This is to certify that the
thesis entitled

BIRTH BY DEFINITION: PERENNIAL MEDICALIZATION IN SCOTTISH MIDWIFERY

presented by

Tara Jean Sara Dosumu

has been accepted towards fulfillment
of the requirements for the

Master of Arts	degree in	Bioethics, Humanities, and Society

Major Professor's Signature

May 12, 2009

Date

BIRTH BY DEFINITION: PERENNIAL MEDICALIZATION IN SCOTTISH MIDWIFERY

By

Tara Jean Sara Dosumu

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF ARTS

Department of Bioethics, Humanities, and Society

2004

ABSTRACT

BIRTH BY DEFINITION: PERENNIAL MEDICALIZATION IN SCOTTISH MIDWIFERY

By

Tara Jean Sara Dosumu

This paper examines the philosophical and structural influence of the medical model of birth on the educational and professional development of midwifery in Scotland. This influence rests on two deeply rooted definitions: the definition of midwifery as inferior and subordinate to obstetrics, and the definition of birth as a dangerous, pathological process in need of medical assistance. The close proximity of Scottish midwifery's roots to those of medicine has had a negative effect on the clinical practice of midwifery. Only by recognizing, exposing, and challenging medically-rooted definitions can supporters of the midwifery model hope to keep "normal" birth flourishing.

For Sarah
Mo nighean donn, gràdh mo chridhe

ACKNOWLEDGEMENTS

I owe thanks to many for their help in completing this project. First, I would like to thank my team of advisors for their unflappable good nature and unwavering support. Alice Dreger, who was willing to take me on and see me through; Libby Bogdan-Lovis, who helped me figure out what I was trying to say and gave me the time to say it; and Fred Roberts, without whom I might have simply given up. Several times. My work has benefited greatly from the careful reading and insightful comments of these good people.

I was also blessed with some wonderful friends along the way. I thank Tess Tavormina, for support and encouragement above and beyond the call of duty and Linda Hunt, for giving me the courage to go out there and do it (not to mention the equipment to do it with!). Thanks to Harry Perlstadt and all at Michigan State University's Center for Ethics and Humanities in the Life Sciences. I also thank everyone in the UK who helped make this possible, especially Fiona Watson, Nyvee Morrison, and Rob Polson. Special thanks to Lister Matheson. And I am greatly indebted to all of the wonderful midwives who gave me their time, their thoughts, and their trust. I will not soon forget your kindness.

Finally, I thank my family, especially my sister Amy Beltz (who put up with me all those hours in the car) and my parents, who have sheltered and fed me, body and soul, along the way. I thank Christopher Diener, the love of my life, for his gentle patience and understanding. I thank God, whose still small voice kept reminding me that "those who hope in the Lord will renew their strength. They will soar on wings like eagles; they will run and not grow weary, they will walk and not be faint" (Isaiah 40:31). And I thank my daughter Sarah, for sharing the years of her childhood with my dreams.

PREFACE

In general, my passion for gardening has not served my academic interests well. Each autumn, I am torn between the need to plant the newest strain of daffodil bulbs before the frost comes and the need to complete end-of-semester obligations. Each spring, the brilliant green shoots of the perennial border begin to need my attention roughly two weeks before my papers need to be finished. I confess, the garden occasionally wins.

This spring was different. As I began the final write up of my research project on Scottish midwifery, I found that the garden was just the thing I needed to help me illustrate my observations of the four Scottish maternity units I visited last summer. First, I coded the open-ended semi-structured interviews I conducted with five practicing midwives, and cross-coded the related literature and fieldnotes gathered at each site. Then, the anthropologist in me recognized a pattern, the historian in me suggested how it may have developed, and the gardener in me provided the vision to bring it all together.

The pattern I noticed was a repeated contradiction in my interview data. On one hand, some midwives suggested that they were supporters of the midwifery model, which defines birth as a an inherently safe physiological and above all *normal* process, and defines midwives as assistants to women. On the other hand, these same midwives did and said things that suggested adherence to the medical model. My historical research revealed the philosophical and structural influence of the medical model on the educational and professional development of midwifery in Scotland. My vision was of a weedy overgrowth of medicalization driven by two deeply rooted definitions: the

definition of midwifery as inferior and subordinate to obstetrics, and the definition of birth as a dangerous, pathological process in need of medical assistance. I believe that the close proximity of Scottish midwifery's roots to those of medicine help make this overgrowth possible. I also believe that only by recognizing, exposing, and challenging medically-rooted definitions can supporters of the midwifery model hope to keep normal birth – that is birth without any medical intervention – flourishing.

A look at the history of midwifery in Scotland reveals its increasingly close ties to medicine. I noted evidence of the early stages of this relationship, and the increasing medicalization of childbirth that came with it, in a collection of mid-nineteenth century Scottish hospital records. The roots of the birth-as-pathology definition, to be expected in a hospital setting, are evident with the use of a column which recorded whether a woman was "cured" of her pregnancy or "died" from it. The hospital records also reflect a medicalization of birth language – for example, the change in the description of the baby's position in the birth canal: from "natural," in 1843 to medicalized terms such as "cephalic" or "occiput posterior" by 1900. My research into the decades that followed revealed that childbirth was not the only thing being medicalized in the shadow of the hospital. While midwives were once defined by the community for the community, throughout the twentieth century that definition began to give way to the seeds of medicalization.

Professional midwifery in Scotland developed directly and indirectly under the control of influential obstetricians. True, the conditional support of midwifery by the Scottish medical community has, arguably, been instrumental in Scottish midwifery's continued visibility and viability. However, midwifery education and practice have for

decades been subject to surveillance and control either by physicians themselves, as in the early twentieth century, or by legislative bodies serving medical interests within the National Health Service, as has been the case in more recent years. In particular, my observations revealed an environment in which midwives who were not first trained as nurses are the exception. This environment has been fostered by years of the deliberate linking of midwifery and nursing education. Considering the ongoing struggle for nurses to be seen as autonomous practitioners rather than as the handmaidens of medicine, the effect of this link on midwifery's ability to do the same is not surprising. However, the overt attempts at the redefinition of midwifery have been met with resistance from politically active midwives and lay supporters of the midwifery model.

One of the means by which midwives have been able to successfully assert midwifery-based definitions is with the help of advocacy groups. Some of the groups – like the Association for Radical Midwives - are midwifery-based, and give voice to those within the profession but outside the status quo. Some of these groups are consumer-based, comprised of laypeople working together to change maternity care in the National Health Service. These groups such as the National Childbirth Trust, and the Association for Improvement in the Maternity Services, have challenged routine medical practices and won, gaining ground on which the midwifery model can flourish. One of the reasons these challenges have been so successful is that their champions have based their arguments on the best available evidence. A recent series of documents aimed at overhauling the philosophy and delivery of maternity care in Scotland have also been largely based on statistical evidence. These accomplishments suggest that the use of

evidence may be the most effective strategy yet in the struggle to redefine childbirth and midwifery, and my field observations suggest that this struggle is still going strong.

The maternity units I visited ranged widely in size and location, but in all of them there was evidence of a conflict – either past or present – between the notion of "ideal" midwifery and the midwifery actually practiced, and between definitions rooted in the midwifery model and those rooted in the medical model. In some units the conflict was obvious, and the contradictions abundant. In other settings, the conflict between the midwifery and medical models was more subtle. In most places I was told that the midwives there practiced "straightforward midwifery" and "normal birth," but when analyzing data gathered, my assumptions of what informants meant by "normal" were challenged. While clearly acknowledging birth without intervention as the ideal, two midwives spoke of their fear of what might happen should birth take place without medical assistance available. I interpret this finding as a direct reflection of the medically based birth-as-pathology definition operating in the philosophy and practice of these midwives. In comparing the answers of these informants to those at two other hospitals, it became clear that the definition of "normal birth" varied as widely as the terrain between each setting, and that this definition was the key element in promoting or constraining the practice of the midwifery model.

A midwife in the largest hospital I visited expressed a definition of birth that fit closely with the midwifery model, while in the same breath acknowledging that many midwives in her setting practiced care reflective of a completely different philosophy. Her comments led me to more closely examine the effect of context on definition, and when interview data from the three larger hospitals was compared with that from the

smallest, it became clear to me that the biggest factor influencing these midwives' definitions – and subsequently their practice – was not just the physical but the philosophical proximity of each unit to the nearest obstetrician. Midwives in the smallest hospital, the one with the least amount of obstetrical contact, and the only one employing a non-nursing trained midwife, exhibited the most midwifery-based practice. What I found in the maternity centers was that common roots bore common fruits, and what I concluded was that the midwifery model of birth simply cannot coexist and thrive in the same setting as the medical model.

My research left me with three main impressions. The first is that among this small sample of midwives two sets of definitions exist. One of them, reflective of the midwifery model, defines normal birth as the rule instead of the exception, and as the province of midwives – "the practitioners of normal." These definitions were easy to elicit, both in the words of my informants and the institutions supporting them. The other set of definitions constructs normal birth as pathological, a disaster waiting to happen, and midwives as assistants in preventing disaster. These definitions were more subtle, and it was more difficult to tease them out of the data, where they were hidden underneath the language of woman-centered care and informed choice.

This leads to my second main impression – that the coexistence of these opposing sets of definitions is counterproductive to the practice of the midwifery model and to the survival of normal birth. My research suggests that midwives practice what they believe, and at the heart of this belief are the definitions of birth and midwifery. If a conflict was evident between what the midwives said and what they did, it may well have been because of a conflict in their definitions. In environments that supported and encouraged

the definition of birth as an inherently safe and normal physiological process, midwives were able to practice closer to the "ideal" they all expressed. In environments that structurally and socially supported the medical model of birth, the clinical articulation of this "ideal" definition was drowned out by the perception of danger and the desire to minimize risk.

The third main impression brings me back to my garden. The opposing definitions I observed were difficult to extract from the data, and I believe they will be even more difficult to extract from midwifery practice due to the foundation on which current practice has been built. The medical model of birth has a firm foothold on maternity services in Scotland, a security it owes to years' worth of embedding itself in the education and legislation of midwives, and in the structure of midwifery care. I believe that exposing and challenging the medically based definitions underlying much of midwifery care is one way to change medically based practices. Midwives and those who support them might question which set of definitions their practice supports. Perhaps with the continued help of advocacy groups and statistical evidence, proponents of the midwifery model may be able to change educational and legislative structures enough to create an environment in which midwives are free to "practice what they preach." Once exposed, the roots of the medical model may be more easily extracted from midwifery, allowing practices that support normal birth to flourish.

TABLE OF CONTENTS

Introduction

Just off the northern coast of Scotland is a small island. Bailetorach,[1] the closest big city, is a seventy mile drive from the island's nearest coast. From the far side of the island, that drive might lengthen to as much as a hundred miles. The regional "consulting" hospital (a facility with specialist obstetricians), is located in Bailetorach. There are two small hospitals (known as "GPUs") on the island staffed by general practitioners and midwives; both are equipped for "normal" births. During the year 2000, the estimated number of women on the island of childbearing age was approximately1300, yet there were only 14 births on the island (Registrar General 2003). Unless only 1% of the women of childbearing age gave birth that year, the numbers indicate that the vast majority of women are either experiencing "abnormal" births or they are choosing for other reasons to give birth somewhere else. What's happening on the island?

I visited the island the summer before I began my research on Scottish midwifery. As a beginning graduate student in medical humanities, I knew where my interests lay before the visit, but didn't have an area of focus. I found one on the island. In addition to being awestruck by the mountains covered with stones and waterfalls, I was amazed when I was told by one of the local midwives that most women from the island gave birth in Bailetorach. I had by this time toured what I now know is, by Highland standards, a relatively spacious birthing unit, and had observed a good proportion of women of childbearing age in the area. I was puzzled to say the least. Here was a reasonably well-equipped birthing center, right on the island, yet women traveled the distance year round to make the trek to Bailetorach, some of them leaving home weeks in advance to wait for labor, some of them arriving around their due dates for scheduled artificial inductions

(Reid 2000). While my first inclination was to ask women on the island and in similar northern rural areas where they were giving birth and why, I also began to question the midwife's role in the calculus of the decision. Why did the midwife I spoke with seem perfectly content to assist in an average of just one birth every 6 weeks? Why had she told me that all first time mothers had to give birth in a consulting hospital, propagating a "myth" which was vehemently refuted by a later contact? Why was I told that an island woman wanting a home birth was being actively discouraged from such a choice? Did midwives play a role in the fact that most women were giving birth in Bailetorach? Why else might women choose to give birth in a highly medicalized, technologized setting when what I, both as a mother and as nurse, saw as a kinder, gentler option was also much closer to home? Why weren't the midwives fighting to keep birth on the island? These questions eventually formed the structure of my inquiry, and shifted my emphasis from birthing women to the midwives who assisted them. Instead of examining women's reasons for choosing to give birth in a particular place, I began to ask how and why midwives here might be contributing to what I saw as the medicalization of childbirth.

Method

I approached the question through both a comparative ethnographic analysis of midwives practicing in philosophically and regionally different birth settings, and a historical analysis looking at the development of and challenges to Scottish midwifery over time. While carrying out my research, I had the honor of interviewing five midwives from a variety of settings in northern Scotland. Those settings included two Highland maternity units and two units from just south of the Highland line. They varied in size from one where there were around 25 births a year to one where there were close to 2000. With one exception, my

[1] The names of hospitals and midwives in this study have been changed.

sample of midwives was obtained via the "snowball" method, with midwives giving me the names of others who might be interested. Following the review of a consent form approved by my university's Institutional Review Board, audio-taped semi-structured interviews were conducted in the maternity units themselves. Interviews were systematically coded and the results compared across units. I was also given a tour of each unit and collected the literature that would commonly be given out to pregnant women on their first visit. Observations of first visit literature and fieldnotes from the tours were analyzed using the same coding system. In addition, I distributed surveys to women of childbearing age via convenience sampling in two Scottish towns. While the small number of respondents (20) does not allow for statistically meaningful conclusions to be drawn, the data gathered, I use the data gathered to illustrate important concepts. I also examined various primary source documents held in the library archives at Glasgow University Medical School, the Highland Health Sciences Library in Inverness, and the Grampian Health Board Archives in Aberdeen. I used the data I gathered to determine whether and to what extent medicalization had shaped and defined midwifery and childbirth in the areas I studied.

Hypotheses

My original hypothesis was that the differences in the maternity units would have something to do with proximity to the highly technical "centers of excellence" in the cities. I assumed that medicalization would increase with proximity to the city, and that outlying maternity units in remote and rural areas would be less technologically dependent. This hypothesis was not supported. Intriguing differences emerged among the midwives and maternity centers I studied, but they were not the differences I had expected. For example, why was it that notions of technology came up often in the interview at the most rural unit

while in the big city itself, arguably more technical by default, the subject hardly came up at all? Why, in a rural maternity unit known for its technical ability (Reid 2000), were midwives afraid to practice without doctors, while those at one of the smallest and arguably least technical rural units did so on a regular basis? And why were some midwives telling me one thing while they seemed to be doing another?

*****

I recently bought a house, a former rental sorely in need of a landscaping update. A few daylilies, a scraggly stand of Phlox, and a wild patch of *Ajuga Reptans* overgrown into the lawn comprised the sum total of the lot's horticultural embellishments. As an avid gardener, I relished the opportunity to take a relatively clean slate and replace it with an ever-blooming oasis that would give hummingbirds, butterflies, and neighbors a reason to stop by. I planned tall grasses and bright Clematis for the walkway, a variety of *Nepeta*, Coral Bells, and Beardtongue to line the drive, and some Yarrow and miniature roses along the side of the garage. First I would need to prepare the soil by weeding. It wasn't until after I had easily uprooted an army of pesky yellow dandelions, loosening the taproots lunging straight down from the stem, that I realized I had a much bigger problem.

Snow on the Mountain. Gardeners I know roll their eyes and moan when they hear these words. Aphids, weevils, moles, even crabgrass – anything but Snow on the Mountain. The only real remedy is to give the affected area the "Napalm treatment," spraying Roundup or some other noxious herbicide at two-week intervals until it kills every remnant down to the roots. It's the roots that are the problem. They extend their delicate, white tentacles into every inch of soil they can find. They overlap and twist,

running deep and wide, sprouting new plants in places 5 feet to the left of where you thought you had uprooted the last trace. The roots are fierce and aggressive, choking off the lifeline of anything else bold (or foolish) enough to put down roots of its own in an occupied patch, and working their way into areas of the garden where they are not invited. I have seen carefully tended borders sprout the telltale variegated leaves literally overnight. However, the scourge has its uses. It grows nearly anywhere if given the opportunity. A swampy, shaded area under a tree? A parched, sandy stretch by the side of the road? No problem. Snow on the Mountain will flourish in any conditions because its tenacious roots adapt to and eventually become those conditions. The problem is that under Snow on the Mountain conditions, all other roots have to fight to survive.

*****

My observations of Scottish midwifery have more than a little to do with my garden. Most midwives and scholars of midwifery agree that midwives are in theory the champions of normal birth, or birth without routine medical intervention. (Lichtman 2000; Hunt et al., 2002; Jones 2000; Reid 2000). The concept of "normal birth" is key to the definition of the ***midwifery model of birth***, whose supporters define birth as "an inherently normal physiological process with powerful emotional and spiritual dimensions" and directly in contrast with the ***medical model of birth***, which critics argue defines birth as "inherently pathological...a problematic mechanical process in danger of constant malfunction" (Fielder 1997:163). Comments made by the midwives I spoke with indicated that they believed they were practicing the midwifery model. For example, when asked to describe what they did in their respective units, all provided some version of the description "normal, straightforward birth." Reflective of the midwifery model,

some of their practices did indeed support the emotional and spiritual dimensions of birth and work to promote normal physiological function. However, more often I found that a disconnect existed between what interviewees said and what they did, evidence of a hidden conflict between the ideals they expressed verbally or on paper and those ideals they expressed through clinical practice.

In a healthy garden, all of the layers interact with one another to produce the substratum, the growing medium for a variety of species. What I observed in my study is that what begins as the seed of "normal birth" in the minds of these midwives gets stunted on its way to fruition by a mass of deeply embedded and conflicting interests tenaciously rooted in the medical model. Though midwives are in theory the champions of normal they are often practicing in an environment in which the medical model, like Snow on the Mountain, flourishes and replicates itself to the detriment of most other influences. My small scale ethnographic study exposes the root structure underlying these midwives' often unconscious participation in the medicalization of childbirth – a process best understood in all of its professionally, historically, socio-politically, and individually constructed and reconstructed complexity.

This analysis hinges on the notion of definitions. The definition of the midwife and her role has long been contested in Britain. Through the years since its inception, the NHS has been compelled to issue several official statements redefining and spelling out this role (Scottish Home and Health Department 1973; UKCC 1992; Scottish Home Office 1993). Among midwives and medical professionals the debate has an even longer history (Donnison 1988; Leap and Hunter 1983; ARM 2000). Why all this attention to

definition? First, because definition has utility. Valerie Fleming, a midwifery scholar, discusses the ways in which

> The international definition of midwifery was used by midwives in the UK as a basis for their campaign over the last 15 years against the use of D and E grade positions[2] for newly qualified midwives. Following this, midwives have become more aware of the possibilities for extending their role and are drawing upon this definition in other settings. This definition...has [been seen] as something for use by countries to establish a midwifery base (2000:68).

Second, for those who provide health care, definition has immediate and substantial applications. Within organizations important to practicing Scottish midwives such as the WHO (World Health Organization), the UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting), and the RCM (Royal College of Midwives), definitions of "midwife" simultaneously delineate the midwife's duties and/or scope of practice. This is evidence of the concrete, day-to-day importance of definition. For example, the UKCC's Nurses, Midwives and Health Visitors (Midwives Amendment) Rules 1998, a document formally and legally structuring midwives' practice in the UK, begins with the section "Definition of a Midwife" (UKCC 1998). In the world of healthcare providers, if the definition changes, the nature of the job changes on a very concrete level. This is the definition of midwifery that I discuss in the paper, a sort of "lived" definition. It is not abstract; it extends beyond the theoretical into the material day to day practice of midwifery. Rather than a fuzzy "perception" or an ephemeral "concept," the definition of midwifery is the essence--the bottom line, drawing boundaries around what is doable, what gets done, and by whom.

Like the definition of midwifery, the definition of birth has power. Robbie Davis-Floyd (1993) described a sort of continuum of definitions expressed by a sample of

American women who had recently given birth. This continuum stretched from "birth as holistic, physiological process" on one end to "birth as technological, pathological process" on the other. Davis-Floyd found that the proximity of a woman's childbirth definition to one extreme or the other of the spectrum was instrumental in determining which care providers she sought, where and how she gave birth, and how she felt about it afterwards. In *Birth in Four Cultures*, Brigitte Jordan (1993) suggests that birth is a time in which the social and biological are like threads woven together, a time in which the meaning of the biological event is constructed within and by the social worlds of those participating. "*The way in which a culture defines the birth event is inherently linked to its cultural meaning and the importance of this meaning can be manifest in the clinical setting*" (Jordan 1993:149, emphasis added). The importance of the definition – sometimes the fertilizer, catalyzing the process of medicalization, sometimes the last hope of any alternative ideas sprouting – cannot be underestimated. In this paper, I concentrate my analysis on the definitions of midwifery and childbirth, tracing them from their roots in the medical model of birth to their fruits in the practice of five Scottish midwives.

I believe that the chief way in which proponents of the medical model have attempted to choke out the midwifery model is through actively restructuring the definitions of midwifery and birth to reflect medical model values. In my research, I observed past and present attempts by these proponents to redefine the midwife and her role: from one that sees midwives' ultimate focus as assisting women to one whose ultimate focus is promoting the interests of biomedicine. I also observed efforts to shift the midwifery definition of birth from a normal, physiological experience to a medical

[2] Positions low in prestige and pay on the NHS scale.

condition requiring surveillance, intervention, and hospitalization. While the first attempted change has been overtly pursued, contested, and negotiated among proponents of both models in Scotland, the second has not been as widely and directly challenged, nor as successfully defended. In this paper I illustrate stages in this tug-of-war over the definitions of birth and midwifery, and describe strategies that have been used by those on both ends of the rope. It is my hope that in doing so, the conflicts underlying midwifery practice in Scotland today will become clear.

Mapping it Out

In the pages following, I begin with a look at the historical relationship between midwives and physicians and the foundation of this relationship on the medical model of birth. I then describe how that foundation paved the way for the medical model's infiltration of the past and present structure of midwifery education and maternity care in Scotland, and describe how the embedded nature of these structures affects the current relationship between midwives and physicians. In the next section I then describe other voices, such as those of consumer advocacy and "political pressure" groups, currently clamoring to define and construct childbirth and midwifery in Scotland. These voices, whose interests are often at odds with those of physicians, add to the conflicts inherent in Scottish midwifery practice. In the next section, I discuss the ways in which conflicting interests come together in the production of documents and directives intended to improve upon the definition and delivery of midwifery care. Key to this discussion are the directives contained in the document *Changing Childbirth* (Department of Health 1993) and their expression in a pregnancy and childbirth information book called *Ready, Steady, Baby* (2002). An analysis of this and other literature given to women on their first

visit with the midwives helps form the basis for a discussion of the different maternity units in the last section.

The background given in the first half of the paper is fleshed out in the second half, via my observations of five individual midwives attempting to practice the midwifery model of birth in their various contexts. My observations demonstrate the ways in which these midwives appeared to be unconscious participants in the medicalization of childbirth, and describe the context of conflicts that may have contributed to this finding. In the last section of this paper, I suggest some of the underlying reasons why, within this particular Western biomedical system, efforts to pull birth towards the pathological end of the physiological/pathological continuum have been largely successful, while efforts to redefine midwifery have met with resistance; I also continue to speculate on the role of midwives in re-shaping these definitions, and look towards future strategies that may contribute to increasing the viability of "normal" birth.

Justification

Why is this study important? The medicalization of childbirth is not a benign phenomenon. One need only scan the conclusions of the Cochrane Collaboration's information database[3] as proof that the effectiveness of many routine medical interventions is unsupported by data. Cesarean births for example, arguably the most medicalized of all, have recently been shown to double a woman's risk of being rehospitalized (Lydon-Rochelle et al. 2000). The dangers of medical interventions, such as continuous electronic fetal monitoring (Banta 1980), artificial induction of labor, and even the hospital environment itself (Tew 1990), are well documented. Jordan, discussing

[3] This online library, for use by those making healthcare decisions, contains regularly updated systematic reviews of the latest research in the medical field.

the centrality of the birth definition to the continued medicalization of childbirth, states that the definition of birth in a group

> serves as a guide for conducting the routine business at hand. At the same time, it furnishes the resources for dealing with 'trouble' by providing the grounds for justifying obstetric procedures if and when they become problematic... A group's definition of the event becomes visible in its members' notions of what constitutes adequate justification of the practices in which they engage. (1993:48)

It is my hope that exposing strategies of medicalization will be useful to the efforts of those working to stop it.

Medicalizing birth has many implications, including the potential oppression of women. Meg Taylor, a midwife and critic of the medicalization of childbirth, discusses the ways in which definition by the medical model obscures the undeniable and potentially empowering physicality of birth. "The control and distortion of childbirth by male dominated institutions serves a purpose which keeps all women suppressed...Childbirth and sexuality are basic and physical. If the physical is distorted, people's sense of self on a deep level is confused or denied. This is a basic principle of oppression" (Taylor 2000). The implications for women are clear, but the redefinition of birth has implications for all of humanity. Birth, like death, is among the few experiences that all of humankind has in common; we are all born into this existence and we all die. When machine technology and biomedical manipulation become a necessary, inherent part of a physiological process in which all human beings participate, who is in control? If efforts to move birth back into the domain of normal continue to fail, and as the medical model of birth stretches its roots farther and farther, the implications for humanity's perception of itself are immense. It is not a battle that midwives - or anyone - can afford to lose.

Literature Review

While much has been written about midwifery in the UK, a scan of theses and dissertations held at the Royal College of Midwives reveals not one devoted to Scotland. Any discussion of the NHS must at least acknowledge the greater context of the entire UK, and though there are many works written about the history of "British" midwifery, which technically includes Scotland, such works largely concentrate on England and generally tend to address issues of professionalization (Donnison,1988; Heagerty,1990). However, encouraging progress is beginning to be made, so that this paper may find its place alongside works like Lindsay Reid's *Scottish Midwives: 20th Century Voices* (2000), a collection of oral histories gathered from midwives practicing throughout Scotland in the 20th century. Like many themed works on the history of Scotland (Marshall 1983; Beith,1995; Bennett 1992) Reid's work is geographically wide-ranging, with informants coming from areas as far apart as the Borders and Shetland. It is also unfortunately devoid of analysis on the part of the author. A similarly useful work is Leap and Hunter's *The Midwife's Tale: An Oral History form Handywoman to Professional Midwife* (1993), which fortunately includes extensive analysis. Though the authors concentrate on English midwives, their work is invaluable for tracing the effect of changes in the institutional structure on the practice of midwifery from the perspective of the midwife practitioner. Both works combine an anthropological approach (in particular the semi-structured interview) with a historical approach. However, the overall goal of these authors is more descriptive than analytical, and the interviews primarily concern events that take place in the first half of the 20th century. This paper, with its analytical

emphasis and broader historical scope (the mid – 19th century to the beginning of the 21st), can fill a gap.

There also appears to be a gap in the literature written about Scottish midwives from the perspective of medical anthropology. The majority of large and small scale studies of childbirth in the UK have, again, concentrated on English women (Garcia et al.,1998; Gready et al. 1995). Relatively little has been done in Scotland, and I have been unable to find any studies specifically on midwives in rural or Northern regions of the country. Hundley et al. (2000) gave an indication of what is possible in their national survey of all Scottish women who had given birth during a 10-day period in 1998. Their study is important in noting recent trends in the use of maternity services in Scotland, and of the degree to which new woman-centered care ideals have stood the test of reality—that is clinical application. The study revealed, among other things, that a majority of Scottish women remain unaware of the options available to them in childbirth. The authors state that "considerable efforts have been made to improve information and choice for women. However, it is clear that further work is needed if women are to be offered informed choice in the provision of their maternity care" (2000:303). The authors are clear in implicating the NHS for the failure to provide women with this information. Certainly women need to be given greater access to information. However, the study did not address the role of the midwife in the dissemination of information, which this study explicitly does.

A recently published anthology that specifically discusses midwives and midwifery in Scotland has been invaluable in informing my paper. *Failure to Progress: The Contraction of the Midwifery Services* (Mander and Fleming,2002) attempts to

"create a picture of the position of midwifery at the dawn of the twenty-first century" (2002:xiii) using Britain as a backdrop. This collection encompasses feminist, political economic, cross-cultural, historical, sociological and anthropological perspectives, resulting in a comprehensive picture of the "state of things" past, present and future. For example, in the chapter "Midwifery Power," Mander and Reid use a feminist approach to examine the effects of early legislation on midwives in Scotland and England. Additional chapters discuss the development of political action groups in the UK (Thomas,2000), examine the intersecting roles of midwife and medical practitioners (Mander 2000), and speculate on the effect of recent changes to the education of midwives in Britain (Bower 2000). However, none of the chapters are based on original ethnographic research by the authors, as is this paper. In the first of a two-part comprehensive literature review of women's views of maternity care in the UK, point specifically to the lack of research into the role of the midwife: "The role of the midwife in intrapartum care in community settings was explored in relatively few studies. While details of which staff were present at home or GP unit births have been collected, findings have predominantly concentrated on whether or not a doctor was present" (Dowsell et al. 2001:96). My analysis begins to fill the gap noted by these authors.

In a U.S.-based ethnographic study, scholar Peter Johnson (1998) demonstrated that the ways in which a community defined the role "midwife" were directly tied to the level of confidence they placed in her. It is possible that this confidence level, linked to role as it is, is an important factor in childbirth decision making processes. Sociologist Sandra Howell-White (1997) demonstrated a correlation between a woman's definition of childbirth and her choice of care provider. Anthropologist Robbie Davis-Floyd (1987)

demonstrates a similar dynamic in "The Technocratic Model of Birth," using data gained from a sample of 85 women. These studies, while informative and pertinent to the role of definition, were all based in the U.S. My study contributes data from a traditionally underrepresented region with a national health plan.

CHAPTER 1

Intertwining Professional Roots

The historical development of midwifery's relationship with the medical model

One of the means by which the medical model of birth has overtaken the midwifery model in much of Western medicine is by making itself inextricable from the definition of midwifery. The histories of modern midwifery and the medical model in Scotland are hopelessly intertwined, existing in a dialectical relationship. The obstetrically managed medical model of birth is the Other to which midwifery must point to define itself. Similarly, in terms of obstetrics, midwifery is the Other to which biomedicine has pointed as an example of all it is not. However, due to differential degrees of power on both sides of this dialectic, the biomedical model has been able to systematically assert itself as the superior Self in the minds of birthing women (and even some midwives), and succeeded in gaining control of birth in Scotland. Among the deepest roots in this process are the historical underpinnings of the development of professional midwifery in Scotland. To illustrate this development, I turn first to a pair of notations, the first found in the Glasgow Royal Maternity Hospital's patient register and the second in the case notes of the Glasgow Women's Private Hospital.

Notation #1 9/29/1846

> A midwife and student from the University, High Street were in attendance upon this woman and delivered her of the child, but could not manage to take away the placenta although they pulled and hauled at it for about two hours at the expiration of which time the friends of the patient thought they had been long enough to work without doing any good and came to this hospital for assistance. Mrs. Nevin went and brought away the placenta without the least difficulty.

Notation #2 6/7/1846

> When called to this case the Os Uteri was fully dilated but uterine action had altogether ceased. Dr. S was called upon and immediately applied the forceps. After a great deal of trouble he succeeded in delivering the head of the child, in which position he left it for a short period, hoping that the uterus would then act and expel the trunk, but it did not and he consequently had to use considerable force with his hands in order to bring it away. The usual remedies were had recourse to immediately after, in order if possible, to restore animation but they were of no avail. Owing to the advanced age of this patient before giving birth to a child and also the small stature and great corpulence, the parts were very rigid and dry. By a strict investigation it was ascertained that labour had commenced 3 days previous to the time when assistance was requested of this hospital and that during the whole of that time a midwife had been in attendance.

These notational anecdotes illustrate a time when birth happened at home and physicians were only consulted in cases of extreme emergency. However, they also illustrate the means by which the skills of the midwife, a respect for which is evident in the first, were discredited, as evidenced by the shifting of blame in the second. In the first illustration, Mrs. Nevin, the domiciliary midwife (that is, a community based midwife assisting in home births) is attending a woman at home with a student. As the Glasgow Royal Maternity Hospital was a teaching institution, this would not have been unusual. Why, then, was the case referred to another midwife instead of a physician when it became an emergency? Many explanations are possible. It could be that cases were 'triaged,' and that a retained placenta was not sufficient grounds for physician intervention. However, judging from the numerous entries in the book where a physician is noted to be the one removing the placenta, this supposition is not likely. It could also be the case that all of the physicians were otherwise occupied. Judging from the number of births per year in the hospital at the time (38), this is also not likely. It appears that the domiciliary midwife and her pupil sought help from a qualified practitioner whose skill in

performing this particular maneuver was recognized and respected – even by the physician recording the incident. Several things are of note in the second anecdote. First, the physician, when called, "immediately" uses forceps (tools to which only physicians had access) before he uses his hands (tools which any midwife would have access). Additionally, the information that labor had been in progress for three days is included presumably to underscore the apparent opinion that the midwife should have called for help earlier. The medical model had by this time begun to pay close attention to quantifying labor, and to draw boundaries around what would and would not be considered normal. The midwifery model recognizes that *normal* labor can in fact take days. In these notations, we begin to see the beginnings of the devaluation of midwifery and the growth of medicalization.

I return now to the Glasgow Royal Maternity Hospital patient register for further observations suggesting the possible seeds of medicalization. While the development of man-midwifery and obstetrics in Scotland, along with the Scottish-led rise in the use of chloroform and the Simpson forceps is dealt with in depth elsewhere (Dow 1988), my focus is on the years following those events, and the effect of these changes on Scottish midwifery. The earliest records in the register are sketchy, and roughly outline the picture of a place where poor women could come as a last resort. In the year 1835, the handwritten columns of information recorded include a general address, a name (surnames preceded by Widow, Mrs., or a first name only). Irish names like Mulligan, Garrett and Murphy are mixed with Scottish names like McDougald, Carmichael and Orr, testament to the diversity brought to the city by industrialization – and the poor health of its hopeful followers. Also noted are the kind of labor (natural, breech, tedious), the

length of labor, by whom the labor was attended and by whom the woman was recommended. In the entries from 1835, this last column is blank except for one entry reading "SPPS," a designation whose meaning I have yet to discover. In the year 1836, however, the "by whom recommended" column was filled in with the word "necessity" or the name of a doctor, and by 1837 the notation "poverty" began to be included. A final column, which persisted until 1855, reads "cured or otherwise," with entries reading either "cured" or "died." For the year 1838, 47 births are recorded. Nine of them resulted in stillbirth. It seems clear that women who came here did so because they had no choice. It also reflects a perception of the difference between natural and otherwise, and a persistent but fuzzy awareness that the "natural" condition of childbirth was something for which women needed a cure.

In 1843, the register begins to reflect an increasing medicalization, as well as the increasing use of hospitals as the place of birth. The entry for kind of labor changes to kind of presentation, with notations like "N" for natural, "footling" (a specific kind of breech) and "placental" replacing evaluative statements such as "tedious." In addition to the length of labor, the precise time that it takes for the placenta to be expelled begins to be recorded. By 1855, the columns are pre-printed. They include places for name and residence, time of labor, age of mother, previous number of births, the presentation time of placenta, attended/recommended by and whether the boy/girl was born alive/dead. In 1859, a new column is handwritten in next to the printed columns to record the woman's religion and marital status. By 1900, this information is included in the pre-printed headings, suggesting the growing importance of demographic data, one representative of the link between medical science and the new science of epidemiology. Amidst the

sharply rising numbers of births recorded (double or more than those recorded 50 years previously), it is safe to assume that public health matters would have been of some concern in this hospital at the turn of the century. This trend also reflects the fact that in the latter part of the 19th century the Registrar General's office for Scotland began keeping record of Scottish birth and death statistics.

By 1900, medical management of childbirth is easily recognizable in the entries. Abbreviations, hallmarks of the cryptic medical shorthand that helps keep "medical" knowledge inaccessible to laypeople, begin to appear with increasing regularity. Presentation of the fetus is no longer recorded as "N" for natural but "C" for cephalic (head down) or ROP (Right Occiput Posterior). Also appearing at this time are IVDs, intravenous drips, evidence of the new technology of intravenous fluid replacement, and CHCL3, the chloroform for which women flocked to the hospital. The "notes" column is also increasingly utilized. While in 1843 entire pages were filled with no intervention noted, by 1902 the column was used extensively to record things like manual removal of the placenta, stitches, forceps, versions, and curettage.

While it is possible that the changes observed in the logbook were reflective of a change in recordkeeping, these records nonetheless suggest that in Glasgow the influence of the medical model, with its active management and intervention, was growing. They demonstrate some of the specific means by which medical knowledge began to overshadow midwifery knowledge, and form a backdrop for a continued discussion of the nature of authoritative knowledge. Brigitte Jordan discusses the means by which this conscious takeover was accomplished when she states that "a consequence of the legitimization of one kind of knowing as authoritative is the devaluation, often the

dismissal, of all other kinds of knowing...the devaluation of nonauthoritative knowledge systems is a general mechanism by which hierarchical knowledge structures are generated and displayed" (1992:56). Given this function, it is not hard to see why it was vital for midwifery knowledge to remain "nonauthoritative" in order for physicians of late 19th century Glasgow to increase and maintain their control of birth.

Active Redefinition Begins

In the generations prior to the institution of the National Health Service in Britain, the role of the midwife was essentially community defined. In *The Midwife's Tale*, a collection of oral histories, Nicky Leap and Billie Hunter speak of a time when the woman who helped in childbirth might have been the same woman who laid out the dead, and performed a number of other functions in the community. She was the handywoman, "the woman you called for," or "the one who would go" (1993:29). These definitions reflect the dynamic status of the role – a role that did not exist without the context of community. How did the nature of this vital role shift? The different outcomes of the above anecdotes seem to be a case of differing knowledge and skill levels, which also exist among physicians. How did variation in individual skill level become translated into a text in which the efficiency of the midwife's hands became inherently inferior to the instruments of the obstetrician? How did the handywoman become the enemy – and whose enemy did she become? I believe the transformation of the handywoman was due in large part to a calculated shift in the definition of authoritative knowledge and in a displacement of the mechanism by which midwives were defined.

Jean Donnison (1988) suggests that the fictional character of Sairey Gamp in Charles Dickens' *Martin Chuzzlewit* was the kind of negative publicity instrumental in

dealing a death blow to traditional midwifery in Britain. In Victorian London, the image of the drunken, bumbling midwife, like Sairey, was consciously used by the medical establishment (and by upper class midwives) as a scare tactic to awaken public outcry and force unlicensed midwives to become licensed or lose all. True, not all midwifery practice was sanitary or safe. Early historians of midwifery relate many stories that would make a twenty-first century practitioner's skin crawl (Blankenship, 1863; Hamilton, 1795). Additionally, as I have shown above, skill and knowledge levels vary among practitioners. Sairey Gamp, however, was the very definition of bad practice, an old stereotype with a new name, valuable cultural currency revived and circulated to crystallize public opinion. Far from disappearing into literary obscurity, Leap and Hunter demonstrate that the stereotypically inept Gamp was still alive and well almost one hundred years later, in the oral histories of British midwives (1993).

In 19th century Britain, as in many other Western countries, scientific knowledge came to be identified with the minds of Great Men, and technical expertise – clothed in the successes of the scientific revolution – began to escort birth farther and farther away from "normal" into the realm of pathology. This was not coincidental. Like Jordan, Donnison (1988) suggests that this medicalization was the result of a concerted effort by physicians to firmly establish themselves as the only source of "real" knowledge about childbirth. In 1872, the recently formed Obstetrics Society began awarding midwifery certificates that demonstrated that the bearer had met the Society's standards – standards set by the (male) obstetricians. "Certified" midwives were more likely to get a response from physicians when they called them in the event of an emergency, and to be hired by more affluent women who paid well.

In "Authoritative Knowledge and its Construction," Jordan discusses the ways in which "the label 'authoritative' is intended to draw attention to its status within a particular social group and to the work it does in maintaining the group's definition of morality and rationality. *The power of authoritative knowledge is not that it is correct but that it counts*" (1992:58). After the passage of the first Midwives' Act in1902 , which required all midwives who intended to practice "habitually and for gain" to be certified, the definition of "midwife" came to mean "approved." Other, "non-approved" midwives were re-labeled "bona-fides," and it was expected that they would obtain approval within a designated time frame or find other means of supporting themselves and their families.

While the place of birth moved slowly in the ensuing decades from home to the hospital, one of the final steps in this movement was the change in 'official' definitions of birth and midwifery that followed the 1970 release of a government-commissioned study known as the Peel report. In this document, which gave medicalization the official governmental stamp of approval, the authors stated that "sufficient facilities should be provided to allow for 100% hospital delivery. The greater safety in hospital confinement for mother and child justifies this objective." (Standing Maternity and Midwifery Advisory Committee 1970). Though no facts were ever advanced to support this assertion (Walton and Hamilton 1995), the Peel report was nonetheless upheld by the British obstetric community as proof that birth anywhere but the hospital was unsafe. In a Scottish document outlining the new organization of maternity services following the Peel report, the impact of the birth-as-pathology definition on Scottish midwifery is clear. Adopting what physicians Brody and Thompson refer to as the Maximin strategy,[4] chapter one describes the "integration of

[4] "...choosing the alternative that makes the best of the worst possible outcome, regardless of the probability that that outcome will occur" (Brody and Thompson 1981).

maternity services" under the jurisdiction of "a Specialist Obstetric Unit which should be of such a size as to include all that is necessary for the welfare and safety of mother and child in any abnormality, *actual or potential*" (Scottish Home and Health Department,1973:3, emphasis added). GPs, though medical doctors, were not immune. The authors of the new organizational scheme agreed that "the best place for the general practitioner to look after patients is within the confines of a specialist obstetric unit" and, in places where that was not possible, to locate the maternity unit "alongside other acute beds. Care should be exercised in pursuing ideal clinical conditions for the patient's welfare that a counter-reaction is not created which will lead to an increase in home confinements" (Scottish Home and Health Department,1973:11). Clearly, the "ideal clinical conditions" (necessary for the *patient's* welfare or the obstetricians'?) were as close to the highest degree of technology available. Midwives were also to be directly under the supervision of specialist obstetricians. The authors further state that

> the organization of midwives should be based on the specialist hospital and the senior midwife in the Maternity Services Division should have her headquarters there. Responsibility for supply of midwives for outside duties in the surrounding areas in the surrounding area of the hospital, e.g. assistance at clinics, domiciliary confinements, should be borne by the Midwifery Division in the specialist hospital." (1973:10)

In Scotland, as elsewhere in the UK, hospital birth thus became the norm.

Jordan states that "a society's way of conceptualizing birth constitutes the single most powerful indicator of the general shape of its birthing system. In all settings, the definition of the event is of fundamental importance in that it informs participants regarding the proper who, where, and how of birth" (1993:48). Following the Peel report, the definition of birth became 'a medical condition requiring hospitalization.' In changing the definition, with the dual authority of medical and epidemiological science (however spurious its claims)

and the British government, birth ceased to be, at least officially, perceived as a normal physiological life event. The "who" of birth became those trained to handle extreme cases and emergencies. The "where" became the hospital. The "how" had become with medical surveillance. In defining birth as abnormal, dangerous, and requiring specialist attention, midwives, the "practitioners of normal" (Ministry of Health 1959), were simultaneously redefined as underqualified. It is against the influence of this change in governmental definition that midwives battle still today, as is the legacy of this influence on midwives who were trained under post-Peel "Maximin" conditions.

CHAPTER 2

Complex Socio-Political Roots: The NHS in Scotland

Redefinition Through Education

Currently there are a number of ways to obtain midwifery certification in the UK. Someone practicing as a midwife today may have taken any number of routes to get there. As a result of the combined efforts of the RCM and the UKCC there have been major changes to those routes in the past decade. However, while the structure of midwifery education has changed dramatically, the relatively low turnover rate among the midwives I studied has resulted in a climate of diversely educated professionals all practicing under the same name. A midwife is a midwife is a midwife? Given the shift in focus and strategy in the educational structure that current practice represents, probably not. An overview of the different ways in which currently practicing midwives may have

received practical and theoretical training coupled with an awareness of the different philosophies underpinning that training may help explain some of the differences in the units I studied.

Nurses and midwives in the UK fall into several categories, each representing a different length and depth of education. One way to become a midwife in Scotland is by first becoming a nurse and obtaining additional qualifications. By this route, known as "post-registration," nurses complete at least an additional 18 months of education and training. Another route to becoming a midwife is through "direct entry." These programs are al least three years in length and require no previous medical background. The RCM and UKCC have looked towards increasing the numbers of direct entry midwifery programs in attempting to meet the growing shortage of midwives in the NHS, but current numbers remain small (Bower 2002). Both the post-registration and direct entry routes of education can result in either a diploma or a degree in England, the difference being somewhat analogous to the difference in the U.S. between an Associate's and a Bachelor's degree. In Scotland, only those completing the 18-month post-registration program can obtain a degree. Either program of study will prepare midwives for examination and registration as a midwife, and graduates typically obtain a salaried position within the NHS. While independent midwifery is also an option, it is exercised by very few midwives. Those who do choose independent midwifery are freelancers, not directly reimbursed by the NHS for their services and excluded from the RCM's umbrella of liability protection (Taylor 2002).

Whether choosing a degree or diploma, nursing first or direct entry, those seeking midwifery education in the twenty-first century navigate a very different course of

education than their predecessors. This is due in large part to the document *Project 2000*, published in 1986 by the UKCC. This document effectively began the overhaul of the midwifery and nursing education system in the UK, taking it out of separate schools of nursing and midwifery, which required student midwives to serve on the staff of training hospitals, and incorporating it into university-based institutions of higher education. The change also combined a large portion of midwifery education with nursing education, an "interprofessional" strategy some have criticized as diluting midwifery's claim to a separate knowledge base and weakening the autonomy of the profession (Henderson 1994; Bower 2002). While the effect of increased graduate education on midwifery is still being debated (Bower 2002; Kirkham 1996), what is clear is that shift in the nature and location of midwifery education means that future midwives will bring a new, non-hospital based context to bear on midwifery practice. The relevance of this alteration in perspective is best understood in comparison to midwifery education as it has existed in the past. Such a comparison will illustrate the difficulty for midwives trained in the 1970's and 80's – the majority of those registered, based on age demographics (NMC 2002) – of practicing in any context but the medical. The institution defines itself, and an examination of underpinnings of midwifery education reveals the ways in which the definition of what midwives do within the NHS has been systematically medicalized and institutionalized through educational structures.

Following a long struggle over the control of midwifery and the rise and fall of several privately funded efforts at standardizing and supervising the education of midwives during the 19th century, government sponsored training programs in midwifery were instituted first in England with the Midwives Act of 1902 and later in Scotland by the

Midwives (Scotland) Act of 1915. (Donnison,1988; Henderson,1994). Both of these Acts were the end result of lengthy debates over the licensure and regulation of midwives, and both Acts signaled the official government recognition of the midwifery profession. That recognition came complete with the establishment supervisory bodies (the Central Midwives Board and Central Midwives Board Scotland or CMB and CMB[S]), whereby medical men were placed in charge of that licensing and education. Mander and Reid (2002) discuss the ways the Scottish Act differed from the English Act in terms of the relative degrees of "empowerment" they afforded the midwife. They explain how the Midwives (Scotland) Act left Scottish midwives even more at the mercy of the medical profession than their English counterparts. Due in part to a physician majority on the CMB[S] that persisted until its dissolution in 1983, and the broader powers afforded physicians trained within the a Scottish medical system (in which general practitioners were taught "medicine, surgery *and midwifery*"), the stage was set for an educational climate which fostered a tradition of "close links with the patriarchal medical world." (2002:12,16). The fact that midwifery practice and education were under medical supervision for nearly a century highlights the radical nature of the changes implemented with *Project 2000*. Was such a change needed?

The close ties between midwifery education in the UK and the rampant patriarchy of the medical model of birth have been discussed by Ashkam and Barbour (1999), Donnison (1988), and Tew (1990). When birth was home based, as it was in the UK for the majority of the 20th century, a great deal of midwifery education was also home-based. Centralization and standardization of education was difficult to accomplish under domiciliary conditions, and in the 1920's "theoretical teaching by midwives varied from

the excellent to the barely adequate, and there were no qualified tutors and no courses for prospective midwife teachers" (Towler and Bramall 1986:207). In response to the relatively high maternal mortality rate in Scotland, (hovering around 5 per 1000) the House of Commons passed the Maternity Services (Scotland) Act of 1937, guaranteeing every woman the right to "retain the services of a midwife and a doctor, and, if the need arose the doctor would be able to call in the services of a consultant obstetrician," and granting the Local Supervising Authorities half of the funding to make this possible (Brotherston 1987:79). That the maternal mortality rate fell following the passage of this Act is noted by Brotherston to be related more likely to the new accountability for the "improved services offered by the Act" and advances in general sanitation than with the association of physicians. Though the falling rate was likely also related to the increase in resources afforded by the new funding and the increasing use of antibiotics to combat infection, the groundwork was being laid for the move of birth into the hospital.

With the hospitalization of birth came the hospitalization of midwifery education. From the Peel report until the changes brought about by *Project 2000* and successive documents, midwifery education was, like nursing education, part of the structure of hospital-based obstetrics (Henderson 1994). Schools of midwifery were largely residential and heavily practice oriented. Maternity units depended heavily on the labor supplied by students of midwifery and schools of midwifery depended on the experience gained in the hospital setting. The popularity of the post-registration program, with its shortened course of study for those who were qualified nurses, led to a large number of women pursuing this course of education. Liz Sargeant describes the physician/midwife dynamic as it existed in the 1980's:

> Midwives were working with obstetricians and GPs trained in a hierarchical model of care where doctors determined the care that their patients should receive and nurses then carried out that care...It is relevant that at this time the majority of midwives had completed a certificate of general nursing prior to midwifery training. It is therefore not unreasonable to suggest that many midwives may have felt comfortable with the familiar hierarchy, similar to the one they had trained in as nurses. Many young women left home to train as nurses in an institution which was dominated by a familiar patriarchal system with the (mostly male) doctors in overall control and the (usually female) matron in charge of the nurses. [2002:44-45]

This medically dominated patriarchal interdependence of the context of midwifery education has had a major impact on the nature of the relationship between midwives and physicians. The rooting of midwifery education in the medical model, in which "a midwife was conditioned to seeing her role as that of assistant to the doctor, a machine minder or technological handmaiden" (Sargeant 2002:46) was evident in the units I studied. The influence of the medical model does not stop with the education of midwives; it extends into the structures within which midwives practice, and the organizations and governing bodies that legislate that practice.

The Implications of Structure

In terms of childbirth in Britain today, the NHS still wields the tremendous power of "official" definition and in the UK, health care is a government business. This has many ramifications, one of them being that the scope of healthcare professionals' practice is being continually redefined by those outside the arena of clinical practice. It is necessary, therefore, to pay close attention to the nature of these sorts of groups. Midwifery is one such profession, and, due to its unique features – namely that it concerns only the bodies of women and is practiced by women almost exclusively – its position within the institutional structure of healthcare in Britain has been somewhat of a political pawn both in the days

before and since the NHS. As one informant stressed to me, in order to get a clear picture of birth in the NHS "You must be sensitive to the context" – a context that she went on to describe as "a parallel universe." No discussion of contemporary birthways in Scotland would be complete without attention to the context of the National Health Service. Sorting through this puzzle of overlapping associations, ever-changing acronyms, and often fragmented responsibilities is quite daunting and can confuse even the most careful observer. However, it is worth the attempt to understand how the pieces articulate with one another, if only for the fact that it illustrates the complexity midwives must negotiate on a regular basis.

The National Health Service in Scotland began with the passage of the National Health Service (Scotland) Act 1948. Like the English Act, the Scottish act was a post-war effort at providing free comprehensive medical care. However, NHS Scotland was never a cookie-cutter version of the NHS in England. Scotland had long been a leader in the development and implementation of organized health services, and historian Jaqueline Jenkinson (2000) argues that the NHS was in fact patterned on successful Scottish health care innovations. She maintains that the Scottish "legislation...did not neglect the traditions of independent Scottish health policy" (2000:14). A key difference was that the Scottish system was more centralized. For example, while in the English system administrative control of the NHS was divided into three branches, (the hospitals, the local authorities and the executive), in the Scottish system the Scottish Secretary alone had final administrative power (Jenkinson 2000). While the centralization of power means that the Scottish system may have run a smoother course than its English counterpart, it also means that the legislative structures are not obligated to share that power, and that guidelines and changes follow a more direct course from the top down. Considering midwifery's place within the NHS Scotland, this is

noteworthy given the physician-dominated composition of those legislative structures. This physician dominance is part of what nursing scholar Fiona O'Neil calls "the politics of the double bed," whereby "the state was to become reliant on the doctors for the running of health policy particularly in the area of the allocation of resources, while the doctors were to be dependant on the state not only for their income but also for the resources at their command" (O' Neil 2000:57).

Much has changed since 1948. After the devolution of 1998, ultimate Scottish control of the NHS transferred from the English into the hands of the new Scottish Parliament, giving the Scots administrative and legislative power over the system. In the current NHS Scotland the Minister for Health and Community Care oversees NHS Scotland via the Scottish Executive Health Department, known simply as the Scottish Executive. This department is charged with making sure the NHS stays financially solvent and meets the performance goals it has established, a task it accomplishes in large part through periodic "audits" comparing practice to theory. Currently, the Scottish Executive works with 15 NHS Boards (also known as Local Supervising Authorities) in different regions of the country, who create Local Health Plans, factoring in the needs of a region's population and the allocating the resources it has available. Beneath this are 28 Trusts, the "operations" branch of the system, responsible for directly implementing health plans and services.

The current structure of the NHS in Scotland has important implications for practicing midwives. Until the 1980's the Trust responsible for the supervision of midwives was the CMB (Central Midwives Board). The tenacious, intentional domination of the CMB by medical men is well documented (Towler and Bramall 1986; Donnison 1988), and the UKCC, which replaced it, was seen by some as a change for the better. However, in the

UKCC the responsibility for nursing, midwifery and health visiting was combined under one nursing-dominated organization. Among midwives, the strategy has been criticized as "a top-heavy and overly bureaucratic organization that has perpetuated and even strengthened divisions within the profession" (O'Neil 2000:64). Midwives are in an unenviable position, to say the least. Valerie Fleming writes that

> Because midwives are accountable for their practice to the UKCC (previously the CMB), they are thus legally obliged to practice within a sphere of practice as defined by these Rules. However, due to the constitutions of these Boards these Rules were, until recently, medically controlled and midwifery practice was placed within strict limits. As Midwives' Rules have been updated over the last century it is not therefore surprising to see how they reflected an increasingly medicalized approach to childbirth. [2002:66]

That medicalization was no doubt linked to the domination of the UKCC by the nursing profession, one whose chief role is arguably that of assistants to medicine. However, change within the NHS is the norm, and in April 2002, the responsibility formerly held by the UKCC was assumed by the National Midwives Council. As it relates to midwifery, the new NMC is "responsible for the provision of standards and guidance to Local Supervising Authorities with regards to the supervision of midwives" (Duerden 2002:93). In addition to policy setting and implementation, the NMC is the registration authority, determining which midwives can practice and at what rate they are compensated. Following the overall trend towards devolution and regionalization of control in the NHS, midwifery manager Jean Duerden speculates that in the future, the functions of the NMC will become further decentralized (Duerden 2002).

The change from UKCC to NMC has been too recent for the effects to be factored in to this study, and what it all means for midwives remains to be seen, but criticism has already been raised. For example, during the formation of the NMC, Beverly Lawrence Beech, chair

of AIMS,[5] voiced concerned over the lack of midwifery representation on the new board – concerns that went unheeded.

> The plans for a new Nursing and Midwifery Council are unacceptable and those aspects of the plan which are concerned with midwifery are totally unacceptable. Token acknowledgement is made of midwifery as a separate profession from nursing, but the proposed structure does not support this and as a framework supposedly designed to fulfill the obligation to protect mothers and babies, it is a failure. [Beech 2001]

In discussing the trend towards devolution and its effect on the rest of the UK, Beech cited the "different and in some cases inferior standards" of midwifery in Scotland. "Midwifery has been eclipsed to a Greater extent in Northern Ireland and Scotland and has moved more towards obstetric nursing. Our members in both countries are very concerned" (Beech 2001). While the midwives I spoke with all held firm to the conviction that what they were doing was "old fashioned midwifery," in many cases it was clear that their definition of midwifery had been strongly influenced by generations of increasingly close contact with specialist physicians, the hospital, and the medical model of birth.

The structure of maternity care delivery systems in Scotland is only slightly less confusing than the structure of the NHS itself. Depending on her personal circumstances and place of residence, a pregnant woman might have access to several options in maternity care. As I will demonstrate in later sections, these factors often combine with regional preferences and local interpretations to constrain choices. However, a general set of options for "booking" (scheduling the type and location of maternity care provision) is theoretically possible. Obstetrician-led care in a consulting unit is the most common (BirthchoiceUK 2003). These types of units are staffed by obstetricians and a large number of midwives, and antenatal care and birth take place in the consulting hospital.

[5] The Association for Improvement in the Maternity Services, a highly visible political action group.

General practitioners may also provide maternity care. When this is the case, antenatal care takes place in the GP's office, and birth takes place at a GPU – usually a smaller hospital in which GPs are the only physicians. GPs may also work with midwives to provide "shared care." In a shared care model, women see both a midwife and a GP antenatally, and birth takes place in the GPU, with either a midwife or GP in attendance. Another option is the DOMINO (Domiciliary In and Out) birth, in which a woman is technically under the care of an obstetrician, but actual care is provided by a midwife who goes to her home when labor starts, accompanies her to the hospital for the birth, and returns home with her shortly afterwards. Midwifery-led care is an increasingly common option, with midwives providing antenatal care in a variety of settings and birth taking place either at a birthing facility staffed by midwives or in the woman's home. As I will demonstrate below, the definitions of normal birth and midwifery vary widely in these settings, as does the relationship between physicians, midwives and the women they serve.

Challenges to self-definition and barriers to change

Part 1: The current relationship between midwives and physicians

My data echo the general feeling that the years of consultant-led obstetrics in Scotland have lessened the status of the midwife in the eyes of the public. This has resulted in midwives having to wrestle with obstetricians for recognition. Some of my best insights into the current struggle with physicians came from a midwife I will call Bridget, who works closely with consultant obstetricians on a regular basis. She spoke of the impact of the consultant-led phenomenon on midwives:

> And of course that's in a woman's consciousness as well, that they have to see a doctor and that will be a consultant and therefore the midwife's role

> may have well been eroded in women's minds and potentially in midwives' practice, simply because they have to refer all normal women to a consultant as well.

The midwives I studied all spoke of the ongoing struggle to maintain protective boundaries around the scope of midwifery care when those boundaries were constantly being challenged and breached by physicians. Bridget spoke of the need to repair the damage done to the status of midwifery by post-Peel obstetrical management of birth, to regain some measure of respect. When asked if there was anything she would change about the unit in which she worked, Bridget replied that

> Very simply, midwives would be responsible for midwifery care, and the consultants would only be involved if there was a deviation from normal. Unfortunately that doesn't happen currently because of the historical routines and rituals that have underpinned the care that midwives give anyway. For instance, discharging a woman in the postnatal period...the consultant will go through all of the information you [the midwife] have just gone through with that woman for a post-natal discharge.

It is the challenge to be both patient-oriented carers and medically-oriented doers that seems to be at the heart of midwives' ongoing difficulty in obtaining respect and recognition by the standards of obstetricians. This dynamic was also found by Ashkam and Barbour (2000) and Elizabeth, a midwife I interviewed who also worked closely with consultants:

> I tell you what's good – there are no junior medical staff [in this unit]. Communication can break down. Sometimes, as with any obstetrician, I think what was wrong was their reluctance to accept that midwives do think and feel and understand and perhaps are slightly intelligent...I think sometimes there's trouble seeing nurses and midwives as professional people.

She blamed this lack of respect on the fact that midwives are known for their caring, and that, when caring was mentioned in "medical" contexts, the attitude was, in her words, "oh, don't go there!" For the midwives I studied, a core element in their definition of midwifery appeared to be a close, personal, caring, knowing relationship with the women

they assisted – a knowing based in the midwifery model. As Pat Schan, a midwife and proponent of home birth, explains, this kind of caring and knowing renders midwives impotent in the face of "objective" science: "We do not have the big stick of randomized controlled trials that obstetricians wave, but when you see a family in their own home, with their new baby, you do not need multi-centre trials to tell you this is better" (Schan 1998).

Part 2: Challenges to Self-Definition

The midwives I spoke with were relatively clear on a notion of what midwifery care was – or should be. Key themes emerged in my interviews, pointing to a shared definition of midwifery. To all of my interviewees, one of the most important elements of *real* midwifery care was autonomy, and all spoke of fighting for it in one way or another. In Bridget's unit, the struggle for autonomy figured prominently. Speaking of having won a battle with the consulting physicians about water birth in her unit, she bristled as she told me of another unit, not so lucky, close to Glasgow where "...they're not allowed to, not *allowed* to give birth in water because the consultants will not have it. It's not allowed. Now I wonder, do consultants give midwifery care? No. Who's responsible for midwifery care? Midwives." Midwives in the most "midwifery-led" of all the units, where the midwives were in charge of everything and practiced without obstetrical back-up, seemed confident in defining themselves as *real* midwives. When asked "How would you describe your job here? What is it that you do?" they quickly interjected, with the answer "practice midwifery" overlapping the question. Speaking of an anticipated change in her unit which would allow midwives to "book" (schedule) their own deliveries rather than having to go through a consultant, Bridget told me "That's just to

give more choices to women and midwives so they can practice as midwives, not always having to ask a consultant when things are perfectly normal." These comments reflect an awareness that some midwives know they are the keepers of normal, and that the medical model is seen as a threat.

Its close historical and structural ties with the medical model of birth requires midwifery to continually reassert itself as an autonomous profession in the face of the medical model. In my interviews, I heard stories of midwives using whatever means necessary to meet the challenge to self-definition and to the freedom to practice they way they would like. Often caught between a metaphorical rock and a hard place, they can be faced with challenging and changing at the potential expense of their livelihood. Bridget related a story of a time when she had posed as a pregnant woman seeking a waterbirth and had "spoken with the important midwives, the midwives in a position to potentially change things." These midwives suggested, not knowing who she was, that as a layperson she could act on her own and fight for the waterbirth herself, championing a cause they would or could not. Some element of this is certainly historical, based on years of habit. Bridget explained the paternalism in the maternity services: "It's just a given that doctors are important. And you do what the doctor says and you do not question.... That's very much what's led the obstetric service in the Highlands for many, many years. They [obstetricians] have dictated it." Some of the difficulty in instigating change is also likely related to the influence of supervisory organizations such as the General Medical Council, which encourages midwives "not to initiate action against colleagues or break the culture of a mutual cover-up" and who tell them that "disparaging the services of a fellow practitioner is an offence" (Palmer 1995:9).

Indirect manipulation was one of the ways in which the midwives I studied negotiated the constraints of professional practice. It had been Bridget's experience that "if you do challenge, you challenge by the back door." The most candid of all my interviewees, she was the only one who spoke so openly of using the "back door" means of getting things done. However, all other midwives I spoke with made reference to having used some form of indirect manipulation--but these references were only made when the tape recorder was not running. One midwife told of a GP maternity clinic that held appointments with the women of the community in which she worked once a week. She arranged to have midwives assist the GPs at the clinic, under the guise of helping with the patient load. She told me the real reason was to make sure they were doing it right. The GPs eventually relinquished that "chore," and the midwives took over the clinic. These are just a few examples of the challenges midwives face in the struggle to assert and define themselves and refine their scope of practice while working alongside physicians.

Part 3: Barriers to Change

While emphasized more by some than others, close interpersonal relationships seemed to be important in defining midwifery practice according to all of the midwives I studied. These included relationships with one another and with patients. A common theme among the midwives was to speak positively of themselves as part of a "team," made up of dedicated professionals, and long tenures were the norm. This strong cohesion among the midwives was instrumental in helping them creatively solve problems. However, it also seemed to create its share of problems. Elizabeth laughingly described one such recurring problem. "We have horrendous arguments, especially when

we have a bit of PMT (Premenstrual Tension). We all seem to have it at the same time, but then it gets it out of the way for the next 3 weeks." One midwife, however, did not speak of her midwives positively as a team. She described them more as a pack, functioning to police from within the ranks, using cohesion as a weapon. "It is the culture, it is." She said. "And they will tell you. And it's not a case of burnout. You will be ostracized. There's been a recent local incident about a particular midwife being very well ostracized from a unit, and [she] has been removed from that unit and is now working in another unit." This midwife had also expressed her feeling of being somewhat marginalized personally, and it is possible that her negative view of cohesion was a result of that attitude. However, as a nurse, I have seen my share of this type of behavior. I also realize that the power of this cohesion is so strong that to disclose this type of behavior to a stranger while a tape recorder is running a risk, and I'm not sure I would have felt safe doing the same. While the shape of cohesion may bend one way or the other depending on the perspective of the speaker, the notion of cohesion in some form or another was universal among these midwives. Such cohesion has power, and in my observation, among the factors interfering with midwives' ability to practice outside the medical model are midwives themselves.

Other voices, outside interests

In the UK, various professional organizations and active consumer groups have been instrumental in helping or hindering midwives' efforts to keep the definitions of birth and midwifery rooted in "normal." Particularly in the years after the Peel report, British women's organizations began to rally together around the cause of normalizing childbirth. One of these was ARM, the Association of Radical Midwives, founded in

1976 in response to a growing trend towards medicalization and widespread dissatisfaction with birth experiences. Run by women for women, working to improve midwives' situations both professionally and economically, the group is an active presence in the struggle for redefinition and a voice for midwives within the NHS. The ARM has established its own peer reviewed journal, *Midwifery Matters*, signaling recognition of the need to communicate in the same language as proponents of the medical model of birth.

However, there are some key differences. The midwives of ARM vehemently refuse to accept the medicalized definition of expertise. ARM midwives instead assert their own form of expertise, which they argue comes from a different source. They also recognize that this non-quantifiable, non-authoritative knowledge is still not what officially "counts." Meg Taylor, a midwife and member of ARM, writes that "midwifery knowledge is not systematised, it is intuitive and cannot be made to fit easily the paradigms of male institutions...midwifery knowledge, I believe, accommodates [differences] and allows for a wide range of experience. It is not easy to distil a wide range into easily transmissible facts" (2000). Using this alternative model of expertise, the ARM midwives have sought to redefine themselves by their own standards. "A midwife" their leaflet reads, "is a specialist who is qualified to give total care to a woman and her baby during pregnancy, labour and after the baby is born. The midwife does not have to call in a doctor unless there is a potential or actual problem which requires medical assistance (Association of Radical Midwives 2000).This definition clearly separates midwifery from medicine and reclaims birth as a "normal" process, in which the presence of the medical man (or woman) is not requested unless required. In 1986,

ARM published a document called *The Vision*, a "draft proposal for the future of maternity services" which called for an increase in community-based midwifery, "greater autonomy for midwifery practice and increased choice and autonomy for women" (Sandall 2000:357). This document was influential in shaping later government inquiry into maternity services that eventually resulted in major structural changes.

Another important organization is AIMS, the Association for Improvements in the Maternity Services. Originally founded as the Society for the Prevention of Cruelty to Pregnant Women in 1960, AIMS grew out of consumer complaints over routine birth practices. Among other activities, the "up front and confrontational" group publishes the AIMS Journal, "The only forum where consumers can tell their own unabridged stories of maternity care and it has become a valuable resource which midwives and other practitioners can use to reflect on their own practices and philosophies" (Thomas 2002:26). AIMS routinely campaigns for woman-centered care, informed choice and a reduction in the use of medical procedures in childbirth. Another significant force in the survival of the midwifery model is the National Childbirth Trust, formed in 1956 to promote increased confidence among childbearing women through childbirth education. The NCT has been "involved in persuading the medical authorities to consider new approaches to birth," including the acceptance of lay support people in delivery rooms and later promotion of home birth (Thomas 2002:25).

Unfortunately, midwifery-focused organizations have not always been helpful in advancing the cause of the midwifery model. The oldest recognized British midwives' organization is the Royal College of Midwives, which grew out of the Midwives Institute, founded in 1881. The RCM, as it is known, was created to "promote and advance the art and

science of midwifery and to raise the efficiency of midwives" and the organization's main concerns are the "continuing education of the qualified practitioner and consideration of the professional practice of the midwife" (Towler and Bramall 1986:244). Aside from continuing education, it has also functioned as the profession's trade union since 1976, a position weakened by what midwifery scholar Lindsay Reid calls its policy "against taking industrial action" (Reid 1997:602). While the RCM has no official power in the regulation of midwifery, it is a recognized representative of midwives voices, and as such, it can only speak for those it hears. In this the RCM has been criticized both for its structure (which has traditionally been dominated by midwifery managers instead of practicing midwives) and its silence (in the face of increasing medicalization of childbirth) (Tew 1990; Thomas 2002). Scholar Marjorie Tew states that for many years the RCM

> accepted obstetricians' claims about the greater safety of their methods as uncritically as did everyone else...as late as 1985, when a conclusive analysis establishing the greater safety of midwifery methods was given wide coverage in the lay press, the spokeswoman for the RCM could only echo the invalid bluffing offered in self-defence by the spokesman for the RCOG [Royal College of Obstetricians and Gynecologists]. [Tew 1990:67]

However, recent developments within the RCM suggest that things may be changing for the better. The online June 2003 issue of the *Midwives Journal* calls obstetricians to task for the Department of Health report that shows less than 50% of British women experience normal birth. Rather than a shortage of obstetricians, the cause suggested by the vice president of the Royal College of Obstetricians and Gynecologists, the RCM states that "it is the involvement of obstetricians in the care of women in normal labour that has resulted in higher rates of intervention" (RCM 2004). Additionally, in the interest of promoting the most effective midwifery care, the group has recently organized a "virtual institute for normal birth," which uses scientific evidence as the basis for changing practices. The group has also been

instrumental in the publication of a new journal, *Evidence Based Midwifery*. If recent history is any indication, the RCM may be on to something. Evidence based medicine may be the most successful strategy yet in the struggle de-medicalize birth and midwifery.

Through the visible, vocal presence of politically oriented groups such as ARM and AIMS, as well as organizations like the Cochrane Collaboration, the late 80s and early 90s saw unprecedented policy changes on the part of the NHS. Archie Cochrane's awarding of the "Wooden Spoon Award" (Cochrane 1972) to the obstetric profession helped to make possible new roads of critical inquiry into the medical model of maternity care. Advocating the use of meta-analysis to review large sets of data on "scientific" practices of obstetricians, who were by the 1980's directly supervising all but the independent (and thus financially at risk) midwives, and overseeing essentially all but 1% of births, he reported that many obstetrical practices that had become routine, such as episiotomy, shaving the perineal area, birth in the lithotomy position and the administration of enemas, were in fact unsubstantiated by data. Riding the wave of skepticism Cochrane had begun, other organizations (including ARM, AIMS, and the Royal College of Midwives, by now the largest organization of its kind in the world) all produced their own reports. The government finally responded with a series of reports culminating in the bar-setting *Changing Childbirth* (Department of Health 1993).

The power of evidence-based medicine to change practice has now been firmly established in the UK. Cochrane's legacy lives on in the work of the Cochrane Collaboration, a group of medical professionals who regularly and systematically review the results of randomized controlled trials for inclusion in an evidence database called the Cochrane Library. The mission of the Collaboration is to "help people make well-informed decisions

about health care by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions" (Cochrane Collaboration 2003). For the purposes of this discussion it is important to note that some of the people using the database to make decisions are purchasers of services for the NHS, and that much of the evidence gathered by the Collaboration supports a midwifery model of care. Within the NHS there is a growing emphasis on the use of evidence in the formation of clinical practice guidelines. Following the model of the Cochrane Collaboration, in 1993 the NHS Scotland established a group called SIGN (The Scottish Intercollegiate Guidelines Network), which works with its English equivalent NICE (The National Institute for Clinical Excellence) to decrease "variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for practice based on current evidence" (SIGN 2003). Among other things, SIGN guidelines will determine, based on the best available evidence, what the NHS Scotland will pay for and what it will not. Considering the fact that the bulk of evidence supports care based on the midwifery model, this is good news for supporters of normal birth.

Changing Childbirth? Interpreting the literature

A Department of Health survey of maternity care (MORI 1993) showed that women value the clear pregnancy and childbirth information they are given by midwives. Keeping this in mind I asked the midwives in each maternity unit I visited to give me the materials that would usually be given to a pregnant woman on her first antenatal visit (also known as the "booking visit"). Such a technique does not imply in any way that materials gathered at this first visit are emblematic of the overall content of antenatal education. Neither does it discount the efforts of each individual midwife in tailoring the

selection of appropriate information and augmenting it with months of individualized, face-to-face interaction and "Parentcraft" classes. However, when these first visit materials are held up to the same analytical light, the results are striking. Such a comparison may serve to illustrate the ways in which the ideals and best intentions of midwives and government agencies can be translated into the idiom and accent of regional and individual agency, and may begin to shed light on the role of midwives in the medicalization of childbirth.

For the purposes of this discussion, the "ideals and recommendations" are those contained in *Changing Childbirth*, also known as the Cumberledge Report. This document heralded in the radical alteration of the landscape of birth in the United Kingdom. In this section it is my goal to demonstrate some of the ways in which the woman-centered recommendations of the *Changing Childbirth* authors have (or have not) worked their way into the information commonly given to women in the maternity units I studied.

Changing Childbirth was thought by some midwives to be the answer for which they had been lobbying (Walton and Hamilton 1995). These "tablets of stone from the mountains of Westminster" (Schan,1998) were inscribed with the very things for which professional, consumer and watchdog groups had fought over the years. Greater autonomy for midwives, "normalization" of birth, empowering women to make their own choices – all were present and accounted for. Among other things, the two-volume report recommended a largely independent midwifery-based model of care, which at least theoretically gave back to midwives a great deal of the independence that had been wrested from them over the previous decades. The report advocated teams of midwives,

working in midwifery-led units, who would provide care in an independent manner, and recommended that every woman should be able to develop a relationship with one midwife (the "named" midwife) who would then ensure the continuity of her care. Additionally, the report gave unprecedented power and responsibility to pregnant women. They were to be allowed to carry their own medical records, and to be given information about alternative maternity services from which they could choose. The plan was for "woman-centered care," and birth was once again redefined as the province of birthing women and midwives. The hope that the potential for real, government-authorized, NHS-supported change was finally within reach led one midwife to proclaim: "This is the age of the midwife and our time has come" (Flint,1994 in Reid,1997). But has it?

Midwives Irene Walton and Elizabeth Hamilton (1995) give a point by point interpretation of the document through the eyes of NHS midwives in Midwives and *Changing Childbirth*. Walton and Hamilton begin by tracing the trail of influential documents from London that led up to *Changing Childbirth*, from those in the years preceding the Peel report to the Short report (House of Commons 1979-80), the Maternity Services Advisory reports (1982,1984,1985), and the Winterton report (House of Commons 1991-92), following the childbirth debate through the 1970's and 80's. While these documents were meant to represent the state of British obstetrics at large, both Scotland and Wales have a well-established national identity complete with separate NHS entities. The English reports were received with mixed reaction in Scotland, where the medical community had been issuing reports of its own for years. The Scottish reports occasionally preceded the English, as in the case of *The Provision of Maternity Services* (Scottish Office Home and Health Department 1993), published 3 months prior to

Changing Childbirth. However, in the eyes of one midwife with whom I spoke, the importance of these documents was not whether the composition of the authoring group was interdisciplinary (which seemed to be a concern of the government agencies commissioning them), but whether their findings were given credence or their recommendations were implemented in such a way as to improve maternity care. According to this midwife, whether or not the Provision of Maternity Services supported a home or Domino birth (which it did), the real deciding factor in whether women could exercise these options or not was whether the local "medical fraternity," who were in the position to interpret and apply the findings, did so in a pro-active manner. While some centers may have utilized the Domino model, in this unit they did not.

This series of British and Scottish reports, which critically examined the maternity services in the NHS, laid the groundwork for the sweeping reforms suggested by *Changing Childbirth*, and it is *Changing Childbirth* that was mentioned by my informants as having had the greatest impact on policy, if not practice. Their eventual efficacy may have been bolstered by the concurrent rise of evidence-based medicine (which, in Britain, had gained prominence by systematically exposing obstetrics as the least evidence-based specialty) as a force to be reckoned with on the British medical scene. The reports also coincided with extensive reforms of the NHS and other government agencies based on, as Walton and Hamilton put it, "a commitment to quality and consumer choice and participation" (1995:5). Whatever the cause, by the time *Changing Childbirth* was published, the ideas it espoused had strong consumer and professional backing in England and beyond. Both the participation of the consumer and the choice-driven nature of that participation are reflected in its recommendations.

While a full analysis of the document is beyond the scope of this paper, certain recurrent themes bear consideration, both as important factors in an analysis of first antenatal visit material, and in considering the interaction of the roles of midwives with the role of the childbearing woman as an authoritative decision-maker. Along with the (re)creation of midwifery led units, the document established woman-centered care as the new doctrine for maternity services in the NHS. If the goal of *Changing Childbirth* was to demedicalize and re-midwiferize childbirth, woman-centered care was its standard. In my discussions and observations, woman-centered care was a major touchstone, a basic guideline to which most first visit materials (and the midwives who distributed them) referred to in some way or another.

The main components of woman-centered care and the role of the midwife within it, ideally "an equilateral triangle with the pregnant woman at its centre" (RCOG 1992), are summed up below. An emphasis on informed choice coupled with the notion of a known, trusted care provider are key in the woman-centered model. In Walton and Hamilton's midwifery interpretation, woman-centered care means:

- "Facilities for care should be locally accessible and relevant to the population served."
- "Women should be able to gain, within their locality, information about the available services and also have a choice about whether to contact a midwife or general practitioner when first presenting for care."
- "Each woman should have an identified local midwife who will be available for help and advice should this be needed, and who may take the role of lead professional. Throughout her pregnancy the woman should be cared for by people with whom she is familiar and in whom she trusts."
- "The birth plan should be made out when the woman is ready to do so and after she has had enough information to make decisions. The woman should know that there is flexibility to change her plans and to know that the professionals will respect her right to choose. The care plan must be individually tailored to meet her needs."

- "Antenatal care and visits should be seen by the woman as relevant to her needs."
- During her labor, the woman should be made to feel that 'her psychological and physical needs are understood, her privacy is maintained and her autonomy respected.' (1995:14-21)

While this list is not exhaustive, I believe it is representative, and covers much of the woman-centered approach as it relates to this discussion. In 1993, it seemed that years of lobbying and mountains of official reports had finally paid off. While there were doubts raised as to the full implementation of the recommendations (Porter 2000), their woman-centered emphasis bloomed triumphant to the eyes of women and midwives alike (Schan 1998; Reid 1997). However, the conflicting relationship between ideals and reality, between the new and improved and years of socialization and habit tangle like deep running roots embedded into the soil of Scottish midwifery, serving to problematize what looks simple on the surface.

Changing Childbirth's effect on the dissemination of information: *Ready, Steady, Baby!*

The complexity of choice is evident in *Ready, Steady, Baby*!, published by the Health Education Board for Scotland. This Scotland-only manual of pregnancy and childbirth is the one document that is distributed to pregnant Scottish women in all settings—from the biggest urban consulting unit to the smallest and most rural.

Ready, Steady, Baby! was first published in 1998 and has been revised twice since then, with the most recent version having been published in 2002. Beautifully illustrated and bound, at 158 pages *Ready, Steady, Baby*! is full of information covering everything from the first signs of pregnancy up to and through the toddler years. At first glance, the book is an information-seeking pregnant woman's dream come true. Everything you wanted to know (and some things you didn't), in living color and all its sticky-babied,

bare-breasted glory. Full of medical information, presented in easily accessible language, and designed to appeal to a wide variety of audiences, *Ready, Steady, Baby*! covers a range of possible scenarios presented in a format that alternates between standard textbook and casual question and answer presentation. The book answers questions women may not ask for fear of embarrassment, such as "will I need stitches after the birth?" to those they might not have thought of, like "can I eat in labor?" and includes images of real people having real babies. It is practical and self-consciously realistic.

How does *Ready, Steady, Baby*! stack up to *Changing Childbirth*? On one hand, by its very existence, it empowers women to make their own choices. It thwarts such institutional obstacles to "informed choice" as overworked care providers who might be tempted to skimp on information at the end of a long day. It pre-empts unexpected situations where a quick decision about an unusual complication may be necessary. By covering everything from twins to separated symphysis pubis (in which the pubic bone might temporarily separate to accommodate the expanding girth of pregnancy), and recommending that women make lists of their questions in advance of each visit, the book assures that a careful reader is thoroughly informed of medically-related childbirth information well in advance. On the surface, the book seems like a great contribution to the woman-centered model of care. However, a closer look at the presentation of knowledge in *Ready, Steady, Baby*! reveals elements that could be interpreted as perpetuating a tradition of the infantalization of pregnant women, and language that may instead give women a false sense of empowerment.

Brigitte Jordan states that

> together with birth territory and specialization of personnel, decision-making is particularly, intimately tied to the question of who 'owns' the

> birth. Who is entitled to determine what happens when, and who determines what is to be seen and treated as normal or abnormal indicate who holds the running responsibility and final achievement for the birth produced in a particular setting. [1998:87]

Walton and Hamilton also acknowledge the sensitivity of the birthplace decision, stating that "it is the duty of the professionals to give the woman as much unbiased and objective information as possible" (1995:19). An examination of pages 46-47 of *Ready, Steady, Baby*! – pages that cover the birthplace decision – provides a good example of the subtleties inherent in the book's presentation of information, and of the persistence of the post Peel influence, which led the Scottish Home and Health Department to recommended that "the resources of health education be directed towards reducing the number of home confinements" (1973:13). It is first important to note the placement of the section. Sandwiched between a section on types of and indications for diagnostic testing for abnormalities (blood tests, amniocentesis, etc.) and one on "problems" (covering the gamut from bleeding gums to pre-eclampsia), information on the birthplace decision is (symbolically?) placed in the middle of doubt and fear. In the birthplace section, with its bold, red heading: "Your Choices and How to Make Them," it is difficult to understand who the real decision-maker is. The sub-heading "Where and How to Have Your Baby" does little to lessen the confusion. Is this a woman's choice or a prescriptive statement? The rest of the presentation is just as subtly orchestrated, and the 'choices,' from left to right, are as follows: 1) hospital, in a consultant-led unit, 2) hospital in a midwife-led unit. These two options are on a matching beige background, immediately underneath the heading "Where and How to Have Your Baby," also printed on the same beige background. 3) Domino birth, while still on the same page, is printed on a white background. A fourth option (home) is listed on page 47, on an avocado green

background. A casual observer might wonder why all options were not listed on the same page – a page which includes instead a large color picture of what appears to be a tour of a hospital birthing room. Together with a wide graphic decoration across the bottom of the page, the images take up half of the available printing area. The presentation of the different birthplace choices appears to silently privilege hospital settings over home birth, and while the arrangement is subtle, it is not easily ignored or explained.

Another notable element of *Ready, Steady, Baby*! is the way in which it displaces and disembodies the sources of information given. To begin with, the book claims to be "written by an experienced author who is also a mother and a team of experts." However, no author is listed on the cover or the title page. Under the section "About This Book," the reader learns that "We have produced [*Ready, Steady, Baby*!] to give clear, up-to-date information about pregnancy, childbirth and caring for your child up to the age of three" (2002:3). The reader does not, however, learn who "we" is. In with the small print information about the book's copyright is the "Acknowledgements" section, which says in part "this book reflects many discussions, suggestions and comments made by health professionals, professional bodies, lay and voluntary organizations, and parents" (2002:1). However, the professional bodies responsible for the book are nowhere to be found, while the naked bodies of women are used as illustration throughout. There is a named task group, "responsible for working on this project," and "provid[ing] invaluable input and support" (2002:1). There is a notation giving credit for the "original text" to one person; however, this particular *Ready, Steady, Baby*! is the revised second edition and not the "original text." Who, then, is responsible for this text? The book fails to cite published literature that would allow women to double check its information. For follow

up questions and clarification of information readers are encouraged to "see the Further Help section at the back of the book" which will "put you in touch with local sources of information in your area." In this way, all of the book's information is essentially filtered and interpreted locally. "While the book represents the consensus of good practice," reads the overleaf, "please remember that different circumstances and clinical judgment may mean that you have slightly different patterns of care." This disclaimer is reiterated throughout, with readers continually being directed to local antenatal clinics, midwives and physicians.

The standardization of information given to pregnant women is an important goal, one that can surely contribute to *Changing Childbirth*'s goal of continuity. And it is certainly unreasonable to expect that a rural GP or midwifery led unit would offer the same choices as a large consulting unit. However, while its goals are laudable, *Ready, Steady Baby!'s* displacement of information and built in regional diffusion has profound implications on the implementation of the *Changing Childbirth* initiatives across Scotland, particularly in remote and rural areas. One of my informants spoke of the difficulties of implementing progressive maternity care in her unit despite an active, vocal, professional lobby, and speculated on the "state of things" for a woman in an isolated area, where childbirth choices may be overseen by a single physician. She noted that in some cases exercising informed choice may mean "taking a GP by the throat," something I doubt many pregnant women would feel comfortable doing. What is clear is that no matter how well informed a woman is, every decision must ultimately be approved by her care provider. The only one who is in the position act on the wishes of the pregnant woman is the one who ultimately controls the extent to which that care is

centered on her. One might wonder why women who want to make other choices don't start by choosing different care providers.

While encouraging dissemination of the knowledge that women are free to choose and to change providers is a goal expressly stated by *Changing Childbirth*, it is possible that not all women are aware of this. In addition, in Scotland one must consider the remoteness of areas served by just a handful of care providers. Transportation is an issue, and there are many women for whom any option besides the local center is logistically unfeasible. The distance between maternity centers is often at least an hour's drive, and unstable road conditions are the norm in rural areas of Scotland, public transportation notwithstanding. In addition, midwives can only offer the resources that are available to them. Thus depending on the geography of the countryside (or of the local maternity services), women who wish to exercise informed choice may have few options in terms of care, and little real decision making power. As I will demonstrate below, the role of midwives in facilitating or constraining this power is immeasurable.

Ready, Steady Baby! is the one piece of information given to all pregnant women who seek care within NHS Scotland. Though the book is certainly a useful tool in terms of standardizing information across a large geographical area, as I have demonstrated, its usefulness in promoting the woman-centered ideals of *Changing Childbirth* is entirely, explicitly context dependent. In terms of encouraging women "to gain, within their locality, information about the available services," as it does throughout, *Ready, Steady, Baby*! is a success. However, it is difficult to see how informing women of options they simply may not have while simultaneously deflecting accountability for that information constitutes a progressive strategy. The information given regarding childbirth choices is

subject to regional and individual readings, and can be modified to fit the terrain of each birth setting. As midwifery scholar Liz Sargeant points out,

> It is an inescapable feature of the National Health Service that government policy is translated into local health policy, which then becomes adapted to meet local needs. The workings of the policy makers can seem very remote to the midwife caring for a woman at home who has had a sleepless night, while her three-day old baby tries to feed from her rapidly engorging breasts. Effective woman-centered care requires advocacy and support from midwives who assess and evaluate the needs of women they are caring for, and then use their knowledge to help shape services to meet those needs. [2002:58]

In places where woman-centered care is promoted and supported, a progressive midwife can be a great ally. Access to resources notwithstanding, in units where medical knowledge trumps midwifery knowledge, or where the medical model dominates and infiltrates the midwifery model, "services" offered can be constrained.

In the places I studied, *Ready, Steady, Baby*! is augmented with other information, often maternity-unit specific. In each unit I visited, the type and amount of information differed. An examination of these differences may provide a useful frame in which to examine the intersecting roles of the pregnant woman and the midwife in each setting, and to gain a sense of each unit's approach to birth. These materials are in no way meant to be representative of the content or quality of all information given to women antenatally. It may be argued that the purpose of the first visit is assessing and assigning risk status and it is therefore not the appropriate time to discuss options in childbirth. This argument obscures the supposed function of prenatal care – to promote the wellbeing of woman and child. As a mother with many years of experience caring for and educating childbearing women I can say that most of them have wanted as much information as they can get about everything as soon as possible. A comparative analysis of first visit

artifacts allows for speculation about the path from policy to practice as it relates the *Changing Childbirth* recommendations, and may raise further questions about whose agenda is being served in the dissemination of information.

CHAPTER 3

Competing Interpersonal Roots

Midwives and maternity units

Before continuing, I remind the reader of this fact: most midwives are women, and the majority of them are also mothers. In reaching the goals of woman-centered care and the practice of "normal" birth, these facts complicate the role of the midwife. Each of the midwives I spoke with responded to my questions as both mothers or potential mothers and therefore reproductive peers of the women they served, and as trained professionals with varying degrees of autonomy. I was reminded of this during one interview, in which I attempted to separate "a midwife's opinion" on the most pressing concerns for childbearing women in the area from "a woman's opinion" on the subject. My informant quickly reminded me that they were one and the same. I am also reminded of my consent form, which informed potential interviewees that they had been chosen not because they were midwives, but because they were women of childbearing age. Simply by virtue of being women and mothers or potential mothers, midwives play several roles in the drama of childbirth. While this position leaves them ideally suited to bridge the gap between the pregnant women they assist and the Royal College of Obstetricians and Gynecologists to which they ultimately answer, such duality also means that midwives are positioned in simultaneous relationships fraught with potential pitfalls. The goals of these relationships can often be at odds with one another. A close examination of first visit materials from each unit I visited will shed some light on the dynamics of these intertwining roles and relationships, and set the stage for an analysis of the role of the midwife as it relates to childbirth choices.

Breithleigh Regional Medical Center

The Maternity Unit

Breithleigh Regional isn't hard to find. Like any large urban hospital, the way is clearly signposted from the first off ramp into the city. A carefully engineered one-way traffic pattern directs patients and visitors to separate parking areas, and a uniformed security guard monitors the entrance to reserved lots on the north side of the building. Decorated in early 1980's industrial chic, with large swaths of color delineating the walls of one unit from another, it isn't easy to get lost – provided you know which color stands for what.

The maternity unit at Breithleigh sprawls over two floors. The labor and delivery rooms are one of the main centers of activity, located on the second floor and equipped with the latest technology. A wall of video screens dominates the nurses' station, part of a system that allows the information from the electronic fetal monitor in each labor room to be broadcast and monitored from a central location. There is a feeling of intense business, a controlled quiet belied by the constant hum of computers tracking every second, waiting for something worth reporting. A nurse near the wall of monitors glances up briefly as I pass on my tour. She does not smile. Like a 12 hour shift on any given day at my own Michigan hospital, the unit passes in a dizzying blur of impressions that I struggle to hold clear in my mind.

A second hub of activity is the midwife-run antenatal clinic on the first floor where most routine prenatal care takes place. I observed the clinic for an afternoon and noticed that there was a giddiness that hung in the room when each expectant mother returned from her visit with the midwife, carrying the newly-minted ultrasound image of her baby. In my work

as a nurse, I have seen many, many ultrasounds. They aren't pretty. They rarely look human. Yet I witnessed the boundaries of each family stretch and expand as they crowded around the vague image as though it was a birthday celebration and someone was just about to blow the candles out. The families stood shoulder to shoulder, chirping and pointing, welcoming their newest member before it was even born. In scene after scene, the midwife was the generator and interpreter of that image, the medical authority, the liaison between the now and future family. This is a role driven on one hand by the necessity of midwives' ability to demonstrate fluency in the language of authority. It is also a role that places the midwife in what Sarah Franklin calls the "spectator position" whereby "computer generated simulacra assist medical imaging technology in a manner that underscores the technologically dependent nature of the entire process" (1995: 333).Watching the scenario over and over again convinced me that midwives here are active participants in reifying the technological in the interpretation of pregnancy, and using it to regain a measure of control and prestige in the eyes of the interpreted.

There are no physicians in the midwifery clinic. Along with the Parentcraft prenatal education program, also on the same floor, the antenatal component of pregnancy care is the midwife's domain. The tiptoeing negotiations and expert feather-smoothing machinations my informant went through to get me in the door suggest that these midwives exercise every ounce of the control they have in guarding this token of independence, hard won in a consultant led facility where everything ultimately hinges on the approval of a physician.

Breithleigh Regional is the only tertiary care center in the area, housing the regional authority in obstetric consulting and the region's only neonatal intensive care unit. Its relatively urban location means that the hospital serves one of the region's most ethnically

and economically diverse populations – and its largest. In the year 2002, there were more births at Breithleigh than at all of the other area hospitals combined and doubled (Birthchoice UK 2003). Taking these factors into account, it is safe to say that the midwives here face many challenges on an instrumental level in attempting to provide care that is "accessible" and "relevant to the population served" (Walton and Hamilton 1995:14-21). First visit literature at Breithleigh Regional provides insight into the ways in which these challenges have been met.

The Midwife

Bridget gave me the impression that she was somewhat of an anomaly in the place where she worked; it was clear she felt that her outspokenness and her passion for activism and change made her somewhat of an outsider in her area. Mindful of her own professional constraints – a consultant-led unit which she described as almost hopelessly paternalistic – she sympathized with the plight of a woman who might have to fight to exercise childbirth choices in a region she felt was unusually traditional.

Bridget acknowledged that midwives could be "very controlling of women." While a full analysis of the complex functions of that control is beyond the scope of this paper, there are a few particularly relevant functions worth discussing here. One function is clearly to streamline the allocation of resources. This function was certainly apparent in Bridget's busy metropolitan hospital. We spoke at length about the multidimensional nature of midwifery's control of women, and the ways in which midwives can function as "gatekeepers" in terms of accessing information and allocating resources. It was her opinion that midwives:

> gatekeep in the sense that they're mindful of the resources that are available, and in a way that reflects their practice and their experience. That's the downside, because their experience isn't necessarily representative or generalizeable to a woman's particular situation. They

> can get odd ideas because they've seen someone, or two women say, with a large postpartum hemorrhage, so in that sense they can gatekeep inappropriately. Sometimes they can gatekeep appropriately because they're trying to support that woman and her decisions and they keep her away from other options because they're trying to [encourage her to] give her all her energies to other things.

Bridget spoke extensively of the struggle she faced trying to practice the midwifery model in her particular professional context. When asked to relate a story of a birth that exemplified her personal approach to birth, she told me of a time when her ideals conflicted with those of another midwife. They were sharing responsibility for a laboring woman's care, and the other midwife had already begun the 'cascade of interventions' so familiar in the medical model:

> I was faced with it and I thought, OK, I can't do anything about it, it's already happened. Fortunately, the labor was continuing, things were fine, progress was being made, but my colleague wanted to start syntocinin.[6] I said "why do you want to start syntocinin at all?" She said, "Because base contractions aren't great, you can tell just by looking at her we're going to have to start it. I'm going to hook up the tubing. I'll speak to the doctor." I said, "Hang on a minute. I've been in there I'm sure things are going to be fine. Can I negotiate 30 minutes with you?" In 30 minutes the woman had started pushing so of course the need for syntocinin had gone, but I was on my knees. I had a horse riding lesson booked but I knew I couldn't let this woman go. I was saddened that the care she was going to get would have been less than ideal, and unnecessary. So I stayed. And took care. I negotiated. I was fortunate because [of my position] people respect me and I could negotiate that. But perhaps if I'd been a student, it would be impossible. The patient's journey had already been determined from the minute she'd arrived on that ward that she was going to have an amniotomy, she was going to have syntocinin and I thought no, no, no, she doesn't need it. I still feel this quite keenly, I knew what was going to happen so I had to stay with her. I just thought, I can't leave, I can't leave. But then I have to leave everybody, I can't be with all of them.

The frustrations of this hospital-based midwife, clearly dedicated to the midwifery model, were echoed only by a refugee of the hospital system, one who had found her place in a midwifery-led unit.

The Literature

One of the surest ways to see that pregnant women get the information they feel is relevant is to allow them to choose it for themselves. This idea is reflected in the rack of pamphlets lining one entire wall of Breithleigh's antenatal midwifery clinic. Here women can pick up information on everything from sexually transmitted diseases, smoking, exercise and nutrition during pregnancy, and family planning to name a few. While it seems a good strategy in meeting the needs of a diverse population, a theme reflected elsewhere in discussions with midwives from this unit (Reid 2000), this haphazard method of information dissemination fails to take a few key factors into account. One is attention to the sources of information. Some of the pamphlets displayed are the products of human service agencies such as HEBS (The Health Education Board for Scotland). Others are the products of pharmacy chains or drug companies, such as the pamphlet entitled *Inducing Labor: What Happens*. The last page of this pamphlet advises the reader to "remember that induction is not unusual – about one in five labours is induced." Close reading of the back of the pamphlet reveals that it is put out by a company called Pharmacia. A bit of homework reveals that Pharmacia manufactures the drug Cytotec, commonly used for artificial induction of labor. It is challenging to imagine how such inherently biased information meets the goal of "unbiased informed choice," and equally challenging to imagine the quandary faced by midwives working with consulting obstetricians who may prescribe the use of a drug like Cytotec several times a day. Another factor not taken into account by the wall of pamphlets approach is the lack of individualization of information, a goal stressed by Walton and Hamilton's interpretation of *Changing Childbirth* – one that midwives here could easily lose sight of in the effort to provide at least basic care to such a large volume of patients.

---

[6] A synthetic hormone used to speed up labor.

Like those in *Ready, Steady, Baby*!, these sources of information are disembodied and impersonal. It is the lack of unit-specific information and the potential for conflict of interest that dominates first visit material at Breithleigh Regional.

In addition to the opportunity to peruse the wall of pamphlets, all women who visit the clinic are given a "Bounty pack," an 8x10 inch plastic pouch full of coupons, advertisements and still more pamphlets. The slick, glossy magazine stock pages of the Bounty pack give generalized pregnancy advice interspersed with advertisements for everything from breast pumps to maternity clothes. In addition to being handed out at the clinic, the packs are provided at the pharmacies where women may go to purchase prenatal vitamins, and at the obstetrician's office (an alternative site for women who do not qualify for midwifery-based antenatal care). The "Bounty pack" seems to have worked its way into every stage of pregnancy and beyond, including the "mum-to-be" pack, the "new mum" pack and even a "toddler" pack. "Trust Bounty" the introduction reads "from the first breath to the first steps" (Metland and McGrail 3:2003) As with the Pharmacia pamphlet, the role of the midwife as educator is displaced by commercial information-with-an-agenda in what are actually obstacles to the goal of informed choice disguised as helpmates to busy midwives. The fact that access to resources was mentioned less frequently in the Breithleigh Regional interview than in any other leads me to believe that there may be a correlation between the lack of resources such as time and staff and the use of generalized, consumer-driven, non-unit specific information. The lack of unit-specific information given out at the first visit becomes even more noticeable when compared to information given out at other units.

Eagalach Memorial Hospital

The Maternity Unit

In my observation, it is clear that, regardless of NHS decrees or physician influence, midwives' communities still play a large part in defining and imparting status to the role of the midwife. I believe that this power is reflective of how they (the community) see birth. In Eagalach, the midwifery unit itself is often the focus of collective efforts. Since the town's maternity services are up for review (and potential "downgrading") by the NHS, one woman dressed up as a midwife, and with a group of others, decorated a "save our maternity unit" float and circulated a petition at the town parade. With government resources being scarce, midwives in this same unit have often benefited from the generosity of the community to meet needs. A midwife here who described her unit as "the heart of the community" told me that "All the firms in the area, all the businesses, are for fundraising. They say 'Oh we'll raise something for the maternity unit.' There's always a grandfather [who] works somewhere or a grandmother or an auntie who's enjoyed the experience, being here." The fact that the unit has such solid support in the community indicates that people are happy with things that way they are. In order to maintain this level of support, the midwives at the unit must keep the people happy and keep giving them what they want. My observations of Eagalach Memorial Hospital illustrate the subtle and dynamic ways in which a prominent midwife can use her role to influence the definition of birth in a community. They also illustrate the conflicts of a midwifery service trying to practice "normal" under the supervision of obstetricians, and the ways in which "normal" can *become* "under the supervision of obstetricians."

The hospital sits near the center of the small town of Eagalach, across from the library and the police station – literally "The heart of the community." The two story building has a small parking lot for employees and a slightly smaller one for patients and visitors. On the day of my visit two women (who appeared to be employees based on

their identical white uniforms) watched me through a wall-sized window as I walked from my rental car to the lobby as if they were waiting for me to stop and explain my business there. Their unabashed surveillance left me with the impression that not much went unnoticed here. The maternity unit occupies its own wing on the second floor of the building. One set of doors leads to an anteroom whose walls are covered with pictures: wide-eyed newborns stunned by the camera, toddlers with toothy, drooling grins, beaming mothers and a handful of women who I later learned were midwives.

The Midwife

Elizabeth met me during her lunch break and eventually spent over two and a half hours talking to me about midwifery, giving me a tour of the unit, and insisting that I stay for tea and scones. A warm, motherly woman, the steely will that nonetheless flashed occasionally through her smile would have served her well in these outer regions of the country. She had been well mentored.

> When I first came here I thought 'I'll never be like these women.' They were wonderful! They were so inspiring! Oh you'd be ready to quit and she says "Let's stop it, let's do this, we can do this. We'll manage this." In situations they were in the labor rooms I thought "I'll never deal with this – I'll have to leave here. This is dreadful, there's no doctor, there's no, how are we going to cope [and they would say] come on now we'll be fine." They really gave you the courage and the inspiration to continue.

As a proud resident of a traditionally independent town, she stressed elements of community much more than any other in her interview, and more than all other interviews combined. Closely tied to this theme was the notion of resources – mentioned by her more than any other interviewee. While cohesion amongst midwives did come up in our interview, it came up less so than in any other. Putting the pieces together, Elizabeth's comments reflected the idea that "it takes a village" to birth a baby, and that the midwives may have depended more

on outside support and influence than on the support and influence of other midwives. The importance of maintaining the status quo within the community when one's livelihood and status are tied to satisfaction within that community is clear. "It's quite nice, it's quite informal," Elizabeth said. "Because it's a small area, we know nearly everybody who's having a baby from very early on. The staff are easily identifiable in the community, and many of them are friends with their own children going to school. So it's very good in that you have a close relationship with a woman."

With one exception, the midwives I spoke with all cast their role in the community in a positive light. These women seemed to see themselves as part of the fabric of the towns in which they practiced, part of an extended community family, with personal and professional roles overlapping. It seems this intimate sense of community can be a bit intrusive, though. Several of the women mentioned that they "couldn't get around the Tesco[7] without being stopped." Speaking often of women coming to her at home, on the street, or in the grocery store, Elizabeth also expressed her bemused exasperation at such visibility. "So, sometimes it's very good in that you have a close relationship with a woman. Sometimes it can be very, like, "oh no, just five minutes, please" because they come to your door at home and say "can you help me?" She told a story of a specific instance in which the professional intruded on the personal:

> I remember my father was up visiting once and we were sitting outside of the front door on a beautiful sunny day and this pregnant woman called whom I knew very well and she says "I'm just not feeling very well today" and I says "What's wrong?" "I don't know, I've twinges, I just, I'm not feeling right." She says "I feel it inside me." I says, "come on here" I says "Father we're going in here, just you stay there the now while I'm gone. I says to her, "I'm not happy with this. I think you should just go up to the unit. I'll phone them and tell them you're coming up to have a tracing [electronic fetal monitor evaluation]." So she came up, she had a

[7] A local supermarket chain.

> tracing done. She had a [urinary tract infection] and her blood was a bit low, so it was just a very simple thing, but my father says, "Why don't you just put a line of chairs there and everybody can sit and have tea?" While he was there for the week there were about 5 different times when they passed the door and said "Oh, can I ask you about something?"

As she spoke, Elizabeth's eyes sparkled with a pride that told me the intrusion was a burden she was honored to bear. Among some of the midwives I studied, power and authority are negotiated in a symbiotic relationship between them and the women they serve. The symbiosis has evolved from overt control by the midwives (Thomas 2002) to an emphasis on empowering women with control on the part of the midwives taking on more subtle forms. One of those forms is the dissemination of information.

The Literature

Walton and Hamilton state that one of the goals of *Changing Childbirth* was that "the woman should be cared for by people with whom she is familiar and in whom she trusts" (1995:16). This goal is certainly taken to heart in Eagalach. The information given out at the first visit also demonstrates this dynamic and correlates with the *Changing Childbirth* goal. There is a distinctly personal touch, clear evidence that the literature comes from local midwives with an investment in the local community, and from this specific maternity unit. Some handouts, for example, have handwritten information alongside the printed information. Others are homespun photocopies featuring the maternity unit's logo--a stork holding a bundled baby on its beak--or the name of the unit spelled out on "nappies" (diapers) hanging from a line. A double-sided leaflet containing a nursery rhyme written by one of the midwives is designed to serve as a go-between, smoothing the way for women who might face breastfeeding opposition from mothers or

mothers-in-law who believe that bottle is best and who may actively engage in behaviors that thwart successful breastfeeding.

> Mummy is breastfeeding me because she knows it's best
> But I suspect you're wanting to help her get some rest
> I'm very time consuming now because I am so new
> I know how much you wan to help – there's lots that you can do
> Washing, cooking, ironing – you can think of more
> Let mummy do the feeding 'cause that is not a chore
> Both mum and I need practice until we get the knack
> So please don't say "Good gracious! Another little snack?"
> Granny you've got lots of tips – for you are very wise
> We welcome your suggestions but please don't criticize
> You were once like mummy and now her turn has come
> With your love and patience she'll make a smashing mum!

Signed by a local midwife, the pamphlet displaces the interfamilial repercussions for what may be an unpopular decision (to breastfeed) away from the new mother and redirects them – by way of a fictitious newborn – to a professional with high status in the community. It intervenes on behalf of the mother and suggests alternative pro-breastfeeding activities in a gentle, non-confrontational way. It is a helpful gesture, one that might be made by a friend - or a caring midwife with an intimate knowledge of family dynamics, the local history of maternity care, and gender roles in the community. The closeness of the midwives to their community is evident in first visit literature.

A large portion of the *Changing Childbirth* initiatives centered on informed choice in childbirth, and, due to a rich base of resources, choices at Eagalach Memorial seem to abound. Compared to other units in my study, Eagalach Memorial was almost off the chart with respect to resources. In addition to cutting edge machinery, the hospital offers epidural anesthesia (unlike many rural maternity centers in Scotland), aromatherapy, a drop-in "daycare center" for on-the spot-checkups and fetal monitoring, a self-catering kitchen, a labor tub (not to be confused with a birthing tub), and a variety

of classes for expectant mothers. My informant spoke of a plethora of paid core and ancillary staff, auxiliary staff working with the unit at outlying centers, and even of retired staff who come in to help out. The ready access to both human and literature resources allows birthing women to choose from a wide range of services rivaling any big city hospital. Along with instructional literature such as how to do pelvic floor exercises, how to best recover from a caesarean, and several breastfeeding pamphlets, handouts detailing certain of these choices made up a significant portion of the first visit literature I collected at Eagalach Memorial.

Rich in resources, Eagalach is also the only unit that even came close to Breithleigh Regional in terms of technology. Machine oriented technology is everywhere at the hospital, and it featured prominently during both the interview, the tour of the unit and to a certain extent in the first visit literature. They're proud of their technology here, and rightly so. Eagalach Memorial is over 100 miles from Breithleigh Regional. While the distance is a source of anxiety for pregnant women and midwives, it has been used by the community to justify a level of technical bells and whistles unheard of in most of the North American level II maternity units I've visited. As a consulting unit, Eagalach Memorial is equipped with an incubator as well as a neonatal ventilator, CPAP (Continuous Positive Airway Pressure – a therapy used to keep neonatal lungs from collapsing) and the expertise to use them. There are self-contained laboratory facilities allowing the midwives to "take blood, make a diagnosis and start therapy" before a transport team arrives. The unit has its own Sonicaid system, allowing electronic fetal monitoring to take place at home while the results are summarized and transmitted to the

hospital. Eagalach may be miles from the nearest level I trauma center, but this is no backward Hicktown General.

The language of science and technology is evident in first visit literature – in particular the midwifery record, the "case notes" women are to carry as a result of *Changing Childbirth*. The case notes given at Eagalach Memorial seem to be a catalog of medical problems with a nursing focus. The record is 14 pages long. One page is reserved for demographic information. There are two pages reserved for prenatal and postnatal planning, with space left for the midwife to record topics discussed and details of plans. Then there are six pages worth of "observations," all quantifiable, objectively measurable and neatly fitting within predetermined categories. There are boxes of 1x4 cm to record information on the mother's vital signs, lochia, vulva, perineum, and for baby things like urine, stools, color, id bands. The format of the document suggests that these are the sorts of things that should be observed. There are 2 pages worth of "daily report" on the mother and fetus/baby – the kind of information that would be pertinent to pass on to the next care provider in a shift change. Finally, there are four pages reserved for freehand listing of "potential problems." As a nurse, it is the kind of thing with which I am quite familiar: assess and observe the situation, diagnose the problem, plan and carry out an intervention, evaluate the outcome – Nursing Process101. It is worth noting that of the midwives at Eagalach Memorial all were nurses prior to becoming midwives and would have received their training in the shadow of the hospital. It is difficult for me to determine how this "midwifery record" would be any different if it were titled "nursing record." It seems clearly and undeniably medical in orientation and woman-centered only in that the woman is the central object of observation. The definition of birth reflected in

the notes is a pathological, quantifiable, biological process fraught with "potential problems." The carrying of notes is supposed to empower women, but it is difficult to see how the plethora of abbreviations and untranslated information contained in these notes is empowering. Medicalization of the process under the guise of empowerment seems to thwart the goals of *Changing Childbirth* and subvert the goal of normalizing birth.

Another observation of first visit literatures here is the foregrounding of only approved choices. There is, for example, a heavy emphasis on breastfeeding in the literature. I return briefly to the "Dear Granny" poem discussed above. While serving the purpose of supporting a woman's choice to breastfeed on one hand, the poem also serves the purposes of midwives in foregrounding breastfeeding as the acceptable, supported choice. On of the pamphlets included as part of the "case notes" is a "feeding log," intended to help new parents keep track of the newborn's feeding schedule. The Highland Primary Care NHS Trust (a major funding agency) has a breastfeeding policy which states that "We as health professionals recognize the benefits of breastfeeding. We promote breastfeeding by offering information, help and support to all mothers." This directive, followed by nine others, was also part of the packet of breastfeeding. It is clear that the midwives in this area intend to follow the directive. "We have very high breastfeeding rates," Elizabeth told me proudly. There was no bottlefeeding information given. I was told that the inclusion of only breastfeeding information was intentional, and meant to encourage breastfeeding as a choice – the only choice.

Following this pattern, the choices generally offered in first visit literature at Eagalach Memorial are few, with clearly marked boundaries outlining the medical model of childbirth. For example, there is a full page two-sided handout detailing the induction

process, the timing of and intervals between interventions spelled out in advance. The induction/cesarean options were highlighted by Elizabeth as a benefit of the Eagalach unit - women here may have their labors induced or choose to have elective caesarean sections. In the year 2002, Eagalach Memorial's induction rate was 29%, well above the national average of 22%, and the caesarean rate (23.6%), while close to the national average of 22.1% was far above the collected averages for other remote maternity centers (Birthchoice UK 2003). Given the information I collected, it seems clear that women receiving those materials would be well informed about a certain set of choices and under informed about their full range of options. The influence of this level of technology on the definition of midwifery is evident the words of Elizabeth, who said her unit was "...a lovely unit to work in. I love it. I came here years ago, and I thought I'd come to heaven because I was able to be a midwife to do all the things I wanted to do without anybody looking over my shoulder." While the degree of autonomy she expresses seems clear cut, it is complicated by the fact that she also seemed to be terrified of losing those very obstetricians whom we could assume might be looking over her shoulder. When asked what she thought might happen if the obstetricians were pulled out of her area by the NHS, she said "We're very concerned about where it's going to go. I really think that we're going to be midwifery-led. I really see that."

The main handout "Personal Delivery Service" gives information about visiting hours, what to bring to the hospital, local support groups and "what is available during your pregnancy and after the birth of your baby." There is no information about what options are available during labor and birth, times when, according to Walton and Hamilton, the autonomy of the woman is to be respected and unbiased informed choices

are to be offered. It is here that a disconnect becomes apparent. For example, while I was told that homebirth is an option, no printed information about how to exercise that option is given, leaving me to believe that the availability of home birth is among those *Changing Childbirth* recommendations subject to local interpretation. That interpretation is influenced by the connection the midwives here feel to their patients. The hospital is seen as the preferred choice and it is seen as a personal affront when a woman does not choose to give birth in the hospital. Elizabeth told me "A couple of local ladies have had home delivery because they had disliked their care, and so we've looked at it and we'll say "what have we done wrong?" She added that homebirth is something usually done by outsiders, not those who are considered part of the community. "Most of the ladies who opt for home delivery are ladies who've moved into the area, who've had babies south and found it a very unpleasant experience," she said. "Most of our ladies who know the unit, who know of us, who know what they get here, they've no interest in doing it [home birth] because they say 'Oh we'd rather go in for a few days because we know everybody.' We don't have a huge rate of home delivery requests. It's mainly because they're new to the area." It is possible that as new women are socialized into the town, they also become socialized into its birthways. As another Highland informant told me "You don't make yourself exceptional in these parts." Somewhere between the plush technology and the personal touch lies the disconnect between *Changing Childbirth*'s idea of choices and the actual choices available to women in this area. Birthways here are technological in nature and the fact that women have other choices is not clearly reflected in any of the unit-specific literature they are given. The emphasis is on a technologized, medicalized birth with, its edges smoothed by pastel colors and aromatherapy.

MacDragh Hospital

The Maternity Unit

I arrived at MacDragh's maternity unit for a tour and interview at shift change. Having come through the sparkling u-shaped courtyard lined with red geraniums, my sense that the unit was an important and well-cared for part of the community was confirmed by the blinding sheen on the gray tile floor leading to the unit's double doors, and the beauty of the surrounding area that was reflected in silver-framed photographs that lined the walls. Two day-shift nurses were leaving as I walked up to the semicircular desk at the center of the unit. They seemed as curious about me as I was about them, but were more eager to go home after a 12-hour shift than to stay for an interview.

MacDragh Hospital is technically classified as a "shared care" unit, a MLU/GPU. However, Morag told me that there was only one GP who actually practiced with the unit, and that the midwives were quite content with the arrangement, and quite capable to handle a variety of situations. Following a general trend in Scotland, specialization among the midwives here was encouraged. Substance abuse, teen pregnancy, ultrasound scanning, and breastfeeding were some of the specialties Morag mentioned. She characterized the relationship between the GPs and the midwives here as mutual tolerance at best. For instance, in speaking of the various training sessions midwives attend from time to time to brush up on the latest management of shoulder dystocia or postpartum hemorrhage, she indicated that the GPs were welcome "if they can be bothered to come along." The GPs, it seems, are not the physicians with which these midwives allied themselves. Instead, all complications were referred to the nearest consulting unit, and a consultant visited once a week. Up to date technology was used to

enable constant communication and transfer of information between MacDragh and the nearest consulting unit. "We foster good links with the consultants. We rely heavily on them. We need them," Morag told me. In reviewing the first visit literature at the unit, the shadow cast by this relationship was clear.

The Midwife

A 20+ year veteran of midwifery, like many of my interviewees, Morag had seen the "before" and "after" of sweeping changes in the NHS way of birth. Describing herself as "a generic midwife," she included care of the birthing woman before, during and after birth as part of her job description. A soft-spoken woman, she expressed a personal interest in teen pregnancy as a member of a unit where individual specialties were encouraged. This emphasis on specialization is not surprising in that comments dealing with the role of the midwife and available resources came up often during the interview. Morag told me, laughing at the thought, that she had wanted to be a midwife since she was a child watching the local midwife ride around town on her bicycle. Her job satisfaction was evident in the huge smile that appeared when, midway into our discussion of midwifery qualifications, a new mother and her baby stopped by to say hello. An experienced mother whose first birth was "a complete disaster," due in large part to lack of support, Morag prized the ability to support women and their families in their choices throughout the birthing process.

Living up to her patient-centered ideal, she claimed to put her patients first, especially in terms of safety. She clearly expressed the fact that the unit where she works only serves low-risk women. "We're not in the business of taking chances with people's lives," she said. Morag's least favorite part of the job? "I hate when things go wrong," she said. This desire to minimize risk was reflected throughout the first visit literature.

While Morag said that midwives generally encouraged choice among birthing women, as an experienced midwife who had seen plenty of good things go bad, it was clear that the safety of her patients trumped the concern for honoring individual wishes. "We're happy to accommodate," she said. "We'll accommodate as far as is safe."

The Maternity Unit

Morag gently shook my hand and immediately began leading me on a guided tour of the unit, past the two private rooms and the bright kitchen for use by patients to the labor and delivery room. The birthing pool, bigger than any I'd seen here or back home, formed the central feature of this room, with the bed off in one corner. I began to get a sense of the forces that might constrain the choices of birthing women when I asked about the pool. Birthing pools, while common in most units, are nonetheless not usually located right in the middle of the delivery room, so I assumed that the pool was used very often. Not everyone, Morag told me, was "ofay" with water birth, and they weren't sure they wanted to be "ofay" with it either. While cohesion among the midwives was mentioned here at least twice as much as anywhere else, the degree to which this finding reflected the real state of things was called into question when I was speaking to another midwife. As one who wholeheartedly supported the use of the pool for birthing, she told me that the pool was a major source of trouble in the ranks of midwives. Though requested and paid for by the community, its installation was not universally supported among the midwives, and several of them flat out refused to use it for anything other than labor. This was not the only finding that led me to question the degree of choice truly available to women, even in a unit where individualization of care was touted as a distinguishing feature.

While Morag indicated that the idea of empowering birthing women to ask questions and make choices was a good thing, the empowering of midwives and the struggle for autonomy were not mentioned once in her interview. While this could mean that it was a moot point, that in her unit midwives had obtained autonomy, I am inclined to interpret the observation differently. One reason is that while the relationship between the midwives and the local GPs was mentioned only obliquely, the unit's close connection to the regional consulting center was directly mentioned several times. The technology and personal effort that made this connection possible were also highlighted as a special and beneficial feature of the unit. A second reason I interpret the scarcity of autonomy in the interview as I do was that while questions of power did emerge, they were unrelated to midwifery's relationship with physicians. This struggle focused more on the power wielded by the midwives themselves, and reflected the power wielded by the medical model of birth. In my interpretation, this midwife believed midwives in her unit to be autonomous practitioners, but the conflicts evident in Morąg's words and the first visit literature reflect a false sense of autonomy that allowed them to practice independently as long as they stayed within the constraints mapped out by the medical model.

The Literature

MacDragh distributes a stapled and photocopied pamphlet entitled "Your Care in Pregnancy." It is entirely unit-specific and regional, informing women of "who will look after you during your pregnancy and what choices are available to you in this area." Following a description of the unit and a listing of options for prenatal care is a bulleted section with the heading "Did You Know?" The items highlight informed choice and the "normal only" nature of the clientele, echoing Morag's statements. On the following

page, under the heading "You have the right to give birth in the place of your choice" is a description of MacDragh's scope of practice and definition of normal. "To be booked to have your baby [here] you should be healthy, and have had no complications in this pregnancy or previous deliveries." To cover first pregnancies in which no obstetric history exists, the following paragraph begins with a watered down version of The Myth: "In your first labour you have a higher chance of needing some help from a doctor with the delivery of your baby. The local GPs all have experience in obstetrics but are not specialist obstetricians or pediatricians. They do not have the same skills and experience as the doctors who work in specialist units." The potential need for and superiority of the obstetricians' skill is highlighted again a paragraph later, following the information that a GP would be notified of each admission. "In the event that you need emergency care, such as a forceps delivery your GP will do this to the best of their ability." While the pamphlet states that complications and problems are rare in "low risk" pregnancies, the prominence of potential danger and emergency complications on the page effectively eclipse this fact. Being informed that an underskilled physician might be performing emergency care "to the best of their ability" might slant the decision of a first time mother who has just read that she is apparently more likely to need such care.

It is worth remembering that all of this information, including the potential for "an emergency cesarean section" and transfer to a consulting hospital, is meant to help women who "have the right to give birth in the place of their choice." It is also all included under the heading "MacDragh Hospital," which would lead the reader to believe that the sections following would give more information about that hospital. This would follow the pattern used on the next few pages (Hospital Unit Run by Consultant

Obstetricians, Domino Delivery, and At Home). Instead, women are given information about how that choice might lead to suboptimal emergency care and potential transfer. Given the closeness of the relationship between the midwifery unit and the consultants, and the degree to which it was stressed both in the interview and in the first visit literature, I suspect that here "normal," and the choices that accompany it, are territory closely guarded and narrowly defined by the medical model of birth. While not entirely one-sided, the pamphlet's emphasis on the potential danger of birth and the potential or actual involvement of the physician in the process (even if midwifery led services are chosen), color "normal" with shades of pathology.

The midwives I spoke with made it perfectly clear that, midwives in the recent past exercised overt control over women. However, all of my interviewees told a story of changing attitudes within the midwifery profession. Attitudes are changing, and the empowerment of birthing women following the directives of 1993 was a nearly universal theme in the interviews. Morag, who had been practicing since before the *Changing Childbirth* recommendation that women carry their own documentation, characterized the difference in involving people in their own care as "amazing." It seems that the ease of access to health information is a factor, but, according to Morag, not any more so than the role of midwives in promoting the shift in responsibility and the continuing drive for women in the area to assert themselves.

> Some of them are very very informed. There is quite a group of women who now, they come back [and say], 'I've read this article or I've heard this or somebody told me about that - can you tell me more about it?' There's always been a group who would go out and find out even before the internet came around, but I think it's easier for folk to access information and so there's probably more of them doing that. And I think possible we encourage women to be more interested. I mean certainly I've had 3 pregnancies, and I can remember

> saying "yes, yes, if you tell me to do that, I'll go and do that, that's absolutely fine." But we actively encourage people – it's your pregnancy, it's your body, you're responsible for it, we're here to support you.

From my observations, it seems that the Scottish women in the areas I studied are not content to be in the dark about the choices available to them, and not only with respect to the setting in which they will give birth. Following the British tradition of vocal women's organizations, many birthing women in these areas want to be active participants in helping to shape the choices available to them throughout the birth process and beyond. However, this is only one part of the picture, and the conflict this newfound empowerment has sparked among some midwives was clear in my interview. For example, during the interview itself, notions of patient choice figured prominently. At a later point, however, Morag remarked that women were often "sheeplike" and did what they were told. The duality this represents was also evident in terms of patient choices. At different points during the interview, Morag mentioned that women had the option of going home after 6 hours, of having extended family members attend antenatal visits, of having whomever they wanted present at the birth, and of tailoring the course of childbirth education to name a few. During labor, women could choose to move around, to use Reiki massage, music and aromatherapy. Depending on their circumstances, however, women were not free to make basic choices, such as the choice to give birth in this unit as opposed to another. Additionally, the availability of some choices would be dependent on whether or not a woman labored with a midwife who supported them. Morag's comments regarding waterbirth provide a good example of this type of constraint. Comments made at Breithleigh Regional regarding obstetricians flatly disallowing waterbirth suggest the influence of the medical model is at work here,

restricting choices. Pat Thomas, who writes often on maternity care, cites a misguided notion of "choice" as one of the reasons why *Changing Childbirth*

> failed to change childbirth. The report's emphasis on choice led many practitioners, and even consumers, to temporarily lose their focus. Women were encouraged to 'choose,' for instance, how they would like to be induced, or which forms of conventional pain relief they would like to use. Managers and practitioners, unaware of the difference between free and restricted choice, have never fully understood the outrage that consumer groups felt when it became obvious that these 'choices' were nothing more than a pre-selected and very limited menus of options. 2002:33

While the menu at MacDragh may seem full and varied, the actual choices available are determined by each midwife's comfort level with the various options.

Gairdeachas Birth Centre

The Maternity Unit

The Gairdeachas Birth Centre sits on a hill overlooking a residential area outside of the town center. It was the smallest of all Scottish birthing centers I visited, with only three rooms – one for antenatal and postnatal checks, one for the labor, birth, recovery and postpartum periods, and an office. A hallway, crammed with equipment such as a portable birthing pool for home births and racks of teaching literature, joined all three rooms. There was a separate entrance at the far end of the hallway leading directly to the parking lot used to save women from having to check in at the main hospital desk. On the day that I visited, the sun was bright and the air was unusually balmy; the door was propped open allowing light, warmth, and the occasional bumblebee to filter in.

The unit has undergone major changes in the last decade. Until the late 1990's there were 19 double duty nurses who practiced in the community hospital, in the emergency department, and as midwives assisting the GPs who covered maternity care for the 2000

square mile region. The effect of this system on maternity care in the area was that midwives became "deskilled" and lost confidence in their ability to practice midwifery. As a result women in the area, in addition to experiencing a lack of continuity (since the area was covered by such a large number of midwives), effectively lost the choice of place of birth. Midwives, not trusting their skills, discouraged women from giving birth in the community setting and encouraged them to go to the consulting hospital instead. In the years following *Changing Childbirth*, services in the area were reviewed and the decision was made to establish a dedicated midwifery service in the area (one whose midwives were not also practicing as nurses). Midwives practicing at that time were given the option of joining the new midwifery-only service or continuing as nurses, thereby relinquishing their midwifery certification. Two of them chose to stay, a senior midwife was recruited from elsewhere and two new midwives (one of whom is direct-entry) joined, making up the current staff mix of five.

There are several key elements that made Gairdeachas different from any of the other units I visited: its size, the role of the community in shaping it, and the absence of physicians. First, Gairdeachas is small. Its staff of five was less than half the size of MacDragh, the next largest unit, where there were also ancillary staff assistants. While cohesion among staff was mentioned by my interviewee at MacDragh several times, the comments of another Town midwife led me to believe that all was not quite as cohesive as it seemed. In Gairdeachas, the midwives were so like-minded and worked so well together that the thought of adding another staff member to ease the significant on-call commitment was dismissed out of a desire to "not dilute the team." The size of the unit also meant that midwives were their own

managers, and had a high level of involvement in administrative activities, attending meetings and sitting on committees.

The role of the community in shaping the area's maternity services was greater than anywhere else I visited. When the new service was begun in the late 1990's, part of Gillian's task was to redevelop the role of the midwife in the community. This was accomplished in part through the development of a "user's group." Gillian explains:

> We had been up and running here for about 5 years and we felt that we needed to develop the service but we weren't sure how. So we thought who do we need to ask? We need to ask the people that use the service. So we advertised, put a wee note in the local press, and asked if there would be anybody interested in coming along to look at maternity services. So the user group formed and we advertise it now and encourage women to come along.

She describes the group as "interested women who have either had children in the past, are currently pregnant or are anticipating having a baby." The midwives see themselves as resources for the Group, and the Group as representatives of women in the community who are the owners and users of the service. The Group's formation coincided with the publication of the document *A Framework for Maternity Services in Scotland*, and the women demonstrated their confidence in Gairdeachas unit by doing research into the opinions of community members and generating a report promoting the area's midwifery services, using the *Framework* as a pattern. "All credit to the women," said Gillian. At no other point in my studies of Scottish birthways have I come firsthand across such a savvy and effective use of NHS language and structures by birthing women to promote the midwifery model of care. I believe that the success of this dynamic and pro-active group in supporting midwifery services is correlated with the absence of obstetricians and GPs in the unit.

The absence of physicians is the most notable feature of Gairdeachas unit. While GPs do provide maternity care in the area, they do so in their own "surgeries" (offices). A consultant obstetrician visits twice a month. During my tour, I asked about the fetal monitor I saw in one corner of the small mint green birthing room. I was told that while it was used occasionally, it was by and large "irrelevant," as the only births here were normal and thus did not need electronic fetal monitoring. It seems that physicians, too, are irrelevant in this place where the midwifery model of care operates unhindered. In a sense, whatever happens here is by default within the scope of practice because the midwives are the only practitioners. Birth with all of its unknowns is taken in stride. Grace, discussing the fact that midwives often staffed the unit alone, said "You just do what needs to be done. If it's just routine antenatal visits that we have already marked out, fair enough but an emergency occurs, you deal with that or if somebody comes in labor you deal with that, so you're very varied in what you're doing throughout the day." The lack of physician oversight also means that it is solely the midwife's prerogative to determine what she is willing to classify as normal.

The broader definition of normal was evident in a home birth story Gillian told when asked to recount a birth she had attended that exemplified her own or the unit's approach to birth. This particular mother was giving birth to her sixth child. By baby number six, a woman is considered to be a "grand multipara" and her pregnancy is no longer classified within the NHS as low-risk, no longer officially "normal." However, the midwives attended this birth nonetheless, meeting the needs of the birthing woman who "Had five other children to look after. She had had straightforward normal deliveries, and she was not going to go." When asked what she liked most about her job, Grace said it was the freedom to practice

autonomously and the ability to give women the choices they had available to them. Here, as everywhere else, the choices women have available to them are dependent on the degree to which midwives support them. The women in this area are cared for by midwives whose autonomy allows them to collectively decide to support choices that would be unavailable elsewhere. In the absence of physicians, and without competition from medical interests, the definition of "normal" birth is constructed by the birthing woman, her family, her community and her midwives.

The absence of physicians has other effects as well, notably that the midwives are able to encourage women to challenge the status quo without fear of professional repercussions. For example, Katharine said that in the past the climate of area maternity services was such that women were simply told they had to go somewhere else to give birth. Birth at the consulting unit was the status quo, and those desiring to make other choices would not have had ready access to information on alternative choices. Now, midwives have the tool they need to support women wanting to make other choices – evidence. The link between evidence-based care and autonomy was apparent at Eagalach too, where Bridget was able to successfully institute waterbirth as an option in the face of opposition by both midwives and physicians by citing the evidence in its favor. At both Eagalach and MacDragh, the power of anecdote and personal experience were noted to increase the number of prenatal ultrasounds practiced in the region and restrict the use of the birthing pool, respectively. In Gairdeachas, evidence was used to successfully combat the tradition of The Myth. Grace said that "Traditionally the first time moms were encouraged to go to a consultant unit and were told that they couldn't, actually told that they *couldn't*, come here to deliver - which has changed since the service has changed. It's been changed completely

because we have got the evidence to suggest otherwise. It's all part of encouraging people that there's the service locally and that not everybody has to go away to have the baby."

The Midwives

Gillian

Gillian carried herself like a queen. The most senior of the midwives I spoke with, she had advanced over the years from the position of staff midwife in the pre-Peel era to supervisor of a midwifery-led unit. Both halves of the role were important to her and placed her in a unique position to discuss midwifery care in Scotland. While encouraging choice among women and practicing autonomously were rewarding parts of her job, she indicated that "supporting the midwives to practice to their full capabilities" was the element of her job that she enjoyed the most. "It's great when I do look after women and support them through, but equally it's great to support the midwives and see them through." In her interview, encouraging both choice amongst childbearing women and their role as active participants in childbirth were mentioned more so than at any other unit, as were positive aspects of autonomy and the use of holistic, non-interventionist measures to aid in childbirth. While one interviewee brought up the association of fear and danger with childbirth 6 times, it was mentioned only once during Gillian's interview, and "technology," the various machines associated with the medical model of birth, was not mentioned at all.

It is worth noting that Gillian's unit accepted only women in the lowest risk category, which in itself would affect the issues raised in an interview. However, technology, fear, and danger both came up several times in the interview with the midwife from the other "low-risk only" unit I visited. I believe it was Gillian's definition of birth that was instrumental in making her interview different from the others. When asked to tell a story that reflected her

personal approach to childbirth, she actually told two; while her unit only sees a handful of home births a year, both stories were of home births she attended. In one story the key point was that the new mother was out in her garden two hours after the delivery. The focus for Gillian was not on what could go wrong – it was on what went right, time and time again. Her comments suggested that Gillian was a believer in "normal" birth, and had faith in the body's ability to do its job with a minimal amount of assistance.

Grace

Grace, whom I interviewed with Gillian, shared many of her opinions. In fact, the women often spoke in tandem or completed each other's sentences. Grace answered my questions quietly and gently, almost absentmindedly as she led me on a tour of the tiny 3-room unit. A young member of the midwifery team, she echoed Gillian's sentiments, but with a conviction that told me they were very much her own as well. After a long pause, she told me that best part of her job was "being able to give the women the choices that are available to them and to be autonomous practitioner. Having the scope and the reason to be able to do that." Coming from a high-volume, high-intervention consulting unit, she found the midwife-only service to be a relief from what she called "very frustrating and restrictive environments" elsewhere. Clearly, the philosophy and practice of the midwife-only service was in line with her own, and she felt empowered by the freedom to do normal. "We practice old-fashioned midwifery," she said.

In compiling profiles of Grace and Gillian, I primarily used the field notes I had collected from my visit. Re-reading them, I found the following phrase scribbled at the bottom of the page: "Used to perceive it as a disaster waiting to happen. Now changed 180 degrees. Expect things to be normal." It speaks volumes to note that while I failed to record

the speaker, I don't think it would matter. The quote stands on its own as a representation of the philosophy of the women practicing at this unit. It is not that, as experienced midwives, they are naive enough to believe that things don't sometimes go wrong in childbirth. It is only that they have collectively chosen to acknowledge and act upon the fact that it is far more common for things to go right, to define birth as inherently normal. It is a brave choice. In the words of midwife and scholar Roberta Durham:

> The realm of midwifery practice has always been and always will be surrounded by elements of magic, uncertainty, unknowability and unpredictability. Midwives, more than most other health professionals, are raised to tolerate those uncertainties. But they tolerate that not knowing with the underlying theoretical and philosophical underpinnings that pregnancy, labour, birth and postpartum are normal processes. The expectation is normal – complications are the exception. 2002:126

The Literature

Grace told me that in the past, midwives "took over" and "managed everything, thinking it's for the best." She said "Attitudes generally have changed quite a lot from the last few years in terms of women. They're much more aware of what they can have and what choices there are." Comments indicating that women were offered choices were made more at Gairdeachas than at any other unit, and the attention to choice is evident in the first visit literature as well. The emphasis on women's ownership of their own bodies and choices, and even the maternity unit itself, is evident on the cover of the main pamphlet. The image of a pregnant woman arm in arm with what appears to be a midwife is set underneath the words "Plan *Your* Care in East County,*" and next to the words describing the pamphlet: "A guide to *your* maternity services in East County" (emphasis added). The partnership, a "with woman," relationship, suggested by the pamphlet is

reinforced on the first page. The first and last names of the midwives are listed, a direct application of *Changing Childbirth*'s recommendation that each woman have a "named midwife," and the woman-centered language used on the cover page continues: "You now have your own team of midwives who will support you and your family, at home and in the hospital, to make informed choices." Also evident in the pamphlet is a recognition of women's "unique" knowledge of their own bodies, and a respect for that knowledge as a valid, authoritative source of information – the use, for example, of symptoms and instinct (which the medical model refers to as "presumptive") and pregnancy tests as equally definitive indicators of pregnancy. "Lots of women already know they are pregnant," it says, inviting them to the midwifery clinic "*if* [they] wish to have pregnancy confirmed" (emphasis added). The adherence to the midwifery model is evident throughout the first visit literature here, and it is my opinion that its prominence is directly related to the absence of physicians in the environment and a structure that supports a midwifery definition of normal birth. The midwives here are not faced with the situation midwives may encounter in the shadow if the hospital, where "however much the midwife may want to provide supportive care for normal labour at a home birth, she may be continuously looking over her shoulder fearing criticism from her manager and the consultant obstetrician" (Thomas,2002:30).

Case study: Eagalach, distance, and birth

You might have thought it was the Mojave desert: sunny and 65 degrees, the small town was teeming with pedestrians weaving around each other on the sidewalk, wearing tank tops and shorts, carrying water bottles. There were people picnicking on the grass. A traveling carnival had set up next to the pier; there was an outdoor flea market in the town

---

* The name of the county has been changed to protect the location of the maternity unit.

square with a PA blasting music by Kenny G. A general feel of summer lit on the faces of those in the downtown area. "It's a beautiful day!" They would laugh at me in my windbreaker, hood pulled up around my face to block the wind, trying to remind myself that it was actually August. These Highlanders are either crazy or they know, in these parts, to take their sunshine while they can get it.

The main drag, a winding two-lane tourist route, cuts through the center of town. During the daytime it is constantly bottlenecked, with cars waiting through two or three stoplights before continuing on. There is one grocery store, a fish-and-chips shop on every corner, and an abundance of families of all sorts. Extended families, teen parent families, dads with babies in strollers, moms with toddlers in tow -- the whole town seems to have turned up to enjoy the weather.

The thing you can't get away from in this place is the wind. It is a driving, permeating wind, with no regard for coats or sweaters. It follows you everywhere, waiting on the doorstep for you to come out of buildings, its urgent fingers prying into alcoves you thought would protect you. The seagulls don't seem to mind – they play with it, flinging their bodies into each gust like expert surfers riding the crest of a perfect wave. Occasionally, the wind stops to catch its breath and for a second the crying of the seagulls pierces through clearly. They, too, are everywhere. From the outskirts of town to the double harbor that encircles Gairdeachas center, the air gets steadily thicker with gulls as those scattered by the wind make their way to the rest of the flock. Once the wind remembers its mission, the shrill cries of the gulls shatter once more into shards sprinkled at random over the bay.

This is Eagalach. Perched in the northernmost corner of the Highlands, trying to hang on, to make its voice heard above the roar of lowland politicians. Trying to stick together,

knowing that there is strength in numbers. Trying to preserve its integrity amidst forces that would scatter its cries to the wind. Why?

A recent study showed that Eagalach's maternity unit at Eagalach Memorial Hospital was superfluous to the NHS, and that funding used to support the obstetricians trained to handle emergency situations could be better utilized elsewhere in the system. In Eagalach, the loss of the obstetricians translates into the "loss of the unit," and there have been town meetings and petitions to the Crown to "save" the Eagalach maternity unit. The whole community has rallied to this cause. In fact, Elizabeth told me that the last time the services in the area were up for review, the health board organized a public forum to discuss the proposed changes and put out sixty chairs. "The hall was packed," she said. "There were hundreds of people." The women of Eagalach have even organized a group with the express purpose of fighting what they see as a "downgrading" of the maternity services at the unit.

If the obstetricians were to be pulled out by the NHS, the same midwives who have been delivering babies for decades would still be on staff at Eagalach Memorial. The facilities and amenities would remain essentially unchanged. A woman with a "normal" pregnancy could still give birth at the same place and in the same way she would have when the obstetricians were in residence, yet midwives and birthing women alike are fighting the "loss of the unit." In fact, women on the streets were happy to fill out a very personal survey for a complete stranger "if it would save the unit." Why was it that in this place, as far as you can get from the urban centers of Scotland, the women were eager to discuss maternity services, while their big-city counterparts in Bailetorach literally gave me the cold shoulder when I approached them? What does distance really mean to the midwives and the inhabitants of Eagalach?

I spent a good deal of time talking with the women who stopped to participate in filling out surveys on the main street of Eagalach on that brilliant afternoon in August. I spoke with only a handful of women, and yet amazingly, half of those in my convenience sample mentioned the distance issue. One woman was from a town 30 minutes' drive up the coast on a clear day. The information that she was "scared to death" because she lived so far away came unsolicited. Another woman, with two children who looked under the age of five, likened her most recent birth to the movie *Twister*. She was strolling the streets with a friend who declined to fill out a survey but who did volunteer the information that she had a child who died shortly after she gave birth to it in an ambulance on the A17, the main artery connecting the Eagalach to Bailetorach, and Breithleigh Regional. In fact, the loss of a baby on the A17 was a common theme in the town meetings regarding the loss of the unit. Elizabeth told of a woman "Who stood up and told her story. She had lost her baby halfway down the A17. She needed to be transferred and that baby died just post delivery. And there was another young lady who stood up and talked about her great aunt who died giving birth on the A17 because there were no obstetricians." Physician Thomas Newman speaks of the power of storytelling in influencing clinical judgment and overruling statistical evidence. In particular, he cites the personal presence of the storyteller as an important factor:

> It's not just that these awful things happened, it's that they happened to the person telling the story. This enables a connection with the listener...beyond what would be possible if the story were recounted by a dispassionate observer, and it infuses the storyteller with a passion to tell the story over and over again, thus multiplying its influence...the problem with these compelling stories is that their apparent simplicity and focus can lead to the neglect of complicated considerations of what else we might do with our resources and how we should make these decisions (2003:1426-7).

The power of individual horror stories to influence policy was evident

elsewhere in Elizabeth's interview, when she recounted that a routine 32 week "scan" (ultrasound) had been instituted at Eagalach Memorial and other hospitals in the region "because something was missed."

A few minutes spent on the A17 as it stretched further and further north was all it took to convince me, a driver relatively accustomed to blind Scottish curves and one lane roads, that this would not be the travel route of choice for a pregnant or laboring woman to travel. People in Eagalach do not do much traveling unless they have to. In fact, the counties of served by Eagalach Memorial have the lowest per capita car ownership in the Highlands. Given the prospect of navigating the A17, who could blame them? Sheer cliffs drop off to the right, the expanse of the sea beyond stretching and shimmering into the horizon. The A17 is paved, I'll give it that. But no more. It is an unforgiving road, and brutal in the winter, according to the inhabitants of Eagalach. Because of its coastal location, sea storms and fog are a common problem, with entire sections sometimes closing due to mist. At several points it is impossible to see where any given curve ends – no trivial matter on a highway where signs reading "oncoming traffic in middle of road" dot the shoulder. Drivers struggle and twist vehicles up lonely stretches of asphalt only to be faced with the prospect of careening back down to where the road almost kisses the sand, breathless and white-knuckled around every turn, aware of having suddenly become the "oncoming traffic in the middle of the road." The drive from Eagalach to Bailetorach is over two hours. Over two hours of the A17.

It is not just the prospect of travel that frightens birthing women and their care providers in Eagalach. It is the remoteness of the place, the sense of being cut off from help, of having to fend for oneself. Speaking of midwifery students, Elizabeth said "I think for a lot of the younger girls who come it's quite frightening because they come from places where

they can press a buzzer and a pediatrician comes, or they have help immediately and we're not in that situation. I think that can be quite daunting for people." The fear is not a matter of substandard skills, it is a matter of having been trained in a medically dominated educational system, and of perceiving birth as an inherently dangerous event which might at any minute necessitate 'pressing a buzzer.' In the midwifery training scheme of the NHS, Eagalach has traditionally been one of the places where student midwives could be assigned in order to get intensive training because the midwives there have the reputation of being able to fend for themselves, confident enough in their skills to handle almost anything. The midwives of Eagalach pride themselves on their expertise – but that expertise has limits nonetheless. When asked about the implications of the loss of the Eagalach Memorial Hospital obstetricians, Elizabeth answered "Where are we going to be, what's going to happen? It makes us very nervous. Not because we're frightened of what midwifery skills we have, but we're not going to have any backup medically at all. Ask any midwife... I think they're very frightened...knowing what can go wrong in the blink of an eye in the most straightforward pregnancy ever."

What became clear in Elizabeth's interview was that the community liked its consulting unit and the high degree of technology and the safety they felt it brought them. The words of the post-Peel opinion of the Scottish Home and Health Department, "we think confinement in remote areas far from specialist units carries an inherent risk" (1973:13), still resonated, and in my survey data I saw evidence that this opinion had also been internalized by the women of Eagalach. I believe that among other social factors, one of the reasons the women in Bailetorach were not as invested in conversations about their region's maternity services was that they are not perceived to

be under threat. In Eagalach, years of close proximity to specialist consultants and the communal memory of stories of women and/or babies dead on the way to Bailetorach helped shape a definition of birth that was squarely pathological: the thought of change was paralyzing. A manipulation of this fear is one of the ways in which supporters of the medical model of birth have succeeded in naturalizing medicalization. Jordan, citing Bourdieu and Passeron (1977), calls this the process of 'misrecognition,' "whereby the authority of any knowledge system and the power relations supporting it and benefiting from it come to be perceived not as socially constructed, relative and often coercive but as natural, legitimate, and in the best interest of all parties." She further discusses the ideas of Charlotte Linde (1988), describing the ways in which "This process makes the achieved order of the world appear to be a fact of nature, with the consequence that the dominant positions in that order are also a fact of nature and hence cannot be changed. In other words, the best way to avoid change or revolution is to make change or revolution unthinkable" (Jordan 1997:57)

The midwives I interviewed all spoke of the importance of personal relationships with their patients. This type of relationship was echoed in the survey data I gathered from the women residing in the areas I studied. Physicians were seen by one woman as "medically interested not personally interested." Half of the women surveyed rated relationship with care provider 5 (somewhat important) or higher (very important). When asked to write the first thing that came to their minds upon reading the word "midwife," women chose either neutral descriptions (babies, birth) or those with a positive tone, such as "really brilliant" "trustworthy" "great, supportive" and "very nice people." When asked to do the same with the word obstetrician, women either responded with neutral comments (doctor, gynae

appointment) or those with a negative tone (scary, complications). I suspect that when midwives use the closeness of this relationship to exercise control over women, it is not done simply out of a spiteful urge to win a power struggle with obstetricians. Instead, it is my opinion that midwives may control women and restrict information in order to minimize risk – both to the patients and the midwives themselves. The complicated nature of this type of control is characterized best in the words of Morag, whose definition of midwifery care explicitly includes the minimization of risk, and illustrates the dynamic by which the special relationship between a midwife and a birthing woman can be used to steer women away from what are perceived as dangerous choices:

> If there is any doubt, you will be told you are not suitable for here. And you know the women are really good by and large. 99.9% of them will say to you, 'Ok, that's fine, you're telling me that.' But I think that's because they build up a really good relationship and good rapport with us so that they know that we're talking to them in their best interest. We're not just saying 'oh we don't want you here.' And they trust us, and that's the vital part of this kind of midwifery support.

I believe that the closeness and duration of the relationship between midwives and the women they assist, built on intimate ties between midwives and the communities in which they practice, on trust and on mutual respect, is instrumental in setting midwifery apart from obstetrics in the eyes of birthing women. However, it is also one of the means by which the medical model has been able to assert itself in the midst of midwifery. Elizabeth's fear over "the loss of the unit" reflects my observations that some midwives have accepted and internalized the definition of birth as a disaster waiting to happen. These midwives, to repeat the words of Morag, "are not in the business of taking chances with people's lives" – especially when the lives in question are those of neighbors and friends. In an area like Eagalach, where the horror stories are attached to familiar faces,

changing this definition would be unthinkable, and would call into question the multiple loyalties of a midwife daring enough to support such a change. Unlike Morag, whose unit would not accept women "if there was any doubt," the midwives at Gairdeachas, were willing to take on an the "high risk" case involving a grand multipara, and to support her choice for home birth. Do they care less about the women they serve and assist? I think not. I think it has to do with faith in the normal of birth – a faith that is fostered in a practice environment unclouded by the shadow of obstetricians.

In most of the maternity units I visited, "low risk" was conflated with normal. The best example of this is the "myth" that all first time mothers are required to give birth in the consulting hospital. The reason given for this is that they have no obstetric history and thus the course of their labor and delivery will be unpredictable. Unpredictable equals high risk. But normal birth involves risk – if nothing else, the risk that things will not go as planned. Physiological life processes are often "unmanageable," no matter how we try to manipulate them with pills, creams and surgeries. There is risk in driving a car, risk in playing ice hockey, risk in living. Some risks are socially acceptable, even seen as honorable, such as the risk a soldier takes for his or her country, or the risk in challenging an act of discrimination. Some risks are seen as unnecessary and foolish, such as hiking alone in winter, or driving home from a party after having had one too many martinis. It all depends on your perspective. Slowly but surely a consensus has been formed within Western medicine, in the face of refuting evidence, that birth is inherently risky, and that attempting it without medical surveillance and the intervention it entails is unnecessary and foolish (Jordan 1993). A midwife's approach to, as Elizabeth put it, "the thing that happens when there's nobody around to help" rests on her definition of normal. Is the

unpredictable, the unmanageable, the undesirable part of normal? While it is true that on the way to normal, there can be enough blind curves, mysterious forks in the road, and 180 degree spins to rival the A17, what is also true is that the majority of births do not *necessitate* medical intervention. Instead, what is often called for is a slower navigation of the curves and a careful attention to the changing terrain. Normal birth can be unmanageable and unpredictable. How one deals with this unpredictability is directly dependent on how one defines birth.

CONCLUSION

I began this study trying to understand if and why midwives might be contributing to the medicalization of childbirth. Why were some midwives espousing and idealizing birth as physiological but practicing and reinforcing birth as pathology? When I began my study, I had a vague sense that the answer would be related to distance – that medicalization would increase with proximity to the city while fear would decrease; that the definition of birth would be closer to normal the farther away I got from the urban centers. But this idea did not explain why, upon driving to one of the most remote maternity units in Scotland, I found a high level of technological dependence. It did not explain why, in the middle of the big city, the most pressing concern of birthing women was thought to be "that they get to [the hospital] in time." It did not explain why two units virtually equidistant from the nearest regional consulting hospital would exhibit such radically different models of care. Eagalach is far from the nearest big city, but so is Gairdeachas. Rather than muting the influence of the medical model, the distance has served to amplify it in Eagalach, while in Gairdeachas, distance has contributed to the thriving of a midwifery-led unit. Perhaps the relative degree of each unit's theoretical and clinical proximity to the roots of medicalization was a much bigger factor than its relative distance to the nearest big city.

The variations in the ways midwives approach the unknown of childbirth are linked to the ways in which birth is defined in their personal and professional contexts. Each midwife's definition of normal birth may lean far towards the "birth as pathology" end of the continuum, depending on her frame of reference. I, for one, can attest that as a health care provider having been trained in a hospital, and currently practicing where the

air is thick with paternalism and pathology, my own definition of normal birth necessarily involves a number of routine interventions. One sense of normal is "the way we normally do things" and in this understanding, at my hospital we do "normal" birth. The thought of doing birth without the "necessary" interventions and safeguards on which my practice is based is spectacular and unthinkable enough to make the home birth stories of Gairdeachas seem like so many fairy tales. Part of me thinks: *They lived happily ever after? Sure. What about latent sepsis? Malignant Hyperthermia? Postpartum hemorrhage? "The thing that happens when there's nobody around to help?" They won't always be so lucky, and eventually they will be sorry.* But what is different about Gairdeachas is that the unknown and the uncontrollable are accepted as part of the lived definition of normal birth. This is not to say that the midwives there do not refer women appropriately, or that they routinely take unnecessary risks. It is to say that in their lived definitions, doing absolutely nothing counts. Normal birth is birth without medical intervention. The quiet acceptance that the vast majority of births will turn out well is part of this definition. It is a definition that their particular social ecosystem of birth allows them to live freely.

The NHS, RCM, AIMS, WHO, the midwives in my study, even physicians agree on the point that midwifery is about normal birth. From there, however, the definition of normal runs off in a dozen different directions, fragmented and filtered down through pedagogical structures entrenched in paternalism, the interests of physician dominated or controlled legislative bodies, pro-midwifery political action groups, and Local Supervising Authorities, to a one on one interaction between a midwife and the woman she is assisting. Each midwife brings any number of contexts and influences to bear on

that interaction: proximity to and perceived need of physician assistance; access to literature and human resources; personal history as a student, a mother, and oftentimes, a nurse; the respect of a community of professional and personal peers. I believe the multiplicity of interests influencing key definitions is related to the conflicts I observed. The roots of these conflicts are multilayered and interwoven with the medical model. The midwifery model of birth is inherently at odds with the medical model. In accepting and internalizing medicalized definitions, midwives have become unconscious participants in the medicalization of childbirth. I believe this internalization was instrumental in creating the conflicts I observed in my data, in which midwives clearly had the best interests of women in mind and desired to provide woman-centered care. However, what is in the best interest of the birthing woman changes depending on whether one views birth as normal or pathological. The conflicts I observed between words and actions amongst a handful of midwives practicing in different settings thinly conceals a deeper set of conflicts about the birth process itself.

EPILOGUE

I began this paper by looking at a particular remote and rural location – the island – in order to determine why women there made the choices they did when other choices were available, and what part midwives played in influencing those choices. What I discovered is that the availability of choices is dependent on a collective definition of birth and that definitions are influenced by many, many factors. Since my visit two years ago, much has changed. Following a Highland-wide report, maternity services in the area have undergone major restructuring, not the least of which is the institution of a midwifery-led service on the island. The front page of the December 26th edition of the local newspaper shows a beaming woman holding a newborn baby girl, her sleeping head lolling to one side. The woman is surrounded by her husband, two other children, and two midwives. The baby was born at home. Her planned home birth is the result of years' worth of lobbying, reporting, studying and restudying, and gathering the evidence to secure governmental, community, and midwifery support for the women of the island to have more choices. Clearly, regional variations in the definition of birth do not reside in the midwife alone– they are shaped by countless influences, including the members of the community, what the Local Supervising Authority can afford and will allow, and the proximity of area physicians to name a few. In addition to the importance of birth definitions, what I hope to have demonstrated here is that the unique social ecology of each place I visited consists of many layers, all influencing one another. What the developments on the island might prove is that when the social ecology of the place is altered, changes in practice become possible, and alternate definitions of "normal" can begin to flourish. During this research trip, I was not able to return to the island. Future

research might investigate the factors that allowed for this dramatic change there, and the effects of the changes on childbearing women in the area.

Medical birth is here to stay. For many women, it is the preferred option. But it should not be the *only* option, and it should not be allowed to have Snow on the Mountain reign over birth. In my research, I did not observe one instance of a true midwifery model coexisting with the medical model. Instead, the more midwives were immersed in the medical context – either ideologically, physically or both – the further their practice was from "real midwifery." It seems that in order to acknowledge the medical model's contribution and still allow the midwifery model to remain viable, the two must be separated. In terms of strategy, it might be helpful to think like master gardener Janet Macunovich. She speaks of having successfully contained an invasive but useful plant by "leaving enough space between the bully and its neighbors so that the stems of the two plants would not interfere with each other...this means the plants have room to grow" (1997:75). It might seem daunting to imagine Scottish midwifery thriving on its own when its existence has been so closely linked with medicine for so long. However, it is helpful to remember that midwifery was there first. Many midwives cite a unique foundation of midwifery knowledge as the key to its unique perspective on birth. I believe that a truly midwifery-based definition of normal birth is the essence of that foundation, and that keeping all traces of the medical out of that definition is imperative to the survival of midwifery in Scotland. How might this be done? As Macunovich says, "When removing an established weed colony, work from the center of the plant out toward the perimeter" (1997:76). To work for change, one must strike at the root. Using

the best available evidence and speaking the language of those with the power to change things, opponents of the medicalization of childbirth may have just the tool for the job.

BIBLIOGRAPHY

Association of Radical Midwives
2000 *What is a Midwife?* Electronic document,
http://www.radmid.demon.co.uk/whatis.htm, accessed July 14, 2003

Ashkam, J. and Barbour, R.S.
2000 "The Role and Responsibilities of the Midwife in Scotland." In VanTeijlingen et al., eds. *Midwifery and the Medicalization of Childbirth: Comparative Perspectives.* Huntington, NY: Nova Science.

Banta, David
1980 "Benefits and Risks of Electronic Fetal Monitoring." In Holmes et al., eds. *Birth Control and Controlling Birth: Women Centered Perspectives.* Clifton, NJ: Humana Press.

BirthchoiceUK
2003 Basic Maternity Statistics for Scotland 2003. Electronic document,
http://www.birthchoiceuk.com/Frame.htm

Beith, Mary
1995 *Healing Threads: Traditional Medicines of the Highlands and Islands.* Edinburgh: Polygon.

Beech, Beverly
"Under-Motivated, Under-Skilled, Under Threat." *AIMS Journal*, Winter 2000/2001 12(4). Electronic document,
http://www.aims.org.uk/Journal/Vol12No4/undermotivated.htm, accessed June 25, 2002.

Bennett, Margaret
1992 *Scottish Customs from the Cradle to the Grave.* Edinburgh: Polygon.

Bower, Heather
2002 "Educating the Midwife" in Mander, R. and Fleming,V., eds. *Failure to Progress: The Contraction of the Midwifery Profession.* London and New York: Routledge.

Brody, H. and Thompson, J.
1981 "The Maximin Strategy in Modern Obstetrics." *The Journal of Family Practice* 12(6):977-986.

Brotherston, Sir John

1987 "The Development of Public Medical Care 1900-1948." In MacLachlan, G, ed. *Improving the Common Weal: Aspects of Scottish Health Services. 1900-1984.* Edinburgh: Edinburgh University Press.

Ministry of Health
1959 *Report of the Maternity Services Committee*. London: HMSO.

Cochrane, A.
1972 *Effectiveness and Efficiency: Random Reflections on Health Services.* London: The Nuffield Provincial Hospitals Trust.

Cochrane Collaboration
2003 The Cochrane Leaflet. Electronic document, http://www.cochrane.org/resources/leaflet.htm, accessed March 30,2004.

Coyle, Karen et al.
2001 "Normality and Collaboration: Mother's Perceptions of Birth and Centre Versus Hospital Care." *Midwifery* 17:182-193.

Davis-Floyd, Robbie
1993 "The Technocratic Model of Birth." In *Feminist Theory and the Study of Folklore.* Hollis et al., eds. Urbana, IL: University of Illinois Press.

Department of Health
1993 *Changing Childbirth: Report of the Expert Maternity Group.* London: HMSO.

Donnison, Jean
1988 *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth.* London: Historical Publications.

Dow, Derek, ed.
1988 *The Influence of Scottish Medicine : an Historical Assessment of its International Impact.* London: Parthenon.

Dowsell, Therese et al.,
2001 "A Review of the Literature on the Midwife and Community Based Maternity Care." *Midwifery* 17:93-101.

Duerden, Jean
2000 "Supervision at the Beginning of a New Century" in Mander, R. and Fleming, V., eds. *Failure to Progress: The Contraction of the Midwifery Profession.* London and New York: Routledge.

Fielder, D.

1997 "Authoritative Knowledge and Birth Territories in Contemporary Japan." In Davis-Floyd, R and Sergeant, C.,eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives.* Berkeley: University of California Press.

Fleming, Valerie
2000 "Statutory Control." In Mander, R. and Fleming, V.,eds. *Failure to Progress: The Contraction of the Midwifery Profession.* London: Routledge

Franklin, Sarah
1995 "Postmodern Procreation: A Cultural Account of Assisted Reproduction." In *Conceiving the New World Order: The Global Politics of Reproduction.* Ginsberg, F.D and Rapp, R. eds. Berkeley: University of California Press.

Garcia, J. et al.
1998 *First Class Delivery: A National Survey of Women's Views of Maternity Care.* London: Audit Commission.

Glasgow Royal Maternity Hospital *Register of Patients 1834-1961.* Greater Glasgow NHS Board Archive, Glasgow, Scotland.

Glasgow Women's Private Hospital *Case Notes 1903 – 1925.* Greater Glasgow NHS Board Archive, Glasgow, Scotland.

Gready, M., Newburn, M., Dodds, R. et al.
1995 *Birth Choices: Women's Expectations and Experience.* London: The National Childbirth Trust.

Heagerty, B.
1990 Class, Gender and Professionalization: The Struggle for British Midwifery 1900-1936. PhD Thesis Department of History, Michigan State University.

Hamilton, James
1795 *Select Cases in Midwifery; Extracted from the Records of the Edinburgh General Lying-in Hospital. With Remarks.* Edinburgh: P. Hill.

Henderson, Christine
1994 "The Education and Training of Midwives." In Chamberlain and Patel ,eds. *The Future of the Maternity Services.* London: RCOG.

Howell-White, Sandra
1997 "Choosing a Birth Attendant: The Influence of a Woman's Childbirth Definition." *Social Science and Medicine* 45(6):925-936.

House of Commons
1979 –1980 *Social Services Committee, Second Report, Perinatal and Neonatal Mortality.* London: HMSO.

House of Commons
1991-92 *Health Committee, Second Report, Maternity Services.* London: HMSO.

Hundley, V., Rennie, A.M., Fitzmaurice A., et al..
2000 "A National Survey of Women's Views of Their Maternity Care" *Midwifery* 16(4)303-313.

Hunt, L., Namino, M. and Halperin, D.
2002 "Childbirth Care Seeking Behavior in Chiapas" *Health Care for Women International*, 23:98-118.

Jenkinson, Jaqueline
2000 "Scottish Health Policy 1918-1948" in Nottingham, C. (ed) *The NHS in Scotland: the Legacy of the Past and the Prospect of the Future.* Hampshire: Ashgate Publishing Limited.

Johnson, Peter and The Midwifery Research Project Group
1998 "Midwife and Nurse Midwife: The Effect of Title on Perception and Confidence in Services Provided by Professional Midwives" *Journal of Nurse-Midwifery* 43(4)296-304.

Jones, Shirley
2000 *Ethics in Midwifery.* London: Harcourt Publishers Limited.

Jordan, Brigitte
1993 *Birth in Four Cultures: A Cross-Cultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States. 4th ed.* Prospect Heights, IL: Waveland Press.
1997 "Authoritative Knowledge and its Construction." In *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives.* Davis Floyd, R. and Sargent, C., eds. Los Angeles: University of California Press.

Kirkham, M
1996 "Professionalisation Past and Present: With Woman or With the Powers that Be?" In Kroll, D., ed. *Midwifery Care for the Future.* London: Balliere Tindall.

Leap, N. and Hunter, B.
1993 *The Midwife's Tale: An Oral History form Handywoman to Professional Midwife.* London: Scarlet.

Lichtman, Ronnie
2000 "Medical Models and Midwifery: The Cultural Experience of Birth." In VanTeijlingen et al., eds. *Midwifery and the Medicalization of Childbirth: Comparative Perspectives.* Huntington: Nova Science.

Lydon-Rochelle, M. et al.
2000 "Association Between Method of Delivery and Maternal Rehospitalization." *Journal of the American Medical Association* 283:2411-2416.

Macunovich, J.
1997 *Caring for Perennials: What to do and When to do it.* Pownall, VT: Storey Books.

Mander, R. and Fleming, V. ,eds.
2002 *Failure to Progress: The Contraction of the Midwifery Profession.* London: Routledge.

Mander, R. and Reid, L.
2002 "Midwifery Power." In Mander, R. and Fleming, V.,eds. *Failure to Progress: The Contraction of the Midwifery Profession.* London: Routledge.

Marshall, Rosalind
1983 *Virgins and Viragos: A History of Women in Scotland from 1080-1980.* Chicago: Academy Chicago.

Maternity Services Advisory Committee
1982 *Maternity Care in Action Part 1 – Antenatal Care.* London: HMSO.

Maternity Services Advisory Committee
1984 *Maternity Care in Action Part 1 – Care During Childbirth.* London: HMSO.

Maternity Services Advisory Committee
1985 *Maternity Care in Action Part 1 – Care of the Mother and Baby.* London: HMSO.

Metland, D. and McGrail, A.
2003 *Your Pregnancy 1st Edition 2003.* Norfolk: Bounty Limited.

Ministry of Health
1959 *The Report of the Maternity Services Committee.* London: HMSO.

MORI
1993 Maternity Services Report. *Research Study Conducted for the Department of Health.* London: Department of Health.

Morton, T.
1993 Three Die After Ambulance Crashes on Black Ice. *The Scotsman*, December 16:A1.

Newman, Thomas B.
2003 "The Power of Stories Over Statistics." In *British Medical Journal* December 327:20-27.

The Nursing and Midwifery Council
2000 *Statistical Analysis of the Register 1 April 2001 to 31 March 2002.* Electronic document, http://www.nmc-uk.org/nmc/main/publications/Statistical_Analysis_2002.doc, accessed March 30, 2004.

O'Neil, Fiona
2000 "Speaking in a Different Voice? Devolution and Nursing." In Nottingham, C., ed. *The NHS in Scotland: the Legacy of the Past and the Prospect of the Future.* Hampshire: Ashgate Publishing Limited.

Palmer, A
1995 "Now, Then, What Seems to be the Trouble?" *The Spectator* 29 July 9-12 In Jones, Shirley 2000 *Ethics in Midwifery.* London: Harcourt Publishers Limited.

Porter, M.
"Changing Childbirth? The British Midwife's Role in Research and Innovation." In VanTeijlingen et al., eds. *Midwifery and the Medicalization of Childbirth: Comparative Perspectives.* Huntington: Nova Science.

2002 *Ready Steady Baby: A Guide to Pregnancy, Birth and Early Parenthood: Revised Second Edition.* Edinburgh: Health Education Board for Scotland.

Reid, Lindsay
2000 *Scottish Midwives: 20th-Century Voices.* East Linton: Tuckwell Press.
1997 "The Challenge of Negotiating the Maze of Woman-Centered Care in Scotland." *British Journal of Midwifery.* 5(10)602-606.

Registrar General of Scotland
2003 *Scotland's Census 2001:Key Statistics for Council Areas and Health Board Areas Scotland.* Edinburgh: National Statistics.

The Royal College of Midwives
2004 News. Royal College of Midwives Journal. Electronic resource, http://www.midwives.co.uk/default.asp?chid=439&editorial_id=13602, accessed 4/19/2004

Royal College of Obstetricians and Gynecologists
1992 *Maternity Care in the New NHS. A Joint Approach.* London: RCOG.

Sargeant, Liz
2002 "Practice and Autonomy." In Mander, R. and Fleming, V., eds. *Failure to Progress: The Contraction of the Midwifery Profession.* New York: Routledge.

Sandall, Jane
2000 "Choice, Continuity and Control: Changing Midwifery Towards a Sociological Perspective." In VanTeijlingen et al., eds. *Midwifery and the Medicalization of Childbirth: Comparative Perspectives.* Huntington: Nova Science.

Schan, Pat
1998 "Lost in a Maze." *Midwifery Matters* 77:Summer. Electronic document, http://www.radmid.demon.co.uk/patschan.htm, accessed December 6, 2002.

Scottish Office Home and Health Department
1993 *Provision of Maternity Services in Scotland. A Policy Review.* Edinburgh: HMSO.

Scottish Home and Health Department
1973 *Maternity Services - Integration of Maternity Work: Report of a Joint Sub-Committee of the Standing Nursing and Midwifery Advisory Committee and the Standing Medical Advisory Committee of the Scottish Health Services Council.* Edinburgh: HMSO.

Scottish Intercollegiate Guidelines Network *Introduction*
www.sign.ac.uk/about/introduction.html 4/19/2004

Standing Maternity and Midwifery Advisory Committee
1970 *Domiciliary Midwifery and Maternity Bed Needs: Report of a Sub-Committee.* London: HMSO.

Taylor, Meg
2000 "Is Midwifery Dying?" *Midwifery Matters* Spring:84. Electronic document, http://www.radmid.demon.co.uk/megtaylor.htm, accessed December 6, 2002.

Tew, Marjorie 1990 *Safer Childbirth? A Critical History of Maternity Care.* New York: Chapman and Hall.

Thomas, Pat
2002 "The Midwife You Have Called Knows You Are Waiting...A Consumer View." In Mander, R. and Fleming, V., eds. *Failure to Progress: The Contraction of the Midwifery Profession.* London: Routledge.

Towler, J. and Bramall, J.
1986 *Midwives in History and Society.* London: Croom Helm.

Tough, Alistair
2000 The First 50 years of the NHS in Scotland. A Less Celebratory View in Nottingham, C., ed. *The NHS in Scotland: the Legacy of the Past and the Prospect of the Future.* Hampshire: Ashgate Publishing Limited.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting
1987 "The Future Preparation of Nurses, Midwives, and Health Visitors." In *Project 2000: a New Preparation for Nurses.* London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting

1998 *Nurses, Midwives and Health Visitors (Midwives Amendment) Rules.* London: UKCC.

Walton, I. and Hamilton, M.
1995 *Midwives and Changing Childbirth.* Cheshire: Books for Midwives Press.

Blenkinsop, H.ed.
1863 *Observations in Midwifery : as Also The Country Midwifes Opusculum or Vade Mecum.* Warwick: H.T. Cooke and Son.