Examining the social construction of childbirth in Australia:

The politics of power

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CERTIFICATE OF AUTHENTICITY

I hereby certify that this thesis has not already been submitted for any degree and is not being submitted as part of a candidature for any other degree.

I also certify that this thesis has been written by me and that any help I have received in preparing this thesis, and all its sources used, have been acknowledged.

Signature of Candidate ……

Date ……

ACKNOWLEDGEMENT OF COUNTRY

I would like to acknowledge the traditional custodians of the Sydney region on which the University of Technology, Sydney stands – the people of the Eora nation. The Eora people are the traditional owners of this land and are part of the oldest surviving continuous culture in the world. I pay my respects to the spirits of the Eora people. I honour the ongoing cultural and spiritual connections to this country and endeavour to act with respect for the cultural heritage, customs and beliefs of all Indigenous people.

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I dedicate this work to all the childbearing women I have ever encountered, those who I am yet to meet, and to all the care providers who are working tirelessly to serve them. May we live and work with grace and with our eyes open.

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LIST OF ABBREVIATIONS

ACM - Australian College of Midwives

AIHW - Australian Institute of Health and Welfare

AMA - Australian Medical Association

ANF - Australian Nursing Federation

ANMC - Australian Nursing and Midwifery Council

ANZCA - Australian and New Zealand College of Anaesthetists

ASIM - Australian Society of Independent Midwives

AYF- Australian Youth Forum

DHA - Department of Health and Ageing

EFM - Electronic Fetal Monitoring

GP - General Practitioner

HA - Homebirth Australia

ICM - International Confederation of Midwives

MC - Maternity Coalition

MSR - Maternity Services Review

NHMRC - National Health and Medical Research Council

OECD – Organisation for Economic Co-operation and Development

RACGP - Royal Australian College of General Practitioners

RANZCOG - Royal Australian and New Zealand College of Obstetricians and Gynaecologists

RCNA - Royal College of Nursing Australia

RDAA - Rural Doctors Association of Australia

GLOSSARY OF TERMS

Artificial Rupture of Membranes (ARM): An intervention performed by a midwife or obstetrician which involves the intentional breaking of the membranes surrounding the fetus, releasing the amniotic fluid in order to induce or accelerate the progress of labour.

Augmentation of Labour: Accelerating the process of labour through ARM and/or the intravenous administration of an oxytocic drug to increase the frequency and strength of uterine contractions.

Birth Centre: A maternity care setting that offers a home-like environment (in terms of furnishings) but is usually located within or nearby a maternity hospital. This model of care commonly involves a small team of midwives attending the woman throughout her antenatal period, labour and birth. It is offered to women experiencing a low-risk pregnancy who wish to avoid unnecessary intervention in birth. If medical care is required the woman must transfer to regular hospital care.

Caesarean Section (CS): An obstetric operation involving extraction of the fetus from the uterus via an incision made in the abdominal and uterine walls.

Cardiotocography Machine (CTG): An electronic form of external monitoring of the fetal heart rate and maternal uterine contractions via an ultrasound monitor strapped to the woman's abdomen. This provides graphical correlation between fetal heart rate and maternal uterine contractions and is commonly used to assess fetal wellbeing in both pregnancy and labour.

Electronic Fetal Monitoring (EFM): A method of examining the condition of a baby in-utero by noting any unusual changes in its heart rate. EFM can be utilised either externally via CTG or a handheld Doppler, or internally via a fetal scalp electrode attached to the fetal skull.

Homebirth: When a woman plans to give birth at home and is attended by a registered midwife or midwives of her choice. The woman will also receive antenatal and postnatal care from her midwife/midwives at home.

Induction of labour (IOL): An intervention used to initiate the process of labour prior to spontaneous onset. Methods of induction include the use of prostaglandin gel to soften the woman's cervix, ARM, and the intravenous administration of oxytocic drugs to create uterine contractions.

Instrumental birth: The use of an obstetric instrument such as forceps or vacuum extraction by an obstetrician to expedite the process of vaginal birth.

Normal birth: Sometimes used interchangeably with the term *vaginal birth* which simply refers to a fetus being born through the vaginal passage, whether obstetric intervention occurred or not. Truly normal birth only occurs when a woman gives birth without the use of induction, augmentation, instruments, epidural or spinal anaesthesia and without caesarean section.

Ultrasound Scanning (USS): Also known as *ultrasonography,* ultrasound scanning is a radiological technique involving the use of ultrasonic waves directed into the tissues to allow visualisation of the deep structures of the body. Used commonly in obstetrics to confirm pregnancy and estimate gestation, locate the placenta, estimate fetal size, weight and maturity, and identify fetal abnormalities.

ABSTRACT

Background: In 2008, a national review of maternity services was commissioned by the Australian Government. A number of significant reforms to the funding, organisation and delivery of maternity services were proposed with the stated intention of improving women's access to high quality, safe maternity services. A community consultation process was undertaken as part of The Review, inviting interested parties to comment on the proposed reforms. Over 900 individuals and professional organisations responded.

Aim: The aim of this study was to uncover the perceptions, beliefs and meanings associated with childbirth held by the key stakeholders in Australian maternity care.

Methods: Discourse analysis was chosen as the methodology for this project as it enabled examination of the unspoken or hidden messages in the data, paying particular attention to the construction of childbirth and the manifestation of power relations. The data set comprised of 11 submissions from peak professional and consumer bodies to the National Maternity Services Review (MSR).

Findings: The expression of, or desire for, power and control was found to be the major discourse underpinning all of the submissions analysed. In the context of maternity service reform, this discourse confirmed the existence of fundamentally different constructions of childbirth by the key stakeholders. This resulted in diverse opinions on how maternity services should be managed and operationalised. A discourse of risk and safety was used by the peak medical bodies to argue against the majority of proposed reforms. In contrast, peak nursing, midwifery and consumer groups used language that constructed childbirth as a normal life event. As such, submissions from midwifery, nursing and consumer groups demonstrated

strong support for the Government's reform agenda, arguing for a new vision for the future of maternity care that placed the childbearing woman at the centre of care.

Discussion: A clash of ideologies was evident amongst the key stakeholders in Australian maternity care. The fundamentally different constructions of childbirth possessed by obstetricians and midwives (supported by nurses and consumers) support the notion of 'turf wars' in the maternity care system. Whilst midwives and obstetricians already work together collaboratively, it appears that their interactions are often underpinned by the 'politics of power'. The findings of this research raise important issues around power and control in childbearing. They raise questions about women's right to have control over their bodies in childbirth – including decisions about their most suitable care provider, model of care and intended place of birth. As long as the struggle for power underlines the actions of care providers, women will not truly be at the centre of maternity care.

Conclusion: Understanding the different ideologies inherent in the professional and public discourses of childbirth provides insight into how each party can work together more effectively to ensure the delivery of high quality maternity services for Australian women. The encouragement of professional courtesy in practice would go some way in ameliorating the 'politics of power' that underpin maternity care providers' interactions. Changes to the way medical and midwifery students are educated, including greater exposure to normal birth, is required. Further research into the socio-cultural meanings associated with birth is warranted as developing greater awareness of the different constructions of childbirth supports harmonious relationships between maternity care providers.

CHAPTER ONE - INTRODUCTION

> Everything about pregnancy and birth – how it is perceived by society, how the pain of birth is endured by women, how birth is 'managed' by birth attendants – is highly cultural (Wagner 2001, p. 36).

PERSONAL UNDERSTANDINGS AND EXPERIENCES

When I was offered a place in the first ever Bachelor of Midwifery in NSW it was with great excitement and anticipation that I accepted. I felt as if all the elements of my young life were finally aligning in order to send me on the path of my calling, the path of the midwife. The journey, however, has been far from straightforward or easy. Unlike the birth stories I so cherished in Ina May Gaskin's renowned 1975 text 'Spiritual Midwifery', the way I witnessed birth being managed in the large tertiary hospital of my first clinical practice lead to feelings of deep distress and the shedding of many tears. Over the years my distress at this way of managing birth has not lessened and, at times, tears of sorrow are still shed. The sense that women are being robbed of one of the most powerful experiences of their life by the medical management of birth provides a 'fire in the belly' that pushes me to keep going in the hope that I can facilitate better birth experiences, even if for just one woman.

In my clinical experience as a student midwife, I came to realise that the type of care a woman receives (obstetric, midwifery, fragmented or continuity of carer) can heavily influence her experience of pregnancy and birth. I witnessed many interactions between women and caregivers and noticed how differently each care provider treated women. Some treated their *patient* (I emphasise the use of the term patient as it implies subordinance and illness whereas use of the term *woman* implies recognition of the individual and her experience of a normal life event) as if her experience of pregnancy and birth was not particularly important or special,

whilst others expressed their gratitude for being invited to share the journey of childbearing with the woman and her family.

At times I found the language, behaviour and attitude of some maternity care providers very disturbing. I felt ashamed to call those health professionals colleagues and also felt powerless as a student midwife to protect the woman from harm. Six years on from commencing my midwifery studies I am now a qualified midwife and am also a mother. After witnessing the way birth is managed in hospital as a student, I chose to give birth to my first baby at home and will continue to choose this option with subsequent children. I choose homebirth because I believe it is safe, not only in the *physical risk* sense, but also safe from the unnecessary interruptions and inappropriate interventions that I witnessed all too often in the hospital birth environment.

I was brought up a feminist and this worldview affects everything that I do and everything that I am. I believe strongly in a philosophy and ethic of midwifery that serves the best interests of women by honouring their power in birth rather than taking it away. The word midwife means to be *with woman*. The emphasis of midwifery care is on the relationship between the woman and the midwife and it is this element of midwifery that I enjoy so much. Midwives are the experts in normal birth and I do not believe it is appropriate for women experiencing normal healthy pregnancies to be cared for by obstetricians, who are the experts in abnormal birth. I do, however, believe that midwives and obstetricians can work collaboratively, respecting each other's unique skills to provide the best possible care for women.

For this reason I was, like many in my profession, excited by the prospect of significant reform to maternity services as proposed by the Australian Government in their 2008 National Maternity Services Review (MSR). I became interested to *hear* the stories of others like myself, as well as learning how the key stakeholders positioned themselves at what seemed like a pivotal point in Australia's childbirth history. Underpinned by my feminist philosophy, I considered that analysing some of

the submissions to the MSR using discourse analysis would be a great research project for me to tackle as an Honours student. In this way I hoped to highlight the unspoken elements of maternity care providers' fundamental attitudes towards birth. It was those very attitudes that I believed may have the power to influence a woman's experience of childbearing; something that is bound to be one of the most powerful experiences of her whole life.

This thesis thus provides an analysis of submissions made by the key stakeholders in Australian maternity care to the National MSR, allowing insight into their construction of childbirth and the impact this has on the way maternity services are operationalised and the outcome of the Government's reform agenda.

AIMS AND OBJECTIVES OF THE STUDY

Ultimately, the purpose of this research project was to improve women's childbearing experiences through highlighting and bringing greater awareness to the public and professional discourses surrounding childbirth. The language used to describe pregnancy and birth is important because it reveals information about the history, current approaches and possible future directions of maternity care (Hewison 1993). The development of this study was driven by the research question:

> *What does the language used by the key stakeholders in Australian maternity services reveal about how they construct childbirth?*

The aim of the research was to use discourse analysis to explore and critically analyse the language used by 11 key stakeholders in maternity care and demonstrate how this rhetoric frames the way in which childbirth is constructed in the Australian context.

The expected outcome was that evidence from the study would provide greater knowledge of the underlying constructions of childbirth held by 11 key stakeholders in maternity care. This would deepen understanding of current socio-cultural meanings associated with childbirth within the Australian context and provide insight into how the Government, professional bodies and consumer groups can work together effectively to ensure adequate maternity service reform and quality service provision.

In this chapter I give an overview of the current context of maternity services in Australia. The Australian healthcare system is briefly outlined, along with a description of the roles played by the two principal providers of maternity care; midwives and obstetricians. Following this is an account of the different models of midwifery care currently available and recent data regarding place of birth, birth outcomes and interventions. A background to the 2008 National MSR and an outline of the community consultation process involved is provided, as this is where the data for the research was drawn from.

CONTEXT: MATERNITY SERVICES IN AUSTRALIA

Whilst my study makes reference generally to the social construction of childbirth in Western culture, it is primarily concerned with maternity service reform in Australia and the data set is drawn solely from Australian sources. This section provides the context for the study by outlining the predominant mode of maternity service delivery in Australia and explains the different models of care available. It also outlines the latest statistics on birth outcomes, interventions and place of birth in Australia.

Overview

On the whole, Australia is considered to be one of the safest countries in which to be born or give birth (Commonwealth of Australia 2008). Data from the Organisation for Economic Cooperation and Development (OECD) shows that over the past decade, Australia has had consistently lower maternal and perinatal death rates than the majority of countries with a similar economic demographic (OECD 2011). There are, however, significant inequalities faced by Australia's Indigenous population as well as women living in rural and remote areas of Australia. Maternal mortality rates for Aboriginal and Torres Strait Islander women are more than two and a half times that of non-Indigenous women (Sullivan, Hall & King 2008). They are more likely to experience stillbirth and neonatal death, have a higher proportion of low birth-weight babies and are more likely to give birth pre-term (AIHW 2010). Pregnant Indigenous women tend to access antenatal care later and with less frequency, the reasons for which are complex and multifaceted (Homer et al. 2009). Women living in rural and remote regions of Australia are also at much greater risk of experiencing neonatal deaths and stillbirth (AIHW 2005). Across Australia, a total of approximately 130 maternity units have closed down in the last 15 years, many of which were in rural and regional areas (Commonwealth of Australia 2009; NRHA 2010). As a result, rural women generally have much poorer access to maternity care than those living in metropolitan areas and often have to travel great distances to major tertiary hospitals for birth (Commonwealth of Australia 2008; NRHA 2010).

Australian healthcare system

In Australia, free access to healthcare in public hospitals is facilitated by the Medicare system. Medicare is a national health-financing scheme that was first introduced to legislation in 1984 (Bloom 2000). Medicare forms an integral part of health policy as it greatly reduces financial barriers to accessing healthcare for Australian residents by offering free access to public hospitals, subsidised access to

medical practitioners and subsidised access to pharmaceuticals (primarily for prescription medications) (Bloom 2000; Duckett 2004). Around 45% of the Australian population possess private health insurance, with policies that offer women greater choice in their healthcare provider and cover around 15% of the 'gap' in costs not covered by Medicare (Australian 2020 Summit 2008).

Compared with other developed nations, the Australian Government spend an average amount on health with less than 10% of the country's Gross Domestic Product (GDP) dedicated to healthcare (Australian 2020 Summit 2008). Hospitals are a major focus in the current model of healthcare delivery as they are allocated approximately a third of all healthcare spending per capita (Australian 2020 Summit 2008).

Maternity care providers

Maternity services in Australia are provided by a range of different healthcare professionals including midwives, obstetricians, and General Practitioners, some of whom have additional obstetrics qualifications. Care is provided in a variety of settings with the majority of women accessing public sector care with midwives (AIHW 2010). The International Confederation of Midwives' (ICM) defines a midwife as:

> … a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures (ICM 2011, p. 1).

Midwife-led continuity of care has been shown to have significant benefits for childbearing women including; a greater sense of control, better rates of spontaneous vaginal birth and breastfeeding, as well as reduced rates of instrumental birth, use of epidural anaesthesia and episiotomies (Hatem et al. 2009). This is, perhaps, due to the philosophy of midwifery care being focused on the normality of birth and placing emphasis on the natural ability of women to give birth without intervention (ACM 2004; Hatem et al. 2009; ICM 2010). Midwife-led care is available in the public hospital system to women experiencing normal, healthy pregnancies. Midwives work collaboratively with obstetricians and part of the midwife's role is to refer a woman to medical care if problems arise during pregnancy or birth (ACM 2004; ICM 2010).

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), define the role of the obstetrician as to:

> …reflect that pregnancy and child birth is a natural and personal process in which the role of the obstetrician is to deliver expert advice and treatment in a caring professional manner to maximize the safety and well-being of mother and baby (2010b p.1).

In addition to their original involvement in complicated pregnancy and birth, over the past 100 years, obstetricians have increasingly become responsible for the care of women experiencing normal pregnancy and birth (Hamilton 2011). Women experiencing normal or low-risk pregnancies can choose to privately employ an obstetrician for their maternity care and many obstetricians in Australia currently have thriving private practices (Hamilton 2011). This model offers excellent continuity of carer during the antenatal period, though during labour the woman will be cared for primarily by unknown midwives with the obstetrician usually attending for the birth (Dahlen 2010a). Evidence suggests that obstetric-led care is associated with higher rates of intervention and lower rates of normal birth than midwife-led care (Hamilton 2011; Roberts, Tracy & Peat 2000) although this is contentious as

obstetricians often care for women with higher risk. It is acknowledged that due to the type of education and training obstetricians receive, which focuses primarily on the pathology of pregnancy and birth, they are more likely to intervene in the birth process (WHO 1996). As a result, medical interventions have become more widespread amongst women without obstetric complications (Hamilton 2011; WHO 1996).

A more comprehensive description of the roles played by different maternity care providers and allied health professionals is provided in the Methods chapter.

Models of care

In the Australian maternity system, midwives practice in a range of different models of care including independent or private practice, caseload, team and fragmented care (Hatem et al. 2009; Homer et al. 2009). The majority of pregnant women in Australia will receive fragmented midwifery care in pregnancy, attending their local public maternity hospital and seeing as many as 30 different midwives throughout pregnancy, birth and the postnatal period (Commonwealth of Australia 2008). This model is known as 'fragmented' because it involves the pregnant woman attending a hospital based antenatal clinic which may be staffed by a different midwife at each visit. The woman will not meet the midwife who will care for her during labour and birth until she presents to the hospital in labour. She will then be cared for by numerous different midwives on the postnatal ward before being discharged home. It is estimated that women in fragmented models of midwifery care will see up to 30 different midwives in each childbearing episode (Homer 2006). Fragmented care is associated with less satisfaction for both women and maternity care providers, compared with continuity of care models (Hatem et al. 2009; Hodnett et al. 2003; Page, Cooke & Percival 2000)

Team midwifery care involves a woman being cared for by a small team of midwives, giving her the chance to meet each of them before labour (Hatem et al. 2009; Waldenstrom et al. 2000). Evidence shows positive outcomes associated with team midwifery when teams consist of six to eight midwives, however teams are not always this 'small' (Homer 2006; Waldenstrom et al. 2000). The number of midwives that make up a team varies considerably between different hospitals and teams of up to 20 midwives have been reported (Homer 2006). Whilst overall team midwifery care has been shown to improve the woman's chance of knowing her midwife in labour, the larger the team of midwives caring for the woman, the less chance there is for a respectful and trusting relationship to develop (Hatem et al. 2009). The full benefits of continuity of care, therefore, are at times not provided with a large team (Hatem et al. 2009).

Caseload midwifery models involve a pregnant woman being cared for by one primary midwife whom she will, ideally, get to know and trust (Hatem et al. 2009; Page, Cooke & Percival 2000). This midwife is on call for the woman's labour and will continue to care for her in the postnatal period (Hatem et al. 2009). The primary midwife is supported by other caseload midwives in her team who can provide care to a woman on an occasion where the primary midwife is unable to attend. This model provides the most comprehensive one-to-one midwifery care available within the hospital system (Hatem et al. 2009).

Independent or privately practising midwives can be employed by a woman to provide care either at her home, or in a hospital environment (ASIM n.d.; Commonwealth of Australia 2009). While recent changes in policy that developed as a result of the MSR have made it possible for private midwives to provide midwifery care to women in hospital, the majority of private practice midwives currently attend homebirths (Commonwealth of Australia 2009). Homebirth with private midwife provides an excellent level of continuity of caregiver, allowing the woman and

midwife to develop a relationship of mutual trust and respect (Page, Cooke & Percival 2000).

As mentioned previously, continuity of care models present major benefits for both women and the midwives caring for them (Hatem et al. 2009; Page, Cooke & Percival 2000). A key advantage for both parties is the opportunity to develop a meaningful relationship which leads to greater job satisfaction for midwives and increased satisfaction with care for women (Hatem et al. 2009; Hodnett et al. 2003; Page, Cooke & Percival 2000; Waldenstrom et al. 2000).

Birth outcomes

Recent data from the Australian Institute of Health and Welfare (AIHW) (AIHW 2010) on Australia's mothers and babies was collected in 2008. It showed that almost all women (96.9%) giving birth in Australia did so in a conventional labour-ward setting within a hospital (AIHW 2010). Only 2.2% of women giving birth did so in a birth centre and 0.3% of women giving birth planned to do so at home (AIHW 2010). In the past ten years, there has been an increase recorded in the amount of interventions that occur during birth, such as induction or augmentation of labour (IOL), use of pharmacological pain relief and epidural anaesthesia (AIHW 2010). In 2008, approximately 1 in 9 mothers experienced an instrumental vaginal birth (11.4%) with the use of either forceps or vacuum extraction (AIHW 2010). Over the past decade, the rate of caesarean section has been consistently rising from 21.8% in 1999 to 31.1% in 2008, though it has plateaued somewhat in the last few years (AIHW 2010). In 2008, the caesarean section rate for first time mothers was 32.0% and of women who had previously given birth via caesarean section, around 83.2% had a further caesarean (AIHW 2010). Australia's caesarean section rate is now 25% higher than the average rate of all OECD countries (Commonwealth of Australia 2009; OECD 2007).

Of the women who gave birth in hospitals in 2008, 69.8% were accessing public hospitals and 30.2% private hospitals (AIHW 2010). Despite public hospitals caring for the majority of women with complex pregnancies, private hospitals tend to have higher rates of intervention including instrumental births and caesarean sections. AIHW data from 2008 showed the caesarean section rate for women giving birth in private hospitals was 41.3% compared with a rate of 28.1% for women giving birth in public hospitals (AIHW 2010). Forceps accounted for 4.9% of births in private hospitals compared with 3.3% in public hospitals and vacuum extraction accounted for 10.4% of births in private hospitals compared with 6.9% in public (AIHW 2010). The difference in the rates of intervention and caesarean section between women cared for in private and public hospitals is of significance because this indicates that birth outcomes are influenced by both care providers and environment.

Over a decade ago, the World Health Organisation (WHO) stated that the increasing medicalisation of birth was resulting in women giving birth within 'obstetric facilities', regardless of their pregnancy being considered low or high-risk (WHO 1996, p.2). WHO put forward that this trend had resulted in unnecessary use of interventions for women and inhibited women's chances of experiencing normal physiological birth (WHO 1996).

BACKGROUND TO THE NATIONAL MATERNITY SERVICES REVIEW

In 2008, the Commonwealth Chief Nurse and Midwifery Officer, Rosemary Bryant, led a National Review of Maternity Services (hereafter MSR) on behalf of the Australian Government (DoHA 2009c). The results of the MSR informed the development of a Report of the MSR which was released in March 2009 (DoHA 2009c). The Federal Government responded in May 2009 with the historic allocation of $120.5 million in the Federal budget for the implementation of a plan titled '*Providing More Choice in Maternity Care- Access to Medicare and PBS for Midwives*.' (DoHA 2009a, 2009c).

The Department of Health and Ageing (DoHA) prepared a discussion paper titled 'Improving Maternity Services in Australia: A Discussion Paper from the Australian Government' (DoHA 2009c). This was released on the 10th of September 2008 and was available on the Department's website (DoHA 2009c). The discussion paper set the context for the consultation process, drawing on existing research and data both local and international and outlining current service delivery arrangements for antenatal, birth and postnatal services (Commonwealth of Australia 2008).

The MSR canvassed a wide range of issues, with particular emphasis on the importance of women having a range of different birthing options available to them (Commonwealth of Australia 2009). Significantly, part of the reform agenda involved addressing barriers preventing midwives from providing primary maternity care – a move that has historically been resisted by medical professionals (Homer 2006). It was suggested in the MSR discussion paper that a number of barriers to midwife-led care needed to be removed, such as lack of professional indemnity insurance, access to Pharmaceutical Benefits Scheme and Medicare Benefits Schedule, as well as visiting rights for privately practising midwives in the hospital setting (Commonwealth of Australia 2008). This recommendation was balanced with the suggestion that appropriate referral pathways needed to be developed in order to support midwife-led care in the case of high-risk or complicated births (Commonwealth of Australia 2008).

As part of the community consultation process, a series of questions were posed in the discussion paper and an invitation was put forward for all interested individuals and organisations to respond. Advertisements were placed in national and metropolitan print media inviting response to the paper, along with direct emails to known stakeholders (DoHA 2009b). A seven-week period was allowed for submissions, starting on the day the discussion paper was released (DoHA 2009b). The Department received over 900 submissions from individuals, industry groups,

health professionals, researchers, professional organisations and national peak bodies (Commonwealth of Australia 2009).

The content of submissions was varied, ranging from personal birth stories, descriptions of the experiences of health workers providing maternity care, to examples of existing successful models of care both within Australia and internationally (Commonwealth of Australia 2009). Other submissions provided research and strategic policy papers with regard to the many aspects of pregnancy, birth and postnatal care (Commonwealth of Australia 2009). Women's personal stories made up 407 of the submissions received and a significant proportion of the submissions (53%) were from women who have personally experienced homebirth (Commonwealth of Australia 2009). All of the submissions were considered by 'The Review Team', who then prepared a Review Report for the Health Minister, Nicola Roxon (Commonwealth of Australia 2009). Of the submissions, 832 are available for public viewing on the DHA website.

For the purpose of this thesis, this material provided a rich insight into how key stakeholders in maternity care construct the meaning of childbirth in contemporary Australian society.

THESIS OVERVIEW

The Honours thesis consists of five chapters, commencing here with the Introduction chapter which sets the context for the research. Following this chapter the Literature Review reports on a wide-range of literature regarding the social construction of childbirth over the past three decades. The Methods chapter then outlines the chosen methodology of discourse analysis and explores the influence of feminism, poststructuralism and the ideas of French philosopher, Michel Foucault on the stated methodology. The Methods chapter also provides a description of the data set and outlines the particular process undertaken during analysis. Chapter Four

reports on the findings of the analysis process under the title 'The maintenance and resistance of power and control'. The Discussion chapter titled 'The politics of power' places the findings in the context of the current state of maternity care in Australia, drawing on relevant literature to confirm or deny claims made in the findings. The Discussion chapter also offers recommendations for future education, practice and research.

CONCLUSION

This chapter firstly provided a personal introduction to the topic studied. The aims of the research were subsequently described, followed by an exploration of the maternity service context, the role of key players and the Governments intended maternity service reform agenda. In conclusion, whilst childbearing women appear to be offered more choices than they did a decade ago, many of the models of care available continue to reflect a medical paradigm and alternatives are often difficult to access (Newburn 2006). In Australia, maternal and neonatal outcomes are particularly poor for Aboriginal and Torres Strait Islander women and for women living and rural and remote areas. There are also issues of high intervention and caesarean rates, combined with a lack of access to continuity of midwifery care.

While this research project was commenced in the midst of the reform process, it was hoped that by critically analysing the public and professional discourses around birth, the perceptions, beliefs and meanings associated with childbirth in the Australian context could be identified. This was undertaken in order to ascertain how key stakeholders construct childbirth with the aim of improving the possibilities for maternity service providers to work together more effectively for the provision of quality maternity services for Australian women. The next chapter provides a

context to the study by exploring the relevant literature on what others have put forward regarding the social construction of childbirth.

CHAPTER TWO - LITERATURE REVIEW

INTRODUCTION

In this chapter the national and international literature relating to the social construction of childbirth is reviewed with the aim of providing a context for the study. As discussed in the Introduction chapter, the primary mode of maternity care delivery in Australia is hospital-based, available through either the public or private health system. Recent data from the Australian Institute of Health and Welfare (AIHW) shows that in 2008, the vast majority of childbearing women (96.9%) gave birth in hospital in conventional labour-ward settings (AIHW 2010). Of those women 31.1% gave birth by caesarean section and 11.4% had an instrumental birth with the use of forceps or vacuum extraction (AIHW 2010). Only 4.1% of women giving birth in Australia intended to give birth in an environment other than the labour-ward setting such as a birth centre or at home and in total only 3.1% actually managed to achieve this (AIHW 2010).

The Australian Government's 2008 National Maternity Services Review (MSR) discussion paper and subsequent community consultation process were designed to address the 'issues, gaps and priorities which concern Australian women and their families' (Commonwealth of Australia 2008, p. 1). Responses to the community consultation process made by 11 key stakeholders in maternity care form the data set for this research. The MSR discussion paper acknowledged that Australian women experience high rates of intervention when compared with women in demographically similar overseas countries and that this is associated with the higher proportion of women giving birth in hospital rather than birth centres or at home (Commonwealth of Australia 2008). This raises some important questions such as:

- Why does Australia have such high rates of intervention and caesarean section?
- Why do so few Australian hospitals offer access to continuity of midwifery care models when they have been shown to improve women's outcomes and experience?
- Why do such a small proportion of women access birth centres or home birth?
- What is it that has restricted Australia from improving women's access to birthing services outside of the dominant model of hospital-based, fragmented care?

This research is primarily concerned with examining how professional and consumer groups construct childbirth in Australia in order to gain insight into the issues raised above. By examining the power relations between the various maternity care providers within the health system and between healthcare professionals and the women they care for, insight is likely to be gained into the underlying political and cultural drivers of maternity service delivery in Australia.

This chapter begins with an explanation of the term 'construction of childbirth' and goes on to provide a historical overview of the construction of childbirth over time. The concept of technocracy is introduced and explored under the heading 'the technocratic paradigm'. The alternative view, referred to as 'the humanistic paradigm', is then explored. Finally, an overview of the current maternity care system in Australia is given with some final thoughts and discussion on the social construction of childbirth.

THE CONSTRUCTION OF CHILDBIRTH

The term 'construction of childbirth' refers to the concept that everything that is done to, and done by, childbearing women has a cultural foundation (Oakley 1980;

Wagner 2001). According to both the national and international literature reviewed there are at least two distinct constructions of birth, frequently referred to as the 'technocratic' and 'humanistic' paradigms of childbirth (Davis-Floyd 2001, p. 5). A third model, defined and referred to as the 'holistic' paradigm of childbirth by Davis-Floyd (2001, p. 5), was also identified. The holistic paradigm, however, has not been addressed here as it is considered to be so divergent from the dominant mode of maternity care in Australia, of which this thesis is concerned.

The notion of a paradigm features strongly in this area. A paradigm can be thought of as a mode of thinking or world-view, something that informs how one understands and experiences the world (Oxford University Press 2011g). Apart from being labelled the 'technocratic' and 'humanistic' paradigms of birth (Davis-Floyd 2001, p. 5), other authors have described these different paradigms or ideologies as being 'medical' or 'social' models of care (Van Teijlingen 2005, p. 1) and the same concept has been expressed even more simply as care providers being of a 'mechanic' or 'organic' mindset (MacColl 2009, p. 6). Each of these concepts is explored later in this chapter under the titles of 'the technocratic paradigm' and 'the humanistic paradigm'. To appreciate how these contrasting constructions of childbirth developed, a brief historical overview has been provided that demonstrates the changes in how childbirth has been constructed over time and the developing roles of midwives and obstetricians.

HISTORICAL OVERVIEW

This historical overview outlines the major developments in the social construction of childbirth throughout the 16th-19th centuries and introduces the developing roles of midwives and obstetricians throughout that time. The history of caring for women in childbirth dates back to the beginning of time and every society around the world has its own unique culture surrounding birth (Kitzinger 2005). Throughout ancient history, European and Western nations considered childbirth to be strictly women's

business - a matter of which women alone had special understanding, and until early modern times no word existed in any language to describe a male birth attendant (Donnison 2004). The concept of modernity, as used in the disciplines of philosophy and sociology, generally refers to the period of Western history that dates from the 16th to 18th centuries onwards; also known as The Enlightenment (Danaher, Schirato & Webb 2000). Prior to this time most midwifery knowledge, similar to knowledge in other fields, was passed on by word of mouth as few women - even if literate - had the necessary skills to read medical texts which were written in Latin (Donnison 2004). Midwives of the time derived their knowledge both from their own birthing experiences and by attending the births of relatives and neighbours (Donnison 2004; Shepherd, Rowan & Powell 2004). The art and skill of midwifery was also regularly passed down through family lines from mother to daughter (Donnison 2004; Shepherd, Rowan & Powell 2004). Generally, birth took place at home with a midwife and other female friends in attendance. Their role was to carry out rituals to help the mother and baby avoid death and illness which, at the time, was often attributed to ancient superstitions regarding the spells of malevolent spirits (Donnison 2004).

The Enlightenment period brought immense change to society as the superstition and fear of the medieval world was cast off and reason was used to discover the world anew (Dowling 2002). Rather than trusting that God controlled the universe in a manner impossible for humans to comprehend, innovative efforts were made to discover the natural laws that governed the universe leading to significant scientific, political and social advances (Dowling 2002). Remarkable developments were made in the domains of physics and the natural sciences, and by the 1800's people began to place their trust in the men of science and their promises to eradicate poverty, starvation and disease (Fahy 1998). During this period, the rational basis for all existing beliefs was examined; this proved to be a time of great significance for childbearing women and midwifery as surgeons applied this 'spirit of enquiry' to the process of childbirth and for the first time men began to attend births in a

professional capacity (Donnison 2004, p. 1075; Dowling 2002). The Modern era was a time of unrestrained optimism and confidence as people began to believe that humankind was superior to nature and could provide happiness for all people through advancing science and technology, and the subsequently improved economy (Fahy 1998).

It was during this time of revolution that medicine became aligned with science and technology, and birth was moved from the home to hospital. Throughout Europe in the 18th and 19th centuries, midwifery was on the decline and the exclusive role of the midwife as caregiver in childbirth came under increasing medical challenge (Fahy 2007a). As a result, obstetric practitioners - having a greater understanding of the female anatomy and the process of childbearing - started to experiment with new tools and techniques designed to improve birth outcomes, such as the obstetric forceps for assisting obstructed labour (Fahy 2007a; Loudon 1992). Whilst it was recognised that a thorough understanding of anatomy was fundamental to good midwifery practice, women's exclusion from universities where such knowledge was acquired placed them in a disadvantaged position compared with men (Donnison 2004). Custom also discouraged the use of obstetric instruments by women, further advancing the position of men, and as childbirth was increasingly thought of as a 'mechanical process', male attendants and doctors with their instruments began to be thought of as the most appropriate birth practitioner (Donnison 2004, p. 1077). In 1858, the United Kingdom developed a Medical Act which was emulated in Australia shortly after (Fahy 2007a; Willis 1983). This new legislation was an important achievement for the professional autonomy of medicine as it defined and controlled medical practice by limiting who was allowed to practice, permitting the profession of medicine more power (Fahy 2007a; Willis 1983).

Following The Enlightenment, another significant social and economic shift occurred known as the Industrial Revolution. Starting in England in the late 18th Century and later spreading to other countries, a rapid development of industry was brought

about by the introduction of advanced machinery (Powers 2001). The economy was converted from one of agriculture and handicrafts to the mass production of manufactured goods leading to unprecedented economic transformation (Powers 2001). During the 18th Century, Europe experienced tremendous population growth and whilst the cities were rapidly expanding, many people experienced poor living conditions, poor diet and infections leading to malnutrition and disease (Fahy 1998).

It was also during the 18th Century that the first 'lying-in' hospitals were developed throughout Europe, America and Australia with the dual aim of offering free healthcare to poor women and providing access to a large numbers of births for male birth attendants to practice upon (Fahy 2007a, p. 26; Kitzinger 2005; Loudon 1992). The creation of such institutions was somewhat of a mixed blessing for the women who attended. The concept of antiseptic practice did not develop until the late 19th Century and, as a result, many women who attended hospital for childbirth died due to puerperal sepsis - an infection acquired during birth that was closely linked with the poor hygiene practices of hospital doctors (Donnison 2004; Fahy 2007a; Kitzinger 2005; Loudon 1992). After moving birth from the home environment to hospital, maternal mortality actually worsened significantly; this was primarily the result of puerperal sepsis and the use of damaging and unnecessary instruments (Donnison 2004). The general poor health and malnutrition suffered by women in pregnancy was also a contributing factor to the high rates of maternal mortality experienced (Donnison 2004; Fahy 1998; Loudon 1992).

The Industrial Revolution saw the emergence of new technologies, and with that came humankind's ability to dominate and control nature - including our natural bodies (Davis-Floyd 1994a). Technological progress was seen as the solution to all problems, and so developed technocracy – 'a society organised around an ideology of technological progress' (Davis-Floyd 1994a, p. 24). This ideology brought about a new mode of maternity care wherein controlling labour and birth through the use of medical intervention was favoured over allowing the natural process of labour and

birth to unfold (Davis-Floyd 1994b, 2001; Fahy 1998; Kitzinger 2005). Davis-Floyd suggests 'the more able we became to control nature, including our natural bodies, the more fearful we became of the aspects of nature we could not control' (1994a, p. 24). Medical intervention in birth became increasingly common as the modernist medical framework was fear driven, focusing on the risks involved in childbirth and employing a problem-solving approach to maternity care (Fahy 1998). Arguably, this technology driven ideology still exists today, the tenets of which will now be explored in depth in relation to the management of childbirth.

THE TECHNOCRATIC PARADIGM

The technocratic paradigm of birth is a concept that has been written about by numerous authors (e.g. Burris 1989; Davis-Floyd 1990, 1994a, 1994b, 2001; Fahy 1998; Hewison 1993; Hunter 2006; Katz Rothman 1982; Kitzinger 2005; MacColl 2009; Reynolds 1991; Van Teijlingen 2005; Wagner 2001). It is also sometimes referred to as the medical or biomedical model of medicine.

The notion of technocracy refers to a society, government or industry who are controlled by an elite group of technical experts (Oxford University Press 2011i). The term originates from the Greek words *tekhne* meaning art or craft and *kratia* meaning power or rule (Oxford University Press 2011b). Technocracy differs from technology itself, which is defined as the 'application of scientific knowledge for practical purposes' (Oxford University Press 2011j, p. 1) because rather than an application, it refers to an ideology. A technocratic society is one in which the social system is structured around the value placed on each member by the knowledgeable elite, for example, scientists, engineers and health professionals (Reynolds 1991). Those members of society who possess particular technical expertise tend to have their opinions highly valued and, therefore, are able to elicit greater control in decision making processes (Reynolds 1991). Applying this theory to the culture of maternity care suggests that those with the greatest technical knowledge about

childbearing – the doctors – are in a privileged position and have the greatest control over decision making. The next tier of power is possessed by those with intermediate technical knowledge (more than childbearing women but less than doctors) – the midwives. Those considered to have the least technical knowledge – the childbearing women - have the least privileged position and therefore the least say in decision making.

Technocracy is viewed by several authors as the central ideology in Western culture and a belief system that heavily influences the way we manage birth (Burris 1989; Davis-Floyd 1994b; Reynolds 1991). Medical anthropologist Robbie Davis-Floyd suggests that the modern Western system of maternity care reflects the core values of Western society whose governing principles are focused on science and technology, economic profit and governance by patriarchal institutions (Davis-Floyd 1994b). In her description of the technocratic birth culture, Davis-Floyd draws on the work of anthropologist Peter Reynolds (1991), who explains technocracy as a 'mythological system that depends on the ritual transformation of nature to conform to culturally constructed images' (Davis-Floyd 1994b, p. 1125). Davis-Floyd draws on a theory developed by Reynolds known as the 'one-two punch' which she suggests explains the cultural management of American birth (Davis-Floyd 1994b, p. 1125). Reynolds theory of mutilation and prosthesis essentially explains the way Industrialised society destroys natural systems with the one hand, whilst artificially reproducing them with the other (Reynolds 1991). In Reynolds (1991) theory, punch one involves taking a highly successful natural process and rendering it dysfunctional with technology. He gives the example of the practice of salmon swimming upstream to spawn – a natural process that is rendered dysfunctional by human intervention - damming the stream and preventing the salmon from reaching their natural spawning grounds (Reynolds 1991). Punch two entails fixing the problem with technology – further intervention is needed. Using the same analogy, the salmon are taken out of the water, made to spawn artificially, their eggs are grown in trays and once mature, the baby salmon are trucked downstream and released near the ocean

(Reynolds 1991). Examples of how this theory relates to the management of childbirth are outlined below.

Technocratic management of birth

The one-two punch theory is helpful in developing our understanding of cultural processes surrounding childbirth in Western society (Davis-Floyd 1994b; Fenwick 2009). Davis-Floyd (1990) suggests that the mythology of the technocracy is displayed and enacted through obstetrical procedures and routines associated with hospital birth. A mythology is a collection of myths belonging to a particular cultural tradition (Oxford University Press 2011f). For example, in hospital a woman's labour is theoretically divided into distinct stages with time limits set on each phase (Brown et al. 2009; Fenwick 2009; Kitzinger 2005). This time line based on Friedman's curve, a guide developed by an obstetrician in the 1950's that is still used in maternity hospitals today (Zhang, Troendle & Yancey 2002). A labour that is not progressing as it should according to Friedman's curve, will be subject to medical interventions such as the augmentation of labour – intravenous administration of a synthetic form of oxytocin to intensify a woman's contractions (Brown et al. 2009). If the labour exceeds 12 hours it may be deemed 'failure to progress' and steps will be taken to expedite the birth through use of instruments or caesarean section (Brown et al. 2009; Kitzinger 2005). This model is used despite evidence suggesting that the majority of women labouring with their first child have a markedly different (usually slower) labour progress pattern than the one described by Friedman (Zhang, Troendle & Yancey 2002). This example demonstrates a typical feature of the technocratic paradigm; women being restricted to time protocols dictated by the system regardless of their individual situation or experience (Kitzinger 2005). Applying Reynolds (1991) theory of mutilation and prosthesis to this example, punch one could be seen as the division of the woman's labour into distinct stages with time limits set on each phase. When the woman's labour fails to fit into this imposed

model then punch two is enacted: medical interventions are used to speed up labour and/or expedite birth.

In 2009 a systematic review was undertaken by the Cochrane Collaboration (Brown et al. 2009) on research into whether active management of labour for all women reduces the rate of caesarean sections. The review defined active management as: routine artificial rupture of membranes; strict criteria for the diagnosis of the onset of labour and adequate progress in labour; intravenous administration of oxytocin to increase contractions; and one-to-one care which consisted of the continual presence of a midwife throughout labour (Brown et al. 2009). The review found that active management of labour was associated with a small reduction in the caesarean section rate, however the reduction was so minimal that is was not considered to be statistically significant (Brown et al. 2009). There were no improvements found with the use of active management in terms of reducing the number of instrumental births nor was there a reduction in complications following birth for women or their babies (Brown et al. 2009). Contrary to improving women's experience of birth, the authors also found that:

> … the disadvantages of active management are that it can possibly lead to more invasive monitoring, more interventions and a more medicalised birth in which women have less control and less satisfaction (Brown et al. 2009, p. 2).

The technocratic approach to childbirth is characterised by the use of medical interventions designed to reduce the risk of harm to the woman, fetus or baby throughout the childbearing period. This includes medical interventions such as: repeated ultrasound scanning in pregnancy, continuous electronic fetal monitoring in labour, artificial rupture of membranes, induction or augmentation of labour, instrumental birth and caesarean section (see Glossary for explanation of these terms).

Caesarean section is a major intervention and as such is often considered a marker for the general level of intervention being used (Enkin et al. 2000). In 2011, Declerq and colleagues published a study examining trends in the rate of caesarean sections being performed in industrialised countries from 1987 to 2007. The study found that the rate of birth by caesarean section has been rapidly increasing throughout the industrialised world over the last 20 years (Declercq et al. 2011). Declerq et al (2011) suggest there are a number of factors contributing to this trend including a substantial broadening of the criteria considered as an indication for a woman requiring a caesarean section and an increase in the incidence of routine repeat caesarean sections for subsequent births.

The rising caesarean rate has been recognised by some as a problem, however, concerns voiced over the matter are often dismissed by advocates of the technocratic paradigm as ill-founded and illogical (Fenwick 2009). The review by the Cochrane Collaboration (Brown et al. 2009) mentioned previously, however, suggests that rising rates of caesarean sections are of concern because surgical birth does not necessarily offer additional health gains to women. Brown et al (2009) found that caesareans may actually increase maternal risks, have negative implications for women's future pregnancies and fertility and offer serious resource implications for the hospitals performing them. Further to this, a meta-analysis by DiMatteo et al (1996) showed that caesarean sections may have adverse social and emotional implications for the women who have them. DiMatteo et al (1996) compared 23 specific psychosocial outcomes for women who had a vaginal birth with those who gave birth by caesarean section and found that the caesarean group were less satisfied with their birth experience, were less likely to successfully breastfeed, more likely to experience bonding difficulties and were at increased risk of postpartum depression. Despite the serious potential negative clinical and psychosocial implications of caesarean sections, surgical birth within the technocratic paradigm has been reframed as 'the natural solution' (Fenwick 2009, p. 108).

As the rate of primary caesarean section rises, so too does the rate of subsequent caesareans. The decision surrounding subsequent births after caesarean section is complex and multi-faceted (Enkin et al. 2000; Homer, Johnston & Foureur 2011). Evidence suggests that vaginal birth after caesarean (VBAC) is safe for most women (Enkin et al. 2000). Despite this, Enkin and colleagues suggest that 'obstetric practice has been slow to adopt the safety of vaginal birth after previous caesarean section' (2000, p. 368). A recent paper by Homer and colleagues (2011) looked at the outcomes of VBAC in NSW over a nine year period. The research showed that the rate of successful VBAC has declined in that time and is currently around 19% , with the number of 'attempted' vaginal births after caesarean only 35% (Homer, Johnston & Foureur 2011, p. 165). The authors concluded that more effort needs to be made to avoid caesarean section for a woman's first birth and women need to be better supported to have a normal birth following a caesarean section (Homer, Johnston & Foureur 2011).

Whilst obstetric interventions are designed to reduce the risk of harm to the woman and/or fetus during the childbearing process, when used routinely and without clear medical indication for doing so, they may do more harm than good. It has been recognised that 'in the absence of specific indications, vaginal childbirth is the safest route for the mother, fetus, and newborn in the first and subsequent pregnancies' (Society of Obstetricians and Gynaecologists Canada (SOGC) cited in Klein et al. 2011, p. 599). Davis-Floyd states 'we in the West have become convinced that altering natural processes makes them better – more predictable, more controllable, and therefore safer' (2001, p.9). However, as demonstrated by the Cochrane Review into the active management of labour (Brown et al. 2009) mentioned previously, routine use of substantial intervention in labour does not necessarily lead to benefits for the woman or baby and may instead have negative consequences. Apart from the physical aspects of morbidity associated with intervention in childbirth, Davis-Floyd writes of the 'deeply embodied, tremendously empowering experience of giving

birth on one's own, without the artificial aids of drugs and technologies' (2011, par. 1). This viewpoint is typical of the humanistic paradigm and will be explored later in this chapter. On the other hand, the ideology underpinning the technocratic paradigm of birth tends to place little importance on the woman's experience of childbearing, primarily due to the perceived disassociation between the human mind and body. This element of the technocratic paradigm is explored below.

Technocracy and the mind-body split

One of the key differences between the technocratic and humanistic paradigms is the perceived relationship between a person's physical body and their mind – which encompasses both the intellect and emotions (Davis-Floyd 2001; Hunter 2006; Wagner 2001). According to the literature reviewed on the social construction of childbirth, the technocratic paradigm sees the mind and body as separate with neither element holding influence over the other. In this paradigm, the body is compartmentalised with the belief that things are better understood outside of their context (Davis-Floyd 2001; Hunter 2006). The metaphor of the human body as a machine that can be taken apart, inspected and repaired in healthcare is believed to improve clinical decision making as it reduces the healthcare professionals emotional involvement with their patient (Davis-Floyd 2001).

The notion of a technocratic maternity care provider's emotional detachment to the woman they are caring for is supported elsewhere in the literature (e.g. Hunter 2006; Katz Rothman 1982; Kitzinger 2005; Wagner 2001). An example often given that demonstrates this phenomenon is the language used by healthcare professionals that signifies their disconnection from the childbearing woman. Hewison (1993) suggests that the language used by maternity care providers contains hidden, deeper meaning about their construction of childbirth. In the hospital system women are commonly talked about and managed simply as a medical case, for example "the Caesar in room 12" (Davis-Floyd 2001; Kitzinger

2005). According to the literature reviewed, different maternity care providers use distinctly different language when talking to and about childbearing women, depending on how they construct childbirth. The way care providers speak to women about pregnancy, labour and birth, and the language used in public discourses about birth send powerful messages to women about their bodies' ability to successfully conceive, nourish and give birth to a baby (Hewison, 1993; Hunter, 2006; Kitzinger, 2005).

The use of technocratic language in maternity care was noted by Leap (1992) nearly 20 years ago and again more recently by Kitzinger (2005). Kitzinger appears to agree with Leap's argument and both authors highlighted common obstetric terms such as 'incompetent cervix', 'failure to progress', 'inadequate pelvis' and 'trial of labour' suggesting they have the potential to leave women feeling distressed, doubting the adequacy of their bodies and their ability to give birth (Kitzinger 2005, p. 61; Leap 1992, p. 60). Kitzinger (2005) proposed that obstetric language is mechanistic, whereas women's language is experiential. She suggested obstetric language tends to be about conflict, employing metaphors of war and aggression such as the 'aggressive management of ruptured membranes' (Kitzinger 2005, p. 61). The examples provided above demonstrate the way language can influence the social meaning of an event and how this may influence the experience of maternity care for women and care providers.

Another area of practice that is thought to reflect a technocratic maternity care provider's disconnection from childbearing women is the level of physical contact they have with women, particularly in labour. Davis-Floyd points out that:

> Although it is well-known that touch and caring are powerful factors that can positively influence both a woman's experience of labour and the outcome of the birth … it is rare to see obstetricians touching labouring women, holding their hands, or sheltering them in an embrace' (2001, pp. 6-7).

This statement may be true, however is not just limited to obstetricians. Fahy (1998) states that some midwives in the hospital system are often too busy with the paperwork, machinery and medical intervention associated with birth in the technocratic paradigm to provide any physical or emotional comfort for labouring women. Whilst those favouring a technocratic approach may argue that a healthcare professional's primary role is to care for a woman's medical needs, those with a humanistic perspective disagree. Sociologist Barbara Katz Rothman (1982) contends that the type of care offered in the technocratic paradigm dehumanises women and fails to serve all of their needs. This is because, according to Katz Rothman (1982), in transitional life periods such as childbearing, medical needs are only a small part of the needs women have. The humanistic perspective and the concept of dehumanisation will be explored later in this chapter under 'the humanistic paradigm'. The way risk is viewed in the technocratic paradigm is another area where its philosophy deviates from the humanistic paradigm and is closely linked with the concept of control in childbearing. These ideas are expanded upon in the final section of 'the technocratic paradigm' below.

Risk and control in the technocratic paradigm

Risk is an important concept in maternity care as many decisions are made based on perceived risks to the health of the pregnant woman and her baby throughout each childbearing episode (Enkin et al. 2000). When cared for in hospital, women are usually classified as being of either low or high obstetric risk according to a number of factors relating to their personal and family history, obstetric history and their physical and emotional health in their current pregnancy. Although poorly defined, this classification system is used to determine what options are available to women in relation to who is deemed their most appropriate care provider (midwife or obstetrician), the place of birth (hospital, birth centre or home) and the possible use of interventions in pregnancy, labour, or at the time of birth.

American midwife Lauren Hunter (2006) identifies that from the technocratic viewpoint, childbirth is inherently dangerous and can only be deemed normal or safe in hindsight. This concept of safety in childbirth is essentially true – there are risks posed to the health of both the mother and baby at every birth – however within the literature there are several criticisms of the emphasis placed on risk in the technocratic paradigm of birth. One such criticism is that focusing so intently on risk has the potential to increase fear in childbearing women and their care providers, furthering their need to try and control the process of birth (Hausman 2005; Kitzinger 2005). In the technocratic paradigm, this desired control is thought to be best delivered by using medical interventions such as induction or augmentation of labour, continuous electronic fetal monitoring or caesarean section. The disadvantages of managing birth in this way is that it encourages women to hand over control of their childbearing bodies to health professionals as they are seen as the only ones who can reduce or control these risks (Hunter 2006; Wagner 2001). Further to this, according to Brown et al (2009), the use of unnecessary medical interventions has a potentially adverse impact on a woman's experience of birth.

Nearly twenty years ago Deborah Lupton (1993), an Australian sociologist, addressed the discourse of risk in public health and suggested that it was used to control women's understanding of, and choices in, childbirth. She proposed that in maternity care, risk is always weighted towards disaster and serves to incite fear rather than create peace of mind in the childbearing woman (Lupton 1993). Lupton (1993) proposed that risk discourse in public health reinforces *the system* (and those acting on behalf of it) as the owners of knowledge, able to exert power over the people. This is supported more recently by the work of American feminist scholar and Professor of English literature, Bernice Hausman. Hausman asserted that the concept of risk is one that 'frames medical childbirth protocols, beliefs and actual practices' in the hospital setting (2005 p. 25). Hausman proposes that the way risk is framed in the 'obstetrical encounter' is crucially important to the medical and social construction of birth and advocates for new ways of considering obstetric risk (2005

p. 26). She sees risk as being both produced and maintained by the institution in order to maintain power and control over the woman (Hausman 2005).

Similarly, obstetrician Marsden Wagner (2001), suggests that because most maternity care providers have only ever witnessed birth in the hospital under the technocratic paradigm, they cannot truly understand the damage that the perpetuation of the technocratic ideology is causing to women and birth. Wagner suggests that dehumanised birth is so entrenched in contemporary Western culture that 'fish can't see the water they swim in' (2001, p.26). The concept of humanised birth, which is viewed as the alternative to the management of birth in the technocratic paradigm, is now explored in 'the humanistic paradigm'.

THE HUMANISTIC PARADIGM

The literature reviewed for this study regarding the social construction of childbirth described the primary alternative to the technocratic paradigm as the humanistic paradigm, also referred to as the organic or social model (Davis-Floyd 2001; MacColl 2009; Van Teijlingen 2005). The ideology of the humanistic paradigm is primarily concerned with humanising birth. To humanise birth is to reclaim the personal power of women in childbearing, essentially by treating them as human beings rather than as metaphorical baby-making machines (Davis-Floyd 2001; Van Teijlingen 2005; Wagner 2001). Davis-Floyd describes humanism as an attempt by doctors and midwives who work within the medical system to 'reform it from the inside' (2001, p. 10). The humanistic movement in childbirth has developed as a response to the perceived problems associated with the technocratic model, such as escalating rates of intervention and caesarean sections, that is dominant in most Westernised countries (Davis-Floyd 2001; Hamilton 2011). As demonstrated in the historical perspective earlier in this chapter, the technocratic model has been in existence now for several hundred years; the humanistic model, on the other hand,

has only come about in the past few decades in an effort to *reclaim* birth (Davis-Floyd 2001; Hamilton 2011; Wagner 2001).

Humanistic endeavours to be woman-centred, rather than practitioner or institution-centred (Banks 2001). This involves placing the woman's needs and wants at the centre of everything the care provider does, in order to individualise care for each woman and her family (Banks 2001; Van Teijlingen 2005; Wagner 2001). Humanistic ideology places great emphasis on the woman's experience of childbearing and sees birth as a potentially empowering and personally fulfilling experience (Kitzinger 2005; Wagner 2001). Like the technocratic paradigm, the ultimate goal in the humanistic paradigm is to have the end result of a live, healthy mother and baby; though the humanistic perspective of health is broad and inclusive of psychological, social, spiritual and cultural forms of health (Hamilton 2011; Van Teijlingen 2005). Unlike the technocratic perspective, the humanistic philosophy also places value on satisfying the individual needs of each woman and her partner in their childbearing experience (Van Teijlingen 2005). One of the key differences between the technocratic and humanistic paradigms of birth is the interpretation of the connection between the human mind and body; something that is thought to affect how healthcare professionals practice. This element of the humanistic paradigm is explored below.

Humanism and the mind-body connection

A central tenet of the humanistic paradigm is the perceived connection between the human mind and body, as opposed to the technocratic paradigm's mind-body split (Davis-Floyd 2001; Van Teijlingen 2005). The humanistic approach considers the mind to have a distinct influence on the body and suggests that it is 'impossible to treat physical symptoms without addressing their psychological components' (Davis-Floyd 2001, p. 11). The theory of the mind-body connection is thought to be demonstrated particularly well in childbirth (Davis-Floyd 2001). For example, fear is

an emotion that has a known physical effect on the body. When a person feels fear they experience what is known as a 'fight or flight' response; stress hormones such as adrenalin and cortisol flood through the body and blood circulation is prioritised to the limbs – arms for fighting and legs for fleeing - and other essential organs such as the lungs, heart and brain (Simkin & Ancheta 2005, p. 17). For a woman giving birth (particularly in the first stage of labour) the fight or flight response causes decreased blood supply to the uterus which has the effect of slowing the progress of labour and can also cause adverse physiological responses in the fetus (Simkin & Ancheta 2005; Taylor et al. 2000). This primal safety mechanism is present in both animals and humans, and in labour it allows a woman who may be in danger to halt her labour until it is safe for her to give birth (Simkin & Ancheta 2005; Taylor et al. 2000). Safety in this instance, however, does not just apply to physical forms of danger such as being attacked; it also refers to feelings of fear, anxiety and other forms of emotional distress (Simkin & Ancheta 2005).

For women birthing in an institutional hospital environment, fear and anxiety may be triggered by the birth environment itself (Enkin et al. 2000; Fahy & Parratt 2006). The clinical nature of the hospital can be intimidating and anxiety provoking for women, along with the possible presence of unfamiliar or unsupportive care providers (Enkin et al. 2000; Simkin & Ancheta 2005). Women may also feel distressed due to the application of common medical interventions such as vaginal examinations or electronic fetal monitoring (Enkin et al. 2000). According to Simkin and Ancheta:

> Labor progress is facilitated when a woman feels safe, respected, and cared for by the experts who are responsible for her clinical safety. .. The opposite feelings of shame or embarrassment, of being observed, of feeling unsafe … ignored or insignificant, may elicit a psychobiological reaction that interferes with the efficient progress of labor (2005, p. 16).

It is an understanding of the influence of the mind on the body that leads humanistic practitioners to believe that, at times, emotional support for a woman may be more effective than technological intervention (Davis-Floyd 2001). For this reason, the humanistic paradigm places particular emphasis on the relationship that develops between the childbearing woman and her care provider; this element of the humanistic paradigm is explored further below.

The importance of relationships in the humanistic paradigm

According to the literature reviewed on the construction of childbirth, maternity care providers working within a humanistic ideology have a different way of *being with* women to those using a technocratic approach (Davis-Floyd 1994b, 2001; Kitzinger 2005; Leap 2000; Van Teijlingen 2005; Wagner 2001; Walsh 2004). The relationship that develops between a childbearing woman and her care provider/s is seen as a vital element of maternity care in the humanistic paradigm (Davis-Floyd 2001; Wagner 2001). Under the technocratic paradigm, care providers tend to screen out the emotional effects of decisions, which are thought to 'obscure rational thought', in order for them to make an impartial judgement on the appropriate course of action without the hindrance of personal feelings (LoCicero 1993, cited in Walsh 2004, p. 65). The humanistic approach, on the other hand, encourages the care provider to actively seek to engage with the woman's emotional needs and encourages a relationship of connection and caring to develop (Davis-Floyd 2001; Van Teijlingen 2005). Based on this philosophy, the humanistic paradigm promotes that decisions regarding care be made in conjunction with the woman so that the responsibility of decision making is shared and that power ultimately rests with the woman (Davis-Floyd 2001; Thompson 2004).

The humanistic ideology is based on understanding and providing care for a woman throughout her childbearing experience in terms of the context of her life, rather than in isolation from it. This means that a woman's past experiences are

acknowledged (both in terms of previous births and other life experiences) and decisions around maternity care are made with consideration for the social and emotional implications they may have on the woman and her family (Davis-Floyd 2001; Kitzinger 2005; Van Teijlingen 2005; Wagner 2001). According to advocates of the humanistic paradigm, this allows the woman to feel valued and supported and improves not only her experience of birth but also has the potential to improve her birth outcome (i.e. the health and wellbeing of both mother and baby after birth) (see for example Hatem et al. 2009; Hodnett et al. 2003). Healthcare professionals working with a humanistic ideology also tend to acknowledge a woman's intuitive understanding of her body and unborn baby, working with an overarching philosophy that birth is a normal, physiological process rather than a medical event (Davis-Floyd 2001; Van Teijlingen 2005; Wagner 2001).

Generally, the philosophy of midwifery is thought to be aligned with the humanistic paradigm (Davis-Floyd 2001; ICM 2010; Kitzinger 2005; Van Teijlingen 2005; Wagner 2001). For this reason, much of the literature that refers to humanistic practices is written about midwifery practice. Professor of Midwifery Nicky Leap wrote about the importance of the midwife-mother relationship and suggested that the 'unique nature of midwifery is based on the relationship between the midwife and the woman' (2000 p.4). This view was supported by another midwifery academic, Faye Thompson (2004), who advocates a humanistic approach to childbirth as being based on the midwife's prime relationship being with the childbearing woman, and the woman's prime relationship being with her baby. Thompson (2004) reminds us that it is only through the midwife-mother relationship that the midwife-baby relationship exists. In 2000, Leap suggested that the midwifery relationship is intrinsically different to the type of relationships developed between nurses or doctors and patients. This is because, in a continuity of care model, the midwife-woman relationship is the only one (perhaps with the exception of palliative care) where people engage a healthcare worker to travel alongside them on such a personal, life-changing journey (Leap 2000). This is typical of a humanistic

perspective because emphasis is placed both on the special relationship between the childbearing woman and her caregiver and the emotional nature of *the journey.*

The humanistic perspective on the mind-body connection gives a particularly psychosocial focus to humanistic care and also gives rise to the emphasis placed on the woman's experience of childbearing (Van Teijlingen 2005). Unlike the technocratic paradigm which priorities the 'production' of a healthy baby over everything else, the humanistic paradigm promotes the concept that a woman can have both a healthy baby and an enjoyable birth experience at the same time (Davis-Floyd 1994b, p. 1127). The importance of a woman's experience in the humanistic paradigm is further explored in the following section.

The importance of women's experience of birth in the humanistic paradigm

According to the literature reviewed, the humanistic paradigm sees pregnancy and childbirth as a rite of passage and potentially one of the most important achievements in a woman's life (Davis-Floyd 2001; Katz Rothman 1982; Kitzinger 2005; Wagner 2001). Wagner (2001), suggested that when a woman's birth experience is fulfilling and empowering, this makes the woman stronger and therefore makes society stronger. Several authors (e.g. Davis-Floyd 2001; Kitzinger 2005; Leap 2000; Stephens 2004; Wagner 2001) suggest, that for birth to be humanised, maternity care providers need to recognise the potential for a woman's birth experience to be fulfilling and empowering, and do everything they can to support this. British Social anthropologist and childbirth activist Sheila Kitzinger (2005) also puts forward the notion that when maternity care providers use a humanistic approach, birth is respected as a personal, sexual and potentially life-transforming event for the woman.

The concept of acknowledging the psycho-social nature of birth is sometimes described as being woman-centred care. Woman-centred care occurs when

healthcare professionals truly put the woman at the centre of maternity care by aiming to meet her social, emotional, spiritual, cultural and physical needs wherever possible (Leap 2000; Thompson 2004; Wagner 2001). This concept differs greatly from the technocratic ideology that see's the healthcare professional's role as to solely address the woman's medical needs. The humanistic paradigm also focuses on the desire for a range of healthcare professionals to work together for the best interests of the woman. Davis-Floyd (2001) and later Hunter (2006) suggested that birth is humanised when the woman has control over what happens to her and midwives and doctors work in harmony towards facilitating the best possible experience for the childbearing woman. French obstetrician, Michel Odent (1994), renowned for his promotion of natural birth and pioneering work on the development of home-like birth settings has stated that a woman's experience of labour is heavily dependent on the attitude and personality of her caregivers. Nearly two decades ago Odent suggested:

> Today obstetrics still focuses on the role of the doctor and his preoccupation with how best to control and master childbirth… as a medical discipline, it remains unaware of the potentially negative impacts of male doctors and strangers on the unfolding of labour… (1994, p. 16).

Around the same time, Davis-Floyd (1990) was asserting that in the technocratic model, the woman's experience of childbearing is considered unimportant, justifying the use of unnecessary interventions that serve the needs of the institution rather than the needs of the woman. She suggested that as evidence of the unnecessary and often harmful nature of obstetric procedures became known, increasing numbers of American women were raising their voices in protest of a system that was de-humanising and disempowering women (Davis-Floyd 1990). The humanistic movement continues today in an effort to improve women's experiences in childbearing and reduce the rates of unnecessary interventions being performed. The construction of childbirth in the context of the current maternity care system in Australia will now be explored.

AUSTRALIAN MATERNITY CARE: A MIXTURE OF BOTH

As demonstrated in the historical overview provided at the beginning of this chapter, the way childbirth has been constructed throughout history has often impacted the way maternity services are designed and delivered. Van Teijlingen affirms that when it comes to the social construction of childbirth 'schools of thought are more than just abstract and academic; they are associated with concrete and practical ways of doing things' (2005, section 4.2) Currently in Australia, the majority of maternity care providers are trained and educated in a predominantly technocratic healthcare system which greatly influences their social construction of birth and therefore the way they practice (Davis-Floyd 2001; Hamilton 2011; Hunter 2006; Katz Rothman 1982; Wagner 2001). As previously stated, Wagner identified that the technocratic paradigm of maternity care is so dominant and entrenched within Western society that many care providers have only ever witnessed and been party to what he calls 'dehumanised birth' (2001, p. 26). A recent study published in the European Journal of Obstetrics, Gynaecology and Reproductive Biology by Unterscheider et al (2011) supported this notion when it suggested that in obstetrics:

> Junior trainees are nowadays often better trained in performing a CS [caesarean section] than an instrumental vaginal delivery and a CS is sometimes the first procedure a trainee performs when starting a career in obstetrics (even before performing a normal vaginal delivery) (Unterscheider, McMenamin & Cullinane 2011, p. 141).

This quote suggests that obstetric practitioners trained in the dominant technocratic health system are more comfortable with surgical birth than normal vaginal birth because that is what they have been exposed to. Not only are healthcare professionals often predominantly exposed to medicalised birth, women too have come to see this type of birth as the norm (Fenwick 2009; Van Teijlingen 2005). As birth has become more and more medicalised over time, many women have come to expect and even demand medical intervention in birth (Davis-Floyd 1994b; Hausman 2005; Wagner 2001). Katz Rothman (1982) wrote of this problem nearly

thirty years ago when she suggested that once one had seen birth in an institutional context, it was very hard to imagine birth occurring outside of that context. She went on to suggest, however, that this rule can be applied in reverse; once one has seen birth in a home setting, it is very difficult to imagine returning it to the medicalised management of the hospital system (Katz Rothman 1982).

Whilst the literature review presented in this chapter has very clearly dichotomised the technocratic and humanistic paradigms of birth, this is not in fact a true representation of how Australian, or many other, maternity care systems work. Van Teijlingen (2005) proposes that on a scale of total technocratic care to total humanistic care, all maternity care providers working practice falls somewhere in between. According to Wagner (2001) several industrialised countries, including Australia, demonstrate a mixture of both highly medicalised, technocratic, doctor-centred maternity care alongside a more humanised approach with greater levels of autonomous midwifery care and lower intervention rates.

The notion of Australian maternity care being a mixture of both was also expressed by Australian author and journalist Mary-Rose MacColl. In 2004, MacColl was involved in the review of maternity services in Queensland, a process that considerably deepened her understanding of maternity care in Australia. Since undertaking the review she has further researched childbirth in the Australian context and written a book titled 'The birth wars: the conflict putting Australian women and babies at risk' (2009). In this publication, MacColl suggests that women have become the 'collateral damage in a war being fought between those who see birth as normal and natural and those who see birth as medical' (2009, p. 1). MacColl wrote of the different philosophies of childbirth as being 'mechanic' and 'organic', urging healthcare professionals to sort out their differences in order to improve both women's experiences of birth and birth outcomes (2009, p. 6).

In a similar vein, Klaus and colleagues (1993) wrote of the shortcomings of the maternity care system in America in the early 1990's. According to Klaus et al (1993), childbirth at the time was recognised as being lonelier and more psychologically stressful than ever before. Traditionally in most societies birthing women have had women kin, neighbours and community members as their birth attendants, as opposed to the current model where the majority of women are cared for by professionals; a team of strangers who are assumed to know more about birth than the woman bearing the child does (Kitzinger 2000; Odent 1994). There is no doubt that developments in science and technology have brought about changes in the practice of maternity care that have greatly benefited both women and children. The question now is, 'have we gone too far'? As intervention rates in Australia and other industrialised countries around the world continue to rise, so the numbers of women who experience the triumph associated with achieving a normal birth correspondingly decline. As MacColl suggested:

> Maternity care now is so entrenched in the medical system it is hard to believe that pregnancy was ever regarded as anything other than a medical condition that requires a hospital and a doctor (2009, p. 29).

Davis-Floyd (1990) argued that whilst the technological paradigm is dominant, few women will have the courage to step outside the medical model of birth. According to Davis-Floyd, those who do step outside the medical model, by choosing homebirth or choosing not to be subject to unnecessary intervention in hospital, have to completely 'reinterpret birth, under a different paradigm, as fundamentally safe' (1990, p. 187). There is a community of people – midwives, feminists, mothers, childbirth activists and some obstetricians and men - who are attempting to develop and put into practice a humanistic paradigm of birth (Davis-Floyd 1994b; Katz Rothman 1982; Wagner 2001). This movement is trying to refigure the human body, moving away from the form it has been given by the Western traditions of technocracy and modern medicine and move into an era where a woman's

satisfaction with her birth experience is seen as being of great importance, rather than focusing solely on the production of a live, healthy baby (Davis-Floyd 1994b, 2001; Kahn 1995; Katz Rothman 1982; Kitzinger 2005; Van Teijlingen 2005; Wagner 2001). The experience of childbirth has, for some, come to symbolise wider issues relating to women in society (Hewison 1993; Kitzinger 2005; Stephens 2004). 'Birth power' (a rejection of the technocratic management of birth) is seen as a powerful way for women to challenge or rival patriarchal power, reclaiming the female body as powerful and the process of birth as sacred (Kahn 1995, p. 4).

CONCLUSION

In this chapter a review of literature addressing the social construction of childbirth has revealed that contrasting philosophies exist in relation to childbirth deemed the 'technocratic' and 'humanistic' paradigms of birth. Those prescribing to a technocratic ideology tend to view pregnancy as an illness that requires medical assistance and intervention, and can only be deemed normal or safe in hindsight (Davis-Floyd 1990, 1994b, 2001; Hewison 1993; Kitzinger 2005; Van Teijlingen 2005; Wagner 2001). Those prescribing to a humanistic ideology, on the other hand, tend to view pregnancy and birth as a normal physiological event that has the potential to be personally empowering and transformative for the woman (Davis-Floyd 1994b, 2001; Hausman 2005; Hewison 1993; Kitzinger 2005; Van Teijlingen 2005). The existence of these two distinct paradigms means that birthing women receive different messages about the social meaning of birth depending on the worldview/s of the various care providers they come into contact with throughout their childbearing experience (Kitzinger 2005).

The way maternity care services and healthcare professionals care for childbearing women is influenced by their construction of childbirth, and the way we construct childbirth is influenced our personal beliefs and values which emerge from the culture and society in which we live. Currently, the practices within the hospital

system in Australia reflect the dominant construction of childbirth in this country, whether that is compatible with the woman's own construction of birth or not. Examining the way different care provider's construct childbirth gives us insight into how each party can work together more effectively to ensure the continuing provision of a high quality maternity service for childbearing women in Australia.

CHAPTER THREE - METHODS

INTRODUCTION

As identified in the previous chapter, there are at least two distinctly different ways of constructing childbirth; the technocratic and humanistic paradigms (Davis-Floyd 1990, 1994b, 2001; Hunter 2006; Kitzinger 2005; Van Teijlingen 2005; Wagner 2001). In the context of maternity service reform, understanding the different ideologies inherent in the professional and public discourses of childbirth provides insight into how each party can work together effectively to ensure a high quality service for Australian women. This research project involved the examination of the submissions made by the peak professional and consumer bodies in maternity care to the 2008 Australian National Maternity Services Review (MSR). The methodology chosen for this research was discourse analysis.

This chapter presents the study design, the process of data collection and analysis, and the ethical considerations for the research. This chapter provides the rationale for using discourse analysis and aims to orient the reader to the philosophical underpinnings of the methodological approach. The power of language is highlighted with particular reference to maternity care. This is followed by an introduction into the theories of French philosopher Michel Foucault, and an overview of the philosophies of critical social theory, feminism and poststructuralism. The method of data collection is described with justification for the chosen data set and the process of analysis outlined in order to demonstrate how findings were developed from the data. Finally, the chapter concludes with a brief overview of the ethical considerations for this research.

METHODOLOGICAL UNDERPINNING

Discourse analysis was chosen as the methodology for this research project as it allowed for examination of the unspoken or hidden messages in the data, paying particular attention to the construction of childbirth and the manifestation of power relations (Powers 2001). Discourse can be defined as spoken or written communication or debate and, as the title suggests, discourse analysis involves the interrogation of language (Foucault 1980; Oxford University Press 2011c; Powers 2001). The term language can refer to written, spoken, or non-verbal communication such as body language, and its expression can also involve the use of symbols (Oxford University Press 2011e). Language can be defined as a specific system of communication used by a particular country or community that employs words in a structured and conventional manner (Oxford University Press 2011e). Within maternity care, it is recognised that different languages of obstetrics, midwifery and women are all used to describe the process and experience of childbearing (Hewison 1993; Hunter 2006; Kitzinger 2005; Leap 1992). Applying discourse analysis to the language used by these different groups allows for the revelation of their social construction of childbirth.

A sociological approach to discourse analysis was found to be most suitable for this research as it allowed for the examination of the social and cultural context in which language is produced and understood (Lupton 2004). My research relies considerably on nursing academic Penny Powers' (2001) description of the methodology of discourse analysis. According to Powers (2001), the major theoretical influences on discourse analysis include the work of Michel Foucault, critical social theory, poststructuralism and feminism. This chapter now introduces the ideology behind each of these influences, initially addressing language with specific reference to maternity care.

Language and maternity care

Several authors have written about the social meaning of language expressing that there are hidden socio-cultural messages within language, at once describing and shaping the world in which it exists (Derrida 1997; Hewison 1993; Hunter 2006). According to French philosopher, Jacques Derrida (1997), language cannot escape the cultural history that produced it. Derrida (1997) believes that within language, hidden mechanisms are always at work subtly influencing meaning. He suggests that when we identify the underlying assumptions present in language we begin to recognise the power of concealed symbols that shape our thinking (Derrida 1997). This concept was also expressed by nursing academic Dr Alistair Hewison (1993), who argued that language is central to our understanding of the social world because it both reflects and constructs the reality we all experience.

The way maternity care providers speak to women about pregnancy, labour and birth, and the language used in public discourses about childbearing heavily influence women's views about their bodies' ability to successfully conceive, nourish and give birth to a child (Hausman 2005; Hunter 2006; Kitzinger 2005). Nearly two decades ago Hewison (1993) suggested that language is controlled by the powers of patriarchy and consequently women's experiences are often determined in this way. Patriarchy is a social system in which men dominate, oppress and exploit women in both the private and public domains (Walby, 1990 cited in Bates 2004). It involves the 'systematic organisation of male supremacy over women' (Bates 2004, p. 131) and is believed by some to be so pervasive in our culture that we have come to see it as the 'natural order of things' (Kaufmann 2004, p. 6). According to Kaufmann, the concept of patriarchy does not infer that all men purposefully intend to exploit women, but that inevitably men do so collectively because the oppression of women by men was the 'original power system, which became the template for all others' (2004, p. 6). The rejection of patriarchy is known as feminism, the ideology of which is explored later in this chapter.

Some authors (see for example Kitzinger 2005; Oakley 1980; Walsh 2004) consider maternity care that is organised and delivered in the tradition of hospital or acute based care to be patriarchal. The argument being that this model of care controls women's childbirth experiences, dictating what they can and cannot do (Kitzinger 2005; Oakley 1980; Walsh 2004). Examining the language of this doctrine provides insight into why this might be the case. Nearly two decades ago midwifery academic Nicky Leap (1992) proposed that in maternity care, many words and phrases are used that have the effect of disempowering and trivialising childbearing women. She offered an example of the term *allow* – a word used frequently in the hospital setting in such instances as 'we allow women here to adopt certain positions/ walk about/ go home early/ give birth in water…' etc (Leap 1992, p. 60). Leap suggested that use of the word *allow* reinforced the power imbalance that exists in interactions between maternity care providers and women in the hospital system (1992). Leap also warned that as long as maternity care providers continue to talk about *managing* or *conducting* labours, then they are not providing a truly woman-centred approach to care (1992).

In a similar manner, midwifery academic Susanne Darra (2009) has more recently argued for closer examination of language in maternity care. Darra even questions the widely accepted use of the term *normal childbirth*, suggesting that given how different each woman's experience of birth is, developing a definition of *normal* is problematic (2009). Darra (2009) proposes that not only is the term *normal* difficult to define, it also risks alienating women who experience a so-called *abnormal* or high-risk pregnancy or birth. These examples demonstrate the way in which language in maternity care be used as a 'tool of power' (Hunter 2006, p. 119). Midwifery academic Lauren Hunter suggests that:

> Technologic interventions and medical terminology become symbols of power in the hospital setting and reinforce the control of the provider at the expense of the woman (Hunter 2006, p. 120).

Hunter (2006) proposed that for the culture of childbirth to change, care providers must consciously change their language. Instead of focusing on risk, the process of childbirth should be honoured as a natural phenomenon in which women can trust their bodies as powerful and capable (Hunter 2006).

Language, in particular, can be analysed using a methodology known as discourse analysis. The purpose of discourse analysis is to interrogate spoken language or text in order to reveal its hidden meaning (Gavey 1989; Powers 2001). The methodology was used in this research project to examine the social construction of childbirth in Australia; a description of discourse analysis and its core philosophical influences is provided in the following section.

Discourse analysis

Generally, discourse analysis interrogates the use of language (texts, dialogue, visual images or symbols) in the context of specific situations and aims to make interpretive claims based on the power relations identified (Powers 2001). According to Powers:

> Discourse analysis generates interpretive claims with regard to the effects of a discourse on the oppression and empowerment of groups of people in a specific context without claims of generalisability (2001, p. 1).

In this thesis, the purpose of employing discourse analysis was to explore how language was produced and understood in a particular social and cultural context; the provision of maternity care in Australia (Lupton 2004). Underpinning the need to undertake such an exploration is the assumption that language is a powerful tool that advantages the dominant group in any given situation (Hunter 2006). The intent of this research project was to uncover the socio-cultural meaning of childbirth in Australia from the perspective of the submissions made to the National Maternity Services Review by key stakeholders in maternity care.

Though discourse analysis may be performed in different ways, according to Powers 'all of the procedural variations share common goals and assumptions' (2001, p. 1). The technique of discourse analysis involves the careful reading of texts with a view to discerning broad patterns of meaning, inconsistencies and contradictions (Gavey 1989). According to Gavey (1989), there is no specific recipe or formulae that can be followed when conducting discourse analysis and therefore no set method in the traditional sense. The performance of a discourse analysis involves employing a broad theoretical framework concerning the nature of discourse, whilst making an effort to ensure findings are objective and that the reader can be convinced the findings are genuine (Gavey 1989; Powers 2001). The type of discourse analysis employed in this qualitative study was centred in the philosophies of Michel Foucault, critical social theory, poststructuralism and feminism and the basic tenets of these ideologies are presented below.

Introduction to Foucault's theories

Michel Foucault, born in France in 1926, is now recognised as one of the most influential thinkers of the contemporary world (Danaher, Schirato & Webb 2000). Whilst thirty years ago Foucault was vilified and heavily criticised as a postmodern theorist, his theoretical terms and ideas about power, knowledge and discourse have since become part of the way we understand and think about the world (Danaher, Schirato & Webb 2000). Foucault's ideas and philosophies changed over time, therefore there is no single correct reading of Foucault (Fahy 2002). Selected elements of his work have been addressed here as are relevant to this research; in particular his philosophies on language and power.

Foucault wrote in the tradition of poststructuralism, extending on critical social theory's critique of the application of empirical, analytical science (further explained later in this chapter) (Calhoun 1995; Powers 2001). Poststructuralism is a school of

thought that rejects the concept that cultural narratives can be assumed to possess universality (Gavey 1989; Powers 2001). Where structuralists believe in the existence of bare facts and the superiority of science as knowledge, poststructuralists - such as Foucault - value accounts of the truth that have a more local and personal nature (Powers 2001, 2007). Much of Foucault's work was focused on the concept of power in specific human contexts (Powers 2001). He followed the theory of fellow philosopher Friedrich Nietzsche; that any discourse or body of knowledge could be carefully unwound through analysis to reveal a tangled web of 'historical conglomerates', 'impositions', 'displacements' and 'shifts' that lead to its being (Powers 2001, p. 11). Like Nietzsche, Foucault used the term *genealogy* to describe this process of analysing and uncovering the historical relationship between truth, knowledge and power (Danaher, Schirato & Webb 2000; Powers 2001, 2007).

To Foucault, the concepts of power and knowledge were interchangeable and self-referential (Foucault 1980). Power/knowledge, as Foucault termed it, refers to the concept that a complex flow and set of relations exist between different groups and areas of society that change over time and in different circumstances (Danaher, Schirato & Webb 2000). An example of the power/knowledge concept in maternity care is provided by midwifery academic Kathleen Fahy (2002). Fahy (2002) suggested that the acceptance of medical *knowledge* by the public increases the *power* held by the medical system and its practitioners. Furthermore, having *power* allocated to the medical system by public acceptance of medicine's claim to *knowledge* increases the legitimacy of further claims of such *knowledge* (Fahy 2002). Fahy (2002) purports that it is society that decides which knowledge and authority it accepts and which it marginalises.

The marginalisation of particular discourses is addressed by Foucault in his 1972 text 'The Archaeology of Knowledge'. Foucault highlighted how some discourses are denied an existence due to marginalisation of the source:

> Medical statements cannot come from anybody; their value, efficacy, even their therapeutic powers, and, generally speaking, their existence as medical statements cannot be dissociated from the statutorily defined person who has the right to make them, and to claim for them the power to overcome suffering and death (1972, p. 51).

Foucault (1972) argued that the power of the discourse resides with the perceived legitimacy of the speaker. He believed that our thoughts and actions are influenced, regulated and to some extent controlled by the dominant discourses in our lives (Danaher, Schirato & Webb 2000). Foucault saw language as one of the most significant forces shaping our experience of the world (Danaher, Schirato & Webb 2000). He was not interested so much in language systems as a whole, but rather in individual acts of language or discourse (Danaher, Schirato & Webb 2000). Foucault believed that discourses could be understood as language in action, a *window* that allows us to make sense of and *see* things as they are (Danaher, Schirato & Webb 2000).

Foucault's power perspective

Foucault developed a particular perspective on power which has been influential in the method of analysis used for this research project. According to Foucault, advancements in science and the subsequent development of the Industrial Revolution and capitalism (as outlined previously in the Literature Review chapter) are key to understanding power relations in modern Western civilisations (Danaher, Schirato & Webb 2000; Powers 2001). Foucault claimed that these major historical events caused a gradual shift in the conceptualisation of power which gave rise to a (largely unrecognised) change in the Western practices of people management (Powers 2001). The details of this theory are too complex to explore in the context of this Honours thesis, however the important factor is that his insight into this shift in the conceptualisation of power is what lead Foucault to place such emphasis on

power relations in discourse analysis (Danaher, Schirato & Webb 2000; Powers 2001).

Foucault saw power relations as being dynamic, that is to say, they are produced and reproduced through everyday activities (Lupton & Fenwick 2001). A Foucauldian perspective on power views power relations as unintentional, but rather the 'immediate embodied effect of divisions and inequalities as they occur in context' (Powers 2007, p. 30). From this perspective, power is something *embodied* or *performed* and cannot be separated from political, economic, sexual or knowledge relations (Powers 2007). This notion of power is relevant to maternity care because complex power relations exist on several levels; between maternity care providers (doctors and nurses or midwives); between care providers and the childbearing women they serve; between the maternity care institution (hospital) and its workers and patients; as well as between childbearing women and their partners or family (Powers 2007).

Foucault wrote specifically about the medicalisation of social control. He saw the empirical analytical approach to life as being chiefly concerned with the control of natural phenomena such as birth, life and death (Powers 2001). Society's ability to control natural phenomena was linked with the progress of Western civilisation, something assumed (by those who prescribe to an empirical analytical approach) to provide better outcomes for human beings (Powers 2001; Reynolds 1991). Arguably, this position is still prevalent today as evident in the technocratic paradigm's desire to *control* the natural process of childbirth (Davis-Floyd 1994b, 2001; Van Teijlingen 2005). This theory goes some way in explaining why there is such strong desire for *the stat*e to organise and control women's childbearing experiences (Dahlen, Jackson & Stevens 2011). Capitalist society has a vested interest in childbearing as it is concerned with the production of a potential new worker. Under this assumption, society should be able to determine what is considered *safe* for women and babies in childbearing (Dahlen, Jackson & Stevens 2011).

Critical social theory

Critical social theory is a school of thought derived from Marxism (also known as socialism) and can be defined as a critique of social and political institutions that oppress people, whilst at the same time espousing a practical intent to decrease such oppression (Calhoun 1995; Leonardo 2004; Powers 2001, 2007). Critical social theory puts criticism at the 'centre of its knowledge production', pushing ideas and frameworks to their limits by highlighting their contradictions' (Leonardo 2004, p 12). The ultimate goal of critical social theory is to look for alternate possibilities in oppressive circumstances in order to emancipate human beings (Powers 2001). This is achieved by bringing to their awareness an alternative interpretation of their situation which includes the vision of a different and better future (Leonardo 2004; Powers 2001).

As mentioned previously, Foucault's work was particularly focused on the emphasis of power relations (Danaher, Schirato & Webb 2000; Foucault 1980; Powers 2001). Although he rarely addressed power relations between men and women, his philosophies are thought to apply to feminism, and feminist theorists have clarified and extended on his work (Powers 2001, 2007). The style of discourse analysis employed for this research project was influenced by feminism, the ideology of which will now be explored.

Feminism

In the most basic sense, feminism can be defined as the advocacy of women's rights based on the principle of equality of the sexes (Oxford University Press 2011d). It is a rejection of patriarchy (as explored earlier in this chapter) and the oppression of women in all its forms (Grbich 2004; Kaufmann 2004; Powers 2001). Feminist academic, Tara Kaufmann stated: 'Being a feminist is a world perspective and a life

journey and that all-encompassing sense of self and purpose defies easy categorisation' (2004, p. 5). She proposed that there is no one universal feminist theory because the ideology of feminism is interdisciplinary and diverse (Kaufmann 2004). The common goal of feminist research is thought to be the de-centreing of the dominant discourse of the white, Anglo-Saxon male (Powers 2001). As New-Zealand Psychologist and researcher Nicola Gavey identified in the late 1980's, previous feminist research had observed that 'dominant conceptions of reality and truth in patriarchal Western society have tended to be male constructions which reflect and perpetuate male power interests' (1989, p. 462). Feminist explorations of women's own realities tended to produce different truths, therefore casting suspicion on the concept of *one reality* and *one truth* (Gavey 1989). In this sense, feminism sits well with poststructuralism and Foucault's philosophies because they too deny the existence of universal truth (Powers 2001).

Poststructuralism

Poststructuralism, like discourse analysis, is not easily defined. On the contrary, an important element of poststructuralism is its resistance to definition or identification (Gavey 1989). There are, however, some guiding principles that have been outlined here. Poststructuralism challenges the widely held belief that the scientific method is the best way to achieve bias-free knowledge of social conditions (Miller 2000). In a poststructuralist approach, it is not presumed that one's world view consists of a fixed, pre-existent universal structure of reality that is available to be *discovered* by research (Gavey 1989). Similarly, a poststructuralist perspective on discourse does not consider it to be a static set of concepts with a single style of statement (Powers 2001). Rather than uncovering the truth or revealing facts, feminist poststructuralist research is more concerned with disrupting or displacing dominant and oppressive knowledge systems (Gavey 1989; Grbich 2004). The aim of this style of research is to develop theories or understandings that are socially, historically and culturally specific, and explicitly related to changing oppressive gender relations (Gavey 1989).

Sociologist Leslie Miller (2000) indicated that poststructuralism challenges the privilege of the scientific voice and promises to raise the visibility and credibility of voices at the margins of society. Miller promotes the use of a feminist poststructuralist approach when performing discourse analysis because it allows for a 'politically engaged feminist analysis' by examining language in use (2000, p. 326). The methodology of discourse analysis, using a feminist poststructuralist approach, is appropriate for this research project because the research is primarily concerned with improving the experiences of women. Childbearing is an innately female act and the vast majority of the maternity care workforce are female (AIHW 2011; Walsh 2004). A principle tenet of feminism is the 'unmasking of dehumanising and oppressive practices against women' (Walsh 2004, p. 59). By examining the social construction of childbirth in Australia, insight is gained into the barriers that may prevent reform of maternity services in Australia, ultimately improving the childbearing experiences of women and the experience of maternity care professionals, the majority of whom are female.

The methodological underpinning of the research has been described. The following section outlines the practical components of the research: the process of data collection and analysis. This final section concludes with a brief overview of the ethical considerations of the study.

DATA COLLECTION

Eleven submissions that were made in response to the community consultation process of the 2008 Australian National Maternity Services Review (MSR) form the data set for this research. While the background to the MSR was presented in the Introduction chapter, a description of the community consultation process used in this review is provided below.

The MSR community consultation process

In 2008, the Commonwealth Chief Nurse and Midwifery Officer, Rosemary Bryant led an Australian National Review of Maternity Services on behalf of the Commonwealth Government (DoHA 2009c). The MSR covered a wide range of issues, with a particular focus on the importance of women having a range of different birthing options available to them (Dahlen 2010b; DoHA 2009c). The Review involved a community consultation process, for which the Department of Health and Ageing (DoHA, also referred to as 'The Department') prepared a paper titled 'Improving Maternity Services in Australia: A Discussion Paper from the Australian Government', which was released on the 10th of September 2008 and available on the DoHA website (Commonwealth of Australia 2009; DoHA 2009c). The discussion paper set the context for the consultation process, drawing on existing research and data and outlining current service delivery arrangements for antenatal, birth and postnatal services (Commonwealth of Australia 2009). A series of questions were posed in the discussion paper and an invitation was put forward for all interested individuals and organisations to respond. Advertisements were placed in national and metropolitan print media inviting response to the paper and key stakeholders were contacted directly and invited to participate in the process (Commonwealth of Australia 2009). A seven-week period was allowed for submissions, starting on the day the discussion paper was released (Commonwealth of Australia 2009).

The DoHA received over 900 submissions from individuals, industry groups, health professionals, researchers, professional organisations and national peak bodies (Commonwealth of Australia 2009). The content of submissions was varied, ranging from personal birth stories and descriptions from health workers of their experiences in providing maternity care, to examples of existing successful models of care both within Australia and internationally (Commonwealth of Australia 2009). Other submissions provided research and strategic policy papers with regard to the many aspects of pregnancy, birth and postnatal care (Commonwealth of Australia

2009). Of the submissions, 832 are available for public viewing on the DoHA website, with the rest unavailable at the request of the author, due to issues of confidentiality or extreme sensitivity or due to their format being too difficult to publish electronically (DoHA 2009d). Owing to the volume of the material received, attachments to submissions were not published (DoHA 2009d).

For the purpose of this project, given the limitations of an Honours thesis, 11 of the 832 submissions available were chosen for analysis. Care was taken to determine the peak professional bodies and peak consumer groups representing the key stakeholders in Australian maternity services in order to offer a cross-section of Australian maternity services. Explanation of what constitutes a peak body and justification for the inclusion of each group is given in the following section.

Peak professional bodies and consumer groups

A peak body is an organisation that is established for the purpose of developing standards and processes for a particular profession (e.g. policy development), or to represent the interests of the profession as a whole (AYF n.d; Quixley 2006). A peak professional body will lobby for change, provide policy advice to government and also offer advice and information to the broader community (Quixley 2006). A peak professional body acts as a 'voice' for the profession at a state and/or national level (AYF n.d, par. 1).

The term *consumer*, as used in this project, refers to the women who use maternity services in Australia, i.e. childbearing women, as well as potential future service users. Consumer groups exist in order to protect the interests of consumers, voicing their perspectives and experience, and taking part in decision making processes on their behalf (Consumers Health Forum of Australia 2001; MC n.d). Consumer groups only have consumers as members, whereas peak bodies may represent both professionals and consumers (Quixley 2006).

Of the 11 submissions chosen for analysis, nine were from peak professional bodies representing maternity care providers in Australia, one was from a consumer group and one was from a group representing both midwives and consumers. The 11 key stakeholders chosen for analysis were:

- **Australian College of Midwives (ACM)**
  Peak professional midwifery body
- **Australian Medical Association (AMA)**
  Peak professional body for medical practitioners
- **Australian Nursing Federation (ANF)**
  Peak professional nursing body
- **Australian and New Zealand College of Anaesthetists (ANZCA)**
  Peak professional body for anaesthetists
- **Australian Society of Independent Midwives (ASIM)**
  Peak professional body for Independent midwives
- **Homebirth Australia (HA)**
  Peak body representing homebirth consumers and midwives
- **Maternity Coalition (MC)**
  National consumer advocacy organisation
- **Royal Australian College of General Practitioners (RACGP)**
  Peak body representing General Practitioners
- **Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)**
  Peak body for obstetricians and gynaecologists
- **Royal College of Nursing Australia (RCNA)**
  Peak professional nursing organisation
- **Rural Doctors Association of Australia (RDAA)**
  National body representing rural medical practitioners

A brief outline of each peak professional body or consumer group is provided in Appendix 1. These 11 organisations represent general practitioners (GPs), nurses, midwives, obstetricians, anaesthetists, homebirth supporters and consumers – all of whom are considered to be key stakeholders in maternity services in Australia. As outlined in the Introduction chapter, maternity services in Australia are provided by a range of different healthcare professionals in a variety of settings. The role of each party in relation to maternity services will now be explained so as to justify their inclusion in the study.

General Practitioners

General Practitioner's (GPs) were included in the study as they are commonly the first point of access for women in early pregnancy, providing confirmation of pregnancy and initial consultation and referral to other maternity care providers (Commonwealth of Australia 2008). Further to this role, GPs can obtain an extra qualification in obstetrics which enables them to provide antenatal care to women and attend births (NRHA 2010). In many rural and remote areas of Australia, a GP-obstetrician is the only healthcare professional available to provide antenatal care with the closest regional hospital offering midwifery or obstetric services located hundreds of kilometres away (NRHA 2010). In metropolitan areas, a model of care called GP shared-care is offered in which women attend their GP-obstetrician for antenatal care alternately with a public hospital-based midwifery clinic (Commonwealth of Australia 2009). In this model, women are cared for throughout labour, birth and the postnatal period by hospital midwives and often return to their GP-obstetrician six weeks after birth for a postnatal check-up (Commonwealth of Australia 2009).

Midwives and Nurses

Midwives work in partnership with women to provide care, support and advice during pregnancy, labour, birth and the postnatal period as well as providing care for the newborn baby up to six weeks of age (ANMC 2006; ICM 2011). Midwives can practice in any setting including the home or hospital – both private and public (ICM 2011). In Australia, midwives provide the majority of care for childbearing women and their role involves the promotion and protection of normal birth (ACM 2004; ANMC 2006; Enkin et al. 2000). Midwives work collaboratively with other health professionals to ensure the best outcome for the woman. If a woman's pregnancy or labour becomes complicated, the care she requires may fall outside the scope of a midwives practice; in this situation the midwife will refer the woman to medical care (ACM 2004; ANMC 2006; ICM 2011).

Over the last decade, some major changes have taken place in the way midwives in Australia are educated. In 1997 the first Bachelor of Midwifery was offered in Australia, allowing students with no prerequisite nursing qualifications to gain direct entry into midwifery (Flinders University 2011). Before that time, midwives gained registration after first completing a certificate or Bachelor of Nursing, followed by a secondary midwifery qualification (ACM - NSW Branch Incorporated 2010; Pincombe, Thorogood & Kitschke 2003). Although midwives are now able to be educated and register independently from nursing, the vast majority of registered midwives in Australia are also registered nurses. In 2009, of the 52,273 midwives employed in Australia, only 2,049 were direct entry midwives (AIHW 2011). For this reason, the peak professional bodies representing both midwives and nurses have been included in the data set.

Obstetricians

Obstetricians are medical doctors who have specialised in obstetrics and hold Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Their role is to work collaboratively with other health professionals to deliver 'expert advice and treatment… to maximise the safety and well-being of mother and baby' during the childbearing period (RANZCOG 2010b, p. 1). Obstetricians are specialists in high-risk pregnancy and birth and are involved in care when a woman's pregnancy or birth deviates from normal and intervention is required (Enkin et al. 2000). In the public hospital system, a woman would usually receive care from an obstetrician in the event of a complication that requires medical care (Commonwealth of Australia 2009). Women experiencing uncomplicated pregnancies, however, can choose to employ an obstetrician privately, attending a private clinic for antenatal care and either a public or private hospital for birth (Commonwealth of Australia 2009). Obstetricians work collaboratively with midwives in the hospital environment. Even when a woman has employed a private obstetrician, the vast majority of her labour and postnatal care will be provided by midwives employed by the hospital who will consult with the obstetrician regarding care decisions (Dahlen 2010a). Obstetricians and GP-obstetricians possess special skills required to manage complex births and are the only practitioners qualified to perform caesarean sections or instrumental births.

Anaesthetists

Anaesthetists are medical doctors with specialist postgraduate training to provide anaesthesia – a drug induced state in which the whole body or part of the body is insensible to pain (ANZCA n.d.; Tiran 1997). Anaesthetists are included in the data set because 31.8% of Australian women giving birth in 2008 used regional anaesthesia (epidural or spinal block) for pain relief (AIHW 2010). Further to this, in 2008 31.1% of all births in Australia were via caesarean section requiring an

anaesthetist to administer regional anaesthesia to the woman prior to surgery, manage the woman's health and wellbeing throughout the procedure and ensure she is comfortable in recovery (AIHW 2010; ANZCA n.d.). As the rates of caesarean section and use of regional anaesthesia for pain relief have continued to rise over the past few decades, anaesthetists have played an increasing role in maternity service delivery throughout the industrialised world (Walsh 2009).

Homebirth advocates

In 2008 planned homebirths accounted for only 0.3% of all births in Australia (AIHW 2010). The vast majority of homebirths are attended by Independently Practicing Midwives who are privately employed by the woman to provide antenatal, labour, birth and postnatal care in her own home (Commonwealth of Australia 2009; Dahlen 2010a). The issue of homebirth was particularly pertinent at the time of the MSR (2008) because homebirth was not publicly funded, nor was there any professional indemnity insurance available for attending midwives (Dahlen, Jackson & Stevens 2011). According to Dahlen and colleagues, this position is 'out of step with maternity service reforms in comparable countries' (2011, p. 48). Despite the Commonwealth Government stating its intention in the MSR discussion paper (2008) to improve the range of birthing options available to women, homebirth was 'notably absent from its recommendations for funding and support' (ACM 2011, p.4; Dahlen et al. 2010; Dahlen, Jackson & Stevens 2011).

Despite the small number of women in Australia giving birth at home, homebirth advocates are a very politically active group lobbying for maternity service reform to better support women who want to give birth at home. A testament to this is that of the 832 publicly available submissions made to the MSR, 60% made mention of homebirth and of the over 900 total submissions, 53% were from women who had personally experienced homebirth (Commonwealth of Australia 2009; Dahlen et al. 2010; Dahlen, Jackson & Stevens 2011).

Consumer group

The intention of the MSR was to improve maternity services in Australia for consumers (Commonwealth of Australia 2008); therefore it was important to include the consumer perspective in the data set. Consumers of maternity care tend to be particularly vocal in advocating for the type of maternity service they want; of the total 832 publicly available submissions made to the MSR, 54% were from consumers, ensuring that their voice was heard (Dahlen et al. 2010).

The submissions from the above groups were downloaded from the Department of Health and Ageing (DoHA) website (http://www.health.gov.au) and printed in full. This equated to 311 pages of typed text with submissions ranging from four to 106 pages long. The method of data analysis is described below and several examples are given to demonstrate the process involved.

DATA ANALYSIS

The methodology of discourse analysis was provided at the beginning of this chapter with an introduction to the philosophical underpinnings of this approach. The process of analysing the submissions is described below, allowing the reader insight into how findings were developed from the data. Excerpts from the data have been included in this chapter to demonstrate how patterns were identified in textual material which was then used to draw assumptions about the messages and meanings communicated through the text (Lupton 2004).

By analysing texts that were produced explicitly for the purpose of the MSR, rather than for the purpose of this study, a form of 'unobtrusive' research was performed (Lupton 2004, p. 486). Unobtrusive research can be defined as a method of research that does not involve direct interaction with the source of data (Lupton 2004). Sociologist Deborah Lupton (2004), argues that one of the greatest advantages of

unobtrusive research is that there is reduced potential for bias. The author of the texts that were examined in this thesis did not know, when producing their documents, that they would be examined for research using discourse analysis. This eliminated the risk that authors would alter their language in order to present a particular message that they perceived would please or displease the researcher.

The process of data analysis

The process of analysis was as follows: each submission was read in its entirety and analysed for patterns of variation and consistency in what was said. Close examination was given to each document in order to identify recurring words, phrases, metaphors, ideas and beliefs. Particular words or phrases that were thought to reflect the author's construction of childbirth were underlined or circled. This was also done for recurring words or phrases. Passages of interest were highlighted with the primary theme or initial analysis of the passage recorded by hand in the adjacent border of the document. An example is provided in Table 1.

Patriarchal: wanting to hold all the power. No faith in midwives' abilities.	The AMA would support expanded funding arrangements for midwives provided this is available within a medically supervised model. In this model, there is a team based approach but the highest trained practitioner, the medical practitioner, supervises the overall care of the patient and can delegate aspects of a patient's care to a midwife.

Table 1: How text was highlighted in the AMA submission to the MSR.

Attention was given to how messages were conveyed, how topics were introduced, developed and established and how agendas were set. The way evidence was reported and used to justify argument was also examined. After an initial reading of the document, a summary was written by hand, making note of the general tone of the piece, major points made by the author and any distinguishing standpoints. Hand written notes were later developed into an analysis overview document on the computer. An example is provided in Table 2.

ANF

- Very pro-midwifery.
- Supports access to midwife as lead-carer for all Australian women.
- See's obstetric care for well women as inappropriate and leading to unnecessary interventions.
- Encourages Maternity Service Reform in order to allow continuity of care from midwives > supports PBS, indemnity insurance, Medicare.
- Acknowledges obstetric and medical dominance.
- See midwives as undervalued and unrecognised. Need greater community awareness of the role of the midwife.
- Constructs childbirth as healthy women experiencing a normal life event.
- Concerned about high intervention rates.
- Concerned about inequity in funding of midwifery education compared to medical education.

Table 2: Analysis overview of the ANF submission to the MSR

The submissions were then scanned visually for themes, taking note of the highlighted passages and primary theme of the passage previously marked in the document borders. Quotes from the data were organised in a computer spread sheet under theme headings. An example is provided in Table 3.

The long standing tradition in Australia of channelling all women into medical care, and obliging women to meet certain eligibility criteria to access midwifery care must be discontinued (ACM, p. 9).

Table 3: An excerpt from the ACM submission placed in the theme 'challenging the status quo'

Organising the data into themes by taking quotes from submissions allowed for a thorough assessment of the strength of each theme; the more quotes a theme heading was assigned, the stronger the theme. Finally, the primary theme of 'power' was found to be running through all submissions. As the strength of themes emerged, discourses of 'power' and 'resistance' were identified. It became obvious that key stakeholders in maternity care possessed divergent views on the reform agenda and the way forward for maternity services in Australia.

ETHICAL CONSIDERATIONS

According to the Australian Government's National Health and Medical Research Council (NHMRC) (2011), it is essential that all research is conducted in an ethical manner in order to protect the welfare and rights of participants involved. In consideration of the ethical implications of this research project, it is acknowledged that researchers must ensure that the personal privacy of participants is preserved (Parsons & Oates 2004). The data used in this research project was publicly available and readily accessible via the DoHA website. Authors of submissions made to the MSR had the opportunity to withdraw their submissions from public access after they were examined by The Review committee and those who wished to remain confidential did not have their submissions published on the DoHA website (DoHA 2009d). All of the submissions examined for this research project were made by professional organisations rather than individuals; therefore protection of the

authors' personal information was not required. The principles of integrity, honesty and respect that underpin ethically sound research have been adhered to in this research project (Aita & Richer 2005).

CONCLUSION

In this chapter I have provided an outline of the methodological underpinnings of the study and demonstrated the significance of language with particular reference to maternity care. The methodology of discourse analysis was described and the influence of feminism, poststructuralism, critical social theory and the philosophies of Foucault were explored. A description of the way in which data was analysed has been given in order to allow the reader insight into how findings were developed. The following chapter will report on the findings from the process of analysis.

CHAPTER FOUR – FINDINGS

THE MAINTENANCE AND RESISTANCE OF POWER AND CONTROL

INTRODUCTION

In this chapter I present the findings of a discourse analysis of 11 submissions from key stakeholders submitted to the 2008 Australian National Maternity Services Review (MSR). The expression of power and control were found to be key concepts underlying each of the 11 submissions. Language within each of the submissions was constructed to either maintain or challenge what was considered to be the current dominant power of the medical profession. Each submission, however, also spoke from a position of authority.

The ideology associated with the technocratic paradigm of childbirth, as described in the Literature Review chapter, was clearly evident in the submissions from the peak professional medical bodies. The text within these submissions used discourse or language to urge the government to maintain what they considered was their rightful place as the primary or most appropriate persons to provide and/or supervise all levels of maternity care. At times there was also evidence in the submissions that these bodies believed that this power and control should be extended. The discourse of birth as a risky and unsafe event was used to justify this position. The data from these submissions is described under the theme headings: 'upholding the status quo', 'opportunities for expanded control' and 'birth as a medical event: the rhetoric of risk and safety'.

Foucault's notion that: 'wherever power is found, resistance to power is also found' (Powers 2001, p. 14) was a key concept in identifying the alternate discourses reflected in the submissions from the peak midwifery, nursing, rural doctors and consumer organisations. It was evident in the submissions made by these groups

that language was used to resist and challenge the dominant power, and a new vision for maternity care in Australia was described. In this vision, power was shared more equally amongst care providers and with the consumers of maternity care, childbearing women. Birth was portrayed as a normal life event that held subjective notions of risk. The data from these submissions is described under the theme headings: 'challenging the status quo', 'opportunities for change: a new vision for the future of maternity care' and 'birth as a normal life event: both significant and safe'.

In this chapter, the major discourse labelled 'The maintenance and resistance of power and control' and the contributing subthemes are described. Text from the submissions appears in italics and is used to sort the themes. Table 4 summarises the major concepts that inform the findings.

THE MAINTENANCE AND RESISTANCE OF POWER AND CONTROL	
Maternity service reform: unnecessary or urgent?	♦ Upholding the status quo ♦ Challenging the status quo
The reform agenda: a way forward for whom?	♦ Opportunities for expanded control ♦ Opportunities for change: a new vision for the future of maternity care
The powerful discourses of risk and safety	♦ Birth as a medical event: the rhetoric of risk and safety ♦ Birth as a normal life event: both significant and safe

Table 4. Findings: major themes and subthemes

THE MAINTENANCE AND RESISTANCE OF POWER AND CONTROL

'Power and control' was the major discourse that emerged from the analysis of the 11 submissions. Four of the five peak medical bodies; Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Australian Medical Association (AMA), Australian and New Zealand College of Anaesthetists (ANZCA) and Royal Australian College of General Practitioners (RACGP) employed a discourse that was focused on *maintaining power*. While there was some general acknowledgement that reforms were needed, often in problematic areas such as rural and remote maternity care, the submissions primarily urged the government to ensure the safety of women and their babies. It was advocated that this could be best achieved by maintaining the current status quo, ensuring the medical practitioner retained what was considered to be their rightful place as lead care provider in maternity services. Support for midwifery led-services was limited and at times there was evidence that these peak bodies believed *more control* over maternity services by medical practitioners, was required. The tone of these submissions reflected medical communities' current level of authority within society. Phrases such as: *the Government must not, should not,* and *could not reasonably…* were common to the text, indicating a somewhat authoritative and patriarchal approach to the reform process.

In contrast, the dominant discourses emerging from the submissions by the peak professional bodies Australian Nursing Federation (ANF), Royal College of Nursing Australia (RCNA), Rural Doctors Association of Australia (RDAA), Australian College of Midwives (ACM) and Australian Society of Independent Midwives (ASIM), along with submissions from consumer groups Homebirth Australia (HA) and Maternity Coalition (MC) reflected a 'resistance' to the dominance of the technocratic ideology of birth in Australian maternity services. As stated in the introduction to this chapter, the development of this opposing discourse was based on Foucault's notion that 'wherever power is found, resistance to power is also found' (Powers 2001, p. 14).

The language within these submissions tended to acknowledge that, as it stands, Australia does have a maternity system to be proud of; however, several issues urgently need addressing. These submissions recognised the problems, spoke to the proposed reforms and also clearly articulated a way forward. The tone of the submissions was generally less authoritative, expressing gratitude at the opportunity to contribute their voice to the MSR without the use of intimidating or emotive language.

The sub-discourses emerging from the analysis process can thus be conceptualised on a continuum. Whilst there was a desire to uphold the status quo, there was also a wish to challenge it. Subsequently, where there was evidence that some may agitate for more control, there was also a commitment to supporting a new vision for maternity care which includes woman-centred models of care being accessible to all women. Each sub-discourse will now be explained, using examples of data from the submissions.

MATERNITY SERVICE REFORM: UNNECESSARY OR URGENT?

Upholding the status quo

To uphold the status quo is to maintain everything as it is (Oxford University Press 2011h). In the context of Australian maternity services, this refers to the dominance of obstetrics over midwifery and the medical management of pregnancy and birth (Fahy 2007b; Hausman 2005; Hunter 2006; Katz Rothman 1982; Kitzinger 2005; Van Teijlingen 2005; Wagner 2001; Willis 1983). Submissions that contributed data to this theme were from the AMA, RANZCOG and RACGP. Upholding the status quo involved making statements that defended the way maternity services are currently delivered in Australia. This included citing *excellent* rates of maternal and fetal mortality and morbidity, in combination with what they believed was a *proud* history of medical management of pregnancy and birth. For example RANZCOG stated:

> *Australia is recognised internationally as having consistently lower maternal and perinatal mortality rates than the majority of developed countries* (p. 9).

Such affirmative sentiments were, however, often framed within authoritarian statements *warning* the Government of what might happen to these outcomes if their proposed reforms were to go ahead. The sentence immediately following the one above said:

> *Any change to maternity services must at least maintain and hopefully improve these very high standards* (RANZCOG p. 9).

RANZCOG went on to depict the Government as *naïve* and perhaps somewhat inept for proposing changes to the current funding models. For example:

> *It is clearly naïve to underestimate the importance that the funding model has on the safety and effective delivery of maternity services* (RANZCOG, p. 9).

> *Without funding directed in an intelligent and thoughtful manner, the best of ideas and intentions will fail. High quality women-centred maternity care will suffer with hastily configured, poorly though-out funding* (RANZCOG, p. 9).

Similarly the following example from the AMA's submission is even more explicit in its message:

> *Australia has high quality maternity services which have historically been medically led and which broadly meet the needs of the population and there is no case for radical change ... It would be disastrous if these strong results for Australia were turned around because of poorly considered reforms* (AMA, pp. 5-6).

As discussed in the Introduction chapter, the MSR discussion paper overtly supported a greater role for midwives in the care of childbearing women. It specifically looked at the possibility of facilitating midwives' access to Professional

Indemnity Insurance (PII), Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) in order to better support midwives' ability to work to the full scope of their practice (Commonwealth of Australia 2008). If these reforms were to go ahead, independent midwifery practice would be better supported. Submissions from the three peak medical bodies AMA, RANZCOG, and RACGP not only revealed a desire to uphold the status quo by retaining their current level of power and role in service provision, but argued that there should be clear restrictions on other health professionals wishing to care for childbearing women unless working under the supervision of a medical officer. This notion is evident in the opening paragraph of the AMA's submission where they use a personal account of one of their members, who had initially trained as a nurse, to compare the knowledge and skills sets of the two professions:

> *There is a big difference between the knowledge, skills and abilities of doctors and nurses… I trained as a state registered nurse/registered sick children's nurse (SRN/RSCN) for four years and worked as staff nurse, research nurse, and ward sister for the following seven years… I then went to medical school and found I knew about 10% of the course already… As a GP I still believe that the knowledge and diagnostic skills I have now are not possessed by nurses* (p. 2).

Reaffirming their level of knowledge and expertise in this manner is clearly undertaken in an attempt to assert their dominance and strongly signal to the Government where they stand.

While this opening statement (provided above) refers to nursing, as opposed to midwifery, the AMA submission later moves on to discuss the role and responsibility of midwives, in particular midwives working in private or independent practice. The proposed changes to practice put forward in the MSR discussion paper appeared to generate a genuine sense of alarm with all three peak bodies stating their opposition to the reforms. For example, RANZCOG linked words such as *independent* with

isolation and *poor outcomes*. In combination with the technique of repetition, constructing language in this way conveyed the message that midwives in private practice were not collaborative and likely to worsen outcomes for childbearing women. For example:

> *To provide the best possible outcomes and in regard to safety for mothers and babies, 'Independent' professional practice, where one particular professional group or individual works in isolation, does not have a place in modern maternity care. Independent practice has significant potential for an adverse impact on outcomes for mother and baby* (RANZCOG, p. 2).
>
> *An item number for Independent Private Midwifery is NOT supported* (RANZCOG, p. 8).
>
> *All models of maternity care must be collaborative, both in structure and implementation. Lack of collaboration will adversely impact on maternity care. No model should be described as, or endorse, independent practice* (RANZCOG, p. 9).
>
> *Independent Midwifery Practitioners are inherently isolated in a non-collaborative model* (RANZCOG p. 17).

The AMA was also vocal in opposing a reform agenda that supported women's increased access to primary midwifery led care or independent/private practice. Similar to RANZCOG's submission, the AMA often used emotive language such as *compromise, deterioration, harm* and *dying*. This language was employed to suggest that any changes to the current system that might allow midwives to have greater control and autonomy over their scope of practice, would automatically result in poorer outcomes.

> *The AMA believes that some of the current proposals that are being flagged in the Review of Maternity Services in Australia will actually compromise the*

> *high standards and confidence that we have in mother and baby care in this country, and risk deterioration in health outcomes. This would mean worsening of morbidity and mortality, and that means mothers and babies being harmed or dying* (AMA, p. 2).

As previously suggested, this was often combined with language that conveyed a sense of authority by using instructive phrases such as *the Government should not* or *could not reasonably*… The tone of language used commanded attention. In the following example, the AMA is referring to publicly funded midwife-led homebirth:

> *The evidence for increased perinatal death rates is compelling and the Federal Government could not reasonably nor responsibly introduce payment arrangements which encourage and sanction such activities* (AMA, p. 11).

The above quote highlights the AMA's desire to uphold the status quo, inferring their aspiration to maintain the current level of provider privilege within Australian maternity services and restrict women's access to homebirth.

Acceptance of the role of midwifery care and a woman's right to choose midwifery care was only ever acknowledged within a model whereby medical practitioners retained control.

> *The assessment of the patient by a medical practitioner and delegation to midwife care, if the patient desires, provides the patient with the scope for making secure and safe choices for herself and her baby* (AMA, p. 10).

Similar to this sentiment, the submission from the RACGP expressed support for the provision of access for midwives to the MBS, however only in the context of the midwives providing antenatal care on behalf of GPs.

> *The RACGP recommends that the Commonwealth prioritise accessibility to the MBS item number for nurses and midwives providing antenatal care for and on behalf of general practitioners…* (p. 8).

Generally, however, the RACGP were not in support of models of care that allowed women to choose a midwife as their primary care provider, as demonstrated in the following statement:

> *Overseas midwifery led models such as the UK and New Zealand are often referred to as credible models to be used in Australia. The RACGP advises caution in the adoption of such models* (p. 10).

Finally, both the AMA and RANZCOG made statements that inferred that it was not the government's role to make substantial changes to models of care. The *keep out* and *retain the status quo* message is highlighted in the following example:

> *We believe medical practitioners and midwives have good relationships on the ground and are capable of evolving arrangements which would have the effect of extending maternity access and responding to reasonable patient demands if they are left alone to do so. The Governments role is to support and fund arrangements and infrastructure which provide patients with quality care* (AMA p. 10).

The AMA continues on, directly warning the Government:

> *Highly interventionist government agendas to advance an ideological cause are likely to create problems in the delivery of maternity services and exacerbate tensions in inter-professional relationships, not improve them. Actions by government which favour one particular model of care over another will generally not be in the interests of patients, will restrict real choice and will be inequitable* (p. 10).

Challenging the status quo

In contrast to the language and beliefs that underpinned the sub-discourse 'upholding the status quo', the text contributing to the sub-discourse 'challenging the status quo' was derived from the RDAA, ACM, HA and MC submissions. These groups clearly described the problems associated with the current system of maternity care. Major areas of concern included maternal satisfaction with the childbearing experience, high rates of intervention and caesarean sections and a lack of accessibility to midwife-led models of care. The submissions routinely commenced with a statement outlining the issues such as:

> *Maternity Coalition proposes fundamental reform of maternity care policy to address many pressing problems. The range of issues – rising intervention rates, decreasing accessibility to services, workforce shortages, increasing costs, care that does not reflect the needs of women – will not be addressed effectively by piecemeal adjustments* (MC, p. 1).

> *Challenges include: … an over-reliance on providing primary maternity care to mostly well women in acute hospital settings, which are increasingly overcrowded and understaffed; costly, and pose iatrogenic risks in terms of intervention, infection, medication errors, and other complications…* (ACM, p. 2).

Commonly these submissions commented on and rejected the notion that medicine should dominate and control maternity care and service provision. This is highlighted by the following quotes:

> *In Australia today, a woman has the right to terminate a pregnancy and yet through obstetric dominance that same woman's rights are reduced considerably in childbirth* (HA, p. 5).

> *The current maternity system is predominantly medically dominated and based on a 'medical model' of care…. The choice of carer must be made by the woman, not the doctor* (ANF, p. 10).

Subsequently, submissions in this sub-discourse expressed their concern for the lack of professional autonomy for midwives and an inability to work to the full-scope of midwifery practice. The medical dominance of maternity care and the current fragmentation and organisation of service provision was considered to contribute this problem.

> *The ability to choose a midwife as a lead carer is available to women in many other OECD countries but not to women in Australia* (ANF, p. 11).

> *Consumers report that the effectiveness of current public-funded midwifery models is being undermined by medical interference such as unnecessarily rigid policies and protocols, increasingly narrow restrictions on who can use these services and the unsolicited offering of intervention. While women welcome medical cooperation and input if required, interference is unwelcome and can be sabotaging of women's efforts when they feel most vulnerable* (MC, p. 23).

> *The long standing tradition in Australia of channelling all women into medical care, and obliging women to meet certain eligibility criteria to access midwifery care must be discontinued* (ACM, p. 9).

Concern over the dominance of medicine within the Australian healthcare system, specifically maternity care, was expressed as was the fear that this may undo the reform process.

> *This focus may inhibit choice for some women and hamper reform efforts to develop new collaborative models involving autonomous care provided by midwives within multidisciplinary teams… The choice of carer must be made*

> *by the woman, not the doctor.... It is important that any future reforms do not allow doctors to be 'gatekeepers' to maternity services* (ANF, pp. 10-11).
>
> *The current discrimination that sees our tax-base fund an 'uncapped system of obstetrics' while women choosing homebirth have no funding recourse or even the protection of an insured midwife is patently unfair* (HA, p. 7).

The tone of these submissions was also somewhat different to those described in 'upholding the status quo'. The mere fact that these peak bodies were challenging the status quo from a less powerful or subordinate position may have been reflected in how they framed their submissions. The overall tone of these submissions was one of *thanks* for being given the opportunity to comment and of politely *requesting* change rather than demanding it. The ACM's cover letter set up by offering both thanks and an apology:

> *Thankyou for the opportunity to provide a submission in response to the Government's discussion paper on Improving Maternity Services in Australia. This opportunity is most welcomed by the College as I'm sure you could imagine.*
>
> *Please find attached our submission. I apologise that it is lengthy… (p. 1).*

Like the ACM submission, the ANF's introduction gives thanks for the opportunity to participate and goes on to acknowledge that there have been over 30 government reports recommending reform in the last three decades with little change as a result. Rather than demanding that this be acted upon immediately, they simply make yet another *request* for change:

> *The ANF is pleased to have the opportunity to make a submission to the Department of Health and Ageing on the state of maternity services in Australia. Over 30 federal and state government reports since 1984 have recommended reform of maternity services with a significant emphasis on*

> *enhanced roles for midwives, but little has changed to realise this in service delivery* (ANF, p. 1).

THE REFORM AGENDA: A WAY FORWARD FOR WHOM?

Opportunities for expanded control

The desire for further medical control of childbearing women's choices was also evident, particularly in relation to the role of the midwife, women's choice of care provider and place of birth. The following text illustrates how support for reforms in the form of expanded midwifery roles is only given within the context of additional medical control:

> *The AMA would support expanded funding arrangements for midwives provided this is available within a medically supervised model. In this model, there is a team based approach but the highest trained practitioner, the medical practitioner, supervises the overall care of the patient and can delegate aspects of a patient's care to a midwife* (AMA, p. 9).

The submission by RANZCOG advocated a *collaborative* approach to care. Like the AMA, this collaborative model seemed to be one where the midwife worked under the supervision of the obstetrician, regardless of the woman's risk status. This is a remarkable suggestion given that in the current public health system - while care is medicalised - healthy women and their babies with no complications are normally cared for by midwives with obstetric input only deemed necessary if complications arise. RANZCOG seemed to be using the submission to advocate and *sure up* their role in all aspects of women's care regardless of risk status. RANZCOG described the key features of their proposed collaborative model as when:

> *A defined team of BOTH Midwives and Obstetricians or General practitioners deliver care in pregnancy, labour and the puerperium* (p. 15).

> *RANZCOG advocates collaborative midwifery and obstetric care for ALL pregnant women* (p. 22).

This proposed *collaborative* model works in reverse of the current situation; instead of the majority of women starting as low-risk and possibly developing complications that require obstetric care, a woman would begin her pregnancy care with an obstetrician and effectively be required to *prove* her low-risk status so she can receive midwifery care. In essence the above statement also demonstrates a desire to control women's choice of care provider as it restricts the woman's choice of primary lead carer.

The AMA's description of their ideal maternity unit, outlined below, demonstrates their alignment with the technocratic paradigm of childbirth and a belief that birth requires constant attention from medical professionals. Inherent in the message is also the notion that the birth place should be controlled:

> *The "ideal" maternity unit would include medical obstetric care (including foetal monitoring facilities), anaesthetic and paediatric services, and the infrastructure to deal with an emergency caesarean section if necessary. We support RANZCOG's view that even where women have been carefully assessed for delivery in low technology primary care units, such units should be located within or immediately adjacent to a 24 hour obstetric facility* (p. 11).

In-line with the position of the AMA and RANZCOG, ANZCA exhibited a belief that pregnant women need to be under greater scrutiny by medical health professionals in order to avoid the risks they see as being inherent in childbearing. In response to the question posed in the MSR discussion paper regarding what measures could be taken to reduce high intervention rates in Australia, ANZCA suggested:

> *Improved assessment in the early stage of pregnancy so that any risks can be identified in advance and appropriate steps taken to minimise the risks to the mother and baby and improve safety. Specialist anaesthetists are able to*

> *offer relevant education and training related standards and guidelines to midwives and other health care professionals to assist early assessment and management of risk* (p. 15).

Analysis of the ANZCA submission revealed the way in which the reform agenda was used to argue for expanded medical control. The language within this submission reflected an attempt by this professional peak body to establish their authority as a key stakeholder in Australian maternity services. The techniques used included; providing the reader with a lengthy explanation of their role in maternity services, recounting and repeating their level of education and training, drawing on published research from their own profession, and repeatedly offering to provide training for other maternity healthcare professionals. The following statement appeared in the introduction of ANZCA's submission:

> *Anaesthesia is a broad area of medical practice that underpins many services in acute care hospitals… Modern and complex surgery has been made possible and safe for patients by the advances in anaesthesia, which over the last 50 years, has become a highly specialized and vital area of medical practice* (p. 5).

Three pages later their desire for recognition was visibly highlighted:

> *…the role of the anaesthetist needs to be recognised as an important component of any maternity services plan, in education in relation to labour, analgesia and emergency care, to routine provision of epidural analgesia, and in particular for high risk and emergency response situations* (p. 8).

Clearly, ANZCA believe they deserve to be recognised as a vital player in Australian maternity services.

Opportunities for change: a new vision for the future of maternity care

In contrast to the submissions that used the reform agenda as an opportunity to highlight areas for possible expansion of medical control, were those that used the reform agenda to clearly articulate a new vision for maternity care in Australia. As previously reported, the Government used the MSR discussion paper to raise the idea of implementing several reforms to facilitate greater autonomy for midwives including support for Independent Midwifery Practice and provision of midwife-led models of care within public hospitals. Submissions reflecting a resistance to the continuation of medical domination and control went to great lengths to describe the nature of reform they desired for Australian maternity services. The vision for new and differently structured models of maternity care was coherently argued. For example, the ANF wrote:

> *The ANF views the future of sustainable maternity service as one which is a collaborative model of care, where women can choose their lead maternity health carer and receive care as appropriate from members of the multidisciplinary team who work collaboratively to provide the full range of maternity services to secure the best and safest outcomes for mothers and babies* (p. 2).

This piece of text demonstrates a clear acknowledgment of the need for collaboration and team work. Unlike the previously mentioned medical submissions, however, in this submission the needs and wants of the *childbearing woman* feature prominently. There is recognition that the woman should play an active part in decisions about who is best suited to provide primary care.

Similarly, the RDAA raised the issues of sustainability, funding and workforce and placed the *woman* within the text:

> *RDAA believes that its next contribution in this area must be the collaborative development of a funding mechanism that supports maternity care that uses*

> *the existing workforce more efficiently by focusing on the needs of the woman rather than the current pattern of service delivery* (p. 7).

Not surprisingly, the peak body professional body representing midwives, ACM, supported a reform agenda that recognised the skills and expertise of the midwife within a model that provided women with greater continuity of carer. Using research to support their position, the ACM argued for any changes to become wide-spread and integrated into the mainstream system.

> *The evidence on the benefits of women receiving care by one or two known midwives during her entire maternity episode is unequivocal. This type of care should not be regarded as an optional extra, or as an alternative to mainstream maternity care. Rather it should BE mainstream maternity care. Every woman stands to benefit from continuity of midwifery care* (p. 9).

The benefit of continuity of midwifery care and the link to improved outcomes was also espoused by ASIM:

> *Midwife Practitioners... give women more satisfying birthing experiences. It has been demonstrated that when the birth attendant is well-known to the woman giving birth the quality of the experience is enhanced. Labours are shorter, less medication is used and outcomes are better in both physical and emotional terms* (ASIM, p. 4).

Likewise MC, representing consumers of maternity care, made clear on the first page of their submission what their position was in regards to maternity service reform:

> *We propose primary, preventative care that is woman and family-centred, accessible in a community setting and integrated with other services. This model of care has been documented to provide benefits to women, care providers and taxpayers* (MC, p. 1).

The need for substantial change expressed in these submissions was underpinned by the belief that childbirth was an important experience for women; a time of great significance in a woman's life that had the potential to impact on her long term wellbeing. For example:

> *The act of giving birth is the most important physical and emotional event in a woman's life. Her experiences of birth will be carried with her for life. The impact of poor care can heavily influence parenting and the well being of the whole family* (HA, p. 4).

> *There is … strong indication of the potential of maternity care to influence the health and well being of mothers and babies not only at the time of the pregnancy and birth but for many years afterwards* (ACM, p. 38).

> *…childbirth is a transformative event, maternity care should function to maximize normality* (MC, p. 4).

THE POWERFUL DISCOURSES OF RISK AND SAFETY

Inherent within the major discourse of 'power and control' was the rhetoric and reality of risk and safety. The debate about outcomes such as maternal and neonatal wellbeing was used as a powerful tool and technique by all bodies to support or resist the proposed changes.

Birth as a medical event: the rhetoric of risk and safety

Submissions from RANZCOG, ANZCA and AMA used language that constantly worked to persuade or impress upon the reader/government how inherently dangerous birth was, an event that could only ever be deemed normal in hindsight. Even if the birth process was acknowledged as natural, as in the example below, it was often immediately juxtaposed with words or phrases that contested this image. The

rhetoric of risk was thus used to justify the need for obstetric care for all pregnant women and subsequently provided a rationale for the use of medical intervention. This is exemplified in the following quote from RANZCOG:

> *The assessment of risk throughout pregnancy is problematic. While pregnancy and birth are clearly natural processes, so are death and disability, outcomes that a well trained team of health professionals will seek to minimise and avoid. Intervention in these natural processes, for example induction of labour, intrapartum fetal monitoring and operative delivery can help to deliver the very low levels of maternal and perinatal morbidity and mortality that Australia currently enjoys* (p. 21).

The belief that complications in childbirth were inevitable resulted in midwifery-led models of care for women deemed at low-risk of complications being heavily criticised:

> *Models of Care must recognise the inevitability of unexpected complications for a substantial number of women* (RANZCOG, p. 12).

Within the RANZCOG submission there was also an innuendo that women who desired a normal birth and accessed low-risk models were themselves problematic:

> *Intervention in women labelled as 'low risk' can be seen as an unwarranted intrusion rather than medical indicated [sic], as they desperately try to hang on to their "low risk status". So much better if the intervention, whether surveillance or treatment, is seen as part of their original choice for model of care* (RANZCOG, p. 22).

RANZCOG went on to state:

> *The term "Low Risk" is also a misrepresentation. This causes even more problems… There is an expectation of a problem-free pregnancy and labour.*

> *This of course is an illusion... No pregnancy or labour is without risk* (pp. 22-23).

ANZCA emphasised the importance of anticipating complications:

> *The early assessment of anticipated complexity of labour is the key… All clinical staff should undertake regular written documented and audited training for early recognition and management of severely ill women and impending collapse* (ANZCA, p. 20).

RACGP used their submission to infer that any changes to the status quo would risk the safety of mothers and babies:

> *The RACGP cautions against approaches that could lead to unintended consequences such as reducing access to care or safety of mothers and babies* (p. 3).

Apart from employing the rhetoric of risk and safety to discourage the Government from going ahead with the proposed reforms, the AMA used the rhetoric of risk to advocate for a woman's right to choose medical care. Mimicking the appeal often issued by maternity consumer groups for a woman's right to refuse intervention, the AMA stated:

> *There are many risks for Australian mothers and babies in the current proposals being put forward.*
>
> *Apart from the real risks in morbidity and mortality outcomes, the real loss of choice of obstetric, anaesthetic and paediatric care, there is a risk that Australian women will be made to feel that they are "lesser" women if they choose to have medical specialist and hospital care for their pregnancies and delivery* (AMA, p. 10).

This statement attempts to reverse the argument made by midwifery and consumers groups about honouring a woman's right to informed choice in maternity care. Clearly, the maternity system in Australia is currently dominated by the medical management of birth. The suggestion that women will lose their ability to access obstetric, anaesthetic and paediatric care if the proposals for primary midwifery care were to go ahead is simply untrue. To even suggest that this would be the case further demonstrates the AMA's desperate desire to uphold the status quo.

Birth as a normal life event: both significant and safe

The divergent ideologies around birth were clearly highlighted when comparing and contrasting text from the submissions. Submissions from ACM, ANF, RCNA, ASIM, MC, and HA tended to construct birth as a *normal life event*. Words and phrases such as *natural, wellness, physiological process* and *life cycle* were common in these submissions. For example, MC clearly stated their goal as:

> *To protect pregnancy and childbirth as a natural process* (MC, p. 4).

Similarly, the ACM suggested that midwives were educated to view pregnancy and childbirth as:

> *... essentially healthy, normal life events, and to focus on wellness* (ACM, p. 28).

Rather than focusing on the possible risks involved in childbearing, the language used in the submissions resisting the medical power described birth as a normal life event; one that had the potential to be positive and enjoyable.

> *In the main, childbirth involves healthy women experiencing a normal life event* (ANF, p. 7).

> *Continuity of care can contribute to the growth of love, trust, respect and cooperation within persons and their families…* (ASIM, p. 1).

> *Women… whose choices for or against intervention are respected by their care provider, can find birth a positive and empowering experience…* (MC, p. 15).

Unlike their counterparts, these organisations also commonly acknowledged the existence of disparate constructions of childbirth, for example:

> *There appears to be two distinct cultures in maternity services in Australia. One is that of midwives and many women, which views pregnancy, labour and birth as a normal like event [sic], while another views birth as "potentially high risk" in an "intervention" paradigm, requiring medical care and access to technology* (ANF, p. 10).

> *Community education campaigns to promote natural childbirth as normal experience in the cycle of life only requiring medical intervention in exceptional cases would go some way towards addressing high rates of intervention* (RCNA, p. 5).

> *The current funding arrangements support and encourage childbirth to be managed in a fragmented way and to be viewed as a medical/hospital event rather than as a normal physiological process* (MC, p. 11).

> *In some services caregivers see their role as informing and supporting women to make their own decisions and birth their own babies, while in other services staff see their primary responsibility as achieving patient compliance to hospital policies and procedures* (MC, p. 17).

As a result, the definitions and perceptions around risk differed and were used differently to support arguments for change. The alternate construction was one where the childbearing woman was positioned not only centrally to her care but as

the best placed person to make decisions within an informed choice framework. In explaining their notion of risk, MC stated:

> *'Safety' and 'risk' are viewed as subjective interpretations of objective information* (p. 4).

Others broadened the definition of risk by including psychosocial factors and arguing that there needs to be consideration for the woman's whole being. For example:

> *It is time to acknowledge that 'risk' is not purely a clinical science. The whole being of a woman must be considered. Currently there is little if any acknowledgement to psychosocial factors that increase or in fact reduce risk* (HA, p. 5).

HA went on to further challenge the use of risk assessment in Australian maternity services. In their submission, HA argued strongly that reforms were urgently needed to what they considered were overly strict exclusion criteria applied to women who wish to access publicly funded home birth and/or birth-centres. They criticised the current system saying:

> *Safety to mother and baby is paramount but exclusion criteria are often not about safety, merely custom and practice and accepted norms within Obstetrics* (HA, p. 3).

The two groups representing consumers, MC and HA, both advocated strongly for women's right to access and plan a birth at home. Their discussion of risk and safety also highlighted the need for healthcare professionals to better understand and support a woman's right to refuse a recommended course of action and/or treatment. This was a central construct within these submissions and spoke to the notion that many women feel coerced and dictated to within the current maternity system.

> *It is fundamentally important that care providers respect a woman's right to make an informed choice differing from the recommendation of the care provider. To coerce a woman into accepting intervention that she has clearly refused is considered by many women to be a violation... The principle of informed refusal is very important to women* (MC, p. 15).
>
> *It is understood that midwives providing homebirth services would work within guidelines for consultation and referral (such as Australian College of Midwives Consultation and Referral Guidelines). It is imperative that these guidelines include very clear pathways for women to give informed consent and conversely have the right to refuse* (HA, p. 5).

There is little doubt that the position advocated by these groups is vastly different from that evident in the peak medical bodies discourse, which clearly articulates the notion that authoritarian knowledge resides with the expert practitioner.

CONCLUSION

In summary, several of the peak professional organisations representing medical professionals defended the current state of maternity care in Australia, reporting excellent morbidity and mortality rates as proof. At the same time, they continued to use the rhetoric of risk and safety, warning that birth is dangerous and requires management by medical professionals. This argument was used to justify their vision for maternity services that allowed greater control by obstetrician's over women's choices in childbearing.

Midwives, nurses and consumer groups, on the other hand, expressed a belief in birth as a normal life event; a potentially positive experience with long-term effects for the woman. These groups also presented a different perspective on risk;

believing that women should be involved in any decision made regarding her care and that a woman has the right to informed refusal, without risk of intimidation or coercion from health professionals. Greater access to independent midwifery practice is desired by both women and midwives as it is perceived to facilitate better birth experiences for women, both in terms of a woman's satisfaction and enjoyment of birth and the reduction of unnecessary interventions in pregnancy and birth.

Intimidating and emotive language was used by some authors in order to gain the attention of the reader and drive home their argument. Other's simply stated their case for reform of Australian maternity services, making a request for change.

This chapter has reported on the findings from the discourse analysis undertaken on 11 submissions made by key stakeholders in maternity care to the National MSR. The following chapter will bring the thesis to a close, providing an overview of the entire study and drawing out the claims made in the findings. Relevant literature is incorporated in order to situate the findings in the current context of maternity care in Australia.

CHAPTER FIVE – DISCUSSION

THE POLITICS OF POWER

INTRODUCTION

The aim of this study was to uncover the perceptions, beliefs and meanings associated with childbirth in the Australian context using the methodology of discourse analysis. Discourse analysis was chosen as the methodology as it enabled examination of the unspoken or hidden messages in the data, paying particular attention to the construction of childbirth and the manifestation of power (Powers 2001). The data set comprised of submissions made by 11 peak professional bodies and consumer groups in Australian maternity services to the 2008 National Maternity Services Review.

Understanding the different ideologies inherent in the professional and public discourses of childbirth provides insight into how each party can work together more effectively to ensure the delivery of high quality services for Australian women. In the context of maternity service reform, several issues were uncovered in the data which are potential or actual barriers to national reform. These include the existence of fundamentally different constructions of childbirth by key stakeholder groups and, subsequently, conflicting opinions on how maternity services should be designed, managed and operationalised.

Three of the four submissions from the medical professional groups appeared to argue against the majority of reforms proposed in the MSR discussion paper. This was based on their position that, apart from the state of affairs in Indigenous communities and rural and remote regions of Australia, the current system was providing high quality, safe care. As such, these submissions reflected a sense that the status quo should be upheld, pointing out to the Government the potential

dangers of a reform agenda that sought to place greater control in the hands of childbearing women and midwives. In contrast, submissions from the peak consumer, midwifery and nursing groups supported change and advocated strongly for a new vision of maternity care that constructed childbirth as a significant but normal life event where the childbearing woman was placed at the centre of care. These groups expressed the view that this model supports a woman's fundamental right to make informed decisions and choices regarding her childbearing experience, including place of birth and primary lead carer.

The divergent positions expressed in the submissions, underpinned by the concepts of power and control, suggest that maternity care in Australia continues to be subject to the politics of power. The expression of, or desire for, power was found to be the major discourse underpinning all of the submissions analysed. Discourse analysis is particularly concerned with analysing unspoken relations of power, therefore the identification of power as a major discourse underpinning the findings of this research is in-keeping with the chosen methodology (Powers 2001).

In this chapter, I situate the findings within the relevant literature. In discussing the 'politics of power' I firstly explore what continues to be the *turf wars* between the professions of midwifery and medicine, and to some extent with childbearing women. This leads into a discussion on the meaning of *collaboration* and how the Governments definition of *collaboration* for midwives wishing to have access to Medicare (public healthcare funding) rebates is being used to maintain a medical monopoly. A feminist perspective of maternity care is then offered and related to the current context of maternity service delivery and reform. The chapter concludes by looking at the ways to move forward and best serve the needs of childbearing women in Australia.

THE POLITICS OF POWER

As explored in the Introduction and Literature Review chapters, many Australian maternity services reflect a technocratic ideology wherein a distinct hierarchy of power exists (Davis-Floyd 2001; Reynolds 1991; Van Teijlingen 2005). The politics of power within technocratic maternity care systems place those who possess the most technical knowledge, medical practitioners, at the top of the hierarchy; a layer below are those with intermediate technical knowledge, midwives (and other applied healthcare professionals); and at the bottom of the hierarchy are those considered to have the least technical knowledge, childbearing women. From this perspective, wherever the technocratic paradigm is dominant in childbirth, doctors hold the greatest power over women's choices in childbearing and childbearing women the least. This concept is demonstrated visually in Figure 1.

THE HIERARCHY OF POWER IN THE TECHNOCRATIC PARADIGM OF CHILDBIRTH

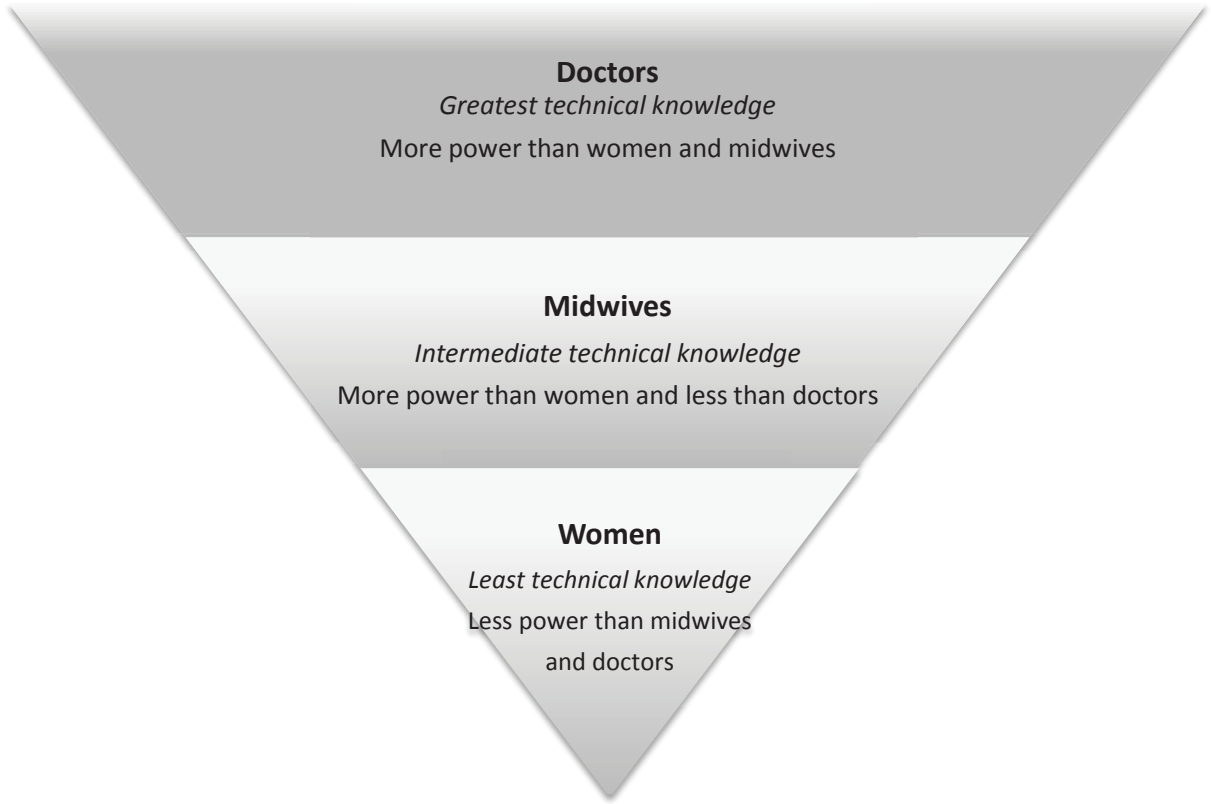

Figure 1. The hierarchy of power in the technocratic paradigm of childbirth.

In discussing the findings of this research, it is important to keep this notion of power in mind. This particular construction of power relations in maternity care has influenced both the way in which the submissions were written and the way in which they were analysed; both for this research and by the Government's Review Team. The findings of this study reflect the hierarchical nature of power as just described. It became evident during the analysis processes for this research that within the Australian maternity care system, distinct power struggles exist between maternity care providers. It appears that, in general, doctors remain committed to the notion that they are the best placed professional to provide maternity care to childbearing women regardless of a woman's risk status. Midwives, on the other hand, demonstrated a resistance to this model and expressed a desire to work to the full scope of their practice; which equates to the opportunity for them to gain more power as practitioners. The power struggles between maternity care providers (in the main midwives and doctors) have been described by others as the 'turf wars' (Hastie & Fahy 2011; Heatley & Kruske 2011; MacColl 2009; Reiger & Lane 2009; Weaver & Vernon 2005). Similarly, consumers of maternity care (childbearing women) argued for a change in their status, proposing that the hierarchy of power needed to be reversed. They desired a greater level of power in order to be in control of their care and to make the decisions they regard best meet their individual needs and preferences. Such power struggles also exist, therefore, between childbearing women and the maternity care system, and at times directly between childbearing women and their care providers.

The findings of this research raise important issues around power and control in childbearing. They raise questions about women's right to have control over their bodies in childbirth – including decisions about their most suitable care provider, model of care and intended place of birth. At the heart of these issues are the 'politics of power'. In their submissions to the MSR, the key stakeholders in Australian maternity care offered vastly different visions for the future of maternity services. This is, in part, due to their fundamentally different constructions of

childbirth as either a normal and safe event in a woman's life, or one that is inherently dangerous and fraught with risk. Given these findings, it is difficult to imagine a way forward for the reform agenda and the future of maternity services in Australia that will meet the needs of all the key stakeholders concerned.

Another major theme for discussion is 'the construction of childbirth: a clash of ideologies'. This will now be explored in relation to the findings from this research and situated in context with other literature relevant to the topic.

THE CONSTRUCTION OF CHILDBIRTH: A CLASH OF IDEOLOGIES

The Literature Review chapter introduced the notion that contrasting ideologies exist with regard to the meanings and beliefs associated with childbirth; especially in resource-rich, Western countries like Australia. These different beliefs fall into two categories; the construction of birth as a mechanical-like bodily function, with no reference to birth having an emotional, cultural or spiritual impact on a woman; and the construction of birth as an intimate, sexual, personal and even transformative event in a woman's life (Davis-Floyd 2001; Hausman 2005; Hewison 1993; Hunter 2006; Klein et al. 2011; Oakley 1980; Van Teijlingen 2005; Wagner 2001). Throughout the literature, these two contrasting belief systems have been labelled in a number of dichotomous ways including the 'technocratic' and 'humanistic' paradigms of birth (Davis-Floyd 2001, p. 5), the 'medical' and 'social' models (Van Teijlingen 2005, p. 1) and the 'mechanics' and 'organics' of maternity care (MacColl 2009, p. 6).

In 2009, Australian author Mary-Rose MacColl wrote a book titled 'The Birth Wars: the conflict putting Australian women and babies at risk'. In this work, MacColl (2009) focuses on the need for midwives and obstetricians to find a way through their disagreements over the best way to manage the care of childbearing women in order to work together more effectively. MacColl acknowledges the clash of

ideologies between what she refers to as the 'mechanics' and 'organics' of maternity care (2009, p. 6). She states:

> How we care for pregnant women and babies speaks not only the society we are but the one we will be. Childbirth is a moment of heightened risk but it is also a moment of epiphany. And yet maternity care cannot accommodate these two moments at once (MacColl 2009, p. 27).

The construction of childbirth does not refer to merely an ideological stance; on the contrary, a maternity care provider's construction of childbirth heavily influences their mode of practice (Van Teijlingen 2005). Along with such fundamentally different ideas and meanings associated with childbirth come radically different views on the way maternity care should be delivered. Commonly, obstetrics is considered to be more aligned with the technocratic paradigm of childbirth and midwifery with the humanistic (Davis-Floyd 2001; Kitzinger 2005; Van Teijlingen 2005). The findings from my research confirmed this notion as the discourses of peak bodies representing medical practitioners tended to represent birth as an inherently dangerous event that required medical supervision at all times. In contrast, the professional discourse of peak bodies representing nursing and midwifery tended to refer to birth as a safe and normal life event; one that is of great significance in a woman's life and has the potential to impact her wellbeing for many years.

When examining the different constructions of childbirth, the notion of *truth* arises as one naturally questions: whose construction of childbirth is true? Foucault saw *truth* and *power* as interwoven concepts (Hill 1997). In his 1980 text 'Power/knowledge' Foucault stated:

> … truth isn't outside power, or lacking power: contrary … Truth is a thing of this world; it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth; that is, the types of discourse which it accepts and makes function as true, the mechanisms and instances which enable one to distinguish true and false statements, the means by

> which each is sanctioned… the status of those who are charged with saying what counts as true (Foucault 1980, p. 131).

According to Foucault's theory, that discourse which is accepted as true, or made by society to function as true, is intimately related to *power*. Applying Foucault's perspective of *truth* to maternity care offers an explanation for the clash of ideologies and disparate constructions of childbirth that exist amongst key stakeholders. Midwifery and obstetric research commonly produce *evidence* with contrary findings on the same topic or question. Much of the disagreement between the technocratic and humanistic perspective is based on an inability to agree on what is the *truth* around medical interventions and environments, and how they affect childbearing. Foucault suggests that there are in fact *many truths* (Powers 2001). Considering this perspective, the purpose of exploring different constructions of childbirth as undertaken for this thesis is not to discover which construction is true. The purpose, rather, is to bring to light the unexamined elements of both dominant and marginalised discourses and examine why they are so.

The following series of subheadings: 'turf wars', 'collaboration' and 'feminist perspectives of maternity care' draw out the findings from this research in order to explore the issues related to 'the politics of power'.

Turf wars

As previously eluded to, a number of writers have portrayed midwives and obstetricians as participating in *turf wars* within the maternity care system (Hastie & Fahy 2011; Heatley & Kruske 2011; MacColl 2009; Reiger & Lane 2009; Weaver & Vernon 2005). This notion seemingly refers to *hostile* interactions observed between the two groups. This is said to be related to power struggles between care providers that are underpinned by the co-existence of different constructions of childbirth and

a genuine desire to do what they see as *best* for the childbearing woman and her baby (Hastie & Fahy 2011; Weaver & Vernon 2005). One strategy used by each *side* to support their position, and thus ultimately the decisions they make in clinical practice, is to draw on a substantial level of *evidence*. The use of this technique was addressed by MacColl who stated that:

> Knowledge about many areas of maternity remains contested, which means different experts have different opinions, often supported by different elements of available research (2009, p. 37).

This technique was also evident in the submissions analysed for this thesis. It was evident from the submissions that maternity care providers and consumer groups all wanted better outcomes and experiences for women in childbearing. However, each group used the research in vastly different ways to create a convincing argument that supported their particular viewpoint. For the Government (for whom these submissions were written), deciphering whose proposed model for the future of maternity care was best would have been incredibly difficult. Despite key stakeholders exhibiting the shared aim of improving childbearing experiences and outcomes for women and babies, the findings of this study demonstrate the reality that there continues to be a struggle of ideologies in Australian maternity care.

Among those that have written about the differences between the professions are a number of Australian authors. These authors have acknowledged that maternity care providers possess 'deep-seated philosophical differences' (Reiger & Lane 2009, p. 315) and 'differing beliefs, values and worldviews when acting in their professional capacity' (Heatley & Kruske 2011, p. 54). Hastie and Fahy argue that the development of one's construction of childbirth is dependent on many different factors throughout life.

> Coming from different professional groups also means that there are differences in some or all of the following attributes: education, qualifications, expertise,

> experiences, values, beliefs, socialisation, and access to organisational and legal power (Hastie & Fahy 2011, p. 73).

The existence of such different constructions of childbirth is recognised as generating significant tensions in the workplace, at times resulting in a lack of mutual respect and trust between midwives and obstetricians and a breakdown of communication (Hastie & Fahy 2011; Heatley & Kruske 2011; MacColl 2009; Reiger & Lane 2009). This was evident in the submissions particularly in relation to homebirth as doctors spoke of not trusting midwives to seek assistance soon enough when a pregnancy or birth became complicated. This example speaks to a lack of trust and respect from both practitioners. Presumably, in the example given, the midwife sought to avoid contact with the hospital and with obstetricians (perhaps for fear of unnecessary intervention or punishment by the medical establishment) and the obstetrician didn't trust in the midwife's ability to make a clinical judgement on when obstetric consultation was required. Such tensions are underpinned by the 'politics of power' which results in defensive and fearful practice.

Hood and Fenwick (2010) undertook qualitative research on the impact of litigation and external obstetric review on clinical practice. The paper demonstrated that within the hospital environment, tensions between the professions are constantly being played out. Midwives talked about *always* being *forced* to advocate for normal birth and how providing woman-centred care, particularly in labour wards where there is a culture of fear, becomes emotionally challenging (Hood & Fenwick 2010). Hood and Fenwick identified that, at times, midwives feel in between a 'rock and a hard place' when balancing their midwifery values and the demands of the technocratic institution (2010, p. 280). The struggle to keep birth normal at the same time as remain vigilant to hospital procedures and protocols was a constant challenge; something that was magnified by a fear of litigation (Hood & Fenwick 2010).

Whilst in the literature, obstetricians tend to be generalised as prescribing to a technocratic construction of birth and midwives a humanistic one, it is important to recognise that one's construction of birth does not necessarily follow prescribed professional lines (Davis-Floyd 2001; Kitzinger 2005; Van Teijlingen 2005). Another common assumption is that midwives desire change and obstetricians resist it (as was the case in the findings of this thesis), however this is not always true (Reiger & Lane 2009; Weaver & Vernon 2005). As acknowledged in the Literature Review chapter, the working practice of all maternity care providers lies somewhere on a gradient between the two extremes (Van Teijlingen 2005). The social landscape in which birth is constructed is a complex one, and in truth, it is never really this simplistic.

According to Reiger and Lane (2009), some midwives have relinquished and/or would prefer to defer decisions around women's care to their medical colleagues. These midwives, therefore, expect less autonomy than those who desire to work, or indeed do work, to the full scope of their practice (for example in the birth centre or with homebirth). Similarly, not all obstetricians are 'equally interventionist' when it comes to providing maternity care and, as a result, they can experience considerable frustration at being deemed 'the enemy' by midwives (Reiger & Lane 2009, p. 321). Reiger and Lane (2009), were able to demonstrate that making assumptions of this nature can lead midwives to inappropriately excluding obstetricians from the decision-making making process (Reiger & Lane 2009). Similarly, obstetricians who fail to acknowledge the role the midwife has in supporting the childbearing woman can exclude the midwife at the expense of the woman. These examples demonstrate how the 'politics of power' play out in the maternity care setting. In both of these instances, power struggles between midwives and obstetricians have the potential to detrimentally affect a woman's childbearing experience and clearly, the woman is not being placed at the centre of care.

Analysis of the data revealed that contrasting ideals resulted in vastly different conceptualisations of how the future of maternity services in Australia should look. In many ways, the hostile interactions described as the 'turf wars' were played out by key stakeholders in their submissions to the MSR. For example, the submissions from AMA and RANZCOG were clearly opposed to midwives being able to work to their full scope of practice in the private health system environment. Offering this type of care to women was considered by these groups to be detrimental to the safe outcomes Australia currently enjoys. This was used as a warning that the Government needed to *stay out*; inferring that *ideological* change to the maternity system was unnecessary and unwanted. To support this call, RANZCOG, the AMA and the RACGP argued that midwives and doctors already worked well together in the current model. The rhetoric of *collaboration* was a strong theme in their submissions. Analysis of this concept through the *power* lens, however, revealed that their notion of *collaboration* reflected the antecedents of the technocratic paradigm; the medical practitioner positioned as the team leader (at the top) responsible for knowledge, decision making and other team members (holding the most power). This was clearly evident in the suggestion that *collaborative* models of maternity care should ensure all the care provided to the childbearing woman is provided and/or supervised by an obstetrician, regardless of a woman's level of obstetric risk.

Collaboration

As part of the National MSR, the Government clearly sought the opinion of stakeholders on the issue of increasing women's access to midwifery-led models of care. In doing so, the MSR discussion paper (Commonwealth of Australia 2008) acknowledged and recognised the unique skills and expertise of the different professionals involved in providing maternity care. The MSR discussion paper (Commonwealth of Australia 2008) and subsequent report (Commonwealth of Australia 2009) highlighted that if change occurred, there needed to be clear referral

pathways and effective collaboration between all health workers in maternity services. The discourse around the meaning of collaboration thus becomes important to explore in relation to power.

In a general sense, collaboration is defined as two or more parties working together to produce something (Oxford University Press 2011a). In the context of maternity services, however, the working definition of collaboration is not so clear. Heatley and Kruske suggest that collaboration in maternity care can be defined as '…maternity care professionals "working together" to produce a "common goal" of a healthy outcome for both women and babies' (2011, p. 54). According to recent literature, both midwives and medical practitioners tend to agree that the two groups must work together in order to be able to provide the best possible outcomes and experiences for childbearing women and their babies (Hastie & Fahy 2011; Weaver & Vernon 2005). The notion of midwives and doctors working together was also evident in the findings from this research. What this working relationship constituted, however, tended to vary considerably between different key stakeholders. This finding is supported by Heatley and Kruske (2011) who assert that there are fundamental differences in the way doctors and midwives interpret the meaning of collaboration.

The findings of this thesis indicate that, in general, the medical groups perceived collaboration as a working relationship wherein doctors maintained their position as team leader and thus retained the right to make decisions in the best interest of the childbearing woman. Whilst submissions from RANZCOG, AMA and RACGP acknowledged the important role of midwives, they clearly constructed them as a team member that deserved medical direction. Philosophers such as Foucault would, perhaps, argue that conceptualising collaboration in this way works to maintain the medical profession's power. From this perspective it is then not surprising that the submissions from these professional bodies reacted strongly to a reform discourse of autonomous practice for midwives. Here they chose to position autonomous (as in

autonomous midwifery practice) as being uncommunicative, independent, unregulated and unsafe. Midwives, however, regularly use the word autonomous to describe how they work to the full-scope of their practice within a system that respects each professional's area of expertise (ICM 2005).

In the lead up to the MSR, Reiger and Lane (2009) conducted a qualitative study into the meaning of collaboration between Australian midwives and doctors in public hospitals. Interviews and focus groups were conducted with over 150 midwives, doctors and managers in metropolitan and rural maternity units in Victoria (Reiger & Lane 2009). The authors found that there were major challenges to the adoption of national and local policies advocating collaborative practices due to philosophical differences and tensions amongst maternity care providers (Reiger & Lane 2009). Similar to the findings outlined in this thesis, Reiger and Lane (2009) reported that midwives desired shared decision making and shared knowledge between doctors, midwives and childbearing women. They saw a 'good doctor' as one who trusted and respected both the midwife and the woman, and who was prepared to listen, negotiate and 'collaborate rather than just dictate' (Reiger & Lane 2009, p. 319).

Obstetricians, however, saw a 'good midwife' as one who had good clinical skills and therefore could be relied upon to work in a team with medical staff (Reiger & Lane 2009, p. 320). Most importantly for obstetricians was clear communication between midwife and doctor, and for the doctor to be 'kept informed of potential problems' without the woman being 'hung unto' too long without consultation (Reiger & Lane 2009, p. 320). Interestingly, some doctors in Reiger and Lane's study expressed concern over being deemed 'the enemy', i.e. not being trusted by midwives and even excluded in decision-making processes in an attempt to protect the woman from intervention and in order to 'keep things normal' (2009, p. 321). Similarly, some were concerned that midwives distrusted them and dismissed them as 'interventionist', when they did not feel that this was the case (2009, p. 321).

As eluded to in this thesis, Reiger et al (2009) found the existence of opposing or disparate constructions of childbirth provided a barrier to maternity care providers working collaboratively. This reality has been realised in the Government's practical attempts to move forward with maternity service reform. Following the National MSR and the announcement of major reforms as a response to the recommendations, eligible midwives were granted access to the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) to better assist childbearing women's access to midwifery led care. This was a historical reform welcomed by midwives and consumer groups. At the last minute, however, an insertion of the 'National Health (Collaborative arrangement for midwives) determination' (DoHA 2010) took place. Without widespread consultation, this document set out a definition of collaboration that in effect meant that midwives wishing to claim on the MBS for the care of a childbearing woman needed to prove a level of engaged support from an individual obstetrician (DoHA 2010).

The decision of the Government to enact this definition almost overnight, rather than the one developed by a multidisciplinary working party set up specifically through the National Health Medical Research Council (NHMRC), perhaps attests to the power of groups such as the AMA and RANZCOG in dictating practical elements of maternity service reform. Given that these two bodies' submissions clearly spelled out their opposition to private midwifery practice, the final outcome of the MSR is perhaps not surprising.

Feminist perspectives of maternity care

Exploring the findings through a feminist *lens* provides further insight into how power and control underpin interactions in the realm of maternity care. Childbirth is an innately female act; therefore the way it is socially constructed is related to the role of women in society. The female body has historically been viewed by feminists

as a site for controlling women's behaviour (Kaufmann 2004; Stewart 2004). Childbearing is a time when the pregnant body potentially becomes a site of public interest and discussion, and also marks a time where (in developed nations) women routinely come into contact with healthcare professionals in order to *monitor* their health and wellbeing, and that of the unborn child (Stewart 2004). Issues of power and control, as described in this research, reflect the patriarchal nature of maternity care within a technocratic paradigm. The desire for further control over women's choices in childbearing, expressed in the submissions by AMA, RANZCOG and RACGP, reveal how professional power can be used to exert control over childbearing women's bodies.

In the workplace a sometimes unacknowledged element of the power struggles and turf wars that exist between maternity care providers are related to issues of gender inequality. Given that the overwhelming majority of midwives (99.0%) and nurses (90.4%) are female, and the majority of obstetricians (61.4%) male, gender relations are an inextricable element of the doctor-nurse/midwife relationship (AIHW 2011; Australian Bureau of Statistics 2008). In their recent study on interprofessional collaboration in delivery suite, Hastie and Fahy argued that stereotyped doctor-nurse/midwife roles 'limit individuals in the performance of their clinical work' (2011, p. 73). They refer to an interaction known as the 'doctor-nurse game' which was first described by Dr Leonard Stein in 1967 (Stein 1967, p. 101). The doctor-nurse game involves the nurse being required to contribute ideas and make clinical decisions whilst still appearing passive so that the ideas look as if they were initiated by the doctor (Hastie & Fahy 2011; Stein 1967). This *dumbing down* of the nurse speaks to the patriarchal nature of the relationship where the nurse (woman) must appear to be under the instruction of the doctor (man).

Arguably, this phenomenon still exists. In 2000, Snelgrove and Hughes undertook research into inter-professional relationships which involved conducting interviews with over 50 doctors and nurses. The results showed that both midwives and nurses

still saw their work roles as being clearly dichotomised down doctor-nurse lines (Snelgrove & Hughes 2000). The findings from this thesis also demonstrate that, in their submissions to the MSR, medical practitioners reiterated the doctor-nurse/midwife divide. This was often performed through recounts of the education and skill level possessed by doctors and echoed in the desire for the medical practitioner to remain the *gate-keeper* to women's choices in childbirth; the development of a collaborative model that kept the obstetrician overseeing midwifery care.

It is interesting to note that when interviewing midwives and doctors about what they sought in inter-professional relationships, Reiger and Lane (2009) reported that doctors appeared not to have given the matter much thought. On the other hand, it appeared to be somewhat of a 'hot topic' for midwives (Reiger & Lane 2009, p. 320). This observation speaks to the historical subordination of women to men and midwives to doctors that carries on today (Reiger & Lane 2009).

The experience of childbirth has, for some, come to symbolise wider issues relating to women in society (Hewison, 1993; Kitzinger, 2005; Stephens, 2004). 'Birth power', which is a rejection of the technocratic model, is seen as a powerful way for women to challenge or rival patriarchal power, reclaiming the female body as powerful and the process of birth as sacred (Kahn, 1995, p.4). Midwifery academic Mary Cronk encourages healthcare providers to see that: 'The most powerful thing we can do as professionals is to empower the parents of the babies at whose births we assist' (2000, p. 26).

LIMITATIONS

This research was limited in its assessment of submissions to the MSR as only 11 of the over 900 submissions were analysed. This was, however, in keeping with the scope of an Honours thesis and ameliorated in some way by the analysis of

submissions from peak bodies representing members of the medical, nursing and midwifery communities as well as peak consumer groups.

The peak consumer groups Maternity Coalition and Homebirth Australia were chosen as representatives of the consumers of maternity care, childbearing women. Arguably, these two groups do not provide a true representation of the population of women giving birth in Australia and their opinions do not reflect the majority of women's perceptions around childbirth.

The voices of childbearing women were notably absent from this study, however by examining the social and professional discourses surrounding childbirth, insight was gained into how these factors influence the way women construct and experience birth.

THE WAY FORWARD: RECOMMENDATIONS FOR EDUCATION, PRACTICE AND RESEARCH

Given the different visions for the future of Australian maternity care described by the key stakeholders, it is difficult to imagine a way forward. Research by Hastie and Fahy (2011) suggests that midwives and doctors agreed that negative interactions in the workplace involved power struggles between the professionals and that these events were often associated with adverse outcomes. Having an awareness of the importance of working together is a fundamental element in achieving this goal. For maternity service reform to be effective, maternity care providers need to be open to one another's opinion, acknowledge the different constructions of childbirth and work towards understanding one another's differences. The desire to serve the needs of childbearing women and their families must be at the centre of all that we do.

Reiger and Lane suggested that 'professional courtesy' and simply 'good manners' was the first step in improving inter-professional relations between medical and

midwifery staff (2009, p. 322). Such *team work* involves: 'sharing, support, civility, mutual trust and respect' (Reiger & Lane 2009, p. 322). Further to this, the modelling of working together in a process of 'critical dialogue' by senior medical and midwifery staff was thought to encourage the establishment of an 'alternative, mutually respectful professional culture' (Reiger & Lane 2009, p. 323). Midwifery academic Mary Cronk challenges care providers to consider their role with women as one of being a 'professional servant' because this reflects the appropriate power base for the relationship between the childbearing woman and her care provider (2000, p. 19). Cronk (2000) emphasised the importance of care providers having awareness of their power relations with women by stating:

> I believe that our assumptions of power over the women for whose benefit we practice at the beginning of their parenting can begin their disempowerment as parents and take from them the feeling of responsibility for their children on which good parenting depends. Our input in terms of nurturing, enhancing and respecting the development of feelings of parental responsibility will, I believe, benefit society. (2000, p. 23).

Whilst there is evidence of maternity care providers working together harmoniously to achieve effective collaboration, there is also evidence of obstruction and interference in the course of maternity service reforms. So long as maternity care providers continue to fight the turf wars, they are distracted from their real purpose, which is to serve childbearing women.

The findings of this study serve as a reminder of the work that is yet to be done in reforming Australian maternity services so that they best serve the needs of the woman, including her need to be *safe* both emotionally and psychologically. Whilst the findings of this study did not provide any substantial new insights into the construction of childbirth in Australia, they do serve as a reminder to those wishing to improve women's experience of childbearing that true reform of maternity services will not be easily achieved whilst such disparate constructions of childbirth

exist amongst key stakeholders. As long as the struggle for power underlines the actions of care providers, women will not truly be at the centre of maternity care. As outlined below, there are several recommendations that arise from this study in the areas of education, practice and research.

Education

Exposure to different modes of birth for both midwifery and medical students would go some way in broadening social constructions of childbirth. Whilst the technocratic paradigm is dominant in most maternity services in Australia, the majority of midwifery and medical students are exposed to birth as it is managed in this environment; most commonly medicalised. The introduction of exposure to out-of-hospital birth environments for students, such as free-standing birth centres or homebirth with privately practising midwives would increase mutual understandings about different practice and types of expertise. Exposure of students to this alternative type of practice would be beneficial as it allows for an alternative experience of childbirth and maternity care to the mode of care practised in hospital. Just as students are exposed to women who have high-risk pregnancies and birth and who require medical intervention such as instrumental birth or caesarean section, so should they be exposed to normal birth with minimal intervention. Exposure to such events encourages students to have a basic understanding of normal, natural labour and birth without interference. It is my belief that, just as health professionals need to understand the normal physiology of the human body before they can understand its pathophysiology, so too must they understand the normal physiological processes of birth in an undisturbed state.

Practice

Several recommendations have been offered in recent literature with regards to improving relationships between obstetricians and midwives in their working

practice. Reiger and Lane (2009) suggested that the notion of professional courtesy needs to be introduced in undergraduate education of healthcare professionals, followed up later in professional development and embedded in policy development processes. Hastie and Fahy (2011), on the other hand, offered suggestions for practical changes to the working environment to foster better collaboration between maternity care providers. These suggestions included the provision of shared tea-rooms for midwifery and obstetric staff, shared hand-overs and shared educational sessions (Hastie & Fahy 2011). They also advocate that the improvement of inter-professional collaboration is strongly dependent on the 'prevailing organisational culture' within a maternity unit (Hastie & Fahy 2011, p. 77). In line with these suggestions, it is recommended that greater attention is paid to the fostering of healthy relationships of mutual respect and understanding in workplace culture both in educational institutions and maternity care institutions.

With regards to language, this study serves as a reminder that the public and professional discourses around birth have the power to shape women's perceptions and beliefs about childbearing. Currently obstetric language tends to reflect the dominance of the technocratic paradigm of birth in its employment of patriarchal, mechanistic language about women and birth (Kitzinger, 2005). Many words and phrases are used that have the effect of disempowering and trivialising women (Leap, 1992). It is only through the use of woman-centred language and the personal empowerment of birthing women that we can begin to reverse the culture of risk that prevails in the dominant technocratic paradigm of childbirth in Australia (Hunter 2006; Leap 1992). Achieving this aim is a fundamental step towards reforming maternity services so that they are truly centred on the needs of women, rather than practitioners or the institution. With this same intention, I recommend that maternity care providers are careful to share knowledge and information with women using language that is easily understood by the woman and her family. We must be mindful of the professional discourses around childbirth that we are

participating in and be careful to use terms that normalise, rather than medicalise childbirth.

Research

Further research is needed into ways to encourage better awareness and acceptance of a diversity of constructions of childbirth amongst maternity care providers. Research that takes a sociological perspective on childbearing and the delivery of maternity services needs to be supported as it offers insight into the current status quo of maternity care and inspires debate around different concepts and constructs of childbirth that deserve attention. The issue of collaboration and its emerging definitions and implications for practice deserves further investigation. The requirement for midwives in private practice to have formal collaborative arrangements with doctors has far-reaching consequences. Currently, the requirement of such arrangements is limiting midwives' ability to practice to the full scope of their capabilities and restricting women's access primary care with a midwife.

It is interesting to note that the vast majority of research of this kind is undertaken by midwives and sociologists. The medical/obstetric community do not often perform sociological research looking at the impacts of their practice on women in a holistic sense. This means that perhaps long-standing perspectives are perpetuated and new paradigms of thinking fail to emerge or be considered. In the future, better cross-disciplinary research might address this possibly narrow view.

CONCLUSION

This thesis involved a discourse analysis of submissions made by the key stakeholders in Australian maternity care to the 2008 National MSR. Analysis revealed that maternity care providers have fundamentally different constructions

of childbirth which results in a clash of ideologies and the practice of turf wars between midwives and doctors. The findings of this study show that, medical practitioners tend to construct birth as a dangerous event and, as a result, discourses of risk and safety were routinely used to justify their need to maintain control over women's choices in childbearing. Alternatively, nurses, midwives and consumers tended to construct childbirth as a safe and normal life event. As such, these stakeholders desired greater control for women regarding their intended place of birth and the provision of improved access to midwife-led care.

The reforms proposed by the Commonwealth Government in the 2008 National MSR offered a way forward for maternity services in Australia. After an extensive public consultation process, the Government demonstrated a significant commitment to the reform agenda by allocating $120.5 million in the 2009-2010 federal budget. Since this time, however, there has been a considerable watering down of a number of key reforms that were originally proposed. Despite comprehensive evidence suggesting the benefits of continuity of midwifery care, this model is still not widely available to women in the Australian maternity care system (Hatem et al. 2009; Hodnett et al. 2003; Page, Cooke & Percival 2000).

In the two years I have spent working on this thesis, the political landscape in Australian maternity services has continued to shift and change. Whilst some exciting major reforms have resulted from the MSR, such as the extension of the MBS and PBS to eligible midwives, the requirement of midwives to form collaborative arrangements with individual obstetricians means that significant barriers to private midwifery practice remain. For women like me who choose to labour and birth at home, and for the midwives that provide care in this environment, the future is even more uncertain. The difficulty faced by midwives in finding an obstetrician willing to form collaborative arrangements means that there is a real risk that midwives will not be able to make practical use of these long-awaited reforms.

The findings of this thesis provide important information regarding the way maternity care providers construct birth and how this impacts the way maternity services are operationalised. They also provide insight into the influence of key stakeholders on the outcome of the Government's maternity service reform agenda. I believe the research I have undertaken in this Honours thesis is noteworthy because it has revealed the unspoken elements of maternity care providers' fundamental attitudes towards birth in the Australian context. It is those very attitudes that have the power to influence a woman's experience of childbearing; something that is bound to be one of the most powerful experiences of her life. Through greater awareness of our individual and collective social roles in creating a positive, life-affirming construction of childbirth, we all have the power to change the meaning of birth.

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APPENDIX 1

OUTLINE OF PEAK PROFESSIONAL BODIES AND CONSUMER ORGANISTAIONS

Australian and New Zealand College of Anaesthetists

Australian and New Zealand College of Anaesthetists (ANZCA) endeavours to cultivate and maintain high professional standards in the training, practice and ethics of anaesthesia, intensive care and pain medicine (ANZCA n.d.). The College is directly responsible for the examination and qualification of anaesthetists in Australia and New Zealand, along with the standards of anaesthesia practice in these countries (ANZCA 2010). ANZCA membership consists of 4,673 Fellows worldwide and 1,553 anaesthetists in training (ANZCA 2010)

Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia, providing a unified voice for midwives and setting education and practice standards in the profession of midwifery (ACM 2009). The ACM provide political representation aiming to influence policy development and decision-making at local, state and national levels (ACM 2010). They also endeavour to raise the profile of midwifery in the community and state that they are 'guided by research evidence that pregnant women and mothers benefit from having access to midwifery care throughout their childbearing experience' (ACM 2009). The ACM currently has a membership of greater than 5000 (ACM 2010).

Australian Medical Association

The Australian Medical Association (AMA) represents registered medical practitioners (doctors) and medical students of Australia and work to protect and promote the interests of doctors and their patients (AMA 2009). They are the leading organisation of doctors in Australia, with more than 27,000 medical practitioner members AMA are the peak health advocacy organisation existing to advance the professional interests of doctors and the health of the community (AMA 2009). The AMA acts as the principal body coordinating and lobbying for the medical profession and aim to promote the maintenance of high clinical and ethical standards in medical practice (AMA 2009).

Australian Nursing Federation

The Australian Nursing Federation (ANF) is the national union for nurses, midwives, assistants in nursing and students in Australia. The ANF represents the professional and industrial interests of over 200,000 members employed in healthcare settings in both the public and private sectors, in urban, rural and remote locations (ANF n.d.). The ANF runs campaigns to raise political awareness and promotes political action when necessary in the pursuit of improved public policy on health, social justice and related issues (ANF n.d.).

Australian Society of Independent Midwives

The Australian Society of Independent Midwives (ASIM) is made up of both midwives and midwifery advocates who are committed to supporting women's birth choices and the promotion of continuity of carer, sensitive midwifery practice and breastfeeding (ASIM n.d.). The Society aims to advance Independent Midwifery in Australia through creating greater public awareness of natural birth opportunities for women (ASIM n.d.). ASIM is associated with over 100 independently practicing

midwives who offer midwifery support for women planning to birth at home, in hospital or in a birth centre (ASIM n.d.).

Homebirth Australia

Homebirth Australia (HA) are a group of consumers and midwives dedicated to ensuring that Australian women continue to have access to homebirth as a birth option, with the overall aim of having publicly funded homebirth available to women across the country (HA 2011). The group is committed to supporting the rights of homebirth parents, increasing public awareness and acceptance of homebirth, providing information to parents planning a homebirth and providing support, information and networking to homebirth midwives (HA 2011).

Maternity Coalition

The Maternity Coalition (MC) is a national consumer advocacy organisation who state they are committed to the advancement of best-practice maternity care for Australian women and their families (MC n.d.). MC is a non-profit, non-sectarian and non-political associated organisation (MC n.d.). Their main role is to act as an umbrella organisation, bringing together individuals and support groups for effective lobbying, networking, information sharing and support in maternity services (MC n.d.).

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) are responsible for the training and accreditation of doctors specialising in obstetrics and gynaecology throughout Australia and New Zealand. The College state that they are dedicated to assuring a high standard of practice in obstetrics, gynaecology and women's health, supporting research into women's health and

acting in an advocacy role (RANZCOG n.d.). RANZCOG have over 4600 members ranging from trainees to fellows (RANZCOG 2010a).

Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners (RACGP) is the largest general practice representative body in Australia with over 20,000 urban members and 7,000 members of the Rural Faculty (RACGP 2011). The College's mission is to improve the health and wellbeing of all Australian's by supporting general practitioners, registrars and medical students. This is achieved by supplying ongoing professional development activities, developing resources and guidelines and regularly assessing doctors' skills and knowledge (RACGP 2011). The RACGP advocates on issues of national significance and provide representatives for national, state and some local healthcare committees (RACGP 2011).

Royal College of Nursing Australia

The Royal College of Nursing Australia (RCNA) is Australia's peak professional nursing organisation with membership open to nurses and nursing students in all areas of the profession. The College is a non-government, not-for-profit organisation with a membership of over 7,500 (RCNA 2009). The RCNA endeavour to enhance the reputation and professional status of nurses and they regularly engage in policy formation, lobbying of state and federal governments for reform as well as providing advice to Government on issues of relevance to nursing and health in general (RCNA 2009).

Rural Doctors Association of Australia

The Rural Doctors Association of Australia (RDAA) is a national body representing the interests of rural medical practitioners around Australia and members are typically drawn from small rural towns and remote areas of Australia (RDAA n.d.). RDAA represent their members at both a state and national level, lobbying for improved support for rural medical practitioners and their communities and providing industrial support and advice (RDAA n.d.).