Midwifery as Feminist Praxis
in
Aotearoa/New Zealand

RUTH JOY SURTEES

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Abstract

This thesis highlights the ways in which the practices of contemporary midwives in Aotearoa/New Zealand are caught within the intersection of an array of competing discourses. The context for this is the reconstruction of midwifery in Aotearoa/New Zealand as an autonomous feminist profession founded on partnership with women. Interviews and participant observation with midwives, based mainly in one New Zealand city, are the basis of an analysis of the complexity of midwives' praxis as professionals. The analysis draws on insights from critical and feminist approaches to Foucault's theories of discourse, power and the subject. It includes discussion of the conditions which came to produce and authorise the concept of 'partnership'. Which subjects can speak about partnership, and when? What claims are made about it? What challenges it?

Partnerships between midwives and women are theorized in the thesis as highly complex and contingent networks of strategic and productive relations. Differing sites of practice/negotiations are analysed as spaces of/for governance. For midwives this negotiative work takes place within the contested terrain of what is (re)constructed as 'normal birth'. This includes the provision of, or resistance to, epidural analgesia/certification and defensive practice. These practices and knowledges are undertaken within professional discourses of women's/consumer choice and midwifery accountability. While midwifery's theoretical and emancipatory political projects are articulated as a counter discourse to medical hegemony, some midwifery practices inadvertently re-inscribe pregnant/birthing bodies within medico-legal frameworks. This is an outcome, not of the sovereign power of obstetrics over women/midwives, but of attempts by midwives themselves to negotiate heterogeneous forms of risk and keep birthing women, and their own practices, safe. Within these relationships and practices of freedom, the midwife performs professionally to construct herself as what I call an 'auditable subject'. These processes produce self-regulation and the disciplinary normalisation of midwives/midwifery. The technologies of the midwife/self occur within the relations of ruling that render the pregnant/birthing bodies of women, and the labouring bodies of midwives, increasingly amenable to subtle forms of liberal governance.

Dedication

This thesis is dedicated to my father,

Harold Edward Surtees,

on his 70th birthday;

for his unconditional love

and on-going inspiration always.

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Contents

Glossary and abbreviations

ACC — Accident Compensation Corporation

APGAR — Scoring system for the baby's physiological well-being at one and five minutes after birth

Caesarean section — Surgical removal of the foetus via the abdomen, usually in an emergency situation

Cervix — The neck of the womb

CHE — Crown Health Enterprise

CTG — Cardiotocograph; monitors and traces the well being of the foetal heart beat and rate (FHR) and the women's contractions together

DEM — Direct Entry Midwife(ry)

DHB — District Health Board

Ecbolic — Drug given to stop uterine bleeding after birth

EFM — Electronic Foetal Monitoring

Epidural — Regional anaesthesia used in labour as pain relief/analgesia

Episiotomy — Cut made in the vagina at the time of birth

GP — General practitioner

HBL — Health Benefits Limited

HDC — Health and Disability Commission(er)

HFA — Health Funding Authority

HHS — Hospitals and Health Services

Induction — Of labour; to induce birth by various means

IPA	Independent Practitioner Association
LLL	La Leche League, international organization for promoting and supporting breastfeeding
LMC	Lead Maternity Carer
MBS	Maternity Benefits Schedule
Meconium	The first faeces expelled by the foetus/baby
MMPO	Midwifery and Maternity Provider Organisation
MOH	New Zealand Ministry of Health
NZCOM	New Zealand College of Midwives
NZMA	New Zealand Medical Association
PHO	Primary Health Organisation
Placenta	(Whenua) The organ which grows and supplies life to the foetus in the womb during pregnancy.
PNMR	Perinatal Mortality Rate
RHA	Regional Health Authority
Sublimaze	Or Fentanyl, a narcotic drug sometimes used in conjunction with an epidural to increase the analgesic effect in labour/childbirth
Syntocinon	Synthetic hormone used to expel placenta or stop uterine bleeding
THA	Transitional Health Authority
WHD	Women's Health Division

Although both are bound in the spiral dance,

I would rather be a cyborg

than a goddess.

(Haraway, 1991)

Why not instead talk much more about their

monstrous sisterhood?

Why not explore the potentials of

cybergoddesses?

(Lykke, 1996)

Introduction

This thesis explores the practice of midwifery in Aotearoa/New Zealand. This profession has recently reconstructed itself as an autonomous feminist profession founded on partnership with women (Guilliland & Pairman, 1995; Tully, 1999). The discursive exploration of midwifery as a feminist profession is the focus of my attention. This analysis is underpinned by the interrelationships between feminism and poststructuralist theories. These are critically explored in the thesis, particularly with regard to new forms of medicalisation of women's birthing bodies within proliferating, and governing discourses of risk (Annandale, 1996; Lupton, 1999c; Weir, 1996). These theories are seen to reflect, reinforce, and re-inform midwifery action.

The ethnographic fieldwork, which generated the material for analysis in this thesis, consisted of observing the practices of midwives in a variety of different sites of practice, home and hospital, rural and city. I also undertook 35 formal interviews, including individual interviews and focus group discussions, with a total of 40 midwives in a variety of roles including management. The transcripts of these interviews and the field notes I wrote during the time of participant observation at different sites of practice generated rich data for discursive analysis. This formal fieldwork took place from June 2000 to September 2001.

As well as the more formal fieldwork, I was personally involved in three births (and three deaths) within my own network of friends and family during the time of my research/thesis immersion. This comprised the informal fieldwork. These events added to a metaphor of the research project as one of 'rebirth' in many ways, and inform the intertextual stories, dispersed between the chapters of the 'real' research project. I dwelt during this time in the borders between theory/practice, work/home, public/private, technology/spirituality, life/death. These fragile borders are disrupted by the subsequent production of this account, with its layering of intertextual stories and valuing of polyvocality, pluralism and difference. It contributes to the recent interest in the representation of postmodern ethnographic research (Coffey, 1999; Ellis & Bochner, 1996; Fox, 1999; Rath, 1999; Richardson, 1997).

The thesis offers new ways of thinking about the constitution of midwifery subjectivities amongst 'differently-positioned' midwives (Tully, Daellenbach, & Guilliland, 1998), in their complex relationships with birthing women. Lather suggests that a politicised poststructural project such as this can "illuminate the intersection of postmodernism and the emancipatory

projects" (Lather, 1991b:12), by interrupting, intervening, displacing or working against the relations of dominance. My desire to contribute to the (re)production of midwifery knowledges by 'interrupting' through research in this way was conceived in the year when I was a midwifery student. As an ex-nurse, I undertook one of the final post-graduate courses for a diploma in midwifery, half way through completing my university degree majoring in Feminist Studies and Education. I provide a small vignette from my time as a midwife in training, before going on to outline the thesis issues, directions and chapter development.

Pain, sublimation, and a naïve search for '(t)ruth'

When I was a midwifery student in 1995, I watched an anaesthetist insert an epidural catheter into a woman's spinal column after the duty registrar made a diagnosis of 'patient distressed' and a treatment plan for 'epidural analgesia'. I had thought the woman was labouring without many problems; it was her first baby, her husband was providing physical and emotional support, and she was also using the gas to provide some relief. I knew there were no obstetric complications and she was an otherwise well woman. Things had seemed fine till now. The midwife was keeping the registrar informed of progress. When the registrar popped her head in the door 'just to see how things were going' and subsequently make her diagnosis, the woman was standing leaning over the end of the bed, moving her hips around in circular motions and moaning rhythmically and loudly, while her husband stood by holding the gas tubing to pass to her when she requested it with one hand, and rubbing the small of her back with the other.

I was doing little things to help me cope with the feeling that I was being intrusive, like passing on cold flannels and sips of water to the husband every so often to give to the woman, whilst silently hoping I would see a normal birth that shift; perhaps even catch the baby. The registrar asked the woman how she was finding the gas, and she replied that it was ok, but made her feel slightly nauseous. After a few brief and quiet words with the midwife that I was not a party to, the registrar left, and the midwife said "Well, I think we'll pop in an epidural just to make things a bit easier for you if you like…I'll just get the anaesthetist down to do it, ok?" The woman seemed ambivalent, but felt that the staff would know best and agreed.

Feeling disturbed but not really sure why, I carried on performing my small and helpful tasks, including smiling, as the anaesthetist arrived with a trolley.

Helping the husband help her up on the bed, holding her knees up, so she could 'curl up tight in a small ball on the edge of the bed with your spine curled towards me', while the midwife helped the anaesthetist by opening packets of gloves and other sterile equipment onto a trolley by his side. Holding her nightie up to be taped to her shoulders while the anaesthetist painted betadine solution on her back, to create a sterile field where the needle would be inserted between certain lumbar vertebrae into the epidural space, in front of the spinal cord. Smiling at the husband, trying to convey a sense of reassurance, of the everyday. Hoping he couldn't see the disappointment in my eyes. Struggling with my feelings of confusion. Not wanting to meet the midwife's eyes (what might I see/convey/not see?) Silently furious with the registrar – had she given birth? How old was she anyway, and why do they always seem so young and inexperienced? Wasn't she familiar with normal birth? How could a female doctor make these decisions? Why does this seem to happen all the time? What had been going wrong?

Then the needle catheter was in, secured and taped over, op-site smoothed down firmly, drip stands organised, the woman settled back on the bed, nightie smoothed down nicely, immobile except for her arms and head, blood pressure cuff blowing up on her arm, all set now, husband beginning to look relieved, ice cubes brought in to measure the level of loss of feeling on her skin, good that's a job I can do now, the block mustn't go as high as the lungs or we're in trouble, midwife just pops in the urinary catheter and drainage bag, that's just there because now she can't feel when she needs to pee as well as to push… CTG machine on and galloping away, baby's heart beat sounds fine ('won't be long now, have we got a name for him or her?') Everything's ok at last, big sigh of relief, husband in chair beside bed, no need to massage her now, she's nice and quiet, midwife's doing the paper work and checking the equipment.

Then I notice the anaesthetist putting an orange sticky label on the fluid bag, and I ask him quietly out of the couple's earshot what he is adding. He says "It's just a small amount of a narcotic we pop into the bag as well, Ruth". I say "Oh. I thought it was just a regional anaesthetic, why do they have that as well?" He said, "Well, we just find things work better in combination like this, different anaesthetists use different combinations of drugs, it's just a

small dose". I say, again, "Oh", and pick up the phial to read the label – Fentanyl, otherwise known as Sublimaze, the label tells me. "Sublimaze?" I say to the anaesthetist – "*Sublimaze?*" I repeat again, unsure myself what I want from him now. "Do they know they are getting it?" I ask, finally, and he says, "Well not specifically, Ruth, they know we use a regional anaesthetic and an analgesic and that they work very well together" – but it is clear his patience may run out soon so I stop my questioning of him. I feel flat, a bit nauseous and dazed, and am simultaneously kicking myself for having these feelings. After all, the woman seems happy, and her husband is certainly relieved. But as I go home soon after that, well before the woman birthed, I can't get rid of the thoughts that the name 'Sublimaze' sounds like a combination of the words 'sublimate' and 'haze' or 'daze'. I look up the word in the dictionary when I get home and find that it says:

> **sublimate** (sub-lim-ayt) **v.** to divert the energy of (an emotion or impulse arising from a primitive instinct) into a culturally higher activity. Sublimation. **n.**

For some reason I feel quite stunned, and wonder for days afterwards if I really will practice as a midwife when I graduate; I almost think I don't want to, I only want to do homebirths anyway, but how will I manage round-the-clock midwifery practice and juggle childcare as a single parent…I feel so exhausted all the time, just by being a student. I'm exhausted by having to ask questions constantly, and a desperate and lonely feeling that I can never find the right answers, no one seems to care about, or know, or tell, the 'truth'.

From the truth to partial perspectives

Fox says that his health research methodology is a 'nomadic movement beyond health' which also informs practice. Although I desperately sought the 'truth' as a midwifery student, Fox argues that 'the truth is not out there' after all (Fox, 1999:174). Neither is the truth in here; a poststructural ethnographic project is only ever concerned with 'partial truths' (Britzman, 2000). The thesis itself constructs a partial truth, rather than uncovering some kind of real truth about midwifery, midwives or childbirth, although I sought those things for myself as a midwifery student more than seven years ago. At that time, I saw the world through a standpoint lens of 'radical lesbian feminism'. I was convinced that the profession of obstetrics functioned to exert a forceful and dominant power over most women. I returned to university somewhat disillusioned in my quest, as the story above suggests, and ambivalent about ever

working as a midwife. I was despondent about my ability to use midwifery practice to emancipate women from the grip of obstetrics, even in the 1990s when midwifery was being established as a newly emerging feminist profession.

As I engaged in more academic work, I began to acknowledge my own conflicted and contradictory experiences. In my subsequent academic work I started to question the relationship of experience to knowledge and hence to power (Flax, 1993; Fuss, 1989; Scott, 1991). Gradually I accepted that perhaps there was not going to be any one truth about midwifery or childbirth, but that there could be a multiplicity of truths and knowledges. Haraway's critical analysis of scientific objectivity, from whence arguably the profession of obstetrics stakes its claim to see the 'truth' hidden inside women's bodies, includes a call for a specifically feminist objectivity. She suggests that what would make this objectivity feminist, and simultaneously avoid the de-politicising pitfalls of relativism, is an on-going process of acknowledgement of the historically situated and embodied knowledges which render perspectives always only ever partial (Haraway, 1991b). In this way, she argues, the vantage points of subjugated peoples and knowledges (many women, and some midwifery work, for example), offer significant promise for feminist theorising (Haraway, 1991b). At the same time, she warns that "The standpoints of the subjugated are not 'innocent' positions…*How* to see from below is a problem requiring at least as much skill with bodies and language, with the mediations of vision, as the 'highest' techno-scientific visualizations" (Haraway, 1991b:191). Do midwives know how to do this, then, I wondered? Do I? What was the relationship between women's experiences of childbirth, being a midwife, and the production of midwifery knowledge(s)?

Harding (1992) suggests that 'standpoint', 'perspective', 'experience' and 'view' are terms often used interchangeably in the quest to provide feminist knowledge. This quest has arisen from a desire to build a body of knowledge that is distinctly not-male, and out of consciousness-raising as a strategy for building feminist theory, research and scholarship. This process included earlier feminist and midwifery criticisms of obstetric knowledge (Annandale & Clarke, 1996; Arms, 1994; Daly, 1987; Ehrenreich & English, 1973; Rothman, 1989). But experience plays only one role in the creation of knowledge, and it doesn't necessarily ground knowledge. For example, all women have 'women's experiences', but only at certain historical points does this produce feminist knowledge (Harding, 1992:184). What assumptions can be

made about the individuals belonging to a feminist profession, I wondered? What does belonging to a feminist profession mean for individual midwives, and how do different midwives do feminism, if at all?

Becoming 'multiple subjects'

As Haraway suggests, a tendency in feminist epistemology has been to assume that standpoint theories produce the least distorted thought. Harding (1992) also documents the development of standpoint logic as a point of departure for the critique of andro/ethnocentric knowledges. This has been important to feminists who consider that the experiences of Western men have shaped and guided the development and (re)production of knowledge. This of course includes scientific and medical knowledges, which generally have posited that 'man' is that to which 'woman' is other. However, in assuming a universal maleness or transcultural patriarchy against which to struggle, the assumption of a universal woman and her experiences necessarily followed. While valuable in terms of generating feminist knowledge, this approach cannot take complex and multiple positions and subjectivities into account, either amongst a group of women, or within just one woman (Harding, 1992). My engagement with these and other feminist theorists led me to review the earlier assumptions I had made as a student about what birthing women might (not) desire. What did I assume about the role of midwives, including myself, with respect to the choices of birthing women?

When there is an assumption of a 'women's experience' or the 'sameness of struggle', as described above, feminist knowledge has often been claimed by dominant group women and subsequently generalised to the lives of other women. Mohanty (1992) describes this process, using Morgan's 1984 *Sisterhood is Global* anthology as an example. Mohanty claims that even: "feminist discourses, critical and liberatory in intent, are not thereby exempt from inscription in their internal power relations" (Mohanty, 1992:76). Mohanty's analysis of Morgan's production of 'women' as a universal category suggests that Morgan's assertions are based on women's shared opposition to androcentrism, that grows directly out of their experiences of oppression and their real or imagined opposition to it (Mohanty, 1992:80). In similar ways I had hoped midwifery would signal, for the most part, a resistance by women and midwives to institutionalised birth, and a shared and gendered opposition towards processes of medicalisation.

Harding suggests that, while we still need to deal with differences between genders, it is starting our analysis from attention to differences within that is most productive. This is a strategy for avoiding generalising about all women, or speaking on behalf of women. She conceptualises this transformative project as 'becoming a multiple subject'. According to Harding, the subject of every liberatory movement must learn to see how race, gender, class, ability and sexuality are used to construct each other in their intersecting ways in order to accomplish goals (Harding, 1992:182). A mutual understanding of our own social locations and learning to see from the logic of multiple subjectivities requires subjective transformation, not interchangeability (Harding, 1992:188). Midwifery, as a feminist profession with liberatory goals, has at times struggled with its own internal power relations in the on-going production and development of its knowledge base, just like other liberatory movements (see Daellenbach, 1999a; Gore, 1993; Lather, 1991b; Luke & Gore, 1992; Rathgen, 1996; Tully, 1999; Weedon, 1999).

As I reassessed my own universalising assumptions about women, wondering how to explore internal power relations within midwifery and articulate them as research questions, differences among midwives them/ourselves began to be addressed within Aotearoa/New Zealand. In particular, differences between midwives in terms of birthing perspectives, sexuality, ethnicity and biculturalism, choice of work location, and interpretations of partnership with consumers were explored (Benn, 1997; Davis & Findlay, 1995; Fleming, 1995, 1998a; Lauchland, 1996; Tully, Daellenbach, & Guilliland, 1998). I finally stopped asking myself 'why can't other midwives see things my way?' and began to ask instead, 'what has prevented me from seeing things differently?'

I gave up my search for one kind of (t)ruth and began to focus instead on multiple, complex, contradictory and fragmented midwifery subjectivities. At that point I began an engagement with the texts of poststructural theorists, and their feminist respondents. I slowly exchanged my radical lesbian feminist lens for a poststructural, and queer kaleidoscope. I wanted to focus now on differences within as well as between different midwives, and on midwives as the non-unitary subject(s) of local knowledges. Just as the same woman can chose an epidural at one time and a homebirth at another, midwives each work in different ways at different times, and midwifery itself is creatively fluid, complex and shifting, according to the historically contingent context in which it is embedded.

Learning about critical and feminist discourse analysis methodologies provided a means of theorising my own complex and shifting location as a knowledge producer in this field. In so doing, I was introduced to the work of feminist theorists who engage with Foucault's theories of power and knowledge, discourses and their analyses, embodiment and governmentality. These theorists often offered new analyses and perspectives of earlier feminist critiques of the medicalisation of women's bodies, which effectively challenged my previously held 'power over' analysis. These analyses include the complex and ambivalent relationship of women and of midwives to bio-technology (Davis-Floyd & Dumit, 1998; Lupton, 1992; 1997a; Ramazanoglu, 1993; Riessman, 1992; Sawicki, 1991; Wajcman, 1991).

I began to ask myself new questions, not ones that assumed a truth prior to its articulation in language and discourse, but ones designed to tease out the ways in which knowledge is produced, and the relationship of power to these dynamics. Instead of asking 'what do different midwifery partnerships with women look like?' I began to ask instead, 'what actions, in which situations, constitute partnership?' I then proposed to analyse texts generated from my conversations with different midwives about the ways in which they apply midwifery theories to practice. For this reason, the thesis explores the ways that midwifery goals are discursively articulated, produced, received and resisted within the contested field of the maternity market place. I analyse the ways in which these goals are strategically counter-posed to the predominant medicalised model of childbirth, using Foucauldian and critical feminist approaches to discourse, knowledge and power. In this way I explore and comment on (but provide no closure or answers for) some of the debates that have taken place over the last decade in Aotearoa/New Zealand, largely among midwives them/our selves. These discursive debates necessarily respond to the claims of other professional providers, and some consumers of, maternity services in Aotearoa/New Zealand today.

Nomadic inquiry within/across borders

As Tully et al suggest, differences among midwives and between midwives, consumers, and others sharing a concern with childbirth and maternity politics in Aotearoa/New Zealand are highlighted at this time, and need to be confronted and negotiated (Tully, Daellenbach, & Guilliland, 1998:253). The thesis makes a contribution towards this process in its discursive exploration of the ways some differently positioned midwives negotiate aspects of childbirth

and maternity politics, in partnership with women. In this way, and with its focus on the production of knowledges, the thesis is situated in/on the 'borderlands' of gender studies, health, education, anthropology, and sociology. It is intended as multi/interdisciplinary, and to disrupt the porous boundaries of each, in an un/disciplined way.

This thesis also re-presents aspects of a postmodern ethnographic journey that traverses borderlands that are personal/political. On one level, it is about the process of becoming, a rebirth, or transition from potential midwifery practitioner to fledgling academic researcher. In my approach to this thesis as 'research as praxis' (Lather, 1991b), one goal was to research aspects of midwifery partnership, in partnership, with midwives. The practical work of trying to understand the philosophies that informed the practices of different midwives collapsed boundaries between theory/practice, as Walker also notes of his nursing research (Walker, 1997). At the same time it addressed and highlighted the tensions between these boundaries. Through this process of developing an academically based, postmodern praxis of my own, I ceased to feel that these positions (practitioner/academic) exist primarily in tension with one another.

Walker has argued that the "mission of the border ethno(autobio)grapher…is a praxis-oriented endeavour not only to better understand a culture, but to actively intervene in its (re)production" (Walker, 1997:3). For Walker, this intervention (in Lather's 1991 terms an 'interruptor strategy') was made possible by his shadowy, nomadic border-dwelling. 'Inhabiting the slash' between theory/practice (Walker, 1997), and 'working the hyphens' between myself/Others (Fine, 1994), in this way felt very much like working against the grain at times as I started my analysis from attention to the differences within midwifery. I was conscious that it might seem politically more productive/sensitive to focus on the similarities, and re-present midwives as a coherent and unified group (see Butler, 1990). However, this 'living in the slash' of insider/outsider (but never really either one) with regard to the profession of midwifery contributed to a degree of critical purchase I would not have gained otherwise. My nomadic border-crossings enable the project to provide understandings of midwifery knowledges and practices as contingently in/coherent, and also to 'actively intervene' in the re-production of these knowledges.

In speaking of research as praxis in regard to these issues, Lather argues that it must be premised on a "deep respect for the intellectual and political capacities of the dispossessed" (Lather, 1991b:55) as particular social groups. Midwives arguably have suffered – and resisted - historical and cultural dispossession throughout centuries of gendered political struggle over claims to meaning, truth and knowledge in relation to childbirth (Lay, 2000). Lather's argument is that for praxis to be possible, theory must illuminate the lived experience and self-understandings within such a group, but it must be illuminated by their struggles (Lather 1991b:55). I take this to mean not just the (assumed) struggles over professional jurisdiction between midwives and obstetrics, but also the struggles within midwifery as a progressive social group. In this sense, my deep respect for midwives is counterpoised with a politicised poststructural commitment to explore differences within midwifery, to 'interrupt'. I attempt this at the same time as desiring the maintenance, rather than the fragmentation of, the key emancipatory goals of midwifery. This requires balancing a need for a certain 'strategic essentialism' (Fuss, 1989; Spivak, 1993), with a critical interest in and advocacy of poststructuralism (Lather, 1991b; MacDonald & Bourgeault, 2000; McCormick, Kirkham, & Hayes, 1998).

Lather's commitment to salvage praxis in poststructural terms means for her, having "the courage to think and act within an uncertain framework…in a time marked by the dissolution of authoritative foundations of knowledge" (Lather 1991b:13). For Walker again, it is a "method 'on the run'; it destabilizes while it authorizes, it represents while it misrepresents, and it threatens to disintegrate as it comes into view" (Walker, 1997:3). For myself, it is borne of an uncertainty about '(t)ruth' in midwifery, combined with a certainty about the need for the critical intervention, interruption and displacement of the production of knowledges about childbirth at this historical point in Aotearoa/New Zealand. The theoretical and methodological issues I have just discussed inform the thesis as a whole. They frame the discussions in later chapters, which are underpinned with the relationships between feminisms and poststructuralism. I go on to map the terrain ahead in the form of a brief chapter outline. The chapter sections of the thesis are themselves 'interrupted' by the intertextual stories, as truth is by uncertainty, as life is by death.

Mapping the thesis

The thesis begins by describing the context for the re-birth of midwives as autonomous professionals in Aotearoa/New Zealand after the Nurses Amendment Act (1990). In examining what professionalisation might mean for different midwives, and debates around the professionalisation of midwifery through the prevailing discourse of partnership, chapter one explores the historically contingent ways in which an occupation like midwifery in Aotearoa/New Zealand becomes professionalised (Papps & Olssen, 1997; Symon, 1996), in this case, as a specifically feminist profession (Daellenbach, 1999a; Tully, 1999). This Foucauldian approach to knowledge explores the ways in which an occupation or profession like midwifery is constituted – produced – within language and discourse. Networks of relations between sets of key actors in midwifery as a new professional field of knowledge can then be traced (Tully, 1999). The discourses identified within midwifery will refer to other discourses, such as those within obstetrics, or nursing, as part of various strategic claims and counter-claims to professional expertise (Pairman, 2002a; Tully, Daellenbach, & Guilliland, 1998; Tully & Mortlock, 1999). There will also be identifiable non-prevailing discourses within midwifery itself, which serve to constitute individual midwifery subjectivities in relation to each other.

The next two chapters explore the methodological and theoretical approaches deployed in the thesis. Qualitative researchers influenced by Foucauldian poststructuralism generally consider discourses to be bodies of knowledge, and may refer to the analysis of specific discourses as a method, or discourse analysis more generally as a methodology (Grace, 1998; Lee & Poynton, 2000; Parker & Burman, 1993). Methodology, method and theory must necessarily be discussed closely together in this context, and indeed are woven throughout the thesis/chapters. The focus of chapter two discusses the merits of a Foucauldian feminist approach to knowledge and power for this particular project. It outlines the concepts of discourse and the relevance of theories of governmentality for health in Aotearoa/New Zealand today (Larner, 1997, 1998a). These issues are situated within a context of neo-liberal and liberal-feminist discourses in health and education which value individual responsibility with regard to choice, particularly in the field of childbirth (Bogdan-Lovis, 1996-97). The chapter explores the theoretical grounds for the analyses made throughout the thesis with regard to the issues of risk, restraint and responsibility. The Foucauldian concept of

governmentality highlights the centrality of the body and the ways in which it is disciplined, inscribed and regulated subject to the power/knowledge of experts within the realms of governance (Mitchell, 1996:203). I focus on governmentality here because of its usefulness in analysing professionalism as "a disciplinary logic which inscribes 'autonomous' professional practice within a network of accountability and governs professional conduct at a distance" (Fournier, 1999:280).

Chapter three pays attention to the issues of hybrid ethnographic and 'nomadic', borderlands fieldwork mentioned in the previous section (Fine, 1994; Walker, 1997), and in health/education research (Fox, 1999; Hunt & Symonds, 1995, 1996; Pillow & E. St. Pierre, 2000; Savage, 2000). Hence the ethno(autobio)graphical nature of this project is signalled in the use in this chapter of my phrase 'midwifery and me(thod/ology)'. The chapter discusses method/ological issues and research strategies. I pay attention to ways in which midwifery care is woman-centred and my research design is midwife-centred. For midwifery, this means that the woman is at the centre of midwifery care, and the midwife has access to other relationships identified as important by the woman only through the woman (Guilliland and Pairman, 1995:24). With each individual midwife at the centre of my research, I had access to other relationships and other concerns within the ethnographic field only via the midwife (or particular midwifery practice) concerned. Because aspects of the research design and some methodological principles are modelled on the midwifery partnership, it can for these reasons also be considered research-as-praxis as well as experimental and evolving.

The next section of the thesis is concerned with my analysis of differing midwifery knowledges, technologies and practices. Each of these three chapters (four to six) explores different aspects of the relationship between midwives and the women they care for, as they labour together in the processes of childbirth. Each contains material that emerges from my discursive engagement with the interview transcripts and field notes, and is concerned with the theoretical issues of power and the governing of midwifery bodies, but each may also be read separately from the other.

The creation of new midwifery subjectivities in partnership with women has occurred in the context of a neo-liberal marketplace, and the implications of this for midwifery discourse and practice are introduced in chapter four. How different midwives have accessed that

marketplace, and the significance of the 1996 introduction of the Lead Maternity Carer system for midwives is explored in this chapter. The self-regulation and surveillance of midwives performed through the discourses of professionalisation construct particular midwifery subjectivities. Midwives remain embedded within the wider networks of power, surveillance and self-regulation within neo-liberal market place and health reform discourses of business ideology; choice and consumer-centred care. Some of the tensions around 'being a business woman' and maintaining a 'woman-centred' practice, and the ways different midwives negotiate those tensions and restraints, form the bulk of the chapter. A key issue explored critically is that of choice, and the role midwives take in facilitating different choices for different birthing women as 'consumers' (Bogdan-Lovis, 1996-97).

What happens when the choices some women make exist in tension with some midwifery (and consumer) perspectives informs the material for chapter five. The phenomenon of women's choice of epidural analgesia in otherwise 'normal' births was discussed, in different ways, by most of the 40 midwives I interviewed. The implications of this for midwifery scope of practice are explored. I attend to the texts of different midwives as they make claims about what counts as empowerment for different women in different birthing situations. The relationships of birthing women to biomedical technologies is established in different ways through the talk of the midwives, who, I suggest, draw on different feminist analyses in their discursive repertoires to establish notions of dis/empowerment. For some midwives, the midwifery discourse of continuity of care is predominant for them in establishing partnerships with individual women. For others, a focus on primary care establishes their midwifery identity, and contributes to the decision of whether or not to obtain their epidural certificate. The attainment and maintenance of an epidural certificate, or the decision to avoid and resist this for philosophical reasons, is important in the subsequent negotiations made by midwives in the spaces of/in labour ward.

Negotiating spaces of risk/safety within the labour ward during times of transfer and hand-over comprises the main part of chapter six. Noting the increasing institutionalisation of birth, midwives constantly engage in negotiations over what constitutes risk, and what constitutes safety. Risk is located by some midwives as within the birthing body, and by some, within the spaces of the labour ward itself. Further, discourses of risk and safety for the midwife and her own practice render her always under medico-legal surveillance and (self) monitoring, at a time

when her focus is on safety for the birthing woman. This requires complex negotiations of time and space and the ability of the midwife to balance elements of risk within the realms of restraint and responsibility. Increasing fears of litigation amongst those involved in childbirth are seen to impact on the midwives I interviewed. I pay attention in this chapter to the ways in which they constitute themselves as safe practitioners within the embodied and discursive spaces of childbirth (Annandale, 1988, 1996; Cartwright & Thomas, 2001; Lane, 1995; Saxell, 2000; Symon, 2000).

The chapters in the following section are somewhat differently focussed. In chapter seven, I examine how new practitioners in particular negotiate some of the issues explored in the previous sections. My engagement with the transcript material of several interviews with two groups of new practitioners (and some individual interviews with others) explores the complexities and ambivalences in the talk of these new practitioners, as they become established Lead Maternity Caregiver practitioners. My focus is on this particular transitional period of a midwifery career because new graduates are uniquely positioned in many different ways in the field.

As some of the first direct entry graduates in this city, these midwives faced particular opportunities, paradoxes and challenges. In many ways, some of the midwives deliberately re-presented in this chapter can be seen as those who are more critically engaged with the praxis of the issues explored in the previous sections, partly as a result of their midwifery education. Theory-practice disjunctures and theory-practice syntheses as well as the contradictions and ambivalences within the discussions portraying their work are highlighted. Midwives learn about becoming professional midwives and specialising in normal birth at a time when interventions into this process are rising exponentially (Savage, 2002). This provides an ideal context to explore rich data for analysis with regard to disciplinary normalisation, (self) surveillance and monitoring (Gilbert, 2001), and the governing of labouring bodies within pedagogies of risk and responsibility.

Chapter eight is different again. It explores the potential for postmodern midwifery subjectivities and embodiment, theories recently developed in the international literature (Davis-Floyd & Davis, 1997; Davis-Floyd & Dumit, 1998; Davis-Floyd, Pigg, & Cosminsky, 2001; Davis-Floyd & Sargent, 1997; Klassen, 2001; MacDonald, 2001; Parker & Gibbs, 1998).

In this chapter, the dualisms of normal/abnormal birth in particular are deconstructed in my readings of the interview texts of midwives. As I engaged with the related literature, metaphors of postmodern midwives as 'cybergoddesses' (Lykke & Braidotti, 1996) seemed highly relevant to my inquiry. Issues related to gender, midwifery, embodiment, birthing technologies and spiritualities are thus explored in relation to the notion of the cybergoddess.

Part of the ethno(autobio)graphic journey then comes to a point of closure for me, while some theoretical developments for further midwifery debate and discussion are simultaneously opened up. I end the thesis with reflection on midwifery/research as 'nomadology', and the possibilities for thinking about birth and about midwifery in ways that avoid either nostalgia or utopia. In these ways the thesis contributes to the interruption of hegemonic obstetric understandings of childbirth. Importantly, it also cautions against the potential development of a normalising and commodifying midwifery gaze; what I call the 'midwiferication' of birthing.

Intertext

28/06/00   Julie/Isabella

Julie: *I started to go into labour with my second baby at the same time I did with my first daughter, Emma, and in what felt like the same way. I had gone to bed around 9.30 pm and soon afterwards small niggling contractions kept me awake, but they were manageable enough that I could still lie relatively comfortably in bed. My husband David came to bed soon afterwards and we lay there awake, contemplating thoughts of a new baby's arrival. At around 2.00 am I called my LMC midwife, as I was slightly unsure whether I was in fact in labour and felt I wanted reassurance from her. She advised David and I to get as much rest as we could and to call again once labour was established.*

My first child, Emma, then 2 years old, woke early at around 5.00 am and we called my sister Nicola who arrived soon afterwards to take care of her as planned. When the midwife arrived I was in bed with a hot water bottle on my back, contractions were coming every 3 minutes and I was having some difficulty breathing through them. After the midwife arrived I tried a few different positions whilst waiting for the birthing pool to fill with warm water. I spent some time kneeling on the floor with my head resting on our bed while her and David took turns pressing hot flannels on my back where the pain of the contractions seemed to be the most intense. I remember being very impatient as I really wanted to immerse myself in the warm water of the birthing pool. Soon afterwards I did just that, and then my other sister Ruth arrived too…

Ruth: As I drove over to Julie's I remembered back to the birth of her first daughter Emma, over two years ago in a small birthing unit attached to an Australian Hospital, with one midwife, my mother holding the torch and David in attendance. Julie had come home now to raise her children closer to our extended family, and this baby was being born at home with home birth midwives. The birth pool had been ready for a while, and when I arrived early in the morning, Julie was in the dimmed bedroom immersed in the warm water. Mum was doing kitchen-y things, Nic was playing with Emma, and Dad was reading the paper, giving every outward sign that hearing loud moaning labour-sounds emanating from down the hall was entirely within the ordinary and every-day. After giggling a bit at this scenario with us, David summoned Nicola and me into the bed/birth room…we were excited at the thought of spending these hours with Julie and as soon as we saw her we felt in awe of her incredible strength. She seemed to be riding through and over the contractions as waves of strong pain came over her. Nic and I sat on the big bed and enjoyed sharing the silence between us as we focussed on Julie's strength and the midwife's peaceful approach to her. She was leaning on

her knees, over the edge of the birth pool so she could pass Julie water to drink, and reach under the water to check the foetal heart at regular intervals. We were entranced by watching them both …

Julie: *I stayed in the pool for the next couple of hours and various family members came and went. My parents who had arrived in the early morning were kept busy in the lounge, keeping the fire stoked, and cooking lunch etc. My two older sisters spent time in my bedroom where I was in the birthing pool, sitting on my bed, quietly supportive. David and the midwife were on the floor near the pool with words of encouragement, a cold drink at the ready and cold flannel for my forehead. Occasionally Emma popped in and out in between contractions to 'check on me'. At around 11.00 am labour seemed to be very intense and I felt weepy at this point. Everyone felt the baby was perhaps not far away, but then, disappointingly for me, the contractions seemed to fade somewhat and it felt like labour was not progressing. I decided I wanted to be alone at this point to re-focus on the work ahead and so my sisters left the room. I felt frustrated with the slowing contractions but the midwife was very encouraging, convincing me that labour was in fact progressing well. She gave me Pulsatilla drops, a homeopathic remedy to try and help the process along, also good for aligning the baby into an optimal position. I was incredibly tired and the warmth of the pool was so relaxing that I dozed off completely in between contractions and had to be gently prodded so as not to slip underneath the water.*

With contractions slowing right down I decided to have some soup that my mother had prepared and then, invigorated by the soup, I got out of the pool and walked up and down the hallway to encourage contractions back. With still no sign of contractions, David and I then decided to hop into bed and try and get some sleep and the midwife went home (a 5 minute drive away) for a shower and some lunch. Ruth also went to some work meeting she had to go to, hoping she wouldn't miss the moment of birth…

Ruth: With the baby still not arrived and Julie feeling the need for a rest and some space, I ducked out to meet my supervisors for a consultation meeting we were having at the local midwifery school. This was to explain my research proposal to the midwifery educators there, and seek their feedback and any ideas they may have for me. I felt a bit nervous about this process, but in a way the fact that Julie was in labour right on this day seemed somehow quite symbolic. It seemed to signify the hopeful start to, and forthcoming birth of my own project. I was impatient to get back to Julie's place, but also knew this meeting was important in terms of what I hoped to achieve in the spirit of partnership with other midwives. I often thought of

my academic supervisors as the 'midwives' I had chosen to facilitate my own re-birth/creative process, and trusted that they would guide me through the meeting as well.

The meeting seemed to go well, given that it was the first time I had spoken to other midwives about what I hoped to achieve. I explained the kinds of questions I would be asking of midwives as well as the analysis of discourses as a method/ology. The midwifery tutors present made various suggestions for refining some of the questions I wanted to ask of participating midwives. At that point I had only been going to interview self-employed midwives, and one of the midwives present suggested I interview hospital-employed midwives as well, to cover a wider range of practice perspectives. I decided to do so, and it considerably widened the sites of knowledge and practice I was keen to explore. After a couple of hours, as the meeting was drawing to a close, a midwife's pager went off…she was to be the back-up midwife at Julie's birth, and promptly left, followed by me soon after. We all laughed at the co-incidence and symbolism - a re-search/re-birth project about midwifery, heralded so fittingly by this birth….

Julie: *Forty-five minutes later after the midwife had popped home, David had called her back as within a very short period of time labour had suddenly intensified. The midwife arrived back 5 minutes later and found me back in the birthing pool, with contractions coming 4:10 and feeling lots of bowel pressure. I wanted her to check and see how dilated I was and she found that I was fully dilated with membranes bulging and so the second midwife was called and arrived soon afterwards. At this point I was pushing with all my might, was in a lot of pain and felt panicked as it felt very different to pushing out my first baby. I was kneeling on the floor of the birthing pool and when the back-up midwife arrived she was fantastic at helping me to focus. She held me by the shoulders, kept eye contact with me, and helped me manage the panic by slowing my breathing, and keeping me grounded by staying focussed on my body. The first midwife had reached right into the pool and was using a torch and mirror to check on the baby coming. She had to peel the membranes back from the baby's face under the water and noted that the baby had her hand and arm up by her head, so there was some delay with the body being born. The baby was passed through my legs and brought up to the surface of the water for me to hold. We stayed like this for 10 minutes before we held the baby up and saw that she was a girl. Soon afterwards we got out of the pool and were wrapped warmly in towels with my family close by to meet the latest addition to the family. The midwives were quietly and discreetly in the background at this time.*

Ruth: I arrived back at Julie's, after taking my supervisors back to university, well after Isabella was born and the back-up midwife had left. I went into the bedroom to find Julie in bed, with the family surrounding her and Isabella. They told me she had been 'born in the sack' – a symbol of good luck in several different cultures. The midwife was tending unobtrusively to various things; paper work, tidying equipment away, and enjoying watching Julie and David get to know Isabella. David began to dress Isabella on the bed, and for all of us then, watching her beginning to move and look slowly around at her new environment and at us, there was a profound sense of gratitude, thanks-giving, and peace in the air – perhaps best described simply as 'magic'.

1

Chapter One

Setting the scenes: the re-birth of the NZ midwife as an autonomous professional

From firm to fluid: mapping the ethnographic beginnings

This ethnographic project is situated within the terrain constituted by the relationship between feminisms and poststructuralism. The analytic framework I use has been informed by and mirrors my personal relationship with/in feminisms and midwifery. The place on which I once stood, firm and fixed feminist ground, now feels fluid, flexible, and sometimes frustrating, as my previous familiar footholds slip in the struggle to keep a grip on feminist theory and/for practice.

My journey into the field of midwifery politics began with a period of personal 'rebirth', which included the birth of my own daughter in a small town hospital in 1989. This coincided with the establishment that year of the New Zealand College of Midwives (NZCOM). After the birth of my daughter, I became a member of La Leche League (LLL) for a number of years and came to see birth and breastfeeding as profoundly political events. Some of the members/friends of that small LLL group were highly politicised women, who were involved in Home Birth Associations and in actively supporting the Save The Midwives Direct Entry Taskforce (Save the Midwives Direct Entry Taskforce, 1990). Two others were homebirth midwives, one a founding member of the NZCOM. We spent many consciousness-raising hours discussing the political relationships between birth, spirituality, feminism, medicalisation and midwifery as we looked after our babies and toddlers together.

I also worked as a psychiatric nurse, part-time tutor, and with district nurses, providing palliative care for people dying at home. I brought spiritual and feminist elements to this work, and for these reasons began to wonder if working with women birthing at home might be just as, or even more, fulfilling for me than working with the dying at home. At that time I had just devoured Mary Daly's *Gyn/ecology: The Meta-ethics of Radical Feminism* (Daly, 1987), and identified then as a 'radical lesbian feminist'. I moved home to the city to begin my academic work in

Feminist Studies, and planned to become a homebirth midwife at some future point. I was passionately excited about the ways midwifery represented, to me, the possibilities of a relationship between feminist politics, radical cultural feminism and women's spirituality. 'Goddess' imagery, and reclaiming the term 'witch' in honour of both lesbians and midwives who were killed as wise-women/witches in Europe during the Middle Ages (Daly, 1987; Ehrenreich & English, 1973; Towler & Bramall, 1986), became ways to link the personal to the political for me and many of my friends, heterosexual as well as lesbian, at this time. When I became a midwifery student in 1995, having almost completed my degree in Feminist Studies, I did so hoping that at last I had found the ideal way to put my feminist commitment to women's health into practice.

My experience as a student of the Diploma of Midwifery (a one year postgraduate course for those who held a nursing registration), however, proved to be different somewhat than I had anticipated. It was characterised by an often-painful combination of ambivalence, excitement, frustration, passion, and powerlessness, as indicated by the vignette that begins this thesis. With hindsight, I was naïvely unprepared for many things, perhaps because I entered the course with many assumptions. I had extraordinarily high expectations of a 'feminist profession' that was only just beginning to articulate its practices in terms of feminist theory (Fleming, 1995; Guilliland & Pairman, 1995). My own previous teaching and learning experiences as a feminist psychiatric nurse and tutor with a strongly critical bent, and my positioning as a pakeha[1] lesbian, all contributed that year to my feelings of ambivalence and confusion. In particular, I thought that while midwives defined their profession as 'woman-centred', the concept remained under-theorized by practising midwives in regard to different

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[1] The term pakeha refers to a non-Maori person of European descent, born in Aotearoa/New Zealand. The term Maori refers to the indigenous people of Aotearoa/New Zealand (see also 'tangata whenua', noted below). These names signify "…the colonial relationship between 'Maori' and 'Pakeha', the non-indigenous settler population" (Tuhiwai Smith, 1999:6). The s elf-identification by some researchers with the term pakeha may signify a politicised positioning within discourses of biculturalism. At the same time, these politics remain troubled by an engagement with post-colonial and poststructural texts (Glamuzina, 1992; Gunew & Yeatman, 1993; Tuhiwai Smith, 1999). Banks (2000b) suggests that pakeha midwives address the power of pakeha in terms of numbers, resources, and leadership in midwifery, by "accepting and understanding" the need for separateness in the voice(s) of the Maori midwives' collective Nga Maia o Aotearoa me te Waipounamu, while holding "tight to the common threads we share as we walk the with-woman path" (Banks, 2000b:5). The NZCOM, in its commitment to biculturalism, maintains a role in supporting Maori midwives and communities in the pursuit of Maori-identified interests (Tully, Daellenbach, & Guilliland, 1998). 'Tangata whenua' means the indigenous people of Aotearoa, literally; people who stand on the land in which the placentas that sustained their life in the womb have been buried (Banks, 2000a; Donley, 1998; Guilliland, 1993).

issues, such as those pertinent to lesbian consumers and midwives (Davis & Findlay, 1995; Fleming, 1995). These issues had been explored and theorized by British midwives, despite there being little overt theorising about the relationship between feminism and midwifery in Britain at that time (Stewart, 1999; Taylor, 1999; Wilton, 1996, 1999). Taylor, another non-practising midwife, writes about her despair at the arbitrary, and 'often co-opted meanings' of the term 'woman-centred', and notes that in Britain, "midwives with a radical perspective largely either cease to practice, as I did, or they go into education" (Taylor, 1999:421). In the end, after completing the year and registering as a midwife, I chose not to embark on clinical practice. Instead, I returned to university in order to reflect on my experiences as the basis for moving into post-graduate and doctoral work. I wanted to embark on research that was relevant for midwifery praxis.

But the 'confession' of this naïve beginning into the field of midwifery is, in itself, a rhetorical performance. It is not independent of the theories I will take up at some predictable point soon in the thesis. The story is a product of discourse itself – a way for me to position myself on a hopeful mission or a 'quest' (to help save women from obstetric dominance), rather than as someone trying to gather qualifications while she subsided on the DPB[2] at that time, or as someone who had no idea of what she wanted to do with her life but thought she didn't want to be a nurse any more, or many other possible subject positions. My confession acts to portray a more palatable subjectivity, and I have deployed it strategically, so you might imagine me as a 'postmodern re-searcher' rather than as a 'solo mother', or 'disruptive student' for example.

Allen and Hardin refer to this process, drawing on Derrida, as creating public models of subjectivity, through which the social production of experience in language is constituted through repetition and difference (Allen & Hardin, 1998:1). The narrative I have offered is seen as a performance or an enactment of identity. What really counts as the 'truth', or exists in peoples' heads, is "not the issue for the discourse-orientated researcher" (Allen & Hardin, 1998:4). The issue, for Allen and Hardin, and for me, is to explore through a discursive inquiry, "the relationships between discourse and social structure, discourse and power, and their articulation through institutions" (Allen & Hardin, 1998:1). In regard to these processes,

Derrida states that the subject exists as an effect of subjectivity, and that to deconstruct (rather than dispense with) the subject, involves moving from a supposed identity which has substance independent of language, to the subject as something inscribed in language (cited in Davies, 1997:274). This focus on language, drawing on theorists influenced by poststructuralism, is the methodological approach I bring to the work in the thesis. While these theoretical issues are discussed fully in the following chapter, I have raised them here initially to signal that my experiences (as a researcher, as a former midwifery student, as a mother), did/do not exist outside of, or prior to, the networked social relationships of language, knowledge and power within which they are embedded in this particular time and place.

This particular methodological approach to knowledge, power, and institutional relations means that my work here is concerned to see the subject as something constantly in process. Davies argues that we should think of the subject as a verb, rather than a noun. Davies puts it like this: "The subject of poststructuralism, unlike the humanist subject … only exists as process; it is revised and (re)presented through images, metaphors, storylines and other features of language, such as pronoun grammar; it is spoken and respoken, each speaking existing in a palimpsest with the others" (Davies, 1997:275). The subjects here then, midwives, myself, consumers of midwifery services, obstetricians, others in the field of maternity politics, and the profession of midwifery itself, are all considered as actors in process. In this field of complex, contesting, and networked relationships our voices mingle, and our (re)spoken stories refer to the stories of others in the palimpsest through which our subjectivities are constructed. As a discursive field or body of knowledge, 'midwifery' will contain an assemblage of objects as well as subjects; by this I mean technologies, concepts, statements, spokespersons and practices (elaborated on in the following chapters). In this chapter I explore contemporary midwifery status as the effect of 'professionalising processes' (Symon, 1996), inscribed in language and discourse. It is to this task that I now turn.

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[2] Domestic Purposes Benefit – paid by the then Department of Social Welfare to sole parents.

Moving from noun to verb: professionalising processes in midwifery

Background – prior to 'the seventies'

The development of a profession like midwifery does not adhere to a particular trajectory in isolation from other discourses, spiralling out of an originary point far back in history. According to Hunt and Symonds, midwives have always occupied an ambiguous and contradictory cultural space, in that there is not likely to be 'a lost golden age', an originary, prediscursive position that midwives could aspire to return to (Hunt & Symonds, 1995:22). Different forms of midwifery identity – and experience - at different times and places are brought into being in and through, rather than existing prior to, language and the law. Therefore, midwifery always develops as part of, and in accordance with, the dominant and prevailing discourses around economic, cultural, social and political regimes of power within which it is embedded. The same can be said for different concepts, such as 'partnership', on which midwifery practice in Aotearoa/New Zealand rests. It was never 'out there', waiting to be 'discovered'. Concepts are produced, and become authorised as 'truth' in language, mediated through relations of power that function within discourses.

Gender relations are also key to an analysis of occupational groups embroiled in early struggles of professionalisation. This includes interprofessional rivalry in the on-going process of the construction of midwifery subjectivities. Witz noted that the development of much professionalisation since the seventeenth century in Europe was related to the division of labour between medical men and midwives, and that this became centred around the difference between simply attending, or intervening in birth (Witz, 1992). The invention and monopoly by upper class men (presumably white), of the surgical forceps is well documented (Arney, 1982; Donnison, 1977; Martin, 1993; Witz, 1992). This invention is generally considered as a significant point in the development of this historic division of labour whereby "'Abnormal' labour was constructed as those conditions requiring intervention, frequently by means of instruments" (Witz, 1992:110). Witz's analysis links (male) gender with (obstetric) technology. It is a linkage that will become problematised in this thesis.

International, as well as local, historical analyses of midwifery have paid attention to the shift in power from the lay (or 'untrained') midwife, to the 'professional midwife' (Daellenbach,

1999a; DeVries, 1996; Donley, 1998; Downe, 2001a; Jordan, 1989). This shift in power is part of the extraordinarily complex history of the medicalisation of birthing and midwifery in Aotearoa/New Zealand from colonial times. These historical issues have been thoroughly discussed elsewhere (see Banks, 2000a; Daellenbach, 1999a; Donley, 1998; Guilliland & Pairman, 1995; Mein Smith, 1986a; Papps & Olssen, 1997; Smythe, 1998; Tully, 1999). The authors document the ways in which, earlier last century, the Midwives Registration Act of 1904 began to phase out lay midwives,[3] and provide training at the new St. Helen's hospitals[4] to prepare midwives for state registration; a process that had a number of different paths (see Papps & Olssen, 1997:84). The regulation of midwifery training was associated with the beginning of the gradual shift over the following three decades for births previously conducted at home with midwives to be confined to hospital and overseen by doctors.

The St Helen's hospitals were originally managed by midwives, but by the 1930s the (largely male) medical establishment gained "…access and eventual control" over the St. Helen's training hospitals (Papps & Olssen, 1997:97). Mein Smith (1986a) documents the rise in hospitalised births amongst Maori and pakeha women; the majority of both groups still birthing outside hospital in the early 1920s; by 1926, 58% of pakeha women gave birth in a hospital, by 1930, 68% did, and by 1935, 78%. Rates for Maori women were slower to rise,[5]

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[3] Prior to the 1904 instigation of different forms of surveillance and regulation of midwives, 'lay' midwives may have had some or various forms of formal or non-formal training (see Papps and Olssen, 1997), and could be considered to be part of an 'autonomous occupation', rather than 'profession' (Donley, 1986, Pairman, 2002).

[4] The Midwives Act 1904 established state control of midwives and provided for the establishment of the 'St. Helens Hospitals' managed by the then Department of Health. These hospitals were to provide training facilities for midwives and subsidised care for 'married working class women', and were initially run by midwives until the access of medical students in the 1930s led to eventual control by the medical profession; a process continually contested and negotiated by various groups of women and midwives (and see also Donley, 1986; Fougere, 1993; Fougere, 1994a; Nursing Council of New Zealand, 1996; Pairman, 2002a; Parkes, 1991; Strid, 1987).

[5] See Mein Smith (1986a), Donley (1989), Banks (2000a), Papps and Olssen (1997), and Durie , for accounts of some facets of Maori birthing practices. Donley (1998) and Banks (2000a) detail the ways in which traditional Maori birthing practices 'understood birth as a natural event which took place at home with the support of the whanau', or family and sometimes with Maori lay midwives (Donley, 1998). Maori women resisted hospitalisation longer than pakeha women; by 1937, 83% were still birthing at home (Donley, 1998:122). The limited scope of this thesis means I cannot do justice to these issues in the more complex manner I would prefer. Longhurst (1996), cautions against the mis/representation of traditional Maori birthing practices and pregnant Maori women as often associated with 'the natural', or 'nature', suggesting that while 'nature' is not to be denied, brief historical representations of particular groups of pregnant women ignore the complex ways in which pregnant bodies are "given meaning and inscribed by discourse…[T]hey ignore the fact that biology/nature can only exist inside of culture" (Longhurst, 1996:246). Longhurst further states: "representations and understandings of pregnancy as natural are temporally and spatially specific [and] hinge on factors such as sexuality, age, culture, ethnicity and 'race'"(Longhurst, 1996:246).

but by 1962, 95% of both groups gave birth in hospitals[6] (Papps and Olssen, 1997:104). Mein Smith suggests these processes existed within paternalistic discourses concerning the safe surveillance and monitoring of the (re)production of population fit for the British colony. (White) motherhood was seen as duty to the nation; obtaining appropriate ante-natal care was one practice encouraged within the discourses of imperialism and patriotism shared by the Health Department in the early twentieth century, and Plunket[7] (Mein Smith, 1986a:25).

Obstetric control of childbirth was largely linked to discourses around pain-relief (requiring technological intervention), and safety, also requiring scientific management and hence, hospitalised birth (Smythe, 1998). Midwifery gradually became subsumed under nursing and eventually lost autonomy completely with the 1971 Nurses Act (see Daellenbach, 1999a). Thereafter midwives required a doctor to supervise their activities while attending childbirth either at home or hospital. The political struggles documented by these authors, between various groups of birthing women, doctors, midwives and nurses, public and private hospitals, health reforms and the state, continued and gained momentum by the 1970s with the second wave of feminism in Aotearoa/New Zealand.

After 'the seventies' – feminism and consumerism

Mapped as it was onto almost a century of medical dominance in childbirth, the second wave of feminism in Aotearoa/New Zealand included a strong critique of the medicalisation of (female) bodies (Bunkle, 1992a, 1994; Coney, 1990; Dann, 1985; Donley, 1986; Strid, 1991). Diverse groups of health and birth activists, including home birth activists and domiciliary midwives, continued the political struggles over a woman's right to choose the place of birth and her birth attendant(s) (Daellenbach, 1999a). These were taking place alongside and with/in other political struggles over the contested terrain of women's bodies with regard to reproductive health choices and fertility and abortion debates (Dann, 1985).

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[6] 'Hospitals' here included the St. Helen's hospitals, public maternity hospitals or wards managed by hospital boards, private maternity or mixed general/maternity hospitals, cottage hospitals; any institution having two or more beds; sometimes an extension onto a doctor's rooms (Papps and Olssen, 1997).

[7] See Donley (1998), for the development and role of the Plunket Society and Karitane hospitals, founded by Truby King, at that time in Aotearoa/New Zealand.

During the mid 1980s, the Inquiry into the Treatment of Women for Cervical Cancer at National Women's Hospital investigated the denial of women's rights to informed consent and choices (Cartwright, 1988). The report ensuing from this inquiry recommended practices of accountability, patient-centred care, self-determination and cultural sensitivity in the health service. The Cartwright Inquiry stimulated a more public discussion of ethics around research concerning Maori. Tuhiwai Smith suggests that on one hand, the inquiry served to cement Maori suspicion of non-Maori research(ers), while on the other, it provided a space for a more explicit and negotiated process between the parties concerned (Tuhiwai Smith, 1999:176). The implementation of these practices included patient advocates in hospitals and consumer representation on medical committees (and see Bunkle, 1992a; 1994; Cartwright, 1988; Coney, 1990, 1993). The Cartwright Inquiry and its ensuing report was instrumental in forming a discursive shift from 'patient' to 'consumer'. Strid states of the Inquiry that it

> …set in place the importance of consumer partnerships. Partnerships between the providers of health services and tangata whenua as well as providers and consumer organisations were identified as providing a community development model conducive to a more enlightened and equitable approach to health care. (Strid, 2000:2)

Tully suggests that the contemporary midwifery concept of partnership with birthing women – now positioned as 'consumers' - has emerged out of this specific historical context as a distinctly feminist form of professional practice. At the core of the discourse articulating their current status as birthing professionals has been midwives' commitment to work in partnership with women. Tully notes the importance of considering feminist professionalisation through partnership as an on-going process of 'doing'. Her 1999 thesis entitled *Doing Professionalism 'Differently'* highlights the ways in which contemporary midwives work(ed) to align themselves conceptually 'with women', rather than with other medical professionals (Tully, 1999).

Tully details the ways in which partnership "…developed out of mutually supportive relations between domiciliary midwives and homebirth consumers in the 1970s/80s, [and] was formalised in the philosophy of the NZCOM" (Tully, 1999:17). Tully discusses the ways in which the language of 'empowerment' and 'choice' in childbirth, drawn from radical feminist critiques of medicalisation, shaped midwifery's definition of itself as a distinctly feminist profession (Tully, 1999). In this sense, "midwives draw on feminist understandings about the

importance of women taking control over their lives and health in general, and reproductive health in particular" (Tully, Daellenbach, & Guilliland, 1998:248).

Feminist conceptions of empowerment through 'choice', as active 'consumers' of health care, rather than passively recipient 'patients', also informed home birth activism in the 1970s-1980s. The Homebirth Association, founded in Auckland in 1978, was a particularly strong lobby group in its challenging of medicalised childbirth (Daellenbach, 1999a:124). Daellenbach argues that this activism was ultimately more successful in advancing women's choices with respect to maternity services than it was in encouraging them to birth at home in large numbers. It popularised the rhetoric of 'choices for childbirth' (Daellenbach, 1999a:192). Daellenbach notes that in the decade prior to the establishment of the College of Midwives in 1989, home birth activists and domiciliary midwives forged understandings of partnership "…out of a shared sense of marginalisation in relation to the dominant medical profession" (Daellenbach, 1999a:204).

It was this intertwined relationship between domiciliary midwives and the homebirth associations that became 'codified' as it moved from more individual to more political ideals of partnership when the NZCOM was finally formed (Daellenbach, 1999a:136). During this time the Direct Entry Taskforce was formed specifically to re-establish direct entry midwifery education and redefine midwifery as a profession separate from nursing (Donley, 1986; Save the Midwives Direct Entry Taskforce, 1990).[8] Pressures for direct entry midwifery education arose from a pressure group called the Direct Entry Midwifery Education Taskforce, within the Save The Midwife Society, to which a number of home birth and consumer activist organisations belonged (Daellenbach, 1999a; Donley, 1986; Guilliland & Pairman, 1995; Strid, 1987).

In the very first issue (1989) of the NZCOM Journal, Joan Donley, known in Aotearoa/New Zealand as our midwifery elder, articulated the importance of continuing consumer control over childbirth. She exhorted midwives to see the inclusion of consumers in their organisation,

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[8] For historical analyses of the development of Direct Entry midwifery education in Aotearoa/New Zealand see Donley (1986), Papps and Olssen (1997), Pairman (2002a), STM DE Taskforce (1990).

not as a threat to 'their status and so-called power', but as a way of maintaining accountability to birthing women in the doing of this alternative form of professionalism, which she saw as "the only form of organisation open to us to enable us to achieve our ends" (Donley, 1989:6-7). She claimed then that the Wellington Obstetrics and Gynaecology Society's consideration that, "the three greatest threats to modern obstetrics are 1. consumerism, 2. feminism and 3. midwives … is of course correct" (Donley, 1989:6).

The 1989 establishment of the NZCOM by consumers/women and midwives provided the context for new legislation. In 1990 the then Minister of Health, Helen Clark, introduced the Nurses Amendment Bill (1990), which was passed into law before the end of the term of the fourth Labour Government. The effect of this ensuing legislation was to return professional autonomy to midwives; a doctor was no longer legally required at a birth. Further, midwives became entitled to claim funding from the state for the services they provide, which may include prescribing and administering certain medications, ordering diagnostic tests, and referring clients to specialist services (Tully & Mortlock, 1999). Midwives in Aotearoa/New Zealand re-emerged as autonomous practitioners whose professionalisation processes had become articulated through a prevailing discourse of partnership with women, based on certain shared understandings of 'birth as a normal life event' (Tully & Mortlock, 1999).

These are some of the ways midwifery has been reconstituted as a feminist form of professional practice in Aotearoa/New Zealand (Tully, 1999; Tully, Daellenbach, & Guilliland, 1998; Tully & Mortlock, 1999). These processes all contributed to securing midwives' position as specialists in normal birth, and to midwifery as a profession that is now distinctly separate from medicine and nursing in the professional control and application of its own body of knowledge.[9] This has culminated in the present situation of post-1990 professional self-regulation.

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[9] See Pairman (2002a), who describes the separation process in education.

Contemporary professionalising: through consumer partnership(s)

Post 1990 – partnership

Recreating midwifery as a profession, in the ways described in the previous section, can be seen from the perspective of a discursive inquiry as a countervailing strategic response. Midwifery, as a professional field of knowledge, contains discourses and practices which respond to various historical de-skilling or demarcation attempts by the profession of obstetrics to control the practice of midwifery (Witz, 1992). Conceptual strategies within these discourses are as much about what midwives are not (nurses, doctors), as about what they are, or do. Tully et al suggest "By constructing a professional identity based on partnership with clients/consumers, midwifery is able to make particular claims over birthing work that differ from those of rival health professionals such as doctors and nurses" (Tully, Daellenbach, & Guilliland, 1998:248). With regard to these differences in professional approaches, Guilliland and Pairman state, "Midwifery is attempting to achieve and maintain its status on the basis of empowerment, rather than the normal exclusionary tactics of professionalism which assumes 'power over' rather than 'power with' (Guilliland and Pairman, 1995:11).

The Midwifery Partnership: A Model For Practice (Guilliland & Pairman, 1995),[10] was developed by two midwives and presented at the NZCOM conference in 1994. It is now a published monograph which expands on midwifery ideals of partnership with women at both NZCOM organisational and individual practice levels. The defining attributes of this midwifery model arising from these understandings of partnership are that: midwives are autonomous practitioners, recognise pregnancy and birth as normal life events, and deliver continuity of care that is woman-centred (Guilliland and Pairman, 1995; Tully, Daellenbach and Guilliland, 1998). These attributes are central to midwifery's claims to feminist professional practice, and function thus as counter claims to medical models of birthing (Tully, Daellenbach, & Guilliland, 1998:249). In relation to this, the introduction of the *Midwifery Partnership - A Model for Practice* states "it is because of this political and personal involvement with women that

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[10] Karen Guilliland is the Chief Executive Officer of the NZCOM. Sally Pairman is the NZCOM Education Consultant. Both women are midwives.

midwifery accepts its responsibilities as an emancipatory change agent" (Guilliland & Pairman, 1995:1).

In Britain the *Changing Childbirth* Department of Health Report of 1993 identified the concepts of 'choice, continuity and control', as vitally important in empowering women in childbirth (Sandall, 1995). In Aotearoa/New Zealand these concepts are echoed in ideals about partnership between midwives and women that involve "… trust, shared control and responsibility and shared meaning through mutual understanding" (Guilliland & Pairman, 1995:1). Guilliland and Pairman also describe the establishment of ideals of partnership as arising from a commitment to biculturalism. They note that the constitutional and legislative structures of society in Aotearoa/New Zealand are based on the Treaty of Waitangi, signed in 1840 between tangata whenua and the Crown. Principles inherent to the Treaty and which are intended to govern this relationship are partnership, participation, protection, and equity (Ramsden in Guilliland & Pairman, 1995; Nursing Council of New Zealand, 1996; Ramsden, 1995). These were also important contributing contextual factors in the development of and shaping of ideals of partnership within the NZCOM.

In its focus on emancipation and empowerment, the midwifery model of care encourages pregnant and birthing women to retain decision-making and control over their own bodies and experiences (Tully & Mortlock, 1999). Guilliland and Pairman state, "…the midwifery profession identifies, acknowledges and requires partnership as part of practice, and provides guidelines for the practice of partnership within its Code of Ethics…" (Guilliland & Pairman, 1995:2). This model of partnership has had a significant effect on the articulation of professional midwifery discourse within Aotearoa/New Zealand. Guilliland states:

> Partnership also assumes that women (not professionals) control the birth process and that Midwives trust them to do so. The Midwife's prime responsibility is in providing the environment for women to realize their own potential. (Guilliland, 1993:6)

The commitment to partnership between individual women and midwives is also extended to organisational partnership between midwives and consumer members of the NZCOM. Consumers sit on National and Regional Committees of the College, and are involved in the evaluation of professional practice through the 'Standards Review' process for practising

midwives. As well as this involvement, consumers have significant input into the Direct Entry Bachelor of Midwifery degree programmes. This input reflects and reinforces the midwifery model of partnership where the woman/consumer is at the centre of care. After some conflict with the International Confederation of Midwives (ICM) over the issue of consumer membership in the professional body of the NZCOM, the confederation adopted the policy statement submitted by the NZCOM in 1993 which articulates midwifery as a profession founded on its partnership with women (Guilliland, 1993; Guilliland & Pairman, 1995; Tully, 1999). Aotearoa/New Zealand maintains the unique position within the ICM of being "the only professional organisation involving partnership with consumers in the policy and decision making structures which guide, develop and monitor the profession of midwifery" (Guilliland & Pairman, 1995:10).

Partnership post 1996 – professionalism in practice

From July 1996, and within the context of continuing complex health reforms,[11] significant changes were made to the funding of maternity provision (see Abel, 1997; Cumming & Salmond, 1998; Guilliland, 2002a; Larner, 1997). Women are now required to nominate a Lead Maternity Caregiver (LMC), who may be a midwife, obstetrician or general practitioner. That provider holds a budget, which is claimed for under modules of care. The budget is the same regardless of the professional discipline of the LMC. Continuity of care is recognised as being vital to the well being of the woman under the LMC system (Guilliland, 1999), the costs of which are met by the state.[12] By 2001, 71% of women in Aotearoa/New Zealand chose a midwife as their LMC, while 15% chose a general practitioner. Most of the remaining women have a private obstetrician; while a small minority present straight to hospitals for care (Guilliland, 2002a:7). Seven to ten percent of women choose home birth with a midwife who may either offer this as one option in her practice, or who may maintain a specifically home birth-centred practice.

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[11] See chapter four of this thesis which discusses the changes in the health system and their implications for midwifery service provision.

[12] The LMC system is now provided for and funded under section 88 (previously 51) of the New Zealand Public Health and Disability Act 2000, which sets out terms and conditions for payment to the provider of maternity services (see Guilliland, 1997; 1999; Guilliland, 2002a, for details of LMC funding and related policy issues).

Midwives acting as LMCs may consult with an obstetrician for specialist advice and allocate money from the budget for this, but remain lead care giver. The consultation and referral process takes place through the Section 88 'Guidelines for consultation with obstetric and related specialist medical services' (Ministry of Health, 2002). This consultative process provides the continuity valued by women and reduces the need to transfer to another professional group (Guilliland, 1999, 2000). Over the last decade midwifery has become a well-established profession in Aotearoa/New Zealand in its own right, providing the bulk of care for birthing women (and see Guilliland, 1998a; Pairman, 1998). Enormous professional advances for midwives have been achieved and the partnership model has been hailed internationally as an innovative model of consumer-centred care (Mander & Fleming, 2002; Young, 1996).

Through a series of complicated manoeuvres midwives and their supporters have created midwifery as a profession in Aotearoa/New Zealand, rather than as an occupation or trade. The importance of this achievement is related to the ability to be autonomous practitioners with a formal body of knowledge, who are self-regulatory and who control their own education processes (Guilliland, 1993; Pairman, 2002a). Claiming jurisdiction to support physiologically normal as opposed to medically pathological births through increasingly rigorous midwifery education has been one way of doing this and demonstrates the relationship of knowledge to power.[13] DeVries and Marland note that in recognising the power of science in modern society, midwives are able to use science and scientific methods to assess the appropriate and inappropriate use of technology itself (in Marland & Raffery, 1997:261). This ability both enhances the profession's public image (because its practice is 'evidence-based'), and benefits the profession itself (because midwifery-only care is cost-effective for governments).

But different understandings of what constitutes partnership between women and midwives as professional practice disrupt any apparent coherence about the concept of partnership. It does not exist in an unproblematic, fixed, or unified way. Tully, Daellenbach and Guilliland have

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[13] Pairman notes, "Direct-entry midwifery education at last gave the profession the opportunity to prepare midwives for their full scope of practice. The new programmes made it possible to provide the in-depth focus on midwifery knowledge and practice necessary to produce midwives who were 'specialists' in normal childbirth, and to give them the skills to practise independently of doctors" (Pairman, 2002a:24).

noted that rather than the NZCOM involving two philosophically aligned and mutually dependent groups, as it appeared to during its inception over a decade ago, "…it now embraces a range of differently positioned practitioners and consumers with potentially different understandings of what partnership involves" (Tully, Daellenbach, & Guilliland, 1998:251). These emerging differences are also the case in other settings (in health, or in community development, for example), where the term partnership is frequently deployed. In relation to biculturalism, for example, some Maori activists involved in on-going disputes over Treaty negotiations with the Crown have criticised pakeha-centred ideals of partnership (Durie, 1998). Some home birth activists engaged in negotiations with the NZCOM also criticise the concept, arguing that midwifery partnership "…is a resource and a lever for home birth associations, but its realisation is shaped by the professional power of midwives" (Daellenbach, 1999a:204).

Daellenbach argues that these particular negotiations over partnership (which merge and intersect in the NZCOM in the relations between Maori/pakeha and consumer/midwife) highlight complex differences as well as some similarities between sets of actors who have been defined as partners (Daellenbach, 1999a:202-7). 'Partnership' frequently remains a contested and slippery concept when used to describe the professional 'midwife-woman relationship' (Calvert, 2002). Some midwives and social scientists have also articulated critiques of the partnership model with regard to its viability in professional terms (in Calvert, 2002; Fleming, 1998a; Tully, 1999; Tully, Daellenbach, & Guilliland, 1998). While midwifery has been reconstituted as an autonomous profession, debates about different models of midwifery care persist, and different opinions about what constitutes acceptable midwifery partnerships are a key feature of the current context. This thesis addresses itself to how differently positioned midwives articulate and practice partnership. Below I outline some of these debates.

'Differently-positioned' partnerships

The NZCOM professional organisation is committed to consumer involvement at all levels of policy and practice and in the decision-making structures that guide it. It is this professional level of consumer involvement that Tully et al suggest poses a challenge to some 'differently-positioned' midwives for whom the concept of partnership challenges their "understanding of

the professional-client relationship" and "involves a radical departure from their training, their sense of appropriate professional boundaries, and their preferred form of practice" (Tully, Daellenbach, & Guilliland, 1998:251). Letters to the editor of the 1995 NZCOM Journal reflected disgruntlement from some hospital midwives not practising continuity of care for various reasons, who took issue with some statements in '*The midwifery partnership*', after reading an abbreviated version published in the previous issue.

In these accounts alternative meanings of partnership perceived by individual, and 'differently positioned' midwives, appear to relate to the interpersonal relationship between the woman and the midwife and the importance of the quality of care as well as its continuity. The objection to perceived 'dogma' within NZCOM definitions, the conflicting relationships between differently positioned midwives (frequently self-employed vis-à-vis hospital employed), the subjective importance of the ability to claim the title or identify as a 'midwife' in varied circumstances, the right to choose the location of practice (hospital or community); and the desire to avoid the imposition of particular philosophies onto the practices of others, all become clearly articulated as well.

These professional debates also continued after the 1996 introduction of the LMC system. In a critique of Guilliland and Pairman's model of partnership as an "unresearched model of the professional status of midwives" which needs to be treated with caution until tested by research, Lauchland argues that "If a partnership exists, surely the woman must ultimately be the judge of that" (Lauchland, 1996:26). She suggests other concepts such as those of 'covenant' and 'reciprocal trust' already utilised by some midwives in their working relationships with women may have value, given that the term 'equal partnership' in the Guilliland and Pairman model has shifting and arbitrary meaning. Lauchland's contribution asserts the central positioning of the consumer/woman's standpoint, from where the assumptions underlying the NZCOM concept of partnership may be called into question.

Fleming's 1995 doctoral research explored aspects of five midwifery relationships with regard to professionalisation based on partnership. Her analysis highlights the ways midwives in her study noted that an "… image of the authoritative professional was creeping into midwifery practice", and quotes one of her participants as saying; "…you've got to **look** competent…we've got to look professional, the whole idea is **looking**" (Fleming, 1995:147).

This participant saw partnership and 'looking professional' as in tension and argued that "…in order to achieve a true partnership this image of professionalism needs to be broken down…". Concerns that "…midwifery may come to be seen as elite and all-knowing in a way similar to that of the medical profession if steps are not taken to rectify this" (Fleming, 1995:148), were articulated by some of the participants in Fleming's study. In her research and later publications Fleming goes on to suggest that specific partnerships between midwives and the individual women for whom they provide midwifery care may not always draw on the politics of consumer involvement in the NZCOM. Fleming suggests that we should not assume that midwives' definitions of partnership necessarily reflect the understandings of their 'clients', and she has posed an alternative model of midwifery care based on the concepts of 'reciprocity and interdependence' (Fleming, 1995, 1998a, 1998b).

Skinner has also reflected on the ideal of partnership from the perspective of a midwifery practitioner and lecturer. She suggests that the growth of consumerism, choice and competition in health has led to individual relationships between women and midwives that may be characterised as those of 'individualist contractualism'. She suggests midwives are opening themselves to 'risk' when they may be operating from different paradigms than the women they care for. She uses an example of exposure to risk as something that may occur after an adverse birth outcome. She suggests that after a poor outcome, the mother may shift from an appreciation of what midwifery has been able to offer and analyse the situation from a medical patriarchal paradigm, "often with pressure from extended family and doctors" (Skinner, 1999:16). Further, Skinner suggests there are "inherent weaknesses when trying to apply partnership in feminist terms" because of a potential for lack of reciprocity in the relationship. This may occur if neither party is effectively politicised, or if either has different expectations from the other (Skinner, 1999:16). Skinner's argument is that partnership at a practice level "as a model for all does presume a homogenous population both willing and able to be partners"(Skinner, 1999:17). She questions whether this is a desirable model for the future, and suggests the use of alternative models.

Benn and Daellenbach both critique Skinner's suggestion that the partnership model only works if the women are 'white, articulate, educated, middle class' (Benn, 1999; Daellenbach, 1999b). Benn, an associate professor of midwifery, asks whether situations such as defaulting on or cancelling visits must constitute an end to the partnership because the woman is then

seen as 'non-compliant', suggesting that differences between the parties could exist instead as an opportunity for increased communication and negotiation between them. She states that, within partnerships where different expectations of each other have developed such that the midwife begins to feel anxious about litigation risks to her career that: "documentation is an essential action that will not necessarily reduce the incidence of, but rather the risks associated with, litigation and will provide some of the evidence needed to explain the actions or decisions taken" (Benn, 1999:19). She draws on understandings of the Treaty of Waitangi in terms of partnership as something dynamic and flexible, where equality is concerned with equity, and the midwife is not intended to have sovereignty over the woman (Benn, 1999:20).

Daellenbach's critique of Skinner's position draws on postmodern feminist thought and argues that we cannot discover one true meaning of partnership. She argues, however, that "definitions of partnership may need to be flexible to take account of different contexts, and that some ways of defining partnership may be less favourable than others" (Daellenbach, 1999b:22). Her suggestion is that partnership is something that may 'embrace mutual agreements', for example, about which decisions the woman may make, and those the midwife may make, during the time they are working together (Daellenbach, 1999b:23).

Pairman's masters thesis research focussed on refining the model of midwifery partnership (Pairman, 1998).[14] She documented the way six independent midwives and their clients mobilised the concept of 'professional friend' to describe aspects of their partnership/relationship. Aspects of the concepts of 'friend' and 'partnership' can be seen in the women's descriptions of their relationships (Pairman, 1998:10). Pairman argues that the partnership model is intended to be fluid rather than fixed, and that in recognition of this, each relationship between an individual woman and midwife will be different. She stresses that understandings of partnership develop as they are experienced in particular contexts with women, and that there is a "constant process of communication and negotiation" (Pairman,

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[14] The concepts of emancipation and empowerment, arising from 'challenging the medical model of birth' and 'developing midwifery knowledge' as a consequence of the partnership relationship were expanded on and added to the diagrammatic form of the original 1994 partnership model to demonstrate the dynamic nature of the relationship after Pairman explored the importance of these concepts to the participants in her research (Pairman, 1998; 1999).

1999:12). Pairman's project leaves the underpinning theoretical assumptions of the partnership model intact, while meanings within the model itself are circulated.

These 'differently-positioned' contesting voices pivot around, and subsequently reinforce, the prevailing NZCOM concept of partnership as something that defines midwifery as a professional process. The term is used in complex and contradictory ways that "have multiple, shifting and contextualised meanings" (Daellenbach, 1999b:22). On one hand, varieties of partnership are called upon in order to challenge and resist the central NZCOM definitions. On the other, this resistance in itself acts to discursively (re)produce and reinforce the concept of partnership as a model for practice through the responses of Guilliland and Pairman and others.

Calvert has noted the predominance of the partnership model regardless of the fact that the original model 'was not grounded in research', and despite the availability of alternative models of the relationship between birthing women and midwives (Calvert, 2002:135). Certainly, differences in philosophy rather than similarities between midwives appeared to be highlighted within the profession towards the later part of the 1990s, as Tully et al (1998) note. In a 1997 editorial for the NZCOM journal about midwifery as a 'people profession', Benn notes that despite the enormous positive changes and innovations since the 1990 Nurses Amendment Act, some reassessment of the profession based on partnership is warranted. She discusses interactions with midwives who are unhappy, critical of each other, or just "waiting for a lawsuit to be taken out" against them. In wondering if relationships and partnerships have moved to a business and competitive focus, Benn believes that midwives need to strengthen relationships with each other and to "start working with each other and not against each other" (Benn, 1997:4).

At the 2000 sixth national conference of the NZCOM, these differences between midwives were highlighted. Judi Strid issued a challenge from a consumer perspective at this conference to midwives when she reminded them that partnership was about "honouring the commitment to women to protect the birth process from medicalisation and to restore to women the confidence in birth and confidence in the role of the midwife to provide the best support without intervention unless needed" (Strid, 2000:2). In exhorting midwives to 'revitalise partnership' in the face of increasing interventions into birth, she reminded them

that "there were clear historical reasons for empowering midwives so as a profession they would be able to protect childbirth from being medicalised and enable women to take control of their own birth" (Strid, 2000:4). Strid's presentation and my personal communications with her formed the basis for some of the discussions I had with midwives during that period of my fieldwork.

Increasing interventions into birth (Banks, 2000b; Guilliland, 2000; Strid, 2000) and the uncertainty of homebirth in the future (Daellenbach, 2000; Donley, 2000) were also explored at this conference by different presenters. Guilliland noted the enormous complexities of the political, environmental and contextual factors in which the evidence of increasing interventions are embedded, particularly in the light of on-going major restructuring to maternity services. While acknowledging the positive influences for women of autonomous midwifery practice, she also asked midwives to consider the role they themselves may play in the high intervention rates. She questioned whether the MOH Section 88 referral guideline thresholds are too low, or whether "the politics of power and fear" are driving these outcomes of increasing intervention (Guilliland, 2000:5).

At the next NZCOM conference in 2002 there could be no doubt that increasing intervention rates were a source of (inter)national alarm (Bree, 2002; Guilliland, 2002a; Guilliland & Campbell, 2002; McAra-Couper, 2002; Savage, 2002). The theme of this conference was 'Diversity within Unity', and many midwifery professional successes were celebrated. My interest was particularly captured by those presentations that critically examined increasing interventions, complex consumer desires, inter/intra professional relationships, gender and technology, and the contested concepts of 'normality' and 'risk' (Bree, 2002; Davis, 2002; McAra-Couper, 2002; Skinner, 2002).

The theme of this conference, 'Diversity within Unity' resonates with the words of Spivak (1993). She stresses the importance of beginning to theorize 'difference' within a subaltern group, such as midwives. She suggests that there will be a historical and contextual critical moment when a mobilising sign such as that of 'women' begins to reap emancipatory success. At this point in time, she notes, the partial and particular interests invested in the sign must become 'scrupulously visible political interests' and its representatives engage in an on-going (de)constructive critique of the theoretical sign (Spivak, 1993). Midwifery can be seen to be at

this social and historical juncture in Aotearoa/New Zealand now. A certain success has developed from second-wave feminist investment in both signs 'woman' and 'midwife'. Together these signs form the slogan or 'essentialising masterword' (Spivak, 1993:3), of 'partnership', which might be usefully understood as a form of 'strategic essentialism'.

Many midwives and women have reaped and continue to reap certain emancipatory success on the basis of different forms of constantly evolving relationships. These are produced as 'partnership', within a discourse and language that precedes the individual midwife. She inherits the use of it, as part of a professionalising discursive repertoire. The repetition and pattern of its use constitutes her subjectivity as a midwife-in-partnership-with-women (Allen & Hardin, 1998). The effects of this are to make claims and counter-claims to certain knowledges about women and about midwifery. These counter/claims exist within the broad field of maternity service provision, or childbirth more generally, and function as relations of knowledge and power. The 2002 conference theme of 'diversity in unity' stressed the importance of avoiding a substantive or 'real essentialism' in the signs 'midwife' and 'woman' in Aotearoa/New Zealand. And at the same time as exploring the diversity of philosophies and practice styles of midwives, the analysis of many of the speakers at the conference suggested that there still remains a need for a certain 'strategic essentialism' – 'unity' - in order to maintain effective challenges to the institutionalised of birth (and see Fuss, 1989; Scott, 1991; Spivak, 1993).

Critiquing new ideals of health (and midwifery) professionalism

Critical perspectives on professionalising and/through 'empowerment'

The 'new professionalism' of many health-care professionals over the last two decades has established ideologies of 'partnership', 'empowerment' and 'patient participation' at many levels. These approaches have occurred in response to feminist and consumer-initiated critiques of traditional medical approaches; the midwifery renaissance in many countries has been a part of this. Health care systems are becoming increasingly complex postmodern systems, with a reliance on post-technological inventions, changing hierarchies and increasing competition (Spitzer, 1998:166). More recently, however, consumer participation within discourses of empowerment in health, presented as something always or essentially positive, is

under critical scrutiny (Davis, 2002; Gastaldo, 1997; Henderson & Peterson, 2002; Kirk & Glendinning, 1998; Lupton, 1995, 1997b).

Kirk and Glendinning have examined patient participation within the contexts of increasing consumerism and the de-institutionalisation of health care. They note that the concepts 'participation', 'collaboration', 'partnership' and 'involvement' are often used interchangeably in policy documents and nursing theories, for example, and appear unclear, shifting and ambiguous (Kirk & Glendinning, 1998). Within the literature there exist complex and contradictory meanings around partnership when it occurs as a relationship between a health care provider and consumer in the increasingly competitive and neo-liberal market place. Parkin has noted that the concepts of 'participation' and 'partnership' combine with the rise of consumerism to produce far-reaching implications for the professionalisation of health care. She focuses on 'functional deprofessionalisation' (Parkin, 1995), which occurs when an occupation begins to reverse its concerns with professionalisation and professional status and return to a service ideal. Paradoxically, increased concern with professionalisation by traditionally subordinated health disciplines, such as midwifery and nursing, can appear simultaneously. Midwifery (re)skilling via the taking up of medical/anaesthetic technologies plays an important role in this process, as I demonstrate in chapter five of the thesis.

In Britain the *Changing Childbirth* report of 1993 was intended to implement continuity of carer, choice and control in childbirth for women. Midwives were able to take up the opportunities afforded by this as a new professional project (Sandall, 1995). Sandall critically examines these professionalising processes in light of health policies and labour markets. She suggests that while some midwives are building on a feminist paradigm of woman-centred practice based on an equal partnership, for other midwives the result may be a divided work force consisting of an 'elite core and casualised periphery' depending on women's opportunities to engage in paid work (Sandall, 1995). She suggests that certain sets of power relations constrain the practice(s) of British midwives. These are the managerial relations within the National Health Service, inter-occupational relations between doctors and midwives, and intra-professional relations between different midwives themselves (Sandal, 1995). She also notes that professionalising projects of midwives in the late 1980s were successfully merged with both state and consumer interests in maternity care (Sandall, 1995).

Some critiques of the professionalisation of health (including childbirth) attend to the subtle ways in which the professions may act primarily to protect themselves, rather than the clients they serve. British nurses (Keleher & McInerney, 1998; Robinson, Gray, & Elkan, 1992), and some British and American midwives (Bradshaw & Bradshaw, 1997; Hunt & Symonds, 1996; Symon, 1996), have begun to critically examine professionalising processes whereby the person becoming empowered may be the professional, rather than the client. Wilson explores the everyday language used by midwives, such as 'professional' and 'client', suggesting that these terms underscore the nature of business relationships in a capitalist society (Wilson, 1999). She argues that it is time to "define midwifery beyond the scope of commerce" (Wilson, 1999:4).

Davis-Floyd notes that the 'commercialisation of childbirth' does not need to have negative connotations, if it means midwives, including homebirth midwives, are able to craft themselves creatively in the market-place with regard to meeting the desires of women in this way (Davis-Floyd, forthcoming). Tritten strongly opposes the professionalisation of midwifery if this is something that comes about via a knowledge base invested in medical skills such as procuring epidurals for women. She argues that the job of midwives is to 'first do no harm', and that as 'guardians of normal birth', midwifery conversations should be centered on women, not on our profession (Tritten, 2001:4). Hunter believes it is simplistic to assume that all midwives are woman-focused or that they have a philosophical commitment to client participation. She cites research into the interaction between midwives and women, such as that by Kirkham (1989), and Hunt and Symonds (1995), which provides challenging evidence of the ways in which midwives maintain control over the women in their care (Hunter, 1998:86). The ways in which midwives constrain or otherwise facilitate the 'choices' available to women have been similarly examined (Lazarus, 1997; Levy, 1999; Stapleton, Kirkham, & Thomas, 2002). Similar issues around these professionalising processes and individual practice(s) are also apparent in different ways in the narratives of some of the midwives I spoke to, and are explored in later chapters of this thesis.

'Partnership' and 'professional' are both concepts that have shifting, arbitrary, and not necessarily mutually inclusive meaning, as are the concepts of 'empowerment' and 'women-centred'. Indeed, not all pregnant women, nor all midwives, agree that professional status is something compatible with earlier feminist commitments for choices in childbirth, nor even a

desirable status. Symon goes further to question the desirability for midwives of attaining professional status at all. He contends that midwifery should not attempt to subordinate its 'female' qualities in an attempt to play men at their own game by trying to attain 'male status goals' such as the title professional (Symon, 1996:544). This is an approach that assumes a prior relationship between gender and particular characteristics such as 'detached' or 'empathetic'. Symon (interestingly, a male midwife), here reinforces the assumption that particular characteristics fit female midwives, such as empathy, and that these characteristics are not compatible with the status professional. He also suggests that interprofessional debates over childbirth may become an argument between midwives and doctors over who 'controls the woman' (Symon, 1996:546). This is a dynamic Guilliland and Pairman also wish to avoid, asserting: "instead of seeking to control childbirth, midwifery seeks to control midwifery, in order that women can control childbirth" (Guilliland and Pairman, 1995:29).

DeVries is possibly the most vociferous critic of professionalisation processes for midwifery. His arguments are based on the idea that modern professionals maintain their status as such in the construction, management, and emphasizing of 'risk' (DeVries, 1985, 1993, 1996). He claims that the role of midwives in childbirth is precisely a non-medical role, one where the qualities of the midwife may not be measurable (such as intuition, sensitivity; the arts of midwifery), and that legal recognition and professionalisation can act as a trap in different ways for midwives (DeVries, 1985). His later work (and work with others) focuses on the ways in which emphasising risk and then managing this with technological interventions will further compromise the traditional role of the midwife (DeVries, 1996; DeVries & Barroso, 1997; DeVries, Salvesen, Wiegers, & Williams, 2001), and is drawn on in chapters five and six of this thesis.

Bradshaw and Bradshaw suggest that factors other than increasing earnings or maintaining influence are involved in becoming professionalised, such as receiving recognition, respect, or achieving occupational maturity in the eyes of others involved in similar professions (Bradshaw & Bradshaw, 1997:24). Davies (1996) and Hartley (1997), both British midwives, similarly look critically at the notions of woman-centred and continuity of care as partnership ideals that can be upheld at all in neo-liberal market-place environments where midwives must continually work to (re)create midwifery as a cost-effective and autonomous profession.

Within recent patient/consumer-centred health discourses in Aotearoa/New Zealand broadly, Opie (1998; 2000), suggests that health professionals will need to pay analytical attention to how their discourses of empowerment and partnership actually work for users (consumers) of health practices. In Aotearoa/New Zealand, the subject 'woman' or 'patient' is now constructed as a 'client' or 'consumer', of health care in the competitive market place, and much is made of positioning this person centrally within the professional relationship. The focus of consumer discourse is to empower them in the health care choices they are making as experts in the knowledge of their own bodies and health; indeed the midwifery professional project of partnership can be seen as an exemplar of this liberatory discourse.

Grace has critiqued the concept of empowerment as it is applied within health promotion discourses. She suggests that there may be more controlling than empowering influences in the construction of healthy subjects as rational consumers able to make positive lifestyle choices (Grace, 1991). She argues that the use of concepts such as empowerment and enabling serve to act as if the professional is facilitating what is already there ('good health', or 'normal birth', for example). Grace draws on a notion of an 'absent, yet guiding professional' to raise questions about the assumption that those in an empowering professional role "do not have an a priori agenda" (Grace, 1991:331).

These critiques of empowerment as a concept in recent professionalising discourses within health resonate with Strid's earlier plea regarding midwifery professionalising through partnership, "Consumer support can be a powerful force but such a force is only mobilised by those who are prepared to serve the interests of the consumer rather than the profession concerned" (Strid, 1991:8). The difficulties of such a position for midwives are noted by Kirkham, who suggests that midwives' aspirations to professional status mean that their allegiance necessarily must lie with the professional body concerned, rather than with clients (Kirkham, 1999). How do different midwives in Aotearoa/New Zealand work out these professional issues in practice? In the next and final section to this chapter I briefly introduce the work of theorists influenced by Foucault who argue that various professional discourses govern professional conduct 'from a distance'. These theoretical concepts are key to my analysis, and will be drawn on throughout the thesis. I make use of their explanations of the ways subjects become self-governing within certain fields of knowledge and produce expert truth claims within rationalities of neo-liberalism.

Foucauldian perspectives on professionalisation in health: the 'liberal' professions

Sociologists argue now that even everyday health is becoming medicalised (see, for example, Petersen, 1997; Purdy & Banks, 2001). This logically extends to the monitoring of the risk for potential illness. Armstrong refers to these processes as part of the rise of 'surveillance medicine' (Armstrong, 2001). Armstrong addresses surveillance medicine in general as the extension of a medical eye over all the population. In this, the 'dissemination of intervention' blurs the distinction between health and illness, and between the normal and the pathological (Armstrong, in Purdy & Banks, 2001:147-8). Arney addresses this specifically in regard to the professionalising project of obstetrics. He documents the changing ways in which the profession of obstetrics gained subtle control over the domain of childbirth with a shift from confinement, to surveillance and monitoring after the Second World War (Arney, 1982).

Rose explains the role of professionals in neo-liberal societies as those who administer to the regulated choices of individual citizens. Professionals are relocated within "a market governed by the rationalities of competition, accountability, and consumer demand" (Rose, 1993:285). Osbourne says, of his idea of a 'liberal profession', that this is one which "seeks to establish grounds of responsibility both within itself, as a profession, and to its constituency without seeking to govern either professionals or their clients in a straightforwardly directive, or 'sovereign' manner" (Osbourne, 1993:346). Those subjects appealing to professional guidance are constructed as doing so freely and of their own accord; they are interested in having healthier lifestyles, happier homes and 'better babies'. Fournier argues that in this way "Liberalism involves a network of diverse techniques and practices through which the governed are constituted as autonomous subjects and are encouraged to exercise their freedom in appropriate ways" (Fournier, 1999:283). Arney, Fournier, Rose, and Osbourne are all useful to my analysis in the thesis, which draws on Foucault's theories of governmentality (Foucault, 1979, 1986). These issues are further explained in the following chapter.

This chapter has attempted to show how the midwifery professionalising project in Aotearoa/New Zealand has its origins in participatory discourses of empowerment which assumes that women, rather than midwives or midwifery, can access their own potential to control the birth process. Midwives control midwifery as a profession, striving not to control childbirth per se, trusting that women will be the experts in the knowledge and control of their own bodies and childbirth. In this chapter I have also introduced key theorists whose work

will be drawn on in subsequent chapters. In attempting to explore these issues critically, I analyse the ways in which midwives are amenable to forms of governance. These include various 'technologies of the self' deployed by midwives as they provide an environment of partnership with women so that women may govern themselves in childbirth. It is the notion of governmentality which is the thread of analysis throughout the thesis. The next chapter further explores the theoretical concepts of governmentality, neo-liberalism and the discourses of risk, restraint and responsibility within which midwives labour.

2

Chapter Two

Foucault and feminism: governing labouring bodies in discourses of risk, responsibility and restraint

> While I was in hospital my midwife came to see me and said the midwives'
> [professional body] had rung her and advised her against caring for me as she'd
> probably get blacklisted and it would ruin her career. I thought this was all about
> looking after the baby, that's what everyone is up in arms about and all
> concerned about, the baby, you know, yet they have the right to stop all that,
> you know, for midwives to pull out on me. ('Nikki', interview on '60 Minutes',
> TV1, 14/11/02)

In this thesis, the home, the labour ward, rural maternity hospitals, and a birthing centre are all sites for an analysis of the ways in which labouring bodies are amenable to various forms of governance. In these spaces, midwifery exists theoretically and discursively as well as practically. Midwifery, particularly as a feminist profession, provides scope for an analysis of the ways in which new subjectivities may be created. The enterprise of midwifery is presented in different articulations of the ways midwives conduct "their prime responsibility [which] is in providing the environment for women to realize their own potential" (Guilliland, 1993:6). According to midwifery leaders, this potential is realized when women are able to have 'choice, continuity and control' in childbirth (Sandall, 1995). These concepts are upheld by midwives as empowering for women, vis-à-vis those of imposition, fragmentation, and chaos, which are considered disempowering. In this undertaking, the 'labours' of pregnant/birthing women are nested within the 'labour' of midwives, in turn conducted through the discourses and practices of the profession to which they belong.

The previous chapter outlined the ways in which the development of feminist discourses of choice and empowerment shaped the interests of midwifery during its professionalising project. Chapters four to seven will each contain a discursive exploration of situations which arise out of the convergence of these interests within neo-liberal relations of power. I will explore interactions between 'differently-positioned' midwives and the women with whom they work in partnership. Each situation illustrates the capillary networks of knowledge/power in which the discourses and practices of contemporary midwives are embedded. The

theoretical threads that integrate the analysis in these chapters draw on Foucault's problematising of the 'arts of government' or governmentality (Foucault, 1979). This chapter explores the relevance of governmentality for the praxis of partnership. The discussion necessarily includes the ways some feminist theorists draw on Foucault's theories of discourse, knowledge and power. Gastaldo notes that:

> The issue of participation is a double-edged sword: it can mean both empowerment and control…. Rather than prescriptive norms of conduct, 'normality' should be constructed in a participatory way. The process of normalisation occurs through the creation of norms and, instead of concentrating on professional's views, in a participatory approach the users themselves create norms and make comparisons based on these norms. (Gastaldo, 1997:120)

In this way Gastaldo echoes Grace (1991), quoted in the previous chapter's brief description of critiques of empowerment. Some midwives asked other midwives at the 2002 NZCOM conference: "If our model of midwifery in New Zealand is so good why are the caesarean section and intervention rates still going up?" (Earl, Gibson, Isa, McAra-Couper, McGregor, & Thwaites, 2002:32). This question reflects Gastaldo's concern that participation is a double-edged sword. What are the unintended consequences of a midwifery profession based on partnership with women as consumers? What forms of normality are constructed and authorised by the users/consumers of midwifery in this participatory/partnership approach? In exploring these issues I begin by foregrounding Larner's 1998 approaches to neo-liberalism, which then warrant my later focus on midwifery subjectivities which are constructed through discourses of risk, responsibility, and restraint. In this way I aim to provide the context for exploring some of the ways in which new midwifery subjectivities are constructed in response to the participation of women as consumers/partners in childbirth.

Approaches to neo-liberalism

Larner's discussions of sociological approaches to neo-liberalism argue that one cannot talk simply about neo-liberalism as a self-evident phenomenon. Instead, she argues that it is a highly complex process in the re-structuring of the previously welfare-orientated state, and that there are differing ways of theorising and understanding neo-liberalism. In this she draws on neo-Foucauldian writers such as Rose (1993; 1994; 1996), to argue for complex and non-totalising understandings of post-social welfarism. Her suggestion is that analyses begun from

specific neo-liberal projects, and from the perspective of 'oppositional accounts' may avoid generalizing accounts of certain historical epochs (Larner, 1998b, 1998a). Larner wonders why "…despite its origins in Foucauldian formulations, remarkably few of these analyses draw from the discourses of oppositional groups as well as those of hegemonic groups" (Larner, 1998b:13). However she credits Fougere's research on the health sector as an exemplar analysis of the ways in which the new 'hybrid' health system is less the result of design from above than 'skilful improvisation' from below (see Fougere, 2001). This thesis attempts to begin analysis from the points of the 'messy actualities' of professional midwifery as a specific neo-liberal project (Larner, 1998b:5). I begin this chapter by outlining the major theoretical frameworks I will draw on as I discuss the ethnographic and interview material used for this purpose.

In distinguishing different theorists of the sociologies of neo-liberalism, Larner suggests that they understand neo-liberalism either as a policy framework, or as an ideology, or in terms of governmentality (Larner, 1998b:5). She states that the most common conceptualisation is the first mentioned above: neo-liberalism as a policy framework. This policy framework provides for an understanding of neo-liberalism as resting on five key values, according to Belsey: "the individual, freedom of choice, market security, laissez faire, and minimal government" (Belsey, 1986, in Larner, 1998b:6). These values, together with an emphasis on managerialism, provide the theoretical impetus for 'deregulation and privatisation'.

Larner suggests that neo-liberalism is analysed as an ideology most frequently by Gramscian theorists, such as Hall and Jensen. Larner reiterates three aspects of Hall's analysis that exemplify this approach for her: "…first, that neo-liberalism is not simply a system of ideas, nor a lurch to the Right in the formulation of policy agendas; second, that power is not constituted and exercised exclusively on the terrain of the state; third, that hegemony is achieved only through an ongoing process of contestation and struggle" (Larner, 1998b:9). Larner goes on to say that neo-Gramscian approaches have also led to innovative socialist-feminist accounts of state re-structuring, such as in the work of Brodie, who stresses that new understandings of gender relations contribute to the complex matrix of discursive constructions and reconstructions of new state forms (Brodie, 1996b, in Larner, 1998b:9).

Larner also mentions Yeatman's work, which makes visible and explores the claims of those cast as 'victims' of state restructuring. Feminist analyses of neo-liberalism as ideology "…explore the notion that power is productive; that the articulations between hegemonic and oppositional claims give rise to new political subjectivities and social identities which then enter into the 'discourse of restructuring' (Yeatman, 1990, in Larner, 1998b:10). In this sense, applying a lens of ideology rather than policy is more useful for feminist analyses of neo-liberalism that explore the shaping of political programmes and individual subjectivities. There is some overlap, and 'only a short step' to the final sociological approach to neo-liberalism that Larner outlines; those which deploy theories of 'governmentality' (Larner, 1998b:8). This theoretical concept, key to my thesis, is developed more fully below and as I apply it to the profession of midwifery, before discussing the use and relevance of other Foucauldian theories to midwifery.

Neo-liberalism as governmentality: 'from a distance'

Larner argues that approaches to neo-liberalism that focus on governmentality signal a theoretical shift from ideology, as outlined above, to theories of discourse, and hence "from Gramsci to Foucault, and from neo-Marxism to poststructuralism" (Larner 1998b:10). This involves attention to the ways in which various authorities and agencies seek to shape the capacities of subjects, and their possible fields of action in certain ways, drawing on Foucault's later theories of power, truth and the self, and his lecture entitled 'Governmentality'. In this lecture, Foucault explored what he called the 'problematic of government' from the sixteenth century onwards. He was interested in the arts of how best to govern oneself, various 'souls and lives', children, the state; all subjects and 'things' assembled within a territory and which have a relationship between them (Foucault, 1979). He was concerned with problematising the 'governmentalization of the state', the latter of which is only knowable through the apparatuses and technologies of the former. Of importance to neo-Foucauldian analysts in the field of medicine/health are the ways in which specific techniques and tactics of the state produce problems of the 'population'. The population, the family and the economy, all interconnected, required various arts of government which must be considered outside the earlier juridical methods of sovereignty (Foucault, 1979).

Rose makes a distinction between 'advanced liberalism' as governmentality and 'neo-liberalism' as a political ideology (Rose, 1993). At its broadest, those neo-Foucauldian writers concerned with governmentality under neo-liberalism or advanced liberalism (within neo-liberal democratic political rationalities), consider it as 'the conduct of conduct' (Bunton & Petersen, 1997; Burchell, 1996; Lupton, 1999a; Osbourne, 1993; Rose, 1993, 1999). Conducting oneself by/and influencing the field of conduct of another, is undertaken in the process of producing claims to knowledge about the self and/or other(s), what is 'normal', or 'moral', for example, and what is not. It is concerned with the construction of populations and of individual subjectivities. It is therefore inextricably bound up in the production of expert knowledges and claims to the truth of things, in productive networks of power.

Rose (1996), suggests there are some important characteristics of forms of governance within advanced forms of neo-liberalism. These encompass the domain of health. There are new relationships between expertise and politics, such as increasing expert conceptions of health (as opposed to illness), auditing, marketisation, purchaser-provider splits and risk lists. Newly-pluralized 'social technologies' supplant older norms, such as service and dedication, with those of enterprise, competition, quality and customer demand, and effect reconfigured networks and flows of accountability and responsibility. Rose states that these processes of knowledge/power bring about new subjectivities such as the empowered client, the customer, or the consumer of health. This citizen will maximize their quality of life through acts of choice, "according their life a meaning and value to the extent it can be rationalized as the outcome of choices made" (Rose, 1996:57). These neo-liberal relations of governance in health are key to the contextual background of midwifery's professionalising project.

Within his discussion of Foucault's approaches, Rose states that to govern in an advanced liberal way is to adopt "a range of devices that seek to recreate the distance between the decisions of formal political institutions and other social actors, and to act upon these actors in new ways, through shaping and utilizing their freedom" (Rose, 1993:295). In Aotearoa/New Zealand, these processes have sometimes been referred to as rolling back the state (see Ashton, 1999; Durie, 1998; Fougere, 1993; Fougere, 1994a, 2001; Krieble, 2000; Larner, 1997). The concept of 'freedom' is integral to theories of governmentality, whether in discussions of consumer 'choice' or professional 'autonomy'. Theories of governmentality stress the ways agencies are now governed not from above, but 'from below', 'from a distance', or in a

'flattening out' of previous hierarchies through technologies such as budget disciplines, accountancy and audit (Power, 1994; Rose, 1994, 1999). In a similar way, Fournier explores the techniques contained within the (post)modern professions that subscribe to a discourse of 'autonomy'. She suggests that this acts as a disciplinary logic which inscribes: "…autonomous professional practice within a network of accountability and governs professional conduct at a distance" (Fournier, 1999:280). This is actualised through discourses of autonomous but responsible employee behaviour, and practices such as auditing and performance reviews.

Foucault referred to the ethics and aesthetics involved in the self-creation of the individual subject as 'technologies of the self' (Foucault, 1986). The individual undertaking of practices of self-discipline can include, for example: reflection, meditation, abstinence, examining conscience, and listening to others. These are seen as voluntary, self-imposed rules for the conduct, betterment and development of the self (Starkey & McKinlay, 1998:235). In the field of health, these may be constituted by attention to the self-development of a healthy lifestyle through discourses of self-help and the monitoring of one's healthy behaviour (see Gastaldo, 1997; Grace, 1991). In what Rose (1993) calls a 'reversibility of relations' of authority, citizens may repossess norms, previously imposed on them from above, and rework them as demands to be made of experts (Rose, 1993:296; and see Gastaldo, 1997).

The governing of the 'free' self, or the 'autonomous' professional occurs as both/either health consumer and professional subjects willingly take up technologies of the self in the production of new 'healthy', 'empowered', or 'professional' subjectivities as the case may be (Fox, 1993; 1999; Rose, 1994). This occurs in a context whereby subjects within neo-liberalism are engaged in a "permanent problematisation of the limits of government" (Dean, 1994:195). Dean considers Foucault's problematising of government a "novel thought-space across the domains of ethics and politics" whereby practices of the self and practices of government are woven together without reducing one to the other (Dean 1994:174). Foucault considered these issues as a double problematic of state centralization, on the one hand, and dispersal and dissidence on the other (Foucault, 1979).

Examples of the practices of government and the self are seen within new discourses of competition and consumer demand. These re-specify the citizen as an active agent able to make autonomous and appropriate choices in health, rather than requiring the impositions of

state-run departments and services that 'know best' what is needed in the treatment of disease. Analysing this in terms of governance means to explore the practices of the self, other actors, and of government. Larner draws on the work of Dean in discussing the ways in which neo-liberal strategies of rule are found in diverse realms such as workplaces, health and education institutions. As citizens, we are encouraged to see ourselves as active subjects with a responsibility for our own well-being in which we are encouraged to work on or improve ourselves in a range of domains. These domains include what Dean calls the 'counter cultural movements', or those domains outside traditional rationalities (Dean, 1994).

Dean's analysis demonstrates the ways in which subjects can take up positions intended as counter-hegemonic and hence liberating, but which may ultimately become (invisibly) constraining. This is because neo-liberal governance is an outcome of the practices and technologies of self-monitoring and surveillance rather than overt domination. In these and other ways, social actors including individuals, agencies, and the 'new professionals'[15] become amenable to forms of governance 'from a distance', within the context of neo-liberal approaches to health (Dean, 1994; Grimshaw, 1993; Jones & Porter, 1994; and see Rose, 1994).

Technologies of the midwife/self in the practices of freedom

Abel, a midwife in Aotearoa/New Zealand, has analysed health policy and the changes to midwifery and maternity services in Auckland from 1990 to 1996 in her doctoral thesis (Abel, 1997).[16] Her approach combines an analysis of neo-liberalism (with its potentials and pitfalls for midwifery) as a policy framework, and as governmentality. While Larner cautions against the privileging of government policy documents and official discourses, these documents are highlighted in Abel's thesis. However, she thoroughly explores the struggles against and negotiations with the state that were articulated by midwives and by consumers during this period of health sector restructuring. She focuses on specific restructuring policies and

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[15] 'New professionals' include those not previously thought of as professionals, such as homeopaths and chiropractors and others who have re-crafted themselves as complementary rather than alternative health practitioners, (as well as now secretaries, restaurant staff, security staff and so on) (Fournier, 1999).

[16] 1990 heralded the Nurses Amendment Act and hence midwifery autonomy from medicine and nursing; 1996 saw the instigation of the LMC system. The significance of these processes are discussed in chapter one of my thesis, and see also Guilliland (1997; 1998a; 1999; 2000; 2002a) as well as Abel (1997).

negotiations at the legislative level, and concludes by suggesting that there will be profound implications for midwives who are re-cast as professionals in the on-going governance of the population. My interest in her thesis lies not so much in her attention to policy and legislation, but in her argument that midwives, through their struggles for professional autonomy, are implicated in the professional role of 'governing agent' (Abel, 1997:270). She suggests that the new maternity arrangements enhance the potential for the governance of the population through the collection of data. This includes, for example, the allocation of a 'National Health Index number' entered into a national database (Abel, 1997:270).

The significance of these practices for midwives, according to Abel, is that, while ostensibly the planning, improvement and provision of maternity services derived from the national perinatal database is seen as constructive and positive, the scope for the ways in which the database may effect forms of governance is considerable (Abel, 1997:270). Further, she says: "In addition, the criteria for referral to secondary care, while intended to ensure a safe service, has the potential to prescribe and limit care options available to women" (Abel, 1997:270). These criteria are now refined as 'guidelines' and are set out in the MOH Section 88 document, defining three levels of referral and 'consequent action' (Ministry of Health, 2002). The complex negotiation of these guidelines was referred to by many midwives in their discussions with me, and has contributed to my analysis of the ways in which midwives negotiate both discursive and real spaces of risk/safety through rigorous practices of self-surveillance and monitoring particularly during situations of referral, transfer and 'handing over' (see chapters six and seven of this thesis).

Abel concludes her thesis by noting the many perceived benefits of monitoring professional practice, such as being flexible and consumer-focussed. The paradoxes she points out are those whereby the providers are "increasingly under the surveillance of the state or a regional bureaucracy which has leverage over them because it holds the purse strings…. in short, in the process of ensuring services are safe and meet the needs of women, the means for further governance are established" (Abel, 1997:271-2). Her analysis, with regard to midwives in this case, resounds with Osbourne's observations that in seeking to empower patients, neo-liberalism does not aim to disempower doctors, but rather inscribes a new form of medical government by which doctors are enrolled alongside managers "as something of administrators and economists themselves" (Osbourne, 1993:353). Osbourne continues: "All

the repertoires of 'quality initiatives', 'audit' and 'decision analyses' that now pervade the Health Service also testify to this overlap between clinical and economico-administrative functions" (Osbourne, 1993:353).

The effects of these processes with regard to the maternity services in Aotearoa/New Zealand are noted by Abel, who states that midwives are now implicated in these procedures whereby economic factors place constraints on clinical practice decisions, and hence "the provider carries the financial risk and the incentive is to adapt one's practice in order to contain costs" (Abel, 1997:272). Midwives who contract to provide primary maternity services must be accountable to the MOH both clinically and financially under the 'service specifications and quality requirements' of what is now known as Section 88 (Ministry of Health, 2002). The devolution of the maternity services to local District Health Boards (DHBs) and Primary Health Organisations (PHOs) within the DHBs is an example of the ways in which midwifery professional practice interests may become subject to new forms of bureaucratic control in the contractual domain, as Abel foresaw, and Guilliland also cautioned midwives about at the recent NZCOM conference (Guilliland, 2002b).

In this thesis I take up certain lines of inquiry identified by Abel. Rather than a focus on neo-liberal health reform policy and legislation, I begin my analysis with the accounts midwives themselves produced in our discussions at particular sites of practice. Larner might refer to these as oppositional accounts, offered by midwives engaged with women in the context of changing maternity policy. I argue that medical dominance in the field of childbirth is no longer maintained by the direct – sovereign - control of the state or medicine over midwives and/or over women. Rather, I suggest that multiple and proliferating discourses of risk in childbirth intersect with discourses of consumer responsibility and participation. The intersections of these fields of knowledge, for example as midwives respond to risk by developing tools for risk management, create ever new norms in 'normal childbirth', and contribute to the disciplinary normalisation involved in the governance of midwifery.

Constructing oneself as a midwife in terms of accountability and 'auditability' (the practices of disciplinary autonomy) was a frequent theme in the fieldnotes and interview transcripts. Being an 'autonomous professional' requires that one's conduct is developed through a logic of competency - practices such as maintaining a professional portfolio, or attending standards

review, that are embraced by responsible professionals. As Fournier states, once a discourse of professionalism pervades organisational life, it is difficult for those involved not to align themselves with it, since no one wants to be marked as 'unprofessional' (Fournier, 1999:304). This does not mean that spaces for resistance are closed off, however, they are not. These resistant spaces are also sites for analysis in my thesis. Some of the ways in which midwives negotiate obstetric consultations, relationships with mentors, or hand over care to another LMC, are analysed as 'governing interfaces' (Burchell, 1996). These sites are where relations of power produce knowledges about childbirth. Some of these knowledges become authoritative, and herald the 'truth'; others become sublimated. All are open to contestation.

As new professionals who are experts in the management of 'normal' childbirth, who trust that women have expert knowledge of and responsibility for their own bodies and birthing processes, midwives and pregnant/birthing bodies are increasingly amenable to governance from a distance (Fournier, 1999). The vision of midwives is to facilitate women in reaching their birthing potential through the provision of an appropriate environment. This leads to a flattening out of the more traditional and hierarchical role claimed by professionals who seek sovereign power over their clients. Midwifery can be seen in this way as a 'liberal profession' (Osbourne, 1993). This is one which, alternatively, seeks self responsibility both for itself as a profession, and as a goal fostered in its client group; indeed midwives act specifically to foster sovereignty in their client group (see Guilliland, 1993; Guilliland & Pairman, 1995; Osbourne, 1993). The belief that consumers hold responsibility for their own health, and will act in their best interests to maximise this through acts of choice, sanctions a market approach to health. The ways in which the market place governs midwifery practice is the subject of chapter four. These issues have implications for midwifery as a feminist profession, but also for women seeking freedom to choose their own childbirth practices, at a historical point where feminists are concerned generally with issues of liberation and constraint (see Grimshaw, 1993). Analyses of governmentality highlight the ways in which people, in believing we are free subjects, conduct ourselves, in/directly influencing the possible fields of action for other free subjects. I move on now to discuss other Foucauldian theories from which my analyses are drawn.

'Discourse': analysing regimes of truth

Theoretical approaches that utilise theories of governmentality usually incorporate a poststructural focus on theories of discourse. This section outlines my Foucauldian-based approach to discourses as specific bodies of knowledge, which contain statements and concepts. According to Foucault, a discourse as a body of knowledge will contain all the possible statements about what can be known, written, or said about a thing (Foucault, 1972). Speaking positions and spokespersons are created within the discourse. Discourses contain objects and subjects, statements and concepts. Certain elements (concepts, relationships) have their existence in and through their relationships within the discourse that they constitute (Foucault, 1972). On this analysis, concepts, such as gender, or partnership, do not exist prior to the discourses which come to authorise them.

Foucault therefore had a critical (rather than traditional or linguistic) approach to discourses and their analyses. His approach demonstrates the: "historically specific relations between disciplines (defined as bodies of knowledge) and disciplinary practices (forms of social control and social possibility)" (McHoul & Grace, 1997:26). His concept of an 'archival' analysis is distinct from that of analysing a collection of empirical data. It is not so much analysing a collection of texts (transcribed interviews, for example), as analysing the form of organisation of the parts of a discourse: its statements (McHoul and Grace, 1997:37).

For Foucault, 'statements' are highly functional, and not only verbal - they are techniques for the production of subjects and objects and functioning of institutions, and always within relations of power (Foucault, 1972; Parker & Burman, 1993). They may include maps, tables, graphs or diagrams. Statements, according to Foucault, operate vertically in relation to others and can only be understood via the rules of formation which govern their functioning. These are not grammatical rules, but rules for what it is possible to know and produce as truth within historically variable bodies of knowledge. In other words, statements function in relation to power by constraining and enabling what it is we can know – and hence can think and say – about a given situation. 'Concepts' within discourses do not exist independently of the conditions which authorised them, or of the conditions which they come to authorise. They always exist embedded within discourse, at the level of discourse itself. For Foucault, the formation of concepts is the result of neither individual work nor collective customs, but of

something which is operational through all individuals who undertake to speak in a particular discursive field. He suggests that the rules which regulate the coexistence of concepts must be analysed at the level of the preconceptual, that is, at the level of discourse itself (Foucault, 1972:60-3).

One of Foucault's contributions noted by feminist analysts of health has been to have "shifted the discussion of power away from properties of classes and individuals to ways of saying and knowing" (Miller, 2000:316). Foucault argued that it matters not who speaks, but rather more what is said (McHoul & Grace, 1997). What can be known, what can be said, the statements that can be made about midwifery by midwives at this particular historical time in Aotearoa/New Zealand is what interests me here, as well as the ways in which discourse analysis can examine how power relations and the co-extensive relationship of power to knowledge are constituted through language. What kind of statements exist or can be made, with what effects and which repercussions? Which statements count as true and which as false? How can midwives (including myself) think/speak/write of midwifery?

An archival approach deprives us of continuity by showing that subjects are "fragmented and changing *sites* across which the flows of power move" within a political field and according to the rules of that specific discursive formation (McHoul and Grace, 1997:41; italics in original). Foucault cautions against searching for original foundations (to thought, or concepts), or indeed an original founder/actual person. He believed a progressive politics would work against these linear ideas, and would seek discontinuities, recognise the historical contingencies of a practice, and pluralize any idea of a single system of thought (McHoul and Grace, 1997:44-5). McHoul and Grace summarize Foucault's approach to discourses and their analysis thus: "what connects discourses - and their analysis - with politics is the whole field of *power* and the position it generates for *subjects*" (McHoul and Grace, 1997:57).

The many different types of discourse analysis may or may not hold any particular allegiance to Foucault's work (Burman, 1996; Jaworski & Coupland, 1999), and may include feminist and/or critical discourse analysis (Allen & Hardin, 1998; Gavey, 1989; Grace, 1998; Lupton, 1992; Miller, 2000; Parker & Burman, 1993). Miller describes a common premise and an approach to the analysis of discourse that I use:

> the fundamental premise of discourse analysis…is that language constitutes rather than reflects reality, and that speakers use talk strategically to accomplish their purposes in particular settings….language is a 'claims-making' enterprise….in the specific sense of an account or story which is designed to further some practical goal. Accordingly, such claims are political and moral, not empirical. (Miller, 2000:317)

A recent rise in the critical analysis of discourses as a methodology, according to Jaworski and Coupland, is because "language takes on greater significance in the worlds of providing and consuming services" (Jaworski and Coupland, 1999:5). Midwifery can be seen as a professional service that contains providers and consumers as well as other actors, so an analysis that focuses on language as a means for making claims within discourses of providing and consuming is relevant here. I am interested in "exposing or deconstructing the social practices which constitute 'social structure'" (Jaworski & Coupland, 1999:6). This approach enhances our understanding of language as a performance or practice, as something inherited, and which precedes the individual. It functions to (re)constitute subjectivity (by a subject repeating particular patterns such as gender orientation), and is produced and reproduced through its use (Allen & Hardin, 1998; Butler, 1996).

The study of discourse can be seen as interdisciplinary and always focuses on, but goes well beyond, language in action. One of my central assumptions is that language works to construct what we refer to as 'reality' and inscribe it in use and action, and always within relations of power (Gavey, 1989; Lupton, 1992; Weedon, 1987). Hence my analysis does not search for the 'truth' reflected in the texts of my interviews with midwives. I approach them as certain sets of statements which function politically in terms of (re)producing professional claims, and contesting those made by others. I am interested in what is produced through their statements and claims to their professional knowledge. For example, in chapter five, I explore the ways midwives use predominant midwifery discourses in different ways and at different times to constitute their subjectivities as professional midwives with complex relationships to birthing technologies.

The insights I draw on will reflect Foucault's theories of discourse, as well as other understandings from neo-Foucauldian and Foucauldian-feminist analysts. Foucault himself refused theoretical (and other) labels, exploring instead the actions that constitute, or effect, an identity. This methodological/theoretical approach deliberately challenges any idea of assumed

ontological integrity, or of a subject ('female', or 'midwife', or 'researcher') that exists prior to its articulation in language, discourse and the law (see Butler, 1990). This means that I am interested in the conditions which came to produce and authorise the concept of partnership. Which subjects can speak about it, and when? What claims are made about it? Which institutions give/are given authority by it? What challenges it?

Midwives in Aotearoa/New Zealand have undertaken analyses based on the identification of discourses in their Foucauldian approaches to knowledge, power and the constitution of the subject (Davis, 2002; McLaughlan, 1997; Payne, 2002). McLaughlan's (1997) master's thesis noted that there are predominantly two available discourses of birthing, either the 'medical' or the 'natural'. While the medical discourse prevails during the pregnancy and birth of the first baby for women, this also provided a potential point of resistance for subsequent births. She argued that where women receive continuity of care, the "…docile body is replaced with a more self-determining possibility" (McLaughlan, 1997:134).

McLaughlan suggested that midwives may be positioned in either discourse, or may also be 'straddling the two' in different times, and at different places of work (McLaughlan, 1997). McLaughlan also described the ways in which discursive relations 'transform and mutate'. She described here the ways the earlier marginalized discourse of 'natural birth' was susceptible to incursion by medical discourse, such that after 1971 and prior to 1990 a doctor was required at all births – even those at home (McLaughlan, 1997:133). She noted that for women in her study, subjectivities were produced precisely through the vagaries of these discourses and their transmutations. Social discourses available to women in a given culture at a given time, such as those identified by McLaughlan, will provide subject positions, constitute our subjectivities, and reproduce or challenge existing gendered relations (and see Gavey, 1989; Jaworski & Coupland, 1999; Wetherell, Taylor, & Yates, 2001).

Another midwife in Aotearoa/New Zealand who has found a Foucauldian form of discourse analysis useful is Payne (2002), who explores in her doctoral thesis the ways in which women over the age of 35 having babies may be constituted as 'elderly primigravidas'. She shows how the discursive object elderly primigravida emerges and is named or judged to exist within certain social and historical contexts (Payne, 2002). Payne's analysis recognises maternal age as a shifting, historical and social construction that complicates pregnancy and birth for women

and practitioners. Rather than examining the texts for a meta-narrative, a shared meaning across the texts, her Foucauldian-based analysis brought to light their contradictions, complexities, contests and diversities. In particular, she foregrounds the multiple and contested meanings of maternal age, birth, motherhood, prenatal genetic diagnosis and disability and the complexities that ensue from this (Payne 2002).

According to Payne, women's decisions regarding place of birth and caregiver, their responses to prenatal genetic diagnosis, and the practices of maternity practitioners revealed a complexity of discursive subject and power positions. Her analysis interprets women's resistances as 'strategies of elusion' or acts of power. Some women and practitioners actively attempt to resist the scientific medical and medical genetics discourses' technologies of power by drawing on contesting discourses (Payne 2002). Payne's analysis demonstrates the formation of particular subjects at particular historical times and places, how institutions attempt to normalise persons on the margins of social life, and how conditions of knowledge come to change and vary (McHoul and Grace, 1997:41). Like McLaughlan, Payne distinguishes between the meta-discourses of the midwifery or 'natural' and the medical approach to birthing. Both Payne and McLaughlan demonstrate the ways in which certain knowledges produced about various women position them within networks of power, and as particular subjects. My interest is in the ways some midwives I spoke to worked discursively and practically to disrupt the boundaries between obstetrics/midwifery, normal/abnormal in creating professional midwifery selves as flexible, adaptable and competent subjects.

Subjects of knowledge/power

Particularly helpful to any analysis of institutions involved in the practical goals of the regulation and monitoring of bodies, whether in medicine, health, or childbirth, is the idea of power as a capillary network, within which subjects of knowledge are embedded. The Foucauldian 'microphysics' of power involves the subtle and multiply directional relations between specific individuals (Faubion, 1994; Foucault, 1977, 1979). Foucault visualized this as a network of power relations whereby various strategies were always at play in order to counteract and contest other forms of knowledge. Social actors in various relationships within this capillary network can be said to be interacting at what Purkis refers to as a 'governing interface' (Purkis, 2001).

In the fieldwork and interviews for this project, for example, I analysed interfaces in different sites wherever a midwife interacted with others; attending a birthing woman, including the other social and technological actors present in the field; or as she consults with an obstetrician, or hands over to core staff, or attends Standards Review or practice workshops. Within this discursive field of knowledge (*savoir*), are contained the statements (*connaissances*), concepts, objects, subjects, instruments, technologies, and institutions necessary to maintain or contest power with another. Importantly, knowledge as well as power is dispersed across this field; it is not held in one specific statement or technology (see Faubion, 1994; Foucault, 1977; Gutting, 1994).

Foucault documents the relationship between seeing, saying and knowing in his histories of medical and disciplinary power during the period of the Enlightenment. He analysed the development of methods for the surveillance and 'disciplinary normalization' of particular populations by drawing on Bentham's architectural plan of the 'panoptican' (Foucault, 1973, 1977; Gutting, 1994). Foucault describes a spatial shift which altered certain relations of visibility and power. This spatial shift was a change from a wide public visibility, directed towards a point of spectacle as a display of power (within an auditorium, at the stake or the hanging gallows), to the outwardly dispersed visibility of large parts of the population. For example, he documents the ways in which rigorous methods of surveillance began during the plague, when those charged with functions of inspection were to constantly monitor every person remaining enclosed in their home, while others dealt with the removal of the dead. This surveillance was:

> based on a system of permanent registration: reports from the syndics to the intendants, from the intendants to the magistrates or mayor. At the beginning of the 'lock-up' the role of each of the inhabitants of the town is laid down, one by one; this document bears 'the name, age, sex of everyone, notwithstanding his condition': a copy is sent to the intendant of the quarter, another to the office of the town hall, another to enable the syndic to make his daily roll call…The registration of the pathological must be constantly centralized. The relation of each individual to his disease and to his death passes through the representatives of power, the registration they make of it; the decisions they take on it.
> (Foucault, 1977:196)

Eliciting forms of knowledge about various subjects or parts of the population through these and other methods of surveillance, creating bodies of knowledge – or discourses - about those

persons or populations, and then regulating or disciplining their behaviours in some way, in order to produce more knowledge, is what Foucault analyses in his works on the development of hospitals, prisons, and sexualities. In this way he shows how practices of surveillance, elicitation, incitement and documentation render behaviour ever more knowable – through becoming visible and audible - and hence even more constrainable (Gutting, 1994:96). This is what he referred to as knowledge/power; that the more one knows about a person or a population, the more recourse one has to intervene in, shape, constrain or otherwise govern the conduct of those persons. At times, this regulation may be achieved through the 'clinical gaze' – or even the 'glance'. In chapter seven I explore how a certain 'midwifery glance' may suffice in a particular pedagogical situation, and how this differs from the 'gaze'. Where the gaze is involved in establishing the truth of a population of bodies through broad relations of modulation and disciplinary normalization, the glance functions instead by settling on one object (in this case a CTG machine) (Foucault, 1973; 1977). Foucault has shown how these types of medical knowledges based on visual distinctions have arisen during and after the eighteenth century as a result of the 'co-ordination of sight and statement', which has usefully been extended by Weir in her analysis of the construction of the foetus as a "co-patterning of lingual and visual distinctions across a variety of bio-medical textual genres" (Weir, 1996:374).

Watching closely and writing about subjects under surveillance in hospitals, prisons and poor-houses also produced prolific knowledges about persons previously inconspicuous or inaudible, as well as those already considered dangerous or in need of control; surveillance techniques were then applied to other contexts, such as the school-house (Gutting, 1994). Further, the creation of new subjects happened in two ways: through new knowledge created about individual and delinquent subjects (the 'homosexual', the 'hyperactive', the 'advanced maternal age pregnancy', the 'low reading age'); and through the emergence of the 'population' as an economic and political problem (Gutting, 1994:98). Foucault said of disciplinary writing in the establishment of the 'clinical gaze' during the eighteenth century that it functioned to homogenize the "individual features established by the [clinical] examination" into a 'medical code of symptoms'; when these documents were accumulated they made it possible to "classify, to form categories, to determine averages, to fix norms" (Foucault, 1977:190). The space of the clinic (with its focus on diseases of one type) enabled 'normalisation' whereby the surveillance of the 'gaze' runs across the group assembled there; rather than resting on individuals within a home or hospital (where the individual patient is the subject of focus).

In these ways, power operates through certain fields of knowledge by designating the ways in which the proper conduct for groups or individuals might be directed; the governing of the sick, or of children, or communities. Foucault clarified the difference he saw between domination and power, where domination means the subject is completely caught, unable to change a situation; but the exercise of power requires the mutual existence of freedom (see Faubion, 1994; Sawicki, 1998). Understanding the ways in which subjects become more or less amenable to forms of governance within a politics of neo-liberalism is significant for contemporary feminists concerned as much with the practices of freedom, as with techniques of domination (see Grimshaw, 1993). This is because governance, in this sense, is to structure the possible field of action of others, even in the most benevolent and well-intentioned of ways (in Faubion, 1994:341; Foucault, 1979), or within liberal discourses of 'empowerment', 'participation', or 'partnership'.

Feminisms and Foucault

Fleming has argued that the explicit relationship between feminism and midwifery has not yet been theorized and developed by midwives them/ourselves in Aotearoa/New Zealand. She suggests that this is a lack that "does not do justice to either feminism or midwifery" (Fleming, 1995:50). Her suggestion is that the rhetoric of midwifery partnership has become predominant in Aotearoa/New Zealand without specific grounding in feminist epistemology, theory or research. However, some midwives undertaking practice-based research have since drawn on aspects of feminist methodologies (Davis, 2002; Fleming, 1995; McLaughlan, 1997; Pairman, 1998; Payne, 2002). Strands of feminist thought are certainly referred to and drawn on in midwifery writing, in the direct entry curriculum, and in post-graduate midwifery education (Fleming, 1995; Guilliland & Pairman, 1995; Pairman, 1998; 2002a; Tully, Daellenbach, & Guilliland, 1998).

If I understand Fleming correctly, she considers that midwifery analysts have not critiqued the basis for their epistemological claims to particular knowledges about 'women', 'midwifery' and 'partnership' adequately. Instead, what Fleming suggests, and Kirby refers to as "by way of feminism's authorizing signature" (Kirby, 1993:21), midwifery became secured as feminist in Aotearoa/New Zealand during its construction as a 'feminist profession'. Kirby states that this is not an uncommon problem, but one which can act as a "convenient alibi to prevent critical

inquiry" (Kirby, 1993:21). Kirby's statement is that precisely what it is that identifies a practice as 'feminist' is not easily determined (Kirby, 1993:20). The particular feminist theorists I draw on for this reason unsettle the epistemological and ontological assumptions upon which claims to knowledge and experience are made. In this way I hope to ask: 'what, precisely, constitutes midwifery as 'feminist' at this particular historical period?'

The relationship between feminism and Foucault is well covered elsewhere, and as a Foucauldian-feminist, or feminist-Foucauldian, or even as 'queer', I take a certain Foucault-friendly space for granted here. With this in mind, in this section I focus on what Foucauldian-feminist thought may bring to this project/thesis, rather than on the epistemological differences and debates between Foucault and those feminists less friendly towards his work (see Ahmed, 1998; McNay, 1992; McNeil, 1993; Ramazanoglu, 1993; Sawicki, 1998; Zalewski, 2000, for these debates).

The importance of Foucauldian discourse theory and analysis for feminist critical theorists who focus on the medicalisation of the body and related issues of power is acknowledged by de Ras and Grace (1997). They suggest that through Foucault's work the (female) body can be perceived both as "a medium of culture and a locus of control" and "constructions of femininity as texts and practices of regulation, normalization and discipline", hence: "the historical constructions of body, gender and sexuality are understood as political, and…deeply inscribed with an ideological construction of femininity" (de Ras & Grace, 1997:8). Papps and Olssen note crucial convergences between feminism and Foucauldian theories with regard to the body, power, and the critique of enlightenment science and Western humanism in their work on the regulation of midwifery (Papps & Olssen, 1997:41). Resonating with this is the work of Mitchell who specifically notes the amenability of bodies to governance and inscription within discourses of 'health', subject then to the regimes of experts in this burgeoning field (Mitchell, 1996). Other critical and feminist theorists of health also draw extensively on Foucault's understandings of governance, and power as productive (Bordo, 1993; Lupton, 1997a; Purkis, 2001; Sawicki, 1991, 1998; Williams, 1997).

These theoretical approaches enable a much broader feminist analysis of power as something that is widely distributed, rather than the property of a few people, and as generated within fields of knowledge (described above as discourses), including midwifery as a field of

professional practice. Poststructural feminists using this analysis of power conceive of it as productive, dispersed, and diffuse, rather than repressive and exclusionary (Burman, 1996; de Ras & Grace, 1997; McNay, 1992; Ussher, 1997). This offers opportunities for resistance and counter-discourse, and in a broad sense, this is how midwifery discourse functions vis-à-vis medical discourse; its statements function to counter those made by the field of medicine in making claims about seeing and knowing the truth in women's bodies, as the work of the midwives Payne (2002) and McLaughlan (1997) show.

Butler's discussion of aspects of the work of Foucault strategically undermines the very subject of feminism itself, the category 'Women'. Her intention was to call into question the notion of 'women' (as an identity, or subject) as a stable category, or even as a useful point of departure for feminist theorising. Her concern was whether a focus on (a common) identity may preclude inquiry into the construction and regulation of identity itself, particularly as she notes that "juridical systems of power *produce* the subjects they subsequently come to represent" (Butler, 1990:2). Her intention was to show how categories of sex, gender and sexuality do not exist prior to their articulation through the laws that construct them, but are produced through the performances of repetitive signifying practices. She made visible the ways in which the law produces those discursive formations and subjects that it only claims to represent; then conceals these processes to suggest that there is a naturally occurring subject before the law (such as Foucault's 'homosexual').

The value for feminist politics in Butler's theorising of identity categories in this way is that, for her, feminists need to understand how the category of 'women', the very subject of feminism, in other words, is produced and "restrained by the very structures of power through which emancipation is sought" (Butler, 1990:2). This includes categories such as 'consumer' or 'midwife'. She aims to show how Foucault's 'repressive hypothesis' produces subjects of power/knowledge by fleshing out his claims that the prohibition of something is its inaugurating moment, even in the attempted negation of it (and see Matisons, 1998). (Again, the subject 'homosexual' comes to mind; but here we can just as easily imagine the subject 'professional midwife'). She does not search for 'truth' or origins, but instead investigates: "the political investment inherent in designating as an *origin* and *cause* those identity categories that are in fact the *effects* of institutions, practices, discourses with multiple and diffuse points of origin" (Butler, 1990, ix).

Butler's ideas, and her refusal of a transcendental subject, were not well received by those feminists keen to retain a politics grounded in a stable identity and which relied on a notion of 'women's experience' (Flax, 1993; Fournier, 2002; Matisons, 1998; Scott, 1991). Sawicki, however, endorses Butler's argument against the humanist subject. She argues that Butler is not rejecting the practices of assuming subject positions and of representing oneself, but is rejecting the foundationalist subject (Sawicki, 1998). The risk Butler took was in 'troubling' the foundations of the feminist subject 'women', at the historical moment that marginal groups were finally breaking silence, and constructing oppositional political subjectivities, just as midwives have done in regaining autonomy. Butler's response to criticisms from Hartstock however over this matter was that: "construction is not opposed to agency, it is the necessary scene of agency" (in Sawicki, 1998:98). Sawicki agrees with Butler and Foucault in rejecting the assumption that an identity must first be in place before political interests can be elaborated upon and action taken. She agrees with Butler's analysis that the gendered self is not a foundation but "a normative injunction that operates insidiously by installing itself into political discourse as its necessary ground" (Butler in Sawicki, 1998:98). Sawicki states, in concurring with Butler, that: "discursive practices are rule-governed structures of intelligibility that both constrain and enable identity formation" (Sawicki, 1998:98).

What Butler, Sawicki and others offer is the critical awareness of the ways in which even new liberatory movements may reinstate aspects of that which against they have initially struggled (McNay, 1992; Ramazanoglu, 1993; Sawicki, 1991, 1998). Sawicki says in this vein that: "appeals to a more holistic, unified, 'natural', 'maternal', or 'feminine' experience of childbirth become merely one of several strategies that we might deploy …in themselves they are no less cooptable than high technology approaches" (Sawicki, 1991:91). Sawicki's discussion of the deployment of different feminist practices such as these are seen as part of a critique of essentialism internal to feminism, and which converge with Foucault's useful radical interrogation of identity (McNay, 1992). These issues here within feminism mirror my research interest in midwifery. Different feminist practices, such as the analysis of discourses around what it means to give birth, or to be a midwife, for example, can be seen as part of a methodological plurality towards constructions of difference and desire. Different midwifery practices may similarly work towards fostering a plurality of birthing styles. I add to this in my desire to explore what may restrain or otherwise subtly govern midwifery practice within these fields of possible action.

Butler discussed pregnant bodies to explain her insistence that bodies are forcibly produced through particular discourses. Her reasoning was that her position did not deny certain sorts of biological differences, but raised concerns about the discursive and institutional conditions under which certain biological differences – such as pregnancy – become the salient characterisations of sex (Butler, 1996). She considers, for example, that pregnancy is not a neutral description of biological constraints, but the discursive imposition of a norm, one which will function to reproduce certain sorts of definitions about that body. This means asking questions such as: 'At what times and places does reproduction become central to the sexing of the body?' 'How can women inhabit their gender differently, and in ways not constrained by reproduction?' (Butler, 1996).

My analysis of Butler's work leads me to note that the midwifery partnership is based on relationships with 'women', while this identity is becoming increasingly problematic and complicated for feminism(s) and feminist research. Are the assumptions underpinning the partnership model based on the identity of women fixed, and assumed to be universal? To use Butler's analysis, is the sign 'woman' in this instance seen as a stable signifier that commands the assent of those whom it purports to describe and represent as a subject existing before the law? (Butler, 1990:3). She asks: "Do the exclusionary practices that ground feminist theory in a notion of 'woman' as subject paradoxically undercut feminist goals to extend its claims to 'representation'?" (Butler, 1990:5). Butler's analysis is useful for midwives, in asking ourselves how the processes that are intended to provide us with autonomy, whether as midwives or birthing women, may act to constrain us. So, for example, in assuming that childbirth might be considered a 'normal' process for women, where does this leave women for whom this might not be so? This view also assumes that there is something natural and normal about the body before it enters into culture and discourse. But as de Ras and Grace point out:

> The body, gender, and sexuality are only meaningful within language and are thus influenced by history, culture, the social and political, religion and philosophy. The scientific perceptions of the body and bodily processes, our perceptions of the body and bodily processes, our perceptions of our own body are influenced by these grand processes, which are constantly changing and are always culturally regulated. (de Ras and Grace, 1997:8)

To this we can add childbirth. It is also in the exploring of these questions based on Butler's analysis of gender that Haraway's 'cyborg politics' may offer ideas around a politics of

'kinship', rather than reproduction (Haraway, 1991a; 1997; 2000). Her metaphor of the cyborg is useful to my project and is taken up in chapters five and eight. It is especially useful in my analysis of the ways in which some midwives act to disrupt dualisms of ab/normal birth in their taking up of different technologies for the management of pain. In this I explore the ways in which (metaphorically) 'cyborg' midwives construct high-tech births with women in ways that are considered 'normal' for that particular partnership. Haraway's notion of a 'cyborg politics' is one which, among other things, acts to 'retrieve and subvert' identity politics (Sawicki 1998:100), as well as emphasizing personal storytelling as a strategy of resistance. These goals are also important to my project. In the ways I have discussed here, Haraway, Butler, Sawicki and other feminists who appropriate Foucault's approach to questions about the production of knowledges, all contribute to the theoretical underpinnings of the questions I raise in later chapters in this thesis about midwifery, subjectivities and power.

Governing risky bodies: responsibility and restraints

Weir (1996) has argued that a key development in the recent government of pregnancy lies in the heterogeneity of risk technologies. These technologies are always related to the liberal governance of pregnant bodies, because they exist in order to promote new modes of surveillance, those of 'systematic predetection' (Castel, 1991), whilst linked to a therapeutic objective 'in the midst of neoliberalism' (Weir, 1996:374). These techniques of liberal government include systematic modes of self-surveillance and monitoring by the pregnant woman of herself and of her own foetus (counting its movements, getting in tune with it), in the practices of freedom. Lupton describes the multitude of ways in which women who are pregnant are interpellated into discourses of risk because of their own heightened sense of embodiment and the public insistence that women police their bodies appropriately and vigilantly, particularly when pregnant (Lupton, 1999c). The movements from 'dangerousness to risk' (Cartwright & Thomas, 2001; Castel, 1991) are explored in my specific chapters concerned with risk, particularly chapter six.

These discourses of risk are always related to strategies of regulatory power, by which populations and individuals are monitored and managed. People are constructed as

responsible for the management of their own risks. In this way the bodies of pregnant women, imbued as they are with proliferating risks to the foetus in its new subjectivity (Weir, 1996), becomes increasingly amenable to (self) governance through the practices of freedom (Lane, 1995; Lupton, 1999c; Petersen, 1997; Rose, 1994). Further, pregnant women are encouraged to take responsibility for their own birthing processes by midwifery itself, as part of its function as a liberal profession which seeks to regulate itself rather than its client group/women. In this way pregnant/birthing bodies are even more amenable to forms of (self) governance, within the constraints provided by discourses of consumer choice. Examples of this are discussed in chapter five in particular with reference to consumer choice for epidurals in normal birth.

Longhurst (1996), notes with reference to Aotearoa/New Zealand that no matter what the approach to pregnancy (presumably here she means 'medical' or 'midwifery'), most women are encouraged to see themselves as in some sort of 'condition' or other, and the body will be inscribed in complex, albeit different ways by these approaches. She states that in these ways the pregnant body is policed not just by health practitioners, but by a myriad of other social agents, including loved ones (Longhurst, 1996, 2000). Longhurst does not distinguish between health practitioners, except inasmuch to state that even those approaches that may appear therapeutic or liberating (rather than domineering) will instil the need for the maintenance of a constant vigilance and monitoring on the part of the woman and/by those close to them (Longhurst 2000).

Midwives as autonomous professionals in similar ways are rendered amenable to increased self-governance. A midwife in Aotearoa/New Zealand who has begun to address the relationship of local midwives to risk is Skinner (2001; 2002). She notes that "The risk status of the woman is closely related to medico-legal risk – the woman's and the midwife's risk is linked", a view which supports aspects of my analysis in chapter six (Skinner, 2002). The ways in which individual midwives negotiate and contest discourses of risk in differing ways is the subject of analysis in chapters six and seven.

The neo-liberal market-place discourses of choice and consumer- centred care can also be seen to act to interpellate particular childbearing women with different ideas about what constitutes risk to themselves, what kinds of choices are appropriate and which responsibilities

they are willing to attest to (see chapter five). Discussions of the relationship between liberalism and liberal feminism are of interest here in terms of choice. Bogdan-Lovis (1996) suggests that liberal feminists in the USA ignored solutions to the medicalisation of childbirth that were located outside the institutional structure. She states, "by view of their attendant class privilege, the women attracted to such liberal feminist ideology viewed the childbirth experience as one involving choices…[and] contributed to a reductionist discourse of choice and responsibility at the individual level" (Bogdan-Lovis, 1996-97:61). Despite the increase in midwives and midwifery care, the medicalisation of childbirth continues to increase in Aotearoa/New Zealand as it does elsewhere (Bogdan-Lovis, 1996-97; Bree, 2002; Calvert, 2002; McAra-Couper, 2002; Savage, 2002).

How the discourses of risk and responsibility act together and traverse backwards and forwards across the daily decision-making and assessment points necessary in the negotiated partnership between the midwife and woman is complex. For example, how might a midwife conduct a partnership with a woman who is a heavy smoker, which may have repercussions for the newborn, but who is adamant that she gives birth at home? In what ways, and under which circumstances, might the development of a 'midwifery gaze' become apparent? Midwives must subject the woman to regulation and surveillance if she is to pose the least 'risk' to the midwife's scope of practice. As Gastaldo comments:

> Focusing on individual bodies or on the social body, health professionals are entitled by scientific knowledge/power to examine, interview and prescribe 'healthy' lifestyles. The clinical gaze is omnipresent and acceptable because its objective is to promote health – as well as promote a disciplinary society. (Gastaldo, 1997:116)

In my analysis of professional midwifery the effects of these knowledge/power-based disciplinary processes constitute the historical and contextual potential for the development of what could be considered a 'midwifery gaze'. I have referred to this elsewhere in terms of what I have called the potential for the 'midwiferication' of childbirth. In this I theorized about the limits of a counter-discourse given the constraints of the law and the depths to which women's lives are frequently medicalised (Surtees, in Fleming, 2000). My term 'midwiferication' is intended to highlight the traversing of the childbearing body by both discourses of a commodification gaze and the normalizing gaze of midwifery (Surtees, 1998).

Davis, a midwife lecturer in Aotearoa/New Zealand, explores discourses of 'individual choice and responsibility' and 'holistic health'. In this she notes that a focus on contractual obligations and individual choice may act to de-politicize health. Davis asks whether a midwifery gaze may ultimately be more penetrative than a medical gaze, because the focus on holism also includes the psychological and emotional life of the childbearing woman. Women are morally implored to avoid the potential for being negligent or risky. Without advocating a return to paternalistic or reductionist approaches to care for women in childbirth, Davis encourages midwives to consider the effects of the discourses of individual choice and holistic health for the women in their care (Davis, 2002).

How are midwives restrained in their practices as autonomous professionals? The effects of discourses of risk on the practices of freedom can also be seen in the ways some self-employed midwives I spoke to no longer attempt to attract women who are pregnant/birthing for the first time as clients, given the perceived added risk of first-time birth, and certainly not drug-addicted women, women expecting a breech baby, women with HIV or hepatitis, or women with disabilities. Clearly, many midwives did not want professional involvement with the woman known as 'Nikki'; the discourse of women-centred in this case excluding women who publicly announce their 'porn star' status, or otherwise are not seen as 'responsible mothers'. On the other hand, other individual midwives may deliberately craft a business that may specialize in serving the needs of particular groups of women who have been marginalized in different ways in the health services, such as those with very low incomes, or those who are teenagers, or lesbians, or immigrant women; much as they have done already in crafting businesses focused on very different sites of practice such as homebirths,[17] or with/in an obstetrician's practice. Midwives can make use of their specific skills and practice philosophies within the market arena in this way, balancing their business model with their midwifery model. Davis-Floyd refers to similar processes performed by midwives in the USA as the 'qualified commodification' of midwifery care (Davis-Floyd, forthcoming), and I explore the ways in which the midwives I spoke to talked about their businesses in chapter four.

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[17] Such that some midwives may specialize in caring for women who want to have a vaginal birth after caesarean (VBAC) at home, or a breech baby at home; women in these situations previously may frequently have felt bullied by obstetric services (see Banks, 2000a, 2001b, 2001a).

How are midwives constructed through various discourses as what I call 'auditable subjects' in their practices of freedom/autonomy? There is a flow of surveillance which begins on the foetus, nested in the body of the woman, whose pending and actual labour is nested within the 'labour' of the midwife. As I mentioned in the beginning of this chapter, the labour of the individual midwife is conducted through the discourses and practices of the midwifery professional body. The flow of surveillance continues upwards and out through networks of protocols and policies, guidelines and decision points, in matrices of power/knowledge that comprise the complex field of maternity services provision within neo-liberalism.

Arney also talks of the flow of writing that links these actors within their networks of power/knowledge (Arney, 1982). Rose states that "Making people write things down, prescribing what must be written down and how, is itself a kind of government of individual conduct, making it thinkable according to particular norms" (Rose, 1996:55). In the texts of the interview discussions with midwives this appears as 'covering ourselves' by many. Along with documentation, Skinner suggests that referral is a 'risk management tool' (Skinner 2002). I suggest the fear of litigation impacts on midwifery practice (and see Savage, 2002; Skinner, 2002; Symon, 1998, 2000). Midwives must defend their actions constantly in a climate of proliferating risk within liberal fields of governance. They do so as they govern their conduct, and the conduct of their woman/client, so as to be beyond anyone's reproach; but they are always caught in the traverse of someone's gaze, from some direction.

If partnership with women was established over a decade ago over something called 'normal birth', then precisely what constitutes normal birth needs re-drawing. I believe that this is necessary in the context of neo-liberal health reforms, and what it means now to be a 'woman' or 'consumer' in the market-place of maternity service. It seems somewhat alarming that partnership hinges on something called 'normal birth', if most individuals as responsible consumers are now 'choosing' births involving inductions, epidurals and caesarean sections. Arney (1982) talks about the ways in which the Western obstetrical back-drop within which midwifery and normal birth is thrown into relief allows for some 'residual normal births' to produce normativity and regulation whilst simultaneously proclaiming something called 'freedom' of choice for women. Weir suggests that the practices of freedom in pregnancy are sustained by the existence of 'unfreedom' (Weir 1996). This reflects Brown's argument in Larner, that "…many well-intentioned contemporary political projects and theoretical

postures inadvertently redraw the very configurations and effects of power they seek to vanquish" (Brown, in Larner, 1998b:14).

Midwives are certainly autonomous and independent practitioners in one sense, but they are inextricably embedded within the visual fields of the legal as well as the medical/obstetrical gaze. This ensures the increasing regulation of the role of the midwife, by midwives them/ourselves within the panoptical obstetric gaze, "…the new form of social control under which subjects were separated, individualized, and subject to constant scrutiny" (Williams, 1997:236). A proposed framework for 'Competence Based Practising Certificates for Registered Midwives' (Nursing Council of New Zealand, 1999) is evidence of further professional regulation and surveillance of midwives using the discourses of 'potential risk', 'public safety' and 'relevant controls', and will soon be implemented. In an analysis of the discourses of governmentality, and in particular those of self-surveillance and monitoring, midwives can be seen to be constructing themselves as what I call 'auditable subjects', in complex and contingent networks of relations in partnership with women.

Weir suggests that three axes of recent change constitute the governance of pregnant bodies: the subjectification of the foetus, antenatal risk management and the liberal government of pregnancy. She describes the critical and feminist counterdiscourses that characterise medicine as 'directive and sovereign' (Weir 1996). What is missing from Weir's account is the ways in which the practices of midwives may be interwoven in complex ways with the pregnant bodies of women. In the chapters that follow, I use my fieldwork and interviews to illustrate how midwives and the bodies of women are inextricably linked. I argue that what constitutes risk to a pregnant woman will simultaneously posit a degree of professional risk to the midwife. Skinner (2002) has also advanced this argument. In chapter six of this thesis, I explore some specific ways in which different risks can be spatial and/or embodied for the midwives who discussed this with me.

For self employed midwives as well as those employed by the hospital, governing technologies may be seen to lie within the discourses and practices of proper professional practice, such as evidence-based practice, clinical audit, clinical governance, the guidelines for obstetric referral, midwifery standards review, the NZCOM code of ethics, and the attainment of hospital access agreements, for example. Attendance at standards review, and workshops, maintaining a

professional portfolio, seeking continuing education, the acquisition of competency-based practising certificates and epidural certificates are all examples of the self-development required of the responsible and professional midwifery subject. While intended to promote and protect the autonomy of the midwife, they also govern her conduct, and function as processes of disciplinary normalization in the potential development of a 'midwifery gaze'.

This chapter has outlined the theoretical approach I will take in this thesis, beginning with the neo-liberal context in which women emerged as consumers responsible for their own health. Women have become empowered to choose; the best for their babies, the place of birth, the best LMC care, the time and style of birth, the presence/absence of pain, in their desiring more participatory modes of childbirth. They are able to re-work definitions of birth that had previously been imposed on them, and construct new norms, asking/demanding that these are achieved as a right or as a choice. The double-edged sword that Gastaldo (1997) refers to in this participatory approach is the way in which these modes of conduct impinge on midwives. Being a professional partner with someone who is able to choose and create demands means the conduct of both is governed in increasingly subtle ways. The (self)-regulation and surveillance of midwives performed through the discourses of professionalisation act to construct contemporary midwifery subjectivities as those who are auditable (and hence professional) during their partnerships with women. In turn, midwives remain embedded within widely dispersed networks of power, surveillance and regulation that subtly guide (govern) their possible fields of action from a distance (Fournier, 1999). That is, while sovereign – direct - power over birthing women and midwives has gone, these forms of indirect, pastoral power implicate midwives as the new governing agents in birth (Abel, 1997; Foucault, 1979). The ways midwives act to re-inscribe birthing bodies as medico-legal bodies as part of this or resist obstetric hegemony are explored. Both re-inscription and resistant paths are increasingly amenable to different forms of governance, and this is illustrated further in chapters four to seven.

3

Chapter Three

Midwifery and me(thod/ology): research design, issues and strategies

> The moment the insider steps out from the inside, she is no longer a mere
> insider (and vice versa). She necessarily looks in from the outside while also
> looking out from the inside…. Not quite the same, not quite the other, she
> stands in that undetermined threshold place where she constantly drifts in and
> out…. When she turns the inside out or the outside in, she is, like the two sides
> of a coin, the same impure, both-in-one insider/outsider…. Differences do not
> only exist between outsider and insider – two entities - they are also at work
> within the outsider or the insider – a single entity. (Trinh, 1991:74-6)

In this auto(bio)graphical exercise, what are the coterminous method/ological issues? This
chapter addresses these issues broadly, as well as detailing the specific methods used to
produce knowledges from within the project as a discursive inquiry. I began to plan my
fieldwork as a trained midwife, but one who had chosen a path of research rather than the
pursuit of hands on midwifery. I was aware of some feelings of alienation from those
midwives who value the latter over the former (or at least the undertaking of a respectable
amount of the latter before the pursuit of the former), and this added to my complex
positioning as a midwifery 'knower', and/or producer of knowledge.

How would I speak? As a midwife? As a birth-giver? Each feeling/sounding out of these
labels felt far too dichotomous, because the adoption of one label would reinforce the binary
Other. As much as I would want to say, 'don't think of me as a midwife, then', I believed
midwives might say, 'even though you cannot speak as a real midwife, you cannot now be a
not-midwife, either'.[18] So from where – and how - do I speak/write? The introduction to this
thesis points to differences that exist within the subject of knowledge as well as between
subjects of knowledge. Perhaps I was a hybrid birth-giver/non-midwife? As Trinh suggests
above, not only am I neither one nor the other, I am never properly One, nor the Other, but
an impure, both-in-one, insider/outsider.

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[18] The title 'consumer' in this context not appropriate since I am, inescapably, a 'professional' by dint of having
trained once to be so. Interestingly thus, the title professional can be seen to erase that of consumer/lay; but
consumer cannot erase that of professional. The movement of erasure is unilateral.

In interpreting these conflicted feelings (of impurity) as the effect of occupying certain positions vis-à-vis other people and the positions they occupied, I was able to see that these positions, including my own, were never neutral or still, but constantly mobile. They were also the result of specific investments in claims to knowledge, and always invested with power. While sometimes painful in personal terms, the theoretical perspective I was initially developing was a complex form of insider/outsider, which can be of substantial benefit to feminist research (Kirsch, 1999; Reinharz, 1992; Ribbens & Edwards, 1998), including within the fields of childbirth and midwifery (MacDonald & Bourgeault, 2000; Sharpe, 2001). Reinharz writes in a similar vein that: "Personal experience can be the very starting point of a study, the material from which the researcher develops questions, and the source for finding people to study" (Reinharz, 1992:260).

My unique, and always partial, perspective as an insider/outsider contributed in a key way to the construction of the project field that I was about to enter. In fact, it was at the point of entry into the research that I 'stepped outside from the inside', but as I write this, I realize the significant difference between my account of insider/outsider research and that of others. What makes me a more complexly hybrid insider/outsider is that I was never really inside midwifery to begin with. I was stepping outside something I did not fully belong to, had not been accepted as part of, nor been initiated into, nor earned my stripes for. All I had done was undertake – and graduate from - the training, and, furthermore, done so in a disgruntled fashion at times. I felt anxious about any kind of credibility midwives would grant me when I told them I was going to skip the actual years of 'real work' at the coal face, and proceed straight (back) to the ivory tower.

Daellenbach has written of her reservations and concerns about her insider/outsider positioning when she undertook research with groups of women belonging to home birth associations, whilst herself a consumer member of the NZCOM, and a member of the local Homebirth Association committee (Daellenbach, 1999a:38-44). She notes that her dual positioning was 'by no means clear cut', but ultimately contributed in significant ways to the richness of her project whereby "the text becomes a kind of dialogue between different sets of knowledge" (Daellenbach, 1999a:42). Daellenbach's resolution for some of her concerns included Harding's 1987 suggestion that when the researcher and the researched are situated on the same 'critical plane', a mutual transparency about their intentions and goals can be

maintained. Daellenbach undertook this, in her commitment to feminist research, by avoiding claims to 'expertise', and an avowal to practice a critical reflexivity about how knowledge claims are "produced and made explicit in writing" (Daellenbach, 1999a:41).

Positioning oneself on the same critical plane as those being researched means that feminist researchers are likely to want to do research along certain axis of power relations, studying across, or up traditionally hierarchical fields of knowledge (Harding, 1987). In this way feminist researchers studying midwifery would attempt to generate research questions from the perspectives of midwives them/ourselves (and see MacDonald & Bourgeault, 2000). Harding suggests that: "If we want to understand how our daily experience arrives in the form it does, it makes sense to examine critically the sources of social power" (Harding, 1987:9). Harding here is referring to turning the tables by studying the very psychiatrists who have for so long studied women. Fine suggests this kind of research is done by the "dissecting of the elite's constructions of Self and Other" (Fine, 1994:75). Placing oneself on the same critical plane as midwives then may mean asking questions during the research process such as: 'in what ways and how does obstetric knowledge/power converge with the discourses and practices of midwives?' 'What kinds of knowledges about pregnant bodies become predominant at different times, and how are midwives able to respond to these?' 'What do midwives themselves make of increasing interventions into childbirth?'

 I began to design my project in a way that would integrate these kinds of questions with my personal feelings in the field, seen as data (Coffey, 1999; Young & Lee, 1996), with what I was learning from feminist theorists who concentrate their critical/discourse analysis on various fields of health and medicine (de Ras & Grace, 1997; Grace, 1998; Lupton, 1992, 1995; MacBride-Stewart, 2001; Sawicki, 1991, 1998; Treichler, 1990). This is a theoretical/methodological approach in which discourses are shown to be always historically located, support different institutions, reproduce power relations and have ideological effects (Burman, 1996; Ian Parker and the Bolton Discourse Network, 1999). In chapter two I mentioned that in a discursive inquiry, theory, method and methodology are not considered separable, but are worked out together. As Richardson notes, "A viable feminist-postmodernist theory would address the relationship between language, subjectivity, social organization and power, linking social processes to individual subjectivities, and both of these to political praxis" (Richardson, 1997:49).

It is important then to acknowledge my deliberate refusal of a position of fixity in favour of the maintenance of a multiple and queered subjectivity throughout this project development and analysis, and the ways in which the personal are woven inextricably/intertextually within the academic. I have referred to Harding's (1992) logic of becoming a 'multiple subject', from which perspective I begin my analysis. This multiply positioned, transient and always mobile perspective brings a degree of critical purchase to the project design and development that would otherwise have been unavailable to me. Walker notes that the border ethnographer is always theoretically located, but not fixed, and is

> … drawn to and lurks among the epistemological/methodological/philosophical interstices of autobiography, ethnography and deconstruction. These spaces are inherently unstable and in flux. None of them commands a final authority, and yet each provokes a curious attention that cannot easily be dismissed. (Walker, 1997:7)

In these ways I began to design my research project based on an experimental and reflexive critical discourse analytic methodology, underpinned by feminist poststructural epistemologies. I felt more (and less) un/settled as time in the field went on in the embodied praxis of dwelling in the shadowy borderlands between theory and practice, where the notion of 'lurking' that Walker uses felt appropriate. As a rough map of the ethnographic/methodological positions that I reflected on for fit as I progressed, what felt initially like a simple dualist insider/outsider position was first troubled with my engagement with Trinh's neither one nor the other thesis, described above. Following Walker (1997), and Fine (1994), I subsequently reflected on the ways in which I 'inhabited the slash', or the 'hyphen', between inside/out, self/other (Fine, 1994).

I inhabited theory/practice borders (Walker, 1997), in ways that felt increasingly fragmented and multiple, but which still seemed to rely on fairly stable referents, even if temporarily. Indeed, a focus on centre/margins, even in the travelling back and forth over the borders, can act to reinscribe and fix identities, while internal oppositions remain minimised, as Fine notes (Fine, 1994:79). In what follows, I discuss the fieldwork methods themselves, which were designed to reflect a discourse analytic approach to knowledge, and through which is woven my developing nomadic subjectivity.

A transient treading softly: entering the field

In a sense, my research design was/is experimental. Because the research design and methodological principles are modelled in part on the midwifery partnership (outlined in chapter one), it can also be considered research-as-praxis as well as continually fluid and evolving. I wanted to place midwives' wishes at the centre of my concerns in a way that is modelled on the negotiated partnership of midwifery care. By this I intended to do research with, rather than on, midwives/women, just as midwifery care ideally takes place with, rather than on women. In other words, midwifery as a philosophical approach to childbirth can be seen to draw on, and have similarities to, a feminist approach to research with women. Midwives in Aotearoa/New Zealand and feminists alike both argue that traditional methods of inquiry impose masculinist paradigms and values on women (Bunkle, 1992a; Guilliland & Pairman, 1995), and that the medical/obstetrical profession is, and has been historically, "…a primary agent in the social control of women" (Davis, 1993:21).

Specifically for my project design, the midwifery partnership principles of "Individual negotiation, equality, shared responsibility, empowerment, informed choice and consent" (Guilliland and Pairman 1995:26) are important. Where midwifery care is woman-centred my research design is midwife-centred. In midwifery, this means that the woman is at the centre of midwifery care, and the midwife has access to other relationships identified as important by the woman only through the woman (Guilliland and Pairman, 1995:24). With the midwife at the centre of my research I wanted to have access to other relationships and other concerns via the midwife concerned only and as she as gatekeeper saw fit. In other words, I wanted to research aspects of doing partnership in partnership with midwives.

The qualitative project design was one in which I used a suite of methods to produce data appropriate for discursive analysis. This data included 35 transcriptions; 7 from formal audio-taped group interviews, and 28 from individual interviews. It also included the field notes (30 000 words), and spontaneous un-taped interviews and memos generated from participant observation. I began fieldwork by conducting initial consultation and negotiation meetings with three midwifery practices, involving midwives of varied educational and training backgrounds, who were all self-employed. The basis for selecting these particular practices was

because of their diversity. I also had a fruitful consultation meeting with the midwifery educators at the local Polytechnic (see Julie/Isabella intertext). They contributed some helpful suggestions, particularly the idea that I include the base obstetric hospital within the Women's Health Division as a site of exploration, and interview core midwives. I decided to follow this advice, hoping that the inclusion of employed core midwifery staff would broaden the project. I obtained ethical consent from the University of Canterbury and from the Canterbury Ethics Committee (CEC), given that I would now also plan fieldwork at the base obstetric hospital, and that this meant there might quite likely be pregnant, post-natal, or birthing women involved. The requirements of the CEC meant I had to draw up another, quite different, information and consent sheet for any clients of the midwives who might also choose to participate, or consent to my involvement on any level (see appendices).

All of the first three self-employed midwifery practices were enthusiastic about their involvement after our initial meeting(s), whether this would be as individuals, or a group. I suggested I come and speak to them about the project and ask for their feedback and suggestions for on-going planning and design. The practices agreed, and I attended planning meetings once with two groups, and twice with the third group. Only one of these practices contained midwives who were known more personally to me. During these meetings I explained a little about my goals and positioning, and made clear my desire to have midwifery concerns at the centre of the research. The midwives then began to make their own suggestions for my involvement, which are discussed below.

The project rapidly began to involve participant observation as well as interviews on the midwives' terms, as they suggested to me the ways in which I may be involved in their practices, often using phrases such as 'hang around' or 'tag along' to describe this. It was important to me that they themselves decided the extent to which I did hang around. I was very aware of how busy midwives are, and that they may have had, and often did, other students involved with them. I also expected that in their role as gate-keepers they might choose to limit or restrict my observations of them as they worked with women for many different reasons, preferring to contribute to the project by interview(s) alone.

During this negotiation phase I suggested that the midwives themselves decide whether their involvement would be as individuals or as a group practice. This decision had ethical

implications in terms of confidentiality and anonymity as well as methodological and cultural implications. If, for example, the groups wanted my involvement and observation of them as a whole practice, then in the writing up of the project they could be identifiable by other midwives within the city both as individuals and as a group by their demographic details, practice philosophies, work histories, training backgrounds and possibly their ethnicity or other personally-identifying details. At this time, and whilst I was seeking ethical approval and making methodological memos and beginning fieldwork notes and a journal, I stumbled across a significant methodological paradox.

I had wanted to focus on diversity and the work of 'differently-positioned' midwives (Tully, Daellenbach, & Guilliland, 1998), but I could not speak of this to some midwives without their guessing which other practices I might have approached. Questions arose for me around the potential for the disruption of anonymity of some midwives, inescapable even in the most discreet mentioning of these methodological issues during planning with midwives. In their research with professional midwives in Canada, MacDonald and Bourgeault note that the study of "professional midwifery will increase visibility of pregnant and birthing women, and that this is a double-edge sword" (MacDonald and Bourgeault 2000). My focus on diverse sites of practice might inadvertently bring to light issues and knowledges some midwives would rather remain hidden, from each other, or perhaps from obstetricians. Others were happy for their practice(s) to be identifiable.

How could I be sure my project would contribute positively to the field of midwifery without contributing to the (increased) surveillance of the same? I approached the particular practices in the first place to take part in the research because their difference from each other was precisely what initially appealed to me. If the midwives decided that they would rather appear as anonymous individuals within the research, then keeping the practice they belonged to unidentifiable would necessarily obscure the components of the specific practice that led to my interest initially. This became a central methodological paradox as I struggled with ways to explore difference amongst midwives while realising that my commitment to maintaining anonymity as well as confidentiality would necessarily (re)produce homogeneity amongst midwives/women, a side-effect I had not fully realized during the course of proposal-writing. These issues of representation are addressed also by MacDonald and Bourgeault who describe the ways in which they juggled their commitment to telling the 'shadow stories' they found in

midwifery against/with their desire to contribute positively to the enterprise of professional midwifery (MacDonald & Bourgeault, 2000).

For these ethical reasons too, and hoping to blur identities, I became more interested in a diversity of training backgrounds, whereas at the inception of my project I had thought I would focus on direct entry trained midwives only, partly because of the more explicit relationship of these new programmes to feminism (Tully, 1999; Tully, Daellenbach, & Guilliland, 1998). There is a chance that some local midwives will recognise the different practices described in the thesis. Some midwives being interviewed as part of their practice group, andsome individual midwives were not concerned about their practice being recognisable when they realized how anonymity would obscure differences, and thereby almost defeat one of the purposes of the research. Where a midwife has been interviewed in a publicly-profiled role, in a position within the NZCOM for example, they have been interviewed in that public position and will be recognisable to many people, although I made the decision not to use real names. Every endeavour has been made on my part to protect the anonymity and confidentiality of the individuals who requested it within each practice.

This issue of group versus individual involvement was also relevant methodologically and culturally. I would have asked different questions of the individuals within a practice than I would of the practice as a group. This was primarily to maintain anonymity. For example, the initial interview guide I designed for the first group I made contact with was intended for use as either a group interview guide or for individual interviews within that practice. For this reason the questions were broad and loosely based on the suggestions of Patton (in Maykut & Morehouse, 1994:107-8). On further reflection, and after my first informal meeting with the midwives, I refined and refocused the questions significantly (see appendix). The process of answering some of the questions could identify the group, if not to the general public, certainly to other local midwives and to the women who had used their service. But leaving some specific questions out means not just ignoring the demographic and historical aspects but the contextual, cultural, and ultimately, epistemological and political aspects of the practice; precisely the things I had wanted to explore overtly.

In cultural terms it was also important not to make assumptions about group or individual identity. I did not want to suggest to specific midwives that because they were independent

practitioners that they then consider themselves as private individuals for the purposes of their involvement with my research, because they might see themselves as part of a group practice or whanau in terms of collective decision-making, consultation and negotiation with women/clients and with Iwi. The Guidelines for Health Research Involving Maori are clear that consultation is a process that includes, "setting out a proposal not fully decided upon" (Health Research Council of New Zealand, 2000:6). While not health research per se, my research design included observations of midwives and pregnant women who might feel quite vulnerable in my presence, even after consenting to participate. As a pakeha woman, I consider pregnancy, childbirth and related health issues as Taonga under Article Two of the Treaty of Waitangi. This meant that I was committed to remaining accountable to all involved midwives for the on-going (re)development of the project at all stages of data gathering. This was also modelled on the midwifery partnership model where the midwife and woman consult each other's expertise and work together in a process of individual negotiation, which is different in, and specific to, each partnership (Guilliland & Pairman, 1995:27).

This issue of accountability to the group practice was a primary reason for my preference for group interviews, which I anticipated leading to more focussed group interactions as data was gathered, and the transcripts returned to midwives. This process is consistent with feminist research and can lead to the production of rich data as participants react to, support or challenge statements made by others in the group (Kitzinger, 1995; Wilkinson, 1998). I also saw this as an opportunity for member checks, whereby my interpretation of the previous discussion could be responded to and clarified as necessary by individual midwives or the practice as a whole. One practice stated that they enjoyed the chance to reflect on their evolving practice as a new group and saw the process as beneficial to them in a variety of ways, including a chance to "…debrief, discuss issues, and think about theory and practice in terms of our midwifery philosophy" (Practice Group 'two', second group interview, December 2000).

My involvement was ultimately different with each group practice. Of the original three, one group chose after two planning meetings to be considered as individual midwives. I did not see them thereafter in their group, but negotiated individual partnerships with the midwives concerned. This process was different with each midwife as I planned interviews and worked around her caseload pressures and other time-commitments. Eight months after the beginning

of my fieldwork, another new group practice formed, and I approached them and had two group practice interviews, followed by one formal, and several informal individual interviews, with one member of that group.

I was interested in the ways in which these individually-negotiated research partnerships differed. There were parallels at times in the research partnerships to birthing partnerships. The midwife I was working with and I were frequently engaged in on-going negotiations over meaning, including reflections on our individual practices together, whether in birthing or in researching, and in building trust and rapport with each other. My commitment to following midwives into their field of expertise meant I found myself deferring to their timetables and sleep requirements, for example, which in turn were organised around the requirements of their clients. Frequently interviews or participant observation visits were postponed or juggled around the shifting needs of clients, and the intertwined needs of the midwives themselves. While aspects of this often meant a re-shuffling of other interview or meeting times for us, I was also increasingly aware of the ways in which the constant juggling of time was a fact of life for midwives, but would be relatively short-lived for me.

My involvement differed considerably within each self-employed practice while working with the individual midwives therein. For example, with one group I conducted two formal group interviews six months apart, while also attending visits approximately once a fortnight with one of two midwives within that practice. This occurred if the midwives were willing and/or able to have me as a participant observer in some instances of their working with women. The midwife would explain my research to the woman without my being present and if the woman expressed interest would leave her with an information sheet (see appendix). If the woman subsequently agreed to my presence during some of her midwifery care, typically this would entail two or three home visits either ante or post-natally. In another practice, I made initial contact with one midwife who then acted as a key informant, gate-keeper and spokeswoman for the group. One practice disbanded shortly after my initial meeting with them and the midwives dispersed to other employment during the course of the fieldwork. However, before this happened, I interviewed two members individually. The other member I interviewed formally twice, and informally several times, and had six participant observation sessions of both ante and post-natal visits with her and one of her clients. These visits all took place at the woman's home around a planned homebirth. I felt enormously privileged to be involved in

situations like this. Often these particular visits would last a duration of two hours or so, depending on everyone's schedules.

The group practice that owned a birthing centre closed because of funding issues during the time of the research and again the midwives sought other employment. Some core midwives I interviewed also worked part-time for an obstetrician or did some self-employed work of their own, such as post-natal visits. This explains how I could be interviewing a core midwife in the morning, and then attending a post-natal visit at a woman's home with the same midwife in the afternoon, for example (see interview schedule in appendix). Midwives frequently explained to me the ways in which their work lives shifted over time, juggled around the requirements of family and young children, and their tolerance for particular shifts or wards, or on-call and on-the-pager work requirements. As I look now at the list of midwives I have interviewed, most of them have had employment changes not only during their time as a midwife, but during the time of contact I had with them in the field.

My involvement with the consumers/clients of midwifery services was different for each practice. I interviewed two NZCOM Consumer representatives, where we focussed largely on theoretical and philosophical questions of partnership that had arisen at the 2000 NZCOM conference. As my interviewing began to snowball outside the original three groups of midwives I initially approached, and I interviewed other individuals from several other practices, I would be involved in different ways with the clients of their services. Some individual midwives were simply too busy to include me in meetings with their clients, or did not think they had any suitable women to approach about including me in their visits. Others were wary of my observing them in action with women for a variety of reasons. The primary reasons given were that it felt inappropriate to the midwife to include an unknown observer in this aspect of a woman's life, or that there were too many students to accommodate already; reasons I had anticipated and respected. Where midwives were willing to approach their clients about my involvement, frequently they did so because they felt that my being a midwife would contribute positively to the woman's decision and her ability to make an informed decision about this.

One group of midwives did not want me to observe them in action with women but suggested that I contact their former clients and meet them without the primary midwife concerned

being present. They provided me with a variety of ideas to facilitate this, including the opportunity to put a notice in their newsletter and by attending certain social functions held on the group premises. This surprised me somewhat; I had not anticipated that midwives may welcome a researcher discussing their maternity provision with recent clients, and I would not have suggested it myself, assuming that the midwife/practice would feel a degree of vulnerability or invasion about the process. I felt anxious about this because it was a departure from the way in which my methodology was modelled on the woman-centred aspect of midwifery partnership. I wanted midwives to be at the centre - the link person between any clients that accepted my involvement and me. I also felt that without these links the project would spin out of control, in any potential direction, and that I might as well have begun gathering data directly from women, which would have been a completely differently-focussed project. When I voiced these reservations, as well as a fear of being over-loaded with tasks and data and hence losing focus, the group responded:

> …well we are fairly confident that the women like us and our practice – we haven't had many complaints so far! And it would be good for us to have feedback to reflect on our practice anyway. This way prevents the women feeling intruded upon, we won't feel 'watched', and the women will self-select for the project, which will be best since sometimes they find it hard to say 'no' to students even when they really don't want to have one. (Birthing centre midwives, preliminary group meeting, June 2000)

I interpreted the above to mean that the midwives were happy for me to listen to their clients discuss whatever seemed important to them. This came about during the planned social settings on-site at the midwifery practice that I was welcomed to. As it turned out, these events were free-flowing and at any time contained a mix of midwives and past clients, and revolved around general discussions of parenting, childbirth, etc. Only one woman contacted me for an interview as a result of seeing information sheets about my work placed in the newsletter which was produced by previous clients of this practice. She contacted me and we had a long and pleasant discussion, more about childbirth generally than anything else, at her home, which I chose not to tape. This was in an effort to contain the amount of data for analysis, and also because I wanted to analyse the narratives of midwives' as they talked of their work with women, rather than analyse the birthing stories of women.

Only once previously had I audio-taped a visit at home with a midwife and client together. This was a post-natal visit with a Women's Health Division (WHD) core midwife who became a key informant. As well as her full-time job as a core midwife, she undertook some post-natal visits for her local General Practitioner (GP). After she discussed my project with a woman at one visit, the woman said she was keen to have student involvement, and would expect that I would be audio-taping our conversation. I arrived with the midwife, my tape recorder in hand. However, I felt very intrusive moving around the small lounge to set up a recorder with plug and microphone, moving around a brand-new baby and toddler who was watching TV, and as I sat there I decided that I would observe only and not tape during home visits from then on, regardless of the women's expectations. I wanted to be as unobtrusive as possible when in women's own homes, which was different from when I was a midwifery student and it was expected that I learned how to interact. The information and consent sheets had covered every possibility in terms of methods for data-gathering, but I decided that the use of the tape recorder was too intrusive. I decided that I would only tape the interviews with midwives and any obstetricians, which would also incur less transcribing work and expense for myself. Where I was engaged in other research opportunities, such as social events, women's homes, workshops, or other meetings I would rely on my extensive field notes as records. These notes were expanded on and written up into the qualitative research software package (NVIVO) that I was using as my data storage, coding and management package.

However, taping the midwife's post-natal visit gave me a learning opportunity which would not otherwise have been available to me. When I returned home, I listened to the tape as I always did the same day of taping. What I had taken-for-granted as I observed the midwife in the field, could only become apparent as I listened to the tape out of the field. I noticed I was listening to silence much of the time, and this forced me to wonder, 'What was the midwife doing then, during the periods of silence?' The tape was a contrast to the tapes of the midwives and me, where there was never a moment's pause! I had to reflect back and remember the visit; the midwife watched, felt, made some baby noises, touched, examined, listened, sang a bit, and even used smell at one stage. She indulged in baby talk and also, in a different way, toddler talk, as well as engaging with the woman; but mostly, she was silent. In other words, I had learned something about the ways in which she was using all her senses in this particular partnership; talk was only rarely used to elicit specific responses from the

woman. This served as an insight into the ways in which close observation may be as beneficial as taping.

The visit also showed me how many senses are involved in midwifery work and I wondered if this related to the ways in which some midwives talked about their midwifery knowledge to me. Midwives talked about the different forms of knowledges that are embodied for them, describing 'intuition', or 'practice wisdom' during the course of interviews, as knowledge that 'cannot be learned from books', or 'can only be learned from the women', and this seemed a co-incidental way of reinforcing those forms of knowledge. I could understand this more clearly after listening to the silence. This incident made me very aware of the ways in which different midwives used different bodily senses in different times and places. I also became aware of the potential limitation in the use of discourse analysis as a method/ology for use in research with midwives. If I was only going to analyse texts generated from taping the talk of midwives, what would exist or lie outside the talk and texts? How could I account for this and other instances of embodied knowledges? In privileging the written texts, would my project contribute to the subjugation of these embodied knowledges? This issue again is one of the double-edged swords noted by MacDonald and Bourgeault, where researchers of midwifery are concerned to "balance critical exegesis with political strategy" (MacDonald and Bourgeault, 2000:161).

This particular visit had also provided me with another researcher experience, specific to my inhabiting the border/slash of insider/outsider research. While the midwife was outside of the lounge-room washing her hands before examining the baby, the woman suddenly said to me in between our general small-talk comments, "Do you think this is thrush?" holding her baby out to me and showing me his mouth. It was clear she was seeking my professional opinion. I was slightly startled and said "Oh, I'm not sure about that, just ask (midwife), she's the proper one, when she comes back", a statement which left me feeling rather foolish. I thought about the times as the mothers of young children my friends and I would self-diagnose various childhood illnesses, sharing knowledge between us that bordered between medical and mothering discourses… "Does this look like mumps to you, your boys have had it, haven't they? Is this or that worth a trip to the doctor, or not? Have you got any of that remedy/medicine left I could borrow? Hold her and I'll try to lance it…I can't afford the doctor…Will you look at so and so, I think he has a temperature…Don't go to the doctor,

you'll only get given antibiotics…" and so on. So in this instance, I felt somewhat mean-spirited, and was thankful when the midwife came back to the room and was promptly asked the same question, for which she had a ready reply.

The issues for consideration that were prompted by this visit were a result of dwelling in the borderlands of insider/outsider participant observation. This occurred often as a result of the consent sheets, which explained I was a non-practising midwife and a mother myself; designed precisely, of course, to appeal to as many women as possible. I decided that I would distinguish between mothering and professional midwifery questions, and where I could safely respond as a mother, I would and did. This was in keeping with my chosen level of minimalist participation, maximum observation, when in women's homes. In later and different field sites, notably at different sites of the Women's Health Division, I was a much more active participant at times. However, there was much in these 'm(othering)' questions and answers that overlapped with what could be described as midwifery jurisdiction too, as the vignette above shows. Midwife/(m)Other? When was I one, when the Other? I could rarely answer this for myself, and only sometimes satisfactorily for women, or for some midwives. Even speaking/responding as a 'mother' felt an impure position as well, given my hitherto political investments in the identity of 'lesbian mother', where I have worked at times to deliberately contest predominant (heterosexual) birthing and mothering discourses and practices. My personal ambivalences with the term 'mother' had always been tempered by my ability to stake a claim to the identity 'lesbian mother', a transgressive position I was ultimately less keen to draw on in the research process. These were some of the issues traversed on this nomadic fieldwork journey, where familiar once-firm identity politics became always fluid, towards the dynamic state of re-assertion, retrieval and/or subversion that a 'cyborg' politics affords (see Haraway, 1991a; Sawicki, 1998; Spargo, 1999).

In my fieldwork, the balance between participating and observing was also fluid according to particular sites, as is consistent with insider/outsider ethnographic research (Griffith, 1998). This strategy by no means eliminated some internal conflict at times which highlighted issues associated with the production of knowledge, experience and power. An example of this (and also related to embodied knowledges), was when I observed a midwife, who had never breastfed, giving advice or assisting with the establishment of breastfeeding, particularly if this was not going well (it seemed to me); the midwife did not seem aware of evidence-based

information, such as optimal positioning for latching-on, or fumbled at times. How is midwifery knowledge about breastfeeding constructed in these instances? How is (breast-feeding) women's or lay knowledge constructed vis-à-vis professional knowledge in sites that differ from each other, such as hospital, home or birthing centre? Breastfeeding (or not breastfeeding) is a particularly volatile site of sets of practices and discourses where issues of class, gender, health, embodiment, sexuality, the natural, Baby-Friendly Hospital Initiatives and so on all converge, and intersect at these nodes of knowledge/power in the midwifery partnership. The knowledges produced are highly contested by different midwives in different practice sites, as well as between differently-positioned women with new-born babies (and see Bradfield, 1996).

At times such as these, my own embodied knowledge and experience of (extended) breastfeeding and LLL membership threatened to erupt, but I managed generally to remain an observer. It was enormously difficult to listen to information that I felt was contradictory or inappropriate, or to contain myself when the midwife left the room. I realized that it was because this was frequently the only (midwifery?/mothering?) situation where I often had more experiential knowledge than the attending midwife. In other midwifery situations it was easier to remain silent because of my clinical inexperience. These situations often seemed to throw into sharp relief for me the issues under scrutiny for postmodern ethnographers – the ways in which experience and truth are such unstable constructs, and how and why certain practices and bodies are valorised, others repressed, or discounted, impossible, or unimaginable (Britzman, 2000).

As well as these fieldwork experiences that took place with women who were not known to me, I also attended the home birth of my sister's baby (see Julie/Isabella intertext). As I intended to be part of three planned home births within my personal network of friends and family in the course of my project, I did not approach a group practice that primarily focussed on homebirths (although homebirth was an option in most practices). Also I wanted to balance my bias towards homebirth, a position I informed midwives of during our early discussions. Further, the two midwives that were from outside the area that had participated in interviews were both homebirth midwives. I wanted to balance my bias and the informal observation opportunities that were already weighted towards home by concentrating my formal interviews on the practices of midwives that were often less familiar, or more

challenging to me. By this stage of fieldwork my life and research were almost completely merged, something feminist ethnographers will expect, if not always welcome (Griffith, 1998; Kirsch, 1999; Reinharz, 1992; Ribbens & Edwards, 1998). The boundaries had always been porous, something I thought I was comfortable with given my predilection to feminist research practices, my increasing theorising around poststructuralism, and my personal circumstances.

Most of the women in my life, friends, relatives, neighbours and workmates are involved in the production and/or consumption of maternity work in some shape or form. Hearing my sister tell me over and over how wonderful her midwives had been, as we spent time together with her new baby, was woven through the ups and downs of my best friend's 10-year attempt to conceive, but repeatedly miscarry in that time. Finally she became pregnant during the course of the research, and I was present at her daughter's birth (see Shelley/Eva intertext). I still have friends from my involvement with LLL when my own daughter was smaller, I have midwife friends both new and old, and many of my friends are involved with feminist health practices in their work or personal life, if not directly involved in planning pregnancy or in early childhood parenting. It seemed as if I could not get away from thinking about pregnancy, babies and childbirth, even if I had wanted to.

As in the circumstances described above, Reinharz notes that since every field setting is immersed in a larger social context, itself embedded within a larger social system, field settings can become 'amorphous' (1992:55). She suggests that while this may be the experience of many ethnographers, for feminists particularly who seek to understand the links between the micro and macro systems of gender politics, information may come in from any place, at any time, for the project. While some traditional ethnographers may caution against the development of this situation, those who are concerned to make explicit the mode of production of the research texts generally place their subjective experiences at the core of the research process, as I do here. The challenge is in achieving a balance in the ethnographic process between implicating the embodied, multiple selves in the analysis, whilst not giving centre stage to one's own presence (Coffey, 1999).

Homing in: on the hospital

As I continued with fieldwork I was aware that my already-present bias towards home-centred birth was being reinforced as I reached a point of data saturation in my work with self-employed midwives. I began then to make plans to move towards what I was beginning to visualise as the centre or hub of the field, the base obstetric hospital. The midwives I had interviewed in their groups or individually over these months had often raised issues which we began to theorize about in relation to the base hospital. Some of the issues self-employed midwives raised were to do with the then 'Section 51',[19] and negotiating the guidelines for referral therein, including issues of handing over and/or transferring care. Some outlined differences in terms of philosophical approaches to birth, and others outlined learning situations during transferring women from home or small units to the base hospital. I began to conceptualise the base hospital as a Foucauldian 'panoptican' (Foucault, 1977), at the disciplinary centre of the obstetric gaze, on the basis of my engagement to date with the talk of self-employed midwives. I made plans to explore this idea further by concentrating my ethnographic fieldwork there. I wanted to see for myself, to engage in prolonged and focussed observation at the hospital, and to become immersed in the social context and network of relations within which different midwifery practices and partnerships intersected. I felt that I had been involved in/on the periphery of the gaze where I was already comfortable for long enough, and that I needed to move in towards the more unfamiliar.

In my early analysis of the data I had gathered, some themes already felt strong. Self-employed midwives had indicated that there was a hugely complex array of networked relationships to navigate, and it seemed to me that it was in the negotiation of these relationships that partnership with birthing women was constructed. Many of the midwives I were working with gave me a sense of things being 'drawn in' towards the centre of the hospital; a sense of a 'tightening up' over the last decade that was both spatial and temporal. The increasing intervention rate was frequently discussed in the interviews, and it seemed that 'epidurals' and 'inductions' were cited by the majority of midwives in their talk that invoked a strong sense of 'pull' towards the hospital. The ways in which midwives responded to/resisted this pull was not altogether clear, but I was curious about how they did so. I needed to follow self-

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[19] Now Section 88 of the New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2002).

employed midwives as they in turn, followed the majority of their clients into the hospital. I made application to hospital management to do so.

My first contact was with the then Obstetric Services Manager of the Women's Health Division (WHD) to whom I explained my project, and asked her advice for the best way to proceed. She suggested I write to herself and the General Manager outlining my proposal. I did so, sending a copy of my full PhD proposal to the General Manager, and received a warm letter of welcome. The letter suggested the next step was to attend a meeting with the Obstetric Services Manager, the WHD Midwifery Educator, the Community midwives' coordinator and the Charge Midwives at which I should outline my project and the support I required from them. This I did, and the Charge Midwives made it apparent that, while they were extremely busy, they would do their best to accommodate a researcher and would pass my information sheets to the midwives with whom they worked. One remarked after I explained what I would like in terms of participant observation, that I "…should just sit in the lounge in labour ward for a while…you will see and hear everything you could possibly want to happening there!" I was given a hospital photo identification badge within the week and told my access would be for the one year I had suggested, from August 2000-01, negotiable thereafter if required.

This entry into the base obstetric hospital marked a shift in my primary method of data-gathering. I shifted from interviewing self-employed midwives and spending time with them as a privileged and largely silent observer in the small birthing centre or the private homes of some of their clients, to on-site participant observer with interwoven discussions with core midwives and others in a much more public and open setting. These discussions and my observations formed the field notes which I recorded once I was at home, often referring to hastily-scribbled key words that I would jot down in a note-book kept in my pocket during my time in the field. As well as spending most of this time on labour ward, I also attended several WHD workshops, meetings of different groups of midwives, ante-natal classes, ante-natal clinics, the Methadone in Pregnancy educational clinics and sessions, a social group for very young mothers, shift hand-over on different wards, presentations of various issues by both local and overseas midwives, and spent time in the hospital library, tearooms and the offices of two key informants (see interview schedule in appendices).

This move from more private to more open and public spaces also marked a difference in my strategic approach to the field in a number of significant ways. Of central concern to me now was the dawning realisation that the warm welcome I had received from top and middle-level management could not be assumed among the midwives whose every day work I wanted to observe. The WHD core midwives varied considerably in their attitudes towards me. Copies of an information sheet designed specifically for this site had been distributed by the midwifery educator and remained on notice boards during my stay at the hospital. This visible notice positioned me as a 'feminist' researcher and a degree of wariness towards me, perhaps because of this, became evident at times.

One of the most obvious occasions of this wariness for me occurred in the labour ward lounge waiting for a morning shift hand-over to take place. This is the time when midwives who may not have seen each other for a few days catch up briefly in the moments before the midwife in charge of the particular shift comes in to give a report to the incoming midwife-in-charge and afternoon staff. I was sitting in one of the chairs surrounded by several core midwives, one of whom had said that I could work with her for the afternoon shift. This meant that the other midwives on duty for that period of time had my presence in their work place whether they wanted it or not, a situation that could not occur when I was with single self-employed midwives in private homes. One of the in-coming midwives arrived and began to pass around what seemed to be a cartoon on a piece of paper, which was received with much hilarity by all midwives whose hands it passed through. The midwife responsible for the hilarity began to pass the joke to others over my head, and I anxiously realized that it was not going to be shown to me; I was to be left out; apparently assumptions had already been made within a fortnight or so of my presence about my sense of humour, and I was clearly being Othered by virtue of this process.

While not familiar with this particular midwifery setting I was and am familiar with other sites of hospital spaces where common assumptions about what is funny are established as part of ward or hospital culture. I knew from the comments generated that it would be a (hetero)sexist joke, and therefore had been judged inappropriate to share with 'the feminist researcher'. Keen to develop rapport and to be accepted as a 'friendly and approachable' researcher instead/as well, I dispensed with formality and leapt up, snatching the piece of paper as it was passed from midwife to midwife over my head. As I read it, I performed

appreciatively and gave the required response in the form of laughter, to which the midwife who had avoided passing me the cartoon exclaimed, "Well, I can see there's a side to you I didn't know!" while the others laughed at both of us. This remark intrigued me given that I felt she didn't know me at all. We had never met except in passing in labour ward once or twice previously; never spoken; never discussed my project; never said more than a shy 'Hi' to each other. What assumptions were made about me that acted, consciously or otherwise, to reinforce my outsider status? How did midwives speak about me in the lounge when I wasn't present? What assumptions did I, in turn, make about midwives, in order to create them as Other to me?

Walker notes in his ethno(autobio)graphic research as a nurse lecturer/practitioner, the many ways in which the participants in a research site could be seen to be 'theorising about the theorist', and that his borderlands positioning of living the slash between service and education, between theory and practice, was ultimately an experience of "…unhappily confused identity in the unit" (Walker, 1997:5). He states that the culture of clinical nursing can at times be 'inexorably conservative', and that "difference, novelty, ambiguity and uncertainty constitute sometimes profound challenges to clinical nursing culture, which has historically (that is to say, institutionally) been constructed so much around markers of homogeneity, tradition, fixity and certainty [and…] worked to marginalise me from the outset" (Walker, 1997:5). Whilst I didn't always feel marginalized, frequently enjoying conversations about research with many different people, I did have a sense of unhappily confused identity from moment to moment on labour ward. I was remembered by some as a midwifery student, who I'm sure seemed just as unhappy and out-of-place then. Some hadn't remembered me at all, while still others remembered me warmly.

Once home for the day, I was able to take refuge in my reading and writing, and the discovery of other ethnographers who had at times felt a sense of embodied confusion and ambivalence in their field. These writers and others consider writing itself a form of nomadic inquiry (Britzman, 2000; Pillow & E. St. Pierre, 2000; Richardson, 1997; St. Pierre, 2000). I took heart in the words of Richardson:

> Like everybody else, I am privileged in some ways, marginalized in others. I am welcome into some communities, shunned in others. The part of me that is marginalized is attracted to poststructuralism, as I imagine is also the case with

> others seduced by postmodern theory. The postmodern game has a flexible, dynamic character. Marginalized speakers can move to the centre…. Others see what I do not see, not just about themselves but about me; and I can see what I saw differently, later. (Richardson, 1997:125-6)

At other times in labour ward I worked to destabilise institutional preconceptions of what it meant to be a feminist researcher, in what felt like part of an on-going, flexible and dynamic postmodern game as Richardson suggests, above. Familiarity with some hospital sites/practices/humours does not simply render those practices as not, or no longer, strange; hospital/heterosexual/humour may be both familiar and persistently strange at once. All too boringly familiar; but still strange, to one who is neither One, nor the Other. The development of rapport, becoming One, required my capitulation to a temporarily constructed sexuality, in this case, much as in the case of responding 'as a mother' to the clients of midwives (hence 'not quite the same, not quite the m/Other'). Moving in and out like this made me realize I was never actually still enough to ever be one, or the other; the call of the nomad, of always be-coming, without ever arriving, grew stronger.

Further, in terms of avoiding potential marginalisation as a 'lesbian researcher', surely a being with even less sense of humour than a feminist researcher, practices such as the one described above can be seen as the articulation of knowledges about sexuality. These practices, including the part I played, construct the labour ward lounge as a taken-for-granted heterosexual space, with all the attendant dangers and pleasures found for a lesbian/queer in the surreptitious playing with, and simultaneously resisting, heterosexual culture. I could ask myself, as a 'lesbian-feminist-ethnographer', doing research about a feminist profession in a heterosexual space: in what ways are the production of midwifery knowledge and theory shaped by the institutional relations of class, 'race' and heterosexist supremacy as well as by male (obstetric) supremacy? In what ways, how and when do I contribute to the production of these knowledges? In my speaking/writing? In my silences? As Fine suggests: "…silence, retreat, and engagement all pose ethical dilemmas…. All are entangled with ethics of knowing, writing, and acting" (Fine, 1994:81).

As well as speculating about what it meant for core midwives to have a feminist researcher in their midst and to re-work notions of this, I began to worry that the process was paradoxically becoming less feminist. This was largely because of the ways in which information and

consent processes were rapidly changing. When I had worked with individual midwives/women in private homes, both written and verbal consent and information-giving were on-going and fluid processes. Informed choice and consent underpin the midwifery partnership model; yet as soon as I was based in a hospital environment those things became much thornier. In labour ward, no midwife could speak to me or be seen to be working with me without everybody else present at the time knowing that she was somehow involved with my project. I felt embarrassed about this situation, which I had not foreseen, but was powerless to change it. There were added ethical complications of the written consent forms I had designed for midwives; did I ask a midwife to sign one each time she spontaneously offered me information in the corridor, in the sluice room, in the operating theatre or the lounge? To do so would have been impractical, intrusive at times and ultimately counter-productive. I finally worked out a compromise solution for myself whereby I reasoned that I already had three official levels of ethical approval, including the hospital management, for the project proposal, which clearly outlined my intentions to observe midwives at work. While I was on-site, I always wore my photo-ID, which stated I was from the University of Canterbury. I decided that the ID operated as a visible sign that I was in data-gathering mode for all who spoke with me, and indeed considered almost everything that came my way as data.

When I formally interviewed a midwife off-site, in her home or mine, and tape-recorded it, I obtained written consent. When I worked alongside a midwife in the hospital, or she volunteered information that I followed up with her during later discussions, information and consent remained verbal. I usually said something like "Is it ok to ask you some more about what you were telling me yesterday?" Or "Is it ok if I watch you do this?" This still felt like a compromise for me and led me to wonder at times to what degree the research process could now be considered feminist. I felt especially conscious that each time one midwife agreed to have me work with her for a few hours on a shift there would be many others present in the field who had not chosen my presence and may be entirely ambivalent or suspicious about my motives for being in their work spaces. I suspected there was rarely a time on labour ward where all would have agreed to my presence. Eventually I stopped worrying that this reflected anything to do with me as a feminist researcher so much as it perhaps signalled more about the complex labour ward lines of communication and/or different relationships amongst the staff therein. Similarly, the process by which the midwives sought my involvement with the

women in their care on labour ward was dramatically different from the ways in which self-employed midwives at their group practice rooms or the woman's own home had negotiated it. Below a vignette from my hospital field notes re-presents something of this:

> Arrived to work in labour ward with J as pre-arranged by phone. She said it would be fine to have me tag along with her for the day so that's what happened. She was looking after a woman who was there for induction. J had her on a monitor and the husband came in and we sat and talked while he watched the monitor with J. J was doing the paper work while the woman was on the bed; the husband and I were in chairs. J said "Now are you happy for the baby to have vitamin K when it's born?" the woman responded that her other kids had had it, no reason why this one shouldn't. J. said "And are you happy to have an ecbolic? That will help stop bleeding after the birth". Again, the woman responded "yes, spose so", after a slight hesitation. It suddenly dawned on me that J may have asked (while I lurked as usual in the corridor), if I could be present by saying; "Now are you happy to have a student in here with me?" an informed consent process I would not have been especially happy with. Again, I felt momentarily mortified with embarrassment. However, it obviously got me into the micro-field, again, and I was not about to leave once I was there.

I quickly learned to compromise some of the values I had learned as a midwifery student for the sake of seeing as much as I could see. I didn't feel, after midwives went to the trouble of having me with them, able to ask that I might negotiate my own presence with the woman myself, or even that I would do it any better; perhaps lengthy explanations and more things to sign would only confuse the woman at times when she was often already overwhelmed? I never resolved my unease with some of these issues, and I am sure that it was apparent to many of the midwives. I didn't want to feel ungrateful, since I was in there, and in the way; and I certainly didn't want to miss out on any material, either. And many situations where I simply got swept up with the proceedings and developed tactics for remaining fairly unnoticed (not making eye-contact with the charge midwife, for example), meant that I was often in situations, crash caesars, for example, where protracted explanations on my part would have been ridiculous.

In these and other ways I negotiated my way around the field. The overall sense was a feeling of being much more out of control than I felt during the time with self-employed midwives. There was many an unforeseen situation, which I had not predicted during my planning, that seemed to arise quickly or spontaneously and simply required the most pragmatic or prudent management. For example, I might have been working on labour ward for a shift with a core

midwife who didn't always know ahead of time what her shift would involve. If she was looking after an already-labouring woman, then I would be introduced and observe alongside her as planned. But if she didn't have a particular woman to look after, because things were currently quiet, then often she would help in-coming self-employed midwives if they needed help or were going to transfer care of the woman to clinic, as well as helping to handle any emergency admissions. I soon realized that this was another situation where I felt somewhat out of control as a researcher. The midwife coming in would be used to the core midwives having midwifery students, but it was another dynamic altogether to have a researcher in the process. It interrupted their anonymity too; my presence at a midwife's side indicated to others that she was taking part in my research. I tended at these times to hang back and let the conferring midwives decide how involved, if at all, I would be in these situations.

Generally my approach in the situations of interaction between LMC and core staff was that as I was attached to the core midwife during my time on labour ward, I was not a part of the situation unless care was officially handed over, or the self-employed midwife suggested that I might as well just come in and observe alongside the core midwife. The most common of these situations was where the core midwife was providing epidural care for a self-employed or community midwife who did not have her epidural certificate. These were often situations that midwives themselves had described in the context of interviews, and I felt at those times that I was witnessing keenly some of the issues they spoke of. The (governing) interface between primary and secondary midwifery care frequently happens within these birthing rooms, unless the woman is rushed straight to theatre.

In these situations I felt I was right in the centre of things, finally witnessing some of the processes self-employed midwives had talked about for months. The hand over, transfer or consultation processes were nodes of knowledge/power at the intersection of different discourses, which traversed the bodies of the birthing women, and the labouring midwives. I observed situations that appeared to flow easily, and situations which didn't appear to flow so well – where I felt awkward and embarrassed, much as I had as a student midwife. Some situations touched me enormously, and some horrified me. I didn't always feel comfortable or familiar, sometimes feeling confused and distressed, wondering why I had ever begun, and how what I was doing could possibly be fruitful for midwives. I was constantly aware of the ways in which my presence altered the field. There were times I could see my presence having

varying degrees of influence; times I am sure conversations stopped, changed, or just drifted away, but other times, such as in emergency theatre, where my lurking against the walls, dressed as the others in blue theatre gear, hat, bootees and mask, operated as a kind of disguise and I could almost pass for a theatre assistant, woman's relative, or junior nurse. An excerpt from my labour ward field notes documents a passage of time that seemed to flow smoothly:

> The woman and her mother and a friend arrived and were taken into room one. M and I went down there and introduced selves, first M and then she introduced me to the woman, mother and friend. M went to get a few things, I chatted to them, and felt that I was a bit useful at least in terms of keeping them company for a bit. M came back, brought trolleys in and got ready to put a luer in, explaining everything really clearly as she did so. She asked if the woman was ok about having a Caesar etc, and listened to the woman explain what a long 3 days it had been, that she was really tired and it was 42 wks etc. She then wheeled in a CTG machine and put it all on to the woman, again explaining everything and putting everyone at ease with her relaxed welcoming manner. The LMC, B, then arrived. She was very pleasant and did not seem at all phased by my presence, asking me questions about the project etc, including me in the general chit-chat about babies names/sex etc. When M got back in the room B was taking the CTG machine off, to my interest, and she stated "I don't think you need this on, really, its been on for 3 days now, hasn't it", including M by looking at her and speaking as if she assumed all present would agree that it was simply not necessary, this decision seemed perfectly ok and flowed well between her and M, it was barely noticeable and did not appear to led to any friction, although the protocol is a 20 min trace on admission. The LMC assumed main emotional contact with the woman, keeping physically very close to her and often spoke in a low and intimate voice. I was interested in the ways she and M stepped aside momentarily and spoke in low tones together about the time the Dr was due to arrive etc, was everything in order, etc. It was clear that the LMC m/w was most involved with the woman. When we went through to theatre, B maintained this intimate physical contact and it was as if she and the woman were in a protected cocoon of their own, while M attended to paperwork, equipment, and facilitating anything B needed.

Various negotiable interactions between the differently-positioned midwives that I was observing on days like this were frequently accounted for in the texts of individual midwives as I continued to interview them. I was tapering off interviews with self-employed midwives, and interviewing more WHD community and core midwives as I developed rapport with them in the work place. I tried to both observe and interview each midwife. If I had observed her working before the interview, I was able to focus on issues in the interview that I might have observed. Similarly, if I had interviewed her prior to working with her, I would remind

her of some of the issues she had raised, and would ask her to show me or otherwise indicate if at all possible, some of the situations she had discussed. Not surprisingly, much of these conversations, snatched during moments when we might duck into an empty birthing room, or tidy an equipment trolley left in the corridor, for example, related to current issues that were being addressed through workshops and conferences at the time. These key events were also a good way for me to raise issues for discussion, such as asking a midwife as we sat together in the lounge or walked around the corridors; "Did you go to the 'normal birth' workshop the other day? What did you take from the CTG monitoring workshop I saw you at yesterday?" and so on.

In these ways most of a year passed in the field, until I felt I had reached a level of data saturation in labour ward as well. I had finished the interviews by interviewing midwives in positions of middle management within the hospital setting, and these contributed to my sense of saturation. Strangely, as it came time to withdraw, my feelings of ambivalence included not wanting to leave. It was not so much that the unfamiliar was becoming familiar, but that I was acclimatising to my shifting dis/comfort. In the letting go of the desire to control some of these feelings and processes, came the ability to manage them.

`Backing off and out slowly: nomadic lines of flight`

I had transcribed the interview tapes and began analysing them alongside the field notes whilst I was still in the field. Broad textual themes across the interviews, such as 'education', 'transferring', 'accountability' became visible to me almost immediately. I wanted to analyse the data around these issues by examining the ways in which various competing discourses acted to construct, constrain, interrogate and disrupt each other (Wetherell, Taylor, & Yates, 2001). I used NVIVO to code and manage these broad themes, and read the transcripts in their entirety as meaningful units for analysis, embedded in their social and historical contexts (Ian Parker and the Bolton Discourse Network, 1999; Jaworski & Coupland, 1999).

In this way I worked across all 35 transcripts, as well as reading each vertically. Fieldnotes were not coded, but imported into NVIVO to read against the transcripts. As I re-read these data forms, as well as the current newsletters and journals I was receiving as a member of the

NZCOM, I asked myself, "what working situations, sites and interactions facilitate partnership, and what can compromise or undermine it? In what situations might midwives be positioned simultaneously within multiple discourses? What kinds of subjectivities are created through these claims-making activities?"

I was interested, for example, in the ways in which the actions of the core midwives worked to support the LMC in her primary role with the birthing women; this appeared to enable a working relationship between the two midwives that is congruent with midwifery professional ideals (Campbell, 2000). Running against this however is a narrative from the text of an interview with Gillian, a midwife who had belonged to core staff for a number of years, and was now self-employed. In this Gillian portrays a quite different scenario; one of discursive struggle between core and LMC midwives over their roles in caring for women during situations of hand over:

> Well, the only time we hand over is for a caesar, and in December half my patients had caesars. I complained about one midwife who took advantage of me. She went and waited in caesar theatre for me after we'd handed over, rather than coming into the room and introducing herself to the patient and taking over care from there while I became the support person. There is a lot of bitchiness and politics and this is supposed to be health care. I've become a traitor; gone over to the other side, you see! Others make comments about me being a 'private' or 'independent' midwife. Or comments such as 'we don't get paid for this, you are, though', to which I usually reply 'you are getting an hourly rate and then after your eight hours you can go home!' We're a funny breed, all being women; there is a lot of horizontal violence. The role of the core midwife in labour ward has changed to one of support, and one of the reasons I left was because I didn't want that any more, I wanted my own patients. (Gillian, self-employed midwife)

Territorial issues, such as a 'traitor' crossing 'sides', 'owning patients', contesting rates of pay, and 'horizontal violence' contribute to this particular narrative as one that actively disrupts the operation of partnership as it exists ideally between the supporting core and primary LMC midwives. Gillian claimed in this she felt taken advantage of by a particular core midwife in this example, yet within the same interview text, or as we discussed issues informally another day in labour ward, whiling away time as the woman in her care laboured, Gillian might have made quite different claims that would appear to contradict the claims she made in the above example. Being a core or a self-employed midwife are not dichotomous and fixed positions, either; often one midwife worked in both positions at the same time (regarded as problematic

for management) – and most midwives had been both self-employed and hospital employed at different times in their career. At times, the talk of midwives in either position worked to make claims about identity, such as labelling some groups or individual midwives as more or less 'medicalised' than the speaker or others, for example.

In my analysis of the talk of differently positioned midwives – core, and/or self-employed – these midwives are seen at different times to engage in the application of forms of knowledge to 'make true' what they each believe about the work they do. In this sense, knowledge, "once used to regulate the conduct of others, entails constraint, regulations, and the disciplining of practices" (Hall, in Wetherell, Taylor, & Yates, 2001:76). Further, these midwifery actions, and the sense made of them through a discursive inquiry, are only possible within the historically contingent conditions of midwifery specific to Aotearoa/New Zealand; a context wherein relationships between self and hospital employed midwives are subject at times to some challenge from their professional body (Campbell, 2000; Earl, Gibson, Isa et al., 2002).

I developed this particular crosshatching method of textual engagement and analysis to trace forms of knowledges produced by different midwives at different times. I progressed with this analysis by immersing myself in, and moving back and forth and across, the data and began to move – in an embodied sense - away from the centre of the field. I had by now engaged with the work of Braidotti (1994) and Fox (1993; 1999). As I began to look for differences, disruptions, complexities and contradictions within the talk of individual midwives as subjects of knowledge, as well as across the talk of different midwives, I noticed a parallel shift in the way I thought about my own claims to knowledge. These were being constantly challenged as I moved about in the field, lurking within relations and borders of knowledge/power, self/other (as I showed in the breastfeeding example of the previous section).

My personal ambivalences about the meanings of feminism were mirrored in the field as I researched some of the issues around what it might mean to belong to and work within a feminist profession. Who has underwritten midwifery as feminist and how/when is it so? Does the authorising signature of the label 'feminist profession' then preclude further scrutiny and critique by feminist social researchers? What of midwives who are not feminist? What kinds of assumptions about feminisms do different midwives make? Was I more of an 'outsider within' (Fine, 1994:78), than an insider/outsider? Which debates would I be invited

into, and when might I be shunned within others? The conversations as a feminist academic I wanted to have with midwives during my training had often felt silenced or marginalized. Why begin now to undertake such a politically tense project?

I couldn't theorize about differences within and between midwives without considering my own embodied 'self/ves' (Rath, 1999). Braidotti suggests, with regard to embodied subjectivity, that 'feminist nomads' are as: "travellers through hostile landscapes, armed only with maps of our own making, following paths that are often evident only to our own eyes, but which we can narrate, account for and exchange" (Braidotti, 1994:172). Braidotti identifies the development/nature of feminist nomadic thought by first outlining what she refers to as three levels of sexual difference. The first level is concerned with the difference between women and men. Woven through the three levels Braidotti reiterates the difference between Woman and feminist – as does Harding (1992), outlined in the introductory chapter to this thesis. Braidotti suggests that given that the sign 'Woman' is structured as the referent of otherness, a critical distance from the institution and representation of 'Woman' is the starting point for feminist consciousness. This process leads to an understanding of the distinction between 'Woman' and 'real women', and hence our irreconcilable differences from each other. This allows for the second level, an analysis of the situated, as opposed to universalised, nature of oppressions, or the differences among women. These first two levels of analysis Braidotti argues are the result of the historicity of feminism, as a response to 'patriarchy', and are part of linear time. The third level of sexual difference sees differences within each woman, and is part of a 'postpsychoanalytic', inner, non-linear, discontinuous, genealogical time (Braidotti, 1994:168).

Braidotti is suggesting here, with other feminist theorists (Butler, 1990; Flax, 1993; Fraser & Nicholson, 1990; Haraway, 1991a), that the crisis of modernity has enabled a historical moment for the de/re/construction of the notion 'Woman'. 'Woman' is no longer a culturally dominant prescriptive model for female subjectivity but has become a topos for analysis. Braidotti wants as many different forms of analysis and modes of understanding as possible, suggesting transdisciplinary "exchanges between theorists and artists, academics and creative minds" (Braidotti, 1994:165). She suggests that positions of feminist nomadism can allow for different modes of representation and understandings of complex subjectivities. This is where a position of nomadic flexibility provides material about embodied subjectivities for

discussion, rather than for divisive effects (Braidotti, 1994:165). Importantly for a feminist, and hence politicised, poststructuralism, none of these theorists want to (yet) relinquish the signifier 'Woman'.

The kinds of subjectivities Braidotti suggests that feminist nomads, or nomadic projects, will explore are those which work to highlight "the complexity of the embodied structure of the subject" (Braidotti, 1994:165), working at/from level three. She draws on Deleuze and Guattari (1988), in imagining embodiment as not mind/body, inside/outside, but something akin to "pure flows of energy, capable of multiple variations… whose materiality is coded and rendered in language…. it exceeds representation" (Braidotti, 1994:165-6). In exploring the complex embodied differences within each woman, Braidotti hopes to show the ways in which identity is always constructed as a play of multiple, fractured selves, as relational, as requiring a temporary Other, and as made of successive identifications which are "…unconscious internalised images that escape rational control" (Braidotti, 1994:166). Some parts of these processes would have been conscious for me as I self-consciously analysed/Othered the talk of midwives; most would not. What appeals to me in Braidotti's work here is the way in which she wants to balance - as the nomad does - a tendency for postmodernist gloom with the subversive force of laughter and the merry spirit that was manifest in the earlier days of the women's movement (Braidotti, 1994). She uses Deleuzean ideas of desire and passion to fuel the nomad's commitment to unearthing complexities. The desire for feminism in itself is an object of intense desire, as well as a rational political belief. The desiring nomad moves through space(s) laughing in the face of her dis/comfort.

For Fox (1999), also drawing on Deleuze and Guattari (1988), nomadology as research in the field of health means a 'line of flight' beyond health. The nomad is always be-coming, never arriving, not concerned with ideals of truth, but with the contingent production and reception of knowledges and the play of power. This means engaging in research/life that is never finished, but always open. Staying engaged, but not attached. It means that knowledge is contingent, the nomad is always on the side of difference, and is fully engaged in seeking out unknown territories and smoother spaces (and see Potts, 2002, for detailed explorations of Deleuze and Guattari's smooth and striated spaces). This is a constant process referred to as reterritorialisation, being in motion, enjoying processes and relationships without relying on

attachments, and without getting lost (there's no place to find). For Fox, it's the nomad commitment to 'be-coming', which is beyond 'health', and even beyond 'liberation', being:

> passionate and angry, [to] love and be loved, stand up for ourselves and others, live and die…. Not being closed down by alcohol and drug dependency… sixteen-hour days at the office, fears of ageing and death or any of the other body-affect confluences which territorialize me and you into the ruts which we may defend because that's all we see before us. (Fox, 1999:216)

This resonates for me as I move away from one point of identity that can only exist in opposition to others, whether midwife, mother, or other Other, into the smooth spaces of a more complex embodiment; it is my re-birthing, being sober, re-searching midwifery and me(thod/ology), and the process of becoming a writer, and the spiritual/academic/embodied *jouissance* in this. For Fox, as for Richardson in her postmodern game play, and Braidotti in her subversive laughter, these politicised cyborg processes are embodied in what the body can do, not what it is called; there is no 'me' and 'you', no longer a fixed 'identity', that of patient, or woman, or disabled person, or midwife, or (m)other, but instead a continual flow of be-coming; a play of multiple selves, multiple (t)ruths…but this is the point to which I will (re)circle around to later in my line of flight and return to in chapter eight.

Intertext

03/07/01   Cathy/Kahu

Marcel rang just as I had gone to sleep about 10 pm, as I had been half-expecting, saying Cathy was starting to be in full-on labour…I drove down to their place feeling hope and excitement. Cathy had had an easy homebirth two years previously, and ten years prior to that, a 'home-centred birth' that required some hospital assistance with forceps when the baby seemed stuck. She had spent only a few hours at the hospital during the period required for the forceps birth and then for the epidural anaesthesia to wear off, and came home straight afterwards. Nevertheless, I hoped this birth, which was going to be her last, would be more similar to the second birth than her first….

When I arrived, the midwife was there, and everyone was having a cup of tea while Cathy walked around the warm lounge holding her back and looking very much in control of the situation. There was an air of subdued excitement and anticipation. I sat down and we all chatted. I knew the midwife and we felt easy together. Cathy's mum arrived to look after the toddler if he should wake. Marcel lay dozing on the sofa, as Cathy, the midwife and I spoke now and then, or remained silent at times when Cathy needed to concentrate to manage her contractions. Her sister Shelley, my best friend and who was herself about 8 months pregnant, arrived. She was excited, imagining how her own planned homebirth might eventuate. Cathy seemed very self-sufficient, moving around and managing the building pain herself over the next few hours.

Shelley chopped up some fruit and Cathy ate when she felt like it. As the pains grew stronger over the next couple of hours, Shelley and I took turns to massage Cathy's back and support her physically in whatever way she asked. At times she lay on a mattress on the floor trying to get some rest in between contractions. Her mum read stories quietly in a corner of the room to the toddler who had woken with Cathy's increasing moaning, and had appeared in the room to investigate the proceedings. Eventually the older son came out too, and helped to massage Cathy at times. Cathy was increasingly talking about the pain, saying it was 'all in her back' and becoming agonising. The second midwife also arrived, at what must have been about 4 am by now. I also knew her and she and the primary midwife conferred over a cup of tea on the sofa while Marcel, Shelley and I continued to physically support and massage Cathy. Cathy began to say between contractions, 'if it carries on like this I'm just going to the hospital, I'm not

going to muck around like this'. It seemed that the pain was becoming unbearable and nothing we did could relieve it for her. The midwives gave her remedies at times, I barely paid attention to what they were as I was starting to feel a sense of the inevitable; that Cathy might need, or choose, to transfer to hospital. The midwives by now had brought all their equipment inside and unpacked everything; oxygen, resuscitation gear, what looked like lots of equipment. Their calm presence and professional deliberations together combined with their discretion meant that it really felt as though Cathy and we family members were the 'hub' while they formed a strong presence around all of us, supporting our actions with Cathy.

The midwives' skill in their role meant that in one sense they were barely noticeable to us as we cared for Cathy, but that unobtrusiveness was only possible because of their intuition and skill. It reminded me of the Zen-like paradox in midwifery care 'the less we do, the more we give'. My mind started to feel in two places at once, whereas it hadn't before now, as part of me switched into wondering how the midwives would act as Cathy's distress grew markedly. The primary midwife asked Cathy if she would like an internal to see if there was a cervical lip in the way of the descending head, and this took place. Cathy found it extremely painful as the midwife tried to see if she could facilitate the descending head by moving the cervical lip a bit, and I began to wonder how midwives could tell, experience I guess, when 'positive, progressive pain', turned into 'abnormal pain'. I grew aware that I was half watching them as well as focussing on Cathy now, too, and it would have been impossible to turn the 'researcher' part of my mind off, as I processed all these things, and at the same time wondering about the way my own 'boundary-dwelling' positioning worked like this in different ways.

As the midwives listened periodically to the foetal heart, which was good, and checked the position of the baby, which seemed to be 'posterior', their incredible calmness was very noticeable to me. I kept wondering what I would be doing if I was the midwife at this point, and decided I just didn't know. I really am not sure why I thought I could be a midwife, I thought to myself a few times, I only wanted to be able to assist women emotionally and physically as I was doing with Cathy; perhaps if I lived in the USA I could have been a 'doula' or 'labour coach', both positions which are becoming new 'professions' in and of themselves over there. My attention wandered back and forth now between the actions of the midwives and the actions and distress of Cathy. Shelley and I ran a bath and helped Cathy through to

the darkened bathroom where we hoped she might gain some relief from the pain. We left her in the bath with Marcel helping her and came out to see the midwives as they were writing in the notes. We asked them if they thought she would have to transfer at some point, both of us expressing our own reluctance about this…we said something like 'can't you make her stay, it must come out somehow, surely, it must be close, if we can just keep her in the bath as long as possible…' they said, 'well, if she's asking to go to hospital we have to take her; we have to do what she is saying she wants', and I said 'but what if you think its nearly there and you know she really wants to avoid hospital?' they said 'well you are able to suggest she waits as long as possible, you can do that in your role, but we can't…we're obliged to do whatever she wants and document that…'

I thought to myself about the medico-legal governing of bodies, while all this was going on, and what midwives do as a result of this; as part of feeling compelled to 'colonise the future', against any potential eventuation. I was starting to theorize this in relation to my own data as those actions taken in 'advance defence'. I had already spoken to midwives in the course of my research who had heard of, or had the situation happen to them where a later complaint had been made that seemed, to me, to invert the entire position of a midwife, such as 'the midwife made me have a natural birth', 'the midwife made me stay at home', 'the midwife made me do it without pain relief'…as bizarre as I thought those claims were, given the midwife's position as 'guardian of the normal', it seemed to me that these anecdotal stories were increasingly important to and worrying for midwives (especially as they seem most often not initiated by the woman, but by others). Most midwives who I spoke to knew personally of a colleague who had had some form of complaint whether formal or informal; several had been the subject of complaint. All spoke of the vital importance of 'trusting' the woman, and this is also reflected in the literature in situations where midwifery commitment to 'non-intervention in the normal process' may actually or potentially conflict with the woman's right to self determination and choices that may differ philosophically from the midwife's. As I realized that I didn't want to make any suggestions that may differ to that of the midwives, and Shelley and I geared up to manage our initial feelings of disappointment, Cathy came out of the bathroom. She paced around the lounge for a bit longer, but the atmosphere had changed somewhat….

Eventually Cathy said 'that's it, I'm going, I'll get my coat', the midwives began to slowly pack some gear up, and Shelley and I assisted Cathy between contractions to get into her winter coat. The dawn was breaking and we could tell it would be a cold and icy ride to hospital. The midwives rang ahead and wrote copious notes. Cathy's mum felt a bit anxious and tearful, remembering the first (grand)son's birth and how hard it was for her to see her daughter in so much pain, and we conferred together in terms of organising childcare and driving. What if the hospital were not 'there', as this strange sort of excess and lack, I wondered to myself. Would the baby eventually come anyway, and how can anyone be sure of these things? In what ways does the knowledge that the hospital is always already 'there', in the background, influence women's decisions to go, and at what stages of labour?

Marcel seemed to be asleep on his feet, but I managed my initial disappointment by feeling a boost of energy. The midwives also both seemed full of energy, yet we must have all been tired, and no one knew how long things would take at the hospital. Shelley and I decided that I would go with Cathy in the car, as I felt most awake, and the midwives would follow behind in one of their cars. Cathy and I hopped in the back seat of the car, and between contractions Cathy and I became like slightly hysterical school girls giggling at the thought of other drivers seeing her in the back seat, screaming at times in agonising pain, naked underneath her winter coat, Marcel trying not to skid on the ice, and all of us having the odd burst of nervous laughter in between Cathy's screaming and moaning and me watching out the back window for the midwives.

I began to feel a bit anxious about arriving at labour ward before the midwives, wondering who was on, whether they knew me, what role they may assume I was in and so on…I suddenly felt sick imagining the midwives not catching up in time and the baby coming in the car or something similar, imagining the newspaper headlines…if that happened, I thought, I'd have to make sure Marcel caught the baby in case there was any confusion over me as a researcher/ex-midwife doing so…these different roles felt so complex and complicated sometimes. My ethical approval covered most eventualities with women (assuming they were not friends), but what about those where my role was multiple, invisible, or completely hybrid and indefinable as in this case? I was there as Cathy's friend, but my re-searching self could not be abstracted from the situation, and other people often marked me as a midwife even when I didn't want that label. Even as a nurse, I would feel some sort of obligation as a 'health

professional' and friend to help if the car broke down or something similar happened before the 'real' midwives caught up with us.

Finally, thankfully, Marcel pulled up in front of the hospital and a wheelchair arrived from somewhere. The midwives pulled in behind and we all arrived at the entrance to labour ward at once. The on duty charge midwife was very pleasant and welcoming, and showed us to the room reassuring Cathy that the doctor and anaesthetist would be in to see her as soon as possible. Cathy was by now screaming for an epidural, and I started to feel quite desperate for it too, as soon as we were in the labour ward. All the various personnel came in explaining their roles to Cathy and reassuring her that it wouldn't be long now…she was enormously grateful to each of them, we all were. We started getting ready to go into theatre, and it seemed that I was included in the getting ready plans. Marcel was in a chair, maintaining a bit of physical distance to manage his own anxieties, while I was the closest physically to Cathy as the midwives liaised with various other staff, got changed into blue theatre gear, did paper work, consent forms were attended to by the medical staff, all while the midwives, both LMC and back-up and core staff organised huge amounts of logistical arranging of beds and furniture and luggage and rooms, all in a blur of speed and efficiency… finally the epidural was placed, and Cathy felt almost immediate relief.

I realized vaguely I was hungry, wondering how/when the midwives would eat…they were both staying on, but one would go home to sleep soon, leaving the primary one with Cathy. All the core staff were enormously cheerful and respectful and bright and friendly…We helped wheel the bed through to the theatre and the various staff came in, I almost wondered why we hadn't come earlier! Cathy was overwhelmed with gratitude and relief to be pain free, she could now cope with thinking about what was going on and focus on getting the baby out. The radio was on in the theatre, which I had always hated previously, but now felt grateful for. It was a way to 'switch off' a bit, to dispel the intensity, as was the usual small talk – "do you know what you're having? Have you chosen a name yet? Has this one got any brothers and sisters waiting at home? You bearing up ok there, Dad? Must have been a bit of a hair-raising ride in! Won't be long now, you're doing well!" I felt amazed at the experience of being in this situation just as a friend, and not ('officially') as a researcher or student midwife. I felt I was welcoming everything everyone did, eager for every word and action, trusting that they knew exactly how to handle anything that would possibly eventuate. I realized how much that

confidence was fostered by the way they acted as if this was 'everyday' – for them, of course, it was.

This perspective was entirely new for me, and I was fascinated at how completely safe it felt. The doctor by this stage was pulling on the forceps with what seemed like all her strength, leaning backwards on them to maintain traction; still the baby's head wouldn't come. The radio singing, clocks ticking, machines hissing, voices murmuring…the cut of the episiotomy; Cathy not feeling anything…blood on the floor, splashed on the doctor's gown, hot, rank, open-body smells. Cathy was pushing when she was asked to at the same time the doctor pulled, she couldn't feel any contractions of her own accord any more, so Marcel stood opposite me; both of us cradled Cathy by the shoulders so she could lean up and push each time she was asked. I felt rising anticipation and excitement – it would only be a matter of minutes and we would know if it was a girl or boy!

I felt sure the baby was healthy, despite its reluctance to come; even if it wasn't, everything was here on hand; the feeling of being in safe hands was huge. The staff were quite open in saying 'doesn't want to come, this one, no hurry, we'll try again when you've got your breath back', they didn't seem at all worried that the baby wasn't coming. I wondered if they were, really, and were hiding it. They tried the ventouse suction cap, with no success; it just kept popping off. Forceps again, were they a different sort? High? Low? The doctor was deliberating …I wasn't noticing those details by now, my head alongside Cathy's, exhorting her to push as she never had before, the spectre of a caesarean suddenly appearing in the corners of my mind. More pushing, more pulling. I worried about the baby's head a bit…finally, with one last huge push and pull, the baby emerged with a rush into the doctor's forceps/arms. Tears flowed, palpable relief, and congratulations from all the staff…another wee boy. Well, quite a big boy. He seemed huge and looked as if he'd been pretty compacted in there. What enormous relief we all felt.

A change of focus now, the tidying up began. Cathy's LMC midwife brought the baby over to Cathy and Marcel to cradle, I stepped back just relieved it was all over now, and went back to wondering to myself how the midwife looked so awake and competent. She was doing so many different things at once, and yet had been in this intense situation with Cathy for well over 12 hours, and as it turned out, continued to work right through the day with her visits to

other women before sleeping that night. I marvelled again at all the midwives I knew who did this in different ways in different situations. I wouldn't have what it took, I knew. But right then, rather than worry about that, I needed to go home and sleep. We all made various travelling/visiting/other arrangements, and I headed home, exhausted and elated at this new experience and the new baby, leaving Cathy grateful and happy with him in her arms, learning to breastfeed.

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Chapter Four

'I see myself as a business woman who has chosen midwifery as a career…': neo(liberal) midwives in the market-place

> And it's also looking at … I went to have a session with my mentor and was having a bit of a moment I suppose about how do you make this work? And she just said, 'look … you're over-servicing your clients. You're over-servicing them. Look at your system, look at the way you're working and get it sorted out. Come and see me in two months time when you've had a good look at it'. And I thought that's true. It is very, very easy to over-service. And also because we're new, we need the clients … I mean that's a reality as well … and we've had the time as well in the past, because we haven't been so busy with clients, but we need the clients … we need to make this business work. So there is that tendency to over-service. (Briar, new graduate midwife)

Chapter two of this thesis outlined the concepts of discourse and the relevance of theories of governmentality for health in Aotearoa/New Zealand today. These issues are situated within a context of neo-liberal and liberal-feminist discourses in health and education, which value individual consumer responsibility with regard to 'choice', including in the field of childbirth (Bogdan-Lovis, 1996-97; Rothman, 1999). In that earlier chapter, I explored the theoretical underpinnings and assumptions inherent to my analysis of discourses within midwifery, positioned as it has been within the context of neo-liberal health reforms in Aotearoa/New Zealand. These reforms in turn can be seen to develop as part of, and in accordance with, the dominant and prevailing discourses around economic, cultural, social and political regimes of power within which they are embedded. The opportunities provided by these reforms have led to the emergence of new midwifery subjectivities, which I will explore in this chapter.

Central to this exploration is a focus on the manner in which discourse "constitutes the object of politics" (Larner, 1998b:10), rendering particular aspects of social and political life knowable. The importance of an analysis of the discourses and practices of oppositional groups lies in the insights gained through an understanding of the ways in which the reformulation of identities constitutes an integral part of the process of restructuring. I will outline some key elements of the health reforms of the last decade in Aotearoa/New Zealand. This explanation includes the role of economic theories of market forces, because of the focus

in this thesis of neo-liberal rationalities and processes of governance in health (Cheyne, O'Brien, & Belgrave, 2000; Larner, 1998a; Purdy & Banks, 2001; Rose, 1994). After that I briefly describe the impact of these forces on the maternity services, including the establishment of the then 'Section 51' (now Section 88) of the Health and Disability Services Act 1993, and subsequent provision for the Lead Maternity Carer (LMC) system established in 1996.[20] Next I will examine the talk of different groups of midwives and some individual midwives who participated in my research. One of these groups established a birthing centre practice together at the beginning of 'big bang' reform in 1993, and the other groups were amongst the first graduates of the new direct entry midwifery programme in this particular city, establishing their practices together in 2000. In examining their talk, I explore some of the ways in which these differently-positioned midwives have been able to insert themselves into the competitive market-place described and have taken up certain positions within this market for services - always in relationship to birthing women as partners.

I will conclude this chapter with the suggestion that the practice of partnership can be seen as a complex network of flexible and strategic relations, which exist within the context of governmental discourses and practices of neo-liberalism. The neo-liberal health reforms along market lines are seen to have opened spaces in the marketplace of primary maternity care provision, which has in turn enabled midwives to re-create complex forms of professional partnership with women in ('normal') childbirth. The coterminous relationship between midwives and women is seen as fluid, and may be mobilised to produce differing effects. In this context I suggest that the professionalising discourse of partnership functions as a conceptual strategy. It makes claims about, and produces certain truths with regard to, childbirth, women, and the professional roles of midwives as subjects and objects of knowledge/power. I turn briefly now to the context for this: the health reforms.

Key elements of the 1990s health reforms

While a more detailed description of the health system(s) of Aotearoa/New Zealand are well beyond the scope of this thesis, I will mention some key points that provide the contextual

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[20] These legislative and policy developments and their impact on maternity funding and services are already extensively described and analysed (see Abel, 1997; Daellenbach, 1999a; Donley, 1998; Guilliland, 1997; 1998a; 2000; Guilliland, 2002a; Tully, 1999).

background to the specific development of the maternity services, including midwifery, as they are provided today. Cumming and Salmond suggest that within Aotearoa/New Zealand, both internal and external pressures contributed to the health reforms of the 1990s (Cumming & Salmond, 1998:122). Internal pressures arose from the structure of health care in Aotearoa/New Zealand until 1980,[21] and external pressures from economic and social policy reform in the 1980s and 1990s (Cumming & Salmond, 1998:125). Fougere argues that these pressures are interrelated, suggesting that a general crisis that originates outside the health system intersects with and becomes: "…refracted in specific ways by pressures within the health field itself" (Fougere, 1994a:107). The dismantling of the previous public health system was intended to make way for a new system based on neo-liberal principles including decreased state intervention, a reliance on market mechanisms, and an emphasis on people's rights as consumers (Cheyne, O'Brien, & Belgrave, 2000:87). Within this new system, providers would compete for funding from the state, and through the operations of the market the "freely acting individual will be best able to pursue their self-interest…it is in the market that the individual can exercise choice" (Cheyne, O'Brien, & Belgrave, 2000:79). The introduction of market principles into the public health sector was hailed to improve the efficiency of, and access to, an affordable and effective health care system (Ashton, 1999, 2001; Cumming & Salmond, 1998; Fougere, 1994a; Upton, 1991). The system proposed in the 'Green and White Paper' by an incoming conservative National government in 1991 was designed to:

- Improve access for all New Zealanders to a health system that is effective, fair and affordable;

- Encourage efficiency, flexibility and innovation in service delivery;

- Reduce waiting times;

- Widen consumer choice of services;

- Enhance the working environment for health professionals;

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[21] The Social Security Act of 1938 had made direct state provision for 'free access to health care for all citizens'. Tax funded public hospital systems undertook this coupled with state-subsidised primary care services (and see Fougere, 1993; Fougere, 1994b, 1994a; 2001, for detailed background to the subsequent reforms).

- Recognise the importance of the public health effort in preventing illness and injury and promoting health; and

- Increase the sensitivity of the health system to the changing needs of the population. (Upton, 1991:3)

The imagined achievement of these ideals was to come from the implementation of three related strategies. These were: firstly, to devise new ways to expand the health budget; secondly, to rationalise the health care system so that it could deliver more with the same input of resources; and thirdly, to shift many of the costs of providing health care services back to users (Fougere, 1994a:109).

Market forces

The central features of this paradigm, sometimes known as 'managed competition', were based on economic theories of the market. Different market mechanisms are the focus of different economic theories, but the main objective of introducing any market mechanism into health care is to change the behaviour of both consumers (demand side) and producers (supply side) using economic incentives (Ashton, 2001:112). These theories are based on certain sets of assumptions that must hold if a market is to be effective. In Aotearoa/New Zealand the introduction of market mechanisms into the provision of state-funded health care consisted of three significant themes.[22] The first was the funder – provider split, whereby four Regional Health Authorities (RHAs) would replace fourteen area health boards, and be responsible for purchasing all health and disability services. Secondly, that there would be competition between providers, and thirdly, that business practices would be introduced into public hospitals (Ashton, 1999:139). Services previously provided by the area health boards would now be supplied by 23 Crown Health Enterprises (CHEs),[23] which would operate as

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[22] Market mechanisms were already operating in the health system between private hospitals.

[23] The end of my fieldwork in the early months of 2001 coincided with the January 2001 disestablishment of Canterbury Health Limited and the establishment of the Canterbury District Health Board as part of the result of the passing of the NZ Health and Disability Bill in parliament in December 2000. This intends to lead to more democratic public involvement in health, such as the public election of board members to DHBs. The DHBs are elected administrators of money allocated to a particular population group by the Ministry of Health. The Health Funding Authority was disestablished simultaneously, as part of the move to re-link funding with providing under the auspices of the new DHBs. Section 51 of the Health and Disability Services Act 1993 is now established as Section 88 (Ministry of Health, 2002), but still provides the funding framework for the Lead Maternity Carer system. Because all the midwives referred to hospitals as Crown Health Enterprises (CHEs) or to the Hospital and Health Services (HHSs) during the course of my fieldwork, I use that term here, writing largely in the past

'enterprises' and contract with the RHAs to provide services (Ashton, 1999:135). The changes were proposed by the then Minister of Health, Simon Upton, in a paper known as 'the Green and White Paper' (Upton, 1991). Ashton notes that:

> The general direction of the reforms was towards a more market-orientated structure in which providers would compete with each other for contracts to provide services. This reflected the direction of the health reforms taking place in other countries (especially the United Kingdom, the Netherlands and Sweden), where competition between providers was seen as the mechanism for improving efficiency in publicly funded health systems. The move towards a more market-orientated structure also followed the direction of economic reform that had prevailed in New Zealand since 1984. (Ashton, 1999:135)

Part of Upton's intention as Minister of Health was to increase the responsibility of families and individuals for the costs of health care. Increasing individual consumer responsibility for one's own health and the cost of health care services, and simultaneously increasing the choices available within the provision of health services through this managed competition between providers, forms much of the rhetoric of neo-liberal reform (Cheyne, O'Brien, & Belgrave, 2000; Henderson & Peterson, 2002). Within this new setting, Upton's intentions were to come closer toward asking people to take more responsibility for their own health care (Upton, 1991). Upton's intentions at the time held certain sets of cultural, political and economic assumptions. Some of these economic assumptions must hold for a market approach to remain effective. According to Ashton, these include:

> The existence of many buyers and sellers; few barriers to entry or exit by producers; full information on the part of consumers; that consumers are best able to judge their own welfare; that consumers aim to maximise their welfare and producers aim to maximise profits; and there are no spillover benefits enjoyed or costs incurred by anyone other than those who are party to a transaction. Few (if any) markets are perfect in the sense that all of these conditions hold. (Ashton, 2001:110)

During the early part of the 1990s in Aotearoa/New Zealand, the language of markets, influenced by economic models and theories, increasingly dominated state funded health care and therefore maternity services. Treichler notes this of childbirth in the USA:

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tense to do so (the CHEs were renamed Hospital and Health Services in 1997). As Abel notes in her thesis, 'real-

> Recent changes in the financing and regulation of health care are acting to dislodge medicine from its position as a (loosely speaking) regulated monopoly: freer market competition with its supposedly more diversified consumer options inevitably subjects childbearing as well to the forces of the market. Certainly the language of the marketplace pervades discussions of childbearing even among those to whom the market approach is repugnant. (Treichler, 1990:114)

The texts of more recently graduated midwives participating in my study is pervaded with the language of the marketplace where they talk of setting up 'in business' … 'we need the clients' … 'we need to make this business work' … 'there is that tendency to over-service'. The 'repugnance' to which Treichler refers among some midwives and others making certain claims about childbirth, may exist where the characteristics of commodification are the antithesis of the values that characterized midwives in the early days of their development (Davis-Floyd, forthcoming). Davis-Floyd suggests that, for midwives in the United States, the challenge in the 1990s was how to professionalise and "commodify themselves without losing the essence of who they are and what, uniquely, they have to contribute" (Davis-Floyd, forthcoming). These issues are addressed by many of the self-employed midwives who participated in my project and who balance their midwifery philosophies of women-centredness and continuity of care alongside their need for financial reward.

For the midwives in my project and those practising in the last decade in Aotearoa/New Zealand, the opportunities afforded them by the marketisation of public health, including the funder-provider split instigated by Upton's reforms, have been important. This opened the opportunity for competition between GPs and midwives, but also meant that midwives who became self-employed are placed in competition with each other, by virtue of their positioning within the market-place environment. This situation has led to the development of a quasi-market, that is, one which may be seen to mirror arrangements found in the private sector. It occurs when providers are split from funders, and those providers are not necessarily 'profit-

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time' or current and on-going, versus 'end-point' and hence retrospective analysis and writing-up are important issues when writing about the constantly changing and highly complex nature of health reforms (Abel,1997:30).

seeking entrepreneurs' as they may be in the private sector (Cheyne, O'Brien, & Belgrave, 2000:83), but may be providing what is seen as a primary health service.[24]

In this case in the public health sector, the state continues to fund maternity service providers. GPs as private practitioners subsidised by the state had operated in this way before the reforms; what is perhaps most significant is that midwives could now act like GPs – be private providers who offered a totally state-funded service. These services include prescribing and administering certain medications, requesting routine diagnostic tests, and transferring clients to specialist services (Tully & Mortlock, 1999). That these services should be free to women is a significant component of the environment in which midwives practice. These opportune changes have led to the on-going (re)creation of new and highly complex networks of midwifery relationships across - and between - sites of practice, as well as with other maternity providers (GPs and obstetricians). This includes the impact of self-employed midwives on those midwives who, for various reasons, have chosen to remain fully or partially employed by a CHE. I explore these relationships in the following chapters of the thesis.

The impact of market forces within health on the maternity services

> RS: What other kind of issues do you think are especially relevant at the moment? Not just to you as a community midwife but to midwifery in NZ.
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> Virginia: I think the issues perhaps would be that there's a lot of midwives out there … a lot of midwives … and I think we need to have more get-togethers with all of us, from all the different practices, whether they're independent or whatever and just, you know … meet up as women and as midwives without this … I sometimes feel like there's a little bit of competition that goes on … because it's a money thing, you know, and so everyone's out there competing to get clients … I don't know whether it is even so much to do a good delivery or it's like just a number … but we need to take care of each other more. (Virginia, WHD community midwife)

The 1990 introduction of the Nurses Amendment Act had enabled midwives to practice independently of doctors, and hence simultaneously set these groups in competition with each

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[24] Where the providers are providing the same professional service, such as midwifery, but vying for funding, the terms 'internal market' is sometimes used interchangeably with 'quasi market' (Cheyne, O'Brien, & Belgrave, 2000).

other. [25] Each group of professionals claimed on a fee-for-service basis for consultations and procedures, which made it difficult to either anticipate or control the expenditure on maternity services. Fees for service were claimed not from pregnant women, but from the Department of Health according to the Maternity Benefits Schedule (MBS). These were the fees also claimed by midwives after the Nurses Amendment Act of 1990, and payments were "received irrespective of whether the practitioners provided the services independently or in a shared care arrangement" (Tully, 1999:161). According to Tully, Upton told midwives in 1992 that "the fee-for-service arrangements led to over-servicing and provided little formal performance-related accountability between Government and providers", while at the same time leading to "rivalry and poor communication between these groups of providers" (in Tully, 1999:161). Tully's 1999 thesis demonstrates the ways in which negotiations over maternity care funding have:

> significant implications for each profession's jurisdiction vis a vis the other in terms of sustaining or undermining that position. Arrangements can advantage one profession more than the other in terms of its capacity to defend its jurisdiction and/or encroach on the jurisdiction of the other. The fact that the stakes are so high accounts for the intensity of the struggle. (Tully, 1999:153)

With the implementation in July 1993 of the funder-provider split, outlined in the previous section, the four new RHAs became the purchasers of all public maternity services in their regions.[26] Upton wanted the RHAs to purchase maternity services that 'actively encouraged women to get the care that was most appropriate to their needs', and would have to 'give women the scope to choose their own provider' (in Tully, 1999:161). The RHAs formed a joint maternity services project in 1993 in order to undertake this.[27] However, as Abel notes, little significant change occurred in the organisation or funding of maternity services until 1996 (Abel, 1997:160). Both independent and CHE providers continued to provide services on roll-over contracts from 1993 while the new RHAs began to develop arrangements for maternity services in line with the new philosophy of the health system, which "…meant

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[25] The circumstances leading to this Act are discussed in chapter one of this thesis; and see also Guilliland 1997, 1998, 2000; Tully 1999, Papps and Olssen 1997; and Abel 1997 for related discussions of this.

[26] The four RHAs were replaced by the Transitional Health Authority (THA) in 1997, which in turn became the Health Funding Authority (HFA) in 1998; midwives claimed fees from the Health Benefits Limited (HBL) section of this (see Tully, 1999, and Davis and Ashton, 2001).

[27] See Tully (1999) and Abel (1997) for full descriptions of the activities of the Joint RHA Maternity Project Group.

taking into account the government's six principles for purchasing health and disability support services – equity, effectiveness, efficiency, safety, acceptability and risk management – and considering these within a framework based on competition and market principles" (Abel, 1997:161). In March 1994 the Ministry of Health (MOH), on behalf of the RHAs, presented to cabinet five key features for the purchasing of maternity services which would herald the Lead Maternity Caregiver (LMC) system. They were:

- Women will choose a 'lead professional' who will take overall clinical and contractual responsibility for her care;

- Services will be purchased for four modules of service: balanced information about choices, care during pregnancy, care during labour and birth, and care following birth;

- Services at the primary level will be purchased by way of fees for each module with some budget-holding for other primary care services that may be needed;

- Facilities such as hospitals or birthing centres will be purchased separately to services;

- Secondary services for those women who require them will be purchased separately. (MOH 1994; in Abel, 1997:166)

At this time the estimated budget for total national expenditure on maternity services was $350 million, a figure the RHAs did not want to exceed. Approximately a quarter of this ($90 million) would be spent on the Maternity Benefits Schedule (MBS), from which midwives and other self-employed providers were entitled to claim, and the remainder would go to the CHEs. Capped payments for carefully defined modules of care were therefore seen as one way to prevent over-spending (Abel, 1997:166). Midwives were in some ways constrained by this attempt to control spending on maternity services, but were also the beneficiaries of these principles. They could contract to provide all of the modules. Unlike their main competitors at that time, GPs, midwives were able – and willing - to work as partners with women in all of the packages, comprising ante-natal and post-natal care, as well as the birth module. Direct Entry midwifery education specifically prepared midwives for continuity of care, that is, to contract to provide all modules of service provision under Section 51.

Section 51

> M1: It's extremely poorly paid … for the responsibility you have … it is poorly paid. We all agree that Section 51 is under-funded … we need more money.[28]
>
> M2: Section 51 is fine but there's not enough money in it so … I feel personally that … and I'm talking from a personal viewpoint, I'm not sure where the others stand on this, but I feel that the modular payment system is very, very difficult for a … specially for a new business … and we're looking at where we are now with a new business … and sure there's enough cash flow … most businesses wouldn't survive on the type of cash flow we get in midwifery … you book a woman at … say an average of, say she might be eight weeks pregnant … we don't get any money paid out until she is 32 weeks.
>
> M1: So you can understand that the cash flow for a new business trying to get off the ground was just horrendous … somehow the cash flow situation needs to be improved.
>
> M2: I think the basic thing though is that it's under funded … ante-natal and post-natal contracts are under funded. They've been applying since 1994 … I think …and there's been an increased cost of living … an increase in petrol…
> (Group 'two' second interview)

In 1996 and during continued negotiations between the RHAs, the New Zealand College of Midwives (NZCOM) and the New Zealand Medical Association (NZMA), the RHAs released the new modular payment framework under Section 51 of the Health and Disabilities Services Act. Negotiations between parties were to continue however, over issues raised by the NZCOM such as: "the cost structures for rural services and postnatal home visiting and the watering down of the LMC concept to one of budget holder rather than primary caregiver" (Guilliland, 1997:9). This could be seen as a consequence of RHA and MOH attempts to contain the costs of a free service. Guilliland further stated that the first RHA drafts of Section 51 had: "failed in our view to recognise women as central, continuity of care, maternity

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[28] In this particular chapter and others there are often quite lengthy excerpts from interview transcripts, with several different midwives talking at once. While I have always given individual midwives pseudonyms in the thesis, in those places where I explore the interview texts of particular groups (referred to as 'group one/two/three' etc), I have referred to the first speaker in each separate speaking instance as M1, the second M2, and so on. In this way the system 'M1', 'M2' functions only to indicate the order of speakers in that particular instance of analysis, and the label is not attached with a particular midwife in the same way as a pseudonym might be. This is because in protecting the speakers' anonymity, I think there is less likelihood for recognition of a particular midwife within the group to occur by a reader piecing together the narratives as they are interspersed through the thesis (see Smythe, 1998, who also discusses this issue). This approach is consistent with that based on the analysis of discourses where what matters is not who speaks, but what is said, and what statements are made – refer to chapter two of this thesis.

services as a core service and midwifery as autonomous" (Guilliland, 1997:6). Despite the ongoing difficulties encountered in negotiations with both the RHAs and the NZMA, the NZCOM considered that to continue to negotiate over Section 51 was vitally important for midwifery as an autonomous profession.

During the prolonged negotiations Guilliland exhorted midwives to recognise and support the philosophy underpinning Section 51 as the 'Contract for Autonomy'. Section 51 would recognise midwifery's autonomous professional status under the Nurses' Amendment Act 1990 and provide midwives with payment equal to that of doctors for equal work. During 1997 the NZCOM continued negotiations with the RHAs over rural definitions and postnatal funding (Guilliland, 1997:9). In an article to midwives in the April 1997 NZCOM journal Guilliland outlined a timeline of continually unresolved MBS negotiations from 1989 to the time of her writing. She called on midwives to understand the implications for women/consumers, as well as for midwives themselves, of the continuing struggle:

> Paradoxically, Section 51, considered the mechanism to preserve midwifery autonomy and consequently women's control over childbirth, also has the propensity to tear the profession apart if midwives fail to understand the principle and politics behind the College's position. Section 51 is a collective, nationally agreed contract which is the foundation for all other contracts negotiated with smaller groups of midwives including CHE midwifery services. It is its collective and combined professional strength which gives midwifery negotiating power. Most midwives are not yet strong enough to guarantee that negotiating power when fragmented into multidisciplinary groups. Neither is society ready to fully stand behind our embattled profession. (Guilliland, 1997:6)

The shift to the new system of managed competition now began to threaten the previous prevailing medical control over health policy through the emerging neo-liberal discourses and practices of governance. Abel states:

> The direction and manner of the changes provided further evidence of the shift, begun in the previous decade, in the controlling influence over health services policy from the medical profession to government agents employing policies based on neo-liberal ideologies. The new system tightened mechanisms for financial and clinical accountability and this coupled with competitive contracting enabled the state to exercise a degree of control over the profession that had not previously been possible. (Abel, 1997:172)

The new system was indeed potentially supportive of the midwifery interests of providing choice, continuity and control in childbirth for women. At the same time, it heightened public visibility of midwives as responsible for financial and clinical accountability in service provision. It significantly challenged previous medical hegemony over the provision of primary maternity services (and see also Abel 1997; Tully 1999).[29] The doctor-held monopolistic control over childbirth was broken in the competition between doctors and midwives within this new system of maternity care that is both market-orientated and state funded and regulated. Midwives have emerged as the dominant providers as a result of the Nurses Amendment Act, the decision to pay GPs and midwives the same amount for providing normal maternity services, and Section 51 (Abel, 1997; Guilliland, 1999, 2000; Tully, 1999; Tully & Mortlock, 1999). However, the new LMC system could not be taken for granted, as Guilliland stated:

> We would be foolish to underestimate the strength of the medical profession which is why Section 51 is still a very important part of our evolution as the RHAs are also neophyte in experience and vulnerable to the political pressure the doctors are exerting. It is therefore not incidental that doctors are fighting so vigorously and so collectively against the Section 51 changes. (Guilliland, 1997:7)

Indeed the medical profession only reluctantly accepted the direction of the changes, and ongoing (re)negotiations continue (see Abel, 1997; Guilliland, 1997; Guilliland, 2002a; Tully, 1999, for details of these negotiations). Medical resistance to the increasing dominance of midwifery, in terms of both lobbying power and service provision, function within attempts to maintain professional control over the field of childbirth. Guilliland believed that the medical resistance against the Section 51 changes was not about safety and quality, as doctors claimed it was, but was a bid for control over the health service and its budget. The doctor led development of Independent Practitioner Associations (IPAs), according to Guilliland, aimed to "disenfranchise midwifery and claim back the total budget under GP cartels or organised collectives (IPAs)" (Guilliland, 1997:7).

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[29] Obstetric/medical control of childbirth was largely linked to discourses and practices around pain-relief (requiring technological intervention), and safety (something also requiring scientific management and hence, hospitalised birth). Midwives in Aotearoa/New Zealand became subsumed under nursing and eventually lost autonomy completely by 1971, thereafter requiring a doctor to supervise their activities while attending childbirth either at home or hospital, until the implementation of The Nurses Amendment Act in 1990.

At the 2002 NZCOM conference, Guilliland outlined the current devolution of what is now known as Section 88 (see earlier footnote this chapter), and of maternity service funding to the DHBs. She reminded midwives that Section 88 provides for a strong, women-centred, government-funded maternity service, which acknowledges and funds midwifery as a core service. It provides for equity of access to facilities as well as supporting homebirth. She repeated the warning she had given five years earlier that midwives would lose negotiating power if they became fragmented into multidisciplinary groups. She exhorted midwives to refrain from joining Primary Health Organisations (PHOs), several of which are likely to be contained within each DHB, referring to the fragmentation of midwifery bargaining power and goals which was already seen when some midwives began to work within IPAs (Guilliland, 2002b). Guilliland believes that it is the collective, coherent, and unified actions of midwives that will be most efficient in challenging medical hegemony. Yvonne, a self-employed midwife who participated in my study draws attention to the potential for fragmentation amongst midwives when they were no longer united against GPs collectively:

> … where we need to go is somehow getting midwives much more united… they were much more united when they saw the GPs as a common, you know … when we banded against the GPs … that sounds terrible but it was quite true - when we no longer had that to keep us together then we all went our own different ways, and as I say, sometimes compromised by money, sometimes compromised by power. (Yvonne, self-employed midwife)

The potential for midwifery dispersal or fragmentation is sometimes encouraged as 'networking' from within powerful PHOs where the emphasis is on the flexible multidisciplinary team (Gauld, 2001; Guilliland, 2002b). Indeed, indications are that emerging PHOs, led by GPs and built around existing IPAs, have shifted their interests from service and budget controls to building bridges and networking with other primary care providers such as nurses, midwives and community health groups (Gauld, 2001). Guilliland cautioned midwives that, while the rhetoric of 'multidisciplinary teamwork' contains an ideology attractive to some, the PHOs will be medically dominated and provider, rather than woman, focussed.[30] The fact that midwives cross DHB boundaries, as well as primary and secondary service provision boundaries, makes geographical confinement to a particular PHO

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[30] And see Opie (1998; 2000), for critical analyses of 'multidisciplinary teamwork' in health settings in Aotearoa/New Zealand.

nonsensical; indeed self-employed midwives may provide services across the boundaries of several different PHOs in just one day of travelling home visits (Guilliland, 2002b).

The NZCOM provides the Midwifery and Maternity Provider Organisation (MMPO) for midwives, which will sit alongside PHOs (Guilliland, 2002b). It is the 'business structure for midwifery' which will provide 'practice management systems', to support self-employed, and employed case-loading midwives (Guilliland, 2002b). Guilliland's concern in continuing to stress the importance of midwifery autonomy (for individual midwives as well as for midwifery as a profession), is also based on the evidence that when midwives do work with doctors in shared care arrangements, in negotiating MOH guidelines for referral, or in attempts to lessen disciplinary conflict, increased intervention rates may be one result of the medical model taking sovereignty over the midwifery model of care (Guilliland, 1997; 1998a; Guilliland, 1999, 2000, 2002a, 2002b).

Midwives: moving in to the market

> This last year has been about learning to be a technician, like taking bloods, IV certificate, epidural certificate – that's just part of the process, we're almost having to become mini-obstetricians. I've just done a reiki course, and want to offer that as well – I can offer the full smorgasbord of medical stuff, now I want to balance it all up again. (Bess, self-employed midwife)

After the passing of the 1990 Nurses' Amendment Act, midwives steadily moved away from employment in hospitals to self-employment. Until the 1996 introduction of the Lead Maternity Carer (LMC) framework accounted for under Section 51, some midwives worked in 'shared care' arrangements with GPs and/or obstetricians. This often served a strategic purpose in terms of enabling midwives to gradually build up a clientele of their own, sometimes also remaining in part time employment with a CHE, as Frania explains:

> I live in a rural area and there was no post-natal service there and so I decided that I could offer that along with working rostered shifts in labour ward … as soon as I made it known that I would do that I was approached by somebody in the community who had been looking for a midwife and no one would look after her because she lived rurally so would I … and I shared care with her GP which in that early part of independent midwifery was a very common thing to do. (Frania, self-employed midwife)

Explaining how she moved gradually into the market of maternity service provision after identifying a potential gap in the (rural) market, Frania went on to talk about the changes to her practice after the LMC system was implemented:

> I feel that the change in 1996 to the new Section 51 has benefited me … I worked quite convivially with GPs prior to that but there were times when you wished that there was only one person making the decisions when it came to something critical … it was always very relaxed and very happy whilst the situation was relaxed and happy but … so the change to do my own work without that shared care has made it a lot easier … and I still have very good interactions with all the GPs I worked with in shared care. They refer women to me. Most of the GPs that I've worked with in the past have reached the stage where they're perfectly happy to stay in their beds at night, knowing their women are getting the care that they think they ought to have. (Frania, self-employed midwife)

At this time many GPs left the field of maternity service provision in the middle of the highly publicised 'turf wars' between midwives and GPs and changes to service and funding specifications (see Guilliland, 1997; Tully 1999). Others boycotted the new arrangements or even advised couples to delay conception until the disputes were settled Guilliland, 1997:7; Tully, 1999:180). The self-employed midwives who participated in my study all went into business during a time of immense conflict between providers. This conflict was played out in the media, with the pregnant bodies of women portrayed within conflicting discourses around safety, and the appropriateness of either a medical, or midwifery approach to birth (Tully, 1999). These portrayals highlighted the centrality of pregnant bodies as 'health consumers', and the ways in which they are disciplined, inscribed and regulated subject to the power/knowledge of 'experts' within the realms of governance (Mitchell, 1996:203), particularly here within the oppositional models of medicine and midwifery. The NZCOM publicity slogan 'Choose wisely: choose a midwife' emphasises the increasing availability of choice for women in normal birth, and if a woman is wise, she will choose a midwife LMC over a GP or obstetrician:

> …but yes, it's working out how you support women in their choices and the information they get so their choices are feasible but in the end sometimes they still make choices that don't inherently make sense to us. Like hospital to have a baby. You know, why would you go to hospital to have a baby? But that's where it makes sense for them to go. (Natalie, self-employed midwife)

Despite the sense of resignation invoked in Natalie's narrative about the different choices women may make for their place of birth, the commitment she and the other self-employed midwives who participated in my study make to both woman's choice and to continuity of care means that, in practice, wherever women choose to go to birth, the midwives will follow. Some of the implications of this are the subject of the next two chapters.

The breaking of the medical monopoly over childbirth in the context of the market-based reforms had opportune consequences for midwives that had not been specifically designed by the authors of the reforms. Fougere suggests that the new 'hybrid' health system in Aotearoa/New Zealand is less the result of design from above than skilful improvisation from below (Fougere, 1997, 2001). In this way the 'skilful improvisation' of midwives meant they could usefully capitalise on the neo-liberal changes. One group of midwives participating in my study recounted the improvisational ways they had moved into the market place during the early days of the health reforms in 1993:

> M1: There were lots of … destructive and negative things about being in a climate of health being an industry and Simon Upton was with the Ministry of Health at that stage … and it was a National Government that had been in … that was carried on by a Labour Government … but … just the idea that health was an industry that needed to pay … to make its way, meant setting facilities and organisations in a state of competition. They were saying health providers need to come up with innovative ideas and ways of providing the service and there were lots of destructive things about that whole ethos … but for us it did present an opportunity because they could hardly say well … the rules of the report say you need to do this and then when you applied to do it say no … so … it was an opportunity for us … just at that time.

> M2: There was a lot of that climate in the hospital system as well … it was sitting over our heads that it was going to close and what are we going to do? Are we going to go independent? Are we going to go and work in a base hospital? Are we … what are we going to do? So we were all sitting with that insecurity over our heads which …

> M1: And the feeling of injustice that they're dictating what sort of service was going to be available to women … and restricting that service. (Birthing Centre, first group interview)

The first midwife's words above suggest (with a hint of Treichler's 'repugnance') that despite the 'destructive and negative things' about a market and competitive approach to health, the reforms instigated by Upton provided midwives with the opportunity themselves to enter the

spaces that subsequently opened up in the market place of primary maternity service provision. The power of bureaucrats to make decisions that would impact on the livelihood of midwives and the experiences of birthing women was something to be seen as a challenge to rise to and resist. The risk that the small low tech hospital where they were all employed might close as part of the reforms meant insecurity 'sitting over our heads' in terms of future employment, coupled with a sense of injustice that a potential closure would restrict services for women. These issues provided the impetus for a decision to manoeuvre themselves - from below - into the market place.

The challenges encountered in establishing what was to be the first midwife-owned and operated birthing centre in Aotearoa/New Zealand were significant under these circumstances where the RHA bureaucratic systems lacked templates or criteria on which to base negotiations for providing licensing and contracts with midwives in this position:

> M1: The opportunity was there and we were going to make them accept that we had taken that opportunity … and even though their rules and regs were so difficult to get your hands on … and you felt like you were taking one step forward and three steps backwards … for instance there wasn't even a license …we had to have a private hospital licence … we couldn't even jump them into thinking of giving us a birthing centre licence … you know…

> M4: There were no criteria.

> M1: Because there was no criteria … all that sort of thing … you got your teeth into it and you just weren't going to give up … you become quite terrier-like … you know… (Birthing Centre, first group interview)

The RHA did not know how to negotiate with a birthing centre - so the midwives were able to improvise. They were able to capitalise on the neo-liberal ideology of choice and competition, and provide care that was state-funded and hence free to women. Working as self-employed midwives and providing an autonomous service to women was very different to their previous working situations, and was something their earlier (non-Direct Entry) midwifery training had not foreseen, or prepared them for. The reconstitution of their midwifery identities emerged as they resisted the power of some bureaucrats to make decisions affecting them, and negotiated in highly improvisational ways with other bureaucrats. This was always done in partnership with women, who, as particular birthing consumers, had an investment in ensuring that there remained facilities for low-tech births. These women/consumers rallied strongly

around this group of midwives, in a similar way as homebirth consumers might rally around homebirth midwives at different times (see Daellenbach, 1999a). In the establishment of this birthing centre, and the part the consumers played in supporting the midwives, it is possible to see how the neo-liberal conception of 'health consumer' can be mobilised for both resistance and opposition to bureaucratic power, but also provide a basis for policy development and the negotiation and reinforcement of professional dominance (Henderson & Peterson, 2002:6).

In contrast to the issues encountered by the birthing centre midwives, midwives who graduated after the 1996 changes grappled with some quite different issues at times. They stepped out of their polytechnic direct entry midwifery (DEM) training, often with student loans of up to $40,000, and entered their professional field where they necessarily inherited the language of the market place as it intersected with and pervaded that of childbirth. The language of the marketplace preceded them into the field of childbirth 'service provision'. Here, this inherited language constituted their subjectivity - as businesswomen - in its reproduction and repetition during the practice of midwifery within the discourses of the profession (see Allen & Hardin, 1998). To train as a midwife, and become a self-employed practitioner is also to become a small-business woman; offering a fully funded primary health care service subject to the legislation and regulations controlling maternity services.

If these new graduates chose to establish themselves as a self-employed group practice immediately after graduating as direct entry midwives they had to set up business 'cold', rather than 'dovetail' in to independent practice while still remaining partially employed by a CHE or sharing care with GPs. One group of recent graduates, in the first of two group interviews four months apart that I undertook with them, talks about their strategies for this setting up process:

> M1: I think because we've been so open …we tell our clients that we're new…and I think it's probably a progression of steps in a way … we've got very good … I mean our brochure is just a brilliant, professional selling point we feel … and our letterheads are good and we've got … these rooms … the fact that you've got the confidence to come and set up in a physical location and say well this is us … we've been in the newspaper two or three times … on the front page of the local rags round here… you know, new midwifery practice… recently graduated… you know, it's something that we've never… um… I think some of the local doctors have been … waiting and seeing.

M2: We've got other practices and other doctors who are actually wanting to come and see us. They want us to come round there for a meeting … we've written to them all … or phoned them and said look, we're a new midwifery practice, working within your area and sooner or later some of your patients are going to become our clients … so it's good for you to know about us. So we've phoned them and it turned out only one of us could go and meet them

M1: Anyway … they were really, really interested in us. And they said they'd like to have another meeting, possibly to discuss some sort of more formal arrangement where they would be able to recommend their clients to come … or give them the option to come here … and would we like to go back for another meeting! And I said 'oh, I'll have to go back and discuss that with my colleagues'… (laughter). (New graduates: group 'two', first interview)

Working independently as midwives after 1996 required the new graduates to establish a complex network of professional and business relationships. These networks included the development of a certain rapport with GPs and many other professionals who are either directly or indirectly (such as laboratory and pharmacy services) involved in the provision of primary maternity services. Furthermore, this is undertaken within a discursive framework of partnership with women which clearly positions GPs as rather more medicalised and paternalistic than midwives as the appropriate providers of this service for women: 'your patients are going to become our clients'. As Tully, Daellenbach and Guilliland note:

> By constructing a professional identity based on partnership with clients/consumers, midwifery is able to make particular claims over birthing work that differ from those of rival health professionals such as doctors and nurses. These claims, which relate to midwives' knowledge/skills and relations with women in childbirth and maternity politics, are made in an effort to secure professional control or jurisdiction over 'normal' maternity care vis a vis doctors. Claims about partnership are therefore used to strengthen midwifery's position in the competitive medical/health division of labour. (Tully, Daellenbach, & Guilliland, 1998:248)

At the same time, the use of the word 'client' indicates a discursive shift from the word 'women', and denotes the intersection of different discourses converging at the site of childbirth. Importantly, both 'client' and 'women' are used to produce partnership, whether in making claims about business partnerships or political partnerships, respectively. This particular group of newly graduated midwives had had varying experiences as professionals and businesswomen in different careers before becoming midwives. They shared similar philosophies and ideas about parenting, and during the course of our group

discussion/interviews and the participant observations I undertook with them, they impressed upon me that it was a strong commitment to their own families that formed the basis for their partnerships with each other and with their clients. They were all concerned to act as role models for the women they worked with in terms of 'looking after ourselves'. One midwife said, 'if we don't look after ourselves and show our clients how we do this, what are we telling them? That we are happy to abuse ourselves?' The development and maintenance of clear personal and professional boundaries contributed to the goals for 'long-term business sustainability' that this group share. As first graduates of the first direct entry midwifery programme in this particular city, their positioning as midwives is historically and contextually specific:

> M2: It was part of our code of practice really wasn't it, that we would see ourselves as professionals ourselves … and therefore it was our responsibility to build up relationships … professional relationships …

> M3: We wrote to them all … we visited all the GPs surgeries around here who are connected with all the Plunket … most of the Plunket nurses. We contacted the Medlab staff … the obstetricians, paediatricians … we've written to them all and we've been to …

> M2: … as well as the hospital management, and the staff of labour ward … we've sort of met with them and we've said look, this is us and this is the way that we work, and what do you want to know of us, and these are the kind of things that we would like to know of you and things like that … and that seems to have worked very well. (New graduates: group 'two', first interview)

This particular group of midwives discussed the ways in which they conducted themselves with regard to their establishment of and discursive positioning as 'responsible' and 'professional' business women in the market place. Each of these statements exists at the level of discourse and can be seen as an effect of power relations within the market place. Techniques such as networking and maintaining 'open communication' within a 'code of practice' have opened the way for their entry into this arena and facilitated working relationships. Before interviewing the midwives as a group a second time, some months later, I undertook some participant observation with two of the four midwives on some ante and post-natal visits at women's homes. After one of these visits, Briar spoke to me of some of the business developments within the practice and the group's decision to subcontract to a locum midwife at times:

…my interest is in business and sustainability; I see myself as a business woman who has chosen midwifery as a career. I am passionate about midwifery and business working together. I am looking at continuity of philosophy, not necessarily continuity of carer all the time, and I think that's the vital thing. We use a locum now, in case I am called to a birth and need to miss a post-natal visit or something, or a fully booked ante-natal clinic; it is very stressful having to reschedule a full day of visits for me and an inconvenience to my clients. We can't be in six places at once, and it's an inefficient use of my time to try and catch up on visits that have been cancelled…so if we need to attend a birth suddenly we call her in for post-natal visits. (Briar, new graduate midwife)

Four months later, I visited the midwives again for another group interview.

M1: It would be really interesting to compare this time to four months ago, because in the last four months we've had quite a lot of learning about the whole business side and we've really looked closely about … are we making any money out of this? Is there any potential for making a living out of it and things like that. It's really making us re-assess and getting a little bit hard-nosed interestingly enough, about it and saying OK, how can we balance our midwifery philosophy with the fact that we are running a business. I think that's something that for me has been quite a startling thing. I'm into it now and I'm thinking OK, it is a business for me … and petrol prices, diesel prices and things like that have gone up … I've really got to be thinking OK, I can't drop things and just go, I've got to organise this so it's not going to cost me any more money to sort of do that kind of thing … and balance that with the need to go, because I do need to go and see a client.

M2: …for me it's been a good process because I'm working through it and feeling good about it but I am changing my position from where I was six months ago…

M1: I think that's been the painful growing up … but it's been really exciting, and it makes sense. We spent three years developing the midwifery philosophy plus all the other life experiences that we've had to get us to that point and that was three years … and we've bought previous business experience with us, there was very, very little time to develop a business philosophy and I'm not sure that it's necessarily the Polytech's role to instil that business philosophy … I think it's something you possibly have to learn on the job but I can understand why a lot of midwives don't succeed at the business side. Just because of the nature of the profession. It's a very … it's one of those caring professions and you end up having your own needs very much put to the background and the needs of your own family … but when we went back and listed some of our original goals and our ideas about setting up a business, and always at the top of it for me has been profit … I've always been profit orientated and when we looked at what we were actually earning per hour we were all shocked … so we've made some changes haven't we? I think we've become a lot smarter at what we're doing and we've probably compromised our midwifery philosophy in order to develop a

> business philosophy that … and I suppose in some way we're learning to marry the two together … but I definitely feel a lot more confident about the future as a business-woman and midwife than I perhaps did a few months ago.
>
> M3: I don't feel that I've compromised my midwifery philosophy … I think I've just clarified it and redefined it a little bit. I don't see it as a compromise.
>
> M1: I see it as streamlining really … and I don't think we've compromised the care we give either. I really don't … we're still aiming for a really high standard. It's just making it workable. (New graduates: group 'two', second interview)

'Making it workable' here requires a complex balancing of personal and family needs with the work involved in 'streamlining' and smartening the business of midwifery work in order to make a profit. This must be done without compromising the care given to women/clients, which would disrupt aspects of the group's midwifery philosophy. In other words, 'business philosophy' and 'midwifery philosophy' appear as different discourses, which intersect with varying degrees of tension. Different midwives have contrasting views on whether this involves professional compromise or not. M1 and M3 negotiate briefly over meaning in terms of 'compromising midwifery philosophy', then concur that while this is something that has not compromised actual care to women, it consists of 'streamlining', 'clarifying' and 'redefining' midwifery philosophy in the 'becoming smarter' required to develop a workable business.

In this excerpt, the midwives are positioned as businesswomen juggling the demands of family and personal life while trying to streamline a new business and make a profit from it. At the same time, their desire is to maintain their commitment to women in being the most appropriate providers of primary maternity care within a midwifery philosophy of continuity of care. As the midwives above suggest, at times this requires a 'marrying together' of two quite different philosophies; philosophies which for some midwives are difficult to reconcile. Davis-Floyd refers to this as the 'qualified commodification' of midwifery (business) practice that midwives must undergo in order to achieve cultural legitimacy (Davis-Floyd, Pigg, & Cosminsky, 2001; Davis-Floyd, forthcoming).

In this thesis I argue that midwifery 'partnership' with women can be seen as a conceptual strategy. It can be deployed and mobilised within a suite of discursive frameworks, each with different political effects. This chapter examines ways in which midwives discursively frame their identities as businesswomen, which necessarily involves the co-construction of

women/partners as 'clients'. At other times and for other purposes, midwives may refer to themselves as 'midwives' and to potential clients as 'women', in order to mobilise around political claims. The NZCOM slogan 'midwives need women need midwives need…' is an example of this. What effect does constructing women as 'clients' have on them? Within a market environment, responsibility and choice are two issues to consider. Guilliland states:

> Midwives' professional status rests entirely on our partnership with birthing women; our role as independent birthing practitioners is to put the responsibility back on to women so they can retain control and power over what happens to their bodies. (Guilliland, in Tully & Mortlock, 1999:174)

The newly graduated midwives in my study frequently talked about the ways decision-making occurred within their relationships with women/clients, which resonate with Guilliland's statement above. While expecting the women to take full responsibility for their pregnancy and birthing choices, the midwives also described some women as 'feeling overwhelmed at times with the choices available', and sometimes resistant to having more responsibilities in their lives. In spite of some clients' resistance to making choices, and their preference for the midwife to 'just tell me what you would do', the midwives all felt strongly about avoiding 'making decisions for' the women. From within this professional midwifery discourse of empowering women through informed choice, making such decisions would constitute an abuse of power, according to the midwives I spoke to. Not making decisions for those women who asked the midwife to do so was a point of tension at times for some midwives who had themselves experienced the desire to be a passive recipient, rather than active agent, in their own personal health-care lives (and see Grace, 1991; Henderson & Peterson, 2002; Lupton, 1995, 1997b). Some midwives spoke about the ways choices are constituted in a restrictive way for women by some GPs and consulting obstetricians, and by some midwives whose practice is constrained by protocol:

> M1: You know, same with the placenta … you know … 'well if you don't want to have an ecbolic for your placenta then you're risking bleeding to death' … is that informed choice?

> M2: It's not choice at all! (laughter)

> M3: It's not, is it.

> M1: And there's. . . and I think you've got that power as a health professional, you do have it … and I think that you always have to be really aware. You know it's like … I mean we kind of talk about this … depending on where women choose to birth … it's very easy to be very effusive and happy about the choices she makes … or be very kind of 'Oh, um, that's, um… nice …'

> M3: 'Are you *sure*? Do you *really* want to go to the hospital … are you sure you wouldn't want to have a look around or…' (laughter). (New graduates: group 'two' first interview; emphasis in original speech)

The issues for midwives of negotiating choice were frequently predominant in their discussions with me. Midwives need to be 'really aware' that they have 'always got that power as a health professional', in order not to abuse that power by making choices on behalf of the women in their care. These midwives are aware, however, of the ways they might subtly influence women's choices, and in a comic moment parodied the ways they might gently guide, rather than directly impose upon, women's choices for birthplace. This guidance is performed largely through facial gestures and voice intonation, and is clearly juxtaposed in contrast to the rather more domineering influence employed by the practitioners M1 refers to.

The ways in which women's 'choice' is facilitated or constrained by midwives is the subject of scrutiny in Britain (Levy, 1999; Stapleton, Kirkham, & Thomas, 2002). The analysis in this thesis suggests that midwifery partnerships, which include the facilitating and negotiating of different choices for women, are conducted within specific local and historical discourses and practices of professionalised midwifery. The discourses of reflecting on practice, self-monitoring and self-surveillance function to govern the professional conduct of autonomous midwives from a distance, within neo-liberal spaces of freedom and accountability (Fournier, 1999). The ways in which choices for women are facilitated constitute the partnership; they are not the result of a pre-existing partnership, but an effect of the discourses within which they are embedded. For the midwives in my study who work within a discourse whereby women are active participants in their own birthing processes, it is more appropriate to gently guide, rather than directly impose upon, some of the choices women might make.

Monopolisation vs medicalisation

Co-constructed together as both business and political partners, midwives and women have been able to resist the historical monopoly of medicine in the marketplace of birth. Midwives

have effectively manoeuvred 'from below' in innovative ways to become the predominant providers of maternity services within the context of neo-liberal health reforms. While some doctors, as Frania noted, are 'happy to stay in their beds at night', others struggle against the new midwifery professional dominance, in their resistance to Section 51/88, and in their establishing of IPAs and PHOs from where they might secure jurisdiction over the total health service and its budget (Guilliland, 1997:7). Midwifery and woman/client selves and subjectivities must change and move in order to avoid being captured and pinned down too long, taken apart, examined, diagnosed and treated as 'Other' by medicine, the law and the media. 'Partnership' functions as a conceptual strategy, whereby midwives and women together can shape-shift at different times and in different places and spaces, forming hybrid relationships. The subject position of '(health) consumer' for women is part of a conceptual strategy within partnership that may be mobilised at different times and places towards different ends. Other forms of partnership may function to unify different midwives for collective action against doctors at times, while still other forms of relationship appear as 'networks' between individual midwives amongst GPs and doctor-led initiatives.

Midwives have developed complex new and strategic forms of 'partnership' with other professionals such as GPs, who previously existed generally as adversaries in the market place as they competed for business in the early 1990s. As GPs have moved out of providing maternity services, they appear to be no longer the adversaries they were for midwives a decade ago, when midwives were just beginning to move into the marketplace. As one participant noted, in the earlier days when midwives were 'banded against' GPs in a collective struggle to establish midwifery as an autonomous profession, midwives were more 'unified'. Now that midwives are secure in the market place, they may 'compete against each other', 'share business' with GPs, form different subcontracting networks with each other, or join IPAs or PHOs. However, this creates the potential for the disruption and fragmentation of midwifery goals, as Guilliland stresses (2002b).

Midwives may have prevented the professional monopoly of doctors in the market place of birth, but has this prevented the medicalisation of childbirth? Arguably not. The regaining of professional dominance for midwives does not mean that childbirth per se falls outside the medico-legal gaze of obstetrical governance (see Smith, 2000). Instead, as Bogdan-Lovis argues, neo-liberal and liberal feminist discourses of choices in childbirth assumed that women

would choose, once they were able to do so, to de-medicalise their experience (Bogdan-Lovis, 1996-97). As Ashton also points out, the market assumptions that consumers will always be given full information, are best able to judge their own welfare, and will aim to maximise this, are tenuous (Ashton 2001:110). Frequently the midwives in my study spoke of the ways in which many of their clients' choices may exist in tension with midwifery discourses and practices of evidence-based practice. This may occur during the course of, or as a result of a consultation with another provider, whether instigated by the midwife, as per the MOH Guidelines for Referral, or undertaken voluntarily by the woman/consumer.

Lupton's work, on risk and on the neo-liberal governance of pregnancy, is cautionary for midwives with respect to understanding struggles for professional dominance in the field of childbirth. She argues that the apparent acceptance by doctors of midwives and 'natural childbirth' should not be considered as evidence of a relinquishing of medical control over childbirth per se. Following a Foucauldian perspective, she wonders if medical control over women has been maintained and intensified rather than diminished (Lupton, 1999a, 1999b, 1999c). This may occur with the increasing visibility of pregnant women, as well as increasing 'foetal subjectivity' (and see Armstrong, 2000; Weir, 1996). The constant (risk) monitoring and surveillance of her foetus by the responsible mother/consumer, of the woman/client by the midwife, and I would argue, of the accountable midwife by the discourses and practices of her professional body, may serve to constitute all these subjects as objects to be governed in an enlarged field of medico-legal visibility (see Lupton, 1994, 1999a, 1999c). Lupton states, in a similar vein to Bogdan-Lovis, that:

> The natural childbirth movement could therefore be regarded as furthering medical dominance over childbirth, by directing intense medical attention on the individual woman's behaviour and self-control during labour and incorporating obstetrical treatment unproblematically into its ideology without questioning the structural aspects of power in the medical encounter. (Lupton, 1994:151)

Bogdon-Lovis asserts that, "By virtue of their attendant class privilege, the women attracted to such liberal feminist ideology viewed the childbirth experience as one involving choices" (Bogdan-Lovis, 1996:61). Further, she states that frequently the women subscribing to this ideology expected childbearing women to be able to make choices seen as 'unconventional', such as refusing a recommended caesarean section delivery. She goes on to suggest that liberal feminist attempts to manipulate birth experiences from inside the hospital institution, which

provides a range of restricted and manufactured choices designed to maintain its protocols, have been naïve (Bogdan-Lovis, 1996-97).

In the various processes (linguistic, political) that are involved in positioning themselves (or being positioned) as businesswomen, midwives position women as 'clients'. Some clients are more desirable than others, just as most certainly, differently-positioned midwives are more or less desirable to differently-positioned women. One midwife, at the end of our interview, explained the comradeship between herself and a local GP, saying: "she could give me any number of clients, no problem, but sometimes she'll ring with one and say, 'oh, you don't want her, she hasn't got a phone, first-timer…shall we just flick her off on the hospital?'" Current market place and neo-liberal discourses of business ideology; choice and consumer-centred care, act to interpellate, or 'hail forth' (Althusser, 1971), particular childbearing women towards particular midwives, as Mavis explains:

> There are often social groupings of clients that different practices may have … it all influences how you work. There may be some practices which have a highly medical model … I could give some examples, not of the practices but of what I might guess to be types of social strata of people. So there might be a group of midwives that work with obstetricians who have the business sector type clientele who are strongly medical oriented, they want scans, they want almost a due date given, induction and … are very happy to … and want a medical input and consultation. Through to perhaps a group of alternative clients who really want no medical intervention, who maybe want home birth, who see birth as being totally natural, totally a process to be un-interfered with and what will happen will happen … and then in between somewhere you have a vast majority of people. (Mavis, self-employed midwife)

This chapter has explored some of the ways in which midwives have moved into the market place of primary maternity provision. Moving 'from below' before the LMC system was established, some midwives moved out of the public hospitals they had worked in and began to 'share care' with some GPs and obstetricians. One group set up the first birthing centre in Aotearoa/New Zealand, while others 'went independent' as soon as possible, either severing employment with hospitals or remaining in part-time employment. After 1996, newly graduated direct entry midwives in my study needed to establish themselves as those operating small business practices as well as professionals beginning midwifery practice. This necessitated negotiating tensions between business and midwifery philosophy in a way that did not overly compromise their commitment to continuity of care.

I argue that the field of obstetrics no longer dominates the pregnant bodies of women and the labouring bodies of midwives from the top down. Instead, in their moving from below into the market place and breaking doctors' monopoly over maternity service provision, midwives and women deployed particular versions of 'partnership' as a conceptual strategy in their newfound professional dominance. The prevailing version in my study is that of the midwife as business woman and woman as client. As with the midwives in Davis-Floyd's (forthcoming) study who undertook forms of 'qualified commodification' to achieve cultural legitimacy, the participating midwives in my study all worked in a variety of ways to 'marry together' two potentially conflicting discourses: that of business philosophy and that of their midwifery philosophy. With the entry of midwives into the market place of primary maternity provision, women are constituted as the appropriate 'clients' of midwives, rather than the 'patients' of GPs or obstetricians. Together midwives govern the conduct of birth within dispersed (market place) spaces and networks of relationships, framed within neo-liberal discourses of responsibility and freedom of choice.

In the next chapter I explore issues around 'consumer choice' as it occurs within the discourses of midwives. I focus on the particular area that most midwives in my study talked to me about with regard to the choices many women currently make in labour. This is the issue of epidurals as pain relief in 'normal' labour, and the practical implications for different midwives in their technologies of the self, whether in the taking up of, or resisting discourses around this increasingly popular form of pain relief. The space and scope of the thesis means I focus on the most significant issues raised by participating midwives. Caesarean section and induction of labour were the other choices also discussed by some midwives. Reference to choice for epidurals, however, was coded across most interviews, and most densely, within individual transcripts. The increase in (some) women choosing caesarean deliveries is critically analysed elsewhere (Kitzinger, 1998). These issues are important for midwives because, as Mavis says: 'it all influences how you work'.

5

Chapter Five

'All our women want epidurals these days; we have to take them to the base hospital…': consumer choice and the relief of pain

> Finally, the ideology of technology shapes motherhood. No longer an event shaped by religion and family, having a baby has become part of the high-tech medical world. But as an ideology, a way of thinking, technology is harder to pin down, so pervasive has it become in Western society. The ideology of technology encourages us to see ourselves as objects, to see people as made up of machines and part of larger machines. (Rothman, 1989:28)

In 1996 Barbara Katz Rothman was a keynote speaker at the bi-annual NZCOM conference. During the conference she referred to her best-selling book 'Recreating Motherhood: Ideology and Technology in a Patriarchal Society', from which the above quote comes. As the conference was drawing to a close, she called upon the midwives in the audience to be mindful of the ways in which epidural analgesia serves to separate the mind from the body, saying "…don't make the same mistake with epidurals in normal birth as what we have in America…back there we have two whole generations of women now who simply don't know how it feels to give birth." I was present when she made this statement; at the time I felt some anxiety and foreboding; a sense that we may have already passed a point of no return, and I imagine I was not the only woman, midwife or consumer, who felt that way.

I later attended a NZCOM meeting at which several midwives from a small rural maternity hospital were present. They had come to ask midwives working as LMCs with women having 'normal' or 'low-risk' pregnancies to encourage their clients/women to birth at their facility. This small rural hospital was frequently under threat of closure as a consequence of the health reforms described in the previous chapter of this thesis. In what sounded like sheer frustration, one self-employed midwife turned to the rural hospital midwives and said: 'Yes, but all our women want epidurals these days! We have to take them to the base hospital!' This stark exchange was a catalyst for many of the questions I brought to the post-graduate work I did in preparation for this thesis.

There is no doubt now that the relationship between choosing an epidural and the increasing intervention rate in childbirth amongst women in Aotearoa/New Zealand is cause for concern (Savage, 2002). Hunter's research (2000), explores the differences between providing midwifery care in small maternity units compared with doing so in a base obstetric hospital. The effects of the steady closure of small primary maternity units over the last 40 years, despite uniformly equivalent or superior outcomes for comparable women giving birth in base obstetric hospitals, can be seen as part of the health reforms, but also as part of the assumption that spatial proximity to hospitals, obstetricians and technology are 'safer' for women and babies in childbirth (Goer, 1995). This claim however, is challenged by many midwives (Banks, 2000a; Donley, 1998; Downe, 1997; Guilliland, 2000; Hunter, 2000; Leap, 2000; Roberts, Tracy, & Peat, 2000; Rooks, 2000; Saxell, 2000), statisticians (Goer, 1995; Tew, 1995); and some obstetricians (Harrison, 1982; Leboyer, 1991; Odent, 1994; Savage, 2002; Wagner, 1994).

The cascade effect of obstetrical interventions that occurs when women with otherwise healthy, low risk pregnancies are 'managed' at base obstetric hospitals, and the impact of an epidural as analgesia in these labours/births is now implicated in the increased instrumental and caesarean section delivery rate (Banks, 2000b; Donley, 2000; Goer, 1995; Guilliland, 2000; Hunter, 2000; Roberts, Tracy, & Peat, 2000; Savage, 2002; Strid, 2000). At the 2000 NZCOM conference, Guilliland explored the influence of the previous decade of midwifery autonomy on birth outcomes in Aotearoa/New Zealand. She noted that as a result of the health sector restructuring the available data have been difficult to access at different times since 1990. Significantly since that time, however, both perinatal and maternal mortality have dropped; the episiotomy rate has dropped and breastfeeding rates have increased somewhat (Guilliland, 2000). Overall, Guilliland went on, women express high levels of satisfaction with a midwife as LMC, feeling that they would receive more information, be referred as necessary and receive more postnatal visits from midwives than they would do from other practitioners (Guilliland, 2000). However, Guilliland stated that the range of instrumental delivery rate from 2.90% to 25.49% during 1998/99[31] is an indication:

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[31] The particular HHS area that I undertook my research in had an instrumental delivery rate of 23.37% in 1998/99 (Guilliland, 2000). This has increased steadily since then (Pers comm., WHD audit midwife 2003).

…that we have a provider problem rather than a population problem. Whilst as midwives we do not actually perform the intervention, we have input into all births. What is the role we play in these outcomes? What is the role of the referral guidelines? Are our referral thresholds too low or are the politics of power and fear the driver of these outcomes? We need to find answers for these questions if women are to benefit from our care. (Guilliland, 2000:5)

At the same conference, Joan Donley, midwifery Elder, spoke of the development and culture of homebirth in Aotearoa/New Zealand. She stated:

Women have been seduced to 'choose' epidurals and elective C-sections, promoting a market where none realistically exists…. Some midwives book too many 'clients'. Unable to provide the necessary one-to-one support, these women get epidurals and interventions. This can result in complaints and indemnity claims. These factors have encouraged midwives to practice defensively accepting the medically promoted 'choices' of screening, interventions, epidurals, etc. Midwives are being colonised…. (Donley, 2000:3)

Maggie Banks, homebirth midwife and author, in her conference presentation stated that there clearly exists a predominant system of medicalised maternity care in Aotearoa/New Zealand and that:

It is clear that there is a very great gap between the midwifery ethos and both the belief system and the reality for childbearing women and babies in New Zealand…. If we verbalize a belief in birth as a healthy experience we need to ensure that our actions are reflective of that belief. (Banks, 2000b:2)

Acknowledging that it is common to hear that many of the unnecessary interventions in childbirth are 'women's choice', she asked midwives to consider the role of language in the provision of such choices to women, saying:

There was a very astute District Officer of Health called Dr. Micheal Watt back in 1917 who questioned: "Would [Twilight Sleep] have gained any popularity if it had been termed *The Dope Delivery Method* or *the Half-Dead Baby System?"* The spirit of that question is as pertinent today as it was over eighty years ago. Would women 'choose' social inductions of labour, electronic foetal heart rate monitoring, artificial rupture of membranes, narcotics, epidurals, arbitrary time limits for completion of labour if they were asked "Are you ready for us to start the Cascade of Unnecessary Intervention?" That is the reality when these things are applied to 'normal', healthy birthing. (Banks, 2000b:3)

At this conference and from a consumer perspective Rea Daellenbach suggested "As long as the legal system penalises non-intervention but not over-intervention in birth, homebirth midwives and families are structurally disadvantaged" (Daellenbach, 2000:4). Judi Strid's paper called 'Revitalising Partnership' issued a strong challenge to midwives, saying:

> Sadly in the last 14 years since then[32] there has been a significant shift to even more medicalised birthing practices and a drop in the number of homebirths…. We now have more autonomously practising midwives than ever before and the highest levels of intervention. Whilst I'm not suggesting midwives are to blame, I am questioning what midwives are doing as the guardians of normal birth…. The changing role of midwives and the extension of the scope of practice into medical areas is of concern. Epidural is about anaesthesia not midwifery and that's doctors work…. Saying women want all this and have brought it upon themselves is not acceptable. This is a distortion of women's choice and is exactly what doctors did. (Strid, 2000:3-4)

The sets of concerns that were addressed at the conference and re-presented here are highlighted because they are central to my inquiry, and to the practices of contemporary midwives in Aotearoa/New Zealand. In the on-going research process/fieldwork, which took place embedded within the political context of the issues raised above, Strid's paper in particular had provoked a variety of responses among midwives. Some told me they felt a sense of frustration; that Strid had seemed to speak to midwives as if they were all somehow 'responsible for such high intervention rates as she suggested'. Others felt that the issue was extremely complex, warranting an understanding of 'what makes women want these things'.

For a while after the conference I used Strid's paper as a focal point for discussion with midwives/consumers who participated in my project. I asked midwives if they had attended the conference, heard Judi's presentation, and what their responses to it were. This strategy stimulated informal discussions many times in as diverse (base hospital) settings as tea-room/lounge areas, midwives' offices, birthing suites, corridors, lifts and stairwells, equipment rooms, sluice rooms, locker/change rooms, operating theatre and recovery rooms. Outside the base hospital discussions took place in midwifery antenatal clinics/rooms, a birthing centre,

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[32] Here Strid was referring to Suzanne Arms' 1986 comments that at 14% the Caesarean Section rate could be described as 'an epidemic' in NZ at that time (Strid, 2000). The World Health Organisation (WHO) states that there is no justification in any specific region to have a caesarean section birth rate higher than 10-15%; in NZ the MOH recommends that the rate ideally remain between 5.0 and 8.4%; and by 1999 NZ's national rate was 18.2% (in Banks, 2000; Strid, 2000). Currently, it is approximating almost 25% (MOH, 2003).

via telephone and e-mail, in social settings, educational settings such as workshops, rural hospitals and midwives'/women's homes as well as in the homes of my personal friends and relatives who were pregnant or post-natal. At times I felt I couldn't get away from my research even if I had wanted to. Even when I was supposedly out of the field I felt immersed in it; issues within the field bled out into my everyday life, and questions from without, bled inwards.

I worked hard to distinguish between those times I was in and those times I was out of the field (Coffey, 1999). I often felt I was both and neither, everywhere and nowhere all at once. As my familiarity with ethnographic writing grew, I stopped attempting to distinguish between the two, coming to recognise the distinction as always already artificial. Simultaneously, I felt both a disturbing sense of fragmentation, but also more recently a sense of wholeness, in crafting an evolving identity as a researcher in this field. Even more recently, the metaphor of wholeness does not seem enough; instead, I am more concerned with a nomadic journey of 'be-coming' as an academic/spiritual process (how/why are the two split?), with this accompanying ethnographic writing itself a form of nomadic inquiry/life (Fox, 1999; Richardson, 1997; St. Pierre, 2000).

In re-presenting accounts of participating midwives from the interview transcript data, I also disrupt the distinctions between my voice as researcher and those of my participants. I do not want my voice to be absent from the portions of transcript used in this text, separate from and lying outside, above or prior to the narratives of midwives in order to sanitise and present it for them, on their behalf. I want my voice to be seen here as part of the data wherever I ask questions, respond or comment within the context of group or individual interviews. At the same time, my voice is as different from those of the other midwives as theirs are from each other. It exists as a questioning, analytical and sometimes confused voice within a polyvocal realm of conflicting, contestable and contradictory speaking positions.

My perspective is always partial and particular; and I always spoke with midwives of my preference for homebirth, for example. Often midwives turned my own questions in on myself; if I asked them to tell me what normal birth meant for them, for example, they responded with something like 'I don't even know if we can think about 'normal' birth any more, can we?' This would prompt a mutually analytical exploration of the issues around the

ways meaning is constructed, and hence contested around childbirth. Sometimes my voice is seemingly not present (visible) in the written text; midwives talked without (my) interruption for minutes at a time, which, when turned into transcribed text, became pages at a time. At those times, when I have taken a portion of the text to re-present here, my voice may appear absent; although a trace of my preceding question or comment may be just audible. These ideas signal my desire to do something with data, rather than saying something about it, as Rath (1999) states about her research processes with women within a Rape Crisis movement. This method/ology:

> …resists the desire for analytic certainty, decentring both the texts of researcher/author and the texts of participants. It foregrounds the negotiation of meaning between researcher and participants, and invites the reader into the text in order to take part in this. (Rath, 1999:131)[33]

In the next section I briefly explore some of the historical issues arising for midwives in their work when women make particular choices about pain relief in childbirth.

The seduction of sedation

> I think that the technology is very seductive in that epidurals, for example, they have appeal… a lot of women are very seduced by the thought of something, anything that would take the pain away … in labour at a critical point - I think that women are vulnerable in labour to the suggestion that there is something that can remove the pain. They believe that it's completely safe … and yes, I can see that it would be very seductive. So I think that a lot more women do really make uninformed choice about things like epidurals because they're not aware of the possible risks or dangers or implications of what might happen next … it's sometimes referred to as a cascade of interventions. (Mandy, birthing centre midwife)

The (presence of the) absence of pain in childbirth has been the promise of the scientific profession of obstetrics since its own conception. Arney's 1982 Foucauldian analysis of the

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[33] As I wrote this, thinking about Rath's passion for 'layered accounts' and for doing things with, rather than saying things about data, an e-mail from an international e-mailing list about research into 'Normal birth' that I belong to arrived. A thread of cyber-discussion lately has been about the dis/advantages of differing strengths of epidurals. I insert it into the text here (with permission); it disrupts what can be taken as in/formal data and/as it signifies the inter/national interest in this subject: "There has been talk of 'walking epidurals' here for some time. However, we find that once women are opting for the epidural they are usually exhausted and needing sleep. Also, once that synto goes up - continuous foetal monitoring. So while walking epidurals sound good, the reality is epidural = medicalised birthing".

'histories' of obstetrics as a profession, notes that the profession gives an account of its own development that is open to contestation by other historians (Arney, 1982). The obstetric profession's own understanding of itself hinges on the scientific, cumulative nature of knowledge with an emphasis on the direct link between knowledge and practice. Technological progress and professional achievement are thought to benefit patients directly (Arney, 1982). The metaphor of the body as machine, originating with the rise of rationalism (and see Martin, 1993, who discusses this), informed all of Western medicine, and the border drawn between normal - handled by midwives – and abnormal – handled by obstetricians, became eroded in different ways. As the increasing medicalisation and technological control of birth replaced the use of midwifery skills, all births came to be seen as potentially pathological. In Britain, doctors assumed the right to designate births as normal or abnormal, and rose to claim obstetrically based power over childbirth. In America, the traditional midwife all but disappeared as the profession of obstetrics found various ways to deal with its 'midwife problem' (Arney, 1982). More locally, Joan Donley has outlined the patterns of dominance and control over childbearing women and midwives by obstetricians as part of the processes of medical professionalisation in Aotearoa/New Zealand (Donley, 1986, 1989; 1998; 2000).

Also writing in Aotearoa/New Zealand, Papps and Olssen argue that continuing struggles for professional dominance by medicine over childbirth is closely linked to discourses around pain relief and safety (and see also Banks, 2000a, Donley, 1998; Mein Smith, 1986a; Smythe, 1998). These authors outline the ways in which the introduction of Twilight Sleep facilitated the shift from birthing at home to birthing at the St. Helen's state maternity hospitals. Twilight Sleep, referred to earlier in this chapter as part of Maggie Banks' 2000 NZCOM conference presentation, was a form of anaesthesia introduced to Aotearoa/New Zealand in the 1920s from Germany, where it had been developed (Papps & Olssen, 1997). A potent cocktail of injections consisting of morphine, scopolamine and ether or chloroform supposedly ensured neither pain nor memory of the birth.[34] When both mother and baby had been sufficiently resuscitated, the baby was presented to the woman, often hours after birth (Sandelowski, in Papps & Olssen, 1997). Eventually there developed enough controversy over the use of Twilight Sleep from within the Health Department itself that alternative forms and

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[34] In fact Mein Smith and Banks both note that significant pain at times was felt, but that the memory of it was dulled.

combinations of drugs were introduced.[35] One of these was a much smaller amount of chloroform, administered by a specially designed inhaler rather than injection. Mein Smith states:

> This procedure could not induce full anaesthesia, but offered some relief from pain during the second stage of labour, and allowed the woman some control…. It was cheaper because of the insignificant dosage and, more importantly, it could be administered by a midwife rather than a doctor.   (Mein Smith, 1986a:83)

This later point was/is important because of the significant professional impact on the scope of practice of the midwife. Midwives were trained to administer the inhaler in the St. Helens' and some other public hospitals, thereby relieving the hospital of the higher cost incurred by the presence of a doctor to do so. Domiciliary midwives and maternity nurses who attended women at home began to retrain in order to use the Murphy's inhaler with women they attended in isolated rural areas, without having to rely on the presence of a doctor. If the midwife did not have the additional training required to administer this pain relief, then the provision of this or of even stronger pain relief made the presence of a doctor appear desirable and preferable. Mein Smith notes that as a result of these professional practice issues, "…some experienced midwives gradually lost their custom to doctors, who admitted more and more women to private hospitals" (Mein Smith, 1986a:84).

The relationship between pain relief and class issues for women in Aotearoa/New Zealand has been documented by Mein Smith (1986a), and further explored by Donley (1998), Banks (2000a) and Daellenbach (1999a). These authors explore the ways in which demands for even stronger forms of pain relief were framed around issues of class inequalities, within groups of predominantly pakeha women. At a time when only women who could afford to pay for private hospital care were able to receive twilight sleep, the midwife-administered chloroform inhalers utilised in the public St. Helen's hospitals were perceived to be second rate by Dr

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[35] Alarm and controversy existed within the Health Department and amongst midwives and some obstetricians over increasing 'superfluous' intervention in childbirth between the two world wars as childbirth became simultaneously hospitalised and medicalised. These 'meddlesome' interventions were instrumental deliveries, obstetrical operations and the use of pain relief in otherwise normal labours, as opposed to their judicious use in the very small minority of pregnancies/labours that were indeed pathological. These issues and others are described in her historical account of the development of hospital birth in Aotearoa/New Zealand between the wars and are meticulously documented by Mein Smith (1986a).

Doris Gordon, who continued to campaign for all women to have access to twilight sleep (Banks 2000a). Labour Women's groups in the 1930s began to lobby for more effective pain relief in the St. Helen's hospitals. In their arguing that effective pain relief in childbirth "…represented medical and humanitarian progress…" (Daellenbach, 1999a:86), these women were effectively rejecting the Biblical indictment that childbirth would be always painful in favour of the obstetric promise that it need not be. They did this by mobilising discourses of women's rights, irrespective of the ability to pay for services or not. Banks (2000a) notes that the introduction of the Maternity Benefit meant that poorer women could now have access to the kind of anaesthesia only wealthier women heretofore could benefit from. The Social Security Act (1938) provided free care for all women under the doctor of their choice. By the time of the implementation of the Social Security Amendment Act (1951), financial payment was guaranteed for anaesthetists, hence also guaranteeing the availability of anaesthesia for all women who birthed in hospitals (Banks, 2000a:69).

The processes briefly described above relating to pain relief, class issues and women's rights in childbirth can be seen as part of the complex processes by which different women became 'seduced' into and subsumed under obstetrical regimes of the governance of childbirth during the 1920s and 30s in Aotearoa/New Zealand. The pursuit of pain relief, particularly technologies of pain relief administered by doctors and anaesthetists, meant that childbirth became hospitalised and hence simultaneously medicalised (and see Donley, 1998, Daellenbach, 1999a, Banks 2000a, Papps and Olssen 1997, Mein Smith 1986a for in depth analyses of the shift to hospitalisation). A prevalent discourse here was the obstetrical promise of relief from pain, requiring the use of medical technologies best provided by doctors and anaesthetists within a hospital environment. Banks (2000a) notes that this flourishing of heavy analgesia and anaesthesia in childbirth in Aotearoa/New Zealand between the World Wars was out of step with Britain and the Scandinavian countries at this time, countries that rarely used sedation in normal labour and were able to report correspondingly 'extremely low' rates of instrumental delivery (Banks 2000a:72).

I want to argue that despite, or as well as, the rebirth of the professional midwife in Aotearoa/New Zealand described in chapter one of this thesis, the field of childbirth predominantly remains part of the continued biomedical governance of daily life. My interest lies in complicating some previous feminist criticisms of 'medicalisation' (including my own)

by exploring not so much the ways in which obstetrics continues to 'dominate', if that can be said, but the ways in which midwives and consumers themselves negotiate and contest different modes of knowledge production in the field, and the actions they take in constructing themselves as contemporary subjects of knowledge/power in childbirth. The freedom from pain that became something that many women demanded as every woman's right in the 1930s has contemporary parallels now (Donley, 1998), as do the resultant implications for midwifery scope of practice. I contend that contemporary discourses around the obstetrical promise of freedom from pain in childbirth are consistently seductive, but that women's responses to this promise are currently framed within and organised around discourses of desire and consumer 'choice' within neo-liberal and liberal feminist rationalities, rather than those of women's 'rights'.

Challenging contemporary obstetrics? Consumer 'choice, continuity and control'

> … but it's also the whole culture of childbirth that seems to have become so … there's been such an embracing of medicalisation. You know, a frightening embracing of it really. Last week I had a woman arrive in saying oh, I don't like pain, I'd like an epidural because all my friends had said, you know, have an epidural because you don't have pain and … (Bess, self-employed midwife)

In the 1920s and 30s in Aotearoa (white) childbearing bodies were constituted as producers (of/for European colonisers). These are now constructed as 'consumer' bodies. According to Bauman "The body of a producer/soldier and the body of a consumer are, sociologically speaking, two different bodies" (Bauman, 1998:226). In late-modern or postmodern societies, in Bauman's view, we do not need producer so much as consumer bodies, to "clear the supply…and keep the wheels of the market economy well lubricated" (Bauman, 1998:226). Indeed new (postmodern) childbearing bodies are constituted as consumer bodies from within two central discourses; that of neo-liberalism, addressed in previous chapters, and that of feminist critiques of medicalisation.

Feminist critiques of medicalisation include advocating that lay people, and women in particular, take back control of their own health within a discourse of empowerment, signified by practices such as becoming a consumer (seen as more active than 'patient'), challenging medical and obstetrical knowledge (seen as paternalistic and holding power over), joining patient advocacy groups and utilising alternative or health practitioners (Lupton, 1997b).

Modern midwives can be seen as one such group of health professionals, with a focus on wellness, normality and health, rather than sickness and medicine (Bryar, 1995; Kent, 2000). Particular to Aotearoa/New Zealand within our partnership model is the inclusion of consumers at every level of NZCOM organisation. In this sense the concept women-centred differentiates the midwifery model of care from the medical model of care (Tully, 1999). What distinguishes midwifery conceptually from obstetrics is the commitment to providing the consumer with a) choices for childbirth, b) continuity of care(r), so that she feels in c) control of her experience(s). In Aotearoa/New Zealand, the authors of 'The Midwifery Partnership' state,

> The midwifery partnership provides a challenge to the dominant ideology of medicalisation of childbirth. It does not ignore or discount the valuable contribution medicine has made to the knowledge base around childbirth but rather challenges its assumption of control over childbirth and the way in which medicine has discounted women's knowledge and thus placed women outside their own experience. (Guilliland & Pairman, 1995:1)

The focus on reclaiming control over the experience of childbirth as a normal life event signifies midwifery accounts of pregnancy and birth and exists vis-à-vis the accounts of potential pathology given by medicine and nursing (Tully, 1999). It is from within this perspective of normality that contemporary midwifery has developed as a profession in its own right in partnership with women and in a manner that is potentially empowering for both women and midwives (Guilliland & Pairman, 1995). These midwifery accounts of pregnancy and childbirth are often referred to as the 'social' model of childbirth, rather than the biomedical model that the profession of obstetrics is grounded in (Bryar, 1995; DeVries, Benoit, Teijlingen, & Wrede, 2001; Kent, 2000; van Teijlingen, Porter, McCaffery, & Lowis, 2000).

Critics of medicalisation and the biomedical obstetric perspective who write from historically revisionist and/or some feminist perspectives, Arney argues, still rely on the profession's own accounts of itself in terms of the developments of technology, knowledge and rapid progress. While obstetric historians themselves argue that these things benefit women, babies and society in general, their critics, such as Oakley, argue that more pharmacological and technological advances, often untested, medicalise pregnancy and birth. Oakley's strongest criticism is towards what she sees as the chief characteristic of the profession, which is the

assumption that more (technology) automatically means better (in Arney, 1982). Similarly, Daly offers an image of the profession in which the unrelenting and systematic advancement of its knowledge and practices, particularly technological, have been to the decided disadvantage of women (Daly, 1987).

Other feminist scholars, in challenging the relationship of obstetrics to progress have rewritten the history of obstetrics, paying close attention to the role and fate of the female midwife. The focus of much radical feminist scholarship has been on how the traditional midwives from the seventeenth century onwards have been eliminated, and on the ways in which the predominantly male profession of obstetrics seeks to control both birthing and midwifery through processes of institutionalisation and medicalisation. While not rejecting the obstetric professions' model of its own development, scholars such as Ehrenreich and English worked to rehabilitate the memories of the midwife and female healer (Ehrenreich & English, 1973). Arney suggests that thus far the majority of (radical) feminist scholarship[36] has concentrated on a rule of dichotomies:

> Birth was normal or abnormal; female midwives attended normal births and called male midwives in abnormal ones; female midwives' technology was rudimentary and oriented towards easing birth, male midwives' technology was destructive and oriented towards the fast termination of birth. (Arney, 1982:8)

Midwifery as a profession is constructed in dualistic opposition to, and functions as a counter-hegemonic discourse vis-à-vis the (medicalised) profession of obstetrics (and see Tully, 1999). More recently, a number of contemporary feminist theorists drawing on insights from poststructuralism, have revisited the medicalisation critique (Annandale & Clarke, 1996; Balsamo, 1996; Clarke & Olesen, 1999; Lupton, 1997a; 1999c; Riessman, 1992; Sawicki, 1991). Sawicki notes that radical feminists offer "…historical accounts of the development of modern obstetrical practice that reverse the narratives of linear progress provided by many traditional historians" (Sawicki, 1991:75). Annandale and Clark also use the example of

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[36] Until the time of his writing in 1982. A full sociological account of the development of the profession of obstetrics and the dialectical development of a radical feminist scholarship challenging the perceived benefits of obstetrics is neither possible nor intended here, but is well documented elsewhere (Arms, 1994; Donnison, 1977; Ehrenreich & English, 1973; Marland & Raffery, 1997; Witz, 1992). This chapter is intended to focus instead on one particular and prevailing obstetric discourse, the promise of delivery from pain, and participant midwives' current and local discursive and practical responses to the complexities of this in terms of the perceived desires of and choices made by women.

midwifery as a 'counterculture' to suggest that feminist critiques of medicalisation which arise from a dualistic, and hence arguably essentialist viewpoint, may become more enslaving rather than liberating (Annandale & Clarke, 1996). Differences in feminist thought about medicalisation hinge on an array of approaches to theorising around biomedical technology as well as around gender. These points of tension between differing feminist viewpoints are highlighted in the data drawn from interviews of midwives participating in this study as they talk of the relationships between women and technology, and will be returned to in the later part of this chapter, and of the thesis.

The midwives who participated in this project and who talked about the provision of pain relief describe their actions as being interwoven with the desires of the woman in their care. The concepts 'choice, continuity and control' intersect during decision-making and other negotiated processes in the provision of their midwifery care. Any one choice affects the subsequent course of action within the partnership, and is open to multiple interpretations. Next I examine this talk in relation to a particular choice in pain relief, chosen as a focus here because most midwives in my study raised as a concern for them the effects of what they sometimes called an 'epidemic'. The effect this has on what is seen as normal birth is explored, as are the results of these networked intersections of knowledge/power in constructing professional subjectivities, and subsequently shaping scope of practice.

From sedation to sublimation

Embracing 'empowerment' through choosing/providing epidurals in normal labour

> RS: What kinds of things are women choosing?
>
> Gillian: What, at delivery?
>
> RS: For everything … what are women wanting?
>
> Gillian: I'll tell you what I have noticed is recently, it could easily be the type of client that I have - and that's epidurals. People go straight for epidurals, often it seems to be where they take their ante-natal classes, all their education things. But they're missing out pethidine now. But the thing is epidurals have their own complications really … not in as in itself but the fact that you're more likely to get interventions as a result. (Gillian, self-employed midwife)

As new consumer bodies, women now choose from a range of possibilities for childbirth, from the choice of a refusal of (re)production, to the employment of a multitude of reproductive technologies, to the choice between LMCs, to choices for place of birth, for non/interventions and for different technologies of pain relief (Caddick, 1995; Davis-Floyd & Dumit, 1998; Davis-Floyd, forthcoming; Rothman, 1999). Many midwives in their discussions with me suggested that while choice in childbirth is an important ideal in itself, women may be 'overwhelmed' at times with choices, or that the very presence and availability of the choice of an epidural itself impacts on women who don't choose it:

> I think it's a lot harder for women to birth these days with that choice because they know that choice is there … I mean you know yourself if you're in a lot of pain, and you think you can get out of it then you'll get out of it … and I just admire women so much that they do have the choice and they don't go for it … I think it's a lot harder for them, than it was for us, when epidurals weren't available. (Eva, self-employed midwife)

Midwives problematised the notion of choice as something belonging to, or arising solely from within the woman, noting influences from 'society', 'media', 'culture', 'medicine', 'obstetricians', 'the woman's mother' or frequently, 'her husband' as playing a large role in shaping the choices women actually do make. In the midwives' accounts this was always linked to the implications for the midwife's practice:

> We were talking about this at work this morning and it's just not that simple, to tell women they can have a normal birth is not that simple. They have gone the other way, they have not embraced the normal, they have embraced the medical and technological model. So it's all very well for consumers to tell us as midwives how to do our job but it's not easy if women, for a whole lot of cultural social and political reasons, have embraced the medical model. I have an epidural certificate so I can stay with a woman if her care becomes less than normal, women feel betrayed if suddenly things are a bit off the track or not-normal, and what do you say? See you later, I'm out of here, you're not normal any more? I want to be able to stay right through with all my women; that is something that is important to me. (Natalie, self-employed midwife)

In the excerpt above, Natalie distinguishes between consumers as politicised and active groups of women 'telling us as midwives how to do our job', that is, to reject medicalisation in partnership with women, and individual and embodied women making choices to 'embrace medicalisation'. This is central to feminist debates around 'Women' as a singular category of identity, and embodied subjectivities of difference and desire. The quote highlights the ways in

which women's bodies are sites of struggle and contestation, functioning as the intersection points of knowledge and power in childbirth (Annandale & Clarke, 1996; Balsamo, 1996; DeVries, Salvesen, Wiegers et al., 2001; Foley, 2001; Sawicki, 1991; Wajcman, 1991). While obstetric technologies are certainly used to act upon women, women themselves also actively appropriate these biomedical technologies in order to gain control over their/our lives (Balsamo, 1996; Kent, 2000; Sawicki, 1991; Wajcman, 1991). Where individual women are seen to do so, and midwives themselves then appear to embrace these ideals accordingly, I think of them as 'cyborg' midwives, drawing on Haraway's metaphor of the cyborg (Haraway, 1990, 1997). I deploy her metaphor here because I am attracted to her thesis that cyborg imagery works as an 'imaginative resource' against the production of universal and totalising theories. Importantly, Haraway states:

> Taking responsibility for the social relations of science and technology means refusing an anti-science metaphysics, a demonology of technology, and so means embracing the skilful task of reconstructing the boundaries of daily life, in partial connection with others, in communication with all of our parts. It is not just that science and technology are possible means of great human satisfaction, as well as a matrix of complex dominations. Cyborg imagery can suggest a way out of the maze of dualisms in which we have explained our bodies and our tools to ourselves. (Haraway, 1990:223)

Midwives identify their partnership with individual women as something that results from the woman feeling in control of her experience, even though women may have embraced the medical and technological model. In this case, midwives explain their professional identity as coming from the ability to follow the woman into the technological field of secondary care provision, and of (re)constituting themselves as 'cyborg' in the deliberate disruption of the ab/normal dualism. When individual women embrace the medical and technological in the pursuit of a pain-free birth that feels normal to them, the logic of midwifery as women-centred means individual cyborg midwives also 'embrace the skilful task' of reconstructing their practices in relationship to biomedical technologies. This occurs to varying degrees in different sites and networks of practice. It happens in complex, ambiguous and fluid ways, from women and midwives whose birthing practices are grounded in discourses of birth as natural and home as safest, but who are willing to rely on hospital transfer if needed, to women and midwives who both prefer hospital as the safest place for birth and for professional practice (Klassen, 2001; Peterson, 1983; Pollock, 1999). These issues are further addressed in chapter eight of this thesis.

In this latter positioning, where women and midwives both may perceive the hospital as safest, some of the midwives I spoke to also acknowledged the constraints of the (medico-legal) context in which they practice, and the subtle ways in which they themselves may also influence the place of birth for women. These issues of the hospital as a site of simultaneous risk/safety are addressed in the following chapter of this thesis. The complex issues for midwives and on women of 'constrained choice' are currently under scrutiny in Britain (Stapleton, Kirkham, & Thomas, 2002), Ireland (Murphy-Lawless, 1998) and America (Bogdan-Lovis, 1996-97), as well as in Aotearoa/New Zealand (Davis, 2002; McAra-Couper, 2002).

Many midwives I interviewed stated that even though they were often at pains to explain the relationship of choosing an epidural for pain relief in a low-risk labour to the resultant cascade of intervention, many women, and particularly 'middle class, well-informed, career women well into their thirties who want total control', and who may have experienced fertility difficulties prior to this pregnancy, still, often quite vociferously, choose to have an epidural for analgesia in an otherwise-normal pregnancy and labour. Epidural as pain relief, according to many midwives, is also chosen/provided in a kind of package deal, which might include induction of labour. The majority of midwives in my project had their epidural certificates, or were working towards them, and this was predominantly to support and respect women's choices. This was seen as empowering women, and as part of working in a manner constituted as woman-centred. The following exchange takes place between a midwife and me in a rural unit as we tried to tease out some of the meanings around the midwifery concept of woman-centred in the course of our interview/discussion. Susan had previously worked for a long time in labour ward at the base hospital as a core midwife, then for a spell on the community teams providing continuity of care, which she said had 'burnt her out', and she was now working in a rural hospital. In the extract below, Susan talks about rates of intervention when she practised as a core midwife at the base hospital:

> Susan: I think you try harder here because of the very fact that you're away from town and … you know, I mean there it's quite easy to pop along and get the anaesthetist … just pop along round the corner and he'll come and put an epidural in and it's great. I mean my epidural rate was very high. Well it was in keeping with the hospital but it was very high … I mean I did Standards Review and I was quite surprised.

RS: what sort of rate are we talking about … what percentage of births?

Susan: Oh, about 60, 70% … my caesar rate was 22% which was obviously the same as the hospital's. My ecbolic rate was 100% … (Susan, midwife, rural unit)

Susan's statement regarding her current practice, 'I think you try harder here because you're away from town', is supported by similar statements made by midwives participating in Hunter's (2000) research. In her research, Hunter explores practice differences between midwives working in rural units, and those working in base hospitals. She notes that:

> Epidural analgesia was not an option in any of the small maternity units used by the midwives, therefore the midwife concentrated on other options. Midwives acknowledged that their options for managing pain differed according to the culture of the setting. (Hunter, 2000:87)

Susan then spoke about her enjoyment of her current role, which was related to the low rates of interventions in her new, and preferred, practice. Often in the exchanges she moved between past and present tense, as she compared her previous working environment to work in the rural hospital in which she is currently employed. Susan is able to position herself as working in a woman-centred way if the requirements or choices made by women, wherever they choose to birth, are met. Again we reflect on the complexities of practice:

RS: I always thought of woman-centred and medical model as conflicting …

Susan: I don't think so … I think you can use both … I mean a lot of women wouldn't even … I mean I like to have a nice normal delivery … don't get me wrong, but I'm using this as an example … a lot of women now would expect an epidural as part of a normal delivery … they see that as the norm … there are certain areas in town who would expect to have an epidural at the first pain, you know … but that's still being woman-centred … because you're giving the woman what she wants and delivering it in a safe manner.

RS: Yes, but sometimes that contrasts with the evidence.

Susan: It does … for the breast-feeding, with epidural … and the outcomes of having to have a more instrumental delivery. You're absolutely right. But as long as they're aware of all those things, they're still going to have what they want … you know?

RS: There's a lot to weigh up, isn't there.

> Susan: There is a lot to weigh up … but you can't deny somebody an epidural. Who are we to say you cannot have an epidural … your pain isn't as great as you think it is. Pain's really subjective. I try not to judge women … if they don't have an epidural and they have a nice normal birth it's absolutely fantastic. But I don't judge them and think they're weak because they wanted an epidural, you know, each to their own … and that's being woman centred. I think to deny them an epidural when they really want one is not being woman centred and that happens, because the midwife doesn't like epidurals, she doesn't want to give pethidine because it would ruin her record that she's set for the last two years. But that's not being woman-centred, is it? (Susan, midwife, rural unit)

Susan's talk highlights the way in which the provision of effective pain relief constitutes her as providing woman-centred care, even in working with particular women, from 'certain areas of town who would expect an epidural at the first pain' and whose births might then have some form of intervention as a result, because that is what the woman may see as a normal birth for her. So, in this exchange, the cyborg midwife who provides effective pain relief regardless of what the outcome may be, is constituted as woman-centred and working in partnership with women, whereas the midwife who 'doesn't like epidurals, doesn't want to spoil her record', is not woman-centred and may be seen to be judgemental of women's subjective pain thresholds. Providing what women choose, regardless of who they are or where they come from, is to empower women in their choices for (pain relief in) childbirth. If they are made aware of the risks involved, then they are not to be denied their choices. In other words, supporting, rather than judging her choices, is seen as the appropriate action to empower the woman, despite the subsequent re-inscription of the birthing body as a medico-legal body from within the institution. Murphy-Lawless suggests that the medical ideology of women's bodies as uncertain, vulnerable, always already fallible, and containing an 'uncertain female psyche', is a fruitful one for obstetrics, within which context 'the liberal use of total pain relief' must be understood (Murphy-Lawless, 1998:42). She goes on to state:

> The actual and potential range of hazards, which is why epidurals require one-to-one nursing, are not readily going to be perceived by women for what they are, not least because of the malleability of the body in relation to scientific technological medicine. Our bodies appear to 'fit' well with these technologies. In other words, what Foucault refers to as a 'looser form of power over the body' also provides an adequate and comprehensible definition of the self. (Murphy-Lawless, 1998:244-5)

I am no longer sure that midwifery challenges to obstetric hegemony that are centred in discourses which privilege the ideal of ' women's choice' can be particularly effective given the

complex and contradictory desires of women as consumers (and see Bogdan-Lovis, 1996-97). The political economy of childbirth service provision structures what we may come to see as 'choice', in a context where the ability to participate in childbirth choices is always a function of power. Treichler (1990) has suggested that where childbirth is represented as a commodity in the open marketplace, the possibilities for contesting meanings around childbirth are increased, but this does not automatically lead to the de-medicalisation of childbirth (Treichler, 1990). Instead, rather than obstetrical domination of childbirth by means of sovereign power, a looser, more subtle form of 'pastoral' power might prevail (Foucault, 1979), in the form of the gentle guidance of birthing bodies by midwives as they follow women into the base hospital in respecting their chosen quest for pain-free birth.

The Foucauldian concept of pastoral power consists of the care of others whereby the establishment of 'trust' is a key element (Holmes, 2002). Midwives are involved in the exercise of pastoral power by the ways they are exhorted to develop trust with women. This includes the establishment of communication and mutual respect in the sharing of control, responsibility and "shared meaning through mutual understanding" (Guilliland & Pairman, 1995:1), and 'building trust' (Thorstensen, 2000). Indeed, Thorstensen states that: "It is well-known that when a woman trusts her midwife, she is more likely to disclose information that may be important and to follow care recommendations and that, when she trusts herself and her own body, she becomes empowered" (Thorstensen, 2000:406). Pastoral power is exercised through the development of the midwifery relationship with individual women in the establishment of trust, mutual understanding and empowerment, the disclosing and confessing of different desires on the part of the woman, and respecting and trusting women's choices in knowing what is best for them as the expert of their own bodies. Together these relations of pastoral power codify the specialised professional discourse of partnership. In trusting that women know and need to control their own bodies and desires, it is difficult for a midwife to strongly advise a woman against an epidural/institutionalised birth without simultaneously implying that the woman cannot know her own body/desires.

Embracing embodied empowerment: (temporarily) resisting the epidural

For other midwives I spoke with, talk about choice and control was linked to the evidence that choosing an epidural as analgesia in an otherwise normal and low-risk labour would very often lead to the cascade of intervention referred to at the start of this chapter. Some

midwives felt that women are demanding epidurals because they are fully informed; on the other hand, women are also seen to demand epidurals despite being informed (of the probable cascade of intervention).

> So I think the intervention rate is about the culture of our facilities … that whole expectation, women are demanding epidurals all around the country and they're fully informed and there's no problem, women's choice, and that's what they want but I still question that; is it really an informed choice in all cases but it's still - that's just like the woman who's demanding obstetrics … you know, the obstetrician as her primary carer and they'll pay for it … and they do. (NZCOM Midwifery Advisor)

Being informed on the one hand is seen as a positive and empowering experience for women; on the other, it acts to reproduce the cultural expectations of increasing reliance on, and 'demand' for technological intervention in birth. Also visible in the quote above is a parallel to the 1930s middle class (usually pakeha) woman who could afford twilight sleep. The relationship of resources (financial, social, cultural) to the desire to avoid pain is borne out by Roberts, Tracey and Peat, who, in a large Australian study, determined that amongst all low-risk birthing women, private patients were: "…significantly more likely to have interventions before birth (epidural, induction or augmentation)" (Roberts, Tracy, & Peat, 2000).

For some midwives, supporting/empowering women in low risk or normal birthing situations in their desire to have an epidural can be seen as disillusioning, and as part of a theory-practice gap, if they feel they can no longer deliver the option of something they may call natural or normal midwifery. Some midwives felt that midwifery goals were in danger of being thwarted unless midwives and women both re-evaluated the meanings of pain in labour. In this case, developing mutual trust and respect may involve actions where the midwife challenges the women's point of view (up to a point):

> Yvonne: And I had this woman saying oh she'd like an epidural and I was trying not to frighten her but saying I don't think it's a brilliant idea for you to go in there thinking of having one. But you can't help them … that's what's coming through. So the whole option of natural midwifery seems to be going and a lot of the women don't actually seem to care … they all want it.
>
> RS: Women or midwives?

Yvonne: Women and midwives. The women just ask for an epidural … they want it. And it makes a bit more of a drama out of it sometimes … I'm feeling quite…I'm disillusioned not just with the medical people but I'm disillusioned with - not disillusioned with … perhaps we've set ourselves up to give the women something which in actual fact we can't give them … there's that as well. (Yvonne, community midwife)

Angela, a charge midwife in a rural unit, talks about the various influences on women's choice for epidural for pain relief:

Yeah … they want epidurals because that's what the medical practitioners tell them they need and because they've been told by people that nobody should endure pain and because people tend not to sit down and explain to them that pain is normal in birth and in most cases with assistance can be coped with. Many women don't have the implications of an epidural explained to them. Things like the increased risk of instrumental delivery, caesarean section or the risks of other intervention being needed, or the risks to the baby. Frequently the husband influences the woman as he can't cope with her pain. (Angela, charge midwife, rural unit)

Medical practitioners, other people both lay and medical, as well as midwives, presumably, and 'the husband' all tell the woman what she needs or influence her decision in other ways. Yvonne says, '…but you can't help them…they all want it'. And Natalie, in the excerpt below, is talking about what (some) women want at a political level in this case as a response to a consumer survey undertaken by the base hospital:

… and they did this wee consumer sort of thing last year to see what women wanted … women wanted to make sure they could get epidurals, you know… there was no consumer response at a political level to work at reclaiming normality and getting pools into the rooms and getting, you know, things that would potentially make it a more personable kind of experience to be in there … that just … it wasn't there. (Natalie, self-employed midwife)

Indeed it appears that for many women now, 'reclaiming normality' is about choosing a technology for pain relief in the form of epidural analgesia (Rooks, 2000). The resultant freedom from pain itself is seen as empowering in this sense, despite the increased likelihood of further medical intervention and is chosen over and above what some midwives would consider constitutes a normal birthing experience. Having the continual presence of a female midwife may be what is considered normal, rather than a particular approach one way or the other to technological birth (MacDonald, 1999). Midwives varied in their responses to my

question 'what is a normal birth?' Below three differently positioned midwives,[37] one from a rural unit, one WHD community midwife and one self-employed midwife talk about this:

> RS: What does 'normal' mean to you?
>
> Susan: Well normal to me is no intervention. A normal vaginal delivery. Perfectly healthy term baby and a normal post-partum period where breast-feeding and bonding are established and all is well. Abnormal is when you need to have medical intervention.
>
> RS: Does that include an epidural?
>
> Susan: Abnormal is an epidural to me. Yeah, absolutely. A normal birth is normal birth (Susan, midwife, rural unit)
>
> Frida: How far away from normal birth have we come when people could even consider the fact that epidural anaesthesia is part of normal birth? I think that's remarkable. I mean it's a spinal anaesthetic for goodness sake. I mean it's what they do huge operations with … I just … it's like there's been some enormous step … it's like there's normal childbirth and then there's other things that are kind of on the periphery like there's always been that thing about having induced deliveries as part of assisted normal childbirth and maybe episiotomies and maybe this and maybe that … and then way way down here we've got epidurals and then all of a sudden it's like ooh … we're down here now. I think that's remarkable. Remarkable. We'll be doing Caesareans next, you'll see. (Frida, self-employed midwife)
>
> RS: Or in general … if midwifery is about normal birth … what do you … what would you call a normal birth?
>
> Yvonne: I just think in this day and age you virtually don't even think of a normal birth. Again, working in an area now where you can get an epidural, that

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[37] In fact most of the 40 midwives I interviewed over all had all changed positions, or maintained different types of employment at once. It was common to talk to a core midwife to find she had worked for a while as a self employed midwife, and vice versa, or that many rotated through different positions to suit different changes in their personal situations, or that they were 'having a spell from the pager' by working shift work for a year or so. In addition, many worked as both self-employed practitioners whilst also working part time for a local GP, or a specialist obstetrician, or doing some shifts at the hospital. It is misleading to attempt to formulate a typology of midwives (or midwifery philosophy) according to their current site of (self) employment. In addition, as I write this, many who were employed in one site have shifted to another, including the closure of two practices/businesses, resignation of other individual midwives from hospital or self employment, shifts from self employment to hospital employment, and vice versa. The designation in the text here of a workplace with regard to an individual midwife, then, cannot and is certainly not intended to signify a particular or individual practice philosophy. Rather, I include the place of employment at the time of the interview to highlight the ways in which different institutional(ised) discourses may refer to other discourses, inscribing and reproducing relations of power within this particular field.

option takes … just about takes away that ideal of normal birth, in my opinion … although other midwives I work with don't seem to have the issue with epidurals that I've got.

RS: What do they think?

Yvonne: Maybe they're just all the new era midwives. They just assume that women are going to have an epidural, but I feel … there was a normal birth workshop recently … I mean it is proven that it lessens the chance of normal birth and yet people are still being taught that it's a perfectly OK option. I mean we all know that it's … that it makes for a much higher incidence of intervention … but it's not being advertised as such … in parent craft classes or anything like that. (Yvonne, community midwife, WHD)

Where midwives have spoken of feelings of disillusionment, of theory-practice gaps, or of the emancipatory goals of midwifery as becoming potentially thwarted in the face of consumer choices for intervention, and where they focussed on epidural provision as outside their professional role as the guardians of normal birth and for these philosophical/political reasons resist the acquisition of an epidural certificate, I refer to them (metaphorically/playfully) as 'goddess midwives'. In this, their key difference from 'cyborg' midwives (but a difference not intended as fixed or inscriptive), is that goddess midwives resist and challenge the normalising practices of the epidural epidemic. Their subjectivity as professional midwives is constructed around primarily supporting those birthing women for whom empowerment lies within the actively birthing bodies of women.

'Cyborg' midwives, on the other hand, largely support women for whom empowerment lies in the transcendence of the birthing body, in the delivery from pain. I do not intend to create artificial divides or dualisms between those with different practice philosophies or between those with a commitment to primary care, and those with a focus on secondary care provision, however. Nor do I intend to homogenise the groups of women with whom these midwives are in partnerships. My attraction to these metaphors is precisely in that they are intended to challenge mutual exclusions and false dichotomies (Lykke & Braidotti, 1996). The metaphors of the cyborg and the goddess in this thesis are utilised in both politicised and playful ways, as Haraway intends, for midwives and women to visualise different ways of be-coming in childbirth. I return to the ways in which these images of be-coming and of multiple, hybrid subjectivity might be beneficial for midwifery as 'nomadology' (Fox, 1999), in the final chapter of this thesis.

From sublimation to surveillance

In one group interview with a group of newly graduated practitioners, the concept of normal is linked to scope of practice where the provision of an epidural simply for pain relief would be inappropriate:

> M 1: But it's not something that … if a woman comes in here saying, I'm pregnant … I want a midwife and I want an epidural then you know, it makes us question really whether …
>
> M 2: Whether they're coming to the right place.
>
> M 1: And we actually now … I don't make any excuses for saying to women well, you know, this is the way we work, and this is how we view epidurals. If you need an epidural after going through and trying all these things and it's really appropriate and we just thank God that epidurals have been invented at those times because they really are appropriate, but to use them inappropriately for me, as a midwife, is not good practice. So we don't do that. (Group 'two' second interview)

In these instances, having an epidural is not seen as part of normal birth. The provision of epidural care for a woman with an otherwise low risk labour would be seen as outside the individual midwife's scope of practice. The way in which the midwives in this group describe epidurals as an excess, something only to be tried after everything else has been tried suggests a philosophical position I might strategically call goddess midwifery. Since an epidural can only be provided in the base hospital and requires the (initial) presence of an anaesthetist, followed by the continual presence of an especially certificated midwife, it constitutes secondary care for this group. In other instances, different (cyborg) midwives said that because epidurals can be considered normal now, they should all work towards gaining the epidural certificate, which enables midwives to top-up the anaesthetic dosage after the delivery catheter has been initially inserted into the woman's epidural space.

This particular discursive repertoire bears parallels to midwives' administering chloroform from Murphy's inhalers in the 1930s at the St. Helen's hospitals. As soon as some midwives become trained in what is essentially seen as doctors' work (Strid, 2000, Donley 2000), pressure is brought to bear on other midwives to provide the same service. If midwives don't wish to provide the service or are not trained to do so, women may in some cases choose

another practitioner, and the midwife risks losing 'business'. This has also been noted by Thorstensen, (2000), an American midwife, who notes that in an American 1998 study, over half the midwives reported negative attitudes about the increased use of labour epidurals, yet 85% of midwives supported a woman's decision to receive one, and 59% felt that not being able to offer the choice of epidural provision would decrease their marketability (Thorstensen, 2000:405). Some independent midwives talked with me about the ways in which the woman's choice for epidural for pain relief has an effect on their scope of practice and relationships with core labour ward staff:

> I don't have an epidural certificate… which isn't against the law … so I should be able to take that woman over and say I'm handing my client over because she wants an epidural and I can't do epidural care… that bit's really clear. But I've had people say to me, you can't hand her over because we haven't got anyone to take her, we're too busy, we haven't got anybody to assign to her … I'd say to them, but she wants an epidural and that's her choice and that's her right … and so to provide her with an epidural I have to hand her over to you, because you're the guys that do the epidurals. But they'll argue black and blue that they're too busy to take her on and because I don't have an obstetric reason for handing her over I can't do it. (Frida, self-employed midwife)

I interviewed the NZCOM Legal Advisor (also a midwife). During our discussion we teased out some of the issues midwives had brought up with me over the course of the previous year. I was especially interested in how caring for women having an epidural or up-skilling in order to gain/maintain ones certificate was constructed from within the secondary care facility. An effect of the liberal interpretation of women's choice for epidurals is that, as the title to this chapter suggests, many self-employed midwives are increasingly interpellated into the centre of the obstetric panopticon; the base obstetric hospital. Once there, their practices become visible to medical and core midwifery staff, within the relations of ruling that govern codes of conduct in the obstetric hospital. Core midwives must oversee the practice of those newer practitioners or self-employed midwives who have not attained, or who resist, the attainment of the epidural certificate. By way of an experimental conversation here below I highlight the ways in which different discourses refer to one another in the process of making claims about the relationship of epidurals to primary and secondary care by differently-positioned midwives:

> Legal Advisor: The concern for me with epidural certificates myself is the mixed message. Midwives are working with women in the area of normal birth … to try and facilitate that birth … by forcing normal practitioners to get what is a secondary care skill … like a certificate for a secondary care situation … what

are you actually saying about normal birth? And what are you doing to their practice? Because if they get a certificate they'll be expected to use it. If they don't use it very often then they're considered … they haven't got sufficient skills to manage an epidural if they have to. You know, like it's almost as if they have to do a certain amount of epidurals, or manage a certain amount of epidurals to maintain their confidence and continue with their certificate. The other thing I worry about is the message that epidurals are just part of normal birth and to be expected. (NZCOM Legal Advisor)

Frida: Even if I got my certificate … which is very unlikely because you have to have X number of women. I wouldn't be skilled at it. It isn't in my field of expertise … it's certainly way out of my comfort zone and I think there are midwives who work in base hospitals who have epidural certificates and do it every day, and of course there shouldn't be such a high epidural rate, that's a different story, but so those women deserve to be looked after by people who are good at it. And that's their field of expertise. And so I think … there shouldn't be a problem there but there is. They feel defensive about it … they think that we … out here in the community … criticise them all the time for their medical interventionist care and we think that they criticise us for our dangerous slack practices of not doing the things that we're supposed to be doing … and so when the time comes to meet which inevitably it does for some people … when you have to transfer or whatever, then the woman gets stuck right in the middle of a whole lot of unsaid hidden agenda stuff. (Frida, self-employed midwife)

Legal Advisor: But it gets even more complicated because in a lot of cases the self-employed midwife is expected to stay on and manage the epidural whether that's her area of speciality or not … now that's when you're getting into a dangerous situation because what is actually happening from the HHS's point of view when they are putting her into the role of pseudo-employee where she is saying well this isn't my area of expertise, this is really outside the parameters of my normal practice

RS: If she hasn't got a certificate?

Legal Advisor: Yes, or even if she has but doesn't use it very often. And she's saying I really want to hand over care and stay on as support and they're saying well we haven't got the staff for that, you stay and look after her. Well they're really forcing her to act on their behalf and manage that epidural.

RS: Is holding an epidural certificate part of having an access agreement?

Legal Advisor: Some access agreements. It depends on the institution. It shouldn't be because it's a secondary care skill. (NZCOM Legal Advisor)

Pressure also is felt from busy core staff who are themselves often under stress and are obliged to provide secondary care for a woman choosing an epidural if the woman's own LMC does not hold an epidural certificate. I interviewed the WHD midwifery educator in her role, again to tease out the issues raised above:

> RS: And from a core perspective I suppose if there's a time when you're incredibly busy then having LMCs come in who philosophically might not want to do epidurals seems….
>
> Educator: I guess it's frustrating at times for them … because if the woman chooses an epidural, I know it starts a cascade of intervention, there's no doubt about that but if she wants an epidural for pure pain relief, there's no other complication, like she hasn't got a medical condition … she's requesting it from a pain relief perspective … then it's really difficult for a core midwife to come in … provide the so-called epidural care while the LMC provides the midwifery care … if I'm going to provide midwifery care then I do it … the epidural is part of the process of the birth and I don't think it can be separated, you either do it or you don't, and it causes great strife amongst the practitioners. (WHD Midwifery Educator)

In this statement, having an epidural for pain relief can be seen as a seamless integration of care; the pain relief cannot be separated out from the rest of the midwifery care that is provided. The philosophical tension between different primary and secondary care providers is noted by the educator. The monitoring and surveillance that constitute contemporary obstetric risk management techniques extend to the management of pain; a midwife with an epidural certificate must remain in the room with the labouring woman where the effects of her epidural analgesia and the well-being of the foetus are continuously monitored. In turn, those more senior, or those supervising the attainment of the epidural certificate monitor the conduct of the attending midwife. Those midwives in turn, whether they are core staff, the LMC's mentor, or her back-up, are in turn under the surveillance of the more senior charge midwives and medical staff of the institution. The desire on the part of many women to use epidural technologies as a main form of pain relief, draws some midwives into the institution and cements certain midwifery knowledges and practices there, while others are sublimated. At the same time this increases the potential for the general surveillance of the midwife and her other actions within the panoptic visual field of obstetric relations of power.

Hunter discusses similar issues in her research with midwife practitioners with regard to the expectations of the institution and epidural 'culture'. These issues include those of 'feeling

watched', with pressure to control women's noise through the use of sedation/epidurals, waiting for the 'knock on the door', and the ways in which "the medicalised culture of the large hospital seems to discourage the use of some non-pharmacological alternatives for managing pain" (Hunter, 2000:91). Rooks (2000) and Murphy-Lawless (1998) note the difficulties for women and midwives both to resist epidurals in a setting where the provision of them is the norm, such that midwifery care has been completely re-organised to meet the needs of women with epidurals. The actions of the midwife will be focussed on the monitoring and surveillance of both the foetus and the woman; she will be watching and writing more than lending constant physical support. For some midwives, this can be a welcome respite from the hours of intensive labour required by her in the provision of labour and birth care that is more focussed on embodied empowerment for the birthing woman. When empowerment for the birthing woman lies, instead, in the transcendence of embodiment, 'in the separation of the mind from the body', to refer back to Rothman's warning quoted at the start of this chapter, the focus is on biomedical technologies of monitoring and surveillance. The use of these technologies, in turn, construct the labouring body of the midwife herself as an object of increased surveillance.

From surveillance to subversion

Some midwives spoke to me about their philosophical reasons for resisting the acquisition of an epidural certificate. Rosalie's talk positions her in partnership with a birthing woman as they together resist hegemonic hospital discourses around pain relief during a situation of transfer from the birthing centre into labour ward:

> And one time I took a woman there who had … I suppose what you'd call failure to progress in first stage and when we got there the first thing they said was oh you poor thing, you need an epidural … and the woman said I don't want an epidural … I'm happy to have Synto; but I don't want an epidural … and they said well, you should have it because the anaesthetist is free at the moment and it fits in with what we need to do at the moment and I said she does not want an epidural … do not push her into it, she will know if she needs one … and the midwife that took over her care of midwifery at that point said to me come outside and she just went nuts at me … and I just said, I hear what you're saying but also this woman does not want an epidural at the moment. Now within an hour the woman did want an epidural, but the one thing for her out of that whole birth experience was that I had said to them that she didn't want one. And I mean it takes … it takes a long time to feel able to do that with them…. (Rosalie, Birthing centre midwife)

Rosalie, positioned here as a 'goddess midwife', suggests that it is possible to negotiate some hospital protocols and timetabling within a discourse of resistance to epidural culture. As she highlights, as an LMC midwife, she also has simultaneous professional and collegial relationships to negotiate with core midwives. Learning to resist, negotiate and sometimes subvert powerful hospital discourses constructively takes a long time, something many new practitioners also note. Natalie talks about the discrepancies between hospital protocol, and best practice, and the ways she is able to draw on the latter as a discursive resource in responding to situations in which she feels her practice is being questioned: "So if I haven't played the game or done the protocol … 'well why haven't you' and I say 'because there's no evidence to do it … like why is it done?" This discursive repertoire, in drawing attention to evidence-based practices, facilitates the potential for the subversion of some protocols. Other midwives may avoid the surveillance of core staff in different ways at different times, and during different births.

In the examples given above by Natalie and Rosalie, empowerment in these instances comes in the form of resistance to hegemonic hospital protocols and practices in the relief of pain. The woman in labour and the labours of the midwife together constitute a particular form of embodied empowerment. Choosing – or rejecting – an epidural as pain relief in normal labour provides subject positions for women in discourses which arise from different feminist analyses of embodiment, choice and empowerment. On the one hand, empowerment is seen to rest in women's emancipation *from* bodily processes, by avoiding or transcending the (potential) pain of childbirth. On the other, and as part of a different claim, empowerment is constructed through and *in* the birthing body, and is manifest in the refusal of the epidural, even if this refusal is temporary. This may be seen to further a practical goal of experiencing normal/non-interventionist birth, and for goddess midwives, acting as guardians of the same. However, holding this position of resistance to epidural certification may be seen as transgressive and disruptive by some hospital staff, and by some other midwives, and it also appears a somewhat tenuous position at this historical point (Bogdan-Lovis, 1996-97; Downe, 2001a; Murphy-Lawless, 1998; Rooks, 2000).

The articulation of internal debates between the participating midwives in my study about the provision of epidural pain relief in an otherwise low-risk, or healthy, or 'nice normal' pregnancy/labour reflects the central issues that are beginning to emerge from the

international literature. Primarily, there is concern that this phenomenon results in a cascade of intervention (Roberts, Tracy, & Peat, 2000; Savage, 2002; Tew, 1995; Wagner, 1994), which impacts on the meaning of normal birth when this is used to define midwifery scope of practice (Downe, 2001b, 2001a). Normal birth may mean different things to different women, however, as it does to different midwives. Whether or not the attainment of an epidural certificate and the provision of epidural care is part of normal birth, or part of something else, the knowledge that care will likely become secondary rather than primary provides points of tension for a midwife if the provision of primary care is what constitutes her professional identity as a midwife. Interpreting an individual woman's choice as empowering for her regardless of the potential for resultant intervention thereafter, constitutes the midwife as having provided woman-centred care that has been appropriate for this particular woman in her specific circumstances. Maintaining ambiguity about the demarcatory notion of 'normal' is one means by which midwives effectively deploy technologies of the cyborg-midwife-self, labouring in partnership with women in ways which disrupt the dualism of ab/normal birth significantly.

The midwifery value of continuity of care is important to midwives in mobilising a discourse of empowerment, as it is influential in some midwives' decisions to maintain an epidural certificate. This means, in effect, that they have a broader scope of practice, encompassing secondary as well as primary care, and can carry on provision of care without having to hand over to core midwives. The valuing of individual women's choices, and the desire to stay with the woman throughout her specific child bearing experience through gaining (and, significantly, maintaining) the skills required for an epidural certificate, is interpreted as part of a rationale for a type of woman-centred partnership in these instances. The skills that are developed and crafted however, are necessarily based on medical technology, and for other midwives, re-valuing and developing different forms of midwifery knowledge and practices related to pain is important in their rejection of epidural certification.[38]

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[38] Homeopathy, hot water, massage, acupuncture/pressure etc and see Nicky Leap (1997) who has noted the remarkable difference in birth outcomes when midwives talk with pregnant women about working with pain, rather than pain relief (whereby a 'menu' of different analgesia is offered to the woman for her to choose from). The midwives who adopted the former approach "…represented an overall philosophy of reflecting on practice, embracing uncertainty, recognising that nothing is absolute…" (Leap, 1997a:263).

There exists the potential for a double subversion in the disruption of ab/normal birth by midwives. On the one hand, in trusting and following a woman's choice for epidural pain relief, some midwifery values must be 'sublimated' to the requirements of the institution, which provides this technology to cyborg midwives/women. On the other hand, goddess midwives may act within the institution in ways which significantly subvert its requirements, such as avoiding the surplus surveillance of medical and core midwifery staff. In this, as Natalie points out, they generally have claims to 'evidence-based practice' as a discursive resource from which they are able to lay claims to being safe practitioners. Hence, experienced core staff are liable to 'turn a blind eye' if a practitioner they know and trust does not follow the institutional protocol of a twenty-minute CTG admission trace; there is no evidence that this improves outcomes for healthy pregnant women and their babies (Wagner, 2002; Walsh, 1998, 2000).

These issues lead to individual midwifery decisions as to whether epidurals as pain relief will be offered as part of an individual midwife's professional scope of practice. Pressure is sometimes exerted by some midwives, who do have their epidural certificates, on those who don't have them, and this can be seen as the effects of disciplinary normalisation. It is seen as perfectly rational that if most women want it, all midwives should be able to provide it, as Bess explains:

> So it's very uncertain all that stuff. And that's a real bone of contention with independent midwives … taking women in … it's something that comes up quite often at College meetings now … and there are a very strong group of midwives who think we should all have epidural certificates and so they badger all the other ones that complain about this process … and say if you had your epidural certificate it wouldn't happen … but in actual fact it would happen sometimes. You might be looking after someone for 20 hours who then transfers in for an epidural and even if you've got your certificate you wouldn't want to carry on that tired. (Bess, self-employed midwife)

This process might mean not that women and midwives have been seduced as docile bodies into hegemonic regimes of obstetric dominance, however, but conversely, in my analysis, that women themselves with midwives have appropriated "…elements of the technology in order to gain a measure of control" over their lives (Hunt & Symonds, 1996:87). This can be seen as one example of cyborg partnership in action, just as resisting this same technology is another form of partnership in action. This constitutes a significant challenge to Rothman's (1989)

assumption which began this chapter, that women do not want to consider themselves as made up of machines, and parts of larger machines. Perhaps they/we do. The interrelationships between birthing bodies and our networked connections with other humans and biomedical technologies are 'cultural formations' (Balsamo, 1996), through and within which women and midwives can utilise differently-formed 'couplings' between organism and machine (Sawicki, 1991).

With regards to these issues, Davies, a British midwife, says: "Until we address the question of who decides what constitutes 'normality', we will only be paying lip service to the ideal of being 'woman-centred'" (Davies, 1996:286). And as Bordo notes, "While it is true that we may experience the illusion of 'power' while actually performing as docile bodies, it is also true that our very 'docility' can have consequences that are personally liberating and/or culturally transforming" (Bordo, 1993:192). Midwives in my study, in their analysis of the epidural epidemic and the reasons that women 'want it all', appear to rupture the dualism between active consumer and passive recipient to quite a significant degree. In this way, they seem to respond to the statements made by Rothman and others at the beginning of this chapter almost by echoing Sawicki's words:

> If patriarchal power operated primarily through violence, objectification and repression, why would women subject themselves to it willingly? On the other hand, if it also operates by inciting desire, attaching individuals to specific identities, and addressing real needs, then it is easier to understand how it has been so effective at getting a grip on us. (Sawicki, 1991:85)

What I consider to be of central importance for the midwives participating in my study who did not want to have epidural certificates, is that the holding of this position was predominantly interpreted by core staff on the labour ward as one of resistance or transgression. For some (goddess) midwives, this position was a temporary one; an ideal held on to after first graduating, or until business decisions had to be made if it was felt clients might be lost now or in the future. Midwives are constructed as the guardians of normal birth, and the midwives in my study deployed this as a conceptually mobile strategy; one in which professional midwifery is constantly reconstructed around shifting meanings in normal birth. There are some real advantages for cyborg midwives and women in mobilising fluid meanings of 'normal', where the boundaries, or hyphen, in ab/normal are porous and seepage occurs in

both/all directions. But as well as this, I suggest that other complex issues also underpin what some analysts interpret as midwifery complicity with individual choice.

I argue that while women's choice for epidural pain relief in normal birth is often cited by midwives in prevailing discourses concerning the management of pain, in practice, the amenability of midwives to various forms of governance can also be seen to contribute to the persistence in the institutionalisation of birth. In what ways does midwifery as a counter-hegemonic discourse focussing on choice inadvertently re-inscribe medicalised birth? What kinds of 'norms' are becoming established within these new participatory modes of liberal childbirth? What are the effects of these norms that might give rise to the development of a midwifery gaze? In the next chapter, I begin to examine the effects of the tensions, discussed in this chapter, for midwifery practitioners as they respond to choices for hospitalised birth. These responses are structured within complex midwifery negotiations of discursive spaces; spaces that in practice are both embodied and geographical, and variably drawn on in the talk of midwives as simultaneously containing/dispersing notions of risk/safety.

6

Chapter Six

'Everybody expects the perfect baby ... and perfect labour ... and so you have to protect yourself': risk/safety in discourses of defence

> I'm still not going to go and get her induced. I'm just waiting to see what happens ... and I'm going to try and normalise her birth as much as I possibly can. But yes, I probably will do a 20 minute CTG ... and do you know why I'm doing it? I'm doing it to *keep myself safe*. Because ultimately we're not judged by how well we look after the normal. We're judged by how well we look after the abnormal. (Cathi, self-employed midwife; emphasis in speech)

What are the implications for midwives in Aotearoa/New Zealand who labour within a professional field permeated by a culture and logic of 'risk' coupled with the increasing awareness of litigation? (Cartwright, 1998; Pearse, 2000; Rothman, 1991; Skinner, 2001, 2002; Smythe, 1998; Symon, 1996; 1998; 2000; Walsh, 1998, 2000). What midwifery actions signal a response to these contemporary issues? How might these actions differ across multiple sites of partnership with women, and what are the effects of these actions? The previous chapter explored some of the implications for midwives when women/clients choose epidural analgesia, troubling the distinctions for midwives between ab/normal birth, midwifery/obstetrics, natural/technological, and seduction/desire. This chapter follows on from that, in much the same way that many midwives' talk of 'fear of litigation' followed on from their/our talk of increasing intervention into birth.

In what follows, I reflect on the recent literature around risk and governmentality generally, and then specifically in relation to childbirth. Then I explore some of the ways the midwives in my study talk about their actions in relation to these issues. I critically examine the ways in which the 'conduct of (midwifery) conduct' (re)produces midwives as responsible or accountable professional actors who work to keep themselves 'safe' within the matrices of cultural assumptions of risk and blame that impregnate (post)modern bodies. At the same time these midwives are concerned with keeping the women in their care safe. The woman's safety is nested within that of the midwife's, whose actions in turn are governed through the discourses and practices of the professional body to which she belongs.

For the midwives I interviewed, 'keeping ourselves safe' takes place in different locations, analysed as those of a 'governing interface' (Burchell, 1996; Purkis, 2001). Both labouring bodies in the partnership, the pregnant body of the woman/client and the labouring body of the midwife, occupy spaces of risk/safety together where, as such, they are amenable to various forms of governance. For the midwives I spoke to, these spaces could exist at decision points of care with women, points of negotiation with obstetricians, times of hand over from primary to secondary care, attendance at standards review or in other midwifery spaces of reflection, and in negotiating the MOH guidelines for consultation and referral. The midwife's (response-able) actions occur within these complex spaces and networks of contestable, but always intertwined, forms of knowledge production, truth and (in)stability.

Risk and the governance of health

Research interest from within the social sciences into the field of 'risk' as a site of contestation has grown rapidly in recent years (Adam, Beck, & Loon, 2000; Beck, 1992; 1999; Cartwright, 1998; Douglas, 1992; Lupton, 1997a; 1999a; Petersen, 1997). Lupton describes three types of contemporary risk rationalities identified by different theorists of risk. Briefly, these are: insurantial risk(s), with regard to insurances of all kinds (Ewald in Lupton, 1999a); epidemiological risks, concerned with a range of abstract factors influencing health outcomes in targeted populations; and clinical or case-management risk involving the qualitative assessment of risk for individuals or groups deemed at risk in any way (Dean in Lupton, 1999a:95-97). Analyses of what constitutes risk from within the Foucauldian governmentality literature suggest that discourses of potential or imagined risks have replaced earlier notions of potential hazard(s) or dangerousness, and that these "…new formulae for administering populations fall within the emerging framework of a plan of governmentality appropriate to the needs of 'advanced industrial' (or, as one prefers, to 'post-industrial' or 'postmodern') societies" (Castel, 1991:281). Like other Foucauldian scholars, Castel suggests that the concept dangerousness has been surpassed by risk, particularly with relation to marginalized individuals. He states:

> A risk does not arise from the presence of particular precise danger embodied in a concrete individual or group. It is the effect of a combination of abstract *factors* which render more or less probable the occurrence of undesirable modes of behaviour (Castel, 1991:287, italics in original).

In this view, according to Petersen, it is the focus on the identification and early prevention of (clinical) risk factors which functions as a contemporary technique of governance. He supports Castel's view that: "…in many contemporary 'neo-liberal' societies there has been a broad shift in forms of surveillance and control from those based on the direct, face-to-face relationship between experts and subjects to those based upon the abstract calculation of risk" (Petersen, 1997:189). Cheek (2000), draws on Foucault's assertion that to govern is to structure the possible field of action of others and adds, "By its very nature, the exercise of this power relies on the knowledge of experts, for it is they who decide what is normal and abnormal within populations, and it is they who identify abnormality in individuals" (Cheek, 2000:27). Increasingly, individuals as health consumers, including pregnant women, are exhorted to take preventative responsibility for their own abstract clinical risk factors, in order to maintain health and well-being, longevity and productivity, and ultimately to become self-governing, responsible citizens. At the same time, as Cheek notes:

> …registers of births and deaths and reports of certain diseases and other health-related statistics enable the monitoring of trends in disease and illness in entire populations. These trends can then be used to establish the norm and to further regulate and discipline the behaviour of both individuals and entire populations, subjecting them increasingly to the gaze of the health professional's authority. (Cheek, 2000:27)

The relationships of governance between sovereign, disciplinary and pastoral power, shape and reshape the conduct of populations and simultaneously constitute and regulate individual subjectivity and norms (Faubion, 1994; Foucault, 1979; Holmes, 2002; Osbourne, 1993). Some researchers interested in critical analyses of risk and governance consider that we may be better placed to theorize from a perspective of risk 'culture', rather than risk society, because the later denotes a sense of institutional domination in response to new challenges enforced upon the world by technologies and practices, while the former perspective emphasizes: "…a far less coherent ensemble of sensibilities and practices informed by uncertainty, contingency, fragmentation and turbulence….[which] embraces all kinds of residual and marginal forms of sense-making practices" (Adam, Beck, & Loon, 2000:5).

Beck's response to these issues over difference in risk culture or society is that there are no significant differences between the two concepts, other than in degree rather than in principle, but others point to "…the unmentioned counterparts of both: which would be risk-aversion

society and risk-aversion culture… hence, risk cultures are marginal counter-discursive articulations against the dominant risk-aversion culture of the sub-politics of expertise and commerce" (Beck in Adam, Beck, & Loon, 2000:5). A critical approach to risk within the fields of health and education necessitates a simultaneous exploration of governmentality because risk is brought into being through the discourses and practices geared to the management and (self) regulation of citizens. It will always be operationalised in the production of certain forms of subjectivity. Hence, no risk is a real or self-evident thing in itself, but can be considered a product of historically and politically contingent ways of seeing (Lupton, 1999a).

In his discussions on forms of government from the sixteenth century onwards, Foucault cautioned against excessive attention to the State per se, suggesting that what may be really important is not so much the "…State-domination of society, but the 'governmentalization' of the State" (Foucault, 1979:20). He defined governmentalization here as:

> …a right manner of disposing things so as to lead, not to the form of the common good, as the jurists' texts would have said, but to an end which is 'convenient' for each of the things that are to be governed…. of employing tactics, rather than laws, and even of using laws themselves as tactics – to arrange things in such a way that, through a certain number of means, such and such ends may be achieved. (Foucault, 1979:20)

The welfare, health and regulation of the population is of chief importance here, through appropriate management of the family and the economy. Foucault's concerns are to analyse the 'conduct of conduct', and to demonstrate the threads of 'upward continuity' via the self-governing citizen, and the relationships between self-government, family government, and state ruling, concerned with morality, economy and politics respectively (Foucault 1979). McNay explains that Foucault's work on governmentality is important because of its significant re-workings of various concepts of power and the self, including Foucault's own previously held concepts (McNay, 1994). Helpful to any analysis of institutions involved in the regulation and monitoring of bodies is the idea of power as a capillary network, creating both subjects and objects within fields of knowledges. The microphysics of power, that is the subtle, multiply directional relations between specific individuals, provides scope for a much broader analysis of power as something that is productive and diffuse, rather than repressive and exclusionary (Faubion, 1994). The government of the self is located at the governing

interface, that is, at the very ends of the capillary network of power/knowledge, which might be in the (discursive and material) spaces of the clinic, home or hospital (Cheek, 2000:27). McNay states, with regard to Foucault's later work on governmentality: "In short, Foucault questions the rationality of post-Enlightenment society by focusing on the ways in which many of the enlightened practices of modernity progressively delimit rather than increase the freedom of individuals and, thereby, perpetuate social relations of inequality and oppression" (McNay, 1994:2).

Nursing theorists, such as Mitchell (1996) and Cheek (2000) have also found Foucault's contributions on the clinic, the gaze, the panoptican and governmentality particularly useful and relevant in their analyses of the regulation and discipline of bodies within the fields of knowledge known as 'health'. This application of Foucault's work highlights the ways in which healthy (rather than 'sick') bodies are disciplined, inscribed and regulated, subject to the power/knowledge of experts within the realms of governance (Mitchell, 1996 81:202). My interest is in the way bodies are disciplined and regulated – reinscribed as either risky or safe bodies - within the epistemologically dualist fields of obstetrics and midwifery. The technologies of the self performed by the actors in these fields are not separate, but are historically and inextricably woven in together.

Within the field of health, in their proposal to explore health professionals' responses to risk governance, Alaszewski and Horlick-Jones (2001) suggest that examining influences on decision making and practice, influences on communication of risk issues to patients, and whether there is evidence of defensive practice are all important areas for social science research into the construction of risk and the subsequent governance of the (healthy) population:

> Risk ideas and techniques now provide an important language for the articulation of policy in a diverse range of areas of health-related practice (Walshe and Sheldon, 1998), and their role, according to parts of the governance-related literature (the Foucauldian 'governmentality' perspective), now transcends simply an analytical capacity to capture contingency, and serves certain deep-rooted functions of power and control (Rose, 1999). (Alaszewski & Horlick-Jones, 2001:8)

In this chapter I explore midwifery response to obstetrically administrated (or realist) discourses of risk with an attendant examination of the effects on working practices in the constitution of safe midwifery subjectivities. My assumption is that all areas of human life and activity are permeated with hegemonic cultural discourses of risk (Adam, Beck, & Loon, 2000; Alaszewski & Horlick-Jones, 2001; Beck, 1992; 1999; Lane, 1995; Lupton, 1997a; 1999a; 1999b). Accordingly, and embedded as it is within language, culture and the law, childbirth also is categorised into low or high risk, normal or abnormal (Saxell, 2000). As a taxonomy devised by obstetricians to govern both normal and abnormal births (Rothman, 1991:132), this logic of risk around childbirth can be seen to prevail culturally and politically in subtle and not so subtle ways, despite the increasing popularity of (and evidence for the safety of) midwifery-only care.

Risk and childbirth

Rothman (1991) discusses the ways in which medicine gained control over pregnancy by defining it as a disease, and hence all pregnancies as potentially pathological, establishing and securing the profession of obstetrics (and see Arney, 1982; Donley, 1998; Ehrenreich & English, 1973; Mein Smith, 1986a; Papps & Olssen, 1997; Sandall, 1995; Smythe, 1998). Smythe, a midwife in Aotearoa/New Zealand whose PhD thesis explores contested meanings of safety in childbirth, notes that one discussion of childbirth risk in an Inuit community identifies three languages of risk: that of the epidemiologists, for whom risk is statistical; that of the clinicians, either obstetricians who use a language of risk factors to lay justificatory claim to more intervention, or midwives who lay counter-claim to less risk and less intervention; and lay people who see risk as an occasional threat, otherwise accepted as part of the natural process of birth (Smythe, 1998:62). This example highlights the ways in which midwifery is constructed as a counter-discourse to obstetrics, the latter with a focus on the abnormal, pathological or high-risk, and the former with a focus on the normal, physiological or low-risk labour (Annandale & Clarke, 1996:30). Indeed no matter how low-risk a woman's pregnancy may be, it is still defined biomedically within a logic of risk, even if it is the lowest possible risk. There can be no category of 'no-risk' (Lane, 1995; Saxell, 2000).

In childbirth, as well as in other sites of knowledge production about the body, the notion of risk has replaced earlier discourses of dangerousness or disastrousness, which had hitherto

contributed to the idea of birth as something requiring hospitalisation.[39] This contemporary shift from dangerousness to risk occurs when a danger becomes measurable or visible through the development of a new biomedical technology, thereafter deployed to quantify and treat the emergent problem (Cartwright & Thomas, 2001:219). If the diagnostic technology can register both the normal and abnormal and show progress between the two states, then:

> When the numbers fluctuate outside the more or less arbitrarily defined limits of "statistical norms", practitioners must either treat the condition or be able to justify why they are withholding treatment. The power of medicine is thus enacted: Risks are identified and can be controlled only through medical surveillance and treatment. (Cartwright & Thomas, 2001:219)

In this way the older concept of danger, a fatalistic notion, is replaced with the more active concept of risk, requiring action and earlier and earlier management in the form of surveillance, monitoring and frequently intervention (Cartwright & Thomas, 2001:219; Castel, 1991). This leads some theorists to suggest that the proliferating development of categories for pregnancy such as 'potential' or 'growing risk', with a concomitant focus on foetal surveillance, monitoring and surgery, exist as evidence of the changing orientation of obstetrics, as it permeates women's bodies and increasingly, those of their foetuses' (Saxell, 2000:93; Weir, 1996). Weir (1996) suggests that the implication of the foetus with its own subjectivity is the central development in the governing of the pregnant body via the increasingly penetrative obstetric gaze.[40] In this the shift from sovereign to pastoral power can also be seen. There is no longer a direct and dominating obstetric power over women's pregnant bodies, but a benevolent and indirect exhortation for the woman to care for her own foetus. This can be done responsibly if one becomes as knowledgeable as possible about the potential risks to the foetus, and establishes a trusting, communicative and confiding relationship with a specialised health professional (midwife) (Lupton, 1999a, 1999c).

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[39] The shift to hospitalisation has been addressed elsewhere in this thesis and also in detail elsewhere (Papps & Olssen, 1997).

[40] There is a large body of literature concerning the visualisation, publification and subjectification of the foetus as Weir notes, and which is beyond the scope of this thesis, except to draw attention to the ways in which this foetal focus contributes to the amenability of pregnant bodies to forms of surveillance and governance, at the same time increasing visibility of and amenability of midwifery bodies to governance (and see Armstrong, 2000; Rapp and Balsamo in Clarke & Olesen, 1999; Klassen, 2001; Lane, 1995; Lupton, 1999c; Martin, 1993; Petchesky, 1987; Rothman, 1991; Squier, 1995; Stabile, 1998).

Indeed, pregnant women are hard-pressed not to be influenced by the discourses of risk/safety that surround them, impregnating every aspect of daily life, inciting/inducing them to action, to some form of conduct. Inherently at-risk because of our always-already potentially failing female embodiment (Klassen, 2001; Lane, 1995; Lupton, 1999c; Martin, 1993; Rothman, 1991), this fallibility increases substantially during pregnancy, so that pregnant bodies are positioned within a web of surveillance and (self-)monitoring. The list of tasks responsible pregnant women must undertake to minimise their own risk factors, and ensure their health and the subsequent safety of their foetuses, is exhaustive: avoid soft cheese, all alcohol, any shell-fish, too much exercise, restrictive clothing, all party drugs; attend ante-natal classes, yoga, swimming and do gentle walking; learn about breastfeeding, infant care, car seats and sleeping patterns, how relationships might change after birth; try hard not to smoke; eat a nutritious diet, take folic acid. Above all, get to 'know your baby'; monitor its progress through regular antenatal checks with the health professional you have chosen as your LMC, and remember: 'choose wisely; choose a midwife'. In choosing the LMC wisely, Smythe notes some of the factors the woman must consider in a safe practitioner:

> …their qualifications and experience, their basic beliefs about birth (eg. regarding pain relief), how many visits they include, how they will attend in labour, what back-up arrangements they make when they are off-duty, how big a case-load they carry, what is their intervention rate, who would they refer to if there were complications, what emergency equipment they carry if a homebirth is planned, and how they have their practice reviewed. (Smythe, 1998:12)

Weir (1996), Lupton (1999a; 1999b; 1999c) and Arney (1982), all argue that these proliferating discourses of risk, as well as the increasing subjectivity of the foetus, are the central features in the dispersed and liberal governance of postmodern childbirth. These activities are always related to the liberal governance of pregnant bodies, because they exist in order to promote new modes of surveillance, those of 'systematic predetection' (Castel, 1991), whilst linked to a therapeutic objective in the midst of neoliberalism (Weir, 1996:374). The obstetric monitoring and surveillance of all births within hegemonic discourses of potential and actual risk is maintained at the base obstetric hospital, and dispersed outwards in networked flows at which midwifery decision points exist at multiple nodes of knowledge/power. Below I explore some of the ways in which midwives described their discursive and practical responses to risk at these interfaced sites where they are particularly amenable to forms of governance.

Responses to obstetrical discourses of risk

Some statisticians, epidemiologists and obstetricians, as well as midwives, articulate contesting responses to obstetrical discourses of risk. The work of Tew (1995), a British statistician, was ground breaking in its support for midwives and midwifery models of care. Tew's major finding was that it is safer to give birth at home (in Britain) with a midwife than in an obstetric unit in a hospital, and that this is safer at every level of risk status for the mother including high risk. In Holland, she found it eleven times safer to birth at home with a midwife than in hospital with an obstetrician (Tew, 1995). Further, in her extensive studies of comparative national Perinatal Mortality Rates (PNMR) of normal-weight infants, she discovered that in Aotearoa/New Zealand the PNMR was lowest in the smallest hospitals, rising steadily to the highest in the most specialised hospitals, and that this upward trend was highly unlikely to be explained by similar upward grading in identified risk from predicting factors (Tew, 1995:355).

Tew's large volume of research has been particularly helpful for midwives in their counter-response to obstetrically managed childbirth, because it demonstrates that in obstetrical childbirth, cause and effect can often be reversed. In this way, according to Tew, if a woman seeks the opinion of an obstetrician first, then she may well succumb to a cascade of intervention. Recent research confirms these findings (Roberts, Tracy, & Peat, 2000; Tracey, 2001). Obstetrically-governed interventions may have dubious benefit and be of actual and potential harm (Cartwright, 1998; Cartwright & Thomas, 2001; Savage, 2002; Saxell, 2000). Tew and others such as Wagner, an epidemiologist, demonstrate that increasing the use of biomedical technology in birth does not reduce maternal and newborn mortality and morbidity (Tew, 1995; Wagner, 1994, 2002). Midwives have therefore been able to challenge the political investment inherent in the production of pregnant bodies as always-already risky by drawing on the work of Tew and Roberts et al as well as others such as Enkin et al (1995), to provide care within a discourse of evidence-based practice.

Butler describes designating as an origin and cause those identity categories that are in fact the effects of institutions and practices (Butler, 1990:2). In Butler's critique of Kristeva's 'reification of the maternal body', for example, she uses Foucault to suggest that the postulation of a maternal body prior to discourse is fundamentally inverted and must be reversed, that is, must be shown to be the product of language. She states that Foucault would

"…doubtless argue that the discursive production of the maternal body as pre-discursive is a tactic in the self-amplification and concealment of those specific power relations by which the trope of the maternal body is produced" (Butler, 1990:92). Problematically pregnant bodies requiring caesarean births in many circumstances of obstetrically-defined risk such as breech presentation, can be understood in this analysis as the effect or consequence of a system that persistently constructs women's bodies as problematic and uncontrollable, and particularly risky when pregnant, requiring surveillance, monitoring and preventative intervention.

Practices seen as safe from within obstetric discourses may hold various potential risks for the birthing woman from within a midwifery discourse, most frequently in any ensuing cascade of intervention (Guilliland, 2000; Roberts, Tracy, & Peat, 2000). As midwife and author Maggie Banks (2001b) states in her critique of the Toronto Term Breech Trial:

> The all-encompassing label of 'failure to progress' is regularly used in medicalised childbirth (irrespective of presentation) to describe those women who do not labour within rigid time frames – time frames that are based on flawed science. It would be more accurate to categorize 'failure to progress' as 'failure to be patient'. (Banks, 2001b:3)

Banks and Guilliland are two midwives in Aotearoa/New Zealand who have challenged risk 'management' responses to realist discourses of perceived risk. Guilliland has noted that the LMC system within the Section 51 (now Section 88) service specifications means that a midwife can remain as a woman's primary care giver when specialist advice is sought. The MOH Guidelines for Consultation provide for continuity of (midwifery) care at the same time as increasing the woman's sense of control over and satisfaction with the process, even if it should include unexpected events (Guilliland, 1999:12). It also disrupts the dualism of ab/normal, given that a midwife can now remain as LMC for a woman who may have a medical condition such as diabetes or epilepsy, or who chooses technologies such as epidural analgesia, and seek the appropriate consultation with an obstetrician during the course of the pregnancy/labour.

During my fieldwork I had one interview with two obstetricians who were about to stop their obstetric practice partially as a result of midwifery negotiations with them around the meanings of safety in childbirth. They explained some of the reasons they were averse to midwives consulting with them when midwives remain LMC to 'risky' women:

> Ob 1: You see you've got the situation where midwives are both financially and morally being encouraged to look after these abnormal pregnancies as the LMC because they only get paid … if the problem is diagnosed when the woman is 28 or 30 weeks pregnant then most of the payment is in the labour and delivery … if they don't look after her in the labour and delivery … it's not worth looking after her at all. Now the encouragement is that the midwife LMC does the care and that we just do the occasional consult.
>
> Ob 2: In (this city) there's a dramatically decreasing number of obstetricians prepared to provide a consultation service, particularly with some of these new practitioners coming out who we consider to be …
>
> Ob 1: Inexperienced …
>
> Ob 2: Inexperienced or untrained for the role they're being encouraged to take on … midwives have three years of training and they might very foolishly then walk out the door thinking they're perfectly capable of looking after everybody and everything … and they're going to come seriously unstuck … or there's going to be some women who will come seriously unstuck as a result of this … uninformed I think … I don't think they're deliberately doing anything that … I'm sure they don't intend to cause anybody any harm but I don't think that they realize the depth of their ignorance. (Two obstetricians)

In spite of these obstetricians' political and financial investment in this discursive portrayal of midwives as incompetent and ignorant, Guilliland notes that all medical colleges (obstetric, paediatric and general practitioner) had reached a consensus with the NZCOM and consumer groups in establishing the referral guidelines for obstetric services. While the MOH referral guidelines document can be seen as a risk list, Guilliland nevertheless says:

> … it remains a woman centred, consent required set of guidelines, despite early attempts by hospital management to make them strict protocols. Midwives were able to have influence in this way because they argue from an evidence base. (Guilliland, 1999:5)

Armed with best-evidence as a discursive resource from within which to base their practice, midwives might still encounter problems with obstetricians in terms of consulting for particularly 'risky' women. I agree with Abel's consideration that the maternity service specifications will increase the amenability of midwifery professional practice to forms of governance. She anticipates this will occur because of the MOH contractual requirements for clinical accountability, demonstrated by the fulfilment of service specifications, abidance to the guidelines for transfer to secondary care and preparation for audit (Abel, 1997:271). These

technologies all render midwifery knowledges and practices increasingly visible and therefore subject to surveillance and monitoring, by others, or by themselves. Natalie, a self-employed midwife told me about her efforts to negotiate an obstetric consultation with an obstetrician who clearly was not impressed with the evidence in this case, but rather more his own medico-legal defence:

> … and I rang one obstetrician who said 'has she had a pelvimetry done?' and I said 'no', and he said 'well I refuse to consult with anyone who's had a previous Caesarean who hasn't had a pelvimetry done' … and I said 'well … the evidence doesn't support that and none of your colleagues require this or use pelvimetry in this situation as appropriate screening'. 'Well, I'm the busiest obstetrician in town and if I got called up to Medical Council then I'd have not a leg to stand on and I don't care what they do … I'm the busiest, so what I'm doing must be right and so go and find someone else'. (Natalie, self-employed midwife)

It is hard not to see aspects of power reminiscent of the King over his subjects – sovereign power – in this obstetrician's lordly injunctions to the midwife/subject. Individual midwives, or newly-graduated midwives may not yet have influence with obstetricians in specific cases like this, where the micropolitics of obstetric and midwifery professional jurisprudence and power intersect. With regard to evidence-based care, Banks (2001b), concurs with Strid (2000) in suggesting that midwives can utilise the World Health Organisation's 1996 document 'Care in Normal Birth', to provide the most appropriate care for women based on principles of best evidence. Banks suggests this approach may "…get past thinking of 'risk management' and the practice of subjecting women to unnecessary interventions that are performed 'just in case' there is a problem" (Banks, 2001a:4). In her presentation to the 2000 NZCOM conference, Strid challenged midwives to consider that it is care based on institutionalised protocols rather than best evidence that comprises the real risk to birthing women:

> We know many interventions used are rarely justified and that most women are capable of birthing normally. This view is not just the view of isolated women and women's groups. It is inherent in the midwifery model adopted by the NZ midwifery profession. It is clearly outlined in WHO reports and in systematic reviews of randomised controlled trials. The Cochrane Collaboration's library and the written publication of Effective Care in Pregnancy and Childbirth provides easy access to evidence that clearly supports the midwifery model and exposes the flaws in the use of many medical practices. Surely midwives want to provide care that is effective, evidence-based and doesn't put mothers and babies at risk? A 'Guide to Effective Care in Pregnancy and Childbirth' and the WHO 'Appropriate Technology for Birth' paper should be indelibly etched into the brain of every practising midwife. (Strid, 2000)

Differing midwifery responses to Strid's presentation formed the basis for much of my discussion with midwives during my fieldwork and interviews (and see the previous chapter in this thesis), and subsequently contributed to my analysis below of risk/safety as both spatial/embodied and slippery features, central to midwifery discourses of defensive practice. Interviews and participant observation took place with midwives from all practice areas covered in my fieldwork; primary and secondary care providers, those working in rural hospitals and a birthing centre. Homebirth was offered as 'an option' in the practices of many of the LMC self-employed midwives who participated in my study. The self-employed midwives involved in my project varied considerably in where they said they themselves preferred, for various reasons, to have the woman give birth. They noted the ways in which they 'slanted' information somewhat according to their own definitions of safety/risk, and that this varied between home or the base hospital and all the options in between.

'Covering ourselves': discourses of defence

Smythe's thesis acknowledges the proliferation of dilemmas and choices in childbirth now available to women in Aotearoa/New Zealand. She suggests that women are currently in a time of paradox and chaos and hence of opportunity, a time when the meaning of safety is endlessly deferred. Many midwives in my study also acknowledged the myriad of cultural and political influences brought to bear on pregnant women and the subsequent impact of these forces on shaping midwifery scope of practice in an uncertain time. In my analysis of midwives as subjects and objects of accountability, several main concerns structure these as risk/safety discourses of defence. These include an awareness of consumer desires as increasingly complex, a feeling of the weight of responsibility both for the woman's safety (in) and/or to the institution, and actions taken to 'cover' oneself. Zena, a self-employed midwife also discusses the role of 'trust' in the partnership, and the bearing this has on practice:

> You have no choice sometimes to do defensive practice and that may be … it comes into partnership a little bit because sometimes there are clients who really as the partnership evolves, that really you realize you're not that well suited to them, that they don't actually … and I think the strong word is trust. They don't really really trust you … and you get that sense that you feel vulnerable. And you have this slight feeling of a vague unease, and you would practice defensively …you would send them for a blood test, or you would do a CTG … whereas on someone else, who you felt very comfortable with you wouldn't do that with, you'd discuss the possibility of it and if they wanted that you would do that … but you sort of feel that they would never, that they wouldn't question you …

that they wouldn't take you to task if they felt you'd been honest and practiced to the best of your ability and explained to them at the time why or why not you were doing something. But others you do … every point where you think oh I'd better do that … better get the scans, I just need to cover myself. (Zena, self-employed midwife)

These statements are made as part of a discursive repertoire which responds to what can effectively be seen as a highly complex and contingent risk culture of birth. The concerns outlined above, which structure a discourse of defence, always necessarily overlap and intertwine together. This is demonstrated in the comments of Hilda, a core midwife who also did some post-natal visits for a local GP in between her shift work at the base hospital. In the first of my two interviews with Hilda she explained her choice of work location:

I suppose you are influenced by your work environment and the people in that environment and as much as you like to think it doesn't influence your practice, it does really, and I suppose, in the back of my mind, like a lot of midwives … you're thinking accountability and safety … and at the end of the day you cover your backside really - you don't want to be making headlines in the paper and so what if the woman wants an epidural; if that's what she wants then let her have it … you're only going to get that type of care at a base hospital … and you know, like I really admire the small birthing centres … but then other women don't think like that … they want to be going to a base hospital.

RS: Mmmm. Why is that?

Hilda: Well … everybody wants the perfect baby with the perfect labour … the pain free labour … and I think they have unrealistic expectations … but it seems to be what they want … put it this way … if you didn't do a CTG … that's fine … nobody's going to come up to you and say hey look … you're supposed to do a CTG on this woman as she comes in the door … but if that woman had an adverse outcome … if she ended up with a neo-natal death or something went really wrong … and somebody said well what was the CTG like when she came in and you said well I didn't do one … you probably wouldn't get a lot of support from … well … you could end up on your own, and I suppose getting back to equipment and stuff… you probably do tend to use it and you're very careful with dotting your 'i's and crossing your 't's especially in maternity … because this is the world where everybody expects the best. Everybody expects the perfect baby … and perfect labour … and so you have to protect yourself. (Hilda, core midwife)

This example shows the capacity for the indirect shaping of the midwife's conduct; no one is going to challenge her directly for not conforming to a protocol which is, after all, not supported by the evidence for best practice (Walsh, 1998, 2000). For Hilda, managing herself

in a professional role as a midwife here involves thinking ahead, anticipating 'what if' there was an adverse outcome such as a neo-natal death, or imagining her future 'if something did go really wrong'. While no one enforces protocol such as an admission CTG trace, the midwife here practices with the awareness that omitting the procedure means she may be 'on her own' and 'without support' from the institution she practices within, should a situation in the future require an examination of her practice from the perspective of hindsight. Note that Hilda also imagines what can be understood as the very worst trajectory of adverse outcome, a death, rather than what might be seen as a somewhat lesser but generally controllable risk, such as a bleed. Murphy-Lawless refers to the encompassing of all risks including death as the 'risk-death pairing'. She notes that this occurred as danger became separate from risk, that is, no longer something unforeseen, unpredictable and uncontrollable, but scientifically predictable and hence actively manageable. This shift occurred towards the end of the nineteenth century as obstetrics 'ceased to read the individual body' in its development of specific obstetric populations (Murphy-Lawless, 1998:171).

This necessity for midwifery foresight is borne out in Annandale's 1996 research, which showed that increasingly midwives, as well as nurses and doctors, imagine the future as they practice in the present: "I am constantly being made aware that every little thing that is done could in the future be used against me" (in Annandale, 1996:420). Hilda also says, with regard to the use of the (CTG) 'equipment and stuff', that so long as it is there, and in imagining the (disastrous) future, then 'you probably do tend to use it', as part of dotting the 'i's, crossing the 't's and hence leaving no stone unturned in the performance of 'covering yourself'. In their discussion on technology and risk, Cartwright and Thomas outline the implications of risk management procedures:

> Once technology becomes available and widely used, it is difficult to move backward to less technology and intervention (Bortin et al., 1994, p. 46). However, as De Ville (1998, p. 201) has noted, there is an irony here: Once a "particular technology is performed frequently and both the profession and the public believe that it generates predictable results and substantial benefit" the rate of lawsuits increases…. failure to diagnose and promptly treat fetal distress is the most common claim in obstetrical malpractice cases. (Cartwright & Thomas, 2001:222)

In the interview excerpts with Natalie below, as we talked generally about the ways midwives reflect on practice, Natalie states:

> …so, how are we practising? I think that we are practising very much more in an environment which is different from the environment that existed 10 years ago, and that probably is a response to … the doctor's response to independent midwifery and their paranoia and their huge power over the media and over women's perceptions, women's choices and information … but also their perceptions on childbearing and midwives … but we're also becoming much more a litigation … we live in a litigation world and that means that we do things that are defensive practice. We do things to cover our butts. To be able to account for what we've done and can't just *say* … I *know* everything's fine, so therefore everything's fine. (Natalie, self-employed midwife, emphasis in speech)

Natalie, in her use of the phrase 'cover our butts' to refer to defensive practice, states that it's not enough to know and say 'everything's fine'; there must be proof that one is knowledgeable, as we live 'in a litigation world'. 'Litigious world', 'litigation culture' and 'Americanised' were terms used frequently to describe something 'over there' (generally in America, but Britain in one transcript), that was slowly 'creeping in' here.

> But … yeah, I mean intervention rates are rising and that's well documented. And I think that's a fear of litigation that's doing that. I think we're becoming a bit Americanised ….(Susan, rural hospital midwife)

Annandale has also noted the ways in which contemporary professional midwifery is increasingly "marked by risk and uncertainty under the dual impact of patient consumerism and organisational accountability" (Annandale, 1996:416). She suggests midwives' "…concern for individual accountability is heightened by the broader self-reflexive culture of late modern society" (Annandale, 1996:417). For the midwives in my study, the awareness of women's/clients' choices (sometimes interpreted and/or referred to as 'demands'), plus the constraints of the organisational settings they were either employed by or had access agreements with, structure the field of professional actions open to them. Vera, a core midwife who also did some part time post-natal visits for another LMC, discussed with me the implications of becoming 'Americanised':

> I think that when you've got … you see we don't get very many normal births, we're becoming very very Americanised, we are … in that you can be sued for sneezing in the wrong place and it's starting to happen here and I guess what most of us are … we're aware of the fact that somebody can take you to court for the slightest little thing and I guess we're just hedging our bets and covering our backs and crossing all the t's and dotting all the i's … we're being very very sure we're doing the right thing. (Vera, core midwife)

Again, she related this to the potential for some sort of future action against her practice, established on the basis of hindsight:

> If it's not broken why fix it. But we do…we interfere a lot…I guess a lot of it is medical paranoia.
>
> RS: What does medical paranoia mean?
>
> Vera: Well I guess we don't want to be sued for the baby, because when you look at it, if you look down the track…. we put a lot of store on all the Apgar scores and all the rest of it, because down the track, you know, people will sue you…Why did my baby have low Apgar scores? Why didn't you do something about it? (Vera, core midwife)

The personal memory for Vera of her son's kindergarten teachers asking her for his Apgar[41] scores on his first day of kindergarten also remained with her and reinforced her practice of imagining the future whilst simultaneously structuring her current work practices to provide a visible record of her conduct and actions should they need to be 'traced' in hindsight.

'At the press of the button': labour ward as simultaneously safe/risky space

Yvonne, a community midwife working within the WHD had previously worked for one of the smaller primary maternity units, as well as being a self-employed LMC for a period of time. In our interview, I asked why she had changed her place of work. She explained that it was related to feelings of safety that were geographically determined:

> I personally probably don't because we don't have the access, probably such good access to obstetricians in those units and I think they and we both don't go there because of the medico-legal problems … if we run into problems or things that are now seen as problems which weren't previously seen as problems we … we're potentially in trouble. You just feel safer where you know you can press a button and get somebody even if it's unlikely that you really need somebody … (Yvonne, WHD community team midwife)

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[41] Apgar scoring takes place at 1 minute and 5 minutes after the birth of the baby. It assesses the baby's general condition in terms of heart rate, respiratory effort, muscle tone, reflex response and colour. It is recognised and used universally. A 'normal' baby in good condition will receive an Apgar score of 7-10; a score below 7 generally indicates that the baby may require some degree of resuscitation (Michie, 1993).

Yvonne's concerns are to feel protected from 'problems', which may result in medico-legal problems, by having somebody close by, at the press of a button. What is significant in Yvonne's interview text is the privileging of a relationship 'even if you know it's unlikely' with someone other than the birthing woman. Here, any talk of partnership with the woman is critically absent from the midwife's account of what may help the midwife feel safe – which is articulated as spatial proximity to obstetric care. Yvonne notes that both 'they and we' (both midwives and obstetricians)[42] don't go to the smaller units because of the medico-legal issues; highlighting that these fears do not belong to midwives only (Bassett, Iyer, & Kazanjian, 2000; Symon, 1998; Symon & Wilson, 2002).

The potential for problems is difficult to negotiate because of the slipperiness of risk itself. Saxell (2000) and Murphy-Lawless (1998) note the lack of precision in shifting meanings of risk which are subject to change over time. Saxell points out that conditions considered normal or marginal in the past are now being labelled 'high risk', while a situation that may have been considered high risk may later on turn out to be within the 'normal' range (Saxell, 2000:88). Murphy-Lawless agrees with perspectives on risk that analyse it as an expression of knowledge/power in the governance of acquiescent subjects. Varying degrees of 'consent or coercion' are then introduced into the equation of what constitutes particular risks (Murphy-Lawless, 1998:176). Natalie's talk highlights the normalisation of risk on the part of an anaesthetist who is procuring consent for an epidural procedure:

> Say if the woman's coming over for an epidural … they're not progressing, or you know, it could become appropriate to go over and that's what we're doing. Then you have got an anaesthetist coming in and saying 'hello, right … you know all about epidurals don't you' … and you know, doing this brief risk comment … we may or may not, often we don't actually see an obstetrician at that stage. (Natalie, self-employed midwife)

Safety that lies in the proximity of an obstetric team to the pressing of a button is constructed differently and challenged in other accounts, such as in my discussion with Susan:

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[42] Frequently midwives also told me that obstetricians 'never go out to the small units now'. Reasons other than the medico-legal one above given for this were that 'they just think all women should be going in to labour ward anyway', or 'they just don't want to spend the time/petrol', and/or 'it's a way for them to have power over us; if we want to consult, we have to go into them' (although some midwives would do this by phone).

… with safety issues, people want … at the end of the day you go into labour …
you know you get pregnant you want a healthy baby out of it don't you … if
they can deliver in labour ward, feel that everything's there if they need it and
then transfer out within an hour or two of the birth… is that such a big deal?
But that's what's happening. People are more aware of the risks involved,
possibly because of incidences that have happened around the place. I mean
you're always going to lose the odd baby … I mean the odd baby's been lost in
labour ward with everybody on deck. It's gonna happen, that's life. But people
are wanting to minimise that risk. (Susan, midwife rural unit)

Here, Susan points out that the odd baby will still die even if everybody is on deck in labour
ward. She articulates a more arbitrary relationship between technology and death/life. Her
reflections differ from Yvonne's account since she acknowledges that the labour ward and its
attendant personnel cannot always exist as/provide a safe space. Vera, like other midwives,
acknowledges this:

A perfectly good CTG could go along beautifully and the next minute you've got
a dead baby … and that's happened. (Vera, core midwife)

But Susan sees the responsible action is to give birth in labour ward anyway, hence minimising
the potential risk (discursively if not actually of 'losing' a baby), and transferring out afterwards
if all is well. Compliance with this practice would help midwives to minimise the risks posed to
the health and well-being of women and foetuses, and, presumably, to midwives themselves.
On the one hand, labour ward is safe because the smaller units (and by implication, homes)
are not; on the other account, labour ward is the safest space despite losing the odd baby. But
by both reckonings, pregnant bodies are re-inscribed as risky bodies to be involved with,
whether they lie either outside (maximum risk) or inside (minimum risk) the space of labour
ward. Later in the interview with Yvonne we spoke about the CTG workshop we had both
attended:

If you've just had a bad experience with something going wrong you're going to
be ultra ultra careful. Mainly because you're thinking of yourself. You have to …
now of course you do a lot more monitoring so you tend to see heart rates doing
funny things which you didn't see before because you didn't use a monitor …
you listened in regularly and worked it out for yourself. And if the heart rate kept
going down after a contraction then you worked it out yourself … it might have
been a cord around the neck so you would transfer, that sort of thing. But now
with the monitoring you see all sorts of things … and we had that study day just
the other day … oh, I see all these… I just really can't work it out… oh, I loathe

> monitoring. Once you get that monitoring, really just about everything seems to be potentially dangerous. (Yvonne, community midwife)

Significantly, in most of these extracts from the interviews there is reference to what Arney calls 'residual normalcy and pathological potential'. He suggests that in order for obstetricians to gain control of the professional field of childbirth, not only over midwives, but also over those physicians who believed birth was largely a normal process, the 'abnormal' had to encroach further and further into the domain of the normal. An effective way to manage this is to claim that all women are potentially at risk during childbirth, bringing all women under obstetric control and surveillance (Arney, 1982). Arney's argument is that because obstetricians could not always depend on any pathology being present, they had to develop ways to foresee pathology and act/intervene prophylactically in births as part of securing their domain of practice over midwives and other professionals (Arney, 1982:51). The obstetric monitoring and surveillance of all births within hegemonic discourses of potential risk is thus maintained at the base obstetric hospitals (Armstrong, 2001; Arney, 1982; Murphy-Lawless, 1998; Weir, 1996; Williams, 1997).

Obstetric risk is fluid and spatial, it mobilises around time (in labour), and space (travelling distance to hospital). For midwives too, it mobilises through time and/in different spaces (in or outside pregnant bodies/distance from labour ward). This correlates with Armstrong's (2001) discussion of risk construction as that with no fixed or necessary relationship to future health/illness; it simply opens spaces for possibility. He goes on to say that those possibilities are spatial, and that they exist in: "a mobile relationship with other risks, appearing and disappearing, aggregating and disaggregating, crossing spaces within and without the corporeal body" (Armstrong, 2001:149). The hospital policies, procedures and protocols designed to contain these risks interpellate many midwives into the discourses and practices of risk minimisation and management, which in turn are imbued with iatrogenic and professional risks themselves. These kinds of risks are explored below.

'Playing it safe': when the risk is to the midwife

> Sometimes it means that, yes, I've done something more interventionist than I would if I wasn't working in a fear environment, I wasn't having to cover my butt and where always … I mean in practice there's that whole thing of what should we do in different situations and so often while we say we know that's probably right it's common knowledge that we're doing something to cover our

> butt. To have something, not necessarily a technological intervention or whatever, or that we've done something … a visit or a phone-call or a … you know, it may … at whatever level … to make sure that it's clear that we've followed up or that we've covered ourselves. And I think that does affect how we can work together with women when we're always feeling like at any time it's going to turn on us and destroy our lives and even if it's not about babies dying or … that sort of stuff, it's about just disaffection that can happen and … I think that that is sad. (Natalie, self-employed midwife)

Natalie talks of the ways her actions are, in a number of different ways, structured around the management of midwifery as a risky practice in itself, rather than pregnant bodies as somehow inherently risky. It's not the process of birth per se that is to be feared or not trusted, but that something in the future is 'going to turn on us and destroy our lives…'. The range of self-management and monitoring techniques designed to cover oneself in this instance is vast, from an extra phone-call or visit, to an extra technological intervention. Extra technological intervention, frequently in the form of CTG monitoring of the foetus, was the most common method of 'covering' oneself, or of 'playing it safe' in these accounts, as well as an ever-increasing and time-constraining focus on documentation. But as Eva highlights below, the paradox is that being seen as having covered oneself does not necessarily entail appropriate, even safe, care for the woman and baby. Indeed, as most midwives in my study point out, often this procedure is directly contrary to 'best practice' or 'best evidence'; it is only done, in some situations, to cover oneself, to be seen as a self-monitoring professional subject because of attention given to monitoring the woman/foetus, whether it is appropriate (evidence-based) or not.

> No, it's not fear of the birth process. I've a lot of confidence in the birth process … it's if something untoward happens, having confidence in your practice and will you think of everything and … I mean all your documentation is all tied up with litigation, the whole lot. You write screeds and screeds to cover yourself. All the time covering, covering, covering … it just proves that it's in your mind the whole time. And it could be years down the track…all this cover yourself, cover yourself … be seen to be doing the right thing … whether it's right or not. I found I just wasn't strong enough to say I don't think it is the right thing. because if you come up to Nursing Council and you're judged by your peers they'll say why didn't you put this woman on the CTG machine, because that's the medical way to do it. That's deemed to be the correct way. (Eva, self-employed midwife)

Cartwright and Thomas note:

> Providers practice in a climate of risk, institutional demands, and a threat of malpractice suits. The most common response to this situation is the creation of protocols and hospital rituals designed to reduce risk, *even in the absence of data supporting their routine use.* (Cartwright & Thomas, 2001:220, italics in original)

Walsh, a British midwife and critic of 'uncontrolled' EFM, argues that; "The opportunity now presents itself to remove monitors from women in normal labour as clinical governance advocates evidence-based practice in maternity care" (Walsh, 2000). A homebirth midwife and researcher/author who also strongly advocates this position discusses these issues with me during one of our interviews:

> Caro: I think that the problems relating to the fear of litigation is a major issue in control of midwifery and I think … perhaps just the general place of women, both as midwives and as women, I don't see that … sometimes I don't feel that a great deal has changed for either… I've supported a lot of midwives who have Nursing Council complaints, and most of those have been driven, a good proportion have been driven by the management and the obstetricians and paediatricians …
>
> RS: But how do you keep an access agreement … the midwives I was talking with yesterday were saying, we've signed a bit of paper to get this access agreement.
>
> Caro: They change the access agreement. What they do is they go to the literature and they find out that continuous foetal monitoring on a woman who has no alerting factors, or her baby has no alerting factors, who's in a normal process of labour it's actually counter-productive … and they base their practice on evidence … and that's what they're not doing. It's like, the thing that I'm currently undergoing the inquisition for … if I try and justify my practice within the medical framework I'm absolutely down the gurgler … I've never done that … never will, my practice is about midwifery and this is the rationale that I use … everything has a rationale … I don't apply practices that have proven to be detrimental to women, and that's all there is to it. (Caro, homebirth midwife/author)

But many midwives in my study said that 'we don't get hammered for doing the most; we get hammered for doing the least'. To 'be seen' as a safe subject, seen to be doing the most, sometimes may entail action that could indeed be detrimental for the woman, from a midwifery perspective. A central dilemma played out in the course of these interviews then is that if the midwife manages any risk to the woman/foetus by prophylactic interventions, also known as active management, she will be (seen to be) minimising risk to herself (and by implication, to the whole of midwifery as a profession) in the form of potential litigious action.

If, however, she does not practice prophylactically, but prefers to conceptualise birth as normal till proven otherwise, and acts accordingly within best practice guidelines, she increases her personal risk of exposure to litigation; she cannot be seen to have covered herself. This catch-22 dilemma is where midwives and women together occupy a site that is simultaneously one of risk and safety. For these midwives, fear exists not of the birth process but of (the potential for) scrutiny or a complaint process from a medico-legal perspective, and that could occur years after practice. Complaint procedures are 'getting easier':

> My defence role's increasing but that's the same for anybody who is involved in defending health professionals. It's much easier now to make a complaint, you can just ring up the HDC, you don't even have to put it in writing any more and an investigation is likely to be launched and so all health professional groups have had a huge increase in clients complaining so there's a lot more complaints going on. (NZCOM Legal Advisor)

Complaints, according to the interview texts of midwives, come rarely from the birthing woman herself, but: from the Nursing Council, 'the woman's GP', 'the hospital management or the obstetrician involved in her care', 'the Health and Disability Commissioner', 'her husband or other family member or friend' or ACC. Angela talks of the impact this knowledge/fear has for midwives first collectively, then for herself and a friend personally. Like Caro, Angela notes that it is often not the woman herself who instigates a complaint:

> Midwives have got to the point now where they realize that it doesn't do us as a collective any favours when these sorts of things reach the press and therefore they tend to err more to the medical model … the obstetric model, because then at least they feel well if anything goes wrong they can say well this is what you said should be done and we followed your guidance, your expertise … and therefore it's not my fault that things went wrong whereas we all know, if you practice long enough it's going to happen to you. I've got people that practice with me, I've even had a complaint made against me, and all complaints, in all cases … none of the complaints were actually initiated by the client, they were initiated by medical people and I just find that really frightening. I've got a friend who's been through it who gave up midwifery because of an investigation that was run by the Nursing Council, which just absolutely destroyed her. This is a woman who had practiced for 22 years … for somebody with that level of experience and expertise to just give up, just walk out the door … I find really scary. And, again, a complaint that was initiated by a GP. The GP just said to the woman 'oh we'll put a malpractice claim in…'. (Angela, charge midwife rural hospital)

Saxell writes of the ways midwifery practice is affected by discourses of risk/risk management, noting that the burden of responsibility is enormous, something which new graduates commented on frequently to me. Saxell suggests that, "in labour, care decisions can be influenced by fear of litigation, the common response being overinvestigation or overtreatment, subjecting labouring women to treatment regimens based on hospital policies rather than an individualized care plan" (Saxell, 2000:94). She states that professionals who have dealt with a serious complication are more likely to magnify the risk of that complication as higher than it is, and that the experience of the last case (for example, a stillbirth), can inordinately affect judgement (Saxell, 2000:94). As Yvonne says: "If you've just had a bad experience with something going wrong you're going to be ultra ultra careful". The WHD community midwives' team manager draws this out below also:

> I think we do practice defensively at times too and you know I don't think you can help yourself. When a midwife has experienced a still-birth, it does affect your practice for some time to come, because you become paranoid, and you blame yourself I suppose to a certain extent for things that happened, think was there something I missed, should I have done something else, so therefore the next few people that come along probably suffer because of that…but I think that's human nature…you just might do CTGs where you wouldn't normally, and maybe sending them to see a doctor where is there a true reason or are you just playing safe…(WHD community midwives' manager)

The work of Symon, a British midwife and researcher, also notes that there is a general perception amongst midwives in England and Scotland (as well as obstetricians and GPs) that litigation is increasing, suggesting that this may be a feature of contemporary maternity care (Symon, 1998, 2000; Symon & Wilson, 2002). The resultant changes to midwifery practice showed 'improving documentation' was cited by 41.5% of midwives as an example of personal change in practice as a result of fear of litigation (Symon, 2000:13). Other changes, reflected in many of my interviews, were seeking medical advice earlier ('playing it safe'), monitoring (CTG) more often, obtaining permission for all procedures and adhering more to unit policies and procedures (Symon, 2000:13). With regard to these issues, Symon states: "If these respondents are relating accurately the reality of clinical practice in their area, then serious questions are raised about clinical judgement, choice, and autonomy for the pregnant woman, as well as the resources of the health service" (Symon, 2000:13). While Symon is referring to issues raised in his study of Scottish and British midwives and there is arguably a much broader range of practice styles and situations for midwives in Aotearoa/New Zealand,

the specific issues around ways to manage risks or defend practice according to the quote below may be similar for most midwives:

> I mean time and again I think midwives will find themselves in situations where if you haven't written it in the woman's notes, legibly … and in reasonable English, then it didn't happen. And it's one of the things that comes up time and time again … in fact it's the biggest thing that comes up at Standards Review. I mean how midwives practice is a philosophical thing for them … it doesn't matter how they practice, if they don't document it and give rationales for it, acknowledge women's choice in it, it's not OK. (Rosalie, birthing centre midwife)

'Advance defence': negotiating risky/safe bodies and spaces together

> Things are done in advance defence, almost. It's not like the old days, now we seem to go looking for trouble with the EFM and routine scanning, in my day you didn't have those things, so you couldn't see the problems! The baby still either came out, or it didn't. (field notes taken from discussions with midwives during a rural hospital visit)

Risks, in the interview texts, are located either inside or outside the bodies of pregnant women. Realist discourses of risk locate risk as inherently inside pregnant bodies; something to be actively 'managed', 'minimised' and contained within the 'safe space' of labour ward, where everything is on hand 'at the press of a bell', and cannot be seen separately from minimising risk to the midwife's practice, as Gillian says here:

> I prefer to deliver them at Women's because everything is there on hand. I always tell my clients that they can have a perfectly normal delivery with no interference at all … but if something happens you've got everything there, you don't have to wait to transfer if someone decides they want an epidural, or wait for an ambulance. I actually think it's safer there and I wouldn't - I feel safer there, basically. (Gillian, self-employed midwife)

If the midwife perceives pregnant bodies as risky and labour ward as a safe space, she feels also that she is 'keeping herself safe', since 'we get hammered for doing the least, we don't get hammered for doing the most', despite the likelihood that there are other sorts of subjective risks involved for the women. But for other midwives and women, risk lies outside pregnant bodies, within the space of labour ward itself. This is because of the potential for the cascade of intervention, bringing with it iatrogenically-induced risks to the well-being of the woman and foetus, and is also very real (Pollock, 1999). These midwives' accounts also reflect the

concerns of Symon above about the misuse and overuse of resources, as well as the cavalier attitude to 'the evidence' as reported by Natalie in her attempts to obtain a consult with an obstetrician. It also supports Annandale's research, which suggests that midwives work to 'colonise the future' (Annandale, 1996), in ways I suggest constitutes their 'advance defence'. There are also times when core midwives may attempt to structure the conduct of incoming self-employed midwives transferring into labour ward from a rural unit or home. Here Natalie refers to questions she may be asked as part of the guidance of her conduct in labour ward, and her response to that guidance:

> So if I haven't played the game or done the protocol … 'well why haven't you' and I say 'because there's no evidence to do it … like why is it done?' 'Oh, because that's the protocol', you know I find that a number of the core midwives don't assess practice on the basis of the evidence; they make their decisions and do their practice on the basis of the protocols of the institution … and sometimes there's quite a big difference between the two. (Natalie, self-employed midwife)

Here it can be seen that midwives must also defend themselves against the claims made by each other at particular times. Yvonne provides an example of the compromises made to her preferred mode of practice when risk is slippery, but is largely external to women's bodies and the (previously) safe space of home:

> I would love to do deliveries at home … I would love to not put her on that monitor … all those sorts of things. I would love not to be thinking oh, I think we need to see a specialist over this or that, and possibly take a few more risks in a way, well, what would be seen as risks now … but just the way things are now, and that woman is part of the society which will sue me … or tell all their other friends how useless I am or something…. (Yvonne, WHD community team midwife)

Risk lies not in the space of pregnant bodies, nor in the space of the home, but in the potential medico-legal and cultural effects on the midwife constituted by her preference for a low-intervention practice. Clearly, a low intervention practice philosophy is always already contraindicated by hegemonic discourses on childbirth in a densely permeated risk culture (and see also Daellenbach, 2000; Donley, 2000). What needs to be continually negotiated is the concomitant risk to the practice of the midwife, if she is/could be seen to be 'doing the least', or even focussing on the normal, as Natalie goes on to say -

> … on and on they're coming back, those are the complaints, it wasn't my thing, it was the midwife that said that to me, that made me go to the low-tech hospital or who made me … or who wouldn't … and because she said that everything's normal … if they don't feel it in their heart … if it isn't what they want to do, if they don't want to give birth at home then they're not going to birth effectively at home. (Natalie, self-employed midwife)

Despite the evidence to the contrary, hegemonic discourses of obstetric safety privilege proximity to technologies of monitoring and surveillance (and see also Pollock, 1999). Home birth exists at the periphery/margin of the obstetric gaze, with rural 'low-tech' units and birthing units lying between home and hospital. As Daellenbach states, "As long as the legal system penalises non-intervention but not over-intervention in birth, home birth midwives and families are structurally disadvantaged" (Daellenbach, 2000:4). As an independent midwife with an access agreement to the base hospital, Natalie (and other midwives like her) must consult with an obstetrician on the occasions for which guidelines are provided under the service specifications of Section 88. She is/they are positioned within certain variable distances from labour ward, which functions as the central eye of the obstetric panoptican. The trajectory of the obstetric gaze designates pregnant bodies as inherently risky, with an opportunity to minimise risks geographically, by increasing proximity to labour ward. Conversely, if the midwife frames her actions within a discourse based 'on the evidence', that is, that healthy pregnant bodies are not inherently risky, she may act to minimise risk to women by maintaining a certain distance from labour ward. She then balances this against the potential for 'exposure' of (rather than 'covering' of) her 'risky' practice.

Self-employed midwives must continually act to (re)negotiate the safety/risky space of labour ward with the crucial tension remaining in the balancing of risk to the woman (cascade of intervention) versus risk to the practice of the midwife (fear of litigation). In this, some of her midwifery (non)actions (exposure/cover) will contradict both the demands of an obstetrician before s/he will facilitate a consultation if needed, but also conflict with other midwives around some of the protocols and procedures in labour ward. This may lead to concern at times around issues of responsibility for primary or secondary care, according to a midwifery educator:

> You end up so defensive practicing that the woman has no choice … and that's difficult, especially for New Zealand midwifery where the women and midwives are supposed to be equal … the issues I have here from a core perspective is

> that we're in the middle of a lot of LMCs - we're the person in the middle … so you have somebody on the ward who's under an LMC … whose care does she actually come under while she's here? And that's hard from a litigation perspective…. (WHD Midwifery Educator)

Maintaining a normalising discourse where risk in pregnancy/birth lies outside the woman's body, in the discourses and practices of labour ward itself as a potentially risky space for birthing women, however, constitutes the midwife (and some midwives, such as new graduates, more than others) as a risky practitioner. In this exposure she is liable to draw attention from core midwifery staff and expose herself to criticism or complaint from hospital management, the woman's GP, or a number of other sources. Her actions with the women then are structured to continually re-negotiate these simultaneous spaces of risk/safety.

Within these spaces, partnership is constituted in capillary networks of power/knowledge. The governing threads of 'upward continuity' (Foucault, 1979), begin with the technologies of the midwife-self: the meticulous attention to documentation, to monitoring; the heartbeat of the foetus, the body of the woman and the actions performed and statements made, or not made, by the midwife in her 'advance defence' of her present practice in case she is called to account in the imagined future. These self-governing actions constitute her as both a subject and an object of accountability. In her 'advance defence' she will engineer and leave a 'trace';[43] she must be traceable in the event of a deferred disaster (Derrida, 1991). Birth cannot be 'normal' here unless proven otherwise; it is always lodged within a medico-legal framework whereby the midwife can be called to account in hindsight for her actions. In her advance defence of her self, she must imagine all that could possibly go wrong in the future. To avoid this risk to herself, regardless of risk to the woman, the midwife must leave a visible trace of all of her actions. In the accounts of the midwives in these interviews, actions are governed by the imagined view of a retrospective re-action against them; the midwife cannot be seen to be presently doing nothing, even when to do nothing, or to wait and see may be the most appropriate midwifery (non)action (Downe, 1997; Leap, 2000). Smythe states:

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[43] In this I signify the electronic trace left by the CTG, and the trace of presence and absence, space and time, in language, of Derrida's *différance.* Here he says: It is because of *différance* that the movement of signification is possible only if each so-called present element, each element appearing on the scene of presence, is related to something other than itself, thereby keeping within itself the mark of the past element, and already letting itself be vitiated by the mark of its relation to the future element, this trace being related no less to what is called the

> Practitioners live constantly in the paradox of being free to practice in whatever manner they choose, while knowing that they could be called to account at any time for any of those decisions. Remember the satirical advice given by Lewis (1945) about the two fatal errors: to show no initiative, or to make the slightest approach to unauthorised action. He describes the space between as being 'perfectly safe'. The problem is, there is no space in between. (Smythe, 1998:266)

In my analysis midwives negotiate this 'no space' within the paradoxical 'practices of freedom', as a space of simultaneous risk/safety where the meanings of both these states are endlessly deferred. In doing so, they must leave a visible trace of all actions conducted in the presence of the woman, and submit themselves to increasingly rigorous self-surveillance and monitoring as they inhabit the imaginary future, as Mandy suggests:

> There are midwives I know that have given up independent practice for a time or forever, that's been a real concern for our profession. They have felt fearful of pressure being applied or their practice being surveyed really. Some midwives have told me they've felt as though all the time there's someone over their shoulder watching them and they couldn't function properly because they couldn't support women to make their own choices if they were too frightened of the consequences … constantly thinking, is this reasonable? Is what we're proposing to do reasonable? How would my peers see it? How would other midwives, and all the specialists, or other health professionals or maternity health be likely to see it? (Mandy, birthing centre midwife)

In the accounts given by midwives in these interviews, their actions construct them as what I call 'auditable subjects' within the liberal discourses and practices of their role as autonomous professionals. In these processes constructing oneself in terms of accountability and 'auditability' (the practices of disciplinary autonomy) appeared paramount in my analysis of the data. Midwifery as a liberal and feminist profession subscribes to a discourse of autonomy. This acts as a disciplinary logic which inscribes: "…autonomous professional practice within a network of accountability and governs professional conduct at a distance" (Fournier, 1999:280), through discourses of autonomous but responsible professional behaviour, and practices such as audit. I argue that obstetric dominance in the field of childbirth is no longer maintained by the direct, sovereign control of the state or medicine over midwives and/or over women. Rather, I suggest that multiple and proliferating discourses of risk in childbirth intersect with discourses of consumer choice and those that restrain midwifery actions within

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future than to what is called the past, and constituting what is called the present by means of the very relation to

subtle forms of neo-liberal governance. In the interview texts, discourses of 'supporting women's choices' prevail over those of 'evidence-based practices' at different times. Birthing women are making particular choices in childbirth/place both as a result of, and in spite of, being given informed choice by midwives. At other times, evidence-based knowledge may be drawn on as part of a discursive repertoire that can be used to challenge the knowledges and practices of some obstetricians and core midwifery staff, and also to gently guide the decisions of some birthing women.

Being an autonomous professional requires that ones conduct is developed through a logic of competency; practices such as respecting the woman's choice of birthplace and following her there, supporting her choice (or 'demand') for technological birth practices, observing the referral guidelines, adhering to labour ward policies, maintaining a professional portfolio, attending standards review, managing risk and providing women with the choices they choose; all practices that would seem to arise naturally or voluntarily from within the responsible professional individual. As Fournier notes, once a discourse of professionalism pervades organizational life it is difficult for those involved not to align themselves with it, since no one wants to be marked as 'unprofessional' (Fournier, 1999:304).

I have argued in chapters four and five that both neo-liberal and liberal feminist discourses of 'consumer choice' have partially shaped increasing interventions into birth. This chapter has focussed on the related, and increasing, amenability of midwives to various forms of governance through predominant discourses of risk. These are open to resistance by midwives in the claims made through the discourses and practices of evidence-based midwifery with regard to what is safe. This analysis does however highlight the ways in which some midwives will consolidate ('cover') their own safety as professionals by engaging in practices that their profession, paradoxically, considers may put pregnant women at risk of further intervention (such as indiscriminate continous foetal monitoring). At the same time, it implicates some midwives in the persistence of the institutionalisation of birth, and perhaps can be seen to contribute to what may be the development of a midwifery gaze. These issues, including the role of evidence-based practice in the self-governing of new midwives, are explored in the next chapter.

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what it is not: what it absolutely is not, not even a past or a future as a modified present (Derrida, 1991:65).

Intertext

05/09/01   Shelley/Eva

This was the morning we had been waiting for…Shelley, my best friend of 30 years, her partner Barry, their LMC midwife and I, were all going into labour ward to have Shelley and Barry's baby induced. Shelley had been trying for a baby for over 10 years and had had several miscarriages during that time…she had started to think that she would have to settle for 'home miscarriages' instead of the home birth she was longing for. Just when she was almost ready to give up trying, at 41 - and I was starting to think of being a surrogate – she got pregnant, and it seemed to 'stick' this time, past the horribly anxious first few months. The astonishment we felt at seeing a real live foetus with a pounding heartbeat, legs, arms, everything - on the monitor in the obstetrician's office was overwhelming. At the end of that visit, the obstetrician said 'well, you've finished with me now; our work together is done; go and find yourself a good midwife'.

Shelley knew who she was going to choose, and already had an excellent rapport with her. Her homebirth practice was long admired by Shelley and me, and Barry came to know and admire her wisdom over the course of the ante-natal period and birth too. As the due date drew near, everyone in Shelley's extended family became progressively more excited. Shelley had hired a birth pool, and Barry was well versed in the rudiments of setting it up, keeping the water hot, and so on. Shelley had been with her sister Cathy while Cathy laboured at home only a couple of months previously; and she felt realistically, that home and hospital needn't be thought of as a mutually exclusive dichotomy. She was hoping very much to stay at home, as I was hoping for her too, but more so she was focussing on becoming open to whatever circumstances eventuated, given that her focus for this birth was intensely spiritual.

Shelley's parents lived next to an obstetrician who had been derisive of someone who would have a homebirth with their first baby at 41 and a history of miscarriages, and that had alarmed them somewhat; but those anxieties had been shared with the midwife when we all met together, until everyone felt as happy about Shelley's plans as she did. But as the extra days ticked on well past any estimated due date, and long walks and other various ways of encouraging the baby to come didn't seem to have any effect, Shelley increasingly became aware that she didn't want to wait much longer. She wasn't sure how or if the small amount of aspirin the miscarriage clinic had put her on might influence anything to do with the labour

and birth. She was aware of medical opinions about 'risks' past 42 weeks of pregnancy, and she didn't want 'anything to go wrong' in the light of her history. So with Shelley's agreement the midwife arranged a day in labour ward to use the facilities there to get things underway.

Labour slowly started during the morning of that day in the hospital and Shelley spent lots of time in the bath, with the midwife, her mum, Barry and I caring for her physically and emotionally. Much of the time was enjoyable for Shelley, able to feel that she was labouring strongly by squatting and trying different positions in the bath, where she clearly felt powerful and in control of her body and labour. The warmth of the feelings flowing between us all tempered the environmental starkness of the lino floor, the hospital sounds, the other body sounds, voices calling. They could be heard close-by, given the toilet and bathroom wall partitions did not reach ceiling height, but we seemed in a protected and womb-like space/time capsule of our own in that small bathroom, aware of the sun pouring through the window shining straight down on Shelley's naked body, listening to the rumblings of workmen and machinery outside, with the rise and fall of Shelley's moans mixing with all these other noises. At the far end of the labour ward, down the furthest end of the low-intervention wing, we were left completely alone. I knew this would be because of the positive and respectful relationship between the LMC midwife and the core/hospital midwives. There was a dream-like period of time of several hours passed in this way; often there was no sound except that of the taps dripping into the bath water, marking time, and the murmurings of Shelley's mother to her eldest daughter in her pain.

Eventually, when Shelley was sick of the bath we moved back up the corridor to her room. We moved about together in the enclosed space, taking turns to give Shelley whatever she wanted to eat or drink, a massage, or have a walk around. It felt like a pleasant and idle twilight time, a space of time where we were all passing from one state of being, to another potential state of being, where both states are experienced or hoped for as positive. At some point I did begin to wonder how long things might take, and slowly morning moved towards afternoon towards evening, and Shelley began to tire. The back-up midwife had arrived in the late afternoon - or early evening, was it by now? – and her presence was just as calming and unobtrusive as the LMC midwife's presence. They had a remarkable working relationship, where as much seemed to be communicated non-verbally as verbally, and their very presence inspiring feelings of trust and safety. They did lots of paper work, as we did much of the

physical work of back rubs, massages, face-sponging, and so on. The midwives knew how Shelley was feeling at all times, and checked the baby regularly. While Shelley was up squatting one time and pushing I thought I could see the baby's head, but it was slipping back as Shelley became more and more tired.

A while later I thought I could see the head again, but one of the midwives realized it wasn't really visible as I had hoped; we were seeing congested vaginal walls instead. I had stopped thinking Shelley would breathe the baby out now and began to encourage her to push, knowing that wasn't necessarily the right thing to do; but I couldn't stop myself. I could see how tired she was getting, and I could also hear footsteps outside in the corridor now and again, and I was wondering when the core staff may feel obliged to suggest things needed to hurry somewhat. I could soon see glances between the two midwives that indicated they were aware of the same potential for impending conformity. Labour wards do impose time limits on labour – even normal labour. At this stage of my research – in my other 'formal' research life - I had also become very aware of the stories midwives told me about the ways voices and footsteps operated in the corridor outside the birth room to 'induce' a sense of having to hurry things and/or at least prove that things were 'coming along ok' inside the room and within acceptable time frames, as Hunter also notes in her midwifery research.

I noticed that whenever I heard footsteps outside the room that seemed to linger there, I strained to hear them, my pulse seemed to rise somewhat, I felt anxious, and would try to interpret the glances and body language of the two midwives. At this point Shelley decided to have a vaginal examination to see how she was going, and also decided to have her membranes ruptured to see if this would facilitate the birth. The midwife explained everything clearly as she did it, the risks/benefits of having the membranes ruptured, what Shelley could expect to feel, what she was feeling inside Shelley, and so on. She said the membranes seemed extraordinarily tough, and were tricky to break; but they did. It didn't seem to speed things up much, and I started to think that Shelley's birth was probably going to become similar to Cathy's, and to become resigned to that. One of the midwives told us that a third midwife from their practice had come in and was talking to the core staff about Shelley's hopes and plans for as low-intervention birth as possible. It was well into evening by now; we were all tired. I sensed we couldn't reasonably hold out much longer. I was holding Shelley, Barry on the other side, both of us pleading with her to use every last ounce of strength in her pushing.

Finally a young doctor came into the room to see us. She was incredibly respectful, and asked Shelley all about her labour thus far. She listened well to Shelley's experience and her exhaustion, and I am sure she spoke with the midwives, but such was the skill of their mutual unobtrusiveness that I don't even remember when or where this took place. After conferring with everyone and explaining that she came from a medical model, so would recommend an assisted delivery, but that it was of course up to Shelley, she left so that Shelley could decide with all of us about the next step.

As soon as the door closed behind the doctor Shelley immediately said, 'I've had enough, get me to theatre and get it out!' The act of taking the time and space to feel as though she was considering her options more slowly felt important to her, as had the respectfulness of the doctor's interaction. Once she had confirmed this decision, one of the midwives began to make the appropriate arrangements with the core staff, and we began to get ready to shift rooms, wheeling Shelley on the bed down to the high-tech branch of labour ward now. I felt a degree of resignation; an internal shifting of gears in the acceptance that this would be another assisted birth. It all seemed relatively quiet in the lounge room as we passed it; the hub of labour ward where I had spent time sitting as a midwifery student and then as a researcher. I wondered what the core staff had been saying, if anything, about the progress of Shelley's labour. We got to the theatre wing and everything fell into place in the practiced clockwork routine of busy staff doing what they are so used to doing. People explained different things to Shelley and to Barry, pieces of paper were signed, it seemed that I was just going to slip into theatre again in my ambiguous role. I hastily got changed so that I was away from Shelley for the least time, feeling surges of adrenaline as I did so. Back in theatre the epidural was sited, everything falling into place, getting all the equipment ready 'just in case' we need to go the whole way and have a caesar; no more pain now, people whistling merrily, enjoying (the) theatre performance - chatting with Shelley and Barry, the old routine, 'do you know what you're having? Got a name picked out? Doing ok, Dad?'

I frantically whispered to the LMC midwife to tell the staff not to announce the baby's sex as I had seen them do every time I saw a birth in theatre; I didn't feel assertive enough to do this myself. She did so, in between doing what seemed like dozens of other jobs, and always, the screeds of vital paper work. Barry was on the opposite side of Shelley to me; together we cuddled her from either side so we could support her shoulders as she pushed. I felt such faith

in the LMC midwife, it was absolute trust that she would keep Shelley safe. There was a sense of deja-vu as I remembered Cathy's birth the couple of months previously, and very similar now, the doctor trying with the ventouse suction cap first, then manipulating the forceps with practiced precision, the baby not wanting to come out, Shelley pushing hard when she was instructed to do so.

An episiotomy cut, forceps re-positioned, an air of managed calm. Exhaustion mingled with rising elation and subdued potential panic. Push, push, hard as you can, come on, keep going…silently praying, don't let Shelley have a caesar, please let this be enough, she's waited so long, it's going to be the only baby, already missed the homebirth, please don't let it get any worse… then out it comes, taken over to the table, everything is so fast, Shelley clutching me crying and asking 'is it all right? is it all there? has it got everything?' I'm straining to see and crying/laughing, the midwife carries the baby back to Shelley and Barry just as the doctor opens her mouth, I knew she'd forget, about to announce it as a lovely baby girl just as Shelley sees for herself and we cry and cry, completely overcome.

7

Chapter Seven

Inductions of labour: discipline, surveillance and becoming an experienced practitioner

> Our Code of Ethics declares that midwives work in partnership with the woman and accept the right of each woman to control her pregnancy and birthing experience. In education there has been a change from a behaviourist curriculum to a process curriculum. Teachers and students now work in partnership with each other, and students are acknowledged as having the responsibility for their own learning. (Smythe, 1993:367)

Direct Entry midwifery (DEM) education has been modelled on the understanding of partnership that informs midwifery practice in Aotearoa/New Zealand. This involves midwifery educators in working with midwifery students to extend their expertise. Just as midwives have been charged with: "assisting women in the emergence of consciousness and their different ways of knowing in order for them to speak with their own voices" (Guilliland and Pairman, 1995:16), so midwifery educators work in partnership with trainee midwives. The responsibility accorded to students, noted by Smythe above, is modelled on the responsibility put to women by midwives, so that women can realize their own potential (Guilliland, 1993). Guilliland states: "Midwives' professional status rests entirely on our partnership with birthing women; our role as independent birthing practitioners is to put the responsibility back on to women so they can retain control and power over what happens to their bodies" (Guilliland, in Tully & Mortlock, 1999:174). In accepting responsibility for their own learning, students are: "introduced to a range of feminist perspectives that address the conflict and contradictions between the dominant institutionalised medical model and women's knowledge and experiences in childbirth" (Tully, Daellenbach, & Guilliland, 1998:251).

Partnership is also put into practice in midwifery education through the incorporation of cultural safety/kawa whakaruruhau components, and consumer input into the curriculum (Ramsden, 1995; Tully, Daellenbach, & Guilliland, 1998:250). Students are placed with pregnant women to follow through the women's particular experiences, and are placed with individual midwifery practices in order to gain clinical experience that emphasises continuity of care (Tully, Daellenbach, & Guilliland, 1998:250). Smythe believes midwifery teachers need

to work from a partnership philosophy of 'being with' students, pedagogically modelling the 'being with' women in pregnancy and childbirth. Her perspective in this, and that of Guilliland and Pairman, is one informed by critical and liberatory theories of education, in which knowledge and learning are shared in a dialectical relationship (Smythe, 1993), or partnership with a goal of emancipatory political action (Guilliland and Pairman, 1995).

These ideals of partnership between women and midwives, and between midwives them/our selves, are complexly contested and renegotiated, and currently differences and diversity are highlighted (Tully et al. 1998:252). Smythe (1993), expresses concern if postmodern thought in education and curricula is no longer concerned with the stability of 'truth', but instead with 'inciting doubt' in students as a way of fostering intellectual autonomy. Her concern is for what may lie ahead if some teachers: "wish to cast the students to the winds of fortune, offering no guidance or restraint, but celebrating the uniqueness of whatever learning a student achieves" (Smythe, 1993:369). My position as both an educator and a student is that to incite doubt as a pedagogical tool in exploring what has been produced and come to be taken for granted as 'truth' can frequently be productive. My interest here lies in exploring the ways in which new graduates give accounts of their negotiations of the guidance and restraints that in/directly govern their conduct in the transition from new graduate to competent practitioner.

How do new midwives manage the transition from student to confident practitioner, in different sites/spaces of midwifery knowledge production? What do they say about the integration of theory and practice? As I interviewed midwives participating in this study, I was becoming increasingly awed with the complexities apparent in their daily working lives. I was interested in how midwives, new midwives in particular, often with large student loans, and perhaps also with children's timetables to juggle, managed to survive setting up a case-loading self-employed business of their own. I was also interested in how some of them wanted to gain 'experience in the abnormals first' by becoming employed workers in an institution, even though the discourses and practices of institutionalised birthing had been subject to some critique during the time of their training, as Tully et al above suggest.

In this chapter I begin to explore some of the issues about what the midwives who participated in my study had to say about their 'induction' into their differing practices. I

examine the ways in which discourses of partnership are embodied in pedagogical interactions of new graduate midwives with women and other actors, especially other midwives. I argue that they are inducted into work in this feminist profession through the microphysics of power operating within the field of relations inhabited by labouring bodies. These bodies are the bodies of pregnant/birthing women, whose care is nested within the labouring bodies of the working midwives. In turn, the practices of the midwife are governed through the discourses of the professional body to which they belong, and/or the institution they are employed by.

I adopt an approach to the analysis of power relations that, rather than analysing power through its own internal rationalities (Foucault, in Faubion, 1994:329), such as 'the power of medicine over women', instead begins at the capillary points where midwives and women learn/labour together in childbirth. In this exploration of how DEM graduates become confident practitioners I am interested in those actions that are involved in the monitoring of birthing bodies. I pay close attention to how the bodies of the midwives who are simultaneously 'labouring' and learning are both externally regulated and the subjects of self-surveillance within relations of power. The value of this approach to analysis for midwives lies in a critical exploration of the 'governing interfaces' (Burchell, 1996; Holmes, 2002; Purkis, 2001), between actors in the field of maternity provision. These interfaces may be wherever there exist possibilities in a field of action, whether as consumers exercising choices in childbirth, as in chapter five, or as midwives working as accountable professionals, as in chapter six of this thesis.

An approach which draws on Foucault's insights concerning governance may expose the spaces in which we think we are choosing/acting freely, but are in fact responding in various ways to relations of power that are no longer domineering. Instead, the ways in which these relations of power are now more likely to occur from a distance (Foucault, 1977, 1979; Fournier, 1999; Rose, 1996), or with a lighter touch (Gilbert, 2001; Murphy-Lawless, 1998), in the context of neo-liberal discourses in health and education are key to the analysis here. Sawicki has challenged the view that feminist analyses should continue to examine power as something exerted over women's bodies. She suggests instead that power operates in different fields of knowledge through the active construction of desire and forms of self-surveillance and control. Disciplinary technologies, she suggests:

…do not operate primarily through violence against or seizure of women's bodies or bodily processes, but rather by producing new objects and subjects of knowledge, by inciting and channelling desires, generating and focussing individual and group energies, and establishing bodily norms and techniques for observing, monitoring, and controlling bodily movements, processes, and capacities. (Sawicki, 1991:83)

I want to examine how relations of power operate in this complex way as the new midwives who participated in my study engage in midwifery practice in a variety of different contexts. I set the scene for this with an extract from the second interview with a group of new practitioners. Their talk establishes the issues of surveillance, protocol, the production of knowledges and embodied resistance that are then addressed throughout the chapter.

M 1: There's pressure … as a new graduate I've always felt that whenever you go into Women's that they're really watching you to make sure you're behaving yourself and following the protocols … you've got to do it this way, or that way … so always when I go in there I'm always really frightened because I'm being watched so carefully … that I'm going to stuff up … I'm getting better at not letting them take over but there's just … and the thing is you go to one of the charges because you want some expert experienced advice … yet even sometimes, now I've realized that they don't…

M 2: You got sent home with that woman who 'wasn't in labour' who homebirthed on her friend's couch an hour later …

M 1: Yes I did … I asked the charge to check a VE (vaginal examination) for me … so it's been a good learning curve for me … I think right, well I'm not going to ask you again … I'll just go by my own judgement.

M 3: And I guess also the protocols, I mean some of the protocols in Women's seem like stuff that I wouldn't do necessarily all the time … you're required to do them in terms of your access agreement.

M 2: Experienced midwives … or midwives that are perceived as being OK by labour ward don't have to do all that, do they?

M 4: It's double standards, isn't it.

M 1: And I think the older charges just aren't interested in us … they just really, well, I feel like they're quite hostile to me … especially if they've had you as a student too, like they've already made up their minds you're this fumbling incompetent … (new graduates, 'group three', second interview)

Trials of labour

Within my field of study, the discursive fields of medicine and of liberatory pedagogy merge at the base obstetric teaching hospital, the central site of the WHD. During my fieldwork I interviewed both core (rostered shifts) and team (continuity/domiciliary) midwives employed at this base hospital and two small rural hospitals within the WHD. I also interviewed self-employed midwives who ran their own businesses and/or held access agreements to use the WHD rural hospital facilities and the base facilities 'in town'. During this time I undertook participant observation, 'working' alongside various core midwives for part of their shift in labour ward. Participant observation and the resultant fieldnote material, as well as formal interviews, informs the analysis in this chapter. I interviewed DE midwives who had recently graduated locally, and established practitioners who had trained some years earlier as part of the first DEM class in another city. Many conversations over the phone, in the corridors of labour ward or other hospital settings such as workshops and education sessions, also contributed to my field notes and provided rich text for analysis.[44]

'Quiet supervision': experienced midwives 'empowering' new graduates

For the purposes of my project, I considered a new graduate to be a midwife who was in her first year of employment, either self or hospital employed. At some stage in the individual interviews I would ask the established midwives (both DE and earlier trained), if they were in a mentor role, or to explain what kinds of things they enjoyed teaching either students or new graduates about midwifery. Most frequently, the response from already established midwives invoked a sense of the practical, the hands on experience required in learning midwifery skills, as Susan explains below. Susan had been employed in a variety of different positions within the base hospital, including on rostered (core) shifts and on the continuity teams, and had moved recently out to one of the rural hospitals, partly to have a break from the pager, and also because she was moving to a more senior position as the acting charge midwife. I asked her what she has enjoyed about teaching over the years:

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[44] For method/ological details see chapter three of this thesis. I have described my use of M1, M2, labels for speakers in groups in terms of anonymity elsewhere in the thesis. For details of the formal interviews and participant observations undertaken, and the formal interview schedule, see appendices.

> I really like teaching them how to do things. Watching how they interact with the women … and just love to just quietly supervise them so they felt that they were actually in control and that they were doing everything … like during the labour situation I wouldn't stay in the room the whole time. I would let the student take over and I would just be there as a back-up and just to gently remind her if there were things that she'd forgotten to do … and I always felt that that really empowered them and made them feel quite special … because you can watch a million babies born, but unless you're doing it yourself … it's the feel, you know … it's a very tactile experience. I mean you can have all the theory in the world but at the end of the day we're a practical profession and you've got to let people practice… at the end of the day it's practical … it's doing things for and with women, using those skills … and that's where the direct entry girls have a problem … because I don't think they get enough practice. They get lots of theory and they're brilliant but they need the practice …. (Susan, rural hospital midwife)

In this transcript excerpt, Susan contrasts the tactile and the practical against theoretical knowledge. A binary is articulated between theory and practice and between direct entry midwives and others, ex-nurses like Susan, who received postgraduate training in midwifery. This posits midwifery as essentially a practical profession, against which the direct entry girls are associated with lots of theory. Specific theory-based midwifery knowledge is constructed simultaneously as excess, and as a lack, against the valorisation of the practical. Moreover, according to Susan, the student or new graduates' empowerment and sense of being special occurs when they are not being overtly watched, but just quietly supervised, sometimes from outside the room. In the pedagogical situations described above by Susan, discreetly supervising from behind the door in this way means the student may feel that they are actually in control, and hence empowered, when clearly they are under the overarching watchful surveillance of the observing experienced midwife.

In watching over or orientating new graduates, generally with a focus on the normal, philosophical differences between midwives may occur in a space 'where the transition from student to practitioner is huge because of the culture of the hospital', as the WHD midwifery educator explains. The culture of base obstetric hospitals is organised around fragmented and foeto-centric care; DEMs are prepared in the main for continuity of woman-centred care. The focus is on normal birth, with the ability to detect abnormalities and refer appropriately (Davis-Floyd, 1993; Kirkham, 1999; Tully, Daellenbach, & Guilliland, 1998). In the educator's account, if new graduates:

> … keep seeing different core midwives nobody knows where they're at as practitioners. It's something I'm really concerned about … like now we have this mentorship programme … the graduates are working for four weeks with the same midwife so they know what they're doing … rather than working with ten different midwives and nobody knows where anyone is. I think the direct entry midwives, never worked in a big hospital before, the whole culture of our hospital in itself is … it's changed, and it's changing but it's a slow change and I think our midwives now are really supportive of the students and the graduates … and so it's a huge turning point for them. I think the more that we have them and the more that we work together … it's getting there. (Midwifery Educator, WHD)

The significance of the slow change and huge turning point for core midwives lies in the challenges to the hegemonic constructions of ab/normal birth that the presence of DEM graduates brings to bear on the cultural space of the obstetric hospital. The practices of core midwifery, and the philosophies of DEM, are necessarily brought into a mutual space of scrutiny and ambivalence by the very presence of new graduates in the hospital/clinic space. This space is one where core midwives have at times struggled to feel valued as midwives, and to value their support role as one of collegial partnership with incoming self-employed midwives. The core midwife's role, according to the NZCOM, is to facilitate the partnership between the woman and the LMC (Campbell, 2000; Earl, Gibson, Isa et al., 2002).

In the accounts new graduates constructed, birthing room doors cannot be closed for long periods without a more senior core midwife knocking and entering to offer help and support to new graduates. As the transcript excerpt above also suggests, the presence and practices of new midwives needs to be visible; it is a problem if no one knows where they are, or if they are subject to the fragmented gaze of different core midwives, rather than the steady gaze of one mentoring midwife over time. At the same time, their being watched and observed in particular and frequently silent ways in different situations could lead to feelings of unease in some new graduates, undermining their sense of autonomy. In fact, the openings and closings of doors operated in highly symbolic ways in the accounts of the practices given by new graduates and the midwives supervising or working with them for a period of orientation (and see Hunter, 2000).

Some of the core midwives I interviewed referred to this practice saying, 'how can we help them if they keep the door closed? You'd think they were hiding something, we can't get near them to help them learn anything'. One also said that some new practitioners were 'often quite

possessive with their women, they won't let us near them half the time'. When I asked the midwives to elaborate on this, at both the base hospital and a rural hospital, discussion ranged between the various core staff feeling a sense of obligation to the institution and its requirements; 'it's on our heads', to wanting the birthing woman to feel as safe as possible, to statements about how competent, or how well known, or not, the new practitioner is to the core staff. The ways new practitioners talked about how they felt at the base institution during their first few times of bringing a client in or first transfer experiences was imbued with a sense of the arbitrary: 'it depends whose on and whether they like you or not'; 'usually they're fine, so long as we bring our own back-up'; 'the first times were hard, wondering what will they think of me, but it gets easier'. One said 'some of them are scary…I hate the way when I'm in there they look at me and go …and you are?' Over all there was a sense of being 'quietly watched, sussed out' for a while, until confidence was gained. This was a mutual and on-going process, requiring both self-confidence, and confidence held by the core staff related to the abilities and skills of the new practitioners. This feeling of mutual confidence became apparent as the sense of being trusted, rather than watched over, grew:

> M1: The good thing about being able to do it yourself…it's like we control what's going on…and that was really good then.
>
> M2: Well there was nobody else in there then …because we were trusted to know what we were doing with the epidural, it was my third one … it's like we were just there doing what we needed to do with this woman. (Group 'two, second interview)

Remaining 'silently watchful' (McWilliam, 1999), is a technique deployed by some core midwives at times because 'we are there to help new practitioners learn'. It can also be seen as a form of governance where the imposition of older forms of teaching and learning are considered no longer appropriate. There is a 'lighter touch' approach to surveillance here; evidence that the institution has the ability to be flexible, move with the times and change its culture, and can respond appropriately to the presence of new practitioners and philosophies (Gilbert, 2001). This may be especially so given the weight of the NZCOM discourse concerning the midwife as an autonomous practitioner. In this she is understood as competent to practice (self-employed or hospital employed) upon registration, but will need support and "a thorough orientation programme to the facility, its policies and procedures" (Pairman, 2002b:4).

For core midwives to remain silent, rather than directly intervene, facilitates the art of self-management in the new practitioner as she comes to feel empowered by the developing trust in and lessening surveillance of her practice. At the same time, if no one speaks directly to her about her practice, she can never be quite sure if her practice is being spoken about, often in the staff lounge. In these ways the pedagogical, as well as the clinical, structure of the labour ward is similar to that of the panoptican; new practitioners know they are being watched, they may or may not be able to know from where (having a mentoring or orientating midwife does not preclude others from watching ones practice), but they can never be quite sure how much is being discussed about their practice, how and where information about this will flow, and what the results of this may be. They are inspired partly by this sense of continuous surveillance to normalise their practice through technologies of the self (Cheek, 2000; Cheek & Rudge, 1997; Foucault, 1977, 1986; Ransom, 1997). These include the fine details of knowing who, when and how to ask for guidance, and at times resisting and challenging the practice of not speaking directly to, but rather about the practices of others:

> M 1: Things are improving in terms of the willingness to speak directly because I had a situation a few months ago where I heard somebody saying, one of the core midwives complaining about a new practitioner, about me in particular… 'oh, these new practitioners, they shouldn't be allowed' sort of thing, 'they're always asking for help … needing help so much'…and so I went and had words with her and she apologised and said it was really inappropriate behaviour…. (Group 'three', first interview)

The governing mechanisms involved in these processes consist of a continual but shifting balance of both external surveillance and internal (self-)monitoring. (Self-)governance occurs as we, as subjects, "internalise systems of surveillance to the point that we become our own overseer" (Orner, 1992:83). This constitutes relations of power between the self and others that Foucault described as 'disciplinary normalization', as opposed to monarchical, or sovereign power. For new midwives, these processes lead over time, and with experience, to their increasing self-regulation as they are guided from new graduate to established practitioner, negotiating choices and constraints in their relationships with birthing women. The new midwives are guided through the hospital polices and protocols by core staff within the constraints of the institutionalised birth setting in the situations of transfer, or bringing a client in the first few times, or being left alone and trusted to manage an epidural procedure.

Burchell points out that the price to be paid for being left alone and being trusted is increasing 'responsibilization'. This occurs when individuals:

> …must assume active responsibility for these activities, both for carrying them out, and, of course, for their outcomes, and in doing so they are required to conduct themselves in accordance with the appropriate (or approved) model of action. This … "responsibilization" corresponding to the new forms in which the governed are encouraged, freely and rationally, to conduct themselves. (Burchell, 1996:29)

The focus for me here is not on what is learned freely and rationally in these ways, but how these knowledges are produced and inscribed within the discourses new midwives come to inhabit. My use of the term pedagogy is deliberately political in the sense that, as Gore intends, it is "…a kind of focus on the processes of teaching that demands that attention be drawn to the politics of those processes and to the broader political contexts within which they are situated" (Gore, 1993:5). Gore argues that when pedagogy is understood as the process of knowledge production, and that knowledge includes a social vision, then both the pedagogy argued for and the pedagogy of the argument itself must be addressed (Gore, 1993:5-6). Foucault's concern with the way people become objects and subjects of governmentality requires an exploration of their pedagogical formation, or the ways in which they simultaneously learn to govern themselves, others, and things; our pedagogical formation "ensures the upward continuity of the forms of government, and police the downwards one" (Foucault, 1979:9).

When this takes place in the space of the 'clinic' (here centred in/radiating from the base obstetric hospital), Foucault's suggestion is that observation, description and experience produce the 'truth', thought to be held in the interior depths of bodies (Foucault, 1973:120). Within the clinical 'gaze', the moment of manifestation of 'truth' is the same moment as the knowledge, the pronouncing and the learning of that truth (Foucault, 1973:110). He argues that in the clinic, seeing, knowing and learning all take place at once, that there is no difference between the clinic as science and the clinic as teaching; and that at the heart of 'clinical experience' lies a form of 'initiation into the truth of things', as those things are made manifest. This is apparent in the accounts of new practitioners who talk of a theory-practice gap, for example; or of seeing something with a midwifery gaze as normal, and subsequently

having that knowledge sublimated during a consultation with an obstetrician or with senior core midwives:

> M1: So, that's when it got interesting because then the core midwife took over and when she came in she said 'oh, you have to be on the bed', and I said, no, she's ok sitting and standing…but I had to go and they said 'you go and hurry and I'll look after her because I haven't got a lot of time to give you a break' so I left her and I was confused as to whether to say no, she's got to stay sitting or standing because she's managing, but anyway when I got back twenty minutes later she was on the bed writhing in agony…how can I say, 'can you give us a bit more time? Why do we have to hurry, when she's done so well with nothing?' (Group 'three' first interview)

It is the 'truth' of these things ('you have to be on the bed'), and their mode of production through the obstetric gaze that new graduates do come to question knowledge claims, 'inciting doubt' as they do so. They incite doubt amongst each other as they develop their intellectual and professional autonomy, trying to synthesise theory and practice, and they incite doubt for established core midwives as well, in the negotiation of some protocols. This space of mutual scrutiny is where different claims to the truth of birthing bodies are produced; in different situations some truths are sublimated, as other truths temporarily prevail. This is what is meant by 'the culture of the hospital is slowly changing', as the educator points out. The point at which individual new graduates 'come to question', and to subvert certain regimes of truth differs as the balance between external and self-monitoring shifts and changes. This will differ in different clinical situations, as part of the on-going development of technologies of the self ('you learn when/not to question').

The observing gaze: sights of risk

In Hilda's account below, the relationship between being able to 'see' what a new practitioner is doing and empowering her as a professional, is also present. Hilda believes that some situations require added surveillance, as in this case because the practitioner was 'new to us', and therefore an unknown quantity, and because the birthing woman was having an epidural. This means that other actors and technologies must be brought into the field of action; there will be continuous foetal monitoring, extra documentation requirements, drugs to check with core midwives, hierarchical channels of communication to negotiate, policies and guidelines to follow, and knowing which staff to consult with when if necessary:

> … it was really busy on Sunday … and then I had to work with this new midwife, she's new to us and um… the thing is when that door's closed you don't know what's going on behind that door… and I went in there to help and this lady had an epidural, which requires regular recordings and she didn't have a monitor set up and hadn't started recording… and when I helped her to the trace had lates… and … accelerations, the whole way through … and she hadn't talked to the Registrar about that… now OK, the more experience you've got the better you are with this … but here she is … a new midwife … she's only had about a year's practice and she was out in the teams… we're getting all these new team midwives… all new grads… and we have to nurture those people along … we have to support them, not go in there and disempower them for a start off … and take over and all that sort of stuff… our staffing's pretty generous really and they're real safety issues… and I think we can do … we can help … a bit more than we do …. (Hilda, core midwife)

In contrast, some self-employed practitioners spoke about closing the door of the labour room to ensure that they had some professional privacy and sense of control in a hospital space where birthing philosophies may be markedly different to that of their own and/or the birthing philosophy of their clients. They may strategically close the door to ensure some relief from feeling watched. This may take some time however, and the development of confidence as a practitioner. One established homebirth-centred midwife (in another city) told me that when she was a new practitioner she began a practice of always taking "…two pieces of invaluable equipment into hospital if the woman wanted to go, both wooden, my pinard and my doorstop; one in each pocket, and I made sure I used them both". Other midwives described and showed me ways in which they would pull curtains around the birthing woman so that they were afforded at least some visual privacy should somebody enter the closed doorway of the room rapidly. Natalie, a graduate of the first DEM degree programme, describes how after six years of self-employed practice she works to maintain the birthing woman's privacy at the same time as her own professional privacy:

> …so I have a lot easier road than a lot of independent midwives because I know the game, I know what their expectations are so they … and I guess they've seen me practice and so there's not that kind of undermining stuff going on and constant supervision and checks and … I mean yes, sure (charge midwife) sometimes will come in … but I work to avoid her getting anywhere near the woman, so what she used to do before there was curtains in the little rooms, was just knock on the door and come in and say hello and do her quick wee review of what's going on, not invited but part of her seeing what was going on in the room, and what state everything was at, and flick her eye on the CTG if there's a CTG on … so she would do this whole kind of wee invade and disappear again, and what she was doing was doing this monitor on what was happening in the

room and didn't just ask what was happening . . . but now with the curtain then I can … by the time she opens the door, I can be at the curtain in order to say hello, what do you want? Yes, everything's fine thanks, bye. (Natalie, self-employed midwife)

After having endured constant supervision and checks as a new DE practitioner, Natalie has learned by now how to resist the invasive and monitoring gaze of senior hospital staff by intercepting and confronting them at the curtain. At the same time, she recognises her hospital privileges, relative to the harder road new practitioners have, because 'they've seen me practice'; she has been seen, she has managed her time of being watched and monitored, and through this watchful supervision she has become empowered into a subject position of that of an established practitioner, that is, being seen as a safe practitioner. What remains to be done for Natalie on the odd occasion now that someone acts to disrupt both birthing and professional privacy is the 'work to avoid her getting anywhere near the woman'. Foucault suggests that once the clinical gaze has made manifest the truth of/in hospitalised bodies, only a 'glance' need verify this truth subsequently. What Natalie is likely to encounter now in her established position is more accurately a clinical 'glance'. The 'gaze', which is 'endlessly modulated' and 'records and totalises', is spread out over an open field (Foucault, 1973:121). In contrast, the 'glance' into an individual room, 'goes straight to its object' (Foucault, 1973:121), as in this case where the charge midwife may 'flick her eye on the CTG' machine.

> The glance… strikes at one point, which is central or decisive…it chooses a line that instantly distinguishes the essential; it therefore goes beyond what it sees; it is not misled by the immediate forms of the sensible, for it knows how to traverse them; it is essentially demystifying. The glance is silent, like a finger pointing, denouncing. (Foucault, 1973:121)

Pairman articulates a response to those concerned that new midwifery graduates may need extra support after registration. In her defence of new midwifery graduates, wherever they choose to work, Pairman (2002b; 2002a), argues that competence should not be confused with confidence, stating:

> The secondary midwifery service is hospital based and provides specialist services, often including midwives with expertise in caring for women with obstetric problems. Most women who birth in hospital *do not require secondary services.* The role of the core midwife who works shifts includes support for the independent midwife who comes into the facility with her clients….Like all new practitioners, they will need support from more experienced practitioners as they

gain confidence and experience. However, they are competent to practise.
(Pairman, 2002b:4, my italics)[45]

Labouring women have limited time and space to birth in an obstetrical hospital, even if most of them do not specifically require secondary care/services. Foucault's description of contemporary power argues that increasingly medicalised discourses in all areas of life are now crucial to legal, juridical, and political domains (in Grosz, 1995:35). Institutions, such as the obstetric hospital where these midwives discuss their labours, and where women come to birth even though they may not need the core services, create a context in which bodies can be regimented, observed and inspected as bodies that are potentially delinquent. In contrast to them, normalized birthing bodies are also produced and surveyed, brought into being through the observations of the watchful clinical gaze (Foucault, 1973). If the labour does not proceed according to hospital norms (or the birthing room is too noisy; see also Hunter, 2000 for this), tensions over procedure and protocol may arise between core and LMC midwives. A firm rap on the door is a warning to the independent and/or new graduate midwife inside that her actions are under surveillance (even a lingering footstep outside is a sign). She must meet the person knocking at the door and explain what is taking place inside, or risk 'the wee invade' or 'wee review' Natalie describes in the act of the often silent glance.

As a surface of inscriptions, the body is pliable to power, and is traversed and infiltrated with knowledges and meanings. It may also, under different conditions, become a site for resistance. The quick review, the wee invade, or the glance, rather than 'just asking' as Natalie would prefer as support from secondary staff, reinscribes all birthing bodies as potentially fallible and in need of medical visualisation and supervision. While the majority of birthing women are not necessarily in need of secondary care, authoritative hospital knowledges produce the 'truth' of pregnant bodies, inscribing them as sites/sights of risk in the medico-legal domain. This means the 'normal' labour has lowest risk potential, but it is always a starting point from where pathology may take off (Lane, 1995; Murphy-Lawless, 1998). In the interview transcripts of the midwives participating in my study, certain forms of knowledge may be produced through the observations of the clinical gaze and subsequent glances, even

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[45] See Pairman for detailed descriptions of the separation of midwifery education from that of nursing and the development of the direct entry midwifery degree programmes (Pairman, 2002b; 2002a).

as this knowledge is mediated and negotiated through the embodied resistance of different self-employed midwives.

For the midwives in group 'three', learning not to ask questions of particular midwives, but to ask different midwives, or to trust their own judgement, or use their bodies in different ways, become technologies of the self in the transitional period from student to new graduate, to confident practitioner. Natalie, a well-established practitioner, engages embodied resistance as she holds the curtain between herself and the core midwife in charge of labour ward. 'Disciplinary normalization', consisting of the intricate micropolitics of bodily supervision and surveillance, is the contemporary answer to the 'macropolitics of spectacular display' previously undertaken as part of disciplinary regimes of power (Grosz, 1995:35).[46] McWilliam discusses the ways in which being 'silently watchful' as an ideal of good governance is woven seamlessly into the fabric of everyday life in a way that avoids the outward appearance of coercive authority, but still produces effects, such as student self betterment (McWilliam, 1999:93). In his discussions of disciplinary normalization, Foucault stresses the importance of the relationships between pedagogy and surveillance, suggesting that frequently

> …three procedures are integrated into a single mechanism; teaching proper, the acquisition of knowledge by the very practice of the pedagogical activity and a reciprocal, hierarchized observation. A relation of surveillance, defined and regulated, is inscribed at the heart of the practice of teaching, not as an additional or adjacent part, but as a mechanism that is inherent to it and which increases its efficiency… and without recourse, in principle at least, to excess, force or violence. (Foucault, 1977:176-7)

These processes are constituted within the relations of surveillance within the clinic/labour ward space, as the interface between new and old, primary and secondary, core and caseloading, theory and practice, normal and abnormal, are played out in what I call mutual scrutiny and ambivalence between midwives. Some new graduates referred to the support they received from core staff in terms such as 'absolutely wonderful', 'incredibly supportive when you need them', and in many other positive ways. What is significant, however, is that this cannot be taken for granted upon entry to labour ward:

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[46] The burning at the stake of midwives in Europe during the Middle Ages as witches, for example, is an example of an extreme form of corporal punishment that Foucault refers to as 'The Spectacle of the Scaffold', chapter two in Foucault (1977); and see Ehrenreich and English (1973).

> I suppose again that midwifery thing, it's horizontal stuff again … and going in there looking sideways at the staff and thinking who's supportive and who's not, who doesn't mind a new grad … and we had that the other day with my back-up's birth. They were quite happy for us to do everything and they said just call us if you need us and we called them because my back-up couldn't quite figure out what was happening on the VE…(Bess, self-employed midwife)

Bess, as did other new graduates, suggests that the degree and style of support and help offered was contingent on 'whether they like you or not', 'whether they like new grads', 'depends on who's on', or 'depends if they support our training or not'. Support was forthcoming this time in Bess's narrative; later in the chapter is an example of an incident which she felt undermined her autonomy. The existence of "failure to respect privacy or keep confidences, non-verbal innuendo, undermining, lack of openness, unwillingness to help out, and lack of support" (Leap, 1997b:689), have been theorized in midwifery in terms of 'horizontal violence'. The issues described by Leap, as well as other forms of subtle bullying within midwifery, are under scrutiny in Aotearoa/New Zealand and overseas (Hadikin & O'Driscoll, 2000; Kirkham, 1999; McIver, 2002; Smythe, 2002). These were all issues addressed at times by most of the new graduates I observed or interviewed. At the same time, and often within the same interview transcript(s), were examples of the ways in which core and other midwives were also highly supportive of new graduates in different ways and at different times. McIver, a midwife in Aotearoa/New Zealand, reported to the 2002 NZCOM conference the results of her study of the effects of horizontal violence on the provision of midwifery care. Her findings share some similarities with the suggestions made to me by some midwives about 'being watched', 'being labelled', 'lack of support', 'being treated unfairly', and, in her analysis, these contributed to "significant risk factors for women and midwives" (McIver, 2002).

Although 'horizontal violence' undoubtedly occurs in different situations, I am not focussing on it per se. I am interested instead in the relations of power through which new practitioners are 'guided and restrained' and otherwise governed 'lightly' in their practice. What interests me in this, is that the context for these relations might actually be designed by the institution to prevent the effects of horizontal violence, and to provide a smooth orientation for new practitioners. The benevolence that constitutes aspects of pastoral power in these ways might be much more effective in ultimately maintaining the good will of all practitioners. This may render resistance to institutionalised birthing practices much more complex and difficult to

undertake, whether for new midwives challenging old practices, or for birthing women. In this poststructural theoretical orientation, my analyses are concerned with the constant, continuous, all-pervading normativity of relations of power including the technologies of the new midwives in the development of their professional selves. In other words, from a governmentality perspective, I am interested not in what gets punished, but in what gets rewarded, and why. The technologies of the midwife-self that are likely to be rewarded and that have been explored in previous chapters include those of reflecting on practice, attending standards review, working towards the attainment of an epidural certificate, developing a mentoring relationship, and drawing on the discourses of evidence-based practice, among others.

Are they safe/we are responsible

Amongst some of the established midwives I interviewed there appeared to be a degree of ambivalence towards direct entry training at times, comprising the mutual scrutiny at the interface between the old and new, medical and midwifery philosophies. This hinged around the uncertainty, for midwives who are nurses as well, that new midwives somehow may not be safe unless they are also nurse-trained, or/and undertake a significant period of what Frania, below, referred to as internship. Frania had been a midwife for a number of years, and like most midwives I interviewed, had been employed in a variety of roles, including a period of being a charge midwife on labour ward. She is now self-employed, and has an access agreement to use the facilities available in labour ward, where most of her clients choose to birth.

> We were just talking about how things are different … and because I've got several grey hairs and I've watched the process of different training … different ways of entering the workforce, and one of the things that I personally at the moment have difficulty with is direct entry new graduates … well just new graduates … not especially direct entry … becoming independent practitioners without an internship and I know that they have mentors, but I consider that closer supervision is more desirable to support new graduates … I guess that they are doing it all right despite criticism… I know they have a mentor, but they're not there sitting right beside them. They still need plenty of practice after they graduate to become safe practitioners without supervision. (Frania, self-employed midwife)

Frania's emphasis is on midwifery as practical, but in this case, the claim that safety, arising out of plenty of practice, is not achievable without close(r) supervision, rather than just quietly watching from behind the door. Becoming safe and/by acting responsibly appear to be key themes in what it is that established midwives are watching for when they in/directly supervise new practitioners. Safety is determined on the part of the supervising midwife. It is something that is always related to practical skills, and to experience. Lilian reflects on the reasons for some of the ambivalence from hospital core midwives she perceived when she undertook her training as part of the first direct entry group to have work experience at the hospital:

> … the management tells them they need to work with us … and I mean end of story and I think they felt at times, quite understandably a bit used … they felt they were busy enough already and this pesky student asking questions and things and not getting any thanks or benefit from it … I can understand why they might have been a bit peeved and so I guess some of it is about their disapproval of the way we're being trained … they just made these assumptions that because we weren't nurses that we weren't OK … that we weren't 'safe'. Basically they were just saying to us … how can you be midwives without being a nurse? It was never really kind of a really big discussion … it was really just undermining … one of the curious things about that was that I would sort of say … that's why we're here really … that's why we're with you so that we can learn some of these skills … because they would tell us about what they thought we didn't cover and I'd say that's why we're here. But there was this real reluctance to share knowledge as well … they didn't think we were OK working without having those nursing skills … (Lilian, self-employed midwife)

Lilian refers to the same discourse evident in Susan's earlier statements which constitute midwifery as something practical and pragmatic, requiring some nursing skills in order to be safe, at the same time as implying that DEM education is an excess (of theory) and/as a lack (of practical skills). Lilian has to explain and qualify her presence before knowledge will be shared. Eva, another new graduate, also notes the constraints for the WHD community midwives within the hospital system who could be providing support to new graduates, particularly since some of them are also direct entry trained, whereas most of the core staff on shift work are not:

> As far as community midwives, sometimes they can't provide support because they're so strung out themselves … and the core midwives in the base hospital, just … there's just a huge gap in communication … it's like they do their job, we do ours … and there's no understanding … no bridge between the two. We were the first lot to come through so they're … I feel that they've been very critical and waiting for us to not be able to do things … and I haven't done

> nursing, there is a lot of things I can't do … I don't understand a lot of tubing and machinery and the technical stuff … and I'm not afraid to admit that … but if you need help … a lot of them just absolutely scorn you … and I've been told how to practice, I've been told the decisions I've made are wrong, just no confidence in my practice at all, which I find very intimidating, very undermining … very very stressful. (Eva, self-employed midwife)

Lilian and Eva both reflect on their days as student midwives during which there were times when they would defend direct entry education as an authentic mode of authoritative midwifery knowledge production. Performing as a responsible student in those days meant asking questions as a way of constructing and displaying gaps in practical knowledge, which could then be filled by the supervising midwife to varying degrees, depending on her willingness to share her knowledge with students. A balance of questioning as students or new practitioners is carefully negotiated during periods of contact with supervising midwives who may or may not be directly mentoring the new midwife. Too few questions may mean the new graduate is interpreted as not safe (because she is not willing to ascertain knowledge from particular midwives). On the other hand, too many questions can be interpreted as challenging to the supervising midwife's particular form of philosophy and practice.

These technologies of the midwife-self are related to those which are 'struggles against the effects of power' that are linked with 'knowledge, competence and qualification' in the creation of particular subjectivities within neo-liberal forms of education (Peters, 1996:82). Importantly, according to Peters, this interpretation assumes the freedom of the individual, because "power is defined precisely in relation to the freedom of the individual to act" (Peters, 1996:83). This is in the broadest sense in which governmentality can be explained; the structuring of the possible field of action of others who believe they are independent and free subjects, here as professionals already registered and qualified to practice on their own autonomy (Foucault, 1986; Fournier, 1999; Marshall, 1996; Peters, 1996).

Of mentoring, meconium, and monitoring…

New graduates learn to monitor their questions in order to fit in to their new roles, and to 'feel safe' and 'be accepted'. If they become self-employed on graduating and want to be able to use the hospital facilities, they need to gain an access agreement with the hospital in order to remain LMC, either if the woman chooses to birth there, or if she is transferred from home or the rural hospitals. If they don't (yet) have an access agreement, they need to hand over to the

hospital, who itself becomes LMC for part of the woman's care (and then also receives payment for that module).[47] Part of gaining an access agreement for a new graduate is having a mentor. This is not strictly stipulated in the MOH 'Terms and Conditions of Access Agreement' (Ministry of Health, 2002), but the NZCOM position is that this is a desirable relationship, and 'one of negotiated partnership between two registered midwives' (NZCOM, 2001).

As Guilliland points out, "Mentor relationships have become essential within midwifery at every level as midwives support each other and work towards caseloads rather than 'duties'" (Guilliland, 1998b:187-8). This is also part of the commitment made to partnership that forms the basis for on-going midwifery education. Guilliland states that it is women who have mentored midwives to "reach their potential as autonomous practitioners by believing in them and demanding an alternative to the medical model of care in childbirth" (Guilliland, 1998b:185). The midwife nominated as the mentor also needs to maintain a current access agreement to the facility. New graduates did not take the politics of making an appropriate choice of mentor midwife lightly. Bess told me about the time it took her to find a mentor (almost a year, and several changes of mentor), with whom she felt shared a similar birthing philosophy, but was also accepted in labour ward:

> Well that's another can of worms … my particular mentor, I was told by someone else … oh, you shouldn't have her because they don't think much of her at Women's … and that was a warning to me that I hadn't made a very appropriate choice in a mentor. (Bess, self-employed midwife)

The mentoring midwife is also under surveillance, as part of the integrated system within which Foucault suggests disciplinary power functions. He suggests that:

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[47] Seven of the twenty-five self-employed midwives who participated in my study did not have access agreements. This was because of midwifery discourses and practices which privilege primary care, in similar ways that 'goddess midwives' in chapter five also resist the acquisition of epidural certificates. Differing complex levels of in/formal hand over take place if transfer from home or the birthing centre to the base hospital became necessary. If labour has already started the LMC midwife receives payment for the labour and birth module. Most of these midwives told me that they would usually stay on as long as possible to provide support to the woman. The discursive struggles that may ensue over meaning and money, policies and protocols, and who 'owns' the birthing bodies of the women that are thus traversed by multiple knowledge/power many midwives referred to as 'grey areas', or as Bess does, 'grey zone'.

> …although surveillance rests on individuals, its functioning is that of a network of relations from top to bottom, but also to a certain extent from bottom to top and laterally; this network 'holds' the whole together and traverses it in its entirety with effects of power that derive from one another: supervisors, perpetually supervised. (Foucault, 1977:177)

In Bess's search for a mentor who would hold a similar birth philosophy to her own, yet also be respected in labour ward, she was aware of how her chosen mentor would also be under surveillance herself at different times and places:

> I did some post-natal care for another midwife and it worked out really well and she was really supportive and she was saying … because she knew I had such a lot of learning to do that she would be willing to help me as a mentor as well … and I said well I already had this other mentor but then there was this subtle thing of her putting down this other one because they have very different practices…my mentor is considered by some people to be unsafe, to have unsafe practices … and I know where that comes from is that she … not bends the rules… but she supports women in really grey zones. It's the same thing … like she came and said, with the meconium at the home birth … she wasn't saying oh yeah you have to go straight to hospital … and it's just part of the learning. It's part of my learning, saying well that's the climate and that's the reality and there will be midwives who are going to be supportive and to find out which ones support my kind of practice … (Bess, self-employed midwife)

What constitutes the 'grey zones' of birth in this account is what falls at the periphery of the stretch of the obstetrical gaze, that is, the homebirth where meconium is present in the woman's amniotic fluid (which may, or may not, indicate foetal distress). This acts generally as a sign that the midwife, following the MOH guidelines for referral, a level two referral in this case, must recommend to the woman that a consultation with a specialist is warranted. This does not mean a transfer of care must happen; that is dependant on the clinical situation and wishes of the woman (Ministry of Health, 2002). If birth was immanent, the woman did not want to move/consult, and the foetal heart sounds were good, many midwives would catch the baby and transfer post-natally so the baby could be checked for meconium aspiration if need be. For other midwives, the presence of any meconium constitutes a risk that is clearly not interpreted as a 'grey' area at all. In this particular event, transfer to hospital was decided on in consultation with Bess, her back-up midwife, her mentor midwife, and the woman and her husband after the woman became ' …really tired and ok by then about transferring'. A large part of the decision for Bess was her status as a new practitioner, and her anticipation that she might 'cop a lot of flak' over this situation, and after describing the rest of the birth,

she reflects on the response she was given when she asked for feedback from the hospital midwives after it was all over:

> I was really upset at the end of that birth, I was in the labour ward, in the staff room and I was absolutely knackered because we'd been up all night and then we'd had to have an episiotomy in this transfer and I was in the labour ward staffroom and the boss midwife and this other midwife were there … I said oh, what's your thoughts on that … about the meconium and I got very very long steely stern faces from both of them and that 'meconium was meconium' and I should never have stayed at home… you should have transferred, and we were talking about transferring … when labour was only just starting and we had a very good foetal heart and they didn't know the full situation … all they knew was that I'd stayed at home with meconium stained liquor and that we transferred in at the end. Now the mentor midwife was quite happy with that situation, she was quite happy with when we transferred. She said you called the shots about that one and that was good … we needed to go then and she quite agreed but that we hadn't needed to go before then … (Bess, self-employed midwife)

Participating as a new practitioner in the 'grey zone' of homebirth means Bess became subjected to the normalising disciplinary action of an obstetrical gaze where there can be no grey. 'Meconium is meconium' indicates that any meconium under any conditions constitutes risk and warrants immediate transfer. Murphy-Lawless however, points out the contested and historically contingent nature over meanings in childbirth, using the presence of meconium as one example. She relates a story told by Freud in which he overheard a student midwife 'from the humbler classes' respond to the question 'what does the presence of meconium after the membranes have ruptured mean?' The student midwife replied, 'it means the child is frightened', and was failed by the doctor for her naïve and unscientific account. But Freud began discussions with her, and her knowledge eventually contributed to his theories about birth and anxiety (Murphy-Lawless, 1998:230).

In the context of which Bess speaks, however, a 'safe' practitioner should have transferred in immediately, according to the senior core midwives whose knowledge is authoritative and who assist in the latter part of the process. Bess is constituted as a potentially risky practitioner within the same discourse that has already established her mentor as 'unsafe'. The pedagogical processes here function within the labour ward at the base hospital as a site of "…discursive conflict over how subjectivities and social relations should be constituted and social relations exercised" (Weedon, 1987:111). This conflict contributes to the governing of bodies at the site

of subsequent births where in order to be seen as 'safe' on arrival at the hospital, new practitioners may monitor themselves and the women in increasingly constrained ways, taking earlier and earlier preventative action to avoid being seen to be taking risks. These 'risks' are complex and must be negotiated through time and space, as discussed in chapter six. In this example, discourses of obstetric risk and spatial proximity to a hospital mean that a midwife can 'never be close enough' to a hospital if she is to minimise perceived risk to her client, and the concomitant professional risk to herself. Of course, in obstetrics, risk is always already present, there can never be no risk, since it is the epistemological basis of risk that it covers every potential to a greater or lesser degree. In birth, risk is endlessly deferred and diasphoric; if it 'begins' inside the pregnant body it splits, multiplies, ruptures, fractures and can be dispersed endlessly through time and space outwards from the body.

The logical extension of this is seen in the amount of time a practitioner is willing to wait past the 'due' date before recommending induction of labour (as an 'informed choice'), something many midwives also talked about in the context of a discourse of 'fear of litigation' and the related practices of 'defensive practice'. In these actions, other forms of authoritative knowledge, such as referring to an evidence-base within the literature and randomised controlled trials, may not be as valued as traditional hospital protocol and guidelines. The normalizing and disciplinary forms of pedagogical practice between the midwives in the 'meconium is meconium' narrative might be considered as part of a discursive strategy, the effects of which are to maintain obstetrical hegemony over birth by constituting all birthing bodies as medico-legal bodies because of the foetus – always already a subject of risk - within.

The issues discussed by the new graduate midwives who participated in my study contribute to my analysis which begins to explore the ways in which the policies and protocols on labour ward may at times function to normalise midwifery practice, as well as to 'ab/normalise' births. This occurs in the space of labour ward despite self-employed practitioners' vast philosophical and practical differences in their sites of practice outside labour ward, and despite the autonomy granted to midwives. In lightly governing independent midwives, beginning from below with the pedagogical formation of new graduates, the clinic can more effectively, because increasingly subtley, govern childbirth. Below an extract from my interview with the NZCOM Legal Advisor refers to the disciplinary normalization processes

involved in situations of transfer to clinic or handing over care, with regard to core midwifery staff as specialists in abnormal birth:

> They're actually there for when things go wrong. They are secondary care specialists, this is the secondary care specialist midwife and her expertise is providing support for anything that becomes complicated and she could be proud of that. What concerns me is this constant judging of other practitioners and making a judgement often on very little information, they often haven't read the labour notes or understand what's going on at home…. it may have been an obstructive labour and the young midwife could have got really important information but instead she's got confrontation and an immediate jump to blame and criticism which might also be conveyed to medical staff and the woman, and undermine everyone's confidence in the new practitioner, that's really tragic, that's a symptom of what's happening to the profession ….
> (NZCOM Legal Advisor)

This is a legal analysis of the 'grey zone' that constitutes the governing interface between primary and secondary care. The 'undermining' of new practitioners through 'constant judging' functions in some accounts given by new graduates, as part of the institutionalised contesting of the value of DEM education as an authoritative field of midwifery knowledge, and DEMs as competent to practise upon registration. In other accounts, it is over what constitutes secondary care and the ways some midwives resist definitions of that, and this has been explored already in the previous chapters ('we'll be doing caesareans next, you'll see'). As Jordan suggests, whilst midwifery training is ostensibly about the transmission of knowledge and skills, it is also always about the "imposition, extension and reproduction of lines of power and authority" (Jordan, 1989). Her study of midwifery pedagogies is based on, but not confined to, the experiences of Traditional Birth Attendants in Yucatan, where apprentice-style training is dominant.[48] One of her key findings was that in apprentice-based midwifery learning, where knowledge transmission requires the acquisition of embodied skills, or the ability to do rather than ability to talk about what is done, midwives also learned new resources for how to "converse appropriately with supervisory medical personnel" in ways which might serve to provide "the semblance of medical legitimisation" (Jordan, 1989:929). This is upheld by Foley, who argues that in America, midwives gain some professional

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[48] With regard to the DEM programmes in Aotearoa/New Zealand, Pairman states: "Midwifery had always supported apprenticeship-type midwifery education and these new programmes combined the best of theoretical educational models with apprenticeship models to facilitate development of evidence-based knowledge from a strong practice base" (Pairman, 2002a:24).

legitimation in their ability to draw on the obstetric discourses of bio-medicine in an 'artful resource' contributing to their crediting (Foley, 2001). This is also seen in the discourses of midwives who draw on 'evidence-based' practice (Winch, Creedy, & Chaboyer, 2002). My interest lies in the ways in which midwifery professional discourses of 'evidence-based' knowledges and 'autonomous practice' themselves may serve to gently guide practitioners in certain ways, and so structure their possible field of action. In these fields of available action, which knowledges become authoritative? Which knowledges become sublimated, or subverted, and with what effects?

Techniques of the autonomous midwife self

M1: Do you think, though, that ultimately you won't be doing many CTGs?

M2: Well because its protocol, when you go to Women's…you have to do the twenty minute CTG.

M3: If you're doing any inductions you've got to put them on the CTG.

M2: Well, that's understandable because then you're interfering…

M3: It's based on a concept that if you check it then because if the baby was born stressed in early labour you can stop big problems later on…

M1: It sort of raises the thing of independent practice. Because as independent practitioners we should be allowed to call our own shots.

M4: That's what…one of my mentors…definitely doesn't follow the protocol, she says, no, I'm the LMC, I'm in charge…

M1: They've got so much more clout than we have. (Group 'three', first interview)

To be accepted as a competent, safe practitioner, when handing over or transferring for secondary care, requires an acquiescence, even if only temporary, to an institutionalised model of birth which is in conflict with what new graduates have spent much of the last three years learning about. During this time, students learn to critique medicalised models of pregnancy/birth and are prepared for "women-centred practice, with an emphasis on meeting the needs of pregnant/birthing women rather than the demands of birthing institutions"

(Tully, Daellenbach, & Guilliland, 1998:250). Midwives are trained in recognising situations where pregnancy and birth will become abnormal, and consult and refer appropriately, that is, via the MOH guidelines for referral and consultation. More recently, Guilliland has queried the role of the guidelines in the increasing intervention rates, suggesting midwives could consult more frequently with each other than with obstetricians (Guilliland, 2000, 2002b; Guilliland & Campbell, 2002).

I wondered if there is a paradox for new midwives in that, while more recently-developed midwifery discourses are based on well-articulated feminist critiques of the medicalisation of birth which in themselves function to (re)produce birth as 'normal' (Tully, Daellenbach, & Guilliland, 1998), many women are now choosing pain and risk management approaches that warrant institutionalised birth. This necessitates the grounding of many midwifery practices and technologies within tighter and tighter medico-legal parameters that necessarily uphold hegemonic assumptions about female bodies. These assumptions warrant claims about pregnant bodies in particular as sites of risk, as I have discussed in the previous chapters of this thesis (and may account for the sense of 'pull' towards the hospital, in some of the narratives). It seemed that the theory-practice gap some midwives spoke of with me might be widening in some respects, rather than lessening. Toni, a midwife on the continuity teams spoke of the gap:

> Well, I mean the tutor did try and make everything a la natural … I mean she would have probably gone through a physiological third stage … like the more natural side of things and you'd think oh isn't that wonderful, that's probably the way midwifery should be, but when you actually went into clinical practice you didn't really see an awful lot of that practice going on. I guess your ideas kind of changed, when you're in a classroom and when you're reading about things, it's great, but when it comes to putting it into practice it isn't, it's not the same.
> (Toni, WHD community teams)

This is related to the desires, or demands, as Toni goes on to explain in the interview, that are made by many women for births utilising medical technologies and hence requiring institutionalisation and perhaps subsequent interventions. And for this group, during a discussion in which we wondered if midwives felt 'love and awe' during births (Harrison, 1982):

> M1: I haven't seen too many healthy pregnancies and labours…

M2: I haven't…I haven't seen any at all…

M1: I've been to a few normal ones…

M3: yeah, I've had a really weird run recently…

M4: we need to hear more of those…I'm getting frightened…

M1: The Christmas day baby was lovely, the home birth…although that was hard work, wasn't it

M3: And out at (rural hospital) we had that primagravida that was good. Lovely pregnancy, very straight-forward. But there's all this nervousness though of doing it the first time. It's very serious kind of – relaxation breathing and focussing and…

M4: how else do you cope with the nervousness of doing things for the first time? (Group 'three', first interview)

And thereafter continued the discussion of various technologies of the self, including 'dropping off fears that are carried', 'leave them at the door or drop them off elsewhere', 'doing little exercises', 'on my way there sort of breathe in and out', and 'going fresh, not carrying anxieties'. These were intended as self-management tools at times when theory and practice were experienced as a disjuncture. Other midwives referred to the different ways in which they had learned about assisting women at births which helped to synthesize theory and practice. Most frequently this was directly from women themselves, rather than 'from books or classes':

> Learning about how women labour … the way they can communicate need to you, without actually saying anything. I learnt a lot about the strength of women, from seeing women in labour. Which is something we never talked about really … it was all about hours of this and dilation of this and station of this. And I learnt that from women … not from anybody else. I guess the theory of it has become … it's either become less important or I don't think about it so much. And maybe I don't think about it so much because I've incorporated it into the way I practice rather than seeing it as a separate thing. You know, I used to see the theory and philosophy as one thing and the practice as something else … and now I don't … I just see it as one big muddle. (Frida, self-employed midwife)

This quote suggests that the praxis of midwifery is established best for this practitioner when the practice of it is 'taught' by the woman herself, rather than theory taught by teachers. It also relates in a wider political sense to Guilliland's assertion, that midwives have been 'mentored' by women into becoming autonomous practitioners, and providing alternatives to the medical model. Lilian talks about intuition and learning:

> The stuff that you just intuit, really … the stuff … you know, like that gut feeling stuff … I'm getting to that point now where I can start having a grasp of, or being able to have a guess, a rough guess about where a woman is in labour just by hearing her noises and things like that … and watching what she's doing … like that stuff you just don't get from a book … once you've seen lots and lots of women the patterns start to emerge … not to say that … it's still to say every birth is different but you know, the things you just learn by watching and listening …and having lots and lots of experiences … you just know … (Lilian, self-employed midwife)

Other new graduates spoke of the ways that the theory-practice gap for them became tempered by a growing confidence in relying on forms of embodied knowledges, described variously as 'intuition', 'experience in', 'growing up', 'being comfortable' or 'gut feelings' about certain situations. There is a growing critical awareness in the international midwifery literature concerning theory-practice gaps in pedagogy and practice. Some midwives reject the contribution of formal theory to practice, in their view that traditionally midwives have found theory to be incompatible with intuitive practice (Begley, 1999; Bryar, 1995; Chambers, 1999; Fullerton, 1998; Thomas, Quant, & Cooke, 1998; Yearly, 1999). Bryar notes that thus far midwifery concepts, theories and models generally have been deduced from other disciplines such as psychology, sociology, nursing, medicine and child development (Bryar, 1995:117-8), as Caro also notes:

> Well I think there's a great deal of knowledge that midwives are taught and accept as being midwifery knowledge … that's actually the knowledge of another discipline and that it's not … much of it comes from the scientific tradition of learning, and comes from the observation of the masses … which is very difficult when you apply that to the principle of the individual … (Caro, self-employed midwife)

Applying what has been learned 'about the masses' to the individual woman with regard to what is 'normal' feels like a big responsibility, according to two midwives below:

M1: The weight of responsibility …is this normal? Help! I've got no one else to ask so I have to decide now. That's what I think shocked…that was a real growing up. So even the point of transfer should be…where do you get outside the realm of normal?

M2: Maybe it's just about growing up and about being comfortable with what's normal and what's abnormal and that's the kind of thing you're never going to be taught. That's the kind of thing you've got to do. (Group 'two', second interview)

For some new graduates, what is perceived as undermining their new knowledge in its application with individual women may also be interpreted as supportive in different situations, so long as it is not likely to happen as much in the future, when it will be replaced with internalised forms of self-surveillance and monitoring. Here, members of a new group practice discuss a recent birth attended by M1 and her back-up, M2, while M3 listens to the story.

M1: … before I went home we did our review, I was asked to do another examination to find out whether she'd progressed from the time before and I really wanted her to have progressed and I said well I think it's changed a little bit … and then they did the assessment, another one … the Reg did one …

M2: How many VEs (vaginal examinations) did this woman have?

M1: I didn't count. She thought it was less than that … she was still 5cms at five o'clock.

M2: But when you did that VE I was still there for that bit and you said oh she's gone to 5 cms the Registrar said what was she at blah blah and you said oh she was 5 … and then the Registrar looked at (core midwife) and said who checked it? And (core midwife) said oh (charge midwife) did … and the Registrar said oh right, that must be right then.

M1: Yeah I heard that too and I thought oh … but on the other hand … I just … I still feel uncertain about my VEs … and I'm really happy if someone checks them … and if that's what they need to believe well that's fine … but in a few years time

M3: It undermines us …

M1: No, at this stage it doesn't undermine me … if they did it in 2 years time when I'm certain about my VEs I would stand there and say hey no, that was right. Because that's what you do when you know for sure your facts. But I

didn't know for sure. So it didn't bother me that much … (Group 'three', first interview)

Foucault discusses the role of the examination in the hospital as that which "…combines the techniques of an observing hierarchy and those of a normalizing judgement" (Foucault, 1977:184). In the interview excerpt above, the examining registrar is attempting to establish the bio-medical truth of the birthing body. Predominant discourses within western medicine state that this truth will lie within the interior of that body, in this case, that the cervix of the labouring woman will dilate by the appropriate amount of centimetres within a prescribed and normative time span. The Registrar clearly observes a midwifery hierarchy of knowledge ascending from the new graduate, whose judgement may be precarious, by-passes the back-up midwife M2, through the core midwife, who will know who checked the work of the new graduate, and reaches the charge midwife, whose opinion is taken to be authoritative. This is an example of the 'upwards continuity' in the governance of childbirth when it remains institutionalised. The pedagogical formation of the new graduate; that is, the 'induction' of her own 'labour' is hailed into and under 'cover' (see chapter six) of the obstetric establishment through hegemonic medico-legal discourses. In the case of this example, these discourses establish verification of the 'truth' through the visualisation and/or penetration of the interior space of bodies across grids of time.

How might this feel empowering, and to whom?

'Praxis' as a concept has been used by critical and emancipatory nursing and more recently, by midwifery academics, for a number of years to imply an integration of theory and practice to various extents, and to combine reflection with action (Seng, 1998; Skinner, 1999; Spitzer, 1998). Discourses of empowerment for women and midwives through emancipatory action and reflection on practice underpin the New Zealand Midwifery Partnership Model (Guilliland, 1998b; Guilliland & Pairman, 1995; Pairman, 1998; 2002a; Smythe, 1993, 1998; Tully, Daellenbach, & Guilliland, 1998). As midwifery students accept the responsibility for their own learning (Smythe, 1993), so also midwifery "accepts its responsibilities as an emancipatory change agent" (Guilliland & Pairman, 1995:1). But the concepts of emancipation, empowerment and praxis are problematised within postmodern thought (McNeil, 1993; Seng, 1998; Spitzer, 1998; Wilson-Thomas, 1995) as is indeed 'feminism'. Other theorists suggest that there is an explorable nexus between feminist praxis and

poststructuralism (Davies, 1998; Flax, 1993; Francis, 1999; Fraser & Nicholson, 1990; hooks, 1994; Lather, 1991a, 1991b; McNeil, 1993; Ramazanoglu, 1993; Weedon, 1999; Zalewski, 2000).

The narrative content of the interviews with new graduates in particular as well as those of the established practitioners demonstrate both the themes of constraint and complicity ('you learn very quickly which questions to ask, who to ask and when to shut up') which are addressed in feminist poststructural critiques of 'empowering', 'emancipatory' and otherwise liberatory pedagogies. These critiques suggest that if these pedagogies remain based on the power of the rational argument and universal processes, rather than on the historically and contextually-mediated contexts within which teaching/learning subjectivities are constituted, then complex relations of ruling persist (Gore, 1993; Luke & Gore, 1992; Matthews, 1996; Popkewitz & Brennan, 1998; Rathgen, 1996). Orner's work on pedagogies of empowerment suggests that these discourses "are premised on the assumption of a fully conscious, fully speaking, 'unique, fixed, and coherent' self" (Orner, 1992:79). Orner argues that discourses of liberatory pedagogy which claim to empower learners do not overtly support relations in which those learning 'are monitored by others as they discipline themselves', and that when these processes are conceptualised in discourses of 'empowerment', they function to perpetuate relations of domination in 'the name of liberation' (Orner, 1992:75).

New midwifery graduates have contradictory, shifting and unstable multiple subjectivities; and fragile and complex allegiances, and these are always negotiated within, and guided by, constraints. They are no longer charged with the responsibility for their own learning as a student, but now as a practitioner for 'assisting women in the emergence of consciousness and their different ways of knowing in order for them to speak with their own voices', so that the midwife and woman both are 'mutually empowered' (Guilliland, 1998b; Guilliland & Pairman, 1995). But the complexities, confusions and chaos often encountered in the transition period from new graduate to established practitioner may overwhelm rather than empower at times, as the nostalgic note in the comment below appears to indicate:

> I was talking to someone yesterday and I said I went into midwifery and I had this absolute belief in birth … this whole-hearted belief that birth was normal and it was those bastards out there that really stuffed it up … you know, the medicalised model … and then I did three years of training and I've done what I've done and it's like now it's like … I'm responsible for the safety of this woman and this baby … nobody else…and the head is nowhere near the pelvis

and she's forty-plus weeks … and I think cord round the neck … you know…
and it's all these things that are kind of in my head, but I would never have
thought about that before… I just would have said, oh, some babies just don't
go into the pelvis and I don't … I mean I would have thought that because I
haven't got the experience to sort of back it up. So it's very easy when you're not
responsible for the safety of the mother and baby to say but of course this is
normal. I don't know if it's normal. I literally do not know what is going on with
this woman. (Group 'two', second interview)

When new graduates begin to address the 'conflict and contradictions between the dominant
institutionalised medical model and women's knowledge and experiences in childbirth' (Tully,
Daellenbach, & Guilliland, 1998), on a practical level it seems, to many of them, that there are
as many conflicts, complexities and contradictions within the institutionalised medical model,
and within women's knowledge and experiences in childbirth, as there are between them. The
midwife in this context was talking about the ways in which she strives to 'normalise the
abnormal' at the same time as negotiating her own limits, and reflecting on and monitoring her
own performance. Her talk can be seen, in Burchell's terms, as reflecting the
'responsibilization' that comes with freedom.

Similarly, when a core midwife's practice always occurs under the more immediate panoptic
gaze of medicine and the law, there are others she will be accountable to for her practice,
which may take precedence over the desire to support graduates whose new ways of doing
midwifery may well represent a cultural crisis within the institution. Orner addresses these
pedagogical conflicts within as well as between subjects of knowledge in her exploration of
disciplinary technologies of self-surveillance (Orner, 1992). Further, Gilbert (2001) warns of
the limits of liberatory educational theory in that it cannot account for the newer forms of
disciplinary surveillance. These are the forms I have explored in this chapter; those very forms
designed to produce subjects of freedom and autonomy through multiple systems of gentle
guidance, such as 'quietly watching'.

The emancipatory responsibility accorded to midwives seems undermined when the majority
of women call for institutionalised births. And the responsibility of the student to learn, and
autonomy of the new graduate to practice, may be similarly undermined, if processes of
disciplinary normalisation and surveillance serve to homogenise the practices of new
practitioners. This may occur when policies and protocols structure the field of possible action
for the midwife, requiring that in the interests of obstetric 'safety', midwifery knowledge

becomes subverted to the requirements of the institution. At the same time, these processes reveal some spaces that new practitioners are able to move into as discursive – and real - sites for resistance.

The explorable nexus between feminist praxis and poststructuralism is a productive one for midwifery whose subjects have complex and contradictory, as well as coherent, aims. Partially as a result of their DEM training, new midwifery graduates can be seen to inhabit this nexus. They are critically engaged with the praxis of complex midwifery issues, which have been explored in the previous chapters. They inhabit the nexus of praxis as a liminal space, one of freedom and constraint, reinscription and resistance, sublimation and subversion. They dwell on the borders, in the 'grey zone' of ab/normal birth, where once stable meanings of 'normal' are endlessly fractured and deferred. In the following and final chapter, I explore aspects of a metaphorical and politicised midwifery 'sisterhood', that returns to, and draws on my earlier metaphors of the cyborg and the goddess.

8

Chapter Eight

In/conclusion: Goddess, cyborg, hybrid or nomad? Imagining postmodern midwifery subjectivities

Re-conceptions…

I began this thesis by proposing to explore issues in midwifery in Aotearoa/New Zealand as a discourse that has emancipatory/feminist goals. I intended to do this by analysing texts generated from my conversations with midwives about the issues they identified as important to them. My primary interest in this was to explore the ways in which these emancipatory goals are discursively articulated, produced, received and resisted by differently positioned midwives, within the constraints of the current maternity market place. I did not consider medicine/obstetrics as essentially repressive, nor midwifery as essentially liberating. Instead, I have examined the ways in which midwifery goals constitute a countervailing discursive response to the dominant medicalised model of childbirth. This has involved asking a number of questions influenced by a Foucauldian approach to knowledge/power and the analysis of different discourses.

The questions addressed through this project include: what acts to constrain or limit the goals of midwifery as a feminist profession if it is constructed in dualistic opposition to the medical hegemony of obstetrics? What are the effects of this strategy, on women, and on midwives? In what ways, if any, might there be increased surveillance, monitoring and regulation of midwives, within medicine, the law and media? How can midwives speak about the practice of midwifery? What can be said about it, and under which conditions? What different discourses traverse the bodies of childbearing women, and the practices of midwives, and with what effects? What knowledges about childbirth become authoritative, under which conditions? What conditions might contribute to the development of a 'midwifery gaze', or to the 'midwiferication' of birthing bodies?

The following section begins with a discussion of the conditions, constraints and potential for the (re)production of midwifery knowledges and praxis. This is followed by an exploration of

issues relating to the contemporary midwifery concepts of 'choice, continuity and control', and their relevance for this study. The final section, 'nomadic midwives: neg(oti)ating normal', is designed to facilitate thinking about midwifery knowledges that are constructed out of the dialogues I had with midwives, and witnessed in my observations of them labouring with women. I draw on feminist theories of cyborg bodies and nomadic methodologies (Braidotti, 1994, 1997; Fox, 1999; Kirkup, 2000; Lykke & Braidotti, 1996), to explore contemporary theories of postmodern midwifery subjectivities.

The thesis examines the ways in which midwives are constituted as maternity service-providers within a neo-liberal approach to health. The women they serve are constituted as consumers as part of a legacy of neo-liberal rationality, and from within various strategic professionalising discourses of midwifery itself. In these ways, midwives are amenable to forms of governance, and so too are women in their care. Midwifery interactions with other actors such as the women for whom they care, other midwives and obstetricians, intersect at what is analysed as a governing interface. The professionalising project undertaken by midwifery is critically explored in this way. Both self-employed caseloading (LMC) midwives and hospital-employed (caseloading or core) midwives work with a range of actors as part of a complex network of relationships, knowledges and technologies. Through these 'traceable' networks, differing pregnant bodies are produced and embedded in partnership with midwives.

Pregnant bodies as consumer bodies are in themselves historically located and constructed bodies with specific needs and requirements. The dominant assumptions located in this thesis are those contained within neo-liberal and liberal feminist discourses and practices which contribute to constructions of consuming bodies as coherent, unified, rational actors. In this context, the bodies predominantly produced have choices and can be expected to want to exercise these; they should be pain-free because they can be pain-free; they should avoid all possibility of actual or potential risk; they should expect to consider the foetus as a visible and hence knowable subject/artefact separable from women themselves, but for whom women are responsible. In decision-making processes it is assumed that these bodies will want to be rational and responsible (for the foetus) in the choices made (in choosing safety over risk, the absence of pain over presence of pain, visibility/knowledge of the foetus and so on). Further, consuming bodies should be able to predict and control all they experience if these appropriate choices are made, but if these experiences are not satisfactory, or, indeed, 'go

wrong', despite the degree of self-responsibility accorded, they should be able to hold others accountable for this dissatisfaction or failure. The midwives I spoke to engaged with this liberal rationality in different ways. Some of their actions are seen to re-inscribe different pregnant bodies in these ways. Other actions were taken up with women to resist and re-negotiate predominant discourses about pregnant and labouring bodies as inherently risky.

In order to work as a midwife after their education and registration, midwives are interpellated into complex networks of diverse knowledge fields drawn from psychology, small business management, medicine, human relationships, food health and safety, medical imaging technologies, medical laboratory tests and techniques, anatomy and physiology, foetal ill/health, pharmacology, pathology, the correct establishment of breast-feeding techniques, foetal heart-rate monitoring, midwifery knowledges and theories, serial scanning, natural medicine, genetic counselling, pre-conception care and fertility enhancement, medico-legal processes, computer informatics, models of holistic health, healing and wellness, infectious disease and its control, clinical governance and procedural auditing, the basics of some anaesthetic processes, homeopathy, neo-natal intensive care and so on. These fields broaden constantly, and new fields of knowledge/power are constantly produced.

What the proliferation of knowledge-fields means in terms of many individual midwives' scope of practice is frequent up-skilling, post-graduate education of various sorts, continual reflection on practice, attendance at standards review, finding a mentor, maintaining a professional portfolio, increasing marketability and over-all self-improvement. This self-improvement is chosen freely and rationally, as part of being an autonomous practitioner. It is understood as arising naturally from within a responsible and professional self, responding to the choices and requests of women, rather than as the effects of discourses of professionalism. The more a midwife can offer in the (quasi-)market place of birth, the better: "I've just done a reiki massage course and want to offer that as well to my clients; I can offer the full smorgasbord of medical stuff, now I want to balance it up again" (Bess).

It is significant that a new graduate practice who had been initially reluctant to obtain epidural certification because of their philosophical beliefs about birth, had already had the experience of 'losing a client'; a woman who had decided not to birth with the particular practice because she wanted epidural pain relief. Treichler's statement that the language of the marketplace

pervades discussions of childbirth is evident in the talk of all of the practising midwives I interviewed. It exists in terms of both the reproduction of marketplace discourse, or in terms of on-going renegotiation of and resistance to the idea of the 'business or for-profit model of birth'. I highlight in chapter four in particular some of the ways different midwives engage in these complex and on-going renegotiations about the 'business of birth'. I suggest that whereas a decade ago midwives were in competition with GPs, they now occupy a particular type of quasi-market whereby they are effectively in competition with each other as they provide women with choices. Some of the complex and possibly unintended effects of this competition between midwives were explored in chapter five.

This thesis has examined the implications for midwifery scope of practice of a 'women's choice' discourse, with a particular focus on the choice for epidural analgesia in an otherwise normal pregnancy and labour. Many midwives spoke about the proliferation of choices and of the importance of women's choices for birthing in a range of areas: whether to have a GP or obstetrician involved concurrently, whether to have an induction of labour, a homebirth or an elective caesarean birth. In these discussions of choice, most midwives spoke to me about the impact many women's choice of epidural pain relief has on their scope of practice and preferred place of practice. The significance of these findings was supported at the 2002 NZCOM conference where this particular issue and the complex relationship of choice to increasing intervention was noted both nationally and internationally (McAra-Couper, 2002; Savage, 2002).

I have identified some of the ways differently-positioned midwives negotiate the right of birthing women to choose epidural pain relief in other-wise 'normal' labour, and how midwives might respond to these choices in practice. In my analysis of these tensions around consumer choice and professional practice I re-visit previous feminist critiques of medicalisation. Differences in feminist thought about medicalisation hinge on an array of approaches to theorising about biomedical technology as well as about gender. The participating midwives highlighted these points of tension between different feminist viewpoints as they spoke about the relationships between women and medical technology. My analysis has stressed the importance of attending to the ways in which midwives-being-with-women is constituted within discourses and practices that utilise liberal-humanist notions of choice and empowerment which may be contested by other forms of knowledge about

childbirth. In my analysis of interview extracts in chapter five, I explored ways in which the midwifery value of continuity of care is especially important to midwives in mobilising a discourse of empowerment, and shaping some midwives' decisions to maintain an epidural certificate. Accessing the professional skills to monitor epidural pain relief broadens their scope of practice, encompassing secondary as well as primary care. The valuing of individual women's choices, and the desire to stay with the woman throughout her childbearing experience is one rationale for acquiring the epidural certificate. The skills that are developed and crafted, however, are necessarily based on medico-legal technologies.

For other midwives, re-valuing and developing different forms of midwifery knowledges and practices related to pain are important in their rejection of epidural certification. They talk about pressures on them from midwives with epidural certificates to acquire such certification, to provide backup or to relieve pressure on core midwives in a busy labour ward. The self-employed midwives I spoke to who did not yet have, or did not want their epidural certificates, often saw themselves as occupying a position frequently interpreted as resistant or transgressive. Frida highlighted this well: "but the more midwives that get them, the more difficult it is for those of us that don't … because we feel the pressure of the charge midwives on labour ward saying to us, 'have you not got your epidural certificate?' or… 'you should have these things, so you can offer the woman choice". Partly to maintain the market that individual midwives have gained, many midwives provide what many women want in childbirth. Their midwifery labour and technologies of the self will then be designed to mediate the effects of the possible cascade of intervention into the birth process.

I argue that the very existence of epidurals-in-normal-birth has set the terms of the debate; midwives/women are interpellated into the discourse in some way regardless of their position on it; it can be resisted, but not ignored. Choosing, or rejecting, an epidural as pain relief in normal labour provides subject positions for women in discourses which arise from different feminist analyses of embodiment, choice and empowerment. On the one hand, empowerment is seen to rest in women's emancipation from bodily processes, by avoiding the pain of childbirth using all available medical technologies ('cyborg' midwives/partnerships). On the other, and as part of a different claim, empowerment is constructed through and in the naturally birthing body, and is manifest in the refusal of the epidural, even if this refusal is temporary. Rosalie, a birthing centre midwife, spoke of a case where there was initial strong

resistance to hospital pressure for an epidural, followed by the woman's decision for the epidural ('goddess' midwives/partnerships). This may be seen to further a practical goal of experiencing normal/non-interventionist birth, and for some midwives, acting as guardians of normal or 'natural' birth. I have argued, following DeVries, that the very presence and availability of medical technologies acts to diminish some other midwifery skills, as well as significantly altering the sources of knowledge and hence power-relations that surround birth, and which may be seen to fuel women's desires and choices (and see DeVries, 1993; DeVries, Salvesen, Wiegers et al., 2001). The knowledges and practices developed are based around hegemonic assumptions about female (particularly when pregnant) embodiment, largely concerning its inherent leakiness, fallibility and risk.

This thesis has also explored the ways in which midwives become objects and subjects of accountability. Discourses of '(self-)defence' were predominant within the midwives' narratives of their working to respond to women's desires for pain management. These were identified in the talk that was structured around an awareness of consumer desires and choices as increasingly complex; a feeling of the weight of responsibility both for the women's safety in and/or to the institution; and actions taken to 'cover' oneself in response to what can effectively be seen as a highly complex and contingent 'risk' culture of birth/work. These resources are drawn on in response to increasing and shifting discourses of risk that encompass cultural, political, professional and personal domains as well as those underpinning medico-legal knowledge of the body.

Predominant obstetric discourses and practices around risk begin with the concern to imbue the foetus itself with a certain subjectivity via the techniques of visualisation (Treichler, Cartwright, & Penley, 1998; Weir, 1996), monitoring and surveillance (Arney, 1982; Clarke & Olesen, 1999). I argue that midwifery's counter-negotiations begin at this point.[49] Responses of 'safety' to 'risk' can then be traced upward through the discourses and practices of self-responsibility, autonomy and accountability beginning with pregnant/birthing women, the midwives, their mentors and/or business practice partners, supervising and/or charge

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[49] In the holding of a philosophy of being 'woman-centred', rather than 'foetus-centred'; this position itself acts as a critique of obstetricians in their practices as foetal 'champions'(Cartwright, 1998; Casper, 1998a).

midwives. Finally the profession of midwifery as a whole is frequently called upon to 'defend' itself as a result of these negotiative actions.

My interest lay in exploring the effects of these issues on midwives' actions and practices in working with women. The freedom from overt control that arises out of their status as autonomous professionals in the birth/marketplace generates the contemporary pressures to be accountable and exercise self-surveillance. The thesis highlights the actual tightening of constraints that takes place as part of the governance of labouring bodies, whether performing birth, or midwifery labour/work. These things occur within spaces that are now considered to be spaces of relative 'freedom' within neo-liberal discourses concerning consumers and providers (freedom of women's choice/autonomous practitioner). New subjectivities are thus shaped and constrained within rationalities of freedom, and 'responsibilization', rather than domination, and are constructed thus from a distance, and with a lighter touch.

I suggest that proliferating, multiple discourses of risk that are contested and negotiated by midwives now may have replaced the rather more central and dominating ideology previously described as 'medicalisation'. Nevertheless, discourses of risk are articulated within and disseminated from the panoptic eye of the base obstetric hospital which functions to maintain hegemonic medico-legal discourses and practices around childbirth. Homebirth is not outside this gaze; it lies at the outer periphery. I have argued that a critical approach to risk must include a simultaneous discussion of governmentality, because 'risk' is brought into being through the discourses, practices, technologies and institutions geared to the management and (self-) regulation of citizens. Risk is always operationalised in the production of certain forms of subjectivity. Hence, 'risk' is not a real or self-evident thing in itself, but can be considered a product of historically and politically contingent ways of seeing. The proliferating development of categories for pregnancy such as potential or growing risk, with a concomitant focus on foetal surveillance and monitoring, exists as evidence of the changing orientation of obstetrics. I have explored the way this surveillance permeates engagement with women's bodies and, increasingly, those of their foetuses', and explored the implications for the governance of pregnant bodies via the penetrating obstetric gaze. Partly because pregnant women are constructed as active and responsible consumers, increasingly the passive foetus, itself, becomes hailed as a potential patient (Casper, 1998b; Newman, 1996; Treichler, Cartwright, & Penley, 1998; Weir, 1996).

I argue that, for midwives in their varying negotiations and contesting of these discourses, 'risk' can be located both in an embodied sense and spatially/geographically. It exists both inside and outside the body, and inside and outside the space of labour ward (and see Armstrong, 2001). I argued that self-employed midwives must continually act to (re)negotiate the safety/risky space of the labour ward while balancing risk to the woman (cascade of intervention) and risk to the practice of the midwife (fear of litigation). Realist/medical discourses of risk locate risk inherently inside the pregnant body; something to be actively 'managed', 'minimised' and contained within the 'safe space' of labour ward, where everything is 'on hand', or 'at the press of a bell', and cannot be seen separately from minimising risk to the midwife's reputation as a 'safe practitioner'. For other midwives and women, risk lies outside the body, within the space of labour ward itself, and the potential for the cascade of intervention, bringing with it iatrogenically-induced risks to the well-being of the woman and foetus, is also very real (Annandale, 1988; Kent, 2000; Lane, 1995; Papps & Olssen, 1997; Pollock, 1999). These fluid and spatial risks were talked about within discourses I analysed of 'covering' vis-vis 'exposure'.

My analysis in chapter six focussed on the ways in which maintaining a normalising discourse where risk in pregnancy/birth lies in the discourses and practices of labour ward itself, constitutes some midwives (and some, such as new graduates, more than others), as risky practitioners. Midwives who adopt such critical discourses and resist interventions in partnership with women are liable to draw attention from some hospital staff (doctors or midwives) and expose themselves to added surveillance, criticism or complaint from hospital management, the women's GPs, the Nursing Council, or a number of other sources. This is because hegemonic discourses of obstetric safety privilege geographical proximity to technologies of monitoring and surveillance, despite evidence to the contrary in terms of outcomes for birthing women (Cartwright & Thomas, 2001; Murphy-Lawless, 1998; Pollock, 1999; Tew, 1995; Wagner, 1994, 2002).

Midwives' actions with birthing women are therefore conducted in ways that continually re-negotiate these simultaneous spaces of risk/safety. Within these spaces, partnership is constituted in capillary networks of power/knowledge, in the effort required by midwives themselves to cover themselves and document the actions taken (Pearse, 1996); the scripting of accountable bodies as 'auditable subjects'. Midwife-attended birth, seen essentially as

'normal till proven otherwise' in response to the obstetric dictum 'only normal in hindsight', is now re-constructed as: 'normal thanks to foresight'. Smythe, in her exploration of the meaning of safety for midwives, suggests that: "they must achieve an alchemy of knowing that prompts them to act with the wisdom of hindsight, foresight and nowsight" (Smythe, 1998:241). This occurs as the effect of the processes of what some midwives called 'advance self-defence'; the disciplinary normalisation of/by midwives in childbirth.

The threads of 'upward continuity' (Faubion, 1994; Foucault, 1979) are evident in the micro-spaces of the governing interface between the woman and the midwife. This occurs in the attention to documentation, to monitoring, or deciding not to monitor, or to monitor intermittently, things like: the growth of and heart beat of the foetus, the body of the pregnant/birthing woman (blood tests, urine, blood pressure, weight, scans, cord pH), and the actions performed and statements made, or not made, or made and (re)qualified by the midwives in response to the desires of birthing women. In these and other ways midwives construct themselves as 'safe' practitioners in the 'advance defence' of present practice, in case they are called to account in the imagined future. Natalie, a self-employed midwife, explained this well: "… we live in a litigation world and that means that we do things that are defensive practice …we do things to cover our butts …to be able to account for what we've done …" Natalie's narrative positions birthing women within fields of knowledge concerning their own particular pregnant bodies, that are shared by the midwife, but that may be contested by other authoritative and predominant forms of knowledge about pregnant bodies.

As I analysed the material generated through interviews and fieldwork, I began to wonder if being a midwife was something of an impossible task. I felt a degree of anxiety about constructing a thesis which seemed to focus on the most challenging features of a profession that had only recently regained its status as an autonomous profession. Yet, like other feminists doing research with midwives, I also felt a strong commitment to writing about the messiness, confusions, complexities for and constraints on practice, given that midwives themselves spoke about these issues, and identified them as highly important to them (and see MacDonald & Bourgeault, 2000; Sharpe, 2001). I found myself doing a mirroring balancing act: wanting to balance my desire for '(t)ruth telling', without disrupting the emancipatory gains already made at this historical moment, just when to 'speak' as a midwife with an

autonomous professional identity based on facilitating women's voice/choice, has become possible.

These questions also influenced my decisions not to include some details of specific midwifery knowledges and practices. I assume that in the main, midwives and midwifery educators will engage with this thesis, yet I have still taken precautions to avoid exposing some knowledges and practices that may simply be seen by others as 'too' transgressive (and see MacDonald & Bourgeault, 2000, who refer to these as 'shadow stories'). These practices are within the grey zones, the liminal spaces of postmodern praxis where new midwives strive to 'normalise the abnormal'. As Rea Daellenbach has said about the politics of research with midwives: "the thesis is as much about what gets left out as what gets included" (in personal conversation with me, 2000). The figuring out of these issues, to circle back to chapter three, midwifery and me(thod/ology), partially constitutes this project with a validity that according to Fox is a 'transgressive validity'. This is because as a project/subject 'on the margins' and that/who dwells in the borderlands between theory/practice, I imagine this research/I will "transgress, challenge, or subvert existing conceptions" (Fox 1999:186). This will happen un/intentionally as part of the process of 'be-coming' researcher/myself.

I listened to the battle-weary narratives of midwives who seemed to spend much of their working lives in self-defence mode, working hard to construct their 'advance defences' as they responded to women's desires for the management of pain, or responded to hospital discourses on risk. Yet they all had reasons for continuing with midwifery, even if doing so had taken enormous personal tolls on self-esteem, relationships and health. I became interested in how midwives, particularly new midwives, integrated these very different forms of knowledge into their actions as midwives with women; how they negotiated and navigated their way around the highly complex, contested and volatile terrain of childbirth and maternity service provision at this particular historical/spatial juncture. The networked relations that govern these negotiative processes were the focus of chapter seven.

I was especially interested in the ways in which some midwives come to reproduce, and others to negotiate and/or resist, midwifery discourses and practices of woman-centred and normal birth within different labouring/birthing spaces. These actions occur in what can be seen as a mutually negotiated constitution of labouring bodies within pedagogies of partnership, at

multiple sites of midwifery knowledge production. Chapter seven concluded by examining some of the ways in which new midwives establish themselves as confident practitioners through a governing process whereby external surveillance becomes gradually less important than the discourses and practices of self-monitoring and self-regulation that are involved in learning to 'keep safe'. These technologies of the midwife/self are undertaken in partnership with the woman; that is, in the professional responding to her contemporary choices.

What might the future hold, if the management of pain and risk in childbirth should remain a central focus for the majority of childbearing women in Aotearoa/New Zealand? The thesis has undertaken a discursive exploration and analysis of the issues outlined above, without attempting to answer the questions. It explores the recreation of midwifery as a feminist profession, which can be seen in Aotearoa/New Zealand as a countervailing strategic response to various historical de-skilling or demarcation attempts by the profession of obstetrics to control the practice of midwifery by female midwives. But in what ways might counter childbirth discourses be always already constrained by the mutually constitutive and intertwined requirements of the law and medicine?

I have used insights from Foucault's work in this thesis to show how juridical and medical systems of power produce the subjects they subsequently come to represent and to raise several points for speculation. Firstly, that these discourses, both hegemonic and counter, exist within a panoptic visual field which radiates out from the central 'eye' of the base obstetric hospital. Secondly, that the way that this control is maintained is largely through the governing discourses and practices of surveillance and monitoring (and see Arney, 1982; Murphy-Lawless, 1998; Williams, 1997). Thirdly, that these discourses give an illusion of freedom and choice while simultaneously producing normativity and regulation. Finally, that the circumnavigation and the learning of these processes leads to the increasing self-defence of midwives through the self-regulation, discipline and control that can be seen in Foucauldian terms as the ultimate goal of a panoptic visual field. In this case, the obstetrical bid to hail foetal subjectivity and perfection via the simultaneous governing of pregnant bodies, and the labour of midwives, is important (Davis-Floyd & Dumit, 1998). The actions of midwives are unwittingly reined in more and more tightly towards a precise moment of potential; that which obstetrics decides is 'life' or 'death' (Murphy-Lawless, 1998).

What lies and is dispersed always from between these dichotomous states is 'risk'. Medi(c)a(l) dramas of risk incite fear within the public arena.[50] Childbirth is presented as always-already risky to a greater or lesser extent, whilst some midwives are represented as potentially unsafe; even as midwife-only care continues to achieve lowest mortality and best cost-effectiveness (Guilliland, 1998a; 1999; 2000). Medi(c)a(l) attention to what 'could go wrong' functions to maintain cultural hegemonic discourses of birth-as-horror, effectively promoting an obstetric/technological approach as the 'safest choice' in the marketing and management of pain and risk-free childbirth. In this lies a paradox for midwives, according to DeVries, whereby professional prestige and power are generally accorded to those who create and then manage risk on technological terms. Claiming expertise in low-risk birth may inadvertently threaten professional credibility for midwives, he suggests. He wonders whether in enhancing their future status, midwives may also need to renounce their tradition, eventually becoming unrecognizable (DeVries, 1996).

These concerns of DeVries' bear some similarities to those of Winch et al (2002), who note that as soon as nurses take up the discourses of 'evidence-based' practice, they are then faced with returning to a purely scientific model of knowledge construction which subsequently governs practice. Many midwives I spoke to valued multiple forms of knowledges, including those embodied knowledges such as 'intuition', 'gut feelings', or 'practice wisdom'. The discourses and practices of evidence-based midwifery are seen as just one discursive resource to be deployed critically in the challenging of obstetric relations of ruling. The suggestion made to me by most midwives is that scientific, evidence-based knowledge supports, rather than supplants, forms of midwifery practice that facilitate low-intervention birth. However, I contend that principles of evidence-based practice have the potential to govern individual midwives, if certain embodied knowledges become sublimated, and to govern the profession of midwifery politically (see Winch et al, 2002:160). This thesis suggests that, in response to these dynamics and dilemmas, midwives must become hyper-vigilant and pre-occupied with re-acting and re-positioning themselves ('safely') as a large part of their professionalising project. These actions are seen to increase the potential for the amenability of midwives and midwifery to forms of governance.

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[50] The NZCOM also maintains a strong media presence in its counter-discursive challenging of hegemonic (mis)representations of childbirth and midwifery.

Of mutual incitements and sets of struggles…

The methodological and theoretical issues I describe here and address in the thesis are played out more generally within the tensions between feminist poststructuralism and the need for a certain strategic essentialism in women's health/research. Midwifery, (re)-produced as a feminist profession in Aotearoa/New Zealand, is now at a historical juncture with respect to these tensions. The issues for midwives are reflected within the questions debated within contemporary feminism; does poststructuralism threaten the possibility of a politically engaged feminist analysis? Do we still need totalising concepts (eg. 'women', and the 'pregnant body') in the service of a feminist politics? (Butler, 1990; Flax, 1993; Fraser & Nicholson, 1990; Miller, 2000). I might ask (again without 'answering'): in what ways does midwifery (still) need a strategic reliance on stable, coherent, fixed, and unitary identities of 'consumer' and 'midwife' as a basis for the construction of the 'partnership' that is seen as underpinning midwifery practice? Also, given that midwifery has emancipatory goals, do alternative formulations of those identities also achieve emancipatory goals, or do they undermine those goals altogether?

Spivak reinforces the importance of beginning to theorize 'difference' within a subaltern group such as midwives, by noting that there will be a historical and contextual 'critical moment' when a mobilising sign such as that of 'women' begins to reap emancipatory success. At this point in time, she notes, the partial and particular interests invested in the sign must become 'scrupulously visible political interests' and its representatives engage in an on-going (de)constructive critique of the theoretical sign (Spivak, 1993). Midwifery is at this social and historical juncture in Aotearoa/New Zealand now. A certain success has developed from second-wave feminist investment in both signs 'woman' and 'midwife'. This success is exemplified in the establishment of (birthing) choices for women and (professional) autonomy for midwives. Complexly, these speaking positions co-exist with the historically contextual production of different consumer or client subjectivities. Central to these debates within feminism and midwifery both is the issue of 'choice'. This issue is addressed in chapters three to five of this thesis as part of a legacy of neo-liberalism specific to midwives in Aotearoa/New Zealand during the last two decades. Below I address it again briefly, but with more reference to general midwifery goals of choice, continuity and control.

Choices, contexts, (controlled) chaos…

Raymond's analysis of the medicalisation of women's reproductive bodies stresses an approach to medical technologies that asks not 'is this natural?' but 'who does it serve?' (Raymond, 1993:87). She suggests that an uncritical focus on choices-as-always-positive for women, in the area of reproductive technologies, fails to take account of the ways in which choice and consumption are collapsed together, or to take account of the ways in which medical-technical expansionism is represented to different women. Her work is useful, not in its limited defence of different standpoint feminist positions, but in its rather more constructive consideration of choice, context and consumption.

Similarly, Davis-Floyd analyses the ways in which some contemporary home birth midwives appropriate what they see as 'qualified' elements of commodification and consumption discourses in shifting, creative and ambiguous ways, in the crafting of their identities as both cultural and political agents (Davis-Floyd, forthcoming). These analyses resonate with the stories some midwives told me about the establishing of their identities as professional women, needing to make a living and with a business to run. They describe the ways in which their midwifery woman-centred philosophies exist in tension with and are (re)negotiated alongside the complex roles they also play as midwives in the construction of women as 'consumers' of a maternity service.

These issues are being played out currently amongst international midwifery theorists (Lazarus, 1997; Mander & Fleming, 2002; Sandall, 1995; Stapleton, Kirkham, & Thomas, 2002). Of recent interest has been a large Welsh midwifery study which demonstrated that because of the widespread belief that more rather than less technological intervention will be viewed positively in the event of litigation, 'informed choice' offered by health professionals including midwives could more appropriately be seen as 'informed compliance'. The study suggests that fear of litigation, power hierarchies, and the technological imperative in maternity care limited the choices available, and that professionals promoted 'normative practices' rather than choice (Stapleton, Kirkham, & Thomas, 2002).

My study supports this in exploring how 'choice' is not a thing-in-itself, but is produced out of complex networks whereby the midwife and woman are positioned in dynamic and coterminous relationships. The broader context, for midwives working in Aotearoa/New

Zealand is the legacy in health fields of the discourses of neo-liberalism and the practices of self-responsibility. The discourses of liberal feminism, emancipation and empowerment within midwifery itself, also governs the conduct of midwives. Most midwives in my study were able to establish themselves as professional midwives working with women or in a woman-centred way if they responded to the choices and desires of women. The catch-22 is that many women are choosing approaches to childbirth that necessitate interventions that some midwives would identify as 'medicalisation'. Furthermore, some midwives appear reluctant to challenge these particular choices, even 'armed with the evidence' to ensure 'informed' choice. Discourses supporting women's freedom of choice prevail over other discourses at this historical point.

Within the context of freedom of choice, midwives' provide the continuity of care women-as-consumers have come to expect, and follow women to the places they choose for birth. The care must incorporate actions to cover women and midwives themselves from the potential medico/legal effects of the cascade of intervention that might occur at a base hospital, or from their exposure if they remain in a 'grey zone'. Many midwives suggested to me that when choosing a hospital-based birth and forms of pain intervention like epidurals, women feel in 'control' primarily because they have a midwife with them throughout to mediate and negotiate aspects of this experience. When women feel in control, and care is continuous, midwives are able to articulate this via a discourse of partnership, regardless of the place of birth or interventions undertaken. Importantly, some midwives explained to me their own rationale for swaying some women's decisions towards birthing at the base hospital, where they, as the midwife, felt 'safe' and 'in control' of their actions. In what ways then, might the desires of some midwives to feel safe and in control as practitioners, govern individual practices, and constrain a more forceful political challenge to institutionalised birth?

In a recent British critique of medicalisation, which explored the role midwives play in these processes, the authors suggest that "medicalisation of the environment could be the dominant effect in the United Kingdom, over-riding potential benefits of continuity and knowing your midwife" (Johanson, Newburn, & Macfarlane, 2002:5). Calvert has also recently explored the apparent contradiction in the success of midwifery as a profession in Aotearoa/New Zealand, while interventions and operative deliveries increase for women. She notes that in countries without midwife-led births, epidural analgesia and caesarean sections are also increasing, and

suggests, as I do, that "fears of litigation and consumer demand [are] two possible explanations that require investigation to assess the impact that they are having on the birthing outcomes of women" (Calvert, 2002:137).

Bogdan-Lovis examines the idea of choice in her description of liberal feminisms' failure to influence childbirth in the USA. She suggests that second-wave liberal feminists stopped short of putting forth an agenda that may well have generated a de-medicalisation of childbirth experiences, such as birthing outside a hospital. Her two-fold analysis hinges on a) the ways in which the construction of the new choices made available by liberal feminist responses to medicalisation relied on the expectation that women would choose de-institutionalised birth, if they could, and b) the ways in which institutions in turn overthrew any effective exercising of choices by incorporating their practices (such as the attendance of a support person), into their procedures. Bogdan-Lovis states that in this way "…the institution structured the range of available choices, and in so doing, covertly structured the experience to fit within institutional guidelines and meet corporate needs" (Bogdan-Lovis, 1996-97:68). Treichler has argued that a central paradox in contemporary childbirth as a 'set of struggles' is that:

> …as struggle and counter-struggle seek to define their own limits, they may grow closer together. An innovative structure – or a deviant definition – lives a double life, for it has grown out of a struggle with a dominant structure which continues to shape it, even cannibalise it. Counter-discourse does not arise as a pure autonomous radical language embodying the purity of a new politics. Rather it arises from within the dominant discourse and learns to inhabit it from the inside out. (Treichler, 1990:132)

I am not suggesting in this thesis that obstetrics has 'cannibalised' midwifery; perhaps the converse is possible to some extent. I am interested in the ways in which different midwives learn to inhabit obstetric/medico-legal discourse 'from the inside out'. The paradox is that despite midwives re-emergence over the last thirteen years as autonomous professionals and as the 'guardians of normal birth', and even though upwards of 75% of women choose a midwife as their LMC, the institutionalisation of birth itself is still increasing in Aotearoa/New Zealand (Guilliland & Campbell, 2002; Ministry of Health, 2003; Savage, 2002).

Guilliland suggests that the increase in intervention may be due to a combination of factors, including those of more defensive practice, understaffing, lack of experienced midwives in

some facilities, and women asking for intervention (Guilliland & Campbell, 2002:5). These suggestions are consistent with the analysis offered in this thesis. Further, at the 2002 NZCOM conference, Wendy Savage's keynote paper entitled "The Caesarean Section Epidemic" reported on a pilot study she had undertaken in Aotearoa/New Zealand in 2000. In this national study, midwives and obstetricians alike listed 'fear of litigation', 'women asking', and 'use of an epidural' as the key reasons for subsequent interventions that contributed to the use of caesarean section (Savage, 2002).

Sue Bree, incoming president of the NZCOM, stated as part of a plenary session entitled 'Keeping Birth Normal', that "the potential for fear of litigation to prevent normal birth is huge…the 'right to complain' is enshrined in the law of the land" (Bree, 2002). She argued that the right-to-complain is something that pregnant women-as-consumers have come to expect. In much the same way, some midwives also said to me that women have also come to expect 'perfection; perfect labour, perfect baby, perfect experience', an approach requiring that 'everything possible must be done', or must be seen to have been done; must be trace-able. This discursive approach is one that includes practices which function to uphold a rationality in terms of the ability to lessen medico-legal vulnerability (Bassett, Iyer, & Kazanjian, 2000; Cartwright & Thomas, 2001; Papps & Olssen, 1997; Symon, 2000). I suggest it plays a large part in inhibiting a desire on the part of some midwives to challenge institutionalised birth. The perceived benefits in feeling safe and in control in a hospital setting are conferred not just on women, but also on many midwives.

A Foucauldian analysis of power relations can be applied to the professional freedom and autonomy of midwives in Aotearoa/New Zealand. Foucault suggests that power can only exist over subjects insofar as they are seen to be free. When subjects exist in a "…field of possibilities in which several kinds of conduct, several ways of reacting and modes of behaviour [are] available" (Foucault, in Faubion, 1994:342), face-to-face confrontation of power and freedom as mutually exclusive facts is unlikely to occur. What is more likely is a complicated interplay, whereby, he suggests, "…freedom may well appear as the condition for the exercise of power" (Foucault, in Faubion, 1994:342). In the exercise of power this way, Foucault says, "rather than speaking of an essential antagonism, it would be better to speak of an 'agonism' – of a relationship that is at the same time mutual incitement and struggle; less of

a face-to-face confrontation that paralyzes both sides than a permanent provocation" (Foucault, in Faubion, 1994:342).

Midwives in some respects are now free subjects. Where once (prior to 1990) GPs and/or obstetricians oversaw their labours, they now have a field of possibilities for acting as midwives open to them. Choices for women, and autonomy for midwives, are interpreted as liberatory gain and emancipatory progress for both. The freedom gained, however, might better be understood as freedom from the overt control that existed prior to 1990, or as the exercise of pastoral, rather than sovereign, power in childbirth. This is because every action taken now by the midwife in the exercise of relative freedom, every utterance, both spoken or written, every touch, ministration, piece of advice, each interaction with the women, each phone call, each choice established, each decision negotiated and reached, each and every minute of the relationship with the women in her care is instead covertly governed by, documented for, and saturated within multiple modes of discrete medico-legal surveillance, in the rigours of the production of (foetal) normativity and perfection. The struggle to escape this is enormous; instead, an unsettled 'inhabiting', and an 'agonism' of permanent provocation, from the inside out, exists.

Rose draws on Foucault to examine the ways in which subjects come to think of themselves as free. He distinguishes between freedom as it is deployed in contestation, and as it is instantiated in government (Rose, 1999). In this second sense, he suggests that an analysis of this requires understandings of freedom as something "… articulated into norms and principles for organizing our experience of our world and of ourselves; freedom as it is realized in certain ways of exercising power over others; freedom as it has been articulated into certain rationales for practising in relation to ourselves" (Rose, 1999:65). Alongside this he examines the competencies required for active citizenship in the subject of government as those of 'self-government, individual choice and personal responsibility' (Rose, 1999:257), in the practices of freedom.

The issues raised by/for midwives in this thesis resonate with Rose's analysis when he suggests that a large part of this self-management is the management of risk in all its forms, and that this kind of logic is geared towards the constitution of all subjects as potentially risky in some form or other. He states that the fragmentation of risk assessment and management

exists as "a perpetual incitement for the incessant improvement of systems, generation of more knowledge, invention of more techniques, all driven by the technological imperative to tame uncertainty and master hazard" (Rose, 1999:257). In this regard my later analysis in particular records the ways in which midwives are embedded within these webs of knowledge production and the proliferation of different discourses of risk. Managing multiple levels of risk in highly complex and contingent ways acts to enable the construction of their subjectivities as autonomous practitioners, competent to practice on their own accord, self-regulating, and free – at least from the overt control of obstetrics in the management of 'normal birth'.

Accordingly, Arney notes that women now have more options in childbirth, but that these options exist in and because of a tightly controlled situation; precisely one in which there exists the absence of overt control. He suggests that in the enjoyment of alternatives and more humane treatment, we perhaps enjoy more freedom, but that this is a freedom in which all must be known. He suggests that, rather than the greatest obstetrical horror today being the 'botched or tragic case', it is, instead, "the *unseen birth*, the birth that occurs "unmonitored and outside the existing system" (Arney, 1982:241, italics in original). He concludes that if flexibility in childbirth is construed as freedom, then: "The one freedom we do not have is the freedom of remaining unseen" (Arney, 1982:241). Arney wonders where the future might lie for contemporary childbirth. He suggests that there may be two directions, one of increasing flexibility, options, alternatives and enjoyment, within an increasingly monitored 'flexible systems' rule, or 'absolutely in the opposite direction'. Arney suggests this route may be almost unimaginable; impossible to think:

> if you wish to replace an official institution by another institution that fulfils the same function – better and differently – then you are already being reabsorbed by the dominant structure".... The opposite direction is toward the rejection of all "theory and forms of general discourse". Such a rejection would commit women and men to an unknown and unknowable situation which contains risks (and possibly joys) that are literally unimaginable under existing conditions. (Arney, 1982:241-242)

How, then, might different midwives begin to imagine the unimaginable? What might this mean, and how might we come to be with birth? Where would we start with this journey 'in

the opposite direction', and how might we begin to map the terrain ahead? If this is barely imaginable, or indeed almost impossible, how will we recognise what we are looking for?

Nomadic midwives: neg(oti)ating 'normal'

The midwifery concept of 'normal' birth, deployed as a central discursive resource as part of the challenge to the obstetric construction of 'abnormal' birth, is receiving much international attention at present (Bree, 2002; Davies, 1996; Donley, 1998; Downe, 2001a; Johanson & Newburn, 2001; Johanson, Newburn, & Macfarlane, 2002; Tracey, 2001; Weston, 2001). Many are wondering what the 'future' may hold for normal birth, given the consistent increase globally of biomedical intervention in pregnancy and birth over the last century. 'Normal' birth has been positioned as part of a binary dualism in modernist midwifery professional counter-claims to knowledge. In this way it is associated with the 'natural' and with 'women', united in a common struggle against the cultural/male domination of the natural/female (Kent, 2000; Pitt, 1997; Rothman, 1989; 1991). These ontological claims to knowledge emerged out of earlier (1960s-70s) dominant radical and cultural feminist constructions of sex and gender (Annandale & Clarke, 1996). Spiritual eco-feminist movements claimed the sign of the goddess as a healing figure promising a return to nature, including a turn away from the technological domination of women's bodies and birthing (Lykke & Braidotti, 1996:23). Lykke suggests alternatives to feminist dichotomising of the technological artefact as evil and nature as good, by introducing a hybrid metaphor of the 'cybergoddess' (Lykke, 1996). In what follows I address some of these issues in a limited way, taking/mixing up the methodological metaphors of the goddess, cyborg, hybrid and nomad, to explore the involvement of postmodern midwives with birthing women as a 'monstrous sisterhood' (in Lykke & Braidotti, 1996:14), through contemporary feminist theories of subjectivity and embodiment.

Monstrous sisterhoods

Haraway's mid-eighties introduction of the 'cyborg' metaphor as infinitely more challenging and promising for feminist action than that of the goddess was cast in its possibilities for

> …not just deconstruction but liminal transformation. Every story that begins with original innocence and privileges the return to wholeness imagines the drama of life to be individuation, separation, the birth of the self, the tragedy of autonomy, the fall into writing, alienation; that is, war, tempered by imaginary

respite in the bosom of the Other. These plots are ruled by a reproductive
politics – rebirth without flaw, perfection, abstraction. (Haraway, 1990:219)

Haraway's cyborg eschews a 'holistic politics' which depend on metaphors of origins and
rebirth that "invariably call on the resources of reproductive sex" (Haraway, 1990:223). She
suggests that in contrast to an organic, gendered female embodiment related to processes such
as mothering, a cyborg body does not seek unitary identity, thereby (re)generating dualisms.
Rather, it takes pleasure in skill, machine skill, which is an aspect of embodiment:

> The machine is not an it to be animated, worshiped and dominated. The
> machine is us, our processes, an aspect of our embodiment. We can be
> responsible for machines; they do not dominate or threaten us. We are
> responsible for boundaries; we are they. (Haraway, 1990:222)

As women whose bodies and practices disrupt binary oppositions between nature and culture,
who are both organic and integrated into the operations of pharmaceuticals, machines and
other manifestations of biomedical technologies, midwives and birthing women exist at a
historical point when a return to something known as 'nature' or 'the natural', upon which
'normal' is constructed vis a vis 'abnormal' (Rothman, 1989; 1991) is no longer possible, or
necessarily even desirable (Braidotti, 1997; Haraway, 1997; Hartouni, 1997; Lykke & Braidotti,
1996; Petchesky, 1987; Robertson, Nash, Tickner, Bird, Curtis, & Putnam, 1996). Indeed,
Hunt and Symonds suggest that the midwife has always "…occupied an ambiguous and
contradictory cultural space" (Hunt & Symonds, 1995:22). Braidotti's position on this is that
the "…nostalgic longing for an allegedly better past is a hasty and unintelligent response to the
challenges of our age" (Braidotti, 1997:521). Nomadic midwives reject nostalgia; they/we need
to travel differently, on 'lines of flight' (Deleuze and Guattari, 1988) towards barely
'unimaginable directions'.

Warning against an oppositional dualistic approach to nature/techno-culture issues, Stabile
suggests that feminists have either withdrawn into "…reactionary essentialist formations",
which she calls technophobia, or "…equally problematic political strategies framed around
fragmentary and destabilised theories of identity", which she calls technomania, citing
Haraway's work as a prime example of this (Stabile, 1997:508). Similarly, Braidotti's work
deconstructs these two dichotomous positions and suggests that a rather more critical
evaluation of the "…historical conditions that affect the medicalization of the maternal

function forces upon us the need to reconsider the inextricable *interconnection* of the bodily with the technological" (Braidotti, 1994:94, my italics), an approach she calls technophilic (Braidotti, 1997). This interconnection is what Lykke's 'cybergoddess' signifies, but importantly, not in an androgynous sense, which simply takes up both aspects of the dualism, and thus remains constrained in its transformative potential.

For Lykke, and for midwives, the importance of the metaphor of a 'monstrous sisterhood' is located instead in its deconstructive potential. Lykke suggests that Haraway's cyborg may inadvertently reproduce the dualism (nature/technology) in its recoiling from the goddess metaphor. Haraway's cyborg contains elements of the organic, however, as the goddess contains technologies (the leaking 'hybrid', or 'monster' in each), but Lykke's concern is that they might nevertheless act to tighten rather than disrupt the dualisms. Her solution is to explore the (monstrous) differences within each, as well as between them (as well as to explore the similarities). Rather than seeing each as unified and bounded, and which may be joined to form an androgynous or holistic being, she suggests a primary focus on the play of differences within each, while remaining aware of the similarities between them which thus constitute their 'sisterhood'. How might a set of strategies clustered around a 'monstrous sisterhood' appear beneficial for midwifery praxis?

For some midwives, becoming autonomous professionals may entail increasing their technological skills, and hence 'cyborgification', as an aspect of embodiment and skill to take pleasure in. Some rural hospital-based midwives now are negotiating these issues with regard to the use of forceps in an emergency situation, for example. Hartley goes so far as to suggest that if midwives consider continuity of carer to be paramount in the midwifery partnership, and they become trained to perform caesarean sections in an emergency, they will either be able to continue with the appropriate care or "…argue from a position of authority against such interventions" (Hartley, 1997:775). In this way midwifery knowledge and practice would emanate from a standpoint drawn on/from the cyborg metaphor. Some 'goddess' midwives I spoke to strongly resist this speculative position. As Frida said (with some horror), "we'll be doing caesareans next, you'll see". Hartley suggests resisting technological change, such as this, might have a detrimental result on a profession where some skills are already virtually obsolete.

Others may see this rush to up/re-skilling as compromising midwifery as professional practice that is based on something defined as normal and natural. Instead, the alternative to cyborgification is a re-valuing and re-focussing on traditional midwifery skills via a discourse of 'guardians of the normal' (Banks, 2001a; Strid, 2000); a returning to, or renewal of eco-spiritual/goddess values in birth – with a twist. This twist might be seen where birth and midwifery practice is centred in homebirth, for example, where medico-technologies are called on as a 'last resort' (Peterson, 1983). Mentor writes of the ways in which during his wife's homebirth, the oxygen tank and the waiting car symbolize the:

> Powerful medical technologies virtually present at every homebirth…the hospital, with its routine fetal scalp monitors and maze of medical protocols, is present as supplement. Yet this supplement is Derridean: the hospital paradoxically both adds to and fills a lack in homebirth. (Mentor, 1998:85-6)

Midwifery knowledge and practice would be grounded in and emanate from the goddess metaphor, remembering that in their 'monstrous sisterhood', these metaphors are not mutually exclusive. In this way the goddess is not intended as a nostalgic remnant of an imaginary past. As strategic metaphors, they can be deployed in different ways, representing two poles on a continuum, either standpoint from which midwifery action can be grounded in and begin from, or as something much more diffuse and fractured. Neither are these metaphors mutually exclusive for many of the women in Klassen's study of spirituality, religion, and homebirth in America. She states:

> At the level of language at least, perhaps the machine really is "us", as resolutely antitechnological homebirthers found the metaphor of the machine a helpful way to express their birthing experiences. Their versions of the cyborg added a twist to Haraway's creature, since these women enlisted metaphors of the machine to further glorify God's role in designing their bodies. (Klassen, 2001:164)

In her study, Klassen explored the ways in which meanings around visionary pain and spiritual transcendence as well as re-workings of meanings in risk, fear and ethics were important to midwives as well as to the women whose home births they attended. A goddess-centred birth does not preclude a relationship with biomedical technologies at different times; they were interconnected, but on the birthing women's terms. In the same way a rather more cyborg-centred birth is not precluded from being the utmost spiritual experience for a woman.

Interestingly, only one of the midwives I interviewed spoke about spirituality in relation to birth or to her midwifery practice (but all spoke about machines). She raised this spontaneously, at the end of our interview, saying that many of the women who chose her as LMC did so because of her spiritual approach to birth, and her willingness to facilitate birth as a specifically spiritual experience for them. She told me that part of that consisted of her willingness to pray either silently or out loud if asked to by the women she cared for, and of her encouraging them to openly express their particular spiritualities through birthing. She also told of the judgements made in labour ward towards herself and her clients at times; saying how in one instance, during the course of a woman's lengthy labour, a bible on her bed-side table, and singing and prayer as pain-relief, supported by the midwife, were evidently considered more properly as signs for scorn and laughter. Elsewhere, other midwives have also articulated their beliefs about birth, midwifery and goddess spirituality, including what I call an 'erotics' of birth (constituted by a predominant discourse of pleasure in childbirth, vis-à-vis one of pain). This may include particularly home and/or unassisted birth as spiritual practice for some midwives and birthing women (Davis-Floyd & Davis, 1997; Gaskin, 1977; Hall, 2001; Klassen, 2001). Again, cyborg imagery is not excluded from these birthing situations.

I have suggested that the profession of obstetrics, since from the seventeenth century constructed something called 'abnormal birth', against which various counter-discourses of something called 'normal birth' were subsequently brought into being and re-articulated as 'Not-A' in opposition to 'A' (Annandale & Clarke, 1996; Arney, 1982; MacDonald, 1999). The struggle to define the limits of 'normal' and 'abnormal' has ultimately undermined their assumed autonomy.[51] Foucault understood that that which is repressed or sublimated "…produces subjects, even the very subjects that challenge these regimes" (Matisons, 1998:17). In addition, recent feminist theorising has demonstrated the ways in which a dualist reification of the 'female' and the 'natural' with regard to reproduction acts to homogenise women in ways that assume the sameness of experience in terms of reproduction,

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[51] This might be understood, for example, in the way some midwives/women suggest the description of 'normal' birth has moved from the ideal of low-intervention (or home-based) birth to something that now encompasses all forms of vaginal birth/delivery, but stops just short of caesarean delivery. Mandy suggests: "some people regard an assisted delivery as normal as long as that birth was achieved vaginally . . . and it doesn't matter whether there was an epidural, IV infusions, or any intervention . . . pethidine, any intervention you can think of".

contraception and mothering. To this end alone, duality has the potential to become more enslaving than liberating (Ahmed, 1998; Annandale & Clarke, 1996; Braidotti, 1997; Weedon, 1999; Zalewski, 2000). The metaphors of the cyborg and goddess, if they are mis/interpreted as representative of ab/normal or technological/natural birth, have the same potential to enslave rather than liberate also.

For many midwives in my study, the concept of 'normal' in their daily practice appears to have no essential meaning, or prior relationship to either nature or to medical technologies, but shifts and changes according to the particulars of the birthing situation at a given time and place, and the various interests served therein (and see MacDonald, 1999, 2001). Within this framework exist multiple possibilities for what might be meant by 'normal birth'. For many contemporary midwives, normal birth is no longer something dualistically contrasted to the (over)use of medical technologies. This might mean several things. One, that midwifery itself has become 'medicalised', despite its earlier intentions. Two, that hi-tech cyborg births are indeed, what (the majority of) women want – so long as they are facilitated by midwives who assist women as they negotiate decisions about the use of available technologies at different stages of the labour process to feel in control of their experiences (Lazarus, 1997; Levy, 1999; MacDonald, 2001). Three, that increasing discourses of medico-legal risk in childbirth are alarmingly more insidious and penetrating than overtly paternalistic medicalisation processes ever were. Finally, that midwives I spoke to might necessarily already see themselves and the women they work with as different versions of cybergoddesses now, as part of exploring the ways in which discourses of 'natural' and 'normal' birth may inadvertently act to constrain us during their very articulation.

Other researchers are noting the ways in which some midwives are acting in ways that increasingly unsettle or disrupt dualisms between abnormal/normal, culture/nature and technology/spirituality. Davis-Floyd and Davis coined the phrase 'postmodern midwives' in their referring to midwives as those who are "articulate defenders of traditional ways as well as creative inventors of systems of mutual accommodation" (Davis-Floyd and Davis, 1997:319). In this 'even the most holistic of midwives' are able to explain and defend their actions in scientific, linear, and logical terms (Davis-Floyd & Davis, 1997; Davis-Floyd, Pigg, & Cosminsky, 2001). Although the analysis here is underpinned by a binary logic, which juxtaposes 'traditional' with 'imported biomedical' knowledges, Davis-Floyd goes on more

fruitfully to draw critically on Haraway's cyborg. Discussing this again elsewhere, Davis-Floyd says: "It's very cool to analyze the human-machine symbiosis of a woman hooked up to the EFM as cyborgian; it's very uncool to know that the price she may pay for being that kind of cyborg is an unnecessary cesarian" (in Davis-Floyd & Dumit, 1998:274).

MacDonald's analysis of postmodern midwives draws on Davis-Floyd and Davis's initial description of postmodern midwives, above (and in MacDonald, 1999; 2001). She also suggests that the ways in which medico-technologies inspire ambivalence in midwifery points to a 'culturally productive tension'. Just as many midwives I spoke to explained how they can act with different technologies to 'normalise the abnormal' in various ways,[52] the midwives in MacDonald's study describe this as occurring in situations where an intervention is able to "confirm or bring back the normalcy of the pregnancy or birth, [and] then it should be viewed as a good thing" (MacDonald, 2001:268). Foley defines postmodern midwives as those who draw on aspects of the bio-medical model as a discursive resource that can be 'artfully used' in the crediting of the midwifery profession as midwives establish themselves as the professional equals of physicians (Foley, 2001).

These are some of the situations in which I imagine midwives drawing from the cyborg or the goddess metaphors, from within fractured and multiple selves in highly mobile, contingent and strategic ways, and that the multiplicity and difference, rather than the either/or, is what makes the 'monstrous sisterhood'. These hybrid practices, according to Parker and Gibbs, are what locate midwifery as a profession, as well as the individual midwives within that, in an uncertain postmodern space, where midwives are 'marginal or liminal figures'. In this, they: "…should be aware of their own discursive constitution as implicated actors working on a complex, postmodern terrain characterised by contestation between differing cultural understandings of the world" (Parker & Gibbs, 1998:151).

As Braidotti and Stabile warn, both positions of technomania and reactionary positions of nostalgic technophobia need to be avoided in this liminal cultural space (and see Kirkup, 2000; Kirkup & Keller, 1992). Hybrid configurations of multiple midwifery cybergoddess images,

different at each birth, but united in their monstrous sisterhood, may be one way to imagine the future out of dualist limitations. Midwives are negotiating these liminal spaces in the ways I have analysed in the thesis, and in other ways, such as approaches which reframe birth in the 'holistic' terms of 'salutenogenesis' (Royal College of Midwives, 2002). Like Haraway, I am wary of the term 'holistic', however, if it acts to simply splice together the cyborg and the goddess from dualist positions. However, as my earlier title for this section suggests, there may be a difference between 'negotiating' these meanings around normal, and deliberately 'negating' any ideals of normal at all, through a deeper, more deconstructive movement. Nomadic midwives may travel further, perhaps, on a route towards the unimaginable.

Many midwives I spoke to appeared to sense that the promise of emancipatory goals, or the threat of reconfigured oppressive regimes, depends on the avoidance of the essentialism of both technophobia and technomania (Davis-Floyd & Dumit, 1998; Davis-Floyd, Pigg, & Cosminsky, 2001; Foley, 2001; Sawicki, 1991). Midwives, in occupying this liminal cultural space, are able to raise appropriate questions concerning the cultural and social means by which these biomedical reproductive and birthing technologies are deployed (and see Lay, 2000; Squier, 1995). Midwives are well positioned to challenge, or to appropriate in critical ways, the technologies of foetal visualisation, monitoring and surveillance that shapes the networked production of foetal subjectivity, individualisation, personhood and rights (Newman, 1996; Weir, 1996).

Midwives need to remain critically concerned with techniques of visual representation in discourses around childbirth, including those arising from some women's choice, rights, demands or desires. This is because of the increasing objectification and visualisation of the foetus as the central feature of the penetrative obstetric gaze in the hegemonic medico-legal governance of pregnant bodies. During counter negotiations midwives and some birthing women will be increasingly required to defend their own embodied knowledges such as intuition and practice wisdom. These may come to be seen as knowledges that are alternative, rather than authoritative, even from within midwifery (Lane, 1995; Newman, 1996; Stabile, 1998; Symon, 1998, 2000; Walsh, 2000; Weir, 1996).

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[52] One of several examples of 'normalising the abnormal' given to me was that of pro-actively inserting an IV

Haraway's cyborg metaphor as a strategy for developing a 'technophilic' approach demonstrates that technology and art are interconnected (avoiding technophobia or technomania). This leads to nomadic thinking and connections which view discourse as positive, multilayered networks of power relations (Braidotti, 1994:76). These approaches will avoid Cartesian dualisms, refuse an over-identification with nature and conceptualise/speak of technology as a material and symbolic apparatus, "…i.e. a semiotic and social agent among others" (Braidotti, 1997:521). Fox suggests that Haraway's cyborg is a powerful metaphoric tool because as a 'transgressor of boundaries' it can conjure up 'potent fusions and dangerous possibilities' in the seeking of new meanings, pleasures and forms of power (Fox, 1999:138). These images offer a profusion of possibilities for pleasure, resistance and transgression for nomad midwives: those willing to engage in the risky business of focussing not on what is ab/normal, inside/outside, but what might lie beyond the dualisms, in terms of plurality, desire, and difference.

Smythe, in discussing safety in childbirth, talks about an 'alchemy of knowing', from which midwives need to base practice and balance risks. She states that within this, midwives need to understand that some babies, just like some adults, will die, no matter how safe the care. She calls this knowing/practice wisdom a being 'ready for throwness', acknowledging "the darkness of practice - that which is unknown, that which is beyond understanding" (Smythe 1998:241). I interpret this as a willingness to move beyond the dualisms of risk/safety, life/death, ab/normal. Becoming nomad requires the courage to move into these grey zones, the darkness of practice. Perhaps there is much more grey there, than black and white. This liminal space of practice, the nexus of postmodern praxis, does not 'expect reciprocity', it is open-ended, 'gift-giving', becoming multiple, and stands in place of theory; importantly, even those theories of liberation or empowerment (Fox 1999).

The issues raised in this thesis demonstrate the ways in which midwives labour together with birthing women as bodies that are "…troublesome in the eyes of the logocentric economy within which to *see* is the primary act of knowledge and *the gaze* the basis of all epistemic awareness" (Braidotti, 1994:80, italics in original). Under these conditions pregnant bodies are

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line early to boost hydration and energy, in anticipating that a woman's increasing tiredness in her lengthy labour may lead to core staff suggesting an (unwanted) epidural.

always already 'morphologically dubious' as they change shape; they are Other, the anomalies that confirm the positivity of the norm (Braidotti, 1994:80). Maternal bodies and the embodied labours of midwives are always monstrous and troubling within a visual and logocentric economy. The knowledges produced by these bodies in partnership may be displaced or sublimated to authoritative obstetric knowledge. These relations of power are negotiated by midwives when reproductive technologies consistently portray the foetus as having its own personhood, and as separate from, or in conflict with, the woman/mother (Braidotti, 1994; Weir, 1996).

In all of this, midwives act in various ways to replace women at the centre of their own reproductive experiences. But this is not uncomplicated, if, as Haraway and others warn, it inadvertently functions to homogenise women in ways that assume the sameness of their reproductive experiences (Annandale & Clarke, 1996; Haraway, 1990; Harding, 1992). What kinds of questions might nomadic midwives ask? At the end of her critique of foetal visualisation, Braidotti asks, "Where has the Cartesian passion of wonder gone?" (Braidotti, 1994:89). In this she notes the "…loss of fascination about the living organism, its mysteries and functions" (Braidotti, 1994:89). She notes that prior to the fifteenth century, "the medical gaze could not explore the inside of the human body because the bodily container was considered as a metaphysical entity, marked by the secrets of life and death that pertain to the divine being" (Braidotti, 1994:89). If we accept Arney's lament that the one remaining freedom we do not have is the freedom to remain unseen, then thinking about pregnancy/foetuses remaining unseen in order that they avoid displacement, either the foetus from the maternal body, and/or women from their experiences, might be a point of departure towards the unimaginable.

Nomadic midwives in goddess and cyborgean modes of practice, or in any hybrid combination of monstrous sisterhood(s), might begin to imagine pregnant bodies as pure flows of energy, impenetrable surfaces of inscription in the smooth spaces of reterritoralised birth. Here pregnant embodiment is a "radical, non-dualistic, non-essentialist, un-natural and an-organic notion of the corporeal; [a body is] not a unitary organism fixed in time and space" (Potts, 2002:143). There is nothing to remain unseen, nor to hide in pregnant bodies if there is no interior. Negating any idea of 'normal' because there is simply no 'abnormal' to be seen/diagnosed, nomadic midwives will necessarily form hybrid and monstrous practices in

their lines of flight…fleeing in multiple directions out from the central eye of the obstetric panoptican. This is a line of flight midwives may take in a trajectory towards new representations of birthing bodies as surfaces of/for re-inscribing in language in different ways, and midwifery itself as a potentially radical form of nomadology (Deleuze & Guattari, 1988).

Neg(oti)ating an in/conclusion…

I began the introduction to this thesis by noting some earlier feminist critiques of the ways in which the experiences of Western men have shaped and guided the development and (re)production of knowledge. This includes scientific and medical knowledges, which generally have posited that man is that to which woman is Other; the dualisms of culture/nature, technology/bodies, obstetrics/midwifery follow. These radical feminist critiques of patriarchal knowledge partially shaped the re-emergence of contemporary midwifery movements in Aotearoa/New Zealand as well as overseas (Annandale & Clarke, 1996; Guilliland & Pairman, 1995; MacDonald, 1999, 2001; Sharpe, 2001; Tully, 1999).

If, in this shaping of midwifery discourses, midwives assume medicalisation is a (gendered male) cultural and technological product laid over the ground of an essential and natural female body, then it will remain limited, as do monolithic theories of feminism, in its emancipatory goals. How do we explain the desire for medical technologies on the part of women when midwives know the birth may well become abnormal as a result? If midwives explore the myriad and complex ways women (including midwives ourselves) may make sense of, collude with, or resist the choices, options, terms and definitions available to them/us, then different understandings of confusing and contradictory situations might emerge.

Feminist poststructuralist understandings of embodiment and subjectivity such as those highlighted in this thesis stress the importance of language and desire in the (re)production of contestable meanings around childbirth. They highlight the role of language in the formation of the subjective self and social institutions. Challenging the authority of established discourses requires a deconstruction of the linguistic organisation of the obstetric hospital. It also requires an unsettling of the assumptions on which midwifery negotiating practices rest, where consumer demand for the management of pain exists. Thinking along completely new and seemingly-bizarre-at-first trajectories can help in the deconstructive work involved in thinking

through the negating of ab/normal, and in the cybergoddess' welcoming of difference and multiplicity in birth. These new lines of flight will occur simultaneously with/in negotiations; we are always at once inhabiting and fleeing discourses.

From here, hybrid midwifery discourses and practices may develop as part of a journey in the opposite direction: the unimaginable, in Arney's terms. This nomadic journey through transgressive research and practice might be towards difference and desire, rather than defence, and contribute towards a monstrous sisterhood of cyborg midwives. Part of this would involve a willingness to think about birth and about midwifery in ways that avoid both nostalgia and utopia. These ways of thinking - lines of flight - would welcome multiple and slippery conceptual forms of cyborgean birth, and embrace a willingness to journey into the grey zones of continual be-coming.

There can be no real truth after all about childbirth, despite my earlier, naïve and nostalgic intentions to find it as a midwifery student. Birth, like midwifery, will always be mediated through and produced by the historically contingent relations of power within which it is embedded. But there is room for a strategic essentialism, perhaps, rather than forms of truth, in the ways midwives can continue to negotiate cultural discourses of obstetric risk. Along with Banks (2000, 2000a) and Bogdan-Lovis (1996), I reject the liberal feminist position that birth can ever be de-institutionalised from within the institution. I strongly reinforce the need for a process of de/reterritorialisation, towards out-of-hospital, home-centred (cyber)goddess birth practices; those within the spaces that are not black or white, but are grey zones. At the same time, my questions in this thesis signal the potential for the development of a midwifery gaze implicated in new ways of governing labouring bodies, both those of birthing women, and those of individual midwives.

The relations of medical domination theorized by earlier feminists cannot account for the subtle features of obstetric disciplinary normalisation that operate within neo-liberal rationalities of freedom. The means by which these processes are contested, resisted, reproduced, or can be neg(oti)ated to varying degrees in/by different midwifery practices needs exploration beyond the confines of this thesis. In the meantime, my contribution has been to create a space to explore the ways in which these counter-responses may increase the amenability of midwives and midwifery to increasingly subtle forms of governance, including

midwifery professional governance. In these ways the thesis contributes to the interruption of hegemonic obstetric understandings of childbirth, while also cautioning against the potential for the 'midwifeication' of childbirth.

Intertext

27/09/01   Heather/Alison

Alison invites me silently with a smile, a nod and raised eyebrows to enter the room. I follow her, trying to be silent and almost invisible, as she indicates a seat for me beside the bed that Heather lies in. I reach out and take one of Heather's hands in mine, after feeling momentarily unsure about whether I should do so at this time; I don't want to disturb what she is doing. She seems so incredibly inside herself, oblivious, almost, to the presence of Alison and me in the room with her. Her belly is huge. I wonder if she is in transition. Her breathing seems quite laboured now, but she seems to have found a certain rhythm to go with. There is some soft music playing; an Indian meditation piece with some very quiet and slow chanting. It provides a feeling of absolute peace and serenity in the room. Alison is completely in tune with Heather's rhythms; she follows her lead in everything. She watches Heather's face continually from the other side of the bed. If Heather licks her lips, Alison holds a glass of water out for her to sip from, before watching Heather sink back into the pillows. She seems to be comfortable; what pain there is seems to be manageable. Alison whispers to me: 'she's just going with the flow so well, isn't she…' and I feel my tears well over at the enormity of being part of this. I am in awe of Alison, who seems to be in a perfect partnership with Heather; they are symbiotic. No one comes to disturb us. There are no noises from outside. It almost feels as if we are in a womb of sorts, ourselves. The lighting is soft and dim and I can see the contours of Heather's face changing as she breathes, and at times hums, and sometimes moans.

Heather's daughter, Celia, who had been born nine years earlier by caesarean, comes in to the room with Heather's mother, ponders Heather's face for a while, and then goes back out to play. She appears unconcerned at what her mother is experiencing, and slips in and out of the room from time to time thereafter. There are three generations of the women in this family present; their connection to and knowingness of each other is tangible. Heather's mother asks Alison quietly if there is anything she can do, but Alison shakes her head, and so her mother sits back down and returns to her reading. It seems a perfect way to give birth; surrounded by women related by blood and by friendship, with no need for words, communicating silently and often with eye contact and facial expressions. There is a sense of incredible peace and acceptance, of going with the flow, accepting the process, and not hurrying the forces of nature. There are no clocks on the wall. I still wish that more women could, or would choose,

to give birth like this, with no hurrying, no time limits, surrounded only by people who love them and will follow their lead in the process. Going through this experience now was the closest Heather had felt to her family in her life, she had told me a few days earlier.

Heather isn't giving birth this time, though; she is dying, of lymphoma. The cancer has swollen her belly to bizarre proportions; the rest of her body is excruciatingly thin. Alison and I have had a whole month of getting used to this moment; for a long time we haven't known whether Heather was 'living' or 'dying', and realized we would have to accept a limbo state, a grey zone of not-knowing, that no one could tell us one way or the other, after treatment stopped, what would happen. So we approached it now almost like a birth, as Heather herself did by that stage. She considered her impending death to be a spiritual transition, and at times talked to me about how this felt. She wasn't afraid of the transition; she had finally let go of her earthly concerns and surrendered herself to the process as it was unfolding. Her sister, Alison, was being with, midwifing, Heather, through this transition.

Spiritual care for the dying has been described as "midwifery for souls …keeping the body comfortable, passage peaceful, soul triumphant, and family present" (in Paine, 2000:367). Perhaps the needs of those dying, and of those birthing, are more similar, and much simpler, than we realize. Perhaps there is not much difference between being-with in birth, or being-with in death, for nomad midwives. Susan, a midwife, discussed the ways in which caring for those dying, and caring for those birthing, are similar. After years of working as a nurse and midwife, the experience of being with her own mother, as she died, led Susan to reflect on aspects of her midwifery praxis. I leave the last words of this project to Susan, as she says of death/birth:

> It's like dying, I nursed my mother when she was dying. Dying is like a birth, it goes through … because when we're nurses we usually only see eight hours of somebody dying, but because I spent the whole two days of that process without ever leaving Mum's side … the whole thing was like a birth … it went through different phases and I've never seen the whole process before, it was the most amazing thing … and I likened it to a birth … absolutely amazing. (Susan, midwife)

Post-partum

Sublime *adj.* **1.** of the most exalted or noble or impressive kind. **2.** extreme, lofty, like that of a person who does not fear the consequences, *with sublime indifference.* **sublimely** *adv.*, **sublimity** (sub-**lim**-iti) *n.*

Appendices

Information Form for midwives

INFORMATION

You are invited to participate in the research project -

MIDWIFERY AS FEMINIST PRAXIS IN AOTEAROA/NEW ZEALAND

In New Zealand a number of authors (Guilliland and Pairman, 1995; Fleming, 1995; Tully, Daellenbach and Guilliland, 1998; Tully and Mortlock, 1999), note that midwifery has reconstituted itself as a feminist form of professional practice based on a model of partnership with women. I want to explore the meaning and relevance of feminist theorising for midwives; how do midwives *do* midwifery as a feminist practice? I am interested in the ways that different practitioners take up and respond to midwifery theories, consider their relevance and apply them in a variety of practice settings and contexts.

I hope to gather data from a number of different sources for up to one year's duration. This will mainly involve semi-structured interviews with midwives working in a variety of practice settings. They may take the form of individual interviews or group discussions. Your involvement in this project will entail one or more interviews. These interviews will be transcribed and analysed.

I may also gather data in a participant observer role. I am hoping to be able to observe some ante and post-natal visits with you and some of the women in your care, as well as interviewing you, so that I can observe the development of partnership in practice. My presence at any ante/post-natal visits would be as unobtrusive as possible. Alternatively, your clients may wish to have an interview with me by themselves or as part of a group. Any women/clients who choose to be involved alongside you will be asked to provide verbal and written consent to my presence.

The results of the project will be used in my doctoral thesis and academic publications, but you may be assured of the complete confidentiality of data gathered in this investigation: the identity of participants will not be made public without your/their consent. To ensure

anonymity and confidentiality tapes will be destroyed after their transcription. Transcripts will be kept for 3-5 years after the study in order to help with journal publications about this study. Pseudonyms will be used for all people. Typists will sign confidentiality clauses. Your transcript(s) will be offered to you for checking and I will provide summary reports of my findings every six months of the project's duration.

In the application of these procedures there are no foreseeable risks to you or the pregnant/postnatal women in your care.

My supervisors are Dr Elody Rathgen <e.rathgen@educ.canterbury.ac.nz> Rosemary Du Plessis <r.duplessis@soci.canterbury.ac.nz> (both phone 366-7001); and Dr Daphne Manderson <mandersond@chchpoly.ac.nz> Please feel free to contact any or all of the above with any questions you may have. My supervisors and I would be happy to discuss any issues you may wish to raise, at any stage in the project. My phone number is (03) 388-4673 any time; my e-mail is <rjs116@student.canterbury.ac.nz>

The project has been reviewed and accepted by both the University of Canterbury Human Ethics Committee, on 13/06/00, and by the Canterbury Ethics Committee, on 25/07/00.

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Consent Form for midwives
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Midwifery as Feminist Praxis in Aotearoa/New Zealand

Department of Education, University of Canterbury

I have read and understood the description of the above-named project. On this basis I agree to participate as a subject in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided, until data analysis is complete. After that time it may be impossible to separate data from individuals.

I consent to my interview(s) being audio-taped YES/NO.

I wish to receive a summary of the results of the study YES/NO.

Signed..…

Date...

Information Form for women

PROJECT INFORMATION FORM

How do midwives put their midwifery theory into practice? My name is Ruth Surtees and I am a Doctoral (PhD) candidate in the Department of Education, University of Canterbury. I am also a non-practising midwife, and have a background in psychiatric nursing and tutoring. I have an 11-year-old daughter, April, and after her birth on the West Coast I was a member of La Leche League for several years. So I have an interest in childbirth and midwifery from several different perspectives.

The research project I am doing is called "Midwifery as Feminist Praxis in Aotearoa/New Zealand" and it is about how midwives put their different ideas about midwifery into practice in their every-day work situations. What does it mean to work as a midwife? What helps midwives put theory into practice? What kind of things may hinder this process? How do different midwives do things differently, under different sorts of conditions?

You are invited to be a part of this project. Your midwife has agreed to be a participant in the study with me, and if you also agreed, you would decide on your own level of involvement and discuss this with your midwife. Just because you are with the midwife/midwifery practice you are does not mean you are obliged to take part; it is entirely voluntary. You have a right not to take part, and a right to withdraw at any stage if you did begin to take part. You do not have to give a reason for withdrawing and this would not affect your midwifery care in any way.

What is involved? I am doing fieldwork with your midwife for up to one year's duration that includes observing the ways she interacts with women. What your involvement would mean is that when you have a visit with your midwife I would sit in on this wherever it takes place. If you agree, then you decide how many of the visits I could attend – from one visit only, to several or most of your visits, if that is what you wish. The midwife and I would check each time that this was ok with you. You could ask me to leave at any time during the appointment. If it was ok with you, I may audiotape one or more visits; more likely I would just observe the midwife talking with you. I would leave during any physical check-ups, or if you asked for privacy or for me just to leave for any reason. There will be no questionnaires, surveys or interviews for you to undertake. There is

no payment of money by me to you, or to the other participants, including the midwifery practice and midwives in this study.

General. It is important that you realize that it is the midwife and her relating to women I am studying, not you or your life situation except as a client of your midwife. Neither your GP nor any other health professional is told of your involvement in the project; it is entirely confidential. If you decide that any of your visits that include me may be audio taped, then only my typist or myself will transcribe them. If you wished you would check the transcription to see that you feel happy with what has been recorded. Your name would be obliterated and a false name used in its place. The tapes will then be destroyed. Transcripts will be kept for 3-5 years after the study in order to help with journal publication about this study. No material that could personally identify you will be used in any reports on this study.

Your rights. If you have any queries or concerns about your rights as a participant in this study you may wish to contact a Health and Disability Advocate, telephone 377-7501, or 0800-377-766 if you are from outside Christchurch.

My supervisors are Dr Elody Rathgen, Department of Education, and Rosemary Du Plessis, Department of Sociology, both of Canterbury University, phone 366-7001, or Dr Daphne Manderson, Faculty of Health and Science, Christchurch Polytechnic, phone 364-9074. They would be pleased to talk with you about any aspect of this project. My phone number is (home) 388-4673 – please feel free to ring at any time.

The University of Canterbury Human Ethics Committee, on 13/6/00, and the Canterbury Ethics Committee, on 25/7/00, have both approved this study.

Thank you for taking the time to read this information sheet and I look forward to meeting you if you decide to take part.

Consent Form for women

Midwifery as Feminist Praxis in Aotearoa/New Zealand

Department of Education, University of Canterbury

I have read and understood the description of the above-named project. On this basis I agree to participate in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided until data analysis is complete. After that time it may be impossible to separate data from individuals. I understand this withdrawal would not affect my midwifery care, and that no other health professionals are given any information about me.

I consent to my interview(s) being audio-taped YES/NO.

I wish to receive a summary of the results of the study YES/NO.

Signed...…

Printed Name …………………………..

Date..

Semi-structured interview question guide

Can you tell me about your practice here - When did you start planning this midwifery practice? How did you get it established? What did you have to do? Do you remember some key moments in the process of getting started? Were there times when you thought it might not happen? Location? Equipment? Business plans?

Can you tell me about the women who come here? How have they found out about your practice? Are they local women? From all over the city? Out of town?

Can you tell me about the differences between being students and being practitioners? What do you do as a midwife that you didn't as a student?

What surprises you about midwifery, if anything?

Who do you work with? Can you tell me about your working relationships with other health professionals? How did you come together as a practice? How do you all get on?

How is this similar to other situations you have experienced? How/why is it different?

What kinds of things have you learned doing this that you could not have learned as a student, if anything? How would you describe the ideal relationship between midwives and midwives? Between midwives and women? Mentors and new graduates?

What do you bring to your practice that you did not necessarily learn as a student, if anything?

What do you think will be different a year from now? What would you like to go on learning, and how? Is there anything else you would like to tell me?

Interview/Participant Observation Schedule

Three pilot interviews 1999

Julie/Bella (informal), and meeting with Polytechnic midwifery educators 28/06/00

Group interview, Group 'one' 25/07/00

One midwifery practice manager – individual interview 27/07/00

Group interview, Group 'two' 28/07/00

One self-employed (SE) midwife – individual interview 01/08/00

One (SE) midwife – individual interview 04/08/00

Core midwife – individual interview and one post-natal PO 08/08/00

One (SE) midwife – individual interview 10/08/00

PO and untaped interview, (SE) midwife 11/08/00

Interview with NZCOM Midwifery Advisor 15/08/00

Core midwife – individual interview and two post-natal PO's 16/08/00

One (SE) midwife, individual interview 16/08/00

PO post-natal visit with core midwife 18/08/00

Charge Midwives' Meeting to introduce self 23/08/00

One PO ante-natal visit, (SE) midwife 25/08/00

One PO ante-natal visit, (SE) midwife 08/09/00

PO with WHD Midwifery Educator 13/09/00

PO Group 'one' clients' afternoon tea 19/09/00

PO ante-natal visit with (SE) midwife 21/09/00

PO visit/interview rural hospital..01/11/00

PO postnatal visit with (SE) midwife..02/11/00

Methadone In Pregnancy clinic with WHD midwife......................................07/11/00

PO post-natal visit with (SE) midwife...14/11/00

PO morning shift labour ward with core midwife 15/11/00

PO WHD workshop re CTG interpretation..16/11/00

Interview WHD community midwife...20/11/00

Follow up interview NZCOM Midwifery Advisor 21/11/00

PO Group 'one' clients' afternoon tea..21/11/00

PO WHD community midwives' team meeting..22/11/00

PO WHD community midwives' general meeting...23/11/00

Untaped interview with Group 'one' client..28/11/00

Interview with core WHD midwife...29/11/00

PO labour ward shift with core WHD midwife...29/11/00

Second Group interview with group 'two' midwives.....................................01/12/00

Individual Interview WHD community midwife...05/12/00

Individual Interview WHD community midwife...07/12/00

Individual Interview (SE) midwife...12/12/00

Visit/interviews to second rural hospital...13/12/00

'Domestic Violence and midwives' workshop WHD 14/12/00

1 interview & Accreditation presentation, rural hospital..............................20/12/00

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