Svigos (2011), in an opinion article for current affairs blog The *Conversation* states

> Women need clear and accurate information about the risks of different birthing environments. As an obstetrician of 30 years, I have these discussions with pregnant women and their partners every week. And many are surprised to learn that giving birth at home is far more risky for their baby than a planned hospital birth.

The notion that women choosing to birth at home are incapable of understanding risk, or being 'misguided' in their understandings (c.f. Svigos 2011; Farnsworth 2013) was common in the media discourse. However, more ubiquitous was the theme that women were entirely *aware* of the risks, but negligently choose to birth at home regardless. For example findings of the coronial inquiry into deaths in South Australia headlined as 'Fatal choice; mum was willing to risk baby's life' (Keller 2011). In this way, homebirth was constructed as a *moral* issue, much like debates about abortion, and mothers demonised for placing their own autonomy over the rights of their unborn child:

> There are two individuals whose rights need to be considered. Our society respects a woman's right of choice and autonomy. The unborn child at law does not have rights, and yet that child in labour is so close to full human rights. Healthcare professionals looking after women in labour are acutely aware of their responsibility for the well-being of the baby. Morally does not the mother have a duty of care to avoid putting her child at increased risk?
>
> Dr James Harvey, Letters, *The Advertiser,* 12 June 2012.

> I think it all depends on whether or not you consider the rights of the unborn child over the mother's preferred option of childbirth. If you do give priority to the unborn child's right to the least risky option, then that should drive the debate. If we give priority to the mother's preferred option, her body her choice, then it should be whatever she decides. Personally I'm not comfortable with the unborn baby not having rights to the safest option possible. At what point should the mother become legally responsible for causing injury or death to her child through negligence?
>
> 'Sal' *Essential Baby,* 9 April 2009.

This discourse also plays into notions of homebirth women as inadequate 'risk managers' (Lee et al. 2010) selfishly and irresponsibly failing their duty as mothers by putting their ideological beliefs before the safety of their babies. These themes were predominately found in opinion

pieces by female journalists and commentators and in online pregnancy and birth forums, as well as commentary from medical professionals:

> But homebirthers are zealots, carried away with a quasi-religious fervour, and unhinged when it comes to unleashing vitriol on anyone who dares to criticise their selfish choice. Because it is selfish. It is putting your short –term emotional fulfilment ahead of your baby's health, treating labour as an extreme sport to be mastered for the sake of your ego, or some mystical feminist business.
>
> Miranda Devine, 'Price of this belief may be a baby's life', *Sunday Telegraph*, 23 October 2011.
>
> I'm astounded that any mother would chose to have her baby at home – regardless of whether a midwife is present or not. The death of a baby during childbirth would be unimaginably heartbreaking. And surely, any mother would go to any length to make sure this didn't happen. So why do homebirthers open their child…to the slightest chance of misfortune?
>
> Alissa Warren, 'Why homebirth is crazy and why hospital is the only place to give birth', *Sunday Telegraph*, April 22 2012
>
> Homebirths strike me as an absurd enterprise when you are deliberately placing in danger not only the life of your unborn child, but also your own.
>
> Eliza Allender, Letters, *The Age*, 16 September 2012.

Commentators also drew on the hegemonic 'common-sense' assumptions about medical progress and the expertise and beneficence of doctors in positing birth at home as inconceivably backward;

> It beggars belief that, given the professional care available to Australian women, given their accessibility to essential drugs such as antibiotics and to the equipment needed for the safe arrival of a baby, that anyone would choose to give birth at home …no hippie reasoning is able to convince me that parents

> who homebirth are placing the good of their child first. They are clearing thinking only of themselves.
>
> Fiona Connolly, 'Homebirths are irresponsible', *Daily Telegraph,* 7 April 2009.
>
> Nothing on this earth would entice me to have a baby at home….I'm all for the protective womb of expert physicians and latest technology in a crisp white hospital environment. The risks are too great, the act of childbirth too unpredictable; the potential loss too devastating to contemplate.
>
> Lainie Anderson, 'The real miracle of pregnancy isn't childbirth', *The Punch*, 24 October 2011, first published in the *Daily Mail,* 23 October 2011.
>
> Home births are selfish, irresponsible, anti-reason and anti-progress. Australia's maternal mortality ratio is 8.4 per 100,000 compared to Somali where 1400 women for every 100,000 die during childbirth. We are gifted with advances in maternity practices that just a few generations ago would have dreamed of and in Australia we have obstetrics which are the envy of the modern medical world.
>
> Mia Freedman, 'Homebirth in the news for the most tragic of reasons', *Mamamia.com.au*, 7 April 2009.

In terms of the discourse of 'intensive mothering' (Hays 1996; Song et al. 2012) then, women who choose to birth at home, are failing in their responsibility as mothers and risk managers, by rejecting expert advice and modern technology. Hegemonic obstetric discourse intersects with powerful moral imperatives to good motherhood (De Mello-Martin and Intemann 2012). Christa Craven's (2005) ethnographic research on homebirth activism and legislation in the North American state of Virginia, similarly found that homebirth women were constructed in popular and medical discourse as deviant, and likened to women who abuse drugs and alcohol during pregnancy. As Miller points out, women who chose to birth at home also often face social stigma and marginalisation 'in a society that equates physician-attended hospital birth with increased safety and responsible parenthood' (Miller 2011: 409).

The Australian coronial inquests into homebirth deaths concluded that the women involved were negligent and 'willing to risk babies' lives' by putting their ideological beliefs ahead of safety (Mitchell 2012; Schapel 2012; Parkinson 2013).Though no criminal charges have been recommended in any of the cases, the women and midwives involved have nonetheless been constructed in the Australian popular media as social deviants, or in the moral panic framework, as 'folk devils' and their impact on wider Australian society, overblown. A key aspect of a moral panic, is the exaggeration of risk to the public in proportion to the perceived moral problem (Krinsky 2013). Though making up only a very small number of women, the media focus and vitriol (especially in online discussions) directed at homebirth women was immensely disproportionate. The coronial recommendations all strongly suggested that Australian women may be being misinformed regarding the safety of birth at home and called for better education of parents (Mitchell 2012; Schapel 2012; Parkinson 2013). In the case of Roisin Fraser's death, the coroner was highly critical of the influence of the homebirth website *Joyous Birth;*

> This propaganda served up on *Joyous Birth*…appears typical of the intention to convert women who visit the site to the view that hospital involvement in their pregnancy and births are undesirable and contrary to the interests of women and children…the views, [expressed on the website] are wrong views extravagantly expressed and quite insensitive to the harm they might do others; whether inexperienced mothers or babies like Roisin (Mitchell 2012: 16).

Coroner Anthony Schapel's inquiry into three babies' deaths in South Australia under the care of (recently) unregistered midwife, Lisa Barrett, recommended that pregnant South Australian women be given 'written information' regarding the risks involved in home birth;

> The evidence in this inquest has demonstrated that there is a need for education of the general public in respect of the risks associated with certain types of childbirth within the home and in order to dispel what appear to be widely held myths concerning the circumstances in which these births are managed in hospital (Schapel 2012).

In the coronial inquest into Victorian baby, Joseph Thurgood-Gates, the Victorian state coroner suggested that the case was an example of medical information taken from the internet and wrongly relied on against obstetrical advice. The coroner stated that;

> This is sadly the case of untrained users using raw data or statistical information to support a premise of risk without knowledge or understanding of the complex myriad of factors relevant the risk.

And like the South Australian coroner, the recommendation was that the Victorian Health Minister 'consider regulating home birth services and developing an information resource to give prospective parents better guidance on issues related to various birthing options' (Parkinson 2013). Coroners and some doctors (Svigos 2011) propose that information gathered from the internet regarding homebirth is inaccurate and dangerous and potentially influential in women's choices to reject hospital birth. However, recent research suggests that while the internet appears to be a space of contestation and subversion of the medical model of birth, it actually 'reproduce[s], perhaps even exacerbate[s], the dominance of biomedical paradigm of reproduction rather than encouraging women to resist it' (Song et al. 2012: 788).

The tragic deaths of these 5 babies in high-risk scenarios eclipsed the possibility of rational debate and understanding in the mainstream media. As Critcher (2006: 3) highlights, 'emotion rules over reason' in the context of a moral panic. However, midwives, women and activist organisations also had access to public discourse in the homebirth debates. News and opinion articles in online and print media presenting a positive or alternative view to the obstetric perspective, featured women's stories of homebirth and framed the debate in terms of a women's rights issue. The safety of homebirth with qualified midwives was reinforced. Positive or pro-homebirth discourse was predominately found in feature articles, letters to the editor, or as opinion pieces from key stakeholders such as such as Justine Caines of Homebirth Australia (2009), Michelle Mears of the Australian Home Birth Network (2012), Hannah Dahlen, Professor of Midwifery and spokeswoman for the ACM (2011, 2012), and academics such, Kerreen Reiger and Karen Lane (2009c), Heather Hancock (2011) and Meredith McIntyre (2012). Common to this group of article were either overt or tacit challenges to medical hegemony; criticisms of the Australian maternity system, of the overuse of interventions such as inductions and caesarean

sections, and the fear that restrictions to homebirth were leading more women to birth unattended at home. Writers drew on evidence to claim homebirth was a safe and responsible option, and indeed a woman's right. Also discussed were the underlying political and philosophical dimension of the homebirth debate; the gendered 'turf war' between midwives struggling for autonomy and professional recognition and privately practicing obstetricians claiming their stake on the market, and the difference between a holistic and medical view of birth.

In the discourse supportive of homebirth, the risk/safety rhetoric was inverted, by positing hospital birth, not homebirth as unsafe. For example, in an online debate moderated by *Herald Sun* columnist Susie O'Brien titled 'Should homebirth be banned' (2010), several respondents claimed hospital birth, not homebirth as unsafe;

> .For me I see the risk is birthing in hospital, babies die there too, so if we are calling for a ban to save babies die[ing] then let's ban unnecessary inductions (I was induced as I was 9 days overdue, no other reason) and also elective caesareans which are risky than normal vaginal birth - if we want to make this a police state then let's go the whole way, yes?
>
> Michelle, commenter in Susie O'Brien, 'Should homebirth be banned'? *Herald Sun Online*, 8 June 2010.
>
> I find it all very interesting how the media tend to discuss home birthing and the dangers. What's the research done on hospital deaths for both the mother and the baby - you will find that it is much higher. There are so many risks associated with hospital births - just as equally with home births. But the less intervention, then with a low risk mother, a home birth is just as safe - if not safer - than a hospital birth because the mother is in her space and power to birth at her pace, in the safety and love of her home.
>
> Mara, commenter in Susie O'Brien, 'Should homebirth be banned'? *Herald Sun Online*, 8 June 2010.

Homebirth Australia, South Australian co-ordinator, Kylie Lawson, in an opinion article for the *Adelaide Advertiser* (2012) writes:

> Rigorous research in Australia, Europe and North America shows that for low-risk women, a planned homebirth with a professional, experienced midwife is as safe and in some cases even safer than a hospital birth. With birth at home there is less risk of infection, and less risk of intervention such as unnecessary electronic foetal monitoring, episiotomies, caesareans and vacuum extractions

Lawson goes on to talk about the benefits of homebirth such as better emotional, psychological and physiological outcomes for mothers and babies. Lawson, and other commentators (c.f. Dahlen 2011; Meares 2012; McIntyre 2012), problematise the prevailing positivist biomedical notion of risk. Writing in online news and opinion website *Crikey*, Hannah Dahlen (2011) argues that:

> The paradigm of risk in much of the developed world is one that holds home birth as risky and hospital birth as safe. The assumption (not entirely wrong) is when things 'go wrong' home is not the best place to be; however conversely we could argue when things are 'going right', hospital is not necessarily the best place to be and can be the cause of things going wrong as women enter what has been described as the cascade of intervention.

Research shows that women who choose to homebirth are generally university educated and devote significant time to self-education around childbirth, compared to women who birth in hospitals (Edwards 2005; Jackson et al. 2013). They are also generally well aware of risks; their perception of risk, however, differs from that of the biomedical paradigm. Recent Australian research for example, suggests that women who chose to birth at home unassisted, or who choose high-risk homebirth with a midwife, perceive the risks of hospital birth as greater than those of birthing at home (Jackson et al. 2013). For these women, risk lies in unnecessary intervention and resulting perceived emotional and psychological harm of birthing in hospitals. The biomedical construction of risk and safety emphasises short term measures of morbidity and mortality, and assesses only immediate cause and effect outcomes. A biomedical paradigm omits assessing the

benefits of homebirth such as less intervention, a supportive, calm environment, less risk of post-natal depression, better rates of breastfeeding, emotional and psychological well-being of mothers (Wendland, 2007; Downe and McCourt, 2008; Walsh et al. 2008; Lokugamage 2011; De Mello-Martin and Intemann, 2012).

In the media coverage of homebirth issues, midwives and academics also pointed out that the recent rise in high risk homebirth and freebirths were due to women's dissatisfaction with the hospital maternity-care system (Dahlen 2011; McIntyre 2012) and that many women choosing to birth at home were thus 'refugees' from a broken maternity system (Maternity Coalition 2008), a claim supported in recent empirical research (Dannaway2013; Jackson et al. 2012; Homebirth Australia 2012). There were, however, marked differences in the voices of homebirth advocates; some advocated for the removal of childbirth entirely from the hospital system, while more moderate voices lobby for better and funded access to homebirth (Newman et al. 2011). Barb Vernon of ACM laments the media's sensationalist reporting of 'freebirthers' who are marginal, yet potentially destructive, to the cause by taking away the focus from the benefits of homebirth with a trained, professional midwife:

> Our position is (that women) should be making informed choices … not going ahead and having a baby without anybody there. They need to be properly supported. Midwives have the skills and equipment for the safe care of a mother and baby in a home-birth situation, and they recognise quickly when something's going wrong. What fails to compete with the sensationalism is … the evidence showing that a trusting relationship between a woman and a midwife, established from early in the pregnancy, means that the woman in labour is feeling safe and less anxious. It's a better experience (Cited In Puddy 2012).

Similarly, writer Katie Atwell, laments that 'dangerous homebirthers' , those who birth at home without a midwife, or who choose homebirth with known risk-factors (such as previous caesarean birth, gestational diabetes, breech, twin births) 'spoil' access to homebirth for the those who choose responsible and 'safe' homebirths:

> …perhaps the lack of support for these programs is influenced by the shrill chorus from the radical fringe of the homebirth movement. Women who believe that they should have the 'right' to have high-risk births at home either alone or with a skilled or lay midwife are bringing death and controversy into what should be a logical option for low-risk birthing mothers. These radical-birthing women are terrified of the medical profession and place such a high premium on 'choice' that the mother's individual choice is the only thing that matters. Consequently, shrill radical-birthers are chipping away at 'choice' from the other direction by demonising the medical profession and representing every intervention as 'medical rape'.
>
> Katie Atwell, 'Dangerous homebirthers spoil it for the rest of us', *The Drum Opinion*, 16 October 2012.

In comparison to the obstetric profession's 'united front' (Newman et al. 2011), the homebirth movement is fragmented and their message often conflicting (see also Gosden and Noble 2000; Reiger 2001).

Homebirth advocates such as the Maternity Coalition lobbied tirelessly, both during the MSR and the subsequent moral panic around homebirth, to reaffirm the safety and benefits of homebirth and independent midwifery (Newman et al. 2011), and strongly challenged the media narrative of homebirthers as deviant, selfish risk-takers, drawing attention the reasons women were rejecting hospital maternity services. However, the obstetric paradigm, strongly reflected in the media discourse, proved too powerful. In the political context directly following the MSR process and legislation, and the ensuing struggle to obtain indemnity insurance for midwives working outside the hospital system, the moral panic around homebirth served to reaffirm medical hegemony. Media debates and obstetric discourse reflected biomedical ideology but like the debates around caesarean birth, intersected with the larger cultural values and ideologies, such as the ideology of intensive motherhood and its resultant obligation to manage risk.

Chapter Six

Negotiating hegemony: Women's experiences of private obstetric care

This chapter focuses on women's agency within their encounters with private obstetricians in order to understand how individual women negotiate, contest or accept medical hegemony in the context of a risk society. As examined in Chapter Three, there is extensive scholarship highlighting the social, embodied and discursive constraints on women's agency in the context of a medically dominated system of institutional maternity care in contemporary risk society (Bèhague 2002; Anderson 2004; Bewley and Cockburn 2004; Beckett 2005; Bryant et al. 2007; Bergeron 2007; Douché 2007; McAra-Couper et al. 2012). I argued that while women are commonly viewed as self-governing and independent, agency is often limited by the set of choices made available by obstetricians in localised cultural contexts and mediated through hegemonic medical knowledge and in the context of neoliberalism. Cultural ambivalence and fear surrounding normal birth in contemporary culture (Reiger and Dempsey 2006) further complicates the notion of 'choice' in relation to childbirth, although little attention has been focused on the ways women experience these hegemonic cultural discourses within individual relationships with their obstetricians.

This chapter has a twofold argument; first, that the women who participated in this study had entered into a relationship of trust with their obstetrician, one based both on their class positioning and their belief and entrenchment within the hegemonic biomedical model of birth; and second that their confidence and trust in their own ability to birth without medical expertise became subtly eroded in the medical encounter as well as through cultural fears surrounding birth. I use the evidence for this claim to make a wider one regarding the limits of choice and agency within the obstetric encounter. Women in medical systems of maternity care are not 'passive dupes' of obstetric hegemony, but their autonomy is nonetheless constrained by their social and economic relationship with their obstetrician and an increasing normalisation of medical birth.

Many international evidence-based medical researchers, health policy makers and consumer groups advocate that care for women with normal pregnancies is best overseen by midwives in low-tech settings (c.f. WHO 1996; Enkin 2000; Romano and Lothian 2007; Sakala and Correy 2008; Birthplace in England Collaborative Group 2012). Yet in Australia some 30% of women, especially those who tend to be older and in higher socio-economic groups, use private obstetric care (Laws et al. 2007). This is a higher figure than in other countries with similar health care systems (Mander 2007: 61). As discussed in Chapter Four, the private obstetric sector in Australia was able to grow as a result of successive governments' support for privatised health-care and tax rebates for singles and families taking up private health insurance. In Australia and elsewhere, women in high socio-economic brackets, with private obstetric care, are more likely to experience medical intervention in childbirth than any other group (Baker 2005; Laws et al. 2007; O'Leary et al. 2007). Yet, as Baker (2002:35) argues, this is somewhat anomalous given that this particular group of women tend to be society's healthiest and therefore the least likely to actually require medical intervention. Previous empirical research concerning women's birth experiences show that while some women experience medical birth as alienating and disempowering, others actively seek out medical intervention and management. The latter group of women are able to sometimes negotiate within medical hegemony in order to exercise agency and control (Sargent and Stark 1989; Davis-Floyd 1992; Lazarus 1997; Zadoroznyj, 1999, 2001; Béhague 2002; Martin 2003). Thus, as Lorentzen (2008: 52) argues, medical power relations can be better understood as a 'process of negotiation in which women experience both benefits and costs'. Nonetheless, the research literature does not contradict the fundamental notion of medical knowledge as hegemonic nor the assertion that women are embedded within this cultural system of understanding. Rather, it points to a more complex understanding of agency and choice that must, as Fox and Worts point out, always be understood in localised social contexts (Fox and Worts 1991; McCallum 2002). While analyses of women's experiences of childbirth within medicalised systems are plentiful (Oakley 1980; Martin 1987; Davis-Floyd 1992; Lazarus 1997; Martin 2002; Maher 2004; Miller et al. 2011), here I focus more specifically on the ways in which Australian women in private obstetric care exercise their limited agency in contesting or accepting obstetric hegemony within their individual relationships with their obstetricians. I pay particular attention to the role that trust plays in this relationship (see also Zadoroznyj 1999, 2001). As Lorentzen (2008: 54) points out 'however ubiquitous medical power/knowledge may

be in society' individual interactions with medical experts 'constitute a more intensive engagement with medical power/knowledge' and therefore may hold a 'greater salience' for a patient than generalized knowledge in the wider society. Waitzkin also argues that it is often at the 'micro-level' of doctor/patient interaction that discourses with ideological messages are conveyed —albeit often unintentionally as is the nature of hegemonic knowledge (1989). Likewise, in her ethnography set in private sector maternity care in Brazil, McCallum (2005: 234) argues that hegemonic medical culture is often 'negotiated and imposed at a quotidian level' in everyday interactions between women and their obstetricians, hospital routines and family.

In view of the existing evidence on the social group most likely to undergo and/or embrace technological births, I specifically sought to discover the views and experiences of professional women over thirty. Ethics approval was granted by the La Trobe University Human Ethics Committee to recruit women via leaflets in obstetrician's offices and via posts to online parenting and birth websites in 2008 (the year of the MSR). Several private obstetric practices were contacted by phone and I gained permission from the practice receptionists to leave leaflets in five practices across the inner Eastern, Western and Northern suburbs of Melbourne. The leaflets invited women to be interviewed about their pregnancy and birth care choices, their views on their caregivers and their experience of birth. A recruitment notice was also posted to four well-known Australian internet pregnancy and birth forums: *Essential Baby*, *Birth*, *BubHub* and *Huggies Forum.* Ten women were recruited via the internet forums, while three were recruited via the leaflets. A further three women who replied proved unsuitable for the research, as they were not using private obstetric care, or were not pregnant at the time. Semi-structured interviews were conducted with 13 women aged between 30 and 37 with an average age of 30.5 either in their own home or via telephone. Ten women lived in metropolitan Melbourne, two in Sydney, one in Newcastle. All were either married or partnered in heterosexual relationships. All except one were in a household income bracket exceeding $AD100K per year and all but one had bachelor level degrees or higher. Three women were born outside Australia (in Denmark, America and Hong Kong), nine women were Australian born with Anglo-Celtic backgrounds, and one woman was Australian born with a Greek background. At the time of the first interview, women were between 16 and 32 weeks pregnant. Five were expecting their first child, six were pregnant with their second child, and two were expecting their third child. I interviewed women

once while pregnant and most of them once again following birth (one woman declined to be interviewed the second time but sent an email response about her birth, and one was not contactable). Three women had planned elective caesareans, two had emergency caesareans, four women had vaginal births but with various medical interventions (induction, epidural pain relief, forceps or vacuum) and three women experienced normal vaginal births without any medical intervention— these were all second births, including one woman, Helena, who had planned for an elective caesarean but whose labour began before her booked date for the surgery. One woman's mode of birth is unknown as she was not contactable by phone, email or letter for the second interview.

Type of birth	**First birth**	**Second birth**	**Third birth**	**TOTAL**
Elective caesarean		2(Scarlett[1], Renata)	1 (Sandra)	3
Emergency Caesarean	2 (Olivia, Louisa)			2
Other intervention e.g. forceps, induction , epidural	3 (Jasmine, Brooke, Sally)		1 (Gabriella).	4
No intervention, spontaneous labour and birth		3(Helena, Theresa, Jenna)		3
Unknown /did not take part in second interview		1 (Kim)		
Total:				13

The first round of interviews, conducted when the women were pregnant, included questions exploring the sources of information about birth that they had consulted during the pregnancy, their expectations of childbirth, their relationship with their obstetrician, their decision-making

[1] All names are pseudonyms

and choice processes, their general attitudes and beliefs about childbirth and their level of awareness of contemporary media debates around choice in childbirth. In the second interviews I asked the women to describe their birth experiences and relationship with care-givers as well as to reflect on how the birth compared with their expectations. I gained the consent of all of the women to gather additional views via a private blog. The blog was created specifically for this project so that the women could journal aspects of their pregnancy and journey to childbirth and answer questions that I posted. Five women participated in the online blog. All interviews were transcribed verbatim and, using the NVivo program, both the transcripts and blog entries were coded for several key themes that emerged.

6.1. Reasons for choosing obstetric are

Most women I interviewed said they chose private obstetric care because they already had private health insurance and thought they 'might as well use it'. As Zadoroznyj's (1999, 2001) research shows, women take on a role as active consumers, shopping around for the right obstetrician. This was the case with the women I interviewed, for example Renata said that she 'searched the internet for obstetricians in Melbourne and I found someone who had a cancellation and who would do an elective, and they could fit me in'. However, the interviews also suggest that the reasons for choosing private obstetric care were more complex than simply pragmatics. In particular the influence of spouses, family and friends and cultural norms and expectations of what one 'should' do, were factors in women's reasoning for choosing this model of care. Sandra, a small business owner, and pregnant with her third child summed it up as 'I think it's just that thing about being 'just what you do' among my circle of friends'. While Brooke claimed it was mostly her husband's choice;

> My husband was quite 'private it is' kind of thing…it wasn't really a big decision, whether we'd go private or not.
>
> Brooke, first pregnancy, interview 1.

Similarly, Theresa stated that;

> I'd always had private health insurance, well I grew up with private health insurance…and I actually didn't know the alternative um methods of care. I didn't know about shared care, I didn't know about midwifery-managed pregnancies. All I knew was that you had your own doctor and that you went to hospital to have your baby. And it wasn't until we started thinking about getting pregnant that I found out about all the costs that were involved and I was like 'oh' but um by that stage, 31 or 32 when I first got pregnant …I'd decided that if I was going to have children after 30, I would go privately anyway, just cause I'm a bit of a princess.

Theresa, second pregnancy, interview 1.

One woman implied that private obstetric care was the choice of 'more highly read' women—a view echoed in obstetric literature as discussed in Chapter Three (c.f Molloy 2005). Some women also positioned themselves in class terms as 'being able to afford the best possible care', differentiating themselves from women who face long waits, different caregivers, 'less qualified staff' and, where they presumed women would receive poorer quality care in the public system. For instance, Louisa had moved from NSW to a regional Victorian town, and relied on work colleagues' (largely negative) descriptions of the local public hospital. Louisa had considered going public as she 'liked the idea of midwifery care' but in the end took the word of her colleagues and chose private care;

> The public hospital…had a pretty shocking reputation- it's one of those ones that's often been closed down for inspections and lets women go 2 weeks overdue or like anywhere up to 2 weeks overdue before they even start talking about things.
>
> Louisa, first pregnancy, interview.

Jenna, a recent migrant to Australia, had also considered public hospital care but was similarly 'put-off' by the rumours of poor quality care in the public system and implied that given they were able to afford it, the choice for private was a logical one:

> I'd heard horror stories about what happens in the public system so um, like having to wait a long time for people and having to oh I can't even remember now; people who I'd worked with at the time had some bad experiences…it was about the level of care that was provided and we just kind of thought well, you know, not that we're totally welfare, so if you have a choice then why not choose that?
>
> Jenna, second pregnancy, interview 1.

The importance of having one care provider was mentioned by several women, although, as I discuss below, they often didn't receive the care-provider of their choice at the time of labour and birth. Women's social positioning came across as an integral reason for choosing the private model of care, and being a 'princess' as Theresa's comment , above suggests, or being 'precious' as some women put it, was, it seemed a mock badge of honour. For instance Scarlett said;

> I liked the idea of continuous care by one doctor, as well as a nice hospital with my own room…I had a bad experience in a public hospital (not birth related) having to share a ward, a disgusting bathroom, shabby curtains with no privacy-hope that doesn't sound too princessy!
>
> Scarlett, second birth, blog post.
>
> You're paying to have it more your way in private. I kind of thought that um…the women that were public, because they didn't have that personal relationship with a doctor, they would have had more decisions made for them. I also think that people in private are more precious, definitely (laughs).
>
> Sally, first birth, interview 1.

Also apparent in these comments, was the implication that the public system was not safe – for instance Louisa commented that they 'let women go to two weeks [overdue]', while Sandra remarked that having the care of an obstetrician in a private hospital eliminated the 'what if scenarios' and that she didn't think that midwives 'were qualified enough' to look after her. Reflected here is the discourse apparent in the public and professional debates around the MSR,

the reinforcement of the necessity of having a 'qualified' medical professional oversee and/or manage birth.

Overall, the women interviewed constructed themselves as particular *kinds* of women who would logically use private obstetric care because their friends and family did, they could afford it and it was safer. Further signifying the connection to their social and class position, four women asserted that they would never choose a home water birth, or a birth centre with midwife-led care, not only because they perceived it as 'unsafe' but also because 'I'm not that kind of person' or 'that's just not who I am'. Jasmine, a medical professional pregnant with her first baby, was interested in 'alternative philosophies' but said she never 'saw myself as the person who would desire a homebirth'. Or, as Brooke put it

> I was pretty resistant to that kind of, um, hippy's not the right word, I guess alternative, um, I was resistant, I didn't think I was that kind of person, and I'd hate to come across [to her peers] as someone pushing an agenda.
>
> Brooke, first pregnancy, interview 2.

Brooke seems to infer that alternative birth models are based in an ideological agenda, a theme prevalent in online pregnancy and birth forums, and the media (Devine 2009). However, medical knowledge and the medical model of birth were never seen as ideological by the women I interviewed. Quite the opposite: for instance, when discussing their sources of information regarding pregnancy and birth, several women commented that they would take the information and stories on online forums 'with a grain of salt' as Jenna put it, while they placed greater weight on medical sources of knowledge which were described as 'factual'. As Jenna explained:

> There's so much on the net that is people's opinion and so I guess I'm a very factual person so I don't, you know there's a lot on the net that can scare the absolute crap out of you, you know if you chose to read it all, so I think the net needs to be treated like a grain of salt when it comes to all that. So yeah, so no, I really only read *Baby Centre* because it only publishes articles from like medical institutions and doctors, you know it only publishes factual things that

> have been researched…um I wouldn't say it was my main source, it's probably that combined with um, my obstetrician and friends as well. I sort try to take everything in and not really take it all too seriously because it's such a personal thing.
>
> Jenna, second pregnancy, interview 1.

Sandra, in relation to whether she should try to have a vaginal birth after a previous caesarean, felt that the knowledge of her mother-in-law and other family members was 'archaic and wrong' and that mothers on online forums were all 'pushing an agenda'. Instead, she said she'd rather trust the 'up to date recommendation' of her obstetrician than the apparently agenda-laden information from other women. Similarly Brooke felt her mother was 'pressuring' her to have a 'natural' birth but she wasn't really sure why it was so 'important' to do so and felt that it was 'ideological' (although as I describe below, Brooke's views changed by the time she'd had her baby). By contrast then, medical knowledge was considered by the women in this study as value–free and authoritative, while midwifery knowledge, the knowledge and advice of other women, including family members, was either 'ideological' or non-factual. Maher's (2004) research similarly suggested that women prefer biomedical knowledge when making decisions about birth.

6.2. Managing risk

In examining the high rate of caesarean rates in South American countries such as Brazil and Chile, researchers found that private obstetric care is linked to class status and that women of higher socio-economic backgrounds chose private doctors as an expression of their privileged class position (De Mello e Souza 1994; McCallum 2005). Thai and Australian women's choice of private obstetric care has also been linked to their social class (Zadoroznyj 2000; Liamputtong 2005; Riewpaiboon et al. 2005). The link between social class and private obstetric care might seem an obvious case of 'being able to afford it', however in their examination of Thai women's experiences of private obstetric care, Riewpaiboon et al., found that the women's social position actually influenced their perceptions of risk:

> Middle class cultural perceptions and values also played a determinant role in the decision to choose [private obstetric care]. Not only were [private obstetric care] users, with their higher education, more trustingly confident in their specialist care and advanced medical technology, but also they were more assertive…and wanted to be in control of their perceived risk and uncertainty (2005: 1413).

Liamputtong's (2005) study also suggests that middle-class women had a heightened perception of themselves as being at risk in comparison to women from lower social classes. Similarly, for the women I interviewed, it would seem that choice of care provider was linked to class positions and possible sharing of the same social values as their obstetricians (Liamputtong 2005). Using a private doctor may be tied to the women's identity as middle class, educated and privileged, but is also, importantly, a method of managing perceived risk. In this way, women were enacting their neoliberal obligation to self-manage risk.

For five women in the study, having obstetric care was important because of prior medical conditions, fertility issues, or previous traumatic birth experiences. These women constructed themselves as at-risk and therefore in need of specialised care and expressed concerns about the process of childbirth harming themselves or their babies. For example Jenna, pregnant with her second baby, described her fear of losing a baby due to a previous ectopic pregnancy

> The first pregnancy was an ectopic so I lost a pregnancy and I lost a fallopian tube so that was actually quite devastating so that affected probably how I felt about the second pregnancy and so um leading up to it I was quite concerned about, I was more, I wasn't concerned about the birth at all, I was concerned about um, just that the baby was still alive inside of me because once you lose one, you're always paranoid about losing another.
>
> Jenna, second pregnancy, interview 1.

Similarly, Theresa had several miscarriages before having a successful pregnancy and birth and thus felt a heightened sense of risk about losing her baby and was therefore not concerned about *how* the baby was born, just that it was born at all. Gabriella had both lost a baby (late term

miscarriage) and had a previous traumatic birth experience in the public hospital system (described in detail below). For her, having the best medical care was essential and her past experiences meant that 'I needed [specialised care] even more':

> [Dr's name] is incredibly good at what he does and if anything goes wrong, he's the best doctor to have around and because I said to you before, I felt I really needed specialised care and someone to really hold my hand and make sure that everything was going to be ok.
>
> Gabriella, third pregnancy, interview 1.

Renata had her first baby in Denmark via elective caesarean section. Renata has high myopia (extreme near sightedness) and explained that in Denmark the protocol is for pregnant women with this condition to deliver by elective caesarean, due to the risk of retinal detachment during labour (due to exertion /pushing during second stage)

> Yeah I'm very short- sighted, high myopia, so I'd been advised not to have normal labour and but it turned out that my pelvis was too narrow to give normal birth anyway so they realised that after the caesarean- they said 'oh you probably wouldn't have been able to have a normal delivery anyway. Ever since I was 14, 15… I was told to be sure that when I was going to have children, to make sure to go for a caesarean.
>
> Renata, second pregnancy, interview 1.

Renata's Australian obstetrician advised her that in Australia, elective caesarean was not normal protocol for myopia and that she could try vaginal birth with epidural and vacuum suction, however Renata said that she 'argued [her] case' and her obstetrician ' basically said fine'.

It was not just the women with medical conditions or traumatic first births who conceptualised birth in terms of risk, however: the majority of women (10/13) expressed sentiments that aligned with the hegemonic biomedical model of birth.

But for me, I just um, for me I was just, needed to be near medical care. Possibly because my mum was a nurse, um…for me there was definitely a comfort thing- there is absolutely no way I entertained the idea of a home birth, um, anything like that. The birth centre that was in the hospital I could deal with but even that was a little bit too casual for me. I needed the comfort of the, for me it was just a safety net kind of thing

M- Did you think that you'd get that safety and better quality in the private system?

A- Absolutely, yeah definitely.

Sandra, third pregnancy, interview 1.

I don't see [birth] as a spiritual experience, no, um I see it as a medical event in your life…I don't see it as ethereal or anything like that.

Jenna, second pregnancy, interview 1.

I'm not really interested in the birthing experience, I just want the baby and if I can have it pain-free, well as I suppose as pain-free as it can be, then, I will.

Theresa, second pregnancy, interview 1.

Like that whole debate about women who have epidurals are stupid because they should do it as naturally as possible, because women have been doing naturally for thousands of years. It's like 'well, fine' but medicine has advanced in the last thousand years you know and I don't go to the dentist and get a drill in my mouth without an anaesthetic, so I don't want to have a baby without an anaesthetic!

Gabriella, third pregnancy, interview 1.

Thus, paramount to women's choice of obstetric care were views that espoused childbirth as a risk-laden medical event in which doctors are the trusted experts. This accord with Green and Baston's (2007) longitudinal research, which suggests that women in the United Kingdom are increasingly willing to accept obstetric intervention in birth and that the women who stated they were willing to accept intervention were also more likely to undergo a caesarean.

6.3. Trusting the Experts

The next theme to emerge from the interviews was around trust. All women interviewed reiterated that they trusted their obstetrician implicitly; not just in terms of their clinical expertise (although this was important too) but also as an individual *person:*

> There's just something about his nature, that he's the kind of person that you just hung on to what he said. Um, you just trusted him…I trusted him implicitly.
>
> Sandra, third pregnancy, interview 1.
>
> He's someone who's specialised and done 10 years of research and I'm figuring it out as I go a long so yeah. I'm big on subject matter experts and he knows more than me about these things, so I trust him.
>
> Louisa, first pregnancy, interview 1.
>
> He's very unobtrusive, he not in your face. So basically he's there to look after you, answer questions, whenever I need him I can call him with any questions…He's always there …he's there just for you, to you know, guide you and stuff…I have the same ob again for this second pregnancy as I feel totally comfortable with him and trust him completely in this scary situation.
>
> Kim, second pregnancy, blog entry.
>
> I feel more comfortable being in the care of a specialist obstetrician as well. And my obstetrician is the head obstetrician of the hospital and he's a professor of obstetrics as well. I feel way more comfortable with this guy knowing that

> the buck stops with him and if anything ever goes wrong it always goes straight back to him anyway and if I've got him looking after me, I can't have anyone better on my side.
>
> Gabriella, third pregnancy, interview 1.

Sally was one of only three woman interviewed who had a female doctor. Sally had described being anxious and fearful of pain involved in labour because she didn't think of herself as a 'strong' person. Sally was adamant from early in her pregnancy, that she wanted an epidural during the birth. For Sally, her relationship with her doctor was close because she felt respected and listened to regarding her choice for pain relief and intervention:

> She got to know me quite well, I felt really comfortable, even though she was there [at the birth] for only 10 minutes, I knew she knew what I wanted and that no one would say 'come on let's give this a go, or' they knew that that was kind of what I was after.
>
> M- So your relationship with your doctor was pretty good then?
>
> I loved her! Someone said you fall in love with your obstetrician (laughs). Just because she was quite matter-of-fact which is what I needed. She was like 'women do it every day, you're not going to die'. She was quite firm with me and because she was very happy with me to have an epidural- she never said you know you should be giving it a go, she never kind of judged that.
>
> Sally, first pregnancy, interview 2.

Trust emerged as significant aspect of maternity care for the women interviewed. Australian research has shown that women express high levels of satisfaction with the one-to-one care aspect of obstetric-led care (Bruinsma et al. 2003). International research highlights the importance of trust and support in labour and birth, suggesting that continuity of care—the support of a trusted care-giver during pregnancy, labour and birth—greatly increases a woman's satisfaction with the birth and reduces the likelihood of interventions such as epidural, episiotomy and caesareans as well as shortening the length of labour (Hodnett et al. 2007). However, it is not

the obstetrician's professional role to provide continuous labour support and in most cases women in private maternity hospitals are cared for by others, mostly midwives, sometimes nurses, during labour, whom they may or may not have met before and consequently have no relationship with. In the obstetric model of care, the obstetrician 'oversees' the labour and usually only attends the final stage of birth. As Sally describes above, her doctor was only attendant at the birth for ten minutes, and this was a common throughout the women's birth stories. Olivia, pregnant with her first child recounts her doctor's attendance at her birth:

> …yeah what happened was, the obstetrician, in that whole time I was in the hospital from 1:30 in the morning till the ob got there at about 10.20 that night to do the caesarean, other than then, the only time I saw the ob [obstetrician] was about 1 o'clock in the afternoon for about 2 minutes…she told me than she'd be back between 6 and 7 but she never came… I only saw her for a total of 20 minutes, not including the caesarean.
>
> Olivia, first pregnancy, interview 2.

Moreover, at the birth, Olivia had a different obstetrician from the one whom she'd fostered rapport and trust in during the antenatal period. Of the 13 women I interviewed, five had an alternative and sometimes unknown, obstetrician from the one they had developed their trusting relationship with. This was due to either the obstetricians' holidays, attendance at another birth, or 'personal' reasons. Olivia, had a very good relationship with her obstetrician whom she'd been seeing for two years for fertility treatment prior to her pregnancy, however when she went into labour she was informed by the hospital that her obstetrician would not be coming in to see her:

> M- So you didn't have your original obstetrician?
>
> Olivia- yeah, because Dr (name) is like the head of the practice, but he's got other obs that he works with so they have like a roster where …you get whoever is on…I went in on a different day, I ended up with a different doctor
>
> M- But had you met her before?

Olivia- no…so it was a bit weird even though I knew it might be a possibility.

Olivia, first pregnancy, interview 2.

Other women (particularly the first-time mothers) described feeling disappointed that they did not see their original obstetrician or, that they did not see their obstetrician *enough* during the actual labour. It seems redundant that women place so much trust in a care-provider who does not actually *care* for them during labour and birth. Even so, women were reluctant to speak negatively about their obstetricians, and trust extended further than to their expertise and personal qualities but also to their general professional motives. For example, although all women were aware of the criticisms aimed at the obstetric profession, particularly surrounding the higher rates of caesareans in private hospitals, many women claimed that their doctor 'wasn't like that' or that their doctor had a low intervention philosophy or that they wouldn't intervene unless 'necessary' even when their own doctor or hospital was known for having a higher than usual caesarean rate; Sandra for instance said that:

> …the ob that I'm seeing is at 'Caesars' Palace'. I never at any point, even knowing that I had to have a caesarean, felt that the decision was made for any other reasons than what was in my own best interest. Um, I have never got the impression that he would suggest a caesarean to anybody that didn't need one.

Sandra, third pregnancy, interview 1.

Gilson's (2003) analysis of trust in healthcare institutions posits that trust can become dependency in relationships that occur in the context of inequality such as that between a healthcare provider and a patient, therefore constraining the agency of the patient. As I argued in Chapter Three, informed choice and autonomy in the context of obstetric hegemony are complex processes, and indeed, according to many scholars, unlikely to be actualised (Begeron 2008; Bewley and Cockburn). The obstetric profession's formal monopoly on knowledge (Murphy-Lawless 1998; Goer 2002), its claim to expertise and the alignment of its values with the broader cultural values of a technocratic modern society (Davis-Floyd 1992; Rothman 2007), and the fact that many obstetricians are male, renders the relationship between women and obstetricians unequal. Moreover, as Reiger (2010) and others argue, while individual doctors might hold

commitment to caring for women and babies, the profession as a whole has been slow to respond to evidence based practice, has manipulated research to its own agenda and has operated with a tribal mentality; covering up medical misdemeanours and sometimes putting women's and babies' lives in danger (Goer 2002; Perkins 2004; Wagner 2006; Reiger 2010). If women, as the women interviewed here, share the same social class, share the same belief in the hegemonic biomedical model of birth, and trust their obstetricians so implicitly—then agency or 'choice' becomes increasingly problematic. Several women in this project stated that they would 'never question' their obstetrician's advice. Thus, as Gilson argues, without a foundation for voluntary trust to mitigate the lack of equality, relationships between health care providers and patients can become more about *dependence* rather than mutual trust (2003).

6.4. Mistrusting birth

Earlier research reveals that middle-class women use medical interventions to enhance or control their birth experiences. This was certainly the case for a minority of the women I interviewed. Several women, for varying reasons described below, chose some form of medical intervention including for Renata, Sandra, Scarlett and Helena, an elective caesarean. Theresa said she thought she would probably have an epidural because she had one for her first birth, however she was the only woman I interviewed who said she didn't 'really care' about how her baby was born, claiming that 'I just want the baby and I don't care whether I have to be sliced downwards or acrosswards or however to get it.'

However, most women expressed a desire for a vaginal birth. Still, there was a wide variety in women's expectations and desires in regards to pain relief and other interventions, and only two women felt strongly that they did not want any intervention at all. Of the women who expressed a desire for a spontaneous vaginal birth, there emerged a common theme of doubt and lack of confidence in actually being able to birth without medical assistance, or of something 'going wrong'. Moreover, most held strong beliefs that birth was not something that *could* be controlled and therefore medical intervention was always a possibility. This was highlighted most prominently when women talked about birth plans:

> But as far as formal [birth plan] like I want this, I don't want this, um I'm just going to basically take it as it comes because I can't predict anything…in talking to colleagues and family I know that birth is unpredictable.
>
> Louisa, first pregnancy, interview 1.

> There was so many people I knew who had like a birth plan and said 'I'm not going to do this and I'm not doing that and I'm going to [have] dolphin music and… like really specific ideas about what they wanted and nobody actually ended up with that so I just thought that planning for a birth just seems ridiculous really in a way… you can only plan to an extent. So we just went into it with it…you just don't know.
>
> Jenna, second pregnancy, interview 1.

Three women described their doctors' dismissing their birth plan — this was even from the supposedly 'low intervention' doctors'. For example Sandra's doctor told her to 'forget it' in response to a question about a birth plan and that as far as he was concerned the 'plan is to get the baby out'. Jasmine's obstetrician told her that 'only women who don't trust us use birth plans [and doulas]'. Jasmine, a health professional in the maternity field, claimed that she'd often seen obstetricians 'scoff' mockingly at 'silly women's' birth plans, so she knew that even if she wrote one it 'would mean nothing'. Sally, pregnant with her first baby, wrote a birth plan, however she says her doctor 'didn't even look at it' telling her to 'give it to the midwifery' (although she had discussed at length with her obstetrician, her desire for an epidural). In this way, medical authority is reinforced and women's autonomy is undermined.

Several women based their views concerning birth plans on the experiences of family and friends. For example Brooke's three sisters all had emergency caesareans, thus she felt that 'you never knew what could happen' and there was no point being prepared for a 'certain kind of birth because you might not get it'. Louisa, a first-time pregnancy also described her sister's experiences;

> My sisters, both of them ended up having to have caesars. One um after basically a failure to proceed, I think she was in labour for about 20 hours or something so she had an emergency caesarean. Um my other sister for her first, um the week before she found there were complications and needed to have a caesar, for that reason, I know that I might not [birth without intervention].
>
> Brooke, first pregnancy, interview 1.

Theresa commented that although she didn't want an episiotomy, she didn't think it was worth putting this in a birth plan because

> I don't think it's anything I've got control over. I mean you can say you don't want one, but um, I met this woman who refused an episiotomy and who then got a 4th degree tear from refusing it.

The experiences of the women's sisters and friends were influential in their perceptions of birth, however, their views also reflected biomedical ideology, where birth is understood as always potentially catastrophic and risky. As discussed in previous chapters, the overarching discourses in Australia during the 2000s reflected the obstetric, biomedical paradigm of childbirth as unpredictable, dangerous and requiring the direct supervision of obstetric experts. May et al.'s (2007) analysis of caesarean discourse for example, showed that contemporary medical discourse centred on the assertion that 'more women need caesareans today than ever before' and that vaginal birth was inherently risky and unpredictable while caesarean birth was safe and predictable (2007: 454; see also Bryant et al. 2007). McAra-Couper et al.'s (2009) interviews with recent mothers in New Zealand, also suggested a normalisation and expectation of surgical birth. Like many health professionals concerned about the rising caesarean rate, Lauren Plante, an American obstetrician and critic of what she terms 'industrialised' childbirth, argues that surgical birth is in danger of becoming the norm as the 'definition of normal becomes ever narrower' (2009:144). Women's assertions then, about childbirth being unpredictable reflect hegemonic 'common-sense' assumptions of medical birth as the 'norm'.

This norm was often reinforced in the women's individual interactions with their obstetricians both in the antenatal period and during labour and birth. Women described interactions in which

doctors continually reflected doubt and fear concerning women's bodies. For instance, some women were told during pregnancy that their pelvis might be too small (although this can only be ascertained through a vaginal birth attempt), or that their babies might be too big or that their baby was in the 'wrong' position. Others were given a percentage of possibility for normal birth; Sally for example, was told 'you have a 70% chance of delivering vaginally', presumably as the national caesarean average in Australia is 30%. Sandra, pregnant with her third child and planning for her third caesarean had been seeing the same obstetrician for eight years; her story demonstrates how confidence in birth can be subtly eroded. Her first pregnancy resulted in an emergency caesarean for 'failure to progress' due to her baby being too big for her pelvis. She had considered a vaginal birth after caesarean (VBAC) for her second baby but was constantly put off by her obstetrician who told her that her pelvis was probably too small, that she only had a 3% chance of 'delivering vaginally'. At 38 weeks, Sandra discovered that 'I had too much amniotic fluid, I was getting too big, too quick. I was getting all kinds of things…' and was finally told that she would require an elective caesarean because her baby was breech. However when the baby was delivered it was discovered that he wasn't breech after all. It was apparent from the interviews with Sandra that she had little faith in her own body and she was disappointed with not being able to birth vaginally, especially as she'd been so fit and healthy prior to birth:

> I had myself prepared for a vaginal birth. The thought of a caesarean, I think because my pregnancy had gone so smoothly…everything was going beautifully, my BP was ok, I was teaching, I was a personal trainer and teaching 6 hours of aerobics twice a week or something like that, you know I was quite fit, there was no reason, that I was aware of, that I couldn't have, that, you know that things would go wrong. I still kind of regret, not so much regret, I don't like the fact that I can't [have a normal birth] but you know, on an intellectual level I know that I can't sort of thing
>
> M- And what do you think that regret is about?
>
> Sandra- I don't know, just…expecting something that I could never have…it would have been nice if I could have and it's a bit sad…

Sandra, third pregnancy, interview 1.

Sandra says she ‘had no choice’ but to have a caesarean (her doctor had discouraged a VBAC) for her third pregnancy and she expressed a lot of anger at other mothers, media and family who she says unfairly put pressure on women to have a ‘natural’ birth, thereby making her feel ‘inadequate’ and less of a mother.

Like Sandra, other women’s confidence to give birth without intervention was eroded in their subsequent births due to highly medically managed first birth experiences. Scarlett described what has been called the ‘cascade of intervention’ (Goer 1995; Wagner 2006) that occurred during her first birth. Scarlett was induced at 41 weeks and although she had planned an active labour using movement, yoga, breathing, massage and other non-pharmacological pain relief, she was attached to a monitor, unable to move and suffering intense contractions due to the syntocin drip. The labour resulted in highly traumatic forceps delivery and post-partum haemorrhaging. Scarlett also required vaginal surgery several months following the birth. This experience led her to believe that women place too much emphasis on ‘natural birth’:

> The first time I had quite a narrow idea of what my perfect birth experience would be, and I really wanted that outcome; a natural, active birth with lots of movement, hopefully no drugs, that natural euphoria of your own body's endorphins; and for my baby to come into the world with minimal interference. I have since decided that although the process is still important to me, there are factors that I can't control and so I don't want to set myself up for disappointment or put undue pressure on myself.
>
> Scarlett, second pregnancy, Blog entry.

Scarlett didn’t blame the medical system, the hospital or her doctor for her traumatic birth experience: she blamed instead the ‘ideal’ of ‘natural birth’ claiming that it was ‘unrealistic’. After several sessions with a psychologist and discussions with her obstetrician, Scarlett decided on an elective caesarean. Following the birth, she expressed relief and satisfaction with decision.

Helena, similarly, described how she had prepared herself for an intervention-free vaginal birth for her first birth but was disappointed and 'traumatised' by the experience. Helena's story is somewhat different however, as although she birthed intervention–free, it was not the 'beautiful' experience she thought it would be:

> My first birth, I was quite adamant that I wanted a natural birth, I always wanted to experience the way labour was and I kind of thought being a woman was part of experiencing labour and I had a doula with me, it was a student doula, so it was only her third birth. I found her on the internet and she wanted to be part of it and I explained to her my desire to have birth without drugs and whatever and she came along and I spent most of the labour at home, probably about 18 hours at home with the TENS machine, had a bath, tried to stay at home for as long as possible and avoid hospital for as much as possible and so that I could get through it without drugs.
>
> Helena, second pregnancy, interview 1.

On arrival at hospital, Helena continued labouring without intervention, using water immersion (at one of the few Victorian private hospitals that allows water birth) and a TENS machine for pain relief. During the second stage she suffered a second degree tear.

> Having done it I think I have a sense of achievement, but the pain was absolutely excruciating and um afterwards I had some stiches and it just took me a long time to feel normal again, a long time to recover and I was in pain for weeks afterwards…I tore, I had stiches, I had to go back to my doctor because something hadn't healed properly and I was really in a lot of pain and I guess emotionally too, I wasn't really expecting it to be that intense and um I decided basically as soon as she was delivered, I said to my husband that I never wanted to go through that again and I suppose because it was so painful that once they put her on me, it wasn't that beautiful moment of bonding, it was more like 'thank god you're out' and then they started stitching me up and they put her on me to breastfeed and I just though you know, I really have just had enough of

> people prodding my body. They gave my baby to my husband and I said to him to cuddle her because I really felt I had nothing left to give her… My doctor missed the whole thing and the midwives delivered me but even afterwards, when they went to stitch me up I just thought oh why should I have to go through this? So much pain, just the whole thing. I s'pose I felt a little demoralised, just my body being tugged here and there, they're tugging at my boobs trying to get the colostrum, I guess I just felt like a piece of meat. I think a lot of women do and I know they say it's a beautiful experience, I didn't feel that, I just felt like it was a really painful experience and I thought next time I want it to feel beautiful, like I've just had a baby as opposed to thinking my body is just going to break in half and I just can't take anymore, yeah.

Helena had not met her midwives before the birth, but did have her own, albeit inexperienced, doula (birth attendant) present. Because of her experience, Helena planned an elective caesarean for her second birth, however she went into labour early at 37 weeks and on arrival to the hospital was told it was 'too late' to do a caesarean and her second baby was born again spontaneously and intervention–free. At the time of the interview Helena was seeking legal recourse as she felt there *was* time to do caesarean and the hospital had not abided by her wishes. Helena felt very bitter about her experience and, like Scarlet and Sandra above, directed much of her anger at 'natural birth ideal'.

Like Scarlett , Sandra and Helena, other women in the study discussed natural or normal birth as an 'ideal', a 'view' or a 'philosophy' rather than a physical reality, reinforcing the common-sense notion of medical birth as the norm. As discussed above, the birth knowledge of 'pro- normal birth' women and midwives was sometimes seen by the women interviewed as 'pushing an agenda', while medical knowledge was perceived as 'factual' and authoritative. Some researchers have argued similarly, that the 'natural' birth discourse of feminists and consumer advocates sets women up with unrealistic expectations about birth, and thus to feel like failures when their pregnancies end negatively or result in highly technical births (Crossly 2003; Frost et al. 2006). However, while this critique has many valid points (indeed for Helena, it really did seem that she had been unprepared for the pain of normal birth), it is also somewhat problematic. Institutional

structures and iatrogenic practices contributing to women's negative experiences of childbirth and resulting in over-medicalised births are overlooked, and instead the 'idealistic' discourse of feminists and birth activists is blamed. Layne (2003: 1889) argues that it might be more useful to examine the role of neoliberal discourse and the emphasis on 'self-determination' which has meant that the message of the women's health movement has had the 'unintended consequence' of making women feel responsible when pregnancies do not go according to plan (Layne 2003). Similarly, Maher (2004: 143) argues that in context of consumer culture, pregnant women are expected to make the right choices, thus 'the responsibility for a good birth experience and a good outcome 'is dependent women's ability to 'engage effectively with information sources available'.

Blaming feminist 'idealism' for bad birth experiences also ignores other important cultural factors. For instance, there would appear to be cultural shift in the way women view their bodies and childbirth and an increasing fear of birth among some women (Reiger and Dempsey 2006). Reiger and Dempsey (see also Dahlen 2010) discuss the ways the ways in which a 'culture of fear' surrounds childbirth in contemporary Australian society. This has resulted in the erosion of trust in childbirth on both cultural and individual levels (2006). They argue that as social processes have direct material/bodily outcomes, in contemporary culture, anxiety and loss of confidence 'can be seen as producing a normative frame of reference that becomes internalised and, most importantly enacted by individual women' (2006: 6). As Murphy-Lawless argues, the practices and discourses arising from the medical model of birth sustain obstetric knowledge and power structures, but they also *produce* the subjectivities of women birthing in this model (1998). Thus, the hegemonic norms of childbirth literally become embodied in birthing women in our culture (Maher 2004; Reiger and Dempsey 2006).

Gabriella and Sally planned medical intervention in advance as way to assuage their fears about childbirth. Gabriella had a severe physical reaction to an epidural (in a previous birth) but was also 'terrified' of the pain of labour. Gabriella's doctor had advised a caesarean however she says was more 'terrified' of being 'cut open' than she was of the epidural's effects. Therefore, in consultation with her doctor and an anaesthetist, Gabriella devised a plan which involved drugs to counteract the negative effects of the epidural which was to be given to her at 3cms dilation and

regularly ‘topped up’ throughout the birth. While Gabriella stated that she was well informed and comfortable with the decision, and was able therefore to exert some agency in this process, her choices were limited to the medical options on offer. Similarly, Sally who was ‘petrified’ of the pain of child birth, was initially offered an elective caesarean, but decided on having an epidural as early as possible in the labour – a decision negotiated with her doctor during her pregnancy:

> I just think I’m a bit of a wuss, I don’t seem to cope really well with traumatic situations like that, you know kind of really hard things. I talked to my doctor about it and said you know ‘I’m really nervous about the pain and not coping and…’ and she said ‘look, have the epidural’ she said to try and get through a bit of labour and then you know it’s all happening, rather than having it too early and then it’s slow and you have to have all the drugs and stuff. And because I didn’t want anything that would interfere; I didn’t want a caesar, I didn’t want the pethidine, I just didn’t like the idea of that, or the gas, and she was telling me that the epidural, ‘it’s just pain relief, it shouldn’t affect the baby in any way if you’re already in labour, it’s just kind of takes your pain away and the baby just keeps doing what it’s meant to’. And it was like clockwork, just like the doctor said- you know a contraction an hour, even though I didn’t feel it. I didn’t miss out on having the, you know, the natural birth experience.

Evident in Sally, Gabriella and Scarlet’s stories is the tendency of obstetricians to pathologise women’s fears and offer ‘choice’ within the confines medical parameters, eroding women’s confidence in their ability to birth (Bewley and Cockburn, 2004: 197). There was no discussion of alternative pain relief such as water immersion, massage, or active labour techniques. Consistent with existing research, women’s fears about vaginal birth were seemingly compounded by doctors who did not maybe critically engage with women’s decisions or counsel them about their fears, but offered a medical solution instead (Staff 2006; Bryant, Porter et al. 2007).

Not all women spoke in accord with the hegemonic biomedical model of birth however. Indeed it was apparent from the women's interviews that there were conflicting knowledges: on the one hand women felt they needed the trusted expertise of a medical professional, on the other they were aware that medical intervention could be injurious or risky and that intervention–free birth was optimal for babies. Theresa for example recounted a story regarding a friend whose baby had died as result of overdose of syntocin (the drug used to induce labour) and many women cited improved outcomes for babies born without intervention. Evident in the interviews were alternative understandings of birth and motherhood, always in conflict with dominant knowledge.

In what follows, I describe two women's stories in detail; Jasmine's and Brooke's as they demonstrate the way in which hegemony is never stable and that hegemonic norms are always contested.

6.5. Contesting hegemony: Brooke's story

The first time I interviewed Brooke, she was 30 weeks pregnant with her first child. She discussed in great length her reservations about friends, family and birth classes 'pushing an agenda' of 'natural birth'. Brooke couldn't make the her private hospital antenatal classes because of work, so searched for privately run classes outside of the hospital that were 'mainstream' and not 'hippy'.

> I didn't want to go to a class where, you know, we're the only couple going to hospital and everyone else is having a water birth in their lounge room, because that's not me. So yeah, I wanted something that felt a bit more, sure there might be people in the course who are having a um, homebirths or whatever, but yeah and I didn't want the course to be um, you know all about here's how to survive without drugs. I guess that's kind of part of it as well. Like I don't necessarily want drugs, I don't know if I've decided that but I don't want, I'm not necessarily anti them, and I don't want to go along and um, you know, I don't want to go along and be educated by someone who's frowning on that. I'd rather have someone who's quite okay with whatever your views on birth are and whatever you choose.

Brooke talked about being a 'very in control type of person' who loves 'lists' and knowing exactly what was going to happen. However, she felt when it came to birth, it might be the 'one time in my life that I can't plan minutely'. She was uncertain and ambivalent about what kind of birth she'd like but quite resistant to the notion that 'natural birth' could be planned and felt she would be guided by her obstetrician's advice.

> Yes my mum keeps saying to me 'are you going to have a natural birth?" and I keep, I say 'Well yes, if I can." But each time she says it I think 'what exactly does she mean? Am I going to have a Caesar? No not unless it's medically recommended and if it's medically recommended then am I going to say no, well probably not. I don't quite know exactly what she means. Um, it's important to me to, try and do things as naturally as possible. I think I'd prefer to not have an epidural, um, I would absolutely prefer it not to be forceps or vacuum suction or whatever they call it. I would definitely rather it not. But having said that, if I'm in labour and the obstetrician comes along and says "look this isn't working and I think I need to use the forceps" or "I think we have to go and have a Caesar for this reason, A, B, C and D" and that kind of matches what I know about when you use those situations, then I'm not going to jump up and down and say 'no' or 'let me try for another 3 hours or whatever. If he thinks that the risks are, if um, you know he thinks that's the best medical response to the situation then I will most likely go with it.

When I spoke to Brooke following her birth, her outlook had completely changed. Brooke had attended out of hospital, independent birth classes and decided that she wanted an intervention-free birth. In the classes she'd learned about the cascade of intervention, the potentially negative outcomes associated with overuse of unnecessary interventions, about the importance of having strong advocates during labour (she brought her own midwifery student as a support person to hospital), learned to recognise moments of vulnerability or 'crises' in labour where she her husband would have to 'remain strong and resist' suggestions of intervention, and learned about

the benefits and health outcomes of normal birth. Brooke was 9 days overdue when her obstetrician suggested an induction

> Yeah, I'd discussed it with [obstetrician] and that was what he'd suggested…I was really keen, both my sisters hadn't gone into labour naturally and I was really keen for everything to happen as naturally as possible and I was really keen to avoid being induced because I was aware that it can make the labour much harder, it wasn't as good for the baby and I was aware that it could lead to a caesarean. The baby was posterior and I was worried that that was why he wasn't engaging and labour wasn't starting, so I discussed it with my student midwife who suggested some natural techniques to bring along labour, so I was taking raspberry leaf tea and walking and swimming as much as possible um and then went and saw um an acupuncturist and had 3 sessions with her.

Brooke still hadn't gone into labour and at 12 days overdue had another appointment with her obstetrician. It was decided that she would be induced. Brooke agreed to receiving gel on her cervix and to her having her waters broken, however Brooke and her husband insisted that they did want the syntocin drip nor to be attached to the foetal monitor because it would limit her movement in labour. Brooke and her husband were told that it was 'hospital policy' to monitor labours that had been induced, however she could use the mobile monitor 'if it was available'. Several interventions then occurred against Brooke and her husband's wishes:

> That was on the Monday and then on the Tuesday night I went in and just had the gel and they wanted me to come back on Wednesday morning to have my waters broken and then wanted to put me on the drip. I asked not to be put on the drip and um, the midwife on duty just said 'no, if you've had your waters broken, you have to have the drip'…And I also asked, my student midwife had suggested that I ask, for the monitoring to be cordless … the obstetrician said he'd come back at lunch time, so in the morning I kind of got through the contractions by moving around, different positions, got in the shower for about 45 minutes….

M: so did you have the mobile monitor on at this stage?

B: I didn't use the mobile monitor at all.

M: so you had the attached monitor?

B: yes

M: ok, how did you find that?

B: at first I didn't mind it, I just had to have it on every 10 minutes, every hour or something, but because I was down on my knees and bending over and on the floor, it kept getting, like it wasn't recording properly so it couldn't get 10 minutes straight in a row and then so instead of 10 minutes every hour it turned into having it on for half an hour at a time. So think it was about 11:30 in the morning and I was like 'right I'm over this bloody monitor, get it off me I requested the mobile monitor' and they just said 'no'.

Despite the denial of her wishes, Brooke felt she was 'doing okay', she had managed to avoid the syntocin drip despite the original midwife's insistence, because her obstetrician was unavailable. She endured contractions by using active labour techniques such as walking and with the support of her student midwife, husband and some 'supportive hospital midwives' who respected her desire for an intervention-free birth. However, when her obstetrician finally came, she was placed on the syntocin drip:

Then [obstetrician] came in and put me on the drip and that was when I started using the gas, which did absolutely nothing. Then another midwife, I think it was a shift change, came in and turned up it up quite a bit higher. So the drip really started kicking in and it was getting a lot more painful.

M: was that the syntocin drip?

B: Yeah. Then at about 2 o'clock, I'd been on the drip for about an hour and I got this massive pain in my side, the midwife in the morning had suggested that

> the baby was probably posterior because all the pain was in my back and so yeah then I got this pain in my side which seemed to just not go away. I mean, I guess it was contractions but in my mind it was like my appendix was bursting or something and I was throwing up and screaming and it was just like, god the other pain just paled into insignificance. It was another hour until that side pain disappeared and yeah so they got me the pethidine after that. The pethidine made me feel even more out of control so for the next 20 minutes I was just out of it. When I finally clawed my way back, I went 'ok, were in trouble cause its 2:30, I've only been on the drip for an hour and half, everyone's saying it's going to get a lot worse, so I'm probably going to have another crisis and were not going to have any options left' oh and the other thing was that when they put me on the drip, I had to have the monitor on full time and I was like 'well what happened to only having it on for 10 minutes every hour'? And they said 'no, that's not what happens, [name of hospital] policy is to have it on all the time now'. And so I was, I had a new midwife who was quite strict and I asked if I could move about around the bed, could I get up on all fours or whatever and she was like 'no, you have stay still for the monitor'. So I was on the bed leaning back against pillows and that was that. [Husband] was massaging me but it really wasn't that easy to get to my back so it was pretty much, on the list of our things, on our birth plan, of what to do to get through contractions, were suddenly quite limited, we couldn't do any of them.

Brooke consented to an epidural as the pain became unbearable and she felt defeated. Her baby was born a few hours later, vaginally, but Brooke said she felt 'removed' from the birth and restricted by hospital protocol and policy:

> I feel that (husband) and I made good decisions in the scenario we found ourselves in. I found that we planned for the birth we wanted, but found ourselves in a completely different scenario. I feel a bit disappointed, I think we should have had our own midwife, I think I should, I could have had a home birth I'm disappointed that I had the epidural, I'm disappointed that I didn't feel

> a part, I felt separate from the actual giving birth part. My husband and I didn't fully realise what birth management in a hospital would be like, even though I'd done the course.

Brooke reflected that without the knowledge gained at the birth classes, she wouldn't have questioned the birth:

> So yeah, it [birth classes] kind of opened our eyes and made us aware of all these things and it's really influenced the way I look at the birth now in retrospect. If I hadn't have been educated in that way [name of birth educators], I think I' probably be less, I might have thought, 'gee that was not such a good birth' but I think I'd be much less critical of it. That gave me the knowledge to evaluate the birth and the experience of the hospital, which was a very medicalised environment. I wouldn't have questioned it if I didn't have that knowledge. I just would have accepted it, accepted it for what it was.

Brooke's story visibly displays the restrictive nature of medicalised hospital birth. Active management of labour, as discussed in Chapter Two, local hospital policies, and caregivers' inflexibility prohibited Brooke's ability to birth unhindered; as Brooke states, she and her husband found themselves in a 'completely different scenario' resulting in different choices being made that were counterproductive to normal physiological birth. Brooke's story also demonstrates how exposure to an alternative paradigm of childbirth, through her participation in independent childbirth education classes, was counter hegemonic: it enabled a resistance to medical birth, even though hospital structures did circumscribe full resistance.

6.6. Contesting hegemony: Jasmine's story

Jasmine was pregnant with her first child and previously worked as a medical specialist in the maternity field. Jasmine's situation was unique: as a medical professional she was enmeshed within the medicalised framework of birth. Jasmine noted that her work colleagues and friends did not put much faith in the normal birth process and often derided women who 'insisted' on 'natural' birth. She had also learnt 'on the job'' that birth can be 'dangerous sometimes'.

However, Jasmine was conflicted by her own ideas that women *can* birth without intervention and have been 'doing so for thousands of years', even joking that she would ideally like to give birth 'in a forest'. Some of Jasmine's family members had interest in Eastern medicine and her mother was very positive about 'natural' birth claiming that: 'women just have babies, simple'. Jasmine had considered a homebirth or having her own independent midwife with her in hospital but was concerned about what her obstetrician and colleagues would think of her. She decided to undertake a 'Hypnobirthing' course but kept this secret from her obstetrician and friends/colleagues. The Hypnobirthing taught her meditation and breathing techniques and offered a more holistic approach to childbirth that was 'much more positive…than the hospital antenatal classes which were all about what could go wrong'. Although Jasmine described the relationship between herself and her doctor as 'collegial' and involving 'a lot of respect', she kept many of her feelings towards childbirth hidden from her.

Jasmine's labour was very long but with the support of her husband (also a medic) she endured the birth using the techniques she had learnt in the Hypnobirthing course. She was continually offered drugs by both the midwives on duty and her obstetrician but she resisted all these offers, confident with the knowledge she'd gained from Hypnobirthing, that her body 'could do this'. She also said she declined the electronic foetal monitor which would have restricted her movements and made her focus too much on the baby's heartbeat rather than her own body:

> …it was great and I don't think I would have got through it if I was on the monitor and on a drip, I think I would have felt even more disempowered. The fact was I didn't have any of that so I was, everything that was happening to me was completely natural and was what my body was meant to do. I felt that the whole time, except for the last hour and half when I was like what's going on? It's been too long, even though labour had gone on for hours and hours and hours, I felt like everything was going on as it was meant to.

Her confidence wavered when her obstetrician and midwife continually offered to 'help' the baby out with forceps; in fact her obstetrician had already 'scrubbed up' in preparation. Ultimately, Jasmine agreed to the forceps delivery and episiotomy. However, she maintains that if it were not for her Hypnobirthing course:

> I would have a caesarean…the thing was I got a lot of information from the Hypnobirthing…I think for me, if I hadn't have done the Hypnobirthing, I would have been induced or I would have gone to the hospital earlier and I would have had an epidural. It was hard enough for me to resist that route, let al.one for someone who hasn't done the Hypnobirthing…I spoke to one of my friends who is an obstetrician and she said 'I'd really like to have a natural birth' but she said 'but I know it's hard to go against the status quo' and all her colleagues had epidurals and caesareans and stuff like that and I said 'look I think you become your best self in your labour'. I was really encouraging other techniques and all that kind of thing. So I think I've changed from before the birth in not wanting to tell anyone about it, I'm not afraid now that I've been through it to be honest about it, and it is such a natural, amazing thing, the whole thing was so amazing, well that's how I feel about it anyway. My body just did what it had to do and I just went into that mode in labour and I wouldn't have wanted to interfere with that process.

Like Brooke, Jasmine's exposure to an alternative model of knowledge allowed her to challenge and resist the norm despite being professionally immersed within a medicalised framework. As a consequence she was able to make choices that reflected a wider frame of understanding, outside of hegemonic constructs. However, what is also important in Jasmine's story was that that she and her obstetrician 'were equals' and therefore she felt her wishes during labour were largely 'respected'. Jasmine was able to have more of a role in the decision-making because she had the strength to 'go against the status-quo' (hegemonic norms) but also because there was the 'true foundation for voluntary trust' that Gilson discusses (2003).

This chapter has argued that women who participated in this research trust their doctors but mistrust the birth process. The women interviewed enter into this relationship of trust based on the construction of themselves as 'at risk', their belief in the hegemonic medical model of birth and their social positioning and identity as middle-class, educated women. However, the inequality inherent within the woman/doctor relationship and the power of the medical model of birth renders the notion of mutual or voluntary trust problematic; therefore the relationship

becomes more like one of dependence, rendering the popular perception of women's agency or 'choice' in obstetric encounters, problematic. Moreover, women's understandings and expectations of birth often reflect biomedical ideology and are shaped by a culture of fear and ambivalence toward childbirth. These fears and beliefs are reinforced in individual interactions with obstetricians, again constraining women's options and experiences. However, exposure to alternative paradigms /understandings of birth allowed two women in the study to challenge hegemonic knowledge and make choices that enabled them to have different birth experiences, though their agency remained curtailed by rigid hospital protocols.

Conclusion

I began with the premise that hegemony is understood as process of 'meaning making' in which competing discourses, arising from different ideological and material positions, compete to give meaning to, and achieve dominance in a discursive field (Laclau and Mouffe 1985). In this process of meaning-making dominant discourses repeated in media, policy and everyday interactions become hegemonic—other discourses are neglected or deliberately repressed and become marginalised. This thesis has argued then, that obstetric discourse marginalises other ways of understanding childbirth because it works with other powerful contemporary discourses prevalent in a neoliberal and risk society. In examining the discursive construction of knowledge around childbirth in Australia in the 2000s, I argued that obstetric conceptualisations of debates, policy problems and maternity care practices have dominated public discourse. Through an analysis of key discursive sites, I have revealed the ways in which obstetric hegemony in childbirth is contested, reinstated and reinforced through discourse. Significantly, I have shown how biomedical ideology intersects with other contemporary discourses in the context of a neoliberal, risk society, in particular the key concepts of individual choice and risk management.

In Chapter One, I examined early feminist analyses of childbirth in the West, that described the historical medical 'co-option' of childbirth as being strategically motivated by both financial incentive, and as a reflection of broader cultural values regarding women's roles and reproductive processes. The 'redefinition' of childbirth into a dangerous, pathological event has ensured the continuing control of childbirth knowledge and practices by the medical profession. This historical transition has been viewed by feminists, and by many midwives, as being detrimental to women, for maternity care practices have been shaped to meet the needs and motives of doctors and not the needs of women and babies. Historical analyses of obstetric discourse and practice reveal that the fundamental core of obstetric knowledge is based on a Western, patriarchal, Cartesian epistemology based on binary oppositions that position women as inferior, 'rational science' and the understanding of the body-as-machine. Today, these foundations of the discipline of obstetrics continue to be influential, with many commentators arguing that maternity-care is increasingly technological and 'industrial' (Plante 2009; Reiger and Morton

2012). I further argued that while early feminist analyses remain pertinent to understanding contemporary childbirth, recent scholarship suggests that the construction of risk is increasingly significant to the continuing power of obstetric knowledge, particularly in the context of a risk-oriented society and neoliberal governance of maternity-care at a state and hospital level (Lane 2012). I then outlined a theory of hegemony as useful for studying how obstetric hegemony is maintained, contested and reinstated through discourse. This then provided the basis of my empirical study.

In Chapter Two, I re-examined the epistemological basis of obstetric knowledge through a critical analysis of contemporary obstetric textbooks used in Australian universities. Compared with previous analyses of obstetrics and gynaecology texts (Koutroulis 1990; Kahn 1995) there was no 'hidden ideology' of paternalism, sexism and biological determinism, and there is now *some* attention given to the role of the socio-cultural factors in the experience of childbirth and an increasing awareness and respect for women's autonomy that was missing from earlier texts. However, the subjectivity of women and their experiences of birth remained largely absent. I argued that obstetric knowledge remains wed to mechanical constructions of birth and positivist preoccupations with measurement and linear time, particularly due to the endorsement of the Active Management system which enforces birth practices that are systematically timed and controlled. While emerging research on physiology of normal birth has been utilised by feminist theorists and midwifery researchers to promote an alternative conceptualisation of labour, birth and the body, this alternative paradigm was not evident in the textbooks, and likewise, there was no mention of promoting normal birth or any reference to the growing body of research examining the complex interplay between hormones and childbirth (Foureur 2008). I argued that the 'Active Management' of labour promoted by all text books examined makes it very difficult for women to exercise any autonomy over the birth experience and may actually inhibit the birth process according to neurobiological research and midwifery experience and knowledge.

In Chapter Three, I examined medical and sociological explanations for increasing rates of caesarean section across the Western world. Medical explanations in the late 1990s and early 2000s tended to focus on caesarean by 'maternal request' though there was little empirical evidence to support the notion that more women were requesting caesarean in the absence of

medical need. On the other hand, sociological, anthropological and midwifery explanations argued that rising rates of caesarean birth should be understood within discursive and cultural contexts and medical constructions of risk and safety, as well an increasing cultural fear of childbirth. Moreover, they point to evidence that elements of obstetric practice such as overreliance on technology, fear of litigation and loss of obstetric skill contribute to increasing caesarean birth rates.

With this in mind, I then examined Australian media debates around caesarean birth using a CDA framework in order to reveal the underlying ideology in media discourse, demonstrating that obstetric constructions of caesareans dominated public debates in the first decade of the 2000s. Though obstetric explanations for rising caesarean rates did not go unchallenged, I demonstrated the way interweaving discourses around risk, and 'free choice' synonymous with a neoliberal consumer ideology, permeated and framed public debates, taking attention away from obstetric practices that may have been contributing to rising caesarean rates. A narrative of 'choice' became evident as women's requests for caesareans came to be justified as a woman's 'right'. Women were presented as flippantly choosing caesareans in the absence of medical need for lifestyle or beauty reasons. In addition to 'maternal choice', rising caesarean rates were also constructed however, as being a problem of an ageing maternal population, growing rates of maternal obesity and other illnesses, thus, caesareans were constructed as being a result of the increasing *pathology* of women's bodies. Thus, in the Australian media during the first decade of the 2000s, rising caesarean came to be understood as being the result of women's individual choice, or pathology. The media narratives represented doctors as the 'experts' in the caesarean epidemic and women as the culprits. In the hegemonic struggle to make meaning of rising caesarean debates, media discourse thus contributed to strengthening of the dominant obstetric viewpoint.

Chapter Four considered policy formation as another key site in where the hegemonic struggle for meaning-making in childbirth occurs. Using a policy as discourse framework (Bacchi 2005), I examined the 2008/09 Maternity Services Review as another crucial discursive site in which childbirth knowledge was contested and obstetric hegemony reinforced in Australia during the 2000s. The MSR was a significant challenge to obstetric-led care in Australian and a

response to pressure from midwives and consumer groups, such as the Maternity Coalition, to introduce more options for midwife-led care and continuity of care models. However, my analysis of the obstetric and medical submissions to the review, in addition to media coverage and policy processes and outcomes, argued that the obstetric profession used the policy process to maintain obstetric control over childbirth practices. They were able to do this by firstly taking credit for Australia's 'record of safety' in childbirth outcomes, and secondly, by framing birth as always risky, unpredictable and thus always requiring obstetric supervision. In this way, I concur with Lane (2012) who argued that obstetricians are better able to convince the government that they are superior risk managers than are midwives. The MSR resulted in positive outcomes for midwives working within the hospital systems, who now have access to the Pharmaceutical Benefit Scheme and a National Professional Indemnity Scheme (for hospital births only), however this was predicated on the condition that midwives prove they work collaboratively with medical professionals, thereby giving obstetricians power of veto. Though the MSR allowed for alternative and marginalised perspectives to be heard in public discussion, providing genuine contestation to obstetric hegemony, the end result cemented obstetric power in Australia and reinforced prevailing obstetric paradigm of risk and safety in public understandings and debate.

The MSR had particular ramifications for independent midwifery and women choosing to birth at home. During, and following the MSR, homebirth thus became a heated topic of media discussion in Australia; fuelled by the publication of several homebirth studies receiving public attention, and the death of several babies born at home making sensationalist news headlines. In Chapter Six I critically examined the cultural and political context of homebirth debates outlining the research demonstrating the obstetric profession's longstanding hostility to homebirth and manipulation of homebirth research and statistics. I then undertook a critical discourse analysis of online and print media articles around homebirth during the period 2009-2012, and coroner's reports of the deaths of babies born at home during this time. Drawing on sociological theories of moral panic in a risk society (Ungar 2001) and the theory 'intensive motherhood' (Hays 1996), I argued that during the period 2009-2012 a moral panic ensued around homebirth. This moral panic was played out in the Australian media and reinforced the hegemonic message of homebirth as inherently hazardous despite widespread contestation from consumers and

midwives and research evidence suggesting otherwise. I argued that the media debates and obstetric discourse reflected biomedical ideology but intersected with the larger cultural ideology of intensive motherhood and the obligation to manage risk in constructing homebirth women as selfish, deviant, but most importantly, as inadequate risk managers. Thus, the debates around homebirth in the Australian public during this time, became another key site where obstetric hegemony was challenged and reinstated.

In the final chapter of this thesis, I presented data from qualitative interviews with 13 Australian women using private obstetric care in order to understand how individual women negotiate, contest or accept hegemony in the context of a risk society and how women's agency is negotiated within their encounters with private obstetricians. I argued that the women in this study trusted their doctors implicitly, but mistrusted the birth process. Women's relationships with their obstetricians were based in the construction of themselves as 'at risk' and their social positioning and identity as middle-class, educated women and ultimately, in their support and belief in the hegemonic medical model of birth. However, I argued that the inequality inherent within the woman/doctor relationship and the cultural power of the medical model of birth renders the notion of mutual or voluntary trust problematic and rendering the popular perception of women's agency or 'choice' in obstetric encounters questionable. Moreover, I argued that women's understandings and expectations of birth reflected biomedical ideology and were shaped by a culture of fear and ambivalence toward childbirth. These fears and beliefs were reinforced in individual interactions with obstetricians, again constraining women's options and experiences. In the telling of two women's stories, Brooke and Jasmine, however, I demonstrated that exposure to alternative paradigms of birth allowed these women to challenge obstetric hegemony discursively, though, importantly, not practically as individual hospital and practitioner policies and practices inhibited these women from experiencing the birth they desired. Brooke and Jasmine's stories reveal the instability of obstetric hegemony, but also the ingrained nature of obstetric hegemony at the *institutional* level.

This thesis has broadened our understanding of the way biomedical knowledge shapes public debates, policies, practices as well as women's experiences of childbirth in contemporary

Australian culture. It further adds a new understanding of how obstetric hegemony works in conjunction with, and is strengthened by other dominant discourses and ideologies.

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Appendix 1: List of interviews

Obstetricians

Dr Caroline De Costa, interviewed on Friday July 25 2009, Fitzroy, Victoria.

Dr Andrew Pesce, interviewed Friday August 21 2009, Westmead, New South Wales.

Dr Ted Weaver, interviewed Tuesday September 1 2009, Melbourne, Victoria.

Dr David Molly, interviewed Tuesday August 18 2009, Brisbane, Queensland.

Two further obstetricians were approached for an interview but declined; Dr Euan Wallace, Dr David Ellwood

Women

Brooke: interviewed Friday June 6 2008, Melbourne, Victoria; Monday 11 August 2008, via phone; Saturday December 6 2008, Richmond, Victoria.

Helena: interviewed Monday 3 November, Malvern, Victoria; Wednesday March 4 2009 via phone.

Gabriella: interviewed Friday July 31 2008 via phone; December 3 2008 via phone.

Jasmine interviewed May 19, 2008 Kensington, Victoria; August 1 2008 via phone.

Jenna: interviewed July 18 2008, Coburg Victoria.

Kim: interviewed April 30 2008, La Trobe University, Victoria.

Louisa: interviewed May 15 2008, La Trobe University Victoria; July 29 2008 via phone.

Olivia: interviewed November 26 2008 via phone; June 16 2009 via phone.

Sally: interviewed July 22 2008, Richmond Victoria; November 10 2008, Richmond Victoria.

Sandra: interviewed May 12 2008, Monee Ponds, Victoria; December 3 2008 via phone.

Scarlet: interviewed April 2 2008 via phone; August 8 2008 via phone.

Renata: interviewed April 9 2008, East Melbourne, Victoria; November 10 2008 via phone.

Theresa: interviewed May 13 2008, Preston, Victoria; July 25 2008, Preston, Victoria.

Appendix 2: Online Sites

ABC The Drum www.abc.net.au/thedrum

The Age Online www.theage.com.au

Baby Bump Project www.babybumpproject.com.au

Birth After Caearean email discussion list BAClist@yahogroups.org.au

BubHub Forum: http://www.bubhub.com.au/community/forums/forum.php

The Conversation www.**theconversation**.com/au

Crikey Health News http://blogs.crikey.com.au/croakey/

Essential Baby Forum www.essentialbaby.com.au/forums/

The Herald Sun online www.heraldsun.com.au

Feminist Breeder http://thefeministbreeder.com/

Huggies Forum http://www.huggies.com.au/forum

Joyous Birth Forum www.joyousbirth.org/forum

Maternity Care Discussion Group email list (International) MCDG@LIST.CFPC.CA

Ozbirthing email discussion list ozbirthing@yahoogroups.com.au

OzMidwifery email discussion list ozmidwifery@yahoogroups.com.au

Repronetwork (international) REPRONETWORK@NEWLISTS.SSCNET.UCLA.EDU

Science and Sensibility http://www.scienceandsensibility.org/

The Unecessarean http://theunnecesarean.com/

Appendix 3: Interview materials

Research project: Information and Choice Processes in Late Pregnancy and Childbirth

Participant Consent Form

I (the participant) have read and understood **the participant information sheet and consent form,** and any questions I have asked have been answered to my satisfaction. I agree to participate in the project, realizing that I may withdraw at any time.

1) ☐ I agree that interviews will be audio taped.

2 ☐ I agree that research data provided by me or with my permission during the project may be included in a thesis, presented at conferences and published in journals on the condition that neither my name nor any other identifying information is used.

Name of Participant (block letters):

Signature **Date**

Name of Investigator (block letters):

Signature: **Date**

****Name of Student Supervisor (block letters):** **Date:**

WITHDRAWAL OF CONSENT FOR USE OF DATA FORM

(This form is to be used by participants who wish to withdraw consent for the use of unprocessed research data).

Project Title: Information Processes and Choice in Late Pregnancy and Childbirth

I, (the participant), wish to WITHDRAW my consent to the use of data arising from my participation. Data arising from my participation must NOT be used in this research project as described in the Information and Consent Form. I understand that data arising from my participation will be destroyed provided this request is received within four weeks of the completion of my participation in this project. I understand that this notification will be retained together with my consent form as evidence of the withdrawal of my consent to use the data I have provided specifically for this research project.

Participant's name (printed): ……

Signature:

Date:

Interview Schedule – Women

1. Can you tell me about your first birth /can you tell me about this pregnancy so far?

2. Have you had any tests throughout this pregnancy yet? E.g. ultrasounds, Amniocentesis?

3. How did you decide on those tests?

4. How are you preparing yourself for the upcoming birth? How is it different this time around?

5. What, if anything, are you reading/consulting?

6. If you use on line forums, how useful do you think the information is? Do you rely on information from forums?

7. How is your husband/partner preparing for the birth

8. Do you have a birth plan?

9. What will it include? I.e.: are you considering pain relief, caesarean etc.? How have you come to these decisions?

10. Is it important to you that you have a natural birth? I.e. without intervention?

11. Are you having a support person? What do you envisage that person's role to be?

Your Doctor

1. How/why did you choose your obstetrician? Did you consider going through the public system at all?

2. What do you expect from your doctor in terms of level of care, support, information, responsibilities?

3. Tell me about your relationship with your doctor. Are you happy with the level of care and information he/she gives you?

4. Do you undertake your own research on birth or do you rely on your doctor's advice? What sources do you use?

Family and Friends

1. What advice have you been given from family, friends etc.? Is it useful advice- any horror stories?

2. Do you have a family history/mythology around birth

3. Is your partner/husband supportive of the kind of birth you want?

Media

1. Are you aware of the recent media debates around choice in childbirth, particularly around caesarean birth? Do you have an opinion on the issues?

2. What have you heard about caesarean birth in the media?

3.
4. Are you aware of the upcoming Maternity Services Review?

5. Do you have any thoughts on this?

Participant Information Questionnaire

Contact Details

Name

Address

Email

Personal details

Age
Country of birth
If born outside Australia, how long have you lived in Australia?

Parent's Country of birth?

Do you identify as Aboriginal or Torres Straight Islander

- ☐ Yes
- ☐ No

Marital Status

- ☐ Single
- ☐ Married/Defacto
- ☐ Same sex relationship
- ☐ Divorced/Separated

How many children do you have?

Education and Employment

What is the highest level of education you have completed?

- ☐ Secondary School, year 11 or under
- ☐ Secondary School, year 12
- ☐ Trade, certificate or diploma
- ☐ Bachelor Degree
- ☐ Postgraduate Degree

Are you currently in the paid work force?

- ☐ Yes full-time
- ☐ Yes, part-time or casual
- ☐ Yes self-employed
- ☐ No

What is your current occupation?

If you are not currently in the paid work force, what is your usual occupation?

What is your annual household income ?

- ☐ <$15,000
- ☐ $15,000-30, 000
- ☐ $ 31,000-50,000
- ☐ $51, 000- 75,000
- ☐ $75,000- 100, 000
- ☐ >$100, 000

Is there a pseudonym you would like the researcher to use?

Interview Schedule for obstetricians

Firstly just a reminder that this interview is being recorded.

If you want to remain anonymous you will need to fill in the consent form

I can send you a transcribed copy of the interview prior to using it in the thesis- you may veto its use in whole or part if you are not happy with the transcript.

1. Firstly a personal question: how did your interest in obstetrics come about? Can you tell me about your training etc?

2. What has motivated your interest in the political side of the obstetric profession?

3. How do you think obstetricians are represented in media and public discourse? Do you feel you they misrepresented?

4.. How do you feel about the criticisms aimed at obstetricians and the obstetric profession in general?

How would your colleagues feel about these criticisms?

6. What do you think about the way debates around the rising caesarean rates are being played out in public discourse/media? E.g. the AMA MSR submission described it as a 'hysteria' around cs rates

7. Medical discourse (e.g. in the MSR, opinion pieces and so forth, often present the rising c-section rate un- problematically, for eg are explained by increasing maternal age, obesity and 'choice'. Are there enough reflexive processes happening within the profession?

8. Do you think women are able to make informed choices about maternity care in Australia?

10. What do you think about the MSR and the subsequent changes to the provision of maternity services? For e.g more autonomy for midwives.

What was your experience of the MSR process - do you think it was fair for instance? Was it necessary?

11. Collaborative care? Midwives say this not possible because of the inherent hierarchy and disrespect within the profession for midwives

12. Why is RANZCOG/AMA/NASOG etc. so opposed to homebirth in Australia despite the numerous new studies showing its relative safety among low risk women?