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Thesis title:

An investigation into how midwives make sense of the concept of risk: how do midwifery perceptions of risk impinge upon maternity care services?

Centre for Health Service Studies
School of Social Policy, Sociology and Social Research

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Mandie Scamell
Name of degree:
PhD
Date: Sept. 2011

Acknowledgements

There are a number of people without whom this thesis would not have been possible: Prof. Andy Alaszewski, whose constant and insightful supervisory support has been inspirational; the Economic and Social Research Council, who, by funding my PhD, gave me the opportunity to carry out this investigation; Alison Barker, who tenaciously examined my grammar and spelling; and the clerical support staff from the SSPSSR postgraduate office, who have patiently ensured that I have stayed on track.

My analysis of risk within midwifery talk and practice could never have happened without the wonderful midwives and mothers who generously agreed to participate in this study. I would like to thank each and every midwife for taking the time to talk to me and for putting up with my constant barrage of questions.

Finally, I would like to thank my two lovely children for accepting my academic endeavours without question, my friend and fellow PhD candidate, Jo Dagustan, for being my sounding board and conference buddy, and my sister Jo, for always being there and for managing to stay alive right up to my submission date.

Abstract

This thesis is the product of an ethnographic discourse analysis of midwifery talk and practice, and the data used to inform this work was collected in the south-east of England. The analytical focus of the thesis is on how risk is understood within the context of midwifery knowledge and expertise and how this is expressed within contemporary childbirth performance. The proposition being made is that the meaning of risk should not be taken as a given and that, although much of routine midwifery activity circulates around sensitivity to risk, the precise meaning of risk is rarely articulated or questioned by practitioners.

By using a combination of both qualitative methodological and analytical devices, it has been possible to explore the social and political operations of the interpretative work midwives do when translating risk into meaningful action and the impact this has upon the way birth can be both imagined and performed. Through the detailed scrutiny of midwifery talk and practice, the meaning of risk in this context has been unpacked to reveal a ubiquitous discourse where risk is understood as something bad and something to be avoided. Pervasive though this discourse of risk has been shown to be in this thesis, the analysis also reveals unsettling midwifery activity taking place at the margins of this discourse of risk.

The thesis shows that the meaning of risk within midwifery talk and practice is far from straightforward. Through the application of a qualitative methodological toolkit, which provided both the flexibility and the analytical sensitivity necessary for examining the finer details of social activity, it has been possible to explore how risk operates through and upon midwifery agency.

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List of Abbreviations

ARM	Association of Radical Midwives
CMB	Central Midwives Board
CNST	Clinical Negligence Scheme for Trusts
GMC	General Medical Council
HCC	Health Care Commission
HSE	Health and Safety Executive

ICM	International Conference of Midwives
NCT	National Childbirth Trust
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council
NSF	National Service Framework
RCM	Royal College of Midwives
UK	United Kingdom
WHO	World Health Organization

Chapter 1: Thesis Introduction

Introduction

This thesis presents an empirically-based analysis of how risk is articulated through midwifery talk and practice in the south-east of England. The research was sponsored by the Centre for Health Service Studies at the University of Kent and was funded by the Social and Economic Research Council (see Appendix 1). It is the objective of this chapter to introduce the case for concern and to offer an orientation to both the structure of the thesis and how the thesis engages with the research problem. This task will be arranged around three sections. The first section will introduce the meaning of risk in maternity care from an embodied perspective. In this section, risk in birth performance will be introduced from the service user and service provider perspective. The second section, in contrast, will locate birth performance and the articulations of risk within that performance in its socio-historic contingent in relation to both current policy and academy attention. In these two sections, the meaning of risk within this context of maternity care will be problematised and the justification for the analysis presented. Finally, the thesis structure will be outlined.

1.i The embodied perspective

This introduction opens with a brief autobiographical account of my personal encounter with risk and childbirth, as a mother and as a midwife. Such privileging of what can be described as experiential knowledge is included for both theoretical and methodological reasons. This personal narrative provides an opportunity to glimpse the complexities involved in the research problem which underpins this thesis – social construction of risk in midwifery discourse; it also stands as testament to the ethnographic discourse analysis and research design, where reflexivity, author

ownership and narrative are paramount (Clifford and Marcus 1986; Denzin 1998; Denzin 2002). As Geertz pointed out:

> 'What we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to' (Geertz 1973 p. 9).

This autobiographical effort is not an attempt to produce an auto-ethnographical account; rather, it shows how the researcher is complexly situated within the research design, process and text production. Once the subject of this thesis has been introduced and problematised, using the technique of autobiography the chapter will proceed to present a more formal introduction by engaging with risk and birth performance.

The journey

There have been two strands to my intellectual and emotional interest in risk and childbirth, each directly driven out of the previous. I began my journey into this territory as a pregnant anthropology undergraduate, which turned out to be much more of a life-changing event for me than I had ever expected. Being an expectant mother made me feel as if the rest of my life had been some kind of trial run. Becoming a mother fundamentally transformed my relationship with my work, my friends, my husband, my mother, and perhaps most unexpectedly, with myself.

During pregnancy and, guided by my midwife, I entered the discourse[1] of normal, or what is sometimes referred to as natural,[2] childbirth and eagerly consumed the work of Gaskin (1975), Odent (1984a; 1984b), Leboyer and Fitzgerald (1975), Kitzinger (1988), and Balaskas (1983). These and other works highlighted for me the issue that would later be the cornerstone of my interest in the role of risk in childbirth discourse in that they valorised an understanding of birth where the woman's body could be conceptualised, not as a site of risk, but as essentially competent.

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[1] Discourse is understood here in Foucauldian terms to mean a set of related statements expressed through text and social action (talk and interaction), which both enables and constrains particular ways of understanding the world. Importantly, discourse is understood not only to constitute social action but itself to be constituted through the process of that action.

[2] The meaning of normal/natural birth is contested in the literature. For details see Chapter 6.

Through my dealings with the medical profession while pregnant, I became fascinated by the tension I was obliged to negotiate between the seemingly competing sets of statements attached to childbirth which prevailed at the time, that is, the natural birth discourse and the medical discourse of birth (in the latter, birth is assumed to be pathological until after the event). I began to wonder about the credibility of the claims made with regards to the nature of childbirth and the role these claims played in how birth could be imagined and performed.

Pregnancy afforded me the opportunity to take up yoga practice for the first time and it was partly through this embodied experience that I carefully planned my home birth, which was to be attended only by a fellow anthropology student, who was also a qualified midwife and friend. These plans were laid upon a kind of faith in my own body, a trust that I could do this thing called childbirth in the privacy of my own home.

My first personal encounter with what I became to realise was the impenetrable face of risk arrived with the passing of my due date. Up until that point in my pregnancy, the estimated nature of this date was always emphasised by all the health professionals I had seen. However, during the week following this date the language changed, the estimation value slipped away from the conversation, and each passing day transmuted into imperative and accumulative risk factors, associated with placenta degradation and fetal compromise. My baby's health status was suddenly encased in uncertainty.

This perceived risk was later compounded by a rise in my blood pressure, at which point all notions of self-autonomy vanished and my midwifery support crumbled, with my midwife hastily retreating from my care. I was left with the prospect of obstetric-led care for my own and my baby's safety, which could only take place within the hospital environment.

After giving birth to my daughter, I was puzzled as to where this insurmountable risk had sprung from. What had happened to my normal birth? Why had this discourse

of normality been so fragile? These questions drove the second strand of my engagement with risk and childbirth performance and, in an attempt to unpick them, I qualified as a midwife. During my training, my attention began to turn towards the precarious predicament within which midwives practise, where seemingly competing professional priorities jostle for supremacy through everyday midwifery activity. My experiences of becoming a midwife were unexpectedly reminiscent of my experience of becoming a mother, as midwifery training and practice challenged my conviction that women possessed capable bodies and that birth could and should be imagined to be a normal physiological process without the need for medical surveillance tools, strict timelines and technocratic interventions.

Of course, like all midwives, I acclimatised to this environment through the process of professional socialisation, becoming well versed in the techniques needing to be demonstrated in order to maintain my status as a health professional. However, the works of Kirkham (Kirkham 1999), Walsh (Walsh 2001; Walsh and Newburn 2002a; Walsh and Newburn 2002b) and Leap (1997), midwives who have researched and published about the cultural tensions within midwifery, resonated so much with my own personal experiences of being a midwife that I became inspired to explore the political dynamic of midwifery in more depth. This process was started through a taught MA in Social Research Methods at the University of Kent. Here, I was introduced to the social theory of risk and realised that the analysis of risk may offer an insight into the crucial component of understanding why, despite the efforts of midwives, women's pressure groups and health policy initiatives to promote and encourage the proliferation of normal childbirth, a preoccupation with medical surveillance and technological intervention continues to prevail.

This current project, therefore, is driven out of my own encounters with risk and birth, firstly as a birthing mother, secondly as a practising midwife and, lastly, as a social science student. This PhD thesis represents a synthesis of all three of these encounters; it is a weaving together of the divergent strands of my experiential knowledge of birth and risk and as such is a partisan account of birth performance in the United Kingdom (UK). My embodied experience of birth performance

crystallised into a quest to understand the perceptions of risk in childbirth and the impact these have upon how birth can be performed.

1.ii Articulations of risk in birth performance using a wider perspective

Having used an autobiographical account to introduce some of the issues surrounding the research problem I am dealing with, I shall now move on to look at this issue from a different perspective. In the following section, I locate the research interest which informs this thesis within the current socio-political context. Although my theoretical orientation to risk may already have been made apparent by the above account, I feel a more explicit explanation should be added at this point. The analytical focus of this thesis is on the social construction of risk. The principal aim of the research has been to understand how risk in birth performance is at once constituted by midwifery activity while at the same time operating to constrain and facilitate midwifery ways of knowing about birth. While attempts to measure risk in terms of statistical probability will not be completely absent from the account, this will not be the primary focus. That is not to say that others have not achieved valiant, and I have to say quite persuasive, attempts at completing this formidable task (Wagner 1994; Goer 1995; Beech 2000; Chalmers et al. 1989); it is just to say that risk, here, has not been explored as a series of measurable and epidemiological facts; rather, it is positioned as a discursive formation made possible through a specific socio-historic contingent. To give a sense of why I considered this theoretical approach to be important, I will now give an overview of how birth is understood and made sense of in today's cultural context.

The context

In 1992, the House of Commons Health Select Committee on Maternity Services reported that:

> 'This Committee must draw the conclusion that the policy of encouraging all women to give birth in hospital cannot be justified on grounds of safety' (House of Commons 1992 p. XII).

Furthermore, the report goes on to state:

> 'There is no convincing or compelling evidence that hospitals give a better guarantee of the safety of the majority of mothers and babies. It is possible, but not proven, that the contrary may be the case' (ibid. p. XII).

These conclusions represent a radical departure from maternity policy published during the twenty years preceding this report. In particular, they position women's birthing bodies in relation to safety and risk in a new and novel way. As the 1980 Social Services Committee referenced in the House of Commons (House of Commons 1992 p. VIII) shows, previous policy recommendations coalesce around understanding that birth is inherently unreliable, unpredictable and risky. Women's bodies, when birthing, were represented as posing a nebulous threat to the well-being of their unborn child. Due to these risks, it was recommended that the performance of birth should take place within the hospital environment (Department of Health and Social Security 1970), where all the necessary technology and expertise are close at hand 'just in case'. By its very nature, therefore, birth demanded intensive care standard medical surveillance, control and intervention.

Despite the 1992 groundbreaking report, which refused to accept that the majority of births posed a physical threat to the mother and baby (House of Commons 1992 p. V, point 4), and the subsequent health policy and professional and service user action campaigns, all of which endorse such repositioning of birth in relation to risk, home birth has remained surprisingly low. In 2009, 97.3% of women chose to give birth within a hospital ward setting (Office of National Statistics 2009/2010), while normal birth rates have continued to decrease and Caesarean section rates to increase (NHS Information Centre 2009). It is the premise of this thesis that this apparent resistance to policy drivers, aimed at curbing the routine medicalisation of birth and the midwifery role in this, deserves academic attention and empirical investigation. Furthermore, it is the premise of this thesis that the entrenchment of medicalised birth practices is a case for concern. Therefore, the object of this thesis is to investigate the interpretative work midwives do in the social construction of risk within contemporary discourses of birth, and to interrogate how this work impacts upon how birth can be imagined and performed. This has been done in an effort to understand why, despite national health policy, professional and service user

pressure, all aimed at the re-categorisation of birth as a health and well-being indicator rather than as a site of risk, does birth continue to be managed within a discourse of intensive medicalisation?

The problematisation of birth performance

I start from the position that current birth practice can be problematised as a case for concern for two related reasons.

Firstly, I posit that it is problematic because implicit in the choice to hospitalise birth is the belief that birth is best understood as a site of risk (Gould 2000), suggesting that both women and health care professionals involved in maternity care concur that women's ability to give birth spontaneously, that is without recourse to technoscientific intervention and control, should never simply be assumed to be possible. Such a position is considered to be suspicious because, as a significant body of feminist literature has argued, such a standpoint constitutes gendered power relations where women are positioned as inferior or inadequate physical beings, (Murphy Lawless 1998; Marshall and Woollett 2000; Martin 2001; LoCicero 1993). Current birth practices, therefore, can, it has been suggested, be investigated as evidence of a resilient gender inequality.

Secondly, I suggest that current birth practices are problematic because of a persistent increase in medical interventions, including Caesarean section, and a decrease in normal birth rates (NHS Information Centre: Hospital Episode Statistics 2010). Increases in the routine medicalisation of birth not only have massive cost implications for government spending in the National Health Service (NHS) (Devane et al. 2010; National Institute for Health and Clinical Excellence [NICE]: National Collaborating Centre for Women's and Children's Health 2004),[3] they also operate to confirm the engendered assumption that women should be thought of as being essentially inadequate.

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3 NICE estimated that a normal vaginal delivery costs between £629 and £1,350 including postnatal stay, compared with a Caesarean section costing between £1,238 and £3,551.

The credibility of the routine medicalisation of the birth process rests upon an understanding that the proliferation of active management practices in childbirth precipitates an increase in safety for both mother and child. While this is unarguably the case in relation to the introduction of aseptic techniques, antibiotics and blood transfusion technologies (Gabe et al. 2004; Tew 1990), the empirical justification for the prevalence of the other technologies, such as the liberal use of hospitalisation, Caesarean sections, forceps, ventouse, induction and augmentation techniques, and electronic fetal monitoring, has been widely contested (Odent 1984a; Chalmers et al. 1989; Johanson, Newburn et al. 2002; Hodnett, Downe et al. 2010; Mander 2008; World Health Organization 2009).

Common-sense understanding of the process of medicalisation rests upon two mutually dependent assumptions. The first, discussed above, is that birth, by its very nature, is best conceived as being a site of risk. The second is that medical surveillance, intervention and technology somehow mitigate that inherent risk. It is the aim of this thesis to not only resist the trenchant allure of this common sense but to unpick the precise nature of the midwifery position to this way of making sense of birth performance.

The paradox of risk

Although it is not the intention of this thesis to examine risk objects in birth as statistical probabilities, a broader account of the decline of hazards associated with birth performance is useful as a starting point to provide clarity about the research problem underpinning this thesis. In particular, it is used here to give a sense of the paradox in which risk is suspended. Early accounts of childbirth portrayed experiences that were fraught with threats and danger to maternal and neonatal health and well-being, affecting peasantry, the urbanised proletariat, industrialists and gentry alike. Furthermore, the picture did not improve as the 'science' of obstetrics developed through the seventeenth and eighteenth centuries, when women were subjected to the effects of poor hygiene and brutal, instrumental procedures, which were frequently the cause of maternal and neonatal mortality and morbidity (Donnison 1988; Tew 1990).

Accounts of maternal death rates for this period are sketchy and vary, the Department of Health's Confidential Enquiries into Maternal Deaths only being established in 1952. However, seventeenth-century England estimates taken from the London Bills of Mortality indicate that 'three (women) in two hundred died in childbed' and around one in two hundred from 'hardness of their labour' (Donnison 1988). It is not surprising, therefore, to find Elizabethan women commissioning portraits of themselves, pregnant, because they feared that they would not survive the ordeal of giving birth (Possamai-Inesedy 2006).

Grim though this picture of birth for the mother is, the situation was significantly grimmer for the child. During the 1700s and 1800s, when managing difficult deliveries, it was not uncommon for doctors to deliberately sacrifice the life of the baby to try to save the life of the mother. Birth assistance during this period came from either untrained female midwives or, from around the early 1700s, male barber/surgeons, whose role, if you could afford it, was to utilise instruments for fetal destruction. Stillbirth and neonatal death were accepted as an inevitable part of the birthing experience, even welcomed in some cases as a natural form of birth control, with estimated infant mortality rates of approximately 150 per 1,000 live births between the years 1896-1900 (Tew 1990). Childbirth then, particularly for the baby, was a hazardous affair where:

> 'fears and anxieties of our 17th century counterparts were bound within living reality. Negative outcomes of pregnancy were expected and attributed to fate, nature or the ineffable intentions of the Deity' (Possamai-Inesedy 2006).

In this world, the insecurities that surrounded pregnancy and childbirth were tangible but, all the same, they were managed within a cultural repertoire, where:

> 'magic, combined with a dash of Christianity, served as the belief system by which threats and dangers were dealt with conceptually and behaviourally, allowing people to feel as if they had some sense of control over the world' (Lupton 1999a p. 22).

Risk – everywhere and nowhere

In contrast, today, as a direct result of improvements in the standard of living, childbirth is no longer associated with the hazards with which it once was (Tew

1990). In the UK, for example, the majority of women can expect to live into old age despite their reproductive careers. It is not surprising, therefore, that maternity health care policy no longer exclusively lingers on the issues of morbidity and mortality and instead centres on maternal choice and personal autonomy (House of Commons 1992; Bourgeault et al. 2001; Department of Health 2007), where the contemporary self can act as 'a reflexive project, for which the individual is responsible' (Giddens 1991 p. 75). Within this socio-historic contingent, women are encouraged to purposefully design their birth experience as part of the late modern process of reflexive autobiography (Bourgeault et al. 2001; Beck et al. 1994). And yet, despite the changes in late-modern society, birth continues to be performed within a culture of fear, where confidence in the possibility of a spontaneous vaginal birth is low (Reiger 2006), and where sensitivity to risk is amplified (Furedi 1997). Paradoxically, women, and their families, now enjoy safer birth experiences than ever before. So safe that picking and choosing the type of birthing environment and care to access is the mantra of contemporary maternity health policy; while, at the same time, women perform birth in ways which tell quite a different story, a story where sensitivity to risk is at an all-time high and demand for medical management remains firmly entrenched (Wagner 1994; Johanson et al. 2002; Henley-Einion 2003; Lowis and McCaffery 2004; Weir 2006). Put another way, birth is performed within a paradox of risk, where risk is at once omnipresent but simultaneously is, statistically speaking at least, insignificant. Risk is everywhere and nowhere.

It is the aim of this thesis to explore this apparent paradox in relation to midwifery activity. Through the detailed scrutiny of everyday midwifery talk and practice, this research attempts to unravel the complexities involved in the interpretative work midwives do when making sense of risk. Furthermore, through this analysis, a tentative explanation of how this might impact upon the manner in which birth can be imagined and performed will be proposed.

1.iii The thesis structure

Having identified the key concerns which underpin the analysis presented in this thesis, the introduction will now move on to look briefly at each of the chapters in turn.

Chapter 2 unpacks the research problem in more detail by locating it within the social science of risk literature. In this chapter, risk in the context of maternity care is described in relation to four perspectives. Starting with an exploration of the taken-for-granted understanding of risk as represented in the dominant/technical paradigm of risk, the chapter goes on to problematise this understanding using: first, the reflexive modernisation thesis of the Risk Society; second, the cultural analytical framework; and finally turning to the governmentality literature. Through this overview of the literature the theoretical and analytical framework of the thesis is introduced.

Chapter 3 describes the research design and methodological orientation adopted to carry out this research. In this chapter, the research questions are used to explain precisely why and how data was collected. Within this chapter, I review the literature in an effort to make a case for justification for choosing an approach which collapses an in interest ethnography and discourse. I will defend the methodological synchronisation of these two devices by giving an indication of how they have been fruitfully applied within this investigation.

Chapter 4 contextualises the research within current health policy drivers which coalesce around risk and risk management. In particular, this chapter looks at how understanding of risk within maternity care is embedded within the contemporary policies surrounding risk management and clinical governance. By reviewing this policy it was possible to give an indication of the discursive environment in which midwifery practice in the UK is placed. This chapter also acts as a bridge to the rest of the thesis in that it introduces some primary data into the discussion.

Chapters 5 to 9 are all data analysis chapters and are arranged around certain themes which emerged during the data analysis process.

Chapter 5 follows directly on from the policy chapter to unpack the dominant themes in how the meaning-making of risk can be articulated through midwifery everyday talk and practice. This chapter introduces the irresistible scare factor of risk, consistent with Beck's Risk Society thesis.

Chapters 6 and 7 take a more cultural approach to the social construction of risk and synthesise this approach with a concern for how risk operates as a form of subjugation through routine midwifery practices. These chapters look at the work midwives do when balancing concordant professional discourses: one, privileging risk sensitivity; the other, the possibility for normal physiological birth. In Chapter 6, the emphasis is on risk communication. Using Armstrong's Foucauldian framework of routine surveillance medicine, the chapter shows how routine midwifery activity can unsettle normality. In Chapter 7, this idea is developed by an exploration of the language of risk and normality and the temporal sandwiching of birth within what Heyman calls the risk virtual object and hindsight bias.

Chapter 8 looks at another central mantra within midwifery discourse – the facilitation of informed choice through women-centred care – to see how this professional priority interfaces with midwifery concerns for risk and risk avoidance. In this chapter, the operations of risk within midwifery talk and practice are explored in order to ascertain how they confine choice within the context of accessing maternity care.

Finally, in the last data chapter, *Chapter 9*, midwifery activity at the margins of the dominant/technical paradigm of risk, as it is represented through the standardisation of care in clinical governance of risk, is explored. Despite the ubiquitous commitment to institutional risk management demands, much midwifery activity went on at the fringes of this discourse and it is this activity that forms the focus of this chapter. The creative ways in which midwives subjugated systems of encoded knowledge in an effort to offer individualised care which promoted the possibility for normal birth are described.

Comment

In this chapter, I have used a combination of techniques to introduce this thesis and the case for concern the thesis will engage with. By locating the work within an embodied biographical account and within a wider socio-political introduction, I have been able to represent a personal journey started by an initial question which developed out of the puzzlement of personal experience and was refined through academic work to reach this point – my PhD thesis. Through this account, I have endeavoured to present the case for why I believe empirical investigation into the interpretive work midwives do in the social construction of risk is imperative for understanding how birth can be performed. It is the intention of this thesis to present this empirical evidence as a vehicle for understanding why, despite national health policy, service user and, ironically, professional pressure, all aimed at the re-categorisation of birth as a health and well-being indicator rather than a site of risk, does birth continue to be managed within a discourse of intensive medicalisation?

Chapter 2: Literature Review: A Theoretical Overview

Introduction

This chapter has two aims:

1. To locate this thesis within the social theory of risk literature.
2. To provide a social and historic context for the performance of birth and the midwives' role in relation to that performance.

This chapter will, therefore, both contextualise the theoretical approach which has informed this thesis as well as give a sense of the cultural context in which the focus of this research – midwifery talk and practice – takes place. Since the latter objective will be supported by the subsequent social policy chapter which is to follow, the primary emphasis here will be on an engagement with the social theory of risk literature in order to explore how this can be utilised to help understand the interpretive work midwives do in relation to birth and risk.

2.i Considering the risk literature

The risk epidemic

Risk has attracted, and is continuing to attract, enormous academic and corporate interest and activity in recent years. This activity cuts across discipline boundaries; indeed, it infiltrates every aspect of organised life, as Power (2004) points out:

> 'Not only private sector companies, but hospitals, schools, universities and many other public organisations, including the very highest levels of central government, have been invaded to varying degrees by ideas about risk and its management' (2004 p. 8).

Various metaphors have been used in the literature to describe this activity. Taylor-Gooby (2002) describes it as a 'mushrooming'; Skolbekken (1995) a 'risk epidemic'; whereas Gabe (1995) goes so far as to describe it as 'an explosion'. Regardless of which metaphor is used, they all carry the same message: risk is a concept to be reckoned with in any analysis of contemporary society.

This enormous academic and operationally-driven activity which has surrounded risk in recent years means that the literature covers a broad spectrum of interests ranging from the highly-academic analysis to applied studies of risk management (Taylor-Gooby 2002). Or, as Green (2009) describes it:

> 'As an incitement to discourse, the call to 'risk' has been remarkably productive, generating a resurgence of multidisciplinary research, headlining generous calls for funded research, instigating new journals and reinvigorating research that deals with the relationships between global structures and how individuals interpret, negotiate and resist those structures' (Green 2009 p. 493).

Despite or, arguably, because of, the numerous projects risk attracts, it is not easy to identify any overarching common themes. As Zinn points out: 'there is comparatively little theoretical integration or discussion between the different approaches' (Zinn 2006). For some authors, the imprecision and insufficient conceptual clarity which has come out of this exuberant activity has rendered the term almost obsolete (Green 2009; Dowie 1999; Luhmann 2005), and it certainly makes for difficult literature review. While there is much to be said for this concern with the risk debate, I feel justified in contesting the 'risk is obsolete' assertions forwarded by Green, among others, on three counts:

1. These exasperations with regards to risk may be an apt description of how it is talked about within the academy. However, I do not feel that it is a fair description of how risk works out there in the real world. In maternity care, for instance, surprisingly little empirical investigation has been carried out to interrogate how risk is made sense of in and through midwifery practice. This is despite the fact that risk has exploded within maternity care as much as it has in any other area of health; indeed, arguably more so in the field of obstetrics as this is considered to be one of

the highest risk areas in the NHS, accounting for the majority of the litigation payments (National Health Service Litigation Authority 2008b). Take, for example, Symon's (2006) book *Risk and Choice in Maternity Care.* It can be rightly argued that the enigmatic nature of risk is evident. However, although the volume is sprinkled with contributions which set out to problematise the operation of risk within the maternity care setting, the work is subsumed by a taken-for-granted understanding of risk where, what can be described as the dominant/technical paradigm of risk management (described below), confines health professionals' activity. Green is quite right in her observations that the social theories of risk offer a rich and, in some cases, divergent, account of the way risk operates. I do not concur, however, that this renders either the term itself or theoretical contributions which attempt to describe and explain it, invalid. Academia simply does not work like that. Indeed, it is those very ontological complexities that academia thrives, even relies, on. As Bell puts it: 'Theoreticians... cease to be interesting, or to offer any hope for the future, whenever they imagine their ideas to encapsulate all that there is to be said' (Bell 1999 p. 3).

2. By focusing on the lack of integration of the theoretical approach Green implies that these contrasting theories of risk are incompatible. The experience I have gained during this PhD of researching risk in the field, however, does not appear to corroborate this claim. Indeed, if anything, I have found evidence to support a varied and flexible approach to risk, suggesting that the distinct theories need not be thought of so much as discordant, as concordant.
3. It is the proposition of this thesis to suggest that the profuse and multifaceted response to risk can, somewhat ironically, be adequately explained through the application of one of those facets in risk theory itself. The fragmentation of the expert's voice, which is how Green describes the risk debate, is precisely that which Beck describes in his analysis of risk (Beck 1992; Beck et al. 1994; Beck 1998). What I am proposing here is that the incoherence in the literature identified by Green should not be seen as a mark of the end of risk, so much as a living example of what Beck calls the 'Risk Society'. But, by drawing upon this theory I am getting ahead of myself. Suffice to say, I think a defence against Green's critique of the risk debate can be found from within the debate itself.

Unlike many contributors to the current risk debate, in this thesis I have tried to embrace the diversity of risk theory and have used it to enrich my analysis of risk in midwifery talk and practice. In an attempt to capture the diverse nature of the literature dealing with risk which has informed this project, I will now navigate my way through the material by drawing on some of the key components that have helped inform and orientate my research. Starting with a description of the dominant/technical paradigm of risk, which, as will be demonstrated in more detail in the subsequent policy chapter, is, I suggest, the most prevalent understanding of risk in the maternity care context, I will then move on to describe the three other theoretical perspectives of risk:

1. The reflexive modernisation thesis.
2. Cultural perspectives and risk.
3. Risk as a form of governmentality.

2.ii The dominant/technical paradigm

The presumptions that underpin the dominant, rational actor paradigm of risk, so prevalent in maternity services, as illustrated in Symon's book, are not peculiar to the maternity care setting (Alaszewski 2007b; Alaszewski et al. 2000; Fox 1998). They are, however, peculiar to our late-modern society. According to the literature, this way of understanding risk is quite distinct from how it was first envisaged. It has been argued that at its inception risk was a predominantly neutral term, concerned with probabilities of losses and gains, reflecting the statistical theory of insurance from whence it originated (Zinn and Taylor-Gooby 2006). Risk originated from the rationality of Enlightenment thinking, where previous superstitious understandings of the world were superseded by an appreciation of scientific laws (Alaszewski 2007a). Enlightened knowledge claims were assumed to be objective, rational and, above all, superior to other ways of knowing.

In its previous context, risk had little to do with accountability or responsibility; rather, it was an operational, mathematical calculation originally applied, most notably, in a maritime insurance context (Lupton 1999a), described by Douglas as

'the probability of an event occurring combined with the magnitude of losses *or* gains that would be entailed' (Douglas 1990 p. 2). Risk analysis within this socio-historic context was a technical cost/benefit calculation; moreover, there was no underpinning assumption that it should be avoided nor was it negatively loaded. On the contrary, great benefits could be gained from risk taking, provided the operational calculation revealed good odds.

In contrast to this, the dominant/technical paradigm view of risk, as it is represented in midwifery journals and/or how it appears in much of Symon's aforementioned edited volume, operates in quite a different way and is distinct from ways of knowing about risk in the past (Zinn 2006). The most notable difference is in the nature of its neutrality. The risk management culture, which saturates all aspects of contemporary health care under the auspices of clinical governance and auditing (Power 2004), claims to be objective and rational. However, this issue of absence of neutrality in the late-modern understanding of risk relates not so much to the explicit knowledge claims made through the operation and language of risk, which privilege ideas of impartial calculation (Pailing 2006; Irwin and Wynne 1996; Slovic 1987), but to something much more implicit in the interpretative work practitioners do when they translate risk into meaningful social action.

In contrast to earlier times, contemporary understandings of risk are morally loaded in that they have a value judgement component which rests upon an imagined fear of potential *hazard* (Alaszewski 2007a). Thus, the much quoted Royal Society definition of risk as:

> 'the probability that a particular adverse event occurs during a stated time period, or results from a particular challenge' (The Royal Society 1992).

The credibility of risk is established here through its origins, which lie in the impartial mathematical calculation of probabilities; however, these origins are infused with another layer of meaning. All aspirations to neutrality have been abandoned, risk has taken on a new meaning; it has been transformed into something which is assumed to be bad. While risk is still understood in the mathematical terms of probability, these calculations coalesce around *adverse events* and *challenges*. Because the term is no longer assumed to be neutral, it is imbued with a sense of

value judgement (Douglas 1990), which in turn introduces a notion of responsibility and accountability. Thus, risk now demands a particular set of actions aimed at reducing or avoiding altogether that imagined potential hazard.

In the maternity care context this means that risks are frequently linked to issues of patient safety (Dixon-Woods 2008). For example, the 2008 Nursing and Midwifery Council's (NMC)[4] Code for Standards of conduct, performance and ethics for nurses and midwives states that as a midwife you should:

> 'disclose information if you believe someone may be at risk of harm... You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk... You must report your concerns in writing if problems in the environment of care are putting people at risk' (Nursing and Midwifery Council 2008 pp. 3 and 5).

Simply by looking at the adjunct attached to risk in the first clause, it is possible to get an indication of the ubiquitous nature of risk in midwifery regulation: in midwifery a risk is unequivocally a *harm*. Furthermore, once this harm is identified the midwife *must* act, giving risk activity a real sense of urgency. With this lexical choice the NMC moves a step further than the Royal Society definition cited above, in that the negative loading of risk in the NMC quote is even more explicit.[5] According to the NMC, risks are not only self-evidently bad but the midwife's role is clearly one of risk surveillance. Furthermore, it is assumed that, through careful and urgent risk activity undertaken by the midwife, risks can be mitigated. Although the method for identification here does not necessarily imply notions of mathematical calculation, the implication is that risk should be understood as a hazard which should be avoided. Once interpreted in this way, risk takes on an explicitly temporal dimension (Adams 1995; Adams 2003; Heyman et al. 2010), which is something I

[4] The NMC is the national statutory registering body for midwives in the UK.

[5] I realise that in dealing with this issue in this manner I am in danger of carelessly slipping out of the literature review genre and into analysis (in particular Critical Discourse Analysis (CDA) (Fairclough and Wodak 1997)) mode. However, I hope that such a slippage is justified in that it illustrates the prominence of risk very effectively. Besides, my commitment to the ethnographic method makes such slippage not justifiable but possibly desirable.

explore in Chapters 5 and 7. What is important to understand at this point about this dimension of risk is that it means that imagined futures, where possible harm may occur, invade practice in the present in a way that reveals the assumption that, through careful risk management, it is in fact possible to 'colonise the future' (Giddens 1991 p. 133), anticipate risk and ultimately control risk. As Giddens (1991) puts it:

> 'Cultivated risk here converges with some of the most basic orientations of modernity. The capability to disturb the fixity of things, open up new pathways, and thereby colonise a segment of a novel future, is integral to modernity's unsettling character' (p. 113).

Thus, in Symon's book Smith (2006) instructs that:

> 'it is important to manage risks which exist within the healthcare setting in order to:
>
> - *Reduce*, and as far as possible, *eliminate harm* to patients
> - *Improve* quality of care
> - *Minimise* the impact of adverse events on the staff, finances, reputation and objectives of the organisation
> - *Ensure lessons are learnt* and that resulting solutions are shared as widely as possible' (Smith 2006 p.75).[6]

Such institutionalised adversity to risk drives organisations to link the past with the present and with the future. By focusing on hazardous situations from the past, a risk-aware hindsight is employed to predict future events which may or may not lead to similarly undesired outcomes. In this approach to risk there is no room for accident or bad luck (Adams 2003); concepts that conjure up a sense of uncertainty and unpredictability (this idea is explored in more detail in Chapter 5). Indeed, risk management as it is described by Smith and the NMC, is an antipathy to this; a device designed to factor out uncertainty through the application and implementation of calculation and reason.

The extracts above are presented as an illustration of not only how risk works in the maternity care context but how it is said to operate in the contemporary setting more

[6] Emphasis added. Not present in the original text.

generally. Thus, the manner in which risk is presented in these texts is representative of how risk is understood in late modernity, where the original approach:

> 'was challenged in the late nineteenth century with the development of a more forensic approach in which chance or accidental elements are discounted and the prime focus is on the identification of the causes of harm in specific circumstances, especially disasters. From the late twentieth century, a more precautionary approach has emerged, in which the fear of future harm influences the management of risk. If a sense of risk is historically bound up with the emergence of probabilistic thinking and an orientation towards the future, that orientation has become less open-ended in a precautionary approach that casts the future principally in negative, potentially catastrophic terms' (Alaszewski 2007a p. 349).

When risk is perceived as an adverse event, it logically begets a sense of risk adversity; it becomes something that should be avoided and something that should be managed using what has been described as the precautionary principle (Alaszewski 2007a). This precautionary approach to risk is underpinned by an assumption that all risk is bad and therefore excludes any possibility for risk taking; nothing could possibly be gained from such an approach. Choosing to give birth to your baby in hospital 'just in case' (which in my experience as a practising midwife is a frequently cited justification) may be seen as an example of the precautionary approach to risk in birth performance. What is interesting about this example is that it shows how far our understandings and usage of risk have ruptured from past usage. Where once mathematical calculations may have been used to assess risk, now risk decision making can stem from a nebulous concern about something *bad* that might happen. The likelihood of it happening, its probability value, has become almost irrelevant. After all, risk in childbirth now is smaller than it has ever been through history but this appears to make little impact upon the just in case mentality. Furthermore, personal experience of this *bad* is also unimportant. The point is, it might happen; no one can offer any guarantees that it won't happen, and this lack of reassurance, this lack of certainty, is enough to drive the decision process. Or, as Alaszewski puts it:

> 'The precautionary approach focuses on uncertainty rather than risk, and uncertainty is often an openly posed condition rather than the bounded and specific challenge common to the more technical conception of risk... It also focuses on the less

> clearly determined aspects of risk, notably the perception rather than its more objectively given dimensions. The emphasis is on the emotional response to challenges, especially fear and anxiety' (Alaszewski 2007a p. 356).

Having outlined how some predominant risk theorists have described the key components which make up the dominant/technical paradigm of risk, I will now consider the second of the four frames: the reflexive modernisation theory of risk. This will add another layer to the description of the contemporary risk context in which midwifery is embedded.

2.iii Reflexive modernisation thesis

According to Beck (1992), a fundamental shift in perceptions (and nature) of risk took place when traditional lifestyles were eroded. While Beck's interest in risk is not so much in its moral loading (this, arguably, is more the preserve of Douglas [Douglas 1990; Douglas 1992]) he does offer an interesting analysis, which goes some way towards explaining our contemporary preoccupation with risk as a hazard and our determination not only to predict it but to try to control it.

Taking a historical perspective, Beck describes how society has moved from one epoch to another, at first by dis-embedding traditional social forms, characterised by uniformity and predictability, which were replaced with the optimism of modern, industrial social forms. This, he says, was followed by a second process of dis-embedding, this time of the industrial forms. These forms were replaced with what he calls reflexive modernisation (Beck et al. 1994), where a hypersensitivity to risk is harboured in an almost debilitating fear of uncertainty (ibid.). For Beck, this uncertainty underpins contemporary concerns with risk:

> 'Risk Society begins where tradition ends, when, in all spheres of life, we can no longer take traditional certainties for granted. The less we rely on traditional securities, the more risks we have to negotiate. The more risks, the more decisions and choices we have to make' (Beck 1998 p. 10).

Like many sociologists before him, Beck conceptualises pre-modern society as being characterised by a sense of predictability, where personal choice was confined by

convention and tradition. This, suggests Beck, offered some sense of security; a security that is conspicuously absent in today's society where 'each person's biography is removed from given determinations and placed in his or her own hands, open and dependent on decisions' (Beck 1992 p. 135). To live in the Risk Society is to undertake the process of inventing and reinventing yourself, each individual being personally responsible for carving out an identity, building a 'do-it-yourself biography' (ibid. p. 135).

In Risk Society notions of certainty have been, somewhat ironically, eroded through the application of Enlightenment thinking. While reason and logic has enhanced knowledge of the natural world, it has also introduced unprecedented levels of uncertainty through, on the one hand, its practical application in the industrialisation process, while on the other, its fragmentation. Modernisation obliviously swept away the more complete and secure knowledge systems of the past (Beck 1996) and replaced them with science which 'does not necessarily provide the type of information by which individuals can manage their lives' (Alaszewski 2007b p. 3).

According to Beck, therefore, sensitivity to risk, identified through the application of divergent expert knowledge, has become a defining feature of society – a driving force in late modernity (Beck et al. 1994). Through the mass media and the Internet we can all access expert knowledge which alerts us to the risks associated with the food we eat, the air we breathe, the water we drink, the lifestyles we lead and, importantly, the way we birth our babies. Late-modern individuals negotiate their daily lives through a 'slalom' marked out by risk technology. Within this risk-sensitive environment the self is described as a reflexive project where an emphasis on personal choice and responsibility prevails. As Lupton (1999a) writes:

> 'Juxtaposed against this world of change are the meanings and strategies constructed around risk, which both spring from the uncertainties, anxieties and lack of predictability characteristic of late modernity and also attempt to pose solutions to them. Risk meanings and strategies are attempts to tame uncertainty, but often have the paradoxical effect of increasing anxiety about risk through the intensity of their focus and concern' (Lupton 1999a p. 12).

Despite the increases in uncertainty and hypersensitivity to risk brought about through reflexive modernisation, Beck is ultimately optimistic about the Risk Society. He sees the stalling effects of risk as an opportunity for the emergence of innovative and more inclusive forms of social action; a sub-politics, which he describes as 'a shaping of society from below... In the wake of sub-politicization there is growing support to have a voice and a share in the arrangement of society' (Beck et al. 1994 p. 23). As the old social forms are dis-embedded, then new reflexive ways of knowing will drive revolutionary political reform, novel ways of organising the world will be realised and, with them, one might assume equally original ways of organising birth performance. Thus, unlike Heyman and others, who suggest that Beck underestimates the possibility for diversity in attitudes towards risk (Heyman 1998 p. 19), my own reading of his thesis does not suggest that people react to risk in an uninformed manner; far from it. I understand Beck's Risk Society to be one characterised by diversity and individualised reflexivity in relation to risk, a snail's pace social upheaval 'on cats paws... unnoticed by sociologists' (Beck 1992 p. 3) that will ultimately change the world.

Birth performance and reflexive modernity

So far in this chapter I have looked at risk using two perspectives. Having started by describing contemporary understanding of risk in terms of what has been called the dominant/technical paradigm of risk, I then considered Beck's thesis on risk. Before leaving this second approach in order to describe the socio-political operations of risk, I want to explore in more detail how this thesis can be utilised to help understand how risk is realised within the maternity care context. What follows, therefore, is the synthesis of two bodies of literature:

- The reflexive modernisation account of risk.
- The medicalisation of birth thesis (Donnison 1988; Henley-Einion 2003; Oakley 1984; Rothwell 1995; Tew 1990) found in both the feminist canon and the professional literature.

While the second body of literature does not necessarily explicitly deal with the issue of risk, as I hope to illustrate, it does share much in common with Beck's descriptions of the emergence of risk. By that I mean the medicalisation of birth

took place simultaneously with the emergence of risk sensitivity and both can be described as attempts to control uncertainty through the application of modernist thinking. To this end, I will examine birth using Beck's historic epoch approach, tracing how it transformed over time as social forms were dis-embedded through the process of reflexive modernisation, thereby offering a theoretical basis on which to make sense of why this change in the way we understand birth and perform birth took place.

The application of technoscience, which shapes today's birthing behaviour in the UK, became a routine practice towards the latter part of the last century; that is to say, its popularity increased as the Risk Society began to emerge. Before this time, birth was managed without recourse to science, medicine or hospitals (Englemann 1882; Jordon 1983; Mead 1973). In the pre-industrial setting the unforeseeable hazards associated with birth were considered to be part of normal life, largely beyond human control and, as such, birth was seen to be an adequate physiological process. No notion of risk had been attached to birth in the traditional cultural setting; the hazards or dangers, no matter how potentially catastrophic, were experienced as pre-given (Cartwright and Thomas 2001). They came from some 'other' – gods, nature or demons – and as such those attending the birthing mother had little influence over or responsibility for them.

Ways of knowing about birth in the 1500s, revealed through the limited published texts, suggest that birth was considered to be a cheerful event, its management being non-directional, relying exclusively on the craft of traditional midwives, usually older women from the local community, who could boast embodied knowledge of birthing (Carson Banks 1999). In 1771, the Encyclopaedia Britannica described midwifery as 'the art of assisting nature in bringing forth a perfect fetus or child from the womb of the mother' (referenced in Carson Banks 1999). In this timeframe there appears to be no aspiration to control the physiological process of birth; birth was managed using traditional frameworks of understanding where 'nature' was pretty much left to its own devices within the domestic context of the home. That is not to say that birth was not dangerous, nor that the midwifery care characteristic of this period should be thought of as idealistic in any way; rather, the point being made

here is that birth had not been defined as a site of risk (Arney 1982; Murphy Lawless 1998). As Cartwright and Thomas (2001) point out:

> 'Danger has always attended childbirth... Danger was transformed into biomedically constructed and sanctioned notions of risk. This was more than a semantic shift: Dangers implies a fatalistic outlook on birth, risk implies an activist stance' (Cartwright and Thomas 2001 p. 218).

Traditional ways of performing birth were, using Beck's terminology, dis-embedded through the emergence of modernity, which brought with it new, scientific ways of understanding and classifying this physiological process. This dis-embedding process was particularly significant to midwifery because pre-modern birth performance had been attended by traditional midwives or handy women, whose expertise was informed by a mixture of traditional, experiential and embodied knowledge (Donnison 1988; Leap and Hunter 1993). Gradually, as tradition gave way to modernity, traditional midwifery knowledge lost credibility through 'the story of doctor's victory over midwives' (Faulkner 1985), where it took 'three centuries before the emergent medical profession fully succeeded in muscling into this female stronghold' (Faulkner 1985 p. 94). This process of what Dalmiya and Alcoff (1993 p. 217) call 'epistemic discrimination' was marked by the traditional and embodied knowledge of birth held by midwives being 'banished to the epistemological fringes' because it could not meet requirements for justification which rested solely upon the modernist notions of 'the right to be sure' (Dalmiya and Alcoff 1993 p. 217). The speak of childbirth became the speak of obstetric science (Steele et al. 2000). Moreover, with this transformation, the risks associated with birth took on new significance.

As the hazards associated with birth lessened through wider public health improvements (Tew 1990), sensitivity to the possibility of those hazards intensified to such an extent that birth could no longer be imagined as being a normal physiological process. Instead:

> 'Technology gave obstetricians the power to define abnormality and gradually a consensus view evolved that pregnancy and childbirth could be perceived as normal only in retrospect' (Tew 1990 p.10).

Birth was redefined; it could no longer be legitimately conceptualised as a normal physiological event but instead became to be seen as a medical problem (Wagner 1994), and birth became a site of risk.

As the country moved towards modernity committed to 'progress' through the application of reason and rationality, superstitious practices, such as those used by the wise-women midwives, were ideologically dismissed as being traditionalist and anti-modern (Jacobus et al. 1990). According to Enlightenment thinkers (Radcliffe 1967), such traditional ways of knowing were based upon uncritical acceptance of 'received wisdom'. In contrast, the modern or scientific approach was based upon the collection of information, interpreted using a form of systematic human reasoning. The two ways of thinking were thereby arranged hierarchically, the latter holding overall supremacy over the former.

Within this process of dis-embedding and re-embedding, the language of birth was transformed. Where ecological metaphors had once been, mechanical and scientific metaphors replaced them (Arney 1982; Martin 2001).[7] According to Martin's critique, the introduction of medical terminology meant that the woman's body came to be seen as a machine. Moreover, this machine was expected to perform in a particular way. If the machine broke, then experts, in the guise of obstetricians, could come along and use their technology to fix it (Martin 2001). According to this linguistic code there is no place for women's agency; instead, the subject is reduced to an object (Code 1995). Women, thereby, are rendered essentially passive in the process; it is their bodies, or more specifically their misbehaving bodies, that become the object of attention on which expert knowledge and technology is targeted.

Within this discursive context, the midwifery profession in the UK embraced new modernist skill sets where pregnancy and birth had to be measured against professionally defined trajectories (obstetrically defined) designed to check for

[7] This is important because, as Bakhtin and Holquist point out, language has a normative function and can be thought of as 'a concrete heteroglot conception of the world' (Bakhtin and Holquist 1982 p. 292). The words and metaphors we choose to describe labour and birth then say much about how it can be understood and, by association, how women are perceived.

mechanical malfunction. Since birth physiology could no longer be trusted to take its course (Grosz 1993), when an individual birth took place and how long the process lasted all had to be strictly charted and controlled through new and distinctly modern, obstetrically-driven midwifery activity. Labour length, for example, could no longer be seen as flexible and personal; it became fixed through the process of surveillance and the application of rigid normalising trajectories (Arney 1982). Moreover, through this fixing, deviations from an expected norm suddenly became identifiable and, once identified, it became the midwife's responsibility to alert those able to control these anomalies through the application of medical procedures such as Caesarean section. Put another way, by becoming a site of risk, birth performance and midwifery activity within that performance were transformed.

As society shifted through the historical epochs, so birth performance was transformed. Pre-modern, traditional ways of imagining birth, where birth could be imagined as being part of normal life, were usurped by an understanding of birth which was steeped in hazardous risk and, as a consequence, needed to be medically managed through a principle of common-sense precaution. As Murphy Lawless (1998) states:

> 'The tendency has... increasingly been to define every aspect of pregnancy and birth in terms of risk in a mistaken attempt to cover all possible eventualities. In this sense, the entire female body has become risk-laden' (Murphy Lawless 1998 p. 21).

By the 1970s, government policy was firmly entrenched in the accepted scientific opinion that birth was a site of risk and should be managed as such (Department of Health and Social Security 1970). However, cracks were beginning to appear as opinion fragmented through the process of reflexive modernity. Dissent was being voiced from both the public and expert realms. The authority of the experts began to falter as their professional opinion fragmented. That is not to suggest that dissenting voices had not been heard before within the discipline of obstetrics (cf. Kloosterman 1982). What was unique about this particular episode of dissent within the ranks, however, was the cascade of social processes it set off, where a sensitivity to risk and uncertainty intensified, spreading from the imagination of some rebellious experts to capture the world view of the public. One of the most notorious voices in the UK

during this time was that of the 'radical in the labour ward' obstetrician, Wendy Savage (Savage 1986). Savage's critique of the accepted medical practices which surrounded birth performance culminated in her being suspended from duty in 1985 for allegedly being 'a danger to her patients.' She was later reinstated and is now described by the British Medical Journal as 'an inspirational leader in women's health', having been awarded a lifetime achievement award in 2009 (British Medical Journal 2009). Marjorie Tew's epidemiological critique of the medicalisation of birth was met with similar resistance at first as she struggled to get her work published in academic journals in the 1970s.

Gradually, as the expert voice showed signs of fragmentation, the reflexive critique gained momentum. Social action user group protests such as that led by the National Childbirth Trust (NCT) and the Active Birth Centre, engaged with the fragmenting expert knowledge base and used it to challenge the rationality behind the medicalisation of childbirth, and it was this engagement which makes this process peculiar to late modernity. This challenge was, initially at least, endorsed within the academy by the feminist critique (Oakley 1984; Graham and Oakley 1981; Haire 1973; Kitzinger 1982; Lomas 1978; Reissman 1983; Rothman 1982). According to De Vries et al., this change in cultural climate:

> 'created a new opportunity for resistance to the kind of care that was available... A consumer movement sprang up, organised by women for women, which soon became a formidable interest group in the struggle over the maternity services' (DeVries et al. 2001 p. 257).

By 1989, with the publication of the *Effective Care in Pregnancy* (Chalmers et al. 1989) – an extensive, edited obstetric volume which collates Random Control Trial evidence to question many of the accepted medical practices of the day – the certainties promised by the hospitalisation of birth were all but dismantled or worse; they began to be seen as a site of risk in themselves.

Interestingly, the midwifery position and its critique of the medicalisation of childbirth is not as straightforward as one might expect. There was dissent in the ranks in the 1970s, the most vocal being the Association of Radical Midwives set up in 1976. However, my reading of the broader midwifery literature suggests that,

despite the rhetoric of midwives being the experts of normality (Crabtree 2008; Gould 2000; Keating and Fleming 2009), which one might assume could be juxtaposed against the medicalisation discourse (Walsh 2009), their contribution to the critique of the medicalisation of childbirth came quite late in the fragmentation process, making its presence most keenly felt in the 1990s after the resistance had moved away from the fringes into the safety of mainstream debate.

Furthermore, in contrast to obstetrics, the midwifery critique comes largely from within the academy, following the professionalisation of midwifery, meaning the practice-based voice was, and still is, at best irresolute in its position. Empirical-based research of midwifery activity suggested that midwifery discourse, as it is played out through care, has more in common with the medicalised ways of understanding birth than it did with any broader notions of birth, where risk toleration might be embraced as a tool for facilitating normality and/or client autonomy (Green 2005; Hunt and Symonds 1995; Hunter 2004; Kirkham, Stapleton et al. 2002; Kirkham 2009; Lankshear et al. 2005). As Warwick, the general secretary of the Royal College of Midwives, points out, the midwifery position in relation to the medicalisation of birth is 'schizoid' (Warwick 2010). It appears that the midwifery quest for professional autonomy and power was more easily achieved through collusion with the medicalisation of birth rather than a resistance to it (Kirkham 1996). As De Vries (1993) points out:

> 'Prestige and power are given to those who manage high-risk situations, not to those who attend low-risk births. But midwives face an unusual predicament: to enhance their status it seems they must renounce their tradition. They can earn their niche in the system only if they cease to be recognisable as midwives' (DeVries 1993 p. 144).

Despite the questionable contribution made by midwives to the dismantling of modernist notions of birth performance, diversity in opinion of how birth should or

should not be managed reached policy level in 1992 with the publication of the *Winterton Report* (House of Commons 1992),[8] which stated that:

> 'the policy of encouraging all women to give birth in hospital cannot be justified on grounds of safety' (p. xciv).[9]

This report was shortly followed by *Changing Childbirth* (Porter 2004; Department of Health 1993) based on three Cs: choice, continuity and women-centred care. This policy was based upon two concepts, both consistent with the reflexive modernisation thesis as it is described by Beck: the first, individualisation, or in this case women-centred care; the second, reflexive decision making and choice, which depended upon accessing expert knowledge in order to reach an informed choice which, it was assumed, would not necessarily involve routine hospitalised/medicalised birth.

It should be noted that, as is consistent with Beck's thesis, apart from some critical feminist commentary the challenge to accepted medicalised practice came largely from within the technical/dominant paradigm of risk; in other words, that such practice entrenched interest in objectively measureable risk. As such, risk adversity remains undisturbed by the process. The reflexivity upon which the critique of medicalised birth practices relied rested itself almost exclusively upon a modernist discourse, where an ever increasing scientifically-driven evidence base was used to dis-embed current practice. Crucially, what this critique failed to offer, therefore, is any sense of certainty. Just as the fear of uncertainty was intensified by the realisation that modernisation had carried with it a threat so great that ecological calamity had to be considered, so came the realisation that, despite the lofty aspirations of obstetrics to control and mitigate the risks of childbirth, these were

[8] Which was in part informed by the Royal College of Midwives' presentation of evidence taken from *Effective Care in Pregnancy* (Chalmers et al. 1989).

[9] A fact corroborated in 1998 when the US National Center for Health Statistics published figures comparing midwifery to obstetric care, which, when controlled for risk factors, showed that midwifery care resulted in: 19% lower infant mortality; 33% lower neonatal mortality; and 31% lower risk of low birth rate.

accompanied by a catalogue of unintended secondary risks succinctly encapsulated through the term 'cascade of intervention'.[10]

Thus, dissenting voices which operated to unsettle medicalised practices did not so much represent a different attitude towards risk per se; rather, they were the reapplication of the language of risk in a new domain. The outcome of this dissent, therefore, was such that the emotive linking of risk with hazards remained not only undisturbed; it was intensified. Ironically, the promises of modernity have been dis-embedded through the tools of modernity. This did not therefore represent a different approach to risk. The dissent, which originated from both public protest and expert debate, did not operate to contain the perceived hazard associated with birth; it was simply a case of broadening the risk-averse gaze to include/expand the site of risk from the home and the woman's body to others, the hospital, the obstetricians and their medical technology. While the modernist discourse of childbirth coalesced around the perceived inherent risks in the physiology of birth, that is, the bodies of women and their babies were reinterpreted as sites of risk, teetering on the edge of disaster, both being a threat to each other (Marshall and Woollett 2000), reflexivity added another layer to this precautionary approach to risk. Not only was the physical process of birth itself seen as a site of risk, through the process of reflexive modernisation those very procedures that were introduced to contain those risks, along with the expert knowledge base upon which they rest, themselves could no longer be trusted (Edwards 2006; Viisainen 2000). That is to say, an acute sensitivity to the possibility of iatrogenic risks associated with routine obstetric procedures emerged. This is an issue to be developed in the policy chapter of this thesis but at this point it is enough to say that the science that had once promised to control the uncertainties of birth in order to maximise safety of the mother and child has itself become a focus for anxiety and can no longer be relied upon to deliver the certainties it originally pledged.

[10] This expression comes from the work of Inch (1989), who produced a diagram to describe how each individual obstetric intervention has a domino-style effect, in that it introduces a cascade of further interventions.

Perhaps it is not surprising, therefore, that policy initiatives have not achieved the shift in practice that was hoped for in the early 1990s (Bourgeault et al. 2001; Walton and Hamilton 1995). In the initial and perhaps more radical wave of dissent against the medicalisation of birth, emphasis was on a vision of the de-hospitalisation of birth (Arms 1975; Lomas 1978; Kitzinger 1988; Kitzinger and Davis 1978; Sargent 1982). As the critique moved from the fringes to become incorporated into the policymaking process, there was a dilution in the vision; a dilution which I suggest both reflected and at the same time operated to reinforce the risk status of birth. By 2007, with the publication of *Maternity Matters*, hospital birth appears to be reinstated through the semiotic choices used to articulate Choice Guarantee:

> 'Four national choice guarantees will be available for all women by the end of 2009 and women and their partners will have opportunities to make well informed decisions about their care throughout pregnancy, birth and postnatally...
>
> 3. Choice of place of birth – Depending on their circumstances, women and their partners will be able to choose between three different options. These are:
>
> a home birth
>
> birth in a local facility, including a hospital, under the care of a midwife
>
> birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option' (Department of Health 2007 p. 5).

While this policy quite patently endorses the notion of individualisation, two things need to be pointed out. Although by definition a home birth would involve exclusively midwifery care, midwifery activity is not associated with this environment but instead is explicitly linked to the hospital setting in both options two and three. Midwifery activity coincides not with normal home birth but remains lexically linked to medicalised birth practices. Secondly, and on a similar point, by definition home birth would involve avoiding the iatrogenic risks of the hospital environment; however, there is no lexical link with safety in this choice option. On the contrary, safety is exclusively the preserve of the hospital environment. This is not to question the logic of some women birthing in hospital; it is just to emphasise that for other women it will be safer to birth at home, and yet this point is not mentioned in the policy. Home birth is included as a concession to choice but it is

never endorsed under the terms of safety. Individuality is enshrined in this policy using a heavily-weighted framework, where the rationality of medicalised birth not only remains intact but is implicitly strengthened through the lexical choices used. As such, the policy fortified risk adversity and confined rather than expanded the way birth can be imagined and performed.

As I have hinted throughout my literature review, the legacy of modernity with its distrust of the unpredictability of birth and with its promises of control and certainty still holds saliency, shaping how birth can be performed in this country. Through a somewhat cyclical logic, late-modern concerns regarding the iatrogenic risks introduced through the modernisation of birth performance, where birth became medicalised, operate to amplify risk sensitivity, thereby increasing, rather than decreasing, dependency upon the promises of science and progressive knowledge. Risk appears to exist within a paradoxical and perpetual feedback, where concerns about man-made introduced risk function to entrench the Risk Society more deeply.

Figure 1: Paradoxical Cycle of Risk in Birth

This never-ending cycle means that birth performance became sandwiched between two risk discourses, both with a heightened and morally loaded awareness of risk:

- On the one side, the possibility of physical pathology associated with birth, regardless of how that risk may be statistically measured, appears to

disproportionately govern practice through the introduction of intensive surveillance and medical intervention.

- On the other side, the unintended consequences of this medicalised way of performing birth has operated to erode trust, thereby ironically intensifying risk management with a further battery of invasive risk surveillance and medical intervention.

It is not surprising, therefore, that, although there is evidence that reflexivity and fragmentation of the expert's voice exists within maternity care, this has done little to unsettle the logic of current birth practices in the UK. As Murphy Lawless (1998) points out:

> 'The cumulative inputs of the childbirth movement, the home birth movement, the consumer movement and the feminist critiques of childbirth, which have all been influenced on some level by the notion of natural childbirth, have failed to dislodge the vast majority of women from hospital, the setting where the overall package of practices in labour and birth is still not in the hands of women' (Murphy Lawless 1998 p. 39).

While Beck's assertions about the Risk Society may be correct, the political optimism that underpins his thesis appears, in the case of birth at least, to be somewhat overstated. Notwithstanding that this tension might be explained, in part at least, through Beck's concession that medical technologies, and the authority these technologies beget to those experts that use them, are likely to remain undisturbed by this process of modernisation, this has been taken to represent a serious limitation in his thesis in this context. By focusing on the dis-embedding effects of reflexive modernisation it is easy to forget that the dominant/technical paradigm of risk still prevails over how birth can be performed. Despite the existence of concordant discourses, or, put another way, despite the presence of reflexive paradigms of risk, which might, as Beck optimistically posits, operate to destabilise the dominant ways of knowing about birth, the performance of birth continues to be hospitalised. It is interest in the work midwives do to both sustain and unsettle this paradigm of risk which forms the basis of the research problem upon which this project rests.

In this chapter so far I have used two approaches to risk – the dominant/technical paradigm and the reflexive modernisation thesis – to explore the social and historic

context in which midwifery talk and practice can take place. I will now shift my focus towards other bodies of work which have helped inform my project, and look at the cultural theory of risk, before ending this chapter with a brief description of the governmentality literature and its implications for health surveillance.

2.iv Cultural theories of risk – Douglas

While some authors have juxtaposed Beck's risk thesis against that proposed by cultural theorists such as Douglas[11] (Lupton 1999a; Wilkinson 2001), my reading of Beck, as I have described it above, suggests that these two approaches need not necessarily be thought of as mutually exclusive and therefore can, if appropriate, be used simultaneously for analysis. That is not to say that the two do not have their own unique contribution to make to the risk debate; rather, what I would like to suggest is that together they offer a detailed account of the social development of a new culture and politics of risk.

Beck, with his interest in the emergent risk-averse consciousness, gives rise to new forms of individualised reflexivity; a soft constructionist approach (Lupton 1999a) as his hypothesis rests, in part, upon ideas of actual or real ecological hazards posed by industrialisation (Furedi 1997; Taylor-Gooby 2000). Some commentators suggest that the cultural theorists' take on risk, with its attention on pre-existing commitments to particular forms of social solidarity, casts doubt on the credibility of such essentialist notions of risk (Wilkinson 2001).

While I concede that Beck does lament over the possibility of ecological catastrophe, my reading of his work suggests that his thesis does by no means depend upon the existence of things like pollution or toxic waste. Indeed, Elliott goes so far as to suggest that:

> 'this really is not a key consideration in any event, since he (Beck) does not wish to suggest that daily life in today's Risk Society is intrinsically more hazardous than in the pre-modern world' (Elliott 2002 p. 295).

[11] Douglas herself at times is an enthusiastic proponent of this approach.

Beck's Risk Society is a social theory of modernisation, not simply a description of reaction to global threats. In this way, Beck is not unlike Douglas, who posits that:

> 'the reality of dangers is not at issue. The dangers are only too horribly real, in both cases, modern and pre-modern. The argument is not about the reality of dangers but about how they are politicized' (Douglas 1992 p. 29).

It is important for my purposes to acknowledge this issue as a point of similarity and not a point of departure, not simply because I have chosen a theoretical stance that attempts to, among other things, take account of the work of both Douglas and Beck, but also because childbirth is in fact safer now than it was in the previous historical epochs described by Beck. While Beck's theory helps account for wider societal attitudes to risk, if it were completely dependent upon an increase in the material possibility of significant harm in late modernity its application to the current maternity care setting would be of questionable value. As Reissman (1987) has pointed out:

> 'In this century an unprecedented decline in deaths associated with birth ... (means that) birth is safer than it has ever been, paradoxically, however, the concept of risk in childbirth is expanding' (p. 263).

Similarly, Possamai-Inesedy (2006) points out safety in childbirth and perceptions of risk in childbirth are positively, rather than negatively, related. That is to say that as the former has increased the latter has intensified. Childbirth may be as safe as it has ever been, or will ever get:

> 'but pregnant women are nevertheless still fearful and anxious about pregnancy and childbirth. These fears do not stem from lived experience but rather from the speculation of risks that women must contend with' (p. 407).

This paradoxical operation of risk has been noted in other areas and has been described by Taylor-Gooby (2000) in terms of timid prosperity, where, despite the ever increasing levels of material security in the West, societal anxiety has intensified. Thus, in maternity discourse, despite childbirth being safer now that it has ever been in human history, social fear and anxiety about birth has crystallised into a discourse of risk (Lupton 1999b; Skinner 2003).

What Douglas offers, in contrast to Beck, is a more detailed account of how risk operates, showing how risk both constrains and allows particular ways of knowing and being in different social/cultural settings. This, I suggest, is not at odds with the reflexive modernisation thesis, but is simply a reflection of divergent methodological interests and as such represents the difference between macro and micro social theoretical orientations more generally. Beck's analysis focuses on the emergence of risk on the societal, even global, level. In so doing, he is able to offer an explanation as to why risk is so omnipotent in today's world. Douglas, on the other hand, is an anthropologist; she uses cultural theory to scrutinise how risk functions as a form of social solidarity. Needless to say, I have great sympathy with this orientation due to my own anthropological background. However, what is important is that, despite these sympathies, I do not believe the so-called cultural approach to risk offers such a complete picture that the reflexive modernisation thesis has to be abandoned. I will show that they can be used simultaneously.

The moral loading of risk

Within the descriptions set out at the beginning of this chapter of the dominant/technical paradigm of risk, reference was made to how the meaning of risk had changed over time and how, in health, risk has now come to represent something which is bad and, moreover, is something which has been laden with moral responsibility (Alaszewski et al. 2000; Fox 1998). It is in relation to this issue that Douglas makes her most important contribution to the risk debate for the purposes of this project. It is also at this point where her work on risk diverges significantly from Beck's thesis. While Beck helps us understand our anxieties in relation to risk, Douglas links risk with cultural purity and danger, unpacking the moral blaming that underpins how we respond to risk. Douglas' analysis of risk differs from Beck's in this respect in that she does not link this transformation to the process of modernisation; far from it. Douglas suggests that our contemporary attitudes to risk are reminiscent of traditional values in relation to taboo, purity and pollution. Taking a Durkheimian view of social solidarity, Douglas looks at social cohesion, arguing that: 'The whole of the universe is harnessed to men's attempts to force one another into good citizenship' (Douglas 1966 p. 3). Like anthropologist Evans-

Pritchard before her, Douglas was concerned to represent those living in traditional societies as being rational actors (Douglas), and with this aim in mind she showed how blame and pollution is accredited to those who are seen to refuse to concede to this accepted notion of good citizenship:

> 'A polluting person is always in the wrong. He has developed some wrong condition or simply crossed some line which should not have been crossed and this displacement unleashes danger for someone' (Douglas 1966 p. 13).

Douglas develops this idea and applies it to modern understanding of risk, arguing that: 'The dialogue about risk plays the role equivalent to taboo or sin' (Douglas 1992 p. 28). This means that risk cannot be thought of in neutral statistical terms but, instead, is laden with responsibility and accountability; every misfortune is someone's fault, meaning that 'under the banner of risk reduction, a new blaming system has replaced the former [based on religion and its concepts of sin]' (ibid. p. 16).

This idea of risk as being morally loaded helps to provide a theoretical understanding of how risk is represented in the clinical governance policy that relates to maternity care (Department of Health 1997; Department of Health 2000) (see Chapter 4); how it appears in the national confidential enquiries into maternal and neonatal death (Confidential Enquiry into Maternal and Child Health 2007; Lewis 2007) (see Chapter 5); as well as going a long way towards explaining how risk is portrayed in the NMC code and rules (Nursing and Midwifery Council 2004a; Nursing and Midwifery Council 2004b). It is my contention, then, to suggest that the cultural paradigm of risk forwarded in Douglas' work, which privileges the moral loading of risk, is a pertinent tool for the analysis of the discursive context in which midwives make sense of risk.

Being 'at risk', according to Douglas, entails the role of the victim being sinned against, suggesting an essential vulnerability (Douglas 1992). This is an important dimension of Douglas' analysis for the investigation of birth performance because such a supposition has some concerning implications for the way we manage birth in the UK and the midwifery contribution to that management. As outlined in the first half of this chapter, the very way maternity services are organised and the way

women choose to access those services suggest that both service users and providers consider women and their babies to be firmly embedded within an 'at risk' category during labour and birth. Through the application of Douglas' cultural model of risk, this common-sense categorisation takes on a new dimension, revealing some rather disturbing, gendered assumptions. According to Douglas, being considered to be at risk necessarily evokes a sense of physical and emotional vulnerability with inevitable loss of personal agency. The female form, it would seem, is essentially faulty, unable to perform the bodily function of expelling her offspring without the help of close medical surveillance and technological intervention (Grosz 1994; Woodward 2003). Such a view of birth is, in many ways, uncomfortably reminiscent of those ill-concealed paternalistic views of the late nineteenth and early twentieth centuries, where women were considered to be 'too nervous and inefficient' (De Lee 1920) to withstand the traumas of childbirth and were recommended twilight sleep for early labour, general anaesthesia for second stage with accompanying extensive episiotomy and forceps delivery (Richards 1992).

This gendered interpretation of risk within the dominant/technological paradigm places midwifery activity in relation to risk and birth on a politically suspicious footing. Although the support and empowerment of women through the spontaneous physiological process of birth is understood to be a professional priority for midwives, within the current system of maternity services, where women are represented as belonging to the category of 'at risk', it is quite difficult to envisage how this could be legitimately expressed. This potential disconnect between what midwives say and what they actually do – which appears to suggest an underlying assumption that the pregnant and birthing body cannot be thought of as either a capable or reliable entity – gives an indication of the complexities involved in midwifery understanding of risk, forming a basis for this investigation.

Having looked at the way the reflexive modernity approach to risk can be synthesised and applied in conjunction with the cultural theory of risk for the interrogation of the operations of risk within the context of maternity care, the chapter will go on to consider the governmentality contribution to the risk debate. In

the section to follow, the theory of risk as a form of surveillance and control will be considered.

2.v Risk and governmentality

One of the most comprehensive applications of a Foucauldian analysis of governmentality to birth was done by Arney in the early 1980s (Arney 1982; Arney and Neill 1982).[12] In his work, Arney looked at the pregnant body as a site of surveillance, describing how the medical gaze, through the development of obstetrics, became a form of social control and discipline. Using Foucault's application of Bentham's panopticon, Arney describes how women are subjected to constant and total visibility through the offer of technologies which promise a guarantee of an optimal experience (Arney 1982 p. 89). Under the guise of reducing population-based uncertainties inherent in pregnancy and birth, women are subjected to a battery of advice and intervention, which are borne out of a scientific interest in what is represented to being impartial probabilities rather than individual experience. What is more, women are willing participants in this process.

Although Arney and others have developed this theory of governmentality to include the critical analysis of public health as a form of self-subjugation (Arney and Neill 1982; Burchell et al. 1991; Petersen and Lupton 1996; Roche 1992), for the purposes of this thesis I feel that governmentality's theory of risk's most salutary contribution comes from its politicisation of the analysis of risk. The application of this theory means that the power relations underpinning operations within the dominant/technical paradigm of risk can begin to be examined. This is important because of the way this paradigm is presented in midwifery texts, such as the documents produced by the NMC (2008) or Symon's (2006) *Risk and Choice in Maternity Care* book, discussed above, where it appears as an impartial product of common-sense reason. Such representations operate to obfuscate the power interests that both produce and are produced by the text.

[12] While his analysis of American birth practice does not claim its position under the risk literature as such, its relevance here pertains to its exploration of the operations of governmentality in the performance of birth.

Through the theoretical application of the governmentality perspective of risk it is possible to unsettle this taken-for-granted understanding. By looking at risk, not as a common sense but instead as a site for power negotiations where routine midwifery surveillance practices operate to discipline the birthing body, it is possible to gain political purchase on the talk and practice which goes on in the labour room.

Like the other theories of risk discussed in this literature review, the governmentality approach to risk is at once valuable and yet, because of the nature of the research problem, needs to be applied with some caution. In this final section of this chapter, I shall look at one of the biggest shortfalls of the governmentality perspective on risk when it is applied to the analysis of childbirth performance.

During my reading of the governmentality literature I have been disturbed by the absence of the corporal body and, by implication, the possibility of normal birth, not as a process of surveillance, but as a personal triumph for a mother. It is as if the female body, doing the quintessentially female activity of giving birth, with the gentle and unobtrusive support of a (what is usually female) midwife, is eerily erased from the post-modernist imagination. The physical body dematerialises, as do the activities it can achieve; all is reduced to a discursive process of social constructionism.

> 'This discursive turn favoured a new determinism in which the original materiality of the prediscursive body began to evaporate in theory. The body became volatile, liminal, and slippery - a function of fragile and shifting discursive terrains and at times a mere blip in cyberspace' (Wallace 2002 p. 22).

Although the body is the focus of much attention in the governmentality literature, it appears as a kind of spectre; a passive and formless entity waiting to be signified through discursive practices. Whether I am uneasy with this because I am midwife with an interest in birth as a physiological process, a mother with hours of embodied

experience of the physical nature of birth,[13] or as an anthropologist interested in placing human activity in its wider ecological environment (Denzin 1999), I am not sure; perhaps it is because of the combination of all three. Whatever the origins of my concern, I consider this to be a problem for the purpose of this project for two reasons: firstly, childbirth is above all else a physical activity that is grounded in embodied sensation. Secondly, birth is an activity that only women can achieve; it is by its very nature a gender issue and as such the corporeal body needs to be theoretically located. As Rose (1994) puts it:

> 'Women's sense of the body is grounded in the real material practice of taking care of both our own and the bodies of others: small babies (which I suggest includes the state of pregnancy and birthing), children and sick... From the perspective of caring the body is no grand linguistic abstraction, but is very concrete, constantly fluctuating, sometimes dramatically and sometimes very subtly' (Rose 1994 p. 49).

The removal of the material body is disturbing, not least because it removes the sense of achievement that can be gained from simply doing birth in a physical and triumphant way. It means that the body is deprived of agency; it is docile (Deveaux 1994) and therefore denies the powerful experience that midwives are witness to every day. As Davis and Walker (2008) point out:

> 'As midwives we are intimate with bodies. We touch them, smell them, hear them, support them, examine them and watch them. Our work as midwives is conducted through our (mainly female) bodies... As midwives, we often marvel at the power of this process and the phenomenal strength of a woman's body' (p. 457).

An analysis that loses sight of the corporeal body is in danger of losing sight of what it is to be a midwife.

[13] The one good thing that has come out of my spectacularly protracted attempts to stave off medical intervention in order to achieve that all-illusive vaginal birth is that I have extensive and detailed experience of the overwhelmingly material nature of birth.

Concluding comment

The aim of this chapter has been to draw attention to the aspects of risk theory that have helped orientate my approach to risk in this PhD on midwifery talk and practice. Although Zinn claims that there has been comparatively little integration or discussion between the different approaches to risk (Zinn 2006), I hope that through my review of some of the key issues in the literature on risk I have been able to show how this need not necessarily be the case.

In this review, I have looked at four threads in the risk literature. Starting with a description of the dominant/technical rational actor paradigm of risk, I went on to engage with: first, Beck's Risk Society thesis; then, the socio-cultural approach to risk; and, finally, the governmentality perspective to risk and health surveillance was introduced. I suggested that Beck's historical approach to risk sensitivity, with attention to the fragmentation of the expert's voice, individualised reflexivity and the introduction of new risk through the technology of the modernisation project, helps explain how sensitivities to risk constrain how birth can be imagined. I went on to show how this more macro approach could be complemented by the details of the socio-cultural approach to risk put forward by Douglas. I argued that, for my purposes, Douglas' work is useful because it offers an excellent theoretical grounding for the moral loading of risk within our birthing culture. In the fourth and final section, I looked at the governmentality approach to risk, illustrating how its emphasis on surveillance makes it an invaluable device for understanding the power relations which lie behind risk talk and practice. The most important conclusion I wish to draw is that, by synthesising together various threads of my reading, it has been possible to identify the points of disconnect within the literature. These points of disconnect, however, should not necessarily, as some have suggested, be thought of as a limitation in the debate. On the contrary, I prefer to see them as invaluable in that they indicate the points at which the theory may be challenged, as well as the points where it makes its most useful contribution to my purpose. Such incompleteness, I argue, can, in part at least, be overcome by looking more widely into the literature for theoretical orientation and combination. In the data chapters to

follow I use a combination of each of these theoretical approaches in an attempt to understand the interpretive work midwives do in the social construction of risk. In particular, I will be looking at the amplification of risk, the fear of risk, the moral loading of risk and risk as a form of surveillance and social control.

Chapter 3: Methodology

Introduction

This chapter aims to explain the rationale behind the research design and gives a detailed account of how the research was carried out. That is to say, the chapter drills down from the research problem to the research design and then on through to the methods, analysis and ethical consideration which have underpinned this project. The chapter falls into three parts:

1. Starting with the research problem and research questions, the chapter will outline precisely what it is this project planned to investigate.
2. This section will be followed by an exploration of the research design. In this section, an explanation of why the particular research strategy was adopted will be presented, along with the problems this strategy caused, and why, in the end, such a strategy was considered to be justified. It will outline why the research design fit for purpose.
3. In the final section of the chapter, the methods and details of what was actually done – how the data was collected and analysed – will be explored, along with the ethical considerations required while conducting this research project.

3.i The research problem

This research comes out of an ever increasing concern with risk within the health service in general (Gabe 1995), with maternity services accounting for the majority of the NHS litigation claims (National Health Service Litigation Authority 2009).[14] Patient safety and risk avoidance are woven tightly together in today's NHS, with intervention initiatives being increasingly aimed at *deep change* (or fundamental change) in the organisation (Dixon-Woods 2008; Patel 2007). It is not surprising

[14] Details of the litigation burden are discussed in Chapter 4.

that the efficacy of such initiatives relies heavily upon staff, on the ground, who are responsible for translating understandings of risk into meaningful practice (Dixon-Woods 2008).

Given this context, what is surprising is the little analysis which has been carried out to investigate how midwives – the professional group responsible for the management of the majority of births (NHS Information Centre 2007; Wilson and Symon 2002; Sandall et al. 2009) – orientate themselves to this concept of risk. It is the extent of the potential influence midwives have upon how birth is performed which makes the lack of research on the interpretative work midwives do when making sense of risk particularly remarkable. Because the understanding of risk is so rarely challenged (see Chapter 4), the interpretative work midwives do when making sense of risk is not only overlooked; it is taken to be neutral. In other words, midwives are treated as technicians, objectively assessing and managing risk, rather than as active participants who, through their interpretations of situations, create risk. The questions:

> How do midwives perceive risk?
> How does the way midwives make sense of risk in their talk and through their practice impact upon the maternity care services?

both, therefore, remain unanswered. The principal driver behind this research has been a concern with the lack of empirical evidence around how midwives make sense of risk and how this meaning-making process impacts upon the way birth can be performed. These two questions therefore represent the primary focus upon which this research has been designed.

Pre-eminent in the majority of the literature that deals with risk in maternity care is the dominant/technical paradigm of risk (to be explored in more detail in Chapter 3), where the distinct professional groups are simply assumed to share a constant and, moreover, common, understanding of risk, despite their divergent training backgrounds and concerns (c.f. Lankshear et al. 2005; McNally 2006; Rich 2006). It is the aim of this thesis to demonstrate that such assumptions are analytically unhelpful because, firstly, they take the coupling of risk with patient safety (Bick

2009), which arguably leads to a culture of risk aversion, to be politically neutral and ideologically unproblematic. Secondly, it is unhelpful because it grossly underestimates the existing power relations through which ideas about risk are negotiated, presuming that risk exists outside of meaningful social action and as such is both consistent and constant (Horlick-Jones and Prades 2009). In the light of the research looking at how practitioners make sense of risk in other clinical areas of health care, which has demonstrated that the interpretative work of risk understanding is never that straightforward (Alaszewski et al. 2000; Cooper 2000; Heyman 1998; Horlick-Jones 2005; Horlick-Jones and Young 2009; Lupton and Tulloch 2002),[15] such a theoretical proposition is taken to be suspect.

This research project was based on a working hypothesis that the meaning of risk in midwifery talk and practice should be understood as being problematic. The principal aim has been to interrogate how midwifery understanding of risk is negotiated within interactions, communications and actions. I wanted to investigate how practitioners select from the possible ways of knowing about and managing risk, and how they translate these into meaningful midwifery practice, gaining an understanding of what kinds of circumstances facilitated those particular selections. This meant that I was examining risk as something that was not necessarily consistent or homogenous. Moreover, I was researching risk in a form that was not necessarily explicitly perceived by the social actors themselves, eliciting knowledge that functions at the tacit level, which exists as taken-for-granted common sense. I needed a research design, therefore, that was sensitive enough to look at the way midwives construct common-sense understanding of risk and how this manifests in their everyday clinical practice and talk. This research design was underpinned by the following research questions:

[15] Interestingly, in their work on prenatal screening, Heyman and Henriksen (2001) hint that midwives may have considerably varied views of risk compared to those held by obstetricians. But this idea is not developed in their and Heyman's subsequent work.

1. In what way does risk enter into professional discourses and influence professional practice?
2. How do midwives define and make sense of risk? How does this impact upon practice behaviour?
3. Is there more than one risk discourse at work among midwives? If so, what is the political dynamic at work and what are the social conditions that engender these different meanings?
4. Is there a tension between risk talk and risk practices?
5. Do working environments affect how risk is perceived and dealt with?

By asking these questions, the project aimed to explore the meaning of risk within midwifery discourse, thereby opening up an analytical opportunity to examine risk as a separate entity from the concept of safety. In so doing, I hoped to create a space where diversity within the midwifery voice might be heard. Of course, in this aim I am not suggesting that risk can be entirely divorced from the issues that surround risk avoidance and patient safety and the laudable strategies that are in place to maximise this; nor do I mean to argue that such a complete separation would be desirable. This analysis does not aim to falsify any risk closure initiatives where safety is prioritised, so much as scrutinise them by drawing attention to the inherent fragility involved in their translation into meaningful midwifery practice. What I am trying to achieve is a tangible means by which to engage the midwifery imagination with the issue of risk, both methodologically speaking for the purposes of my research and practically speaking for the furtherance of professional development. The principal aim of this study, therefore, is to problematise the unquestioned presuppositions upon which risk management within maternity services is based in order to establish the kinds of meaning midwives bring to the risk process, which, I suggest, are not self-evident and are likely to be neither homogenous nor inevitable.

Researching tacit knowledge

This interest in midwifery understanding of risk meant that I needed a research design which could illicit how risk is constrained and/or facilitated by the working/cultural environments in which midwives practise and how this professional understanding of risk at once perpetuates, while at the same time operates, to unsettle

existing organisational culture. However, as Schutz and Natanson (1990) point out, this kind of knowledge tends to form part of the taken-for-granted practice or common-sense ideas which demand little or no explanation and is rarely explicitly contemplated by those involved. Or, as Garfinkel (1967) famously demonstrated, under normal circumstances and in normal interaction, we only refer to those normative assumptions briefly, allusively and in passing. This means that access to these normative assumptions is never straightforward and demands careful methodological consideration. The simple fact that midwifery literature largely fails to engage with or challenge the meaning of risk suggests that this group of maternity care professionals may regard the meaning of risk normatively as something which is a given; a part of practice which can be taken-for-granted.

Access to these more hidden aspects of how risk operates at the discursive level demanded a research design robust enough to penetrate the rhetoric of dominant discourses. This was considered to be of methodological importance in this project because, as Foucault points out, the exercise of power is never absolute (Foucault 2002), meaning that no matter how pervasive a discourse, even in a case such as risk, provided the researcher is armed with an appropriately sensitive research tool, other potentially unsettling discourses can be accessed. One of the most exemplary demonstrations of this was produced by Goffman in his work on what he called 'total institutions' (Goffman 1961). Through the application of the ethnographic method, which involved full participation in the life of the institution, Goffman was able to show evidence of resistance to the organisation's official demands (what he called the primary adaptations), demonstrating how authority is neither absolute nor permanent. Such resistance may not be covert; it may exist in ways that are unexpected,[16] at the fringes of the organisation, but that does not mean that it does not exist at all.

[16] In the Goffman work, patients' resistance to the totalising effects of the institution took the seemingly trivial form of smuggling food, fiddling cigarette rations or conning staff. How these acts of self-determination were expressed was unimportant; what was significant, according to Goffman's analysis, was that they did exist and that they were perceived to be of importance to those people involved: 'these practices seem to demonstrate – to the practitioner if no one else – that he has some selfhood and personal autonomy beyond the grasp of the organisation' (Goffman 1961 p. 275).

This epistemological starting point provided the framework for the research design. My problem was:

- How can such invisible tacit knowledge be made explicit through social research?
- How could I go about the task of researching understandings which were taken-for-granted and rarely questioned by those I was working with?
- How was I going to illicit the interpretative work midwives do in the social construction of risk?

The research design adopted to overcome this methodological problem came through a combination of two distinct methodological devices:

1. Discourse analysis.
2. Ethnography.

3.ii The research design – the justification for the methodological combination

The fusing of these two methodological devices within one design framework came originally within the social sciences out of a desire within anthropology in the 1970s to facilitate a robust and politically sensitive analysis of the copious amounts of data ethnography tends to illicit (Agar and Hobbs 1982). More recently, this interest in combining discourse analysis with ethnography has been driven from the opposite direction, where concerns within sociolinguistic research to ground text analysis within a wider socially grounded context of empirical data has given this collaborative research design further credibility (Blommaert 2005). The approach, therefore, has been both refined and developed and, moreover, importantly for this

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During an interview yesterday I was told that to find evidence of midwifery objection I will need to stand by the kettle in the staffroom or hang out in the staff toilets!

investigation, it has been applied to the research of the health care encounter. Following the work of Gwyn (2002), whose sophisticated application of what has become known as Ethnographic Discourse Analysis to the analysis of the communication of health, I have been able to adopt a methodological flexibility, which has proved to be invaluable. Thus, my chosen research design coalesces around an interest in centring both discourse and ethnography in an inclusive way, which allowed for the scrutiny of everyday talk and practice, where midwives went about the business of making sense of risk.

To give a sense of how the combination of these two methodological devices allowed me access to the detail of data necessary to answer the research questions set out above, I shall first establish precisely what I mean by the terms 'discourse' and 'ethnography'. The next part of this chapter, therefore, will endeavour to sketch out my understanding of each term in order to provide an indication of how each has contributed to the methodological rigour necessary to examine risk operating on this level of meaning-making.

Discourse

Although the term 'discourse' is commonly used in a variety of disciplines, its precise meaning is often vague and is left undefined (Mills 1997); indeed, Cousins and Hussain go so far as to suggest that:

> 'For within the human sciences this term is becoming embarrassingly overloaded and more likely to induce confusion than any clarity it might originally have been set to produce' (Cousins and Hussain 1984).

Although in many respects the allusive nature of discourse is problematic, a Foucauldian-style tactical approach to this concept has proved useful for my purpose, in that it is borne out of Foucault's determination to unsettle the Enlightenment project, where knowledge is assumed to be a progressive accumulation of impartial facts about the world (Foucault 2002). My methodological application of discourse in this project predominantly lies in an interest in this determination.

In relation to risk, upon which the research focus of this research lies, the fact that the dominant paradigm (explored in detail in Chapter 2) is embedded within a common sense that assumes an accumulation of impartial scientific calculation means that both the normative and self-sustaining elements of risk are likely to be hardly noticeable to those involved. Furthermore, in maternity care, concerns about risk coalesce around what is perceived to be a particularly vulnerable group - unborn babies - who are self-evidently 'at risk' (Bassett et al. 2000; Martin 2001). The combined effect of these two mechanisms means that it is all too easy to become subsumed by the logic of the dominant paradigm of risk, where notions of safety are closely linked to a sense of duty of care, where risk aversion prevails, and where risk can only be thought of as something that should be avoided (Cooper 2000; Dixon-Woods 2008). This is especially pertinent for a researcher such as myself, who has spent years under the shadow of this moral loading of risk as a practising midwife.[17]

The nature of the political ramifications of risk tend, thereby, to be obscured through the appearance of neutrality, with the power relations being concealed behind a facade of what is believed to be objective knowledge based around a concern for the baby's and mother's safety. For Foucault, however, such tacit and apparently neutral understandings within any discipline, no matter how auspicious, should be treated with suspicion, arguing that:

> 'It seems to me, that the real political task in a society such as ours is to criticise the working as institutions which appear to be both neutral and independent, to criticise them in such a manner that the political violence

[17] For example, while working with an independent midwife at a home birth during this research, I found myself spending as much time familiarising myself with her emergency equipment 'just in case', as I did writing notes about my observations. Similarly, I soon found that familiarity of the hospital labour care environment was counterproductive to my research interests in that as I learned who was who and what was where I slipped into a preoccupation with anticipating the imagined risk object (Heyman 2010). This had a significant impact on how I went about collecting my data because, although I had originally set out to work three or even four consecutive days on the wards during my weeks of participant observation, I was so consumed by the urge to position myself as being useful in an emergency situation that I had to confine my observations to a maximum of two shifts per week and also had ensure that I avoided doing more than twelve hours in any forty-eight hour period.

which had always exercised itself obscurely through them will be unmasked' (Foucault 1974 p. 171).

Discourse and the body

Such a reading of discourse is pertinent to this study because it allows the body to be investigated in a novel way; not as a fixed entity with a set of predisposing risks but as a performance that is made possible through a set of interrelated utterances, where power relations are manifest in concrete form (McNay 1992). According to Foucault:

> 'Nothing in man (sic) – not even his body – is sufficiently stable to serve as a basis for self recognition or for understanding other men' (1974, pp. 87-8).

Within this methodological framework, taken-for-granted understanding of birth upon which midwifery practice is built, no matter how persuasive or pervasive - where the maternal and fetal body are represented as being a fixed physical entities endowed with both the ability for normal birth while at the same time being encumbered by inevitable risks - can be dismantled through analysis. Common-sense understanding about the birthing body, its ability to birth spontaneously and the risks associated with that physiological process can thereby be unsettled through the process of investigation. Once the body is conceptualised as being fixed only through discourse, the nexus of knowledge and power relations which underpin understanding about the body can begin to be investigated. The centring of this reading of discourse, therefore, provides an invaluable methodological opportunity for reconceptualising midwifery practice in such a way as to expose much of which is simply taken as a given by those involved.

The medicalisation of birth critique: an end to polemic epistemologies

It is important to point out here that the methodological flexibility provided by the centring of discourse within the research design not only helped to render professional notions risk open to the scrutiny of academic interrogation, it also provided the opportunity to move beyond the stale confines of previous critiques of birth performance. Descriptions of contemporary birth culture frequently juxtapose the midwifery position against what has been called the medical model of childbirth (Davis-Floyd and Sargent 1997; Graham and Oakley 1981; Henley-Einion 2003;

Hyde and Roche-Reid 2004; Reissman 1983; Romalis 1981; Rothman 1983; Rothwell 1995; Sargent 1982; Scully 1980; Walsh 2009). Despite the inadequacies of this conceptualisation, the representation is surprisingly resilient (Crowther 2010; Davis-Floyd et al. 2009; Kirkham 2010; Walsh and Newburn 2002). In this body of literature, of which the above is just a sample, birth culture is shaped by two competing ways of knowing and performing, both with their own agenda and set of social practices. In this account of the cultural context of birth, the medicalised framework is described as assuming birth to be a pathological process, a site of risk which demands active management, close monitoring and constant observation. In accordance with this paradigm, it is only after the event has concluded that birth can be diagnosed as being a normal physiological event (Percival 1970).

The midwifery ethos, on the other hand, is represented as being an antipathy for this way of conceptualising birth. Midwives are seen as refusing to believe that they are dealing with illness; on the contrary, they are purported to adamantly profess that pregnancy and childbirth are not pathological (Crabtree 2008; Day-Stirk 2005; Russell 2007). Midwifery is therefore represented as coalescing around an understanding that the physiological process of reproduction is not perceived to be harmful, as a risk to be manipulated or even managed (Leap 2000; Odent 1996; Rosser 1998); rather, the midwifery axiom insists that birth is something to be embraced and preserved, something that needs no intervention or manipulation, only encouragement and facilitation (Day-Stirk 2005; Walsh 2001). According to the Cochrane database review:

> 'The underpinning philosophy of midwife-led care is **normality**, continuity of care and being cared for by a known and trusted midwife during labour. There is an emphasis on the **natural ability of women** to experience birth with **minimum intervention**' (Hatem et al. 2008).

While this polemic may help to theoretically clarify the professional boundaries between midwifery and obstetrics, and in countries where midwifery has only recently been statutorily established (c.f. Weir 2006), for researching British midwifery such a polemic is inadequate, for several reasons:

- It fails to account for the contribution midwives make to today's birth culture.

- It fails to capture or give any credence to midwifery agency and impact this agency has upon how women perform childbirth.
- It fails to account for midwifery activity in relation to risk eclipsing the midwifery voice from the risk debate.

Such oversights are at best theoretically unsatisfactory, if not dangerously misogynistic, and offer inadequate analytical for addressing the research problems which underpin this project, casting midwives as hapless and agentless victims working within an environment over which they have no impact.

The very nature of the research problem meant that I needed a methodological approach, which would allow me to analyse midwifery identity not as fixed, drawing from a contained paradigm that resisted the medical model of birth, but as a site of contestation, where different notions of what it was to be a midwife competed. It was only from this methodological starting point that I could begin to conceptualise the complexities involved in how midwives made sense of risk through their talk and practice.

From discourse to ethnography

To start, it is necessary to establish what I mean by this term 'ethnography'; not a straightforward task because, like discourse, ethnography can be difficult to pin down. Implicit in some of the literature is that ethnography is synonymous with participant observation (Bryman 2004) (it should be noted from the start that this is not my understanding of the term). However, as Atkinson and Hammersley (1994) point out:

> 'definitions of ethnography have been subject to controversy. For some it refers to a philosophical paradigm to which one makes a total commitment, to others it designates a method which one uses as and when appropriate' (p. 248).

My own approach to ethnography might be described as a combination of an interest in the finer details of situated meaning-making that is both shaped by, while at the

same time shapes, the objects and subjects of discourse. That is, I understand ethnography in the broadest methodological sense, which, according to Spradley (1980), is a:

> 'concern with the meaning of actions and events to the people we seek to understand... in every society people make constant use of complex meaning systems to organise their behaviour to understand themselves and others, and to make sense out of the world in which they live. These systems of meaning constitute their culture' (p. 5).

For Spradley, the methodological openness which the ethnographic method facilitates is key to what ethnography is. Indeed, this sense of cultural openness is a prerequisite for conducting ethnographic fieldwork, where the researcher must enter the field of their study with a conscious attitude of almost complete ignorance (Spradley 1980). While this aspiration is likely to be a reflection of the period in which Spradley was publishing, being a legacy of the anthropologist Malinowski and his idea of 'getting off the veranda' and actively participating in the social activity under investigation as a method for collecting data, it represents an important methodological priority, which heavily coincides with my reading of discourse, as outlined above.

Unfortunately, the ease with which these two methodological priorities can be combined is not as straightforward as the above description suggests and is punctuated by the thorny issue of truth value claims. As I shall now go on to briefly explore, the methodological overlap between ethnography and discourse also presents a potential epistemological disconnect, which sets a challenge for those interested in collapsing discourse and ethnography into one methodological approach.

My reading of ethnography, with its privileging of subjective meanings, is, in many respects, at odds with how I have described discourse in the previous section and needs, therefore, to be applied with some caution. For example, Foucault's (2002) interest in unsettling the assumptions which lie behind modernist truth claims arguably should preclude any method which claims to be able to access the truth of what is really out there. His notion of 'historic priori' (Foucault 2002) unsettles the possibility of an impartial ethnographic account, suggesting that such an account

would reflect the existing statements in which the researcher is placed, as much as the subjective meanings of those being researched.

While the anthropological origins of the ethnographic project may have indulged in the realist endeavour (De Laine 2001), which, arguably, is at odds with an interest in a Foucauldian approach to discourse, where the existence of meta-narratives is refuted, ethnography ruptured from this preoccupation some forty years ago. In the 1970s, Geertz (1973) pointed out that:

> 'what we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to' (p. 9).

In other words, the ethnographic account comes out of what Foucault called a "historical a priori" (Foucault 2002), a point in time when conditions made that account possible and where the author, conscious of those conditions, is omnipresent in the account they produce. In its attempts to privilege subjective meaning-making, ethnography has long since been sensitive to the fact that this activity involves a process of translation in which the ethnographic author is ever present. Ethnography, arguably more than other methodological approaches, has been grappling with the interface between representation and subjectivity in the process of research and research design for almost five decades. Or, as Geertz (2002) put it:

> 'The fact is that to commit oneself to a semiotic concept of culture and an interpretive approach to the study of it is to commit oneself to a view of ethnographic assertion as... 'essentially contestable.' Anthropology, or at least interpretive anthropology, is a science whose progress is marked less by a perfection of the consensus than by a refinement of debate. What gets better is the precision with which we vex each other' (p. 194).

Because of this, ethnography developed into something that was not so much about capturing what is out there, the objective truth of how things really are from the subjective perspective; rather, it came to be seen as a process of text production where multiple voices, including the ethnographer's, can be heard. Thus, Moore (1994) argued: 'there are no transcendental truths, no absolute grounds on which one can stand to make judgment, no meta-narratives' (Moore 1994 p. 348). At the height of this self-reflexive phase, in the latter half of the 1980s, the invisibility of the

ethnographer was not only abandoned, the very idea of an 'outsider' being able to represent the voice of the 'other' began to be morally questioned.

Unlike some, who have argued that the ethnographic refusal to aspire to meta-narratives, which purport to capture an impartial account of what is really out there, is at odds with the methodological centring of discourse (Hammersley 2005), the suggestion I am attempting to foreground here is that it is precisely because the ethnographic account positions itself as just one of many possible epistemological arrival points that makes it so compatible with the analysis of discourse.

While ethnography's attention to the minute details of peoples' situated meaning-making may undermine its claims to generalisable meta-narrative or theory, and thereby threatens its scientific credibility, it is precisely this that gives it its empirical rigour. Moreover, through this sensitive scrutiny, social action can be investigated, not as a consistent process or even a rational one, but as a site of ongoing contestation, where creative meaning-making shapes and is shaped by existing sets of statements. Thus, the very thing which forms the basis of ethnography's sharpest criticism represents the method's greatest strength in relation to discourse analysis.

3.iii The application of the research design – from methodology to methods

Because of the nature of discourse as it has been described above and the way it operates on a multidimensional level, the methodological fluidity provided by the application of an ethnographic approach has proved to be invaluable. Through an ongoing process of adjusting and then readjusting the research design while in situ, I have been able to prioritise those methods that proved to be most productive at that given time in that particular context and abandon those deemed not useful for the overall aims of the project. As this task unfolded during the research process, with analysis being a concurrent part of the methodology, so the use of various research tools was adapted, adopted or in some cases suspended (Clifford and Marcus 1986; Denzin 1998; Denzin 2002). Emphasis and prioritisation of approaches, therefore,

changed over time, depending on the issues raised by the data, and included a mixture of:

1. *Participant observation* (Spradley 1980; Malinowski 1932), over a period of nineteen months, of midwives of various levels of seniority including student midwives, newly qualified midwives, experienced midwives and midwifery managers, delivering labour care in three different types of clinical setting (n42):

    - A large, obstetric, high-risk care environment (3,361 births per year) (n15 observation episodes).
    - A midwifery-led low-risk unit situated within the hospital environment (where a full obstetric, anaesthetic and paediatric facility is on hand) (606 births per year); and a free-standing midwifery-led birthing unit (where high-risk care is a 40-minute transfer journey away) (378 births per year) (n23 observation episodes)
    - Home birth environment (224 births per year) (n4 observation episodes).

Direct observation of midwifery talk and practice in the different clinical settings revealed intricacies at work in the local socio-cultural dynamic, which those involved might not notice and might not think worth mentioning in an interview-type environment. By simply being there, 'deep hanging around', I was able to watch how some members of the team sought verification and group approval for their practice, while others assumed a more authoritative position. I was able to see the social and physical spaces which enable certain interpretative work to take place. Moreover, I was able to observe which discursive formations were attached to the authoritative position and which sets of statements had to be more tentatively defended. Importantly, there was often a tension between what people did and what they reported in their interviews as being important to them and practice. This disparity was not unexpected and was consistent with other research investigating midwifery practice in the UK (Kirkham et al. 2002), but it was only through the application of such a fluid and detailed investigative toolkit

that I was able to scrutinise the disparity between various competing and concordant discourses.

2. *Non-participant observation*, the bulk of which took place over a period of three months at the beginning of the fieldwork; this was mainly done in 'behind the scenes' NHS observations, such as board meetings, protocol meetings and risk case reviews, to gain insight into organisational issues, which both constrains and facilitates different kinds of practice (n15).

This gave me the opportunity to observe directly how the official operations of risk worked within the organisation and how the interpretative work midwives do in the social construction of risk within their everyday practice was translated and morally loaded through the risk management agenda (explored in the policy chapter).

3. *Ethnographic interviews* (Spradley 1979) with ten midwifery managers, ten midwives, two students, two independent midwives and three maternity and midwifery pressure group members (n25). This diversity in sample was used, as I was keen to establish whether a disparity existed between how the different members of the team approached risk.

Due to the fluid and unstructured nature of the ethnographic interview I was able to use this approach to test hypotheses and the scrutiny of incidents arising out of the observations to test validity. For example, following an observation, I was able to use my field notes to structure an informal interview with several of my participants in order to interrogate apparent tensions and drill down the precise meaning of what I had observed. At some points during this project I decided to rely heavily upon one-to-one ethnographic interviews. I did this for a variety of reasons, but most prominent was my concern with practitioner confidence. When removed from the clinical scenario, more tentative concordant discourses could be voiced and less vocal members of the midwifery team could potentially voice their opinions less tentatively. That is to say, by artificially removing the discursive hierarchy, inherent in the working environment, access to those voices

and discourses which might have otherwise been stifled by the situated dynamics, could be explored.

Ethnographic interviews were also adopted during the final analysis stage of the project for validation purposes. That is, as themes and patterns arose out of the data analysis (to be discussed below) I revisited several of my participants with newly semi-structured interview guides, inviting them to tell more stories about their practice for verification and confirmation.

All interviews were recorded and transcribed from analysis verbatim.

4. *Text analysis* (Fairclough 2001; Fairclough 2003) of policy; statutory codes and rules published by the NMC; national and local guidelines and protocols; midwifery text books and formative professional papers. This approach gave me the opportunity to examine some of the broader social and cultural issues which surround the research problem as well as providing access to the hegemonic operations of those issues.

All of these research techniques were supported by detailed ethnographic field notes, which operated as both a form of data collection as well as an analytical tool. These notes took on a variety of formats including: detailed, hand-drawn maps of the working environment to show precisely where different interpretations of risk and birth could be voiced; logs of conversations and the turn-taking formats of those conversations (who said what and when); personal reflections on what I was witnessing; a diary of events observed; and an evolving analytical narrative used to inform my ethnographic interviews, orientate my observation decisions and structure the final analysis.

Data collection timeline

Dec 2008	March 2009	June 2009	Sept 2009	Dec 2009	March 2010	June 2009	Sept 2009	Dec 2009	March 2010	June 2010	Sept 2010
Ethnographic interviews											
	Non-participant observation										
		Participant observation									
									Validating interview/observations		

Table 1: Data Collection Timeline

Analysis

Because of the broad and pragmatic ethnographic approach taken in this study, at least five analytical approaches were pertinent in the analysis:

1. ***Conversation analysis*** (CA), which arose from the ethnomethodology of Garfinkel and has been extensively applied to the analysis of the health care setting by Silverman (Silverman 1988), not only gave me an opportunity to both structure my observations, encouraging the recording of things like turn-taking, interruptions and speech patterns and emphasis, but also allowed for the detailed scrutiny of what was being said, by whom and to whom. CA, then, is the detailed analysis of naturally occurring conversation, which looks at not only what is being said but how it is being said, what pauses and gestures occur within the conversation, who takes turns and when do these

turns naturally take place (Sacks et al. 1974). This attention to the communication detail allows for closer scrutiny of the meaning-making process.

Although I had not anticipated this to be the case, I found CA to be at its most useful in the formulation of my observations. In this respect, this approach to analysis was intricately woven into both the data production and data analysis, directly influencing how I went about constructing my ethnographic record. Naively, I had entered the field expecting to be able to seamlessly slide to and from my identity as a researcher and my identity as a practitioner. I had optimistically envisaged being able to manage this identity multiplicity with relative ease. In reality, however, I found that the process of working out who I was while I was in the field threw up a host of both emotional and practical challenges. In response to these challenges the research approach was adjusted and practical safeguards were put into place to avoid my researcher identity from being completely subsumed by a seemingly uncontrollable urge to take on the practitioner role. Firstly, I made every effort to avoid participating in observation episodes on two consecutive days, one following the other. This strategy provided the necessary recovery time to keep my ferocious midwifery identity at bay and to reclaim my analytical perspective. Secondly, during each observation I was careful to keep the CA objectives at the forefront of my mind. This allowed me to keep focused and construct my field notes in a systematic way.

2. *Critical Discourse Analysis* (CDA), which arose out of critical linguistics (Fairclough and Wodak 1997), pays more attention to grammatical structure and lexical choice within language. It is most commonly applied to the analysis of texts and, especially in Fairclough's (Fairclough 2003) work, is closely associated with Halliday's (1994) systemic functional grammar. By examining language and visual imagery as social acts, CDA challenges the

normative parameters by which common-sense understanding of the world is made, and questions the basis upon which we judge social realities.
The combination of these two approaches – Conversational Analysis and Critical Discourse Analysis – is an issue of some debate in the methodological literature (Hammersley 2003). However, my experience of using a research design which aspires to combine both has proven, as Gwyn (2002) suggests, to be very effective. By collapsing a methodological interest in both discourse and ethnography into one research design, I have been able to fruitfully complement the detailed analysis of embedded social practice through CA, with the application of semiotic theory provided by CDA. Although it is true CDA has traditionally focused upon printed texts as a unit of analysis, this focus has never been exclusive and in more recent years there has been some effort in some CDA to embed text analysis within an ethnographic framework, where readings of the text can be grounded in an interplay between text and context (Fairclough and Wodak 1997), and it is precisely this premise upon which this research was designed.

My application of CDA was not, therefore, limited to, as you might expect, institutional printed text such as policy documents and local protocols, although this was a fruitful area of application. Instead, I was able to apply this analytical technique right across the data set. Once a data text had been produced, be it field notes or interview transcript, I was able to look at the text from both a CA and a semiotic perspective, scrutinising the grammar for evidence of social meaning and interdiscussivity. However, I was disappointed in the end at how much time I was able to commit to the application of CDA. The strength of CDA is its attention to detail, its scrutiny of grammatical structures. However, this can also be construed, in this research experience at least, as its weakness. I had set out with high hopes of being able to analyse both my primary data texts as well as several key printed documents using CDA, but in the end found that I had to be more selective than I had first anticipated. Thus, while the initial research design included using CDA to scrutinise most of the interview transcripts, I quite

unexpectedly found that in the end I relied most heavily on thematic coding for the bulk of my analysis (outlined below). Indeed, the coding was used as a selection mechanism for the identification of fragments of the dataset for more detailed CDA, but even that proved more time-consuming than expected. This ended up being a far less rigorous application than I would have preferred and was driven largely out of time constraints. As is typical, I am told, of many PhD candidates, I had underestimated the time needed for analysis of the dataset produced by a project of this size. This I believe is a real limitation of this study and I very much hope to have the opportunity in the future to undertake a complete secondary analysis of the dataset, which is more able to prioritise the use of CDA, as I believe it will bring forth some more very interesting analysis.

3. *Narrative analysis* (Coffey and Atkinson 1996), with its sensitivity to the sense of temporal sequence that people, as storytellers, make sense of their lives. Narrative analysis proved to be versatile in its application and I was able to apply it to various research materials including participant observation data and ethnographic interview data, and it has also been used as a method in itself in the form of narrative interview technique.

Just as CA helped me maintain an analytical perspective during my fieldwork, narrative analysis likewise was an invaluable tool in the data collection process. Using this approach meant that during observation episodes I was able to listen to the ways midwives talked to their clients in terms of the key structures of the narrative. Narrative analysis, therefore, offered insight into understanding how certain choice recommendations were presented as plausible through midwifery talk. Narrative analysis was equally useful during interviews and the interview structure was arranged around an understanding of the importance of storytelling. As discussed above, my research interest lies in eliciting discourses which functioned at the tacit level; I was therefore not so much committed to gaining answers to

specific questions but was more intent on accessing the process of ongoing meaning-making. By encouraging midwives to tell me stories about their experiences of being midwives, rather than asking them direct questions, I was able to build a rich and varied dataset, where concordant discourses could be detected.

Given the privileging within narrative analysis for the temporal sequencing of the storytelling, however, I found that this approach did not sit all that comfortably with the thematic coding approach. To manage this methodological disconnect the main bulk of the narrative analysis took place either prior to coding, during, for example, the process of transcribing (Reissman 1993), or following a rebuilding sequence. What I mean by this is, in some instances, narrative analysis followed on after both coding and CDA were complete. By using coding to identify fragments of data appropriate for more detailed analysis, segments of coded data were lifted out of context. Following this process, these segments were reinserted into their original context and, in some cases of the interview data, this involved revisiting the original recording to gain a more detailed narrative transcript. As with CDA, this was an incredibly time-consuming process and was therefore only carried out on a limited amount of the dataset. However, this opportunity to revisit the raw data provided an invaluable opportunity to test the reliability of the other analytical techniques that had been employed.

4. *Ethnographic Analysis* with its centring of reflexive field notes. Given my interest in situated talk and practice, ethnographic analysis formed the basis from which all the other analytical techniques were engaged.

   Field notes and the process of constant reflection on those field notes represent the cornerstone of ethnographic analysis and, indeed, ethnographic research design (Ditton 1977; Spradley 1980). Through this process of visiting and revisiting the field notes I was able to steer my data collection, my analytic emphasis as well as my reading, creating a grounded feedback

mechanism (Armstrong 1993). Ethnographic analysis, then, is about building a reactive dataset, based upon the particular circumstances in the field. It is about sequential analysis but, most of all, ethnography is about self-reflective narrative, where the ongoing impressions from the field shape and reshape the research design in terms of not only the analysis but also the methods, right down to sampling orientation and prioritisation of particular collection techniques (Coffey 1999). Boundaries between the researcher and the research instrument, between data collection and analysis, are at best opaque within the ethnography (Denzin 1999). As such, all aspects of the research process are collapsed into one. Analysis cannot be described as a distinct part of the research procedure; rather, it is an ongoing part of the field work. As Fetterman (1998) points out:

> 'analysis begins from the moment a field worker selects a problem to study and ends with the last word in the report or ethnography' (p. 92).

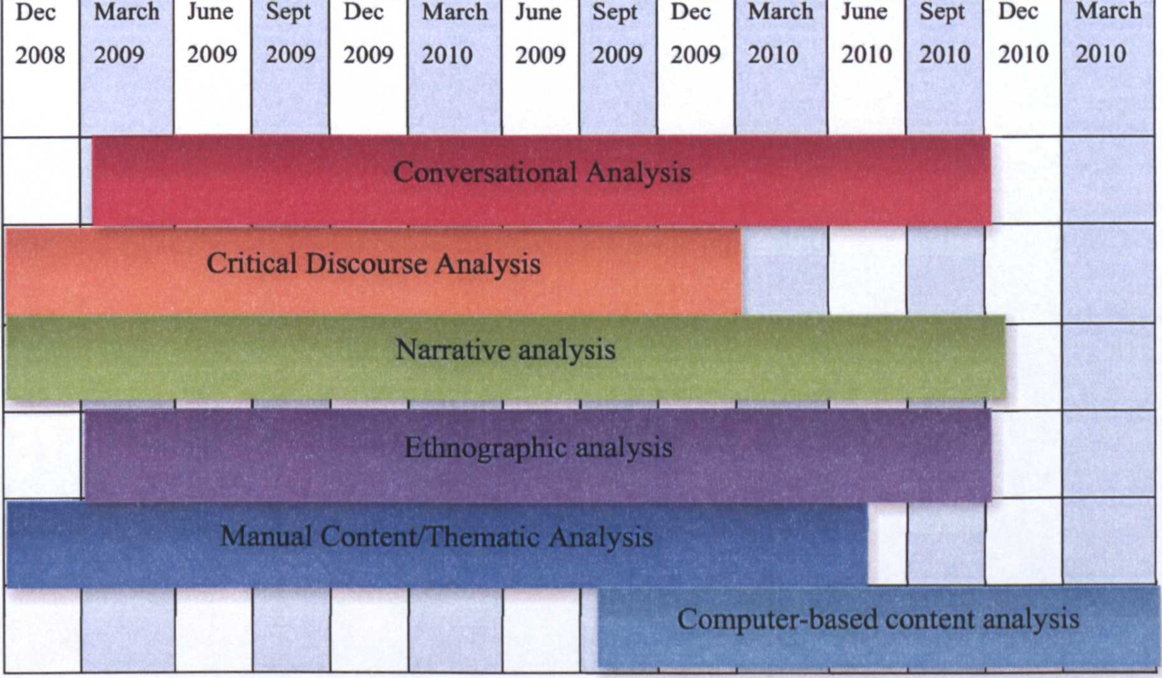
Indeed, analysis is a necessary part of the fieldwork, without which the research would lack direction. Thus, reflective ethnographic analysis formed an integral part of this research, simultaneously functioning as both data and analysis at the same time. Thus, ethnographic analysis was both a research strategy and an analytical technique.

5. ***Content Analysis*** with attention to reliability and replicability. My understanding of content analysis came largely from the grounded theory thesis as it is proposed by Glaser and Strauss (1967). Thus, while my interest in this approach lay in its robustness and its ability to improve reliability and replicability, in keeping with the privileging of an ethnographic agenda, the application of this approach came from an interest in inductive theory building rather than deductive theory testing. This meant that the analysis, which involved the coding and recoding of the data set (Strauss 1987), took place as it emerged through the reflexive research process, both during and after the bulk of the data had been collected (Altheide 1987). This was done manually at first, through listening and re-listening to the interviews, as well

as through the laborious (but very fruitful from this perspective) process of transcription; and through reading and re-reading the field notes and written texts. The manual coding was later intensified using ATLAS.ti.

The timeline

Table 2: Data Analysis Timeline



Access and ethics

This final part of the chapter will describe the participants, how they were recruited and what mechanisms were put into place to ensure that participation was fully consensual. Since this research was an investigation into midwifery understanding of risk, the primary sample group consists of midwives. However, due to the nature of the research design, another group of people, namely service users, were also affected by this project. Although this group were not primary participants, as their involvement was incidental in nature, careful ethical consideration had to be planned into the research design to ensure that these potentially vulnerable people were both fully aware of the study and what it entailed and were happy to take part.

The participants

While the original intention was to have just one group of participants, NHS midwives, this widened during the project to eventually include two further but much smaller groups: independent midwives (n3) and pressure group members (n3). While not my original plan, this kind of flexibility is typical of an ethnographic research design, but it meant three distinct access mechanisms had to be put in place.

The NHS midwives sample (n27)

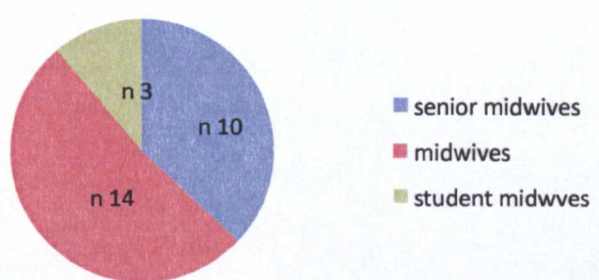


Table 3: Breakdown of NHS Midwives

The initial sample was accessed through a process of self-selection following a recruitment and information campaign targeted at all midwives working in the selected sites (see Appendices 2 and 3 for information letter and poster). Subsequent recruitment was achieved through opportunistic, snowball technique (Bryman 2004), with some attention to purposeful structuring to maximise diversity. The student midwives were all accessed while in the field. Using this combination of techniques, I was able to access a sample of twenty-seven midwives (see chart above for breakdown). Furthermore, I was able to target certain members of staff on the recommendation of recruited participants. This turned out to be of methodological significance, as it meant that, when I was told a story that was particularly pertinent to my research problem, I was able to follow up that story by approaching the individuals involved and asking them if they would be happy for me to work alongside them. While this access strategy did not pay off on every occasion it was

employed it certainly proved invaluable on many occasions as it allowed me to experience first-hand the interpretative work done by different members of the midwifery team working in the various clinical areas (for example, see Chapter 9: Charisma above the margins).

Independent midwifery sample (n3) – why and how

The inclusion of this group came out of unexpected complications in the research process which disrupted the intended timeline. The original research protocol anticipated a commencement date for data collection of September 2008. However, this had to be delayed due to the process of gaining NHS ethical approval. Ethical approval was sought through both national (08/H1110172) and local NHS Ethics (2008/obst/02) and full approval for the study was granted in February 2009 (see Appendices 4 and 5). The project protocol was reviewed and approved, prior to the commencement of data collection, by the NHS Trust's Research and Development Governance Team, the Head of Risk, Assurance and Legal Services and the Head of Midwifery (see Appendix 6). The researcher had an NHS licence to practise for the duration of the data collection (see Appendix 7).

Due to the nature of the research, which involved researcher participatory observation, several weeks were taken up in negotiation between the Trust's Risk, Assurance, and Legal Services and their Research Governance Team in order to gain both access and indemnity insurance and vicarious liability cover for the duration of this access. Existing research bureaucratic structures within the NHS are set up to facilitate research protocols designed around a medical random controlled trial model. This research project, in contrast, failed to fit this structure because: firstly, the main participants were not service users but service providers; secondly, the principal researcher belonged to a professional group not usually involved in setting up research in this context (that is I am a midwife and not a doctor); and thirdly, my deeply qualitative methodological approach was considered to be somewhat of a novelty. These obstacles to gaining access were compounded by the fact that the Head of Midwifery left post during the process and the Head of Risk, Assurance and Legal Services retired, leaving an incomplete audit trail of our negotiations.

This delay, although frustrating, was fortuitous in that it enhanced the quality of the dataset produced by providing the opportunity, and indeed necessity, to broaden the sample frame to include independent midwives. Thus, in the three months prior to NHS data collection, independent midwives were approached and interviewed and plans were put in place for subsequent observation episodes. This sample was purely opportunistic in that it relied on previously established networks to gain initial access. This access was widened through recommendation or snowballing.

Pressure group members (n3)

This small group was accessed largely as a result of the text analysis which formed part of this ethnographic discourse analysis. As I analysed some key texts, I sought out the opportunity to talk to members of the organisation that had produced the texts, which included three organisations: the NMC; the Royal College of Midwives (RCM); and the NCT.

Informed consent

Once access had been gained, the use of an ethnographic research design provided an opportunity to develop research relationships based upon a sequential and mutual understanding, which arguably operates to strengthen the possibility for informed consent. In this project an 'ethico-ethnographic method', as described by Parker (2007), was adopted, meaning that the ethics of informed consent were folded into the method so that all parties were able to continually revisit their understanding of consent.

It should be emphasised, however, that while this continual methodological reappraisal of consent helped build on the more structured processes of obtaining consent, it did not replace them (Burgess 2007). Anticipatory bureaucratic forms of informed consent (see Appendix 8) were, therefore, an important part of the informed consent process of this ethnography. Each potential participating midwife was given an information letter outlining the study, along with a detailed description of precisely what participation would involve, prior to participation, while

information posters were displayed throughout the staff clinical areas (including the inside of the staff toilet doors in all three clinical settings). Some midwives, after reading this material, put themselves forward by signing an accompanying consent letter and returning it to me through the hospital's internal mailing system. Others approached me directly when they saw me working in the various clinical areas, at which point the bureaucratic process was re-established; while I took the opportunity to approach other midwives in person, usually based upon participant recommendation, whenever I was working in the field. Each participating midwife was asked to sign a consent form, which stated that they had read the information leaflet and fully understood what the research project entails, the uses to which the observation and interview material collected will be put, how it will be stored and how and when it will be destroyed.

The information letters were adapted slightly to accommodate the other two smaller sample groups but other than that the consent procedure followed was exactly the same.

Service user involvement

NHS

Although service users were not the focus of this study, they were implicated through the midwives volunteering to participate and my observations of their talk and practice in the labour care setting. Following the requirements stipulated by the National and Local NHS Ethics Committee, a patient information (PI) letter describing the study (see Appendix 9) was distributed to all women expecting to deliver at the units involved within the timeframe of the data collection period, several weeks prior to their expected admission date.

The blanket distribution of 5,000 PI letters was achieved through negotiation with, and kind cooperation from, various NHS staff members. Firstly, a series of meetings with the relevant community midwifery teams was set up. Through these meetings I was able to ensure that all the community midwives could both verbally and formally, via the PI letter, inform the women on their caseloads about the study.

Secondly, the obstetric ultrasound scanning department was approached and a plan put in place, whereby each mother was given a copy of the PI letter during their visit to hospital at twenty weeks gestation for their routine anomaly scan.

The PI letter encouraged each mother to fill in a consent form, if she was happy to participate, and to attach this form to her notes prior to admission. In the event, however, only one mother had followed these instructions and, while all the others talked about knowing about the study beforehand, they had lost the paperwork by the time it came to have their baby. Access, therefore, had to be negotiated on a daily basis and was done through the support of midwives.

NHS service users were approached, in the first instance, following personal recommendation from the midwife responsible for their care. Introductions and explanations were made initially through the midwife, who was careful to check that the women had already heard about the study and were happy to participate. This strategy of access was considered to be appropriate because, firstly, it ensured that all potential participants had been informed about the study prior to participation and as such conformed to the original research protocol. Secondly, this access strategy followed an existing Trust protocol pertaining to student access to the labour care setting. Student midwives are present both as observers and as participants and are given access through service user consent given at the time of their involvement. This means that all service users are routinely informed, before they are admitted for care during labour, that other staff members may be present during their labour and birth. I was able to utilise this aspect of the Trust's routine procedure in that my request, to community midwives, to help me inform women about the study, fitted in easily with their existing information-giving practice about who might be present during their labour and birth. Such prior awareness facilitated unobtrusive access, which in turn operated to reduce researcher impact for the service users.

Once the initial verbal consent was confirmed via the midwife, I then introduced myself and gained further verbal affirmation of consent. At this stage, formal written consent was not necessarily sought, depending upon the clinical

circumstances. I negotiated with the midwife on an individual case by case basis whether it was more appropriate to gain full written consent at the beginning of the observation episode or after the birth had concluded. This meant that, in some cases, written consent was not gained until after the observation had concluded, at which point all the participants were given the option to withdraw from the study.

Although I was able to utilise these existing protocols for access purposes, I was very glad of my twelve years' experience of clinical practice in midwifery and felt that this placed me in a strong position to protect the interests of those service users affected by the study. This experience has meant that I have been able to be mindful of the physical, emotional and psychological needs of the clients involved in the research, ensuring that the research process intruded as little as possible into their care.

Independent midwives service users

Due to the small caseloads these midwives held, I was able to meet all the mothers affected by the study prior to the birth. At these meetings, I explained what the study was about, gave out an adapted PI letter and answered any questions the mothers had regarding what was involved.

'Cleaning'

All transcripts and field notes were 'cleaned', with identifying features removed, as part of the writing-up process. This means that the data included in this thesis has been anonymised through both the use of pseudo names and the removal of any particular feature which may connect the data with the participant involved. Where the observation and/or interview data have been broken down for the purposes of writing up the analysis, the anonymisation process has been, in some instances, strengthened by ensuring that any reference to the original context of the extract is completely removed.

Conclusion

This chapter has drilled down from the research problem to the research design and then on through to the methods, analysis and ethical consideration which have underpinned this project. Through this chapter structure an outline of both why and how the data was collected has been presented. By starting with the research problem and research questions, I was able to set the scene and present the methodological considerations which had to be taken into account when designing this research project. This part of the chapter was followed by a selected review of the methodological literature pertaining to both discourse and ethnography, which offered the theoretical grounding as well as a justification for the research design. Finally, the chapter gave details on the methods adopted for both data collection and data analysis as well as the ethical processes which this research involved.

Chapter 4: Policy and Risk

Introduction

Midwifery talk and practice in the UK is embedded within a specific policy and risk regulation context; the latter, as I argued in the previous chapter, is predominantly framed by the dominant/technical paradigm of risk. The principal aim of the chapter is to locate the research problem within a wider social policy context. I have chosen to realise this aim in a particular way: while the emphasis of the arguments to be made here will predominantly draw upon the social policy literature, particularly in the first half of the chapter, there will also be inclusion of primary data in the form of local policies, media coverage of a risk in birth news story, as well as field observations. It is my intention that this material will operate to introduce what is to follow in the data section of the thesis and as such will function as a bridge between the two different segments of the thesis.

The chapter will fall into three sections. The first section broadly describes risk regulation in relation to clinical governance policy in the NHS. This descriptive section will be followed by a critique of clinical governance. In this section some of the concerns raised in the policy and professional literature will be explored, in particular, the logic of clinical governance will be problematised in relation to four themes: scapegoating; risk amplification; the moral loading of risk; and the standardisation of care agenda. In the final section of this chapter I will look more specifically at how risk is regulated in midwifery practice: first, by taking observational data recorded in my ethnographic field notes to examine the operations of risk management within the NHS where I conducted my research, and secondly, by looking at how midwives are professionally regulated through their professional registration body.

4.i Organisational risk regulation

There is consensus in the literature that the management of risk has become an overriding concern of late-modern social policy (Kemshall 2003); in the UK nowhere is this more evident than in the NHS maternity sector. Notions of risk and corresponding uncertainty are, after all, at the very core of these services – in its application of evolving technology and expertise in seeking to alleviate morbidity and mortality associated with childbirth and pregnancy. However, in order to understand organisational risk management it is necessary to be clear that such 'first-order risks' are not necessarily the target at which the majority of management and regulation is aimed. The inherent risks of pregnancy and birth, those risks which can be captured through morbidity and mortality statistics, are the risks around which maternity services and midwifery activity coalesce. Organisational risk regulation is slightly different and, in contrast, is largely concerned with another level of safety, where the reputation of and trust in the professionals themselves within the organisation, be it the NHS or the wider professional organisation and associated regulatory bodies, are at stake (Brown 2008b). As Scheytt et al (2006) argue:

> 'the relation between organizations and risk management moves beyond 'first order' concerns with... health and safety... and becomes increasingly concerned with the by-products of the world of organizing itself' (p. 133).

Thus, within the NHS, patient safety initiatives have been driven by claims that some health care causes harm to those very people the service is designed to help. Current World Health Organization (WHO) estimates suggest a 1:10 adverse event rate for people who enter hospital in high-income countries, with approximately half of these being thought to be preventable (World Health Organization 2010). According to much of the risk literature, it is public intolerance of such man-made risks, and an organisational concern to contain the litigation burden that grows out of these risks, which forms the basis of organisational risk regulation. This concern has been described as representing a shift in focus, where management strategies aimed at mitigating first-order risk have themselves given rise to a new social problem, itself understood as a site of risk (see Chapter 3). The predominantly social nature of the new problem is important and is, somewhat ironically, created by the very

technologies and services which aim to mitigate risk in the first place where, as Perrow has pointed out, unintended consequences are inevitable (Perrow 1999). Thus, the solution has itself become the problem and, as Pidgeon and O'Leary (Pidgeon and O'Leary 2000) suggest:

> 'a disaster is defined in the man-made disasters model not by its physical impacts at all, but in sociological terms, as a significant disruption or collapse of the existing cultural beliefs and norms about hazards, and for dealing with them and their impacts.'

A point of clarification

It is worth putting a caveat in at this point to clarify the character of the distinctions being drawn in this chapter between the two types of risks: first-order risks and man-made risks. This distinction is not to suggest that first-order risks are any less socially constructed than man-made risks. Indeed, this is an issue which is particularly pertinent to maternity care. Unlike other areas of health, the patient safety debate in relation to birth is less confined, embracing competing discourses concerned with both first-order risks, as well as man-made risks. The safety-of-home-birth controversy is a good example of this, where interpretations of first-order risks, that is concerns about the risks that lie in the woman's body or in the body of the baby, govern professional debate and practice (Bewley et al. 2010: Davis and Johnson 2010: Gyte et al. 2010: Horton 2010: Tuffnell 2010: Wax et al. 2010). Thus, while it is my intention to acknowledge that there are hazards associated with birth, it is the contention of this thesis to posit that, which hazards are problematised, which are chosen to be the target of risk technologies and services, is always socially mediated. The possibility of hazards during pregnancy and birth is unusual, even exceptional but they are very real; the way in which these potential hazards are translated into meaningful action in the present, however, is best understood as being socially constructed. Unlike some authors in the maternity care literature, such as MacKenzie and van Teijlingen (2010), who assume that first-order risks can exist over and above the socially prescribed context from which they emerge, I take what can be described as a soft constructionist stance where both kinds of risk, first-order and man-made, are understood as only becoming fixed into meaningful action

through discursive activities. Neither category of risk, therefore, is conceptualised as being free from the reaches of social and political negotiation and ramification.

It is also worth noting at this point that this chapter focuses upon a particular strand of risk literature and that, according to this strand, the distinction between the two risk categories outlined above is significant. This distinction is not, however, something which attracts much attention in other areas of the risk debate. In subsequent chapters of this thesis, therefore, where I draw theoretical orientation from other material where this particular categorisation of risk is not as prevalent, I will not be drawing such a clear theoretical distinction between these two types of risk.

Risk regulation in the NHS - the story of clinical governance

The concept of clinical governance, originated in the White Paper *The New NHS: Modern, Dependable* (Department of Health 1997), where it is described as being:

> 'A new initiative... to assure and improve clinical standards at the local level throughout the NHS. This includes action to ensure that risks are avoided, adverse events are rapidly detected, openly investigated and lessons learned, good practice is rapidly disseminated and systems are in place to ensure continuous improvements in clinical care' (Department of Health 1997).

The White Paper initiated a series of publications that emphasised that public confidence in health care providers was waning and an understanding that measures should be taken to ensure that performance and conduct within the NHS could be subject to careful scrutiny (Flynn 2002). The precise nature of what clinical governance actually is and how it should be practically translated into practice is far from straightforward. There is agreement, however, that this policy drive represents a fundamental change in the mechanisms for holding medical professionals accountable for the quality of clinical services. Apparent within this increasing demand for accountability within the NHS are the growing concerns about 'quality assurance', 'operational risk', and the 'crisis of trust' that is said to afflict most professions today (Power 1997; Shore 2008). Furthermore, such interests have been

described as being part of the wider process of modernisation, where public trust in professionals has and is being eroded through the processes of risk amplification and reflexivity (Beck 1992; Beck,et al. 1994; Giddens 1991). Within this wider cultural context, high profile cases such as the Bristol paediatric cardiac surgery scandal, the Harold Shipman affair and the earlier Beverley Allitt episode have been held up in the media and in the public's imagination as evidence of wide system errors within the NHS organisation (Freeman and Walshe 2004). In an attempt to regain patients' trust and to contain the NHS litigation burden that is understood to be born out of this diminishing trust in the professionals responsible for health care, techniques of monitoring, auditing, regulating and standardising of performance were made more explicit and transparent. It was assumed that through the introduction of these mechanisms of risk regulation 'public confidence will be rebuilt through openness, improved governance and public commitment to the values and aims of the NHS' (Department of Health 1997).

Governance in the maternity sector

In the UK a swathe of new organisations and mechanisms was set up with the explicit goal of the standardisation and audit of health care provision, and with the introduction of the National Service Framework (NSF) policy guidelines, audit through the Health Care Commission (HCC), the establishment of the Litigation Authority with its Clinical Negligence Scheme for Trusts (CNST), the National Patient Safety Agency, and best practice standards of the National Institute of Clinical Excellence (NICE) maternity services have become firmly entrenched in the clinical governance culture.

As the chart below (taken from the Department of Health's *A First Class Service: Quality in the New NHS* [Department of Health 1998]), graphically illustrates, clinical governance is considered to lie at the very heart of the new NHS.

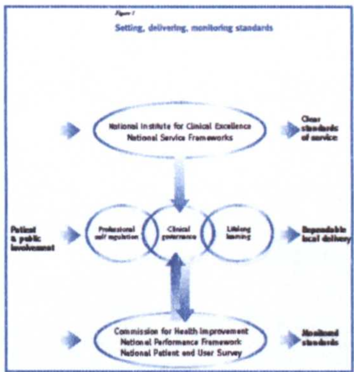


Figure 2: Clinical Governance in the NHS – First Class Service (Department of Health 1998)

In the NHS Trust where I conducted this research, this policy driver has been translated into a robust risk management strategy which, according to their declaration of intent document, aims to achieve four key objectives:

1. Achieving the standards or requirements set by external bodies as appropriate. These external regulations include:
    - HCC's Standards for Better Health
    - NHS Litigation Authority risk management general standards
    - National Patient Safety Agency directives
    - Health and Safety Executive (HSE) risk management requirements and Health and Safety policy statement.
2. Developing the Trust's links with these organisations.
3. Enhancing the Trust's internal risk management processes, which include: directorate integrated groups; quarterly executive performance reviews of directorates; Trust risk management and governance group; patient safety board; online incident reporting system; rolling out the concept of failure mode effects analysis as a risk management tool; strengthening links between incidents, claims and complaints; provision of training; meeting annual staff appraisal targets; ensuring that health and safety committees meet regularly; and strengthening the use of risk information in the annual business cycle.

4. Ensuring that appropriate assurance is provided as to the efficacy of the risk management processes (NHS Trust Head of Risk, Assurance and Legal Services 2008 p. 4).[18]

As these declarations suggest, clinical governance works in very particular ways. Firstly, it involves instigating possibly the most systematic control of clinical practice from outside government agencies ever attempted within the NHS (Harrison 2002) and, as such, is a top-down process with little attention on how staff should be directly involved. Secondly, much of the four objectives described above can be understood to be a response by the Trust, to realise the government's demand for the NHS to become an 'organisation with a memory', where there is learning from clinical errors, whether they result in poor outcome or near misses (Department of Health 2000). Importantly, this learning is translated into robust auditing and accountability structures and the standardisation of care through institutional procedures and protocols. This means that activities in the present and plans for the future are shaped by discrete and usually untoward events which have happened in the past. With the benefit of hindsight, a hindsight which focuses on events in the past where things have gone wrong, mechanisms have been put in place to ensure that a future can be imagined where such events can be anticipated and avoided. Thus, it is a device through which attempts can be made to 'colonise the future' (Giddens 1991), where activity in the present is temporally sandwiched between, on the one hand, a preoccupation with adverse events from the past, regardless of how unusual these events are or whether they resulted in a harmful outcome, and, on the other, an anxiety to ensure that the possibility of an adverse incident reoccurring in the future be removed through structural planning. In this way risk sensitivity becomes the lens through which future service provision can be imagined within the organisation (Heyman et al. 2010) with its incident reporting systems, clinical audit trails, multidisciplinary training programmes and accountability structures.

[18] The reference for this policy document has been anonymised within the thesis bibliography to protect the concealed identity of the participants who volunteered to take part in this study.

4.ii The problem with clinical governance

There are several grounds upon which the current privileging of clinical governance has been criticised within the literature. Not least is the rather paradoxical fact that the efficacy of clinical governance has never been audited and is yet to be established (Brown 2008a). In the next section of this chapter, I will look at some of the more prominent objections which have been levied against the current governance culture to explore the difficulties faced by practitioners working in this kind of clinical environment. In particular, I will be looking at clinical governance in relation to, firstly, the imperfections involved in any attempt at anticipating harms which may not happen in the future and the wider socio-political implications of this world view. Secondly, I will be looking at clinical governance as a tool for standardisation of care to examine some of the implications this has for health care providers working 'at the coalface'.

Arguably, one of the most concerning problems with clinical governance is the flawed logic upon which it rests. Not only does its efficacy rest upon a questionable empirical basis, clinical governance tends to grossly underestimate the imperfect nature of decision making about the future, often ascribing to imperfect management capacity 'full' accountability for adverse outcomes (Scheytt et al. 2006). In an attempt to reassure and guarantee a degree of certainty, ironically, further uncertainty is introduced simply because the goal of colonising the future in this manner can never be fully realised, no matter how robust the governance mechanism is (Perrow 1999). This has two implications: the first is the tendency towards scapegoating; the second is the intensification of risk aversion.

Flawed logic and the scapegoat

To give an illustration of what I mean by scapegoating, I draw from a paper published in the midwifery press where an Australian news story, reporting a maternal death tragedy, offers an illustration of how professional accountability, a key theme in the clinical governance culture, can operate to obscure wider underlying problems. A summary of the story is that a mother of two, who had had

two previous vaginal births, came into hospital in labour with her third child. This baby was in the breech; therefore, on her arrival she was rushed into theatre, where the baby was born by Caesarean section. After the procedure, however, problems arose and she continued to bleed:

> 'After being returned to theatre and undergoing a hysterectomy, the bleeding could not be stopped. She had a cardiac arrest... and died a couple of days later. The greatest portion of the blame landed on the nurses in recovery and their monitoring of the postpartum blood loss' (Dahlen 2010 p. 156).

What is interesting about the account of this story is that, when it is looked at through the prism of clinical governance, it would seem that all procedures have been carried out correctly, the incident appears to have been openly investigated, substandard care was identified and appropriate staff members held accountable. Wider, arguably more political, considerations are:

- Should this mother have been advised to have her baby by Caesarean section in the first place?
- Why is breech birth considered to be pathological despite lack of empirical evidence? [19]

Both issues become obscured from view by the mechanisms of clinical governance. No doubt, the clinicians in question were, quite correctly, following hospital protocol when they offered the mother this mode of delivery, so, again from the apparently politically neutral, clinical governance perspective, nothing is untoward. The fact that this mother died from what might be considered to be the unnecessary medicalisation of birth becomes irrelevant within this discursive climate. As Perrow (1991) points out, through institutional mechanisms such as clinical governance, organisations are increasingly in the business of seeking to externalise the negative consequences of their decisions, exporting them to other organisations or simply to individuals in general. As Harrison (2002) puts it, such an approach:

[19] See (Glezerman 2006).

> '(re)defines the problems of health care practice as tied to individual limitations and failures, rather than...institutional shortcomings.' (p. 479)

In this example, the tying of systemic failures to a few nurses stifles wider and arguably more important debate. This example acts as a sharp illustration of how clinical governance, with its preoccupation with transparency and accountability, can operate as a scapegoating device, diverting attention away from the more deeply embedded and politically sensitive problems. Provided someone is identified and called to account, provided someone is to blame, then the anxiety about the risks, about the uncontrollable and uncertain nature of birth, can be contained, boxed up within the reassurances of robust bureaucracy.

Flawed logic and intensification of risk sensitivity

The second way in which the logic of clinical governance is flawed is in the way it intensifies the very risk aversity it aims to contain. Just as the management of first-order risks has unintended consequences which can manifest in man-made risks (Scheytt et al. 2006), so the mechanisms of accountability in the audit society, which clinical governance can be seen to be part of, aimed at managing those man-made risks, can lead to further risk awareness, which in turn intensifies demands for the audit and clinical governance style management (Power 1997). Take, for example, one of the high-impact risk cases mentioned above, the Bristol paediatric cardiac scandal. The Bristol Royal Infirmary Inquiry, which ensued from this scandal, not only focused public attention on the possible, albeit unlikely, dangers associated with major cardiac surgery, it also instilled a defensive attitude to risk, an attitude Furedi (1997) has labelled a 'culture of fear', where no one can be trusted and must therefore be held accountable for their actions (Giddens 1991). As Nettleton et al. point out:

> 'the very process of making things transparent undermines the trust needed to make expert systems function effectively'(Nettleton et al. 2008 p. 335).

What we are left with, then, is a strange 'chicken and egg' situation; a looped logic, as it were. Within this looped logic, the fear of an adverse event which happened in

the past reoccurring, no matter how unlikely (for example, a doctor being a mass murderer), becomes the focus for future service provision and governance. Through this loop, whole organisational structures have been set up with the aim to reassure and gain public confidence, to allay sensitivity to those fears which, in turn, operate to amplify the very risk which set off the cycle in the first place and serves to increase distrust based on the logic that there is 'no smoke without fire'.

This looped logic in risk management and regulation within maternity services is significant in the context of the analysis of midwifery talk and practice because it constrains how birth can be imagined in the minds of the practitioners, midwives and doctors involved in the performance of birth. Moreover, it constitutes a very particular discourse, where women's bodies are represented as being a site of risk. Within such a discursive environment birthing women are likely to be seen as essentially faulty. Simply by the fact that they are engaged in the activity of reproducing, they are categorised, through the amplification of risk, as teetering on the edge of pathology. As such, pregnancy and birth cannot be trusted to occur spontaneously without technological management (Rothman 1982), encouraging a normative, precautionary approach to risk where midwifery care must coalesce around intensive surveillance of monitoring and measuring (see Chapter 5). Because pregnancy and birth are constituted as loci of risk anxiety, much of midwifery activity entails keeping danger at bay; conversely, such activity helps construct a discourse of birth where notions of women being competent and able are fragile and tentatively placed. According to feminist literature this is problematic because it not only reflects wider attitudes towards women but it also helps to constitute them. As Grosz (1994) argues:

> 'Misogynist thought has commonly found a convenient self justification for women's secondary social position by containing them within bodies that are represented, even constructed, as frail, unruly and unreliable, subject to various intrusions which are not under conscious control' (p. 13).

Looped logic and moral loading

Finally, I want to look at the looped logic of clinical governance from a moral loading perspective; again important because this analysis offers significant insight into how risk manifests within maternity care. As pointed out in the previous chapter, risk and statistical probability are, through the dominant/technical paradigm, presumed to be closely linked. This link helps preserve a semblance of neutrality to the risk assessment process. However, modern understandings of risk, as Douglas (Douglas 1992) observed, are not as impartial as they may seem at face value but, instead, are peculiarly morally loaded. Firstly, the ontological centring of 'learning from mistakes', or near misses, ruptures the link between probability and risk and in so doing focuses attention upon accountability and blame. That is, practice is removed from empirical research evidence via knee-jerk reactions to past adverse events. Through this rupture, the imagined possibility of an unlikely event happening takes on a special status, impacting on how care in the present and future can be conceptualised by the organisation and practitioners alike. This means that sensitivity to low probability but high consequence risks becomes amplified, driving forward a risk-averse governance culture. The likelihood of the event reoccurring, its statistical probability, is removed from the governance process and is subsumed by a hypersensitivity and intense aversity to risk (Krimsky and Golding 1992).

Ironically, this rupture tends not only to be ignored within the risk management archive, it is frequently assumed that the intensification of audit will strengthen and not weaken links to probability reasoning through evidence-based care. Thus, in the *Midwifery 2020* report (Department of Health. Midwifery 2020 Programme 2010) it states that:

> 'The consultant midwife role is a strategic one with the potential to provide leadership and influence a range of areas including... the midwifery contribution to research and evidence-based practice through to audit' (p. 6).

Audit, then, is assumed to be a route which leads towards impartially-based probability reasoning of evidence-based practice (EBP), and not the other way round.

Secondly, and this is a point I will explore in a little more detail, by focusing on the notion of man-made risks, the mechanisms of clinical governance make the possibility for blameless accident culturally unpalatable. The whole point of accountability is to ensure that someone is held responsible when things go wrong. Not only does this function to distract from wider socio-political issues, as highlighted above, but it also means that bad things cannot be thought of as chance events, simply as accidents (Adams 2003; Green 1997). Once the possibility of an accident or chance has been removed from the logic of risk, then someone or something must be held directly responsible for an adverse event occurring, everything becomes man-made. Thus, through the mechanism of governance, risk becomes morally loaded.

Accountability as a form of morality – a cross-cultural insight

A cross-cultural comparison of this moral loading of risk will provide additional theoretical clarity. I therefore briefly compare this process of clinical governance with the anthropological analysis produced by Evans-Pritchard with his work on the Azande (Evans-Pritchard 1976). Evans-Pritchard was writing during a particular period where popularist ideas about 'native' peoples being irrational savages were prevalent. However, through his observations of the Azande, Evans-Pritchard was able to show how 'primitive' ideas about witchcraft should not be seen as evidence of the irrational mind; rather, they can be understood as offering mechanisms of accountability where individuals could be held personally responsible for chance accidents.

The Azande lived in a territory of high termite activity. This termite activity damaged the structure of their wooden granaries to such an extent that these constructions could, and frequently did, collapse. In some cases, such collapses were fatal, as people routinely shaded themselves from the sun by sitting beneath them. What was interesting about Evans-Pritchard's findings was how he showed how the Azande used their understanding of magic to explain why any one building happened to collapse at any given moment in time when a particular person happened to be taking the shade. It was not, therefore, a case of the Azande misunderstanding the

cause and effect of the termite activity, the first-order risk, and the tragedy which had befallen some unfortunate member of the community. They did not deny this logic; they simply added to it since this first-order risk rationality did not explain why the accident occurred at that specific moment in time, impacting so dreadfully upon that particular person. Such explanations needed a second rationality. Moreover, this rationality needed to go beyond the first-order risk, providing the moral opportunity to hold someone personally accountable for the granary accident.

The reason why I include this anthropological account of African magic here is because it shares several commonalities with the logic of clinical governance as I have described it. The example of the Australian mother who died following childbirth can be used as a good illustration of how these two systems of accountability are, in many ways, comparable. As argued above, the clinical governance system in this case operated in a very particular way and, like the Azande magic rationale, it functioned to divert attention away from other wider causes by offering a sense of moral justice. By providing traceable pathways of accountability both cultural systems remove the possibility of an accident. Neither system denies the logic of first-order risks but instead they offer another layer, a morally orientated layer, through which these risks can be understood. The fact that both systems largely ignore the probability calculations of risk becomes irrelevant because what appears to be important is that both are able to coalesce around a sense of moral order where justice, through personal accountability, can prevail.

So far in this section of the chapter I have looked at the logic of clinical governance in relation to its privileging of the notion of accountability, its tendency towards scapegoating and its predisposition for risk amplification. Taking key themes from the governance literature, I have been able to illustrate how this approach to risk regulation can operate to intensify risk adversity by scapegoating and by morally loading the concept of risk in such a way as to obscure wider, potentially more politically relevant, debate. The final section of this critique of clinical governance will involve a shift in focus, moving away from accountability towards the notion of standardisation of care.

As indicated at the beginning of the chapter, clinical governance can be seen as being driven out of two interrelated concerns: the first, accountability, which has already been explored in the preceding section; the second is the concern for ensuring that all practitioners adhere to a standard of encoded practice. It is this which forms the basis of what is to follow in the next section. To explain what I mean by encoded practice and to explore some of the problems associated with this form of regulation, I will be drawing in more detail from Harrison's (Harrison 2002) Weberian analysis of the modernisation of the NHS.

From accountability to standardisation

In his critique of the Labour government's 'modernisation' agenda, Harrison argues that a new, or rather old, form of working relations has been introduced into the NHS. Harrison describes this in terms of a Fordist labour process.[20] What he is describing is the New Labour's policy privileging of the standardisation of care within the NHS where EBP should prevail and inform all clinical decision making, and it is this which forms the basis of how I understand the term 'encoded practice'. The term he uses to describe this new form of labour process is the *scientific-bureaucratic* approach to medicine, which he describes as a way of knowing medicine which relies exclusively upon:

> 'valid and reliable knowledge... mainly to be obtained from the accumulation of research conducted by experts according to strict scientific criteria. The dominant interpretation of these criteria is that randomised controlled trials (RCTs) provide the most valid inferences about the effects of clinical interventions' (Harrison 2002 p. 469).

According to Harrison, scientific-bureaucratic medicine is problematic on several counts: in particular, it overestimates the importance and applicableness of EBP in

[20] Fordism here can be defined as the standardisation and intensification of labour processes using an assembly line working model for the mass production of identical goods. That is to say, it is not focused upon Aglietta and Fernbach's (1979) original concerns with a regime of accumulation and mass consumption norms.

clinical decision making and in so doing marginalises other very important ways of knowing and understanding. This, he suggests, underestimates practitioners' abilities more generally but in particular it discredits the notion of practitioners' clinical discretion and judgement. According to Harrison, therefore, the scientific-bureaucratic model on the one hand rejects the possibility that personal experience, however critically examined, can be accepted as a primary source of valid knowledge; while on the other hand, this model:

> 'assumes that working clinicians are likely to be both too busy and insufficiently skilled to interpret and apply such knowledge for themselves' (Harrison 2002 p. 469).

Although Harrison's work was describing the operations of governance in the NHS in relation to doctors, I think his analysis is useful in this context, not least because it introduces the notion of knowledge and power. Using a Weberian theory of bureaucratisation, Harrison argued that in the scientific-bureaucratic approach to care, where standardisation is privileged, aspirations towards initiative and creativity were stifled under the auspices of the bureaucracy which demanded that behaviour be dominated by goal-orientated rationality. According to Weber's descriptions, the rationalised bureaucracy was a technically ordered, rigid and dehumanised working environment (Weber 2002). Weber described bureaucratic organisation in terms of an *iron cage*[21] where one set of rules and laws operated to restrict individual human feelings and emotions and eradicate choice. Using Weber's analysis, Harrison argued that New Labour's modernisation policies failed to capture the complexities of clinical decision making, reducing medical encounters to the automated access of encoded knowledge and delivery of standardised procedures. Moreover, through the very division of knowledge, encoded and embodied, equating the former with

[21] Although strictly speaking Weber uses this term largely with reference to something he calls asceticism (Weber 2002 p. 181), which might be loosely translated into consumerism and is arguably the equivalent to Marx's fetishism. How this term has been taken up in the Weberian literature, however, is very much in the context of his bureaucratisation thesis and this is how I am using it here in this context.

agency and credibility, a normative dualism was produced, where more inclusive approaches to care became marginalised or even discredited.

Risk management in the maternity care setting

To give an indication of how this operates in the maternity services context, I want to look in more detail at one of the scientific-bureaucratic systems that has been set up to manage risk in the maternity sector in the NHS – The Clinical Negligence Scheme for Trusts (CNST). In particular, I want to explore the CNST's skills drills, but first a few details on what this scheme is and how it works.

In maternity services, the CNST and its standards are a crucial element of the clinical governance culture. The CNST, first established in 1995 by the NHS Litigation Authority, encourages all maternity units to be assessed against national risk assessment standards. These standards are devised to 'minimise the suffering resulting from any adverse incident' (National Health Service Litigation Authority 2008b), but they can also be understood as being driven by organisational concerns about the increasing litigation burden of maternity services.

As the graph below (taken from the 2009 CNST report) reveals, maternity services account for a significant proportion of the overall litigation costs within the NHS and are therefore considered to be a high-risk area, where standardisation and accountability are especially pertinent.[22]

[22] Unfortunately the 2010 report does not break down the payments in speciality. However, details of litigation costs are available in spreadsheet form at http://www.nhsla.com/Claims/

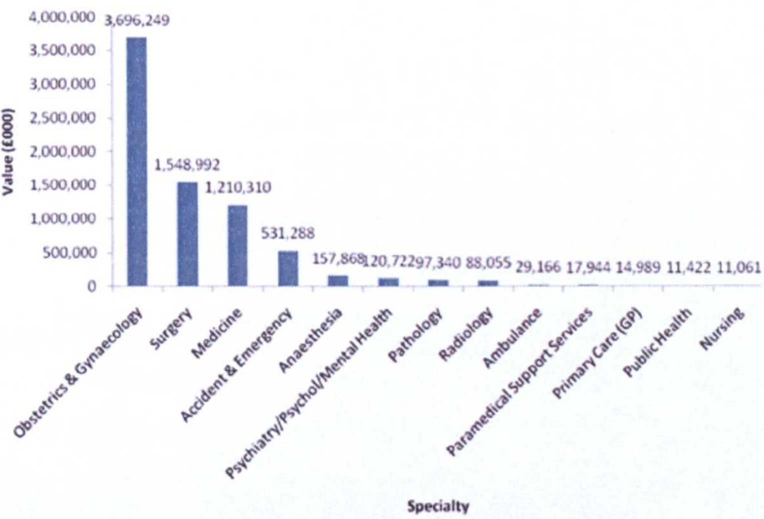


Figure 3: CNST Litigation in Clinical Specialty for 2009

Essentially, the CNST is a financial risk pooling device, which offers litigation insurance to NHS Trusts through the larger Litigation Authority. It is funded by participating NHS Trust contributions, and organisations receive a discount on the maternity element of their contributions where they can demonstrate compliance with the CNST's Maternity Clinical Risk Management Standards. The CNST has devised five standards for maternity services risk regulation: Standard 1: Organisation; Standard 2: Clinical Care; Standard 3: High Risk Conditions; Standard 4: Communication; and Standard 5: Post Natal and Newborn Care (NHS Litigation Authority 2010), and every participating Trust undergoes regular (the frequency of which depends upon the level achieved) mandatory assessments and following these assessments is awarded a level. Maternity services complying with the standards receive a discount from their contributions depending upon which level they achieve. The discounts are: Level 1: 10%; Level 2: 20%; and Level 3: 30%. Because of the size of the maternity litigation burden within the NHS (see above) this discount acts as a huge financial incentive for organisational compliance to the standards set by the CNST.

As part of Standard 1 the CNST expect that:

> 'The maternity service has an approved system for ensuring the delivery of multidisciplinary skills and drills training for relevant staff that is implemented and monitored' (NHS Litigation Authority 2010 p. 54).

On the face of it, this standard seems like a sensible proposal, which would operate to improve the standard of care within maternity services. In the Trust where I conducted this research every midwife is obliged to attend skills drills study sessions every twelve months and, as part of my fieldwork observations (and as a requirement of my licence to operate within the Trust), I too attended several such sessions. To explore how these skills drills sessions work in relation to how care can be imagined and delivered through midwifery activity, I will include extracts taken from field notes written about my observations of one of these sessions:

> 'During the skills drills I sat with 53 other midwives and listened to why we should all be mindful of the findings reported in the 2003-2005 *Saving Mothers Lives* report published by the Confidential Enquiry into Maternal and Child Health (CEMACH) (Lewis 2007). Although it was acknowledged that maternal death associated with birth is extremely rare – 6.24 deaths from direct causes per 100,000 births (ibid.) – the group facilitator was very keen to dismiss this as irrelevant. She gave two reasons for this, both of which were heavily charged with emotion and morality.
>
> Natalie (the senior midwife leading this session) went to great lengths to discuss the emotional impact such an event has on family and friends of the victims. She explained how one of the fathers affected by the death of his partner (which had resulted from a missed post-partum[23] sepsis) has subsequently gone on to set up a charity and write a book about his traumatic ordeal. She read out to the group the blurb from the charity's website (Jessica's Trust 2010):
>
>> *'In the summer of 2004, Ben Palmer was overjoyed when his wife Jessica gave birth to a beautiful baby girl. Emily was their first daughter and a little sister for their three-year-old son, Harry. They had everything they had ever wanted. Six days later, Jessica died of childbed fever, an archaic illness*

[23] The post-partum period is the period immediately following birth. Midwives are responsible for care for up to 28 days after the birth of the baby, although services offered during this period have been significantly reduced under the NHS efficiency drives.

that causes blood poisoning, a condition that can be easily detected and prevented.'

Following this reading it was recommended that we should all read this book in order to get 'a sombre reminder of why there is no room for complacency in our job.'

The second reason Natalie gave for focusing the training session on extremely unlikely events was on account of the fact that the CEMACH report identified both substandard care and avoidable circumstances, which if not present might have prevented the adverse incident from occurring. Again, she read out, this time directly from the report, that there was:

'failure by health care professionals, in all specialties, to recognise and manage common medical conditions or potential emergencies outside their immediate area of expertise. In addition, resuscitation skills were considered to be unacceptably poor in some cases. This concern was reflected in midwifery care where there were cases showing failure by the midwife to recognise deviations from normal, thus failing to refer the woman for medical opinion.' (ibid.) (Field Notes SD1).

The aim of these skills drills sessions was apparently to locate the nexus of risk within maternity services firmly on the shoulders of the practitioners involved in providing care. In this particular case, it was to alert all the midwives in the room that they were themselves all potential risks, each holding the possibility for becoming personally responsible for serious adverse events which may take place in the future. As such, the theme of the session reflects Scheytt et al's (2006) observations that risk management increasingly focuses on the by-products of the management of first-order risks. The session, from which this data comes, was an introduction made at the beginning of the day aimed at setting the scene and justifying what was to follow. The underlying message was clear: a perceived deficit in midwifery care had to be rectified through the standardisation of midwives' skills in the identification of pathological conditions and management of emergencies. Moreover, this standardisation of care could and would be achieved through the

teaching sessions offered during the skills drills sessions, which on this particular day included:

- Hospital life support
- Major haemorrhage
- Breech birth
- Shoulder dystocia[24]
- Neonatal resuscitation

In keeping with clinical governance, the risks being managed by this session were assumed to be man-made. An underlying assumption was that the inadequacies of midwives, their clinical shortfalls, could be successfully managed through the implementation of this training aimed at the standardisation of care. This is, I suggest, problematic on three quite separate counts:

- As pointed out above, Harrison suggests that such management priorities not only grossly confine practice but also significantly underestimate the complexities involved in clinical decision making.
- The justification for this regulation and standardisation is far from neutral and rests upon the amplification of exceptional circumstances, which have resulted in extraordinarily poor outcomes, thereby confining other ways of imagining how care can be given.
- The justification for skills drills training is in danger of overestimating the effectiveness of this risk management strategy, potentially encouraging a culture of complacency.

In what follows I will be using and integrating Harrison's analysis with other diversely placed material produced by organisational analyst Lam, midwife Wickam and feminist Martin, and will be exploring each of the three concerns in turn.

[24] This is when a baby's head is born but the anterior shoulder gets stuck under the maternal symphysis pubis arch.

The complexities of clinical decision making

Harrison's analysis is particularly useful for looking at midwifery work. In what follows, the work of Harrison will be integrated with that of Lam (Lam 2000) and Wickham (Wickham 2009), authors from very different fields but each offering significant insight into the imperfections of this approach to health care. Harrison takes a pessimistic view of clinical governance and its pre-occupation with the standardisation of care. One of his principal objections rests upon the fact that the standardisation of care based on encoded knowledge fails to capture the complexity of knowledge and understanding. Empirical data taken from my observations of how clinical governance is translated into action in the maternity care sector certainly appears to concur with this theoretical proposition as does other empirical research in the field. For example, Ruston discovered in her work with nurses that encoded knowledge is rarely adequate or sufficient as a basis for clinical decision making (Ruston 2006; Ruston and Clayton 2002); a proposition supported in the midwifery literature (Rosser 1998). Indeed, Page estimates that only 12% of midwifery decision making can be done on the basis of evidence-based standardised care (Page 1996). Lam's (2000) work on organisational knowledge gives a comprehensive explanation of why this might be the case, offering an analysis of how knowledge is acquired and used in practice. According to Lam, all knowledge should be understood as being socially embedded and, as such, encoded or standardised knowledge only exists within a context of other ways of knowing about the world. Standardised knowledge, then, should not be thought of as an absolute knowledge which is untouched by social interaction. Far from it; it only exists in talk and practice through a process of translation where it is reformulated and embedded into a complex weave of tacit and embodied knowledge. Standardised knowledge does not exist in a vacuum and should not be thought of as superior to other ways of knowing because it can only exist as part of those other ways of knowing. Moreover:

> 'A large part of human knowledge such as skills and techniques and know-how and routines cannot be easily articulated and communicated in coded forms' (Lam 2000 p. 489).

While Harrison's critique of clinical governance and its preoccupation with the standardisation of care rests upon a wider concern about bureaucratisation, Lam's analysis seems to imply that the objective of standardising care, through skills drills training and the like, rests upon an incomplete understanding of the social nature of activity which takes place in the workplace.

Taking a slightly different approach to Lam, but offering a similar insight, Wickham (2009) criticises the skills drills approach to care on the basis that not only is knowledge socially embedded but the human body itself is similarly socially negotiated and is, moreover, unreliably inconsistent. Skills drills, on the other hand, rest upon a very different perception of the female human physical condition. According to this approach, a woman's body is assumed to be a universal constant; moreover, it can be adequately simulated through a Caucasian plastic training dummy. However, as Wickham argues:

> 'skills drills are based upon air bus disaster training models. Unfortunately most women's bodies refuse to behave like aeroplanes and caring for them requires a very different set of skills which are personal, connected and intuitive' (Wickham 2009).

In reality, then, each situation and each woman is unique, requiring an individualised approach to care; an approach to care which is, ironically, the very approach encoded knowledge aims to eliminate (Harrison 2002). Thus, the standardisation of knowledge through the scientific-bureaucratic paradigm privileged in clinical governance can operate to stifle creative thinking and improvisation (Flynn 2002; Weber et al. 1994), both of which are likely to be vital in emergency situations. The operations of the standardisation of care through clinical governance according to this critique are problematic because, while it may rest upon the objective of providing practitioners with the necessary skills and knowledge base to deal with emergency situations, the ontological assumptions upon which this objective rests, in relation to both human sociality and human physiology, are so confined that they function to obscure a host of other skills which may be key to managing such situations.

Before moving on from this critique taken from the work of Harrison, Lam and Wickham, there are wider socio-political implications introduced by this analysis about the complexities of clinical decision making which deserve attention. In particular, I shall attempt to engage with this critique of the standardisation of care through clinical governance in relation to two socio-political concerns. The first revolves around professional usage of the metaphor of the machine to describe women within the context of reproduction, what Wickham calls the 'air bus' approach to caring for women, and the implications this has on how women are represented. The other applies not only to the standardisation of care but also to clinical governance, more broadly in relation to the audit mentality, and the normative reductionism inherent in the privileging of measurability.

The air bus representation of women

Martin's (2001) critique of contemporary reproductive discourse offers a useful framework for understanding the implications of Wickham's observation. According to this thesis, contemporary understanding of reproduction, constituted through professional discourse, reduces the female form to a mechanical means of production. The routine use of this metaphor for understanding maternity care engenders a particular understanding of birthing women where they can be conceived as being malfunctioning and inanimate pieces of engineering, which not only trivialises imperative aspects of care but also renders women as being essentially agentless in the reproduction process. Following the logic of this metaphor, it is arguably inevitable that health professionals should have exclusive control over the operation of the birthing machine. Within this ontological framework only birth experts can diagnose when the machine is malfunctioning or operating well and it is only they who are equipped to fix the machine when it is seen to be going wrong through expert application of knowledge and technology designed to compensate for the inadequacies in the production process. According to Martin, such understandings of maternity care reflect a wider attitude towards women and it is only:

> 'because the woman is really thought of as someone to control that scientific management strategies are thought to be appropriate' (ibid. p. 62).

What Martin's analysis of professional discourse offers is a way in to looking at clinical governance from a gender sensitive perspective. By applying Martin's analytical framework to Wickham's air bus observation, it is possible to see the wider, gendered socio-political implications which underpin the privileging of encoded knowledge through the national implementation of CNST skills drills. This analysis suggests that the machine metaphor, where embodied knowledge and individualised models of care are delegated, is not only clinically suspect, it raises far-reaching and disturbing concerns about how birth and, by association, women, can be understood more widely. By engaging in activities where women are subsumed within the mechanical metaphor, midwifery activity not only shapes how birth can be performed, it also constitutes a gendered discourse where women are assumed to be incapable of birthing their own babies and where, as a consequence, confidence in spontaneous birth can only ever be tentatively placed.

Machines and measurability

Inherent in the machine metaphor is the assumption that mechanical functioning can be objectified as a measurable entity; moreover, once measured deviations from the expected trajectory can be corrected through the application of expert technology and skills. As Wickham points out, this means that professional understanding of women's bodies has to be both constant and uniform. Within such a framework, maternity care becomes a 'one size fits all' approach. Through the standardisation of care, all practitioners are equipped and able to deal with this one size. Using a Foucauldian analysis of the discourse of birth, Arney (1982) considers the wider socio-political ramifications of such an approach to maternity care for both women and midwives, arguing that:

> 'After the 'normal' trajectory of a process is known and the probability distributions of deviations from the norm are constructed, each individual must be monitored, subjected to surveillance and located precisely in terms of deviations on those probabilities normalizing distributions. Finally any deviations for an optimal 'normal' course must be normalized ... subjects must be subjected to constant and

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total visibility and then offered technologies of normalization to guarantee an optimal experience' (Arney 1982).

Thus, according to Arney, midwives might be described as being agents of social control, their care revolving around the constant checking of women's mechanical bodily functions, their blood pressure, urine chemistry and blood profiles, none of which can be trusted to operate without operator surveillance and intervention. Moreover, within this framework, midwives' understanding of birth has to follow a reductionist paradigm where the subject is reduced to an object (Code 1995). Through the operations of clinical governance and risk management strategies midwives are trained to think of the woman's body as fixed and it is their job to ensure that women conform to prescriptive professionally defined expectations. According to the organisational logic of risk, a midwife's skill could be said to lie predominantly in her ability to police women's individual experiences of pregnancy and birth, ensuring that these remain fixed within the rigid confines of the trajectory, and to recognise any deviations from that trajectory in order to ensure systems are put into place to compensate for the deviance (Nursing and Midwifery Council 2004). It is not surprising, therefore, that the timing of when a woman goes into labour, how her body responds to labour, how long she takes to labour, etc., all need to be closely monitored and controlled through standardised midwifery activity (National Institute for Health and Clinical Excellence 2008; National Institute for Health and Clinical Excellence 2007). Unfortunately, birth can be inconveniently unreliable in that it frequently transcends the fixed expectations dictated through standardised trajectories (Downe 1996; McNabb 2004; Schmid and Downe 2010; Walsh 2004; Winter and Cameron 2006). As a consequence, standardised guidelines recommend that the unpredictable nature of childbirth be constantly supervised through stringent midwifery activity, so much so that the spontaneous rhythms of women's bodies are, in many cases, totally disregarded.[25] There is a suspicious

[25] 'Failure to progress' is the most common reason cited for the clinical decision to perform a Caesarean section. This is when a woman's body fails to produce a baby within the allotted timescale prescribed by the expected trajectory (Mander 2008).

gendered discourse underpinning this practice of birth management: the length of pregnancy and timings of birth cannot be left to the unreliable devices of a woman's body, not least because this kind of birth performance would demand a completely different set of midwifery skills where knowledge of the complexities and inconsistencies of women's unmanaged bodies can be positively embraced. In other words, this kind of birth performance would demand a knowledge base which, in the current system, midwives are inadequately trained for.

Using the exceptional to frame the routine

Having revisited Harrison's critique of modernisation in the NHS and the role standardised care plays in it, I now want to move on to look at the second problem raised above: the inherent amplification of exceptional circumstances which have resulted in extraordinary poor outcomes which underpin this approach. While again this is an issue which has been discussed in the previous section in relation to trust in the health professional and personal accountability, it is of such importance to this example of how the standardisation of care operates in practice, it too deserves more attention here. By framing the skills drills training day in the context of the maternal death enquiry, or more specifically the substandard care associated with the maternal death enquiry, this staff education programme can be understood as an attempt to encode midwifery knowledge within a morally loaded risk avoidance framework. Such risk management within maternity services encourages practitioners to disproportionately focus on the relatively rare risks of obstetric emergencies, as opposed to the more common and more desirable outcome: spontaneous birth. As might be expected, this approach to practice regulation translates into a hypersensitivity to risk, where encoded knowledge is openly welcomed and gratefully received by midwives as tools for self-protection. Any professional aspirations towards promoting normality and confidence in the skills necessary to facilitate normal birth become subsumed by an overwhelming fear of the possibility of something going wrong:

> 'As I looked around the room many of the midwives in the group were grimacing in horror as the session unfolded. Furthermore, the coffee break which followed this session was spent exchanging and collaborating over stories of near misses where

risks lay waiting to develop into future confidential enquiry statistics' (Field Notes SD1).

While I did come across evidence that other ways of knowing can coexist alongside this dominant paradigm where an adversity to risk prevails (a subject I discuss in detail in Chapter 9), these concordant discourses appeared to exist only at the fringes and were often treated with contempt by many of the midwives I observed, as the following extract illustrates. This second field note entry describes another staff training day I attended during my fieldwork. Although this day still comes under the auspices of clinical governance, its focus was different in that it was aimed at community midwives working outside the acute hospital environment. A significant proportion of the day was punitive in nature, categorising midwifery activity as a potential site of risk and alluding to staff failures in relation to things like child protection and CNST standards for record keeping. However, in contrast, a small portion of the day involved a presentation on the normalisation of birth and was presented by a non-NHS midwife. While the presentation itself was interesting in that it refused to collude with the risk amplification agenda so prevalent in the operations of clinical governance (whether that be a first-order risk, i.e. a risk which is perceived to lie in the body of the mother or the baby, or a man-made risk or risk that arises out of midwifery practice), it was the level of hostility this midwife faced from her NHS midwifery audience which was most striking. In particular, the suggestion that risk adversity might not be conducive for good, women-centred midwifery care, met with significant and at times, hostile, resistance.

> 'I looked round to get an impression of how Heather's (the independent midwife) story about allowing a mother to labour in her own time (which did not follow the NICE guideline progress trajectory) was being received. I saw several midwives frowning and muttering amongst one another. Afterwards, however, during the coffee break, their hostility became more overt and during a discussion several of the midwives made little effort to hide their contempt, openly saying:
>
> "That's just ridiculous. No, it's worse than that, it's darn right dangerous."

When Heather tried to defend her position she was shouted down by another midwife who chipped in by proudly announcing:

"Well, that may well be how you do it, dear, but it is not how we do things in the NHS. I would hate to be an independent midwife."

Following this comment three midwives turned their back on Heather and walked out of the room whilst she was still talking. Other voices were more receptive to Heather's suggestions, even awe-inspired, but this admiration was tentatively voiced and only ventured after the more irate midwives had said their piece and departed' (Field Notes ES3).

Although this study day was organised in such a way that encoded knowledge and standardised care could be placed alongside other more inclusive ways of knowing, where the possibility of normality could be ontologically privileged as a way of avoiding iatrogenic or man-made risks, the tolerance threshold for such inclusiveness was low. Thus, what Weber called the *imperative co-ordination* of the bureaucracy, that is the voluntary submission of those working in the organisation to the management goals of the organisation, appear to have been so successfully embedded in this context that other ways of imagining birth where a fear of risk does not necessarily have to preoccupy the mind of the midwife are all but circumvented. Just as Harrison observes:

> 'Emerging research findings from English primary care settings reveal little sign of active resistance amongst rank and file GPs... Nor are there signs of much resistance from the medical elite, for whom scientific-bureaucratic medicine offers funds for research, guideline production and indeed several whole new university units and departments' (Harrison 2002 pp. 481-482).

This incident suggests that the majority of midwives are so entrenched in the clinical governance agenda, with its scientific-bureaucratic model of health care, that other ways of practising appear to be 'darn right dangerous'. Unlike Harrison's medical elites, who have much to gain financially from subscribing so completely to the scientific-bureaucratic model, midwives appear to be driven by another set of incentives. As will become clear in subsequent chapters, it is the contention of this

thesis that this driver is the fear of being categorised as a site of risk, along with a fear of the first-order risks associated with giving birth (see Chapter 5). The implications of this on how birth can be imagined in the minds of midwives and how this impacts upon how birth can be performed is enormous and is the focus of several of the chapters to come in this thesis.

The introduction of clinical complacency through clinical governance

The final issue I want to address in this section of the chapter is that of the introduction of complacency through clinical governance. To achieve this, I want to return briefly to Weber's theory of bureaucratisation. According to this thesis, modern bureaucracy involves rational action, orientated towards attaining particular organisational objectives which systematically eliminate any factors which may stand in the way. Weber's descriptions of this type of rationality suggest that humanity will be confined to such an extent that spontaneity, creativity and individual initiative will be largely subsumed by the interests of the bureaucracy, meaning that 'the world one day will be filled with little cogs, little men (sic) clinging to little jobs and striving towards bigger ones' (Mayer 1998 p. 127). As argued above, in terms of clinical governance and accountability this means that wider socio-political concerns become irrelevant provided all procedures of governance are strictly adhered to. In terms of the CNST's skills drills, this means that, as long as an organisation can prove that all its members of staff have attended their annual skills drills session, it has demonstrated that it successfully manages risk.

While this may provide a semblance of compliance to the standardised care objective, it is very dangerous to assume that this will mean that midwives will be confident in managing life and death situations in real life. As already pointed out above, not only does acute emergency care demand a host of skills which cannot be taught through a drill training format, it also involves the practice of manoeuvres and the operation of technology which many midwives may not be familiar with in their everyday work. Simply attending a skills drills session once a year does not make a

midwife into a competent practitioner in an emergency situation. As Lam's (2000) work suggests, being an expert in any field involves knowing about how things work on a tacit level; it involves routine and familiarity, none of which can be achieved through the artificial learning environment of a skills drills training session. Although attending such sessions may meet the organisation's clinical governance goal set by the CNST, its impact upon care, however, remains inconclusive. On the other hand, it is likely to evoke an organisational complacency which may in the end prove to be very costly for service users and midwives alike.

So far, this chapter has looked at the wider context in which midwives' understanding of risk takes place; in particular, how risk is regulated through local and national protocols and policies of clinical governance. The operations of clinical governance in the maternity care sector have been unpicked using two perspectives: firstly, the mechanisms of accountability in clinical governance and, secondly, the mechanism for the standardisation of care were both scrutinised. Drawing both from primary data taken from observation episodes recorded during my fieldwork and the literature surrounding the issue of governance and modernity, I have been able to offer a critique of the operations of clinical governance in the maternity care context.

In the final section of this chapter I want to look more specifically at risk regulation of midwifery. Having looked at how risk is perceived and managed within the organisation of health care more generally, I shall now concentrate on how risk is placed within the context of professional statutory regulation.

4.iii Risk regulation in midwifery

Following on from the preceding section, the discussion presented here will continue to use the same theoretical orientation to look at the statutory professional regulation of midwives. In one respect, however, there will be a clear distinction here which veers away from one of the central components found in the audit/governance literature. According to much of the analysis around the rise of clinical governance in health, there is an underlying assumption that current policy drivers represent an ontological and political rupture from a past where health practitioners or, to be more

specific, doctors, enjoyed more professional autonomy and freedom to self-regulate (Alaszewski 2003; Harrison 2002). According to this literature, health policy over the last twenty years can be seen to represent the most coherent effort to bring doctors to account ever before attempted in the NHS. It is the proposition of this section of the chapter, however, to suggest that this assumption fails to capture the midwifery situation, in relation to their socio-historic position in maternity care services.

Arguably, both the scrutiny and the standardisation inherent in clinical governance apply to all clinical health professionals and could, therefore, similarly be seen as evidence of the curbing of midwifery autonomy (Weston et al. 2001). As the evidence above indicates, this is indeed the case. There are, however, two important differences between how midwives and doctors are positioned in relation to organisational risk regulation. Firstly, unlike doctors, midwives have traditionally been subjected to scrutiny from outside control and even before they were first officially recognised as a legitimate profession in the Midwifery Act 1902, powerful outside groups constantly tried to regulate their practice. Contemporary clinical governance, therefore, can be said to represent a return of a process of outside control and scrutiny to which midwives are well accustomed. Secondly, midwives are uniquely placed in relation to their client group as women's advocates. As such, advances in accountability to the consumer and developments in consumer autonomy represent a completely different political dynamic for midwives. While the medical profession's autonomy is eroded by increased accountability to the public, the midwifery position, in contrast, could potentially be raised by these changes. It is an interest in these two differences which forms the basis of the remainder of this chapter.

Midwives as a site of risk

Unlike their medical colleagues, midwives have always been precariously placed in relation to understanding of man-made risks. This precarious positioning has meant that the profession has had what might be described as a chequered reputation, with external organisations making concerted efforts to control what was perceived to be

an unruly group of women. Throughout history, attempts have been made by the church, the medical profession and the government to control and regulate midwifery practice. It should be understood that self-regulation is relatively new to midwifery, since midwives were not seen to be trustworthy enough for such professional autonomy.

A brief look at the background to midwifery education and regulation gives an indication of the level of professional autonomy midwives have commanded in the past. For example, nineteenth-century training and professional regulation drives originated largely from voices placed outside the profession (Donnison 1988; Towler and Bramall 1986). Thus, in 1889, the General Medical Council (GMC) stated:

> 'This council regards the absence of public supervision for the education and supervision of midwives as productive of a large amount of grave suffering and fatal disease amongst the poorest classes and urges the government the importance of passing into law some measure for education and the registration of midwives' (quoted in Towler and Bramall 1986 p. 166).

What the GMC were calling for here was an extension of the power of the medical profession to control midwifery practice through outside training and regulation. In 1902, with the passing of the Midwives Act, the Central Midwives Board (CMB) was established, but what was most significant about this professional regulating body was, unlike other professional regulating bodies, its conspicuous absence of midwives. Furthermore, there were never any aspirations for an inclusive policy (Royal College of Midwives 1991). The Board was a mechanism for statutory regulation of midwives by an outside organisation – the medical profession – and it remained so until 1983 with the Board's dissolution.

It is not surprising, therefore, that the first ever midwifery text to go into print, in 1506, was written not by a midwife but by a physician (Radcliffe 1967). Midwives were seen to be not only ignorant, an affront to new, enlightened ways of knowing about the world (Dalmiya and Alcoff 1993; Heagerty 1996), but were considered a threat both to those women who used their services and to the moral fabric of

society. Dickens' creation, Sairy Gamp, the overweight, alcoholic and distinctly unprofessional midwife with a hoarse voice and a red nose, has been said to embody the negative metaphor for the midwife in England (Donnison 1988), suggesting that midwives have always been seen as a site of risk requiring external monitoring and control. Far from being novel, clinical governance in relation to midwifery practice might be described as being a reformulation of previous professional regulation, which has, up until relatively recently, always been the prerogative of those outside the profession.

Maternity health policy and risk

With burgeoning NHS costs, in conjunction with the intensification of the medicalisation of birth performance (Wagner 1994) and the extra costs this entailed, government interest in midwifery models of care began to crystallise and, in 1992, a House of Commons inquiry report into maternity care was published (House of Commons 1992). With this inquiry a significant shift in representation of interests occurred. Where previous policy had coalesced around the interests of the obstetric profession, in the 1990s such privileging was no longer considered to be financially viable. Under the neo-liberal concern for efficiency drives within the NHS, other ways of performing birth gained levels of credibility never before enjoyed. For the first time, normal birth and the importance of the midwife's role in facilitating this process were officially corroborated, potentially shifting how birth and risk could be imagined. The driver behind this inquiry was a concern that the relatively cheap labour force made up of midwives was being underutilised within NHS maternity services (Sandall et al. 2001). Thus, fringe midwifery and service user action groups – the Association of Radical Midwives (ARM) and the National Childbirth Trust (NCT) – both championing resistance to the medicalisation of birth through a campaign privileging normal birth, suddenly found themselves positioned as insiders in the policymaking process. After examining all the evidence, the inquiry questioned the empirical basis underpinning much of the medicalisation of birth, which included where a birth should take place, and called for an extension of midwifery autonomy within maternity services.

In the following year, with the government's publication of the White Paper *Changing Childbirth* (Department of Health 1993) most of the Winterton report's conclusions were corroborated. The White Paper called for a shift in roles and responsibility between doctors and midwives, with the latter gaining more autonomy, while service users were given more opportunity to be involved in their care (Bourgeault et al. 2001). Not surprisingly, midwives welcomed this policy as an unprecedented professional opportunity (Walton and Hamilton 1995); never before had midwives been officially represented in such a positive light. Positioned as women's advocates and in their principal capacity of being 'with woman' in spontaneous labour (Sandall et al. 2009) this policy vindicated midwifery practice in two domains and, more importantly, had the potential to dis-embed the link between midwives and risk.

Despite this policy, however, and the subsequent 2004 National Service Framework (Department of Health 2004) and the 2007 *Maternity Matters*, both of which pursued the themes set out in the 1990s, the profession appears to have failed to exploit the window of opportunity presented to them. Furthermore, the medicalisation of birth continues unabated (NHS Information Centre 2009). The operations of this maternity policy in relation to risk theory has been explored in more detail in the previous chapter, but what is particularly worth noting here is that evidence suggests that this opportunity to reconceptualise how the profession and birth can be imagined has translated into a source of further professional degradation and depletion in terms of professional dissatisfaction and burnout (Sandall 1998; Sandall et al. 2001).

In this section of the chapter, the case has been presented for midwives occupying a unique position in relation to clinical governance. That is not to suggest that midwifery talk and practice is immune to the ontological constraints set by current risk regulation policy within the NHS. As indicated above, organisational risk regulation has a significant constitutive impact upon how midwifery practice and, importantly, how birth, can be imagined and performed. It is important to note, however, that because of other historic, political and policy events, the role midwives play in birth performance could have been positioned to risk regulation in

a distinct way within maternity services, where midwives might be seen as tools of deflection for the iatrogenic, man-made risks associated with interventionist, medicalised models of care. Within the policy climate of the post-1990s, midwives could have capitalised on their, previously discredited, role as normal birth facilitators by positioning themselves as guardians of spontaneous birth, as protectors of women from the risks associated with high technological birth performance.

What is particularly surprising about this situation, however, is that, despite this distinct positioning, midwives have apparently failed to promote a less risk-averse, less interventionist and more physiologically-based birth performance in the UK. It is the intention of this thesis to interrogate the interpretative work midwives do, through their everyday talk and practice, in the social construction of risk to see if this will offer some insight into this problem.

Conclusion

In this chapter, I examined the risk regulation in the UK which surrounds birth performance. Midwifery talk and practice is both shaped and constrained by this regulation and, by looking at the operations of clinical governance in maternity services in this country in relation to both accountability and the standardisation of care, I have been able to unpick how these policy objectives build a normative framework where birth performance and the midwife's role in that birth performance is constituted. By drawing from and integrating three strands of literature[26] and primary research data, the chapter has provided an indication of the wider social and political concerns underpinning current clinical governance objectives. In the final section of the chapter, a different tact was adopted to show how uniquely the midwifery profession is positioned within the clinical governance policy agenda and the questions this positioning raises in how we perform birth in the UK.

[26] With a heavier representation from the social policy strand and to a lesser extent drawing from feminist and professional material.

The discussion of this chapter suggests that midwifery practice is embedded within a risk framework where organisational structures amplify professional sensitivity to risk by privileging a bureaucratic-scientific approach to maternity care at the expense of other, less systematic and more intuitive, ways of understanding the birth process. In this thesis I will consider how such a policy context constitutes midwifery talk and practice and how this in turn shapes the way birth can be performed in the UK. Through the detailed scrutiny of midwifery activity, this project aims to describe the role midwives play, in an effort to understand why concordant national and international policy initiatives aimed at confining the unnecessary medicalisation of birth have proved so ineffective.

Chapter 5: Risk and 'Shit'

Introduction

The aim of the previous sections of this thesis, both the background and bridge sections, was to provide a methodological, theoretical and policy context for this research project. This chapter marks the start of a new section in the thesis, which foregrounds the primary data collected during this research. This chapter also introduces a principal theme which runs through the entire dataset, which was generated by this ethnographic discourse analysis of midwifery talk and practice. By engaging with this principal theme, which arose out of the interpretative work the midwives involved in this study carried out in relation to risk, this chapter provides the analytical framework through which the rest of the research findings from this PhD can be understood. The overall aim of the chapter, therefore, is to describe the discursive statements which, on the one hand, constrain the ways midwives can go about the business of making sense of risk, while, on the other hand, are themselves creatively constituted through the midwifery activity which surrounds the performance of pregnancy and birth.

In keeping with the preceding chapter, the discussion to follow will coalesce around a concern with institutionalised risk management processes. That is to say, I will maintain a focus on how understanding of man-made risks operates in the organisation. However, it is important to note that the points raised in this chapter were observed to transcend the risk categorisations described in the previous chapter and are best understood as applying just as well to how midwives talk about and practice in relation to first-order risks as to man-made risks.

Through an introduction of the processes through which midwives negotiate an understanding of risk, two considerations will be foregrounded: the first and foremost consideration is that expert, midwifery technologies of risk are best

conceptualised as complexly situated and socially relevant constructions; the second is that through midwifery talk and practice risk is closely linked to harm, infusing it with a certain 'scare value', which has significant impact upon how risk can be experienced through the performance of birth.

The chapter opens by looking at some of the previous empirical work that has been carried out in relation to understanding how people make sense of risk, problematising the implicit assumption found in some of this material that lay public perceptions of risk are more socially and less technically grounded than professional understanding. This will be followed by an analysis of the complex interpretative work carried out by midwives, as experts in the performance of birth, in making sense of risk. Using a 'eureka moment', which took place while in the field and which helped shape the analytical orientation of the project, I will give an indication of why the conceptualisation of expert ways of knowing about risk as being essentially impartial fails to capture the complexities involved in how midwives make sense of risk through their talk and practice.

5.i The theoretical premise of the chapter

One of the primary objectives of this project has been to problematise the meaning of risk in midwifery talk and practice. Although the ubiquitous nature of risk in health care, and specifically in the high litigation area of maternity care (National Health Service Litigation Authority 2009), is something that is taken as a given both in the literature and on the shop floor (Bush and Arulkumaran 2003; Edwards 2008; Symon 1998), the precise meaning of this concept in relation to midwifery understanding of birth is an area which has been underexplored.

Interestingly, this is not so much the case in respect to women's understanding of risk and birth (Edwards and Murphy Lawless 2006; Viisainen 2000) and this disproportionate attention reflects a wider picture in the academic activity around

risk. For example, much of the work which has been carried out by researchers interested in the psychology of decision making and risk has tended to focus upon the work lay people do in the social construction of risk, where they are represented as being deficient in their abilities to assess risk, drawing on 'irrational' assumptions when making judgements about choice that are related to risk (Lupton and Tulloch 2002). Other paradigms of social research similarly reflect this disproportionate interest in lay perceptions of risk (Douglas 1992; Douglas and Wildavsky 1983; Pidgeon et al. 2003; Slovic 1987; Wildavsky and Dake 1990; Wynne 1989; Wynne 1996), leaving expert understanding relatively undisturbed by the scrutiny of social investigation. The outcome of such an empirical focus has been an emphasis on the social nature of risk perception within a particular group: the lay community. That is to say, this body of work operates to draw academic attention towards how the public go about utilising information that has been produced through the application of certain risk technologies by apparently impartial and rational experts. Arguably, such academic inquiry into the social construction of risk can be said to operate to reinforce the compilation of the official account of risk discussed in Chapter 3 and described there as the dominant/technical paradigm of risk. Furthermore, such empirical interest does little to unsettle the assumption that expert opinion is immune to the social and moral components of risk. As Heyman (1998) observes when describing research into health risk behaviours:

> 'Studies of health risk compares perceived with objective risk, in order to assess and explain lay errors... such research implicitly takes for granted the superiority of the expert over lay knowledge, and treats communication as a one-way process in which risk experts educate lay people ... risk management, within this approach is therefore equated with increasing conformity with expert advice' (p. 15).

It should be noted that this is not necessarily something that the authors cited above are ignorant of. Wynne, for example, alludes to this insight in what he calls the 'naive sociology' approach to risk (Wynne 1989); similarly, Douglas did much to criticise what she calls the 'culturally innocent approach' to risk, using much the same arguments. According to Wynne, therefore, despite the fact that his work largely focuses on how the public uses and actively contributes to the process of

understanding technical accounts of risk, he insists that this active interpretation and translation of expert technology into meaningful action should not be thought to invalidate the scientific value of those accounts (Wynne 1989; Wynne 1996). Moreover, he suggests that:

> 'Expert assumptions about the social world of risk practices are necessary in order to even frame a technical risk analysis. Yet their assumptions and commitment to this dimension may be no better than the lay public's – indeed they may be worse' (Wynne 1989 pp. 33-34).

This thesis engages with the expert assumptions and commitments, as described by Wynne, which underpin the interpretative work carried out by midwives (birth experts) in the social construction of risk. As such, the thesis represents a shift in empirical attention. Building on the previous research that has focused on how the lay public make sense of the dominant/technical paradigm of risk, this investigation looks at the assumptions and commitments that midwives hold and without which the dominant/technical paradigm within maternity care would not be possible. My aim, therefore, is not to challenge the findings that have come out of the previous empirical research into how people make sense of risk but, rather, to broaden its application by extending the frame of analysis to include the interpretative work carried out by experts.

The data collected during this study through ethnographic discourse analysis of midwifery talk and practice confirms that risk technologies do not exist in a one-dimensional context but, rather, are used creatively as part of a multidimensional, complex and socially embedded process. Where this work diverges from that produced by Wynne, Slovic and the like, is at the point of research focus and design. My interest lies not in how the service users go about the business of interpreting the dominant/technical paradigm of risk so much as in how the dominant/technical paradigm itself is socially constructed through the work carried out by the most prolific experts in the maternity care setting – midwives.

The basic premise of this chapter, as well as the entire thesis, is that expert/scientific understandings of birth, upon which risk perceptions rest, do not exist in a cultural

vacuum outside of the social actions of those involved in the performance of birth. The work carried out in this context in relation to risk is not seen as a contamination of the scientific technology but is simply understood as the active creation of that technology. This thesis, therefore, sets out to explore the interpretative work midwives do in the social construction of risk and in this chapter I aim to set out a principal theme involved in that process.

5.ii The fear factor of risk

While on a lunch break in a staffroom during an observational shift with a senior midwife, something happened that made me realise that, if I wanted to understand what risk means to midwives, I needed to be able to appreciate the scariness of risk and the implications this has on how risk operates in midwifery talk and practice. As the following short field notes entry suggests, risk in this context can be understood as having a certain 'shit value':

> 'A group of midwives began to ask me why I was here and what my research was about. When I gave them a brief description of the study one midwife laughed and, rolling her eyes, candidly exclaimed:
> "Risk? Oh that's easy. We just shit ourselves!"
> No one in the room thought that this description of risk justified any further clarification or demanded any explanation. There was neither protest of objection nor any indication of surprise, only mild amusement' (Field Notes FA 3).

What seemed to be most significant to me about the midwife's comment in this extract was the reaction from the other midwives in the room at the time. While I concede that their apparent homogenous acquiescence to the 'shit value' of risk might have been due to the fact that this group of midwives was more interested in their sandwiches than my research, I maintain that it speaks volumes about the very particular way in which risk is perceived in this context. Moreover, this sense of scariness was a theme which resonated through much of the dataset, helping me make sense of what was being said and done around me. In this chapter, I aim to

describe this resonation and set out how the midwives involved in this study talked to me about risk. This chapter, therefore, is positioned as a baseline from which the rest of the thesis will build.

Risk is a harm

Given that midwifery discourse is represented in the literature as coalescing around concerns for both client autonomy and normal physiology (Hatem et al. 2008) (see Chapter 2), I had entered the field expecting to find a broad interpretation of risk, where risk-taking might be openly embraced as part of good midwifery practice as a means to the highly-rated professional objectives of client autonomy, women-centred care and normality. Following the work carried out by people such as Lupton and Tulloch (Lupton and Tulloch 2002) and Fox (1999), for example, who found that the ontological priorities of the community being studied operated to unsettle the links between risk and harm, I had thought that midwifery understanding of birth as a normal physiological process would have meant birth would be only vaguely linked to the notion of harm. Within this discursive context I had expected risk-taking to be both acceptable and even desirable. Furthermore, I had assumed that to perceive birth as innately dangerous would have been a world view that midwifery talk and practice might resist or even resent.

While there was some evidence of resistance to the risk-harm connection, these broader and less adverse interpretations of risk took place at the margins (see Chapter 9) and were largely eclipsed by a much more dominant discourse, where aversion to risk firmly linked the concept to harm. For example, as Helen explained:

> 'Risk is a potential hazard. Well, potential, a risk is a potential hazard that could occur if you don't put into place mechanisms to eradicate or reduce it.'

Similarly, Dianna described risk as:

> 'Risk is…anything that makes the woman, if you are talking about labour and birth, it is anything that makes the woman or the baby unsafe.'

In this second quote the precise nature of the harm is identified. A risk is a harm that operates to compromise the safety of the mother and/or baby. This linking of risk with harm, and harm with safety, was a theme that ran throughout the entire dataset; it was part of the taken-for-granted knowledge of midwifery, and all the midwives asked to define risk talked about it in this way. This consistency of opinion on how risk should be understood in midwifery practice cannot be underestimated and was expressed regardless of whether the midwife was accustomed to working in a high-risk or a low-risk unit.[27] To give a flavour of the uniformity of response, I include a list of further examples:

> Andrea (senior midwife): 'Erm, I suppose it is something like to do with the likelihood of an adverse event. Something, oh, that is what I would think, the chance of something going wrong really, that there is a risk of something might go wrong... So that is how we have to approach childbirth really.'
>
> Natalie (senior midwife): 'Risk is moving outside the realms of safe parameters I suppose. Erm, yeah, taking a risk is stepping into something that might cause harm or cause a problem depending on what you say.'
>
> Hilary (midwife): 'Risk must be, mmm, the chance of something going wrong I suppose.'
>
> Sharon (midwife): 'Risk? Mmm, well it is not good, is it? It is something that has gone wrong, I don't know, something that is dangerous I suppose.'
>
> Lindi (midwife): 'I suppose it, I suppose really it is about looking at, rightly or wrongly, at the hard evidence out there. The evidence that has been researched, and using that to categorise women and conditions of pregnancy into, categorise them into what is safe, what is not so safe and what is definitely not safe. And using that knowledge to give the best possible care you can.'

Risk sensitivity and risk containment

According to this data (and the list could go on) my expectation to find a broad approach to risk seems ill-founded and unjustified. If midwives see risk in terms of something going wrong, something dangerous and something that is always unsafe, then reactions to risk will inevitably be both consistent and avoidance focused. In

[27] One notable exception came from the data produced by my work with an independent midwife.

this respect, the midwives involved in this study talked about risk in terms of the dominant/technical paradigm of risk, described previously in Chapter 2. In Lindi's description, in particular, the way that risk is understood as an apparently impartial calculation (Irwin and Wynne 1996; Pailing 2006; Slovic 1987) of the possibility of something bad happening in the future can be clearly seen. Within this ontological framework, risk-taking could never be seen to be part of good midwifery practice; rather, risk will always have to be something that midwives should be acutely aware of and able to reduce or even avoid.

As described previously, such negative loading of risk is peculiarly modern. Moreover, it inevitably engenders a moral dimension in terms of professional responsibility. Given that risk is talked about in this way, it follows that midwifery responsibility in relation to risk would be to put into place robust and standardised mechanisms through which risks can be controlled. As Mary explains:

> 'The midwife's role in relation to risk is highlighting potential risks to women or actually to colleagues. And probably minimising the risks.'

Similarly, Gail told me that the midwife's role in relation to risk was to:

> 'Try to stop it before it happens and how... anticipating what has potential risks and having strategies to stop that event from happening.'

Or, as Cindy puts it:

> 'Our skill is in the way of minimising risk that we know will occur time after time. We can't eradicate risk. Sadly, it is something that will be there, something that... will continue to occur so all we can do is put into place processes to try and minimise the risk.'

The linking with risk and harm means that midwives have little choice on how they can choose to react to risk. Midwifery activity in relation to risk has to be about containment; it is about minimising or, in an ideal word, eliminating, all risks. In other words, risk was seen as a threat that had to be countered through expert midwifery skill. Despite the preconceived (and misguided) ideas I had when entering the field, the notion that 'life would be pretty dull without risk' (Lupton and

Tulloch 2002) and that risk-taking can be conceptualised as an opportunity (Adams 1995) held little tenancy in this context. The scare value of risk just would not permit it.

Risk and absence of the accident

Once risk is conceptualised in this way, the possibility of bad luck, an unavoidable chance event for which no individual or system is directly responsible, becomes ontologically remote (Adams 2003; Green 1997). Put another way, within the context of an organised maternity service, when risk is assumed to be a harm, it takes on a new temporal dimension, where the future is assumed to be controllable and where culpability is inevitable.

The temporal dimension of risk

According to Mary, Cindy and Gail, quoted above, risks appear to be things that belong to the future. Through an anticipation of a future inhabited by imagined risks which have not yet occurred (and indeed might never occur), demands are placed upon midwifery activity in the here and now. Conversely, the risk itself is something which does not overtly occupy the present, existing only as an imagined possibility (Heyman et al. 2010). Instead, risk is a 'bad' that might happen at another time. Despite this allusive nature of risk in the present, concrete midwifery activity must take place in order to anticipate those harms that might, at some point, threaten the safety of the mother and/or baby.

Such preoccupation with things that might happen in the future, and the quest to control those things through positive activity in the present, is, according to Giddens (Giddens 1991), an important part of reflexive modernity, something which he calls the 'colonisation of the future'. This is an idea that has been taken up and expanded in the context of health by Heyman (2010), who argues:

> 'The current version of risk thinking requires anticipatory measures to have been systematically put in place across the entire society in order to anticipate the potentially unlimited class of what might happen' (p. 214).

According to Heyman (2010), the most common form of health risk reasoning aimed at colonising the future translates aggregate, statistical calculation into assessment tools, which are then used by practitioners to plan individual client's care. In this way, the uncertainties of the future can be conceptualised in the present as something that is essentially controllable. My findings indicate that this is a key part to maternity care. Formal calculations of a woman's risk status, carried out using aggregate understandings of pregnancy and birth, govern how, where, with whom and even when her birth can take place (Alexander and Keirse 1989; Tracy 2006).

That said, however, it would be wrong to overstate the case for the temporal dimension of risk working exclusively in one direction, since this is frequently not how risk operates in practice. As Douglas (1990) points out, within our scientific paradigm it is easy to assume that risk operates only in a forward-focused temporal mode, when this is not in fact the case. Not only does this assumption tend to overestimate the scientific and impartial basis of how risk works in contemporary society, it also fails to capture the scary element of risk by underestimating a second temporal dimension to risk, something Douglas called the 'forensic approach to risk' (Douglas 1990), and something which Heyman describes as 'closing the stable door after the horse has bolted law' (Heyman 1998 p. 47).

According to the forensic approach to risk, what are often unusual, discrete and very specifically placed adverse events which have already happened in the past, are taken and used in an attempt to map out a future with the benefit of hindsight, which excludes the possibility of such an event ever occurring again. Importantly, once this map is in place, a link between risk and accountability is forged. This means that all future adverse events have to be either the fault of the individuals involved, who have failed to follow the prescribed map, or, alternatively, these events are perceived to be a result of inadequacies in the map itself, which inevitably incriminates the map makers. In his work on risk and the ontological elimination of the possibility of the accident, Adams (Adams 2003) provides a graphic (reproduced below) which offers a useful device for explaining how this temporal dimension of risk implicates as a sense of accountability and blame.

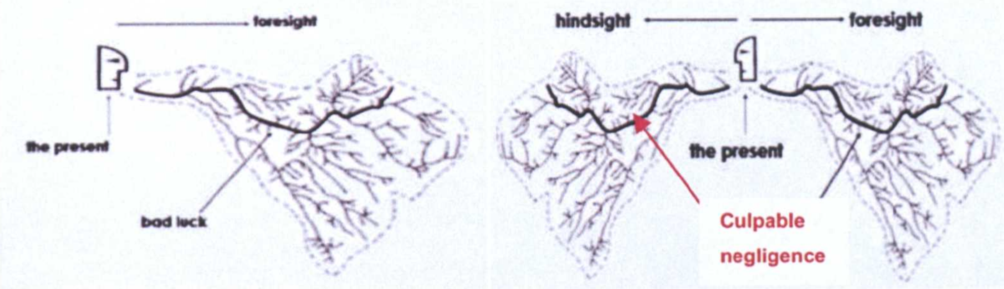

Figure 4: Prospective World View Figure 5: Adams (2003) Retrospective World View

In Figure 4, Adams shows how a forward-focused present allows for uncertainty in the future by anticipating a sense of bad luck; a possible freak accident for which no one is responsible. In this figure the future is imagined as an unknown. When the focus of the present is reversed, however, and bad luck from the past is used to predict the future, then the possibility for prospective bad luck vanishes and in its place is the notion of a culprit, who, as soon as they have been identified as the culprit, must be held accountable for negligence. This is important because, as Douglas noted, once a retrospective approach takes for granted that risks in the future are ascertainable:

> 'Anyone who insists that there is a high degree of uncertainty is taken to be opting out of accountability' (Douglas 1990 p. 9).

To give an example of how the assumptions behind, and commitment to, this particular dimension of risk translate into meaningful action in the NHS Trust in which I conducted this piece of research, I want to use some observational data which illustrates one aspect of their institutional clinical governance system.

Culpability and the scariness of risk

Setting the scene

During my non-clinical observations, I was able to join the especially appointed full-time risk midwives[28] and experienced part of the rigorous systems that have been put

[28] The Trust had two specially created midwifery posts with the sole purpose of risk management.

in place in order to 'learn from mistakes' (Department of Health 2000; Kennedy 2006). That is, I was able to witness the intensity of multidisciplinary activity that goes on 'behind the scenes' in the organisation's efforts to colonise the future by using discrete events from the past to map out acceptable midwifery practice through detailed protocols. These observations suggest that much of the clinical governance activity coalesces around a forensic approach to risk (Douglas 1990), where out of the ordinary, recorded untoward events, or near misses, are reviewed by multidisciplinary professional panels made up of a midwife, an obstetric consultant and a clinical manager for risk, in order to assess the severity of and culpability for that event. The aim of these meetings was to identify system or individual practitioner failures.

Leading directly on from this process is the incident investigation system, which involves scrutinising the care given by those midwives directly involved in an incident, and it is this aspect of the process I want to concentrate on here. My evidence indicates that this process is important because it appears to represent a point where the scare value of risk can be most sharply experienced. Although untoward events themselves and having to deal with those events were seen to be scary by some midwives, this scare factor did not necessarily end at the point the event concluded. In fact the 'shitting myself' factor could be protracted through the instigation of an internal investigation for several months after the event.

The culprit

To give an indication of how this impacts upon midwifery talk and practice I will consider the case of Helen, a midwife I spent time working with at a birth centre. When I first worked with Helen she was a confident, bubbly person to observe. However, when I called her at her home one day to arrange a shift after a break of a few months where I had been working at another unit, she seemed very hesitant; her reluctance was born out of having been personally involved in an internal risk investigation. During this conversation, Helen explained that she wanted to work with me but that she had been having a hard time lately, and she apologised for sounding so low. I explained to her that she did not have to agree to another shift

and that she could withdraw her consent to participate at any time, and emphasised that I was not there to judge her practice in any way. When we did eventually work together again there was a noticeable difference in her demeanour, as this field note entry describes:

> 'Helen kept reiterating that she was nervous, explaining that where she had felt clinically confident in the past, recent events had made her feel 'so shit' that she was unable to make the simplest of decisions sometimes.
>
> The way she overcame her confidence crisis was to picture herself discussing the case with the consultant midwife, P.
>
> "I know this must be okay," she told me, "because this is what P would say. She would say she is not in labour so I know it's okay to treat her like this."
>
> By imagining what a senior midwife would advise her to do in a given situation, Helen could overcome the stresses that had been caused by the recent investigation into her practice and go about the business of being an autonomous practitioner....
>
> Helen and I left the room (where a mother was labouring) so that Helen could discuss her care plan with another midwife who had just arrived at the unit. She went through what had happened that morning, reiterating what she had told me earlier about what she thought P would say about the case. Through this actual, rather than imagined, conversation, Helen appeared to gain the confirmation she seemed to be seeking. During the conversation, Helen revealed more details about the incident that seemed to be haunting her practice so much. Helen explained that she was not traumatised by the event itself, stressing with tears in her eyes that:
>
> "I know I didn't do anything wrong. I know I am a good midwife."
>
> She told me very few details about the clinical scenario itself, which gave me the distinct impression that this was not the thing that was upsetting her.
>
> "I know we are told it is not a blame culture but this thing has been all about blame... It makes you feel like a bloody criminal! This job can be so shit sometimes."
>
> This was followed by the declaration that if she could leave the job she definitely would (Field Notes HJ 4).

The clinical incident being investigated that was having such a devastating impact upon this midwife had taken place *five months* before this observation took place. Although the midwife was confident in her own performance during this incident, the investigation itself seemed to have an ominous effect, casting a shadow over both her ability to practise and her self-identity as a competent midwife. As Heyman (1998) suggests:

> 'Once socially established, risks take on a life of their own, despite their indirect relationship to underlying causal processes, leaving behind their tenuous, debateable origins' (p. 11).

Despite being conscious of the fact that the investigation procedure is not officially about allocating blame, Helen appeared to be also acutely aware of the way the process operated to both amplify risk and identify failing. She was aware that her reluctance to recognise personal responsibility was at odds with the assumptions entrenched in the risk management system. Once accident and uncertainty are eclipsed by our modern notion of risk with its attempts to colonise the future, someone inevitably has to be held accountable (Adams 2003; Douglas 1990).

Although the internal investigation system into adverse events acts as a good illustration of how the scariness of risk works in midwifery talk and practice, it should be stressed that this is not the only mechanism that has this effect. The connection between fear and risk are attached in midwifery discourse; as was expressed through the activity of the midwives involved in this study, it was not dependent upon the instigation of any institutional mechanisms of accountability. That is to say, the shit value of risk is attached to first-order as well as man-made risk processes. As shall be shown in subsequent chapters, the scare factor of risk is part of a multidimensional, complex and socially embedded process, which cuts across risk categorisations and is therefore just as powerful in situations where no culprit has been officially recognised.

Summary and comment

By utilising a key eureka moment which took place while I was in the field and which highlighted for me the importance of the scariness of risk, this chapter has introduced a key principal which underpins the way risk operates within midwifery talk and practice. By using this poignant event, it has been possible to introduce the work midwives do in the social construction of risk in the maternity care context, and to demonstrate that expert and lay ways of knowing about risk have more in common, in relation to their social embeddedness, than some of the literature suggests. This chapter indicates that the social and emotional dimensions of risk are just as pertinent to professional understanding of risk as they are to lay public understanding.

Through this constant process of ongoing meaning-making, risk technologies, which are produced through midwives' activity, are confined by the understanding that risk is something which is essentially scary; something that is closely linked to harm and therefore something that should be avoided. This link logically excludes risk-taking as a legitimate part of good midwifery practice, although, as I will suggest later in this thesis, there are certain situations in which this link can and is unsettled. This chapter, therefore, is not so much about claiming that this is the only discourse of risk at work within midwifery talk and practice; rather, what I am trying to suggest is that what can be described as the risk-harm discourse is pervasive, permeating organisational structures and operating to confine the way midwifery practice can be imagined.

Having introduced the interpretative work midwives do in making sense of risk in their everyday talk and practice, and demonstrated how the ubiquitous nature of the scariness of risk operates to constitute midwifery care, attention will now turned to scrutinise how this particular interpretation of risk impacts upon the role midwives play in the performance of birth.

Chapter 6: The Swan Effect

Introduction

This chapter offers further insight into the work midwives do in the social construction of risk. It builds upon the previous chapter by fleshing out how assumptions about risk, already described, translate into meaningful action. In particular, this chapter will demonstrate the multiplicity of meaning-making involved in midwifery communications with their clients and how potentially divergent professional interests, one rooted in standardised surveillance, the other, normal physiology, can be simultaneously expressed through a Goffmanesque information game, where expression takes place at several levels – something I call 'the swan effect'.[29]

The swan

During a recent conversation I had with a midwife about my current research interests, I was told:

> 'Us midwives, we are like swans swimming across a lake. On the top we look all serene and tranquil but under the water our little feet are flapping about like mad.'

What this midwife is describing is how she endeavours to give an air of professional calmness, a sense of confidence in normality while caring for women in labour; when her activities revolve around a constant concern of 'what if things go wrong' – her imagined risk object. Under the auspices of safety, risk management and the standardisation of care, midwifery activity in the labour room inevitably coalesces around routine surveillance practices. When engaging in such practice, midwives have to cope with attempting to instil a sense of confidence in the mother's embodied ability to birth her baby spontaneously while concurrently attending to an array of risk-focused tests and measurements. Midwives are being vigilant about the

[29] An earlier version of this chapter has been accepted for publication in November 2011 by *Sociology of Health and Illness.*

potential harm that may come to mother and baby; at the same time they are responsible for facilitating normal birth. This chapter aims to explore this tension in relation to the idea of the swan effect in order to scrutinise the interface between midwifery communication and normality in childbirth[30] during birth performance.

The discussion to follow represents a recurring theme, which came out of data collected during this project, and will fall into three distinct parts: starting with a background section, where a brief introduction to the theoretical framework of the chapter will be set out, the discussion will move on to revisit how midwifery understanding of normality is represented in the professional literature. This theoretical section will be followed by observation and interview data, which will be used to illustrate how risk and normality interface within midwifery talk and practice. Using the outlined theoretical framework, the midwifery position to normality will be reconceptualised, and evidence will be presented to show how midwife-client communication in the labour room setting is not simply about what is said. In keeping with Goffman's observations (1969), it will be argued that 'strategic interactions' is as much about meaningful action as it is about the words which are spoken; it is as much to do with what goes on 'under the water', the latent worries which lurk in the back of the midwife's mind and drive her practice, as it is to do with what she actually says to her clients. It is the contention of this chapter that, through routine surveillance practices, midwives implicitly introduce uncertainty, amplify risk and thereby disturb and confine the possibility for women to achieve normal birth. Furthermore, this process is conceptualised as being a major driver in the medicalisation of birth performance in the UK.

[30] Normality here is understood to mean 'spontaneous labour and delivery, where an infant is born spontaneously without medical or technological help, such as where labour has been accelerated by Caesarean section, or induced or by giving the mother an epidural. An infant is born in the vertex position (head down) and between 37 and 42 completed weeks of pregnancy' (World Health Organization 1996).

6.i The theoretical premise of the chapter

There are two strands of literature which have helped inform the analysis presented in this chapter. The first is drawn out of the risk debate; the second comes from the health surveillance literature. As already indicated in Chapter 3, both of these areas of scholarly activity have been prolific and the descriptions of them here will be, by necessity, partial. In particular, this chapter will be considering and integrating the work produced by Heyman (Heyman 1998; Heyman 2010) and Armstrong (Armstrong 1995; Armstrong 1983).

Theoretical strand one

Heyman's work looks at how the increasing sensitivity to risk in the West, which is said to be characteristic of our late modernity (Beck 1992; Zinn 2006), operates in health care. According to this thesis, 'risk thinking provides only one, historically recent, approach to visualizing alternative futures' (Heyman 2010 p. 22). This peculiarly modern way to looking at the world centres, in part, around what Heyman calls the 'risk virtual object' (Heyman 2010 p. 22). What he means by this is how current preoccupations with possible futures, where the worst possible scenario could happen, function to shape health care practice in the present. Developing Giddens' (1991) notion of the late-modern desire to 'colonise the future', Heyman argues:

> 'the lens of risk provides one particularly modern way of thinking about contingency. A contingency is invoked whenever an observer considers that one outcome out of a number of envisaged alternatives might occur... once their presence has been recognized by a social group, contingencies generate substantive responses' (Heyman 2010 p. 24).

Building upon the social theory of risk, with a particular interest in the reflexive modernisation thesis (explored in more detail in Chapter 2), Heyman shows how preoccupations with one possible future, where things go wrong no matter how remote or unlikely that future may be, take on a life of their own, occupying the present in ways which shape how health care can be delivered.

Theoretical strand two

Armstrong's Foucauldian analysis of the rise of surveillance medicine, which he describes as 'a new medicine based on the surveillance of normal populations' as opposed to traditional medicine that focused on ill people (Armstrong 1983 p. 95), provides a second dimension to the analytical approach adopted in this chapter. Although Armstrong's work does not lie within the risk literature, where interest in Foucault has been most concentrated in the analysis of self-surveillance within public health as a mechanism of subjugation (Lupton 1993; Petersen and Lupton 1996) (see Chapter 2) I link it in this chapter to Heyman's work outlined above, because together I believe they offer a comprehensive framework through which the swan effect can be understood.

According to Armstrong, the intrusion of the medical gaze into the lives of the well blurs the boundaries between health and illness, between the normal and the pathological (Armstrong 1995). Through the language of health surveillance, with its implicit message that there is a chance, 'a small chance of a great misfortune', the boundaries of normality have been eroded (Olin Lauritzen and Sachs 2001 p. 498). Moreover, it has been argued that it is the magnitude of the possible hazard rather than the probability of the normal that is heard most clearly by health professionals and clients alike (Pidgeon et al. 2003; Alaszewski 2007).

Risk in birth

Given this background, it is hardly surprising that the language of risk permeates the delivery of maternity care and underpins the development of maternity services. Evidence of this in the UK can be seen through the intensification of clinical governance discussed in more detail in Chapter 4, through initiatives like the implementation of the CNST and the proliferation of local and national guidelines with their associated intensification of surveillance of even normal populations of birthing women. According to the NICE guidelines, for example, caring for a healthy mother in normal spontaneous labour should involve surveillance which includes:

'Every 15 min after a contraction: check FHR.

Every 30 min: document frequency of contractions.
Every hour: check pulse.
Every 4 hours: check BP, temperature and offer vaginal exam.
Regularly: check frequency of bladder emptying' (National Institute for Health and Clinical Excellence 2007a p. 7).

In maternity care, therefore, under a guise of benign concerns with the safety of the mother and her fetus, mothers are subject to continual surveillance and a battery of risk assessments and intrusive tests (Lane 1995; Reissman 1983). In the UK, as soon as a woman becomes aware that she is pregnant she is expected to actively pursue a regime of health surveillance (DeVries et al. 2001). Pregnancy and birth might be described as being a point where Armstrong's theory of health surveillance is at its most powerful, in that every woman, simply by virtue of being an expectant mother, comes under the close scrutiny of the medical gaze (Arney 1982). Through this intensification, where even normal observations are subsumed under a more general discourse of risk (Armstrong 1995), where pregnancy cannot be imagined as being truly healthy, instead it is envisaged in terms of the potentially dangerous category of 'not-yet-patient' (De Swaan 1990 p. 12). A pregnant woman and her unborn child are both categorised as being 'at risk'.

It is important to understand that the intensification of surveillance of the normal in childbirth coincided with a reduction in hazards and improvements in safety associated with birth. Although this is a point which has been explored earlier in this thesis, it is revisited in detail here because it is considered to be pivotal to understanding the wider social and political implications of the swan effect. Tempting though it is to assume that current, medicalised birth performances have improved safety outcomes, epidemiological evidence suggests that other wider social and environmental factors are likely to have had more significant impact than appears at first glance (Tew 1990; Wagner 1994). The observation that the intensification of surveillance coincided with reduced risks, therefore, is not to suggest that there is any causal relationship going on here. Furthermore, as explored in Chapter 4, as the medicalisation of birth has intensified, so has both national and

international concern regarding the iatrogenic risks associated with this intensification (Institute for Innovation and Improvement 2007; Johanson et al. 2002; Mander 2008; World Health Organization 2009).[31]

This creates an interesting paradox characteristic of the way risk is perceived more generally in our late-modern society, where, despite the increase of material and physical security, preoccupations with risk intensify (Taylor-Gooby 2002). Thus, as the dangers associated with pregnancy and birth decreased, both became more densely associated with a climate of fear (Reiger 2006).

Despite childbirth in the UK being safer now than it has ever been in human history, policy drivers within the maternity care service coalesce around patient safety, risk avoidance and health surveillance (National Health Service Litigation Authority 2008). These laudable initiatives aimed at protecting the public crystallise in a discourse of risk avoidance (Skinner 2003). Although midwives and women know that the probability of highly-adverse outcomes are now very low, they are nonetheless fearful and anxious about pregnancy and birth outcomes (Possamai-Inesedy 2006).

6.ii Midwifery and normality

The implications of the language of risk and problematisation of the normal is particularly pertinent to midwifery practice since not only are midwives the most senior practitioner in 66% of births in the UK (NHS Information Centre 2008), according to much of the professional literature midwives should be and are defined as the experts of normality (Hatem et al. 2008; Walsh 2001; Walsh and Newburn 2002a; Walsh and Newburn 2002b). That is to say, rhetoric suggests that midwifery

[31] Ironically, as has been the case with many industrial technologies, the cascade of intervention which frequently accompanies medicalised birth practices, those very interventions which were originally introduced to manage risk, have themselves generated new risks and new hazards through a dynamic process.

philosophy lies within the zones of normal physiology, or as Gould puts it: 'midwives practice within the normal childbirth paradigm' (Gould 2000). According to the professional literature, midwifery and normality are symbiotically linked. Such rhetoric sits rather awkwardly with the health surveillance thesis, as it is described above. While, on the one hand, midwifery practice can be described as coalescing around health surveillance, with its amplification of risk and marginalisation of subjective narratives of health (Gabe et al. 2004), on the other hand, the profession espouses a commitment to normality which privileges women's individual, embodied experience of pregnancy and birth and woman-centred care (Davis and Walker 2008).

All midwifery practice in the UK, regardless of where it takes place, is constrained by the NMC, which aims to standardise care, protect the public from harm and ensure that all risks are identified and avoided (Nursing and Midwifery Council 2004a; Nursing and Midwifery Council 2004b). This, in conjunction with clinical governance initiatives, which, according to Power (2004), now saturate the cultural landscape of health care, means that the majority of midwifery practice centres around health surveillance as it is described by Armstrong (1995). Such statutory obligations operate to increase sensitivity to risk, creating somewhat of a disconnect between how midwifery is represented in much of the literature and what many actually do in their day-to-day working lives. On the surface, the swan may look calm and serene, suggesting her confident belief that everything is fine, everything is normal, but only inches under the water (which is a transparent liquid, making visibility easy), the swan's feet tell quite a different story. It is a story of risk amplification and a story of risk avoidance driven by the so-called Risk Society (Beck 1992).

In their practice, midwives deal with the tensions engendered by this disconnect every day, but such embodied experience and embedded practice, paradoxically, is not often as evident to those involved as you might expect. As Schutz and Natanson (1990) argue, such taken-for-granted ways of being tend to form part of the common sense which rarely is explicitly defined or explained. It is only through the scrutiny

of everyday practice and talk, therefore, that we can gain insight into the ways in which this tension impinges upon midwifery performance during childbirth.

6.iii Measuring normality and the implicit introduction of threats

The measuring of vital signs of both the mother and baby, along with what is described as 'progress' in labour – meaning uterine contraction and cervical dilatation pattern – is key to routine midwifery during labour and birth. At the point when labour is diagnosed, intensive surveillance and record keeping usually commences. Such intensive monitoring is applied to the normal and abnormal alike, bringing all labouring women into visibility. Moreover, with the midwives involved in this study, it was introduced in a taken-for-granted manner, with the precise purpose rarely being made explicit to the woman. Rather, each intervention was introduced as part of the customary care plan, which demanded no explanation. Midwives commonly introduced monitoring activities with comments like:

> 'I'm *just* going to have a listen in again now, *just* to make sure the baby is okay.'
>
> This preceded exposing the woman's abdomen to auscultate the fetal heart (Field Notes GT 20);

or

> 'Can I have your arm a minute? I need to check your blood pressure' (Field Notes RS1).

There seemed to be an implicit understanding in these mother-midwife interactions that repeated checking, rechecking and recording of things like the fetal heart and maternal blood pressure was a good thing. Once the measurements were taken, they were plotted in the partogram[32] and/or written into the labour care section of the maternal notes. The midwives' talk following these measurements was generally quite cheerful. However, this approach did not always allay the fears that this surveillance seemed to introduce, as the following extract from the field notes

[32] The partogram, or picture of labour, is a universal chart designed in the 1970s for recording observations of mother and baby, contraction pattern (rate and strength) and cervical dilatation, etc.

suggests. Sarah, a first time mother, is having a routine vaginal examination to measure the dilatation of the cervix and the descent of the baby's head.

> 'During the examination the room went very quiet. Sarah is lying flat on the bed as instructed by the midwife. No explanation is given to explain why this is necessary and no attempt is made to perform the examination in a position that might be comfortable for Sarah. It is as if any concerns for Sarah's physical or emotional comfort seem to be temporarily suspended given the seriousness of the task of finding out what is going on. The findings of the exam are not mentioned during the procedure, Sarah and her partner are left wondering and waiting; there is a palpable sense of tension. Afterwards, Pauline (the midwife) explains what she found. Both parents look anxious and, although the VE[33] shows progress of the labour was normal, both Sarah and her partner needed to repeatedly have this confirmed. Pauline did not seem surprised by this reaction. She smiled and reiterated that 'everything was fine' at least three times. She then left the room to record her findings in the notes and on the board' (Field Notes PS 14).

In this case, Sarah's labour was following the partogram's trajectory; she had progressed according to the parameters set by the chart. However, although normality was confirmed, the actual conformation process itself introduced a sense of uncertainty. Whereas before the examination both Sarah and her partner had been managing the labour process effectively and pretty much independently, when the time came to monitor progress, to check for normality or, more precisely, to hunt for abnormality, their confidence in the process and their understanding of the active role they could play in that process seemed to dissipate. Indeed, although Pauline stressed that progress was good, Sarah responded by asking: "Is there anything else I should be doing? Am I doing it right?" (Field Notes PS14). Even when a woman's labour fits within the partogram trajectory, the very process of monitoring progress simultaneously confirms and disturbs normality.

Through the action of routine surveillance, midwifery activity appears to be not so much about confirming normality as it is about searching for an absence of

[33] VE means vaginal examination.

abnormality. This is a subtle but significantly different task which tends to privilege imagined possibilities of 'what if things go wrong' and thereby operates to unsettle a woman's confidence in her body's ability to birth her baby successfully. Although midwives may have an objective of reassurance in their intra partum communications, in order to give the impression of the swan gliding gently across the water, their actions expose the unstable base on which understandings of normality rest. Importantly, the labouring woman and her birthing partner are far from oblivious to this instability. The swan's frantically paddling feet are not invisible; water is, after all, transparent. As Sarah's need for professional reassurance suggests, parents can and do easily recognise the midwife's concern with the ever present 'virtual risk object' (Heyman et al. 2010).

The midwives' understandings of birth appeared to be so confined by a preoccupation with surveillance that, in the interview context, they often found it difficult to imagine normal birth existed without explicit reference to monitoring practices designed for hunting the abnormal. Such ontological privileging of surveillance meant that the precise nature of normality, and how its boundaries should be defended, became obscured. So much so that these midwives felt that they should never presume normality had any substance beyond that which is verified through observation and recording. For example, when Mary, a senior midwife, was talking to me about birth, she explained:

> 'But I always have here, in the back of my mind, that things can wrong, so, that's how, that's how I practise as a midwife. That, you know, it can be wonderful but it's wonderful when it is finished. You must be alert to things that can happen. Because I watch very carefully and unpick things and I check everything and, erm, because things happen. I would put her (the mother) in the bracket of 'at risk' of any risk until, until it is over.'

Susan, another senior midwife, expressed a similar sentiment when describing how she felt about a fellow midwife's practice:

> 'There is two things in this monitoring and surveillance. They [midwives] don't seem to understand, just because you [the mother's labour] are normal, low risk, that you are not assessing what's, and monitoring what is happening… Checking all the

time. How does she [the midwife] know? She doesn't know it is going to be normal. How can she tell it is all going to be okay without checking everything and of course writing it down? She might have an op position,[34] you know, even if things are going to be okay, you have to monitor the progress all the time, don't you?'

For Harriet, a student midwife, normality could only be defined via the visual aid of the partogram's trajectory:

> 'Well, you know, when everything is in the normal parameters, making sure, erm, like keep the woman and baby safe by making sure, you know, you are listening in every 15 minutes and that they don't come out the brackets thing, the chart thing... partogram.'

These three interview extracts represent a key theme present in much of the dataset and assume that good midwifery practice is recognisable through the practice of intensive surveillance, which is carried out to check that the birth is following the expected, population-based trajectory as it is depicted in the partogram. It is only when all such surveillance is charted on the partogram that normality can be confirmed. Normality is evident then only with abnormality lurking. Normality is constituted through actions which mark the presence of 'a virtual risk object' (Heyman et al. 2010), an imagined hazard which might happen at some point in the future.

Deviant trajectories

When, as happened in the above case, normality is confirmed by the surveillance techniques introduced by the midwife, the unsettling of normality can be, and often was, temporary. As the demands of labour are attended to by the woman and her

[34] 'OP' refers to occiput posterior. This is a mal presentation; it means that the baby's head has gone into the pelvis facing the wrong way round. This term is used to reference the midwife's interactions with women and birth partners, supporters, etc.

birthing partner, focus on the here and now is regained and concern for what may or may not happen in the future is diluted. When, however, deviation from the norm, as it is delineated by the observation chart, is discovered, a different kind of pressure is introduced.

Finding such deviations places specific demands on the midwife. When plotted on the partogram they become visible to three groups of people: the parents, the midwife, and the multidisciplinary team. The moment a deviation from the expected norm is recorded it crystallises into action, involving a further intensification of surveillance and/or medical intervention (which can include major abdominal surgery). In some cases, the midwife remained cheerful in an attempt to contain the severity of what her recordings imply. She would say things like: 'Your progress isn't quite what we hoped', or 'You have done well but...'

For example, a vaginal examination on Kerry, another first-time mother, revealed that her cervix had dilated two centimetres in four hours, which, when plotted on to the partogram, fell well below the expected progress line. Instead of drawing attention to the shortfall, Miranda, the midwife responsible for her care, emphasised how well she had done:

> 'Miranda sat beside Kerry on the bed after the examination and said to her:
> "I am so proud of you. You are doing so well. All those contractions are working really well and we are getting closer all the time to meeting this baby."
> She then explained that she had to go out of the room for just a minute to write up the notes and let the doctors know that although she had progressed, which was good, the progress was a little bit slower than she had hoped. This is all explained with an apologetic look on her face' (Field Notes ML28).

What can be seen in this communication is an attempt to downplay the implications of the deviant measurement; an under-communication of the risk (Olin Lauritzen and Sachs 2001), or perhaps even an attempt to deny the deviation. Miranda is in the business of comforting the couple. She does this by drawing their attention away from the likely outcomes of the examination findings. Instead, she chose to emphasise the progress made, even though this progress fell significantly short of the

partogram's trajectory. Miranda seemed to be aware of the effect that her surveillance would have on the couple's morale and was keen to minimise the negative impact this might have on the mother's confidence. Although Miranda knew that the charting of her monitoring was an invitation for proactive medical intervention, she tried to preserve a space for normality by under-communicating the risk that her actions had introduced.

This under-communicating of risk is precisely what the midwife meant when she used the metaphor of the swan to describe midwifery practice. It is a feature of midwifery that all the midwives involved in this study recognised, as Diana (a midwife) explained to me:

> 'That is why we all have to be actresses before we become midwives! [laughs] You're sitting there, feeling utterly dismayed by something... I don't know... hear a dip in the fetal heart... you know in your heart that actually it is just second stage of labour and it is just fine but at the same time you have that, you have that little sort of 'Oh goodness, what is that?', but I think if you let the client see that, or the family see that, they start to worry and I do believe that worry and anxiety prevent the progress of a labour. Well, I think we all know that.'

What the midwives did not seem to appreciate, however, was the multi-modality of their communication. While they hoped that their concern with the imagined risk object was obscured by what they said to parents, observations of midwife-client interactions revealed that midwifery communication is as much about meaningful action as it is about use of language. It is as much to do with what goes on under the water, the latent worries which lurk in the back of the midwife's mind and drive her practice, as it is to do with what she actually says to her clients.

Through routine surveillance practices, midwives implicitly introduce uncertainty, amplify risk and unsettle normality. Once the deviant results are charted, the risks, in the sense of dangers and abnormalities, take on a life of their own (Heyman 1998). At that moment, physiology is redefined as pathophysiology (Mander 2004). The medical gaze tends to widen and more intrusive multidisciplinary, technocratic

surveillance invades both the woman's physical body and the space where normality had previously, all be it tentatively, existed. It is precisely this momentum of risk, or what has been described in the literature as the 'cascade of intervention' (see Inch 1989), which drives midwives to under-communicate risk within the context of midwife-client interactions. This represents the basis of the swan effect in midwifery.

Symbolic spatial boundaries and normality talk

Until this point, risk existed as an imagined possibility, expressed through midwifery action rather than talk, but once pathology was detected and recorded the midwife had to work much harder to maintain a sense of normality in the words she said to her clients. Recording pathology in the notes meant that risk took on a concrete form, which brought about a chain of events that invaded the mother's protected space as well as her body. In their concern to stave off this chain of events, midwives tried to suspend the language of risk in their conversations with their clients. At that point unobserved, inter-professional communication commenced. However, all attempts at such suspension evaporated. Taking the maternal case notes away from the care setting commonly opened up an opportunity for more candid professional-to-professional discussions of risk. Once outside the room, the midwifery engagement with risk became more explicit; the swan effect was no longer considered to be appropriate, making a boundary clearly visible. Who was involved in the communication, and where that communication took place, therefore, had a significant impact on how midwives chose to talk about risk. Leaving the room with the notes involved symbolically crossing a boundary. The transgression of this boundary seemed to dismantle any attempts at risk insulation, which had been, up to that point, carefully maintained by the midwife, albeit ineffectively, during midwife-client interaction. As the extract above demonstrates, risks and the associated fragility of normality were often downplayed in midwife-client contact. However, this was not the case when midwives entered into 'staff spaces', as further excerpts from the same observation episode demonstrate:

> 'The first thing Miranda wanted to share when we left the room was her sense of disappointment and exasperation. She felt that the possibility for a normal birth was

dissipating, it was 'slipping through her fingers'. I got the impression that she was feeling frustrated. This was very different from the things she had said to the couple; it was almost as if when she shut the door a whole other narrative could be released. A narrative where her lack of confidence in normality could be aired. When I asked her to explain why she felt like that she told me:

"Well what am I going to say to them? I know exactly what they are going to say... so here goes."

The 'they' she referred to was a mixture of more senior midwives and obstetricians' (Field Notes ML28).

Conclusion and discussion

There is a substantial body of empirical evidence which suggests that pregnancy and birth engage with the language of risk in a very particular way (Davis-Floyd 2003; Johanson et al. 2002; Lupton 1999; Reissman 1983; Rothman 1982). It has been argued that being pregnant invades a woman's own embodied experience of health through the omnipotent presence of latent risk (Marshall and Woollett 2000; Oakley 1984; Weir 2006; Woollett and Marshall 1997). Her personal narrative of well-being is eroded; she can no longer be trusted to be normal (Arney 1982; Scully 1980); she and her baby are at risk. Furthermore, this risk demands intensive and regular health surveillance. This intensity of risk surveillance culminates in the hours that mark the end of pregnancy. Thus, many have suggested that the process of birth is not trusted (Grosz 1994; Martin 2001) and, as a consequence, becomes a locus for risk anxiety (Marshall and Woollett 2000; Reiger 2006).

This chapter has set out to offer a new dimension to this observation. In much of the literature midwifery, models of care are juxtaposed against medical models of care (Annandale and Clark 1996; Walsh and Newburn 2002a; Walsh and Newburn 2002b); moreover, it is the medical models which are presumed to coalesce around a sensitivity to risk. By scrutinising the precise nature of midwifery understanding of birth and risk it is possible to see how midwives are positioned as active agents in the medicalisation of childbirth performance. The data presented in this chapter suggests that through routine midwifery practice uncertainty is implicitly introduced

even to those situations where no deviation from the normal exists. Routine midwifery care during labour and birth is not so much about facilitating the normal as hunting out the abnormal.

This means that, while midwives may purport to work within the paradigm of normality (Gould 2000), they have few resources or practical skills to police the boundaries of normality. Arguably, this would depend on the working environment in which the midwife finds herself. The London-based Albany midwifery practice, for example, has been held up as a show case across the globe, for imagining how midwifery practice could work in ways that resist risk amplification (Reed and Walton 2009; Rosser 2003). Other pre-eminent midwives in the UK have used the independent sector in order to facilitate less risk-averse forms of practice (Scamell 2010). However, the recent and shocking suspension of Albany's services, along with the disproportionate number of independent midwives being investigated and struck off the register by the NMC (Jowitt and Kargar 2009) suggests that such an approach is of dubious value in our Risk Society. Moreover, the working environment had much less of an impact upon the care observed during this study than I had anticipated.

Midwifery knowledge and skill base, observed in all four working environments (a high-risk obstetric unit, two midwifery-run birthing centres and home births), borrowed so heavily from the health surveillance repertoire, designed to seek out pathology in a healthy population (Armstrong 1995), that midwives were left with few resources with which to police the boundaries of the very thing they define themselves by – normality. What is more, despite all their efforts, these midwives failed to disguise this fact from their clients. Midwives may describe themselves as actors or serene swans, but their attempts to cover up the fact that they centre all their activity around an imagined pathology are, at the very best, transparent. The data presented in this chapter suggests that service users are likely to be conscious of the tension created through midwifery talk and midwifery practice and the impact this has on normality; that is, they can see both the serene swan and its madly flapping feet.

This chapter has looked at the mixed modality of midwifery communication to explore the idea of the swan effect. Through this analysis it has been possible to see how midwifery understanding of risk both constitutes practice and shapes how birth can be imagined. The chapter presented data relating to the interface of risk and normality, but this was done in a way that did not problematise the meaning of normality. For the purposes of this chapter, the meaning of normality was taken as a given; moreover, what might be described as a midwifery understanding of normality was adopted uncritically in order to illustrate how this is tentatively placed in relation to risk. While such a strategy has been useful for the discussion above, the next chapter will further develop the analysis of the interface between the concept of normality and risk by unpacking how the language of normality operates within midwifery discourse and birth performance.

Chapter 7: The Window

Introduction

This chapter revisits the interface between normality and risk using a slightly different theoretical orientation. As such, the chapter develops the work already presented in Chapters 5 and 6, to provide further insight into how these two potentially divergent professional interests are used in everyday midwifery talk and practice. Chapter 5 gave an indication of the propensity of risk and, in Chapter 6, using a combination of two theories, it was possible to show how professional risk thinking can be orientated towards the selective imagining of possible unwanted futures, where normality and unassisted safety can only exist as the non-occurrence of these futures. It was argued that risk functions as a mechanism of surveillance, evoking a hypersensitivity to and amplification of risk, which confines the possibility for normality in the performance of birth. This chapter aims to develop this analysis further by incorporating a further dimension, to give an indication of the linguistic and temporal absence of normality offering some more robust insight into why midwives fail to police the boundaries of normality within birth performance.

The window

While chatting to Carina, a participating midwife, who I had the pleasure of working with on several occasions during this project, she very casually explained to me that midwives work with 'what seems to be an ever narrowing window of normality.'

What she was describing here was the apparent relentless expansion of something Wagner (1994) called 'the birth machine', where birth performance is increasingly defined using medicalised practices of intensive surveillance and technocratic intervention (Budin 2007; Henley-Einion 2003; Johanson et al. 2002; Mander 2008; Wagner 1994; National Institute for Health and Clinical Excellence 2007b; NHS Information Centre 2009; World Health Organization 2009).

This observation forms the basis of this chapter, which aims to develop the notion of an 'ever narrowing window of normality' in relation to risk. Using empirical evidence produced through fieldwork and text analysis, the chapter engages with normality as a semiotic absence and the implications this has upon birth performance. By taking data that illustrates the precise nature of how midwives orientate themselves to normality and risk through their everyday talk and practice, the chapter shows how these two concepts interface discursively to constitute the way in which birth can be legitimately imagined. The discussion will introduce two interrelated issues: the first relates to the central importance of language, illustrating how normality is signified only through an absence of risk, having few linguistic signifiers of its own through which it can be defended; the second revisits Heyman's work to examine another dimension of the significance of contingency in relation to the possibility of thinking about alternative futures, where either normality or risk can be imagined.

Midwifery and the window

For adequate appraisal of the implications set out by the discussion of this chapter, it is necessary to briefly revisit where midwives are placed, both discursively and physically, in relation to birth performance in the UK. By way of introduction to the chapter, therefore, the midwifery position in relation to normality will be clarified in this section. Unlike in other Western countries, midwifery in the UK has enjoyed statutory professional autonomy for more than one hundred years (Stevens 2002). On the other hand, in common with those midwives working in countries where rights to practise and rights of lawful recognition have had to be bitterly fought, midwives in the UK similarly describe themselves as practising within a paradigm of normality (Gould 2000; Midwifery 2020 Team 2010; Sandall et al. 2009), where risks might be assumed to be calculated using a rational model of probability. Within this framework, women and their pregnant bodies, arguably, can be conceptualised as being essentially competent. Since the probability of actual harm to the mother or the baby (such as massive haemorrhage or significant birth asphyxia) during the process of spontaneous birth is relatively small, women can be regarded as being capable of birthing their offspring without undue concern for risk.

Such a framework rightly positions the midwife as a facilitator, where professional understanding of the spontaneous physiological process of birth can be applied through practice, to ensure that babies are born with as little disturbance and intervention as possible (Leap 2000; Rosser 1998). Midwifery discourse, which apparently transcends national boundaries and socio-historic context, can be said to privilege notions of birth as a spontaneous, physiological and independent process (Davis-Floyd et al. 2009).

The analysis in this chapter, and in the wider thesis, starts from an understanding that midwives in the UK claim to have a discrete way of knowing about birth and have always been embedded within maternity care services, accounting for the vast majority of the professional labour force in this sector. As such, midwifery activity is conceptualised as having the power to influence how birth can be performed in the UK. Such a starting point draws sharp attention to a disconnect between midwifery rhetoric, which purports to privileging normality and actual birth practices which take place in the 'ever closing window of normality', as they have been described in Chapters 4 and 6. In Chapter 6, I showed how the swan effect operated to introduce uncertainty in birth performance. This chapter develops this analysis by confronting the question: Why, given the centrality of midwifery practice, does the window of normality continue to narrow? By engaging with this question, the chapter will examine midwifery activity in a new and novel way. Using a combination of the social theory of risk and the post-modern feminist theory of language, the previous analysis will be built upon so that midwifery talk and practice can be scrutinised further to examine professional agency in relation to current birth performance trends.

7.i What normality means to midwives

In order to interrogate the ways in which midwifery understanding of normality is confined by risk and how this confinement impinges upon how birth can be performed, it is necessary to explore, not only the interpretative work midwives do when making sense of risk, but, likewise, how notions of normality are socially

constructed. This endeavour, however, is complicated by the fact that the precise meaning of normality, in the context of midwifery talk and practice and birth, is far from straightforward (Crabtree 2008; Gould 2000; Keating and Fleming 2009). Within the dataset, therefore, it is not surprising that attempts to illicit what the participants meant by the term frequently met with laughter or expressions such as: 'Oh no!'; 'I don't know'; 'How am I supposed to answer that?', 'That's a difficult one', or even on one occasion: 'You can't expect me to be able to tell you that!'

Interestingly, a representative from the RCM, while discussing the impact of the college's *Campaign for Normal Birth* (Day-Stirk 2005; Royal College of Midwives 1991), told me that in the UK midwives are so desensitised by overuse of the term 'normal birth' that the term does not really mean anything anymore.

> 'We have had the normal birth debate such a long time in the UK and people are quite... we are slightly blasé about it and people, they sort of ... they have had enough. I mean if I talk to a UK midwife about normal birth they say: 'Well what's that? What's normal to you was not normal to us and does it mean anything at all anymore in the context of modern obstetrics?' It is almost as if it is, I don't know, kind of a nothing if you like.'

The moral loading of normality

This is not to suggest that normality was not important to those midwives I spoke to and worked with during this research project. Paradoxically, although the midwives involved in this study struggled to explicitly articulate their understanding of normality, their emotional investment in the term, their appreciation, expressed particularly through their situated talk and action, was far more unequivocal. Normality was consistently assumed to be a cultural 'good'; its merits were simply taken as given, so deeply engrained into their shared tacit knowledge base that a positive moral loading of the term was common to all the midwives I spoke to. When participants talked to me about normality they simply assumed that I, as a fellow midwife, would share their understanding and appreciation of the term and its virtues. Explicit explanation was therefore irrelevant, even comical. A belief in normality as a cultural good was a basis for professional identity, something to be

aspired to and a source for professional pride and confidence. Or, as midwife Silvia put it:

> 'Midwives very often come into the profession because they are women and intrinsically that they understand that birth is a normal process.'

To be a midwife is to have an undefined and indefinable belief in the possibility of normality in childbirth. Furthermore, several of the midwives I spoke to suggested that normality and midwifery were symbiotically linked – one could be recognised through the presence of the other. As Rachael explained:

> 'Mmm, things like a stretch and sweep[35] and using entonox[36]... well they are all things done by a midwife, aren't they? So I suppose that doesn't make the birth, you know, just because a woman has those sorts of things doesn't mean her birth isn't normal, does it? So, yeah, you can have midwifery care, midwifery care and normality are sort of... well they go together really, don't they? They are the same... because ,you see, midwifery care is low risk care, isn't it? Mmm, and a vaginal birth, yeah, normal vaginal birth, and hopefully a natural third stage, physiological third stage, all the stuff that can be managed exclusively by a midwife.'

According to Rachael, midwifery can be imagined as being symbiotically linked to normal birth. The two concepts heavily coincide; that is to say, the boundaries of normality are marked by autonomous midwifery intervention, described here as the administration of entonox and/or the undertaking of a stretch and sweep for induction of labour. Midwifery activity, even when it is directed towards interfering with the physiological process or introducing pharmaceutical agents to disrupt the woman's perception of the physical experience of birth, coincides with normality to such an extent that they become virtually one and the same thing – a normal birth is a midwifery-managed birth. What this data suggests is that, just as the boundaries of

[35] 'Stretch and sweep' is 'a procedure where a midwife or doctor will "sweep" a finger around the cervix during an internal examination. The aim is to separate the fetal membranes from the cervix, leading to a release of prostaglandins and subsequent onset of labour.'(National Institute for Health and Clinical Excellence 2008 p. xii).

[36] Both interventions into the birth process which are done by midwives without any recourse to the multidisciplinary team. These are what might be called 'midwifery interventions' and as such are not interventions at all but part of a process for facilitating normal birth (Annandale 1988).

normality can be recognised through midwifery activity, so midwifery activity is constrained by the possibility of normality.

Further observational data taken from this study showed how, in situated midwife-to-midwife talk, the term 'normal birth' is frequently prefixed with 'nice'. This lexical choice not only appeared to have a normative function, which confirmed the speaker's professional allegiances, it functioned to emotionally load the term to mean a professional good, as the following field note entry illustrates:

> 'In the nurses' station (on a busy obstetric-led labour ward), Emma, a midwife, was giving a history of the woman she had been caring for in 'hand over' when she told the oncoming day staff:
> "Despite all that (referring to a catalogue of difficulties the mother had encountered during her labour) we did manage to get a 'nice' normal delivery."
>
> The reaction of the other midwives to whom this comment was aimed was one of approval, even mild congratulation. Emma had done well; the fact that she had managed to 'get a nice normal delivery' reflected well on her midwifery skills' (Observation Field Notes E14).

Not only was 'normal' prefixed with 'nice', the phrase 'we managed' in this context suggests that the normal birth should be considered something of an achievement (for both the midwife and the mother). Good midwifery and normality appear to coincide or might even be described as being mutually dependent. There is no question from this data that the concept of normality is value laden in a very particular way within the context of midwifery talk and practice. The question which remains, however, is why, given that normality is a preferable outcome and that normal birth is less hazardous, is birth in the UK increasingly embedded within an 'ever narrowing window of normality', where technocratic practices and interventions designed to reduce risk prevail? (Mander 2008; NHS Information Centre 2009). In an attempt to engage with the issues this question raises, how normality is represented within midwifery discourse will be more closely examined: firstly, by using social theory to look at this concept as a semantic absence; then, by examining its temporal fragility; and finally, looking at risk as a personal status tool.

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7.ii Normality – a semantic absence

Although much of the evidence collected in this study showed that normality, in relation to birth, was considered to be a cultural good, it appeared to exist without any sense of signification; its precise meaning, therefore, was frustratingly elusive. Apart from understanding normality as desirable, the midwives who participated in this study struggled to conceptualise it as a concrete concept at all. Rather, it was frequently described as something that could only be defined in terms of an absence; the absence of other more tangible attributes. More specifically, normality was something that revealed itself through the absence of risk and/or risk management. Nowhere is this more pertinently illustrated than in the *Normal Birth Consensus Statement* (Maternity Care Working Party 2007). Here, normal birth is defined as:

> 'without induction, without use of instruments, not Caesarean section and without general, spinal or epidural anaesthesia before or during delivery.'

This statement was developed by the members of the Maternity Care Working Party, ironically, 'to encourage a positive focus on normal birth' (Maternity Care Working Party 2007 p. 2). However, the choice of wording in this statement renders normal birth without substance; instead, it is only present as a linguistic absence. Normal birth here might be said to allude to the very requirements of representation since it can only be understood as an absence of interventions which are located within the language of risk.

Moreover, further archival analysis suggests that the semiotic absence of normality is intensifying. This intensification means that normality in the context of childbirth does not only now lack a language of its own, its very presence within the official maternity care record is being eroded. For example, in the recent Department of Health's Midwifery 2020 report, commissioned to 'develop a vision of midwifery' (Department of Health Midwifery 2020 Programme 2010 p. 6), normal or normality is mentioned seventeen times in the main body of the text, and of those seventeen citings, twelve are linked to social actors which may be described as having relatively low status – students. This compares to a meagre five occasions when this word was grammatically linked to fully fledged, qualified midwives. Furthermore,

on page 12, which is one of the places in this document where normality is linked to the higher status group of midwives, the concept is located within a long list of nine activities and is positioned at the bottom of the list, in the second to last position. This gives an unsettling sense that normality should not be considered to be top of a midwife's priorities. Similarly, in the 2011 Kings Fund report (Sandall et al. 2011), there is surprisingly little attempt to lexically link birth with the notion of normality. The word 'birth' appears fifty-nine times in the main body of the text and, of those, nine are linked to issues of safety, twenty-five to complications and medical interventions, while just five are linked to normality and six to spontaneous, unaided birth.

Given this wider context, it is not surprising that the majority of midwives who participated in this study saw normal birth in terms of what it was not; as an absence, rather than anything that it was. There simply was no language in which to draw from to speak of normal birth in its own terms. For example, according to Rachael, normal birth is:

> 'Yes, I mean normal birth is a labour that has had minimal intervention. I mean medical intervention, no medical intervention, yeah, no medical intervention. That includes epidural.'

While Hope, another midwife, told me:

> 'Normal birth is, erm, no intervention. That is about it. There must be a bit more to it than that but that's ...yeah.'

In much the same way, Fay described it as:

> 'Normal birth? I suppose it is just really... just without the aid of any medical intervention which would... which would include, erm, any, any like an epidural. So, erm, and certainly any medical intervention. So doctors having to come and intervene in any sort of way, certainly instrumental delivery or anything like that so, so that is what it is.'

Similarly, student midwife, Harriet, said:

> "I suppose no intervention.'

Independent midwife, Hannah, explained:

> 'Well, even now I still do it. I, I go through it and you know the woman's pushing and I'm like, Okay, is this all normal? Yep, we've got no fetal distress; we've got no problem with the woman's observations; erm, she has got this far and there is nothing.
> It is almost like a tick list in my mind, ticking off still now. *There is nothing so it must be normal*' (Emphasis added).

Such linguistic positioning is important since it exposes the linguistic fragility of normality within the context of a culture and, by association, birth is characterised by a sensitivity to risk (Beck 1992; Lane 1995; Lupton 1999; Reiger 2006). This evidence suggests that normal birth can be described as 'the subject that is not one' (Butler 1999 p. 2) in that it can only be (negatively) imagined through the signifier – risk. Or, put another way, in midwifery conversation normality has no language of its own; this means that it has to be defined using the dominant discourse (Kress 1989), which, according to this research, appears to be the language of pathology and medical intervention. There are no words with which to police the boundaries of normality; no linguistic tools to protect its integrity. Normality can only be signified through the absence of the privileged discourse of risk.

Evidence of this semantic absenting of normality can also be found in the texts produced by the NMC. In the Midwives Rules and Standards (Nursing and Midwifery Council 2004a) the NMC manage to describe the midwifery sphere of practice without any explicit reference to normality. Instead, midwifery care is described in the NMC Midwives Rules and Standards as:

> 'care (which) includes *preventative measures*, the *detection of abnormal* conditions in mother and child, the *procurement of medical assistance* and the *execution of emergency measures* in the absence of medical help' (Nursing and Midwifery Council 2004 p. 36).

It is significant that *all* four of the midwifery activities listed by the NMC coalesce around the language of risk. What this definition suggests is that, according to the midwifery statutory regulative body, midwifery activity has nothing to do with

normality; rather, it is about: prevention of risk; detection of risk; being alert to the possibility of problems; accessing medical support to manage risk; and lastly, being versed in managing unexpected disasters should they strike. What is most conspicuous about this official description is the complete absence of normality; it is not just a semantic absence we are talking about here, which would be disturbing enough given the moral loading of the term in midwifery talk, it is an absolute absence.[37] Instead, the NMC appear to be in the business of introducing Heyman's (Heyman 2010 p. 38) 'risk virtual object'; that is, they expect midwifery activity to focus on an imagined future where possibility of pathology is ever present, at the expense of the more probable alternative future inhabited by normality.

A recent interview with Linda, a lay member of a group convened by the NMC, set up to review and update the wording of the Midwives Rules and Standards, revealed exactly how entrenched the NMC preoccupation with risk adversity is. Linda described her frustration when trying to draw the group's attention to the absence of normality in the current definitions used by the NMC to describe midwifery care. She spoke of how she struggled, with apparently little success, to point out that the new 2008 International Confederation of Midwives (ICM) definition of midwifery, which the NMC pertain to use, includes reference to normality. Linda explained:

> 'It was quite interesting because, yes, I looked at the current rules and the definition of the midwife... I kept trying to say that they had used an outdated ICM definition but the convener... she started sort of telling me what the ICM was and that it was international and we couldn't always follow what they said, erm, and I thought.... it was a bit difficult... she had got it in her head that I was a lay member and didn't understand how midwifery works... I think she felt she was clarifying the situation that, erm, you know, there might be an overarching definition but we are looking at something slightly different... It became one of those points that I couldn't keep

[37] The text being analysed here is the printed 2004 version. It should be noted that the online version has an update to include a more up to date International Conference of Midwives' (ICM) definition, which does include reference to normality. The modality of this reference, however, is significantly reduced as the word is sandwiched between other risk-orientated concerns and appears in a list of five activities, four of which coalesce around risk and abnormality.

> bluffing away at. But I must say when the minutes came round that point was not included in it and I wrote back and said, please can that point be included in the minutes.'

Even when the absence of normality in the Midwives Rules and Standards was explicitly pointed out to representatives of the NMC, they were apparently unable to even conceive of it as a point that demanded any attention. Indeed, the linguistic absence of normality was considered to be so irrelevant to their task of regulating midwifery that it did not even make it into the meeting's minutes. Normality in this context appears to be totally eclipsed by a concern for risk limitation. It is the significance of normality within midwifery rhetoric heard through my data that makes this privileging of risk particularly unsettling. The implication of this is that, despite professional commitment to normality and despite normality being the preferred outcome for both mother and midwife, professional activity must, by law, coalesce around an imagined future inhabited by an omnipresent risk – normal birth cannot legitimately be a primary concern for midwives. Instead, a midwife's activity is assumed to centre on 'preventative measures', which include, as we saw in the preceding chapter, intensive surveillance of the well, evoking a sense of unease, as if the body of a woman teeters on the edge of pathology simply by virtue of being pregnant. As such, the pregnant and the birthing body is represented through midwifery action as a site of risk. Moreover, it is the midwife's legal responsibility to mitigate this risk, even if this involves narrowing the window of normality.

7.iii Contingency and the temporal character of normality

Moving away from the text analysis and back to data collected through both ethnographic interview and situated observations, the following section will drive the discussion forward to look at how normality not only devitalised in midwifery talk through a sense of linguistic absence, it was frequently described in ways that meant it lost any sense of tenancy in the present. As Silvia, a senior midwife, explained:

'We are very risk averse, aren't we? We, we will say, within the NHS, the majority will say it (birth) is normal after the event.'

This idea of normality being retrospective and recognisable only after a woman has given birth to her baby and is no longer in the crisis of labour echoed through a significant proportion of the interview data collected during this research. This was particularly noticeable in those interviews that were conducted with senior midwives, reflecting an institutional preoccupation with an ever present imagined risk, which favours a future inhabited by adverse events. These adversities, which this 'normal in retrospect' lens highlights, did not necessarily have much connection to the probability of events in the present; that is, the properties of midwifery risk thinking seemed to lose connection to statistical probability. What was important were the value judgements which individuals make about these adversities. Thus, the likelihood of a risk actually happening loses purchase in the care given in the present; instead, practice coalesces around an apparently irresistible desire to anticipate and avoid even the smallest possibility of an adverse outcome, even when this might involve abandoning any commitment to the notion of normality. As Maria pointed out:

Maria: 'I always tell people that there is high risk and there is low risk but that there is no such thing as no risk... Risk is much more important even if it might not be clinically significant...'

Mandie (Researcher): 'A 1:10,000 risk, is that a high risk or low risk?'

Maria: 'Depends if you are the 1 really, doesn't it?' [laughs].

Normality, despite being a preferred outcome, appeared to have a limited temporal existence in that it could only exist in the past, after the events of birth had concluded; birth in the here and now was overshadowed, perhaps even undermined, by a possibility of future risk and could only be imagined through a lens of risk where normality only exists in retrospect. The ways in which many of the midwives, particularly those midwives in positions of authority, talked about birth indicated that fears about the possibility of things going wrong, concerns with risk virtual objects, functioned to destabilise professional confidence in normality and birth. Sensitivity to possible risk evoked a sense of precaution, which constrained, even

warped (Budin 2007), the ways midwives could imagine the normal physiological process of birth.

In much of the professional literature, this emphasis on retrospective thinking, what Heyman (2010) has called 'hindsight bias' (p. 119), with its associated idea that birth can never be assumed to be normal from a prospective perspective, is usually said to be the preserve of obstetrics, not midwifery. Given the positive emotional charging of normality in midwifery talk, I was quite surprised, perhaps naively so, to find that it was such a prevalent theme in this dataset. According to the health literature, hindsight bias is more likely to occur when it reinforces core values (Heyman 2010 p. 119), but, in this case, the bias appears to reinforce the professional values that privilege a pathological view of childbirth, and as such marginalises midwifery values as they have been described in this chapter and in Chapter 3. This suggests a disconnect where, on the one hand, midwives are claiming to be key proponents of normality, while on the other they are not only failing to successfully police the boundaries of normality but are actually being active agents in the 'narrowing of the window of normality' in the maternity care setting. To flesh out this idea of the temporal perspective in relation to midwifery understanding of normality and risk a little further, the discussion will now introduce the experiential knowledge of adverse events as a mechanism which sandwiches normality in-between an imagined future haunted by possible hazards and a fear of very real, tragic past events.

Temporal sandwiching – the virtuous circle of risk, from the imagined risk to the real risk and back again

Experiential knowledge of actual pathology – having to witness or deal with the consequences of abnormality – operated to intensify sensitivity to risk by invading midwifery understanding of future births for many of the midwives involved in this study. The imagined 'what if things go wrong' or risk virtual object (Heyman et al. 2010), which is just one of many possible futures, may or may not actually materialise, and to some extent this was not that important. What mattered in many instances was that fears about imagined risks were powerfully felt by those midwives who had either been repeatedly involved (as was the case with some of the senior staff involved in this study) or recently involved in events that either

demanded emergency procedures or had bad outcomes. Under these circumstances, the window of opportunity where normality can manifest was invariably narrowed through midwifery action, which is preoccupied with the precautionary principle. As this field notes extract written following a home birth illustrates:

> 'Penny (the labouring mother) was in the birthing pool using entonox when suddenly she stood up screaming: "It hurts in my nu nu!"
> I look up to see Hannah's reaction. I really felt for her, painfully aware that this was the first birth she has done since the stillbirth. And for Penny to describe exactly the same symptoms as the woman last week did just before the baby died! It must have been really hard to hear. We caught each other's eye and all I could do was smile...
> Later in the kitchen, away from Penny, I talked to Hannah about my concerns for her feelings and she told me: "Oh God! Of course it went rushing through my mind. I couldn't believe she said that, of all things, it brought it all straight back... I have wanted to examine her three times now and I know it is nothing to do with what is going on in there with Penny; it's all about my own anxiety. Nothing to do with the clinical indication..."
> Hannah went on to tell me that she was really struggling in there, explaining that she was so glad to have another midwife there as this helped her keep her nerve.
> "When I wanted to do a VE I just looked at your face and I thought, 'No! Hannah, you don't have to do that!'"
>
> Truthfully, I have no idea what face I was making at the time and I can't even recall Hannah even looking at me at that point. Actually, I don't think that was particularly significant; it was about her inner turmoil, her battle against assuming pathology and very little to do with anything I may or may not have done at the time.' (Field Notes HV12)

Invariably, examples of the temporal sandwiching of normality collected during this research gave rise to precautionary practice which pointed away from normality and towards risk management regardless of the original circumstances which stimulated this reaction. For example, although Hannah knew that there was nothing she could have done to prevent the recent stillbirth she had witnessed, no amount of intrusive surveillance or medical intervention would have changed the poor outcome; it was just one of those things, ironically, simply part of normal birth. Her automatic

response was to try to intervene more in the birth process in her next case. Hannah knew that the introduction of such intervention would have made no difference to the tragic outcome she had so recently encountered. Hannah also knew that by introducing such measures into Penny's care, she would increase her discomfort and anxiety, disturb the spontaneous physiology of birth and thereby increase her risk of needing medical intervention. Despite this knowledge, despite this understanding of the complexities of spontaneous birth, Hannah struggled to resist the risk virtual object and the activity profile it evokes. Rather than affirm her commitment to normality, the bad experience eroded her confidence in spontaneous physiology, which encouraged her to actively narrow the window of normality through proactive, risk-averse practice.

The temporal proximity of Penny's birth to the recently experienced adverse event significantly influenced how Hannah interpreted the events as they unfolded. This was a normal, spontaneous birth but in Hannah's mind it was contaminated by a lack of confidence in normality and a hypersensitivity to a selective imagining of possible unwanted futures. Hannah described to me how she struggled against constant urges to disrupt the birthing process by introducing increased monitoring and measuring, suggesting that she could no longer assume normality but wanted to hunt out any signs of pathology. Penny's birth was sandwiched between memories of a very recent past, horrific incident, and fears of an imagined future catastrophe which, I am pleased to report, never happened. While Hannah struggled against urges to practise using principles of precaution, Penny managed to spontaneously birth her baby.

A case for concern

It is conceded that, arguably, this field notes entry could be interpreted in quite a different way and be held up as an example of the resilience of a commitment to normality, in that Hannah successfully overcame her urges to pursue activities where an unwanted future was assumed and thereby shaped her practice in the present. While it is not the intention to refute such a claim, justification for the inclusion of this data was based upon three considerations. Firstly, this observation episode provided very clear insight into the inner turmoil midwives are faced with on a day-

to-day basis, where competing futures, one which assumes normality and one which assumes pathology, jostle for supremacy. Although in this case Hannah managed to resist acting upon an imagined future, where pathology is inevitable, this should not be assumed to represent an inevitable outcome, as Hannah's own reflections suggest she may not have been so resilient without the presence of a second midwife in the form of the researcher. Secondly, this data acts as an excellent illustration of the seductive nature of risk thinking, which is orientated towards the selective imagining of possible unwanted futures. Lastly, and more practically, given the subject interest of the study, proximity to an adverse incident frequently was experienced by the researcher as an obstacle to research, with midwives having been recently involved in a bad outcome being reluctant to take part in participant observation.[38] That is not to say, however, that this was an issue that midwives avoided in their talk, as the subsequent interview data to be presented below will illustrate; rather, what is being suggested here is that observation data to illustrate this process was quite hard to come by.

While the midwives' hesitation to participate in observation following involvement in a case which had resulted in a poor outcome was frustrating, it was understandable. Furthermore, it has been taken as an indication of the intensity of how the temporal component of risk, where unwanted futures prevail in the imagination of practitioners, operates. As mentioned above, this should not be thought of as an issue that the midwives involved in this study avoided or were reluctant to talk about. As data taken from a conversation on the telephone with midwife Emma reveals, it was more a case of the temporal aspects of the interface between normality and risk being so emotively charged that they were difficult for the participants to disclose within the context of more intimate and embodied levels of research involvement. When discussing the possibility of the researcher joining her for a shift Emma explained:

[38] For this reason I was extremely grateful for Hannah's bravery in allowing access so soon after being involved in a case resulting in a stillbirth. This is an issue developed in some detail in Chapter 5 in relation to the impact of clinical governance.

> 'I really don't think I should do it right now (be involved in participant observation). I've only just gone back after it all happened (the case which had a bad outcome) and I'm a bit wobbly... well, all over the place, to be honest. Not sure if I'm coming or going right now [laughs], so I wouldn't be much use to you anyway. Yeah, I'm all over the place really.'

On the other hand, interview data, by contrast, was more forthcoming and is presented here to help give this issue some clarity. As senior midwife, Maggie, explained:

> 'Because people (midwives) are nervous and people will have had, people will have had bad experiences, they will have had bad experiences and you know... things like that, they make a difference, 'cause they make you think twice, don't they?'

This 'thinking twice' appeared to represent a point where midwifery orientation towards the imagining of possible futures shifted. Orientation which might have been occupied by a confidence in normality and unassisted safety seemed to lose any sense of relevance in that second take, to be replaced instead by the selective imagining of unwanted futures. Importantly, this was not only a process of practitioner psychology, although, of course, this is certainly important. The evidence collected during this research suggests that other wider organisational mechanisms set up to facilitate accountability and transparency operated to intensify the thinking twice process Maggie is describing.

Organisational structures and temporal sandwiching

Gail, another senior midwife, pointed out:

> 'Well, you see, if the outcome was fine it would never really get questioned, would it? If there was a poor outcome you would be asked: Why did you do that? Good outcomes, well they never get investigated or celebrated really for that matter; it's only the, the poor outcomes, they're what everyone hears about, they're the things that make people sit up and take notice you see.'

Behind the scenes observations of the risk management system within the Trust confirmed Maggie's and Gail's claims (see Chapters 4 and 5). Through the rigorous processes of clinical governance, aimed at realising the government's demand for the

NHS to become an 'organisation with a memory' (Department of Health 2000; Department of Health 1997), where hindsight learning from clinical errors, whether they result in poor outcome or near misses, could be established, organisational structures and procedures encouraged a midwifery thinking which was orientated towards the selective imagining of unwanted futures where things go wrong; even those midwives who had very little experiential knowledge of adverse outcomes, therefore, were made aware, through institutionalised risk management processes, that such circumstances could, no matter how unlikely, happen to them one day. As the next interview extract (describing a mandatory risk management staff study day) shows, in these circumstance, hearsay knowledge of fellow midwives having bad experiences appeared to be enough to secure the risk virtual object. Through 'talking up' hazardous futures, the possibility for assuming a birth where all is well became eclipsed by other unwanted futures, where risk might crystallise into real hazards:

> *Gail*: 'I was giving a talk about supervision and it was in reference to serious untoward incidents and it was about, one of the cases happened at a birth centre and two of the cases were at the acute site and they all had led to intrapartum[39] stillbirths. And at the end of this little, you know, forty minutes chat, it was coffee time and these two midwives came up to see me, one of them sobbing her heart out because she said: "Well, I don't want to go to the birth centre!"
> And I said: "Well, why don't you want to go to the birth centre?"
> She said: "Because that thing, that happens!"
> I said: "But I did one case from the birth centre two from, which were worse, happened on the acute side with doctors and you know. It happens wherever."
> She said: "I can't do it. I will be on my own. I have to, you know, I have to be with doctors. I have to be with other people. I can't, I can't be on my own. I can't be on my own; it is too frightening. I would hate it."'

What is particularly noticeable about this story is the severity of reaction of the midwives and the way this reaction operated to close the ever narrowing window of normality. The midwives listening to Gail's presentation could just have easily taken these case studies as proof that working in environments where normal birth is prioritised and facilitated, that is, delivering midwifery care in either the woman's

[39] Intrapartum refers to the period of time when mother is engaged in labour and childbirth.

home or in a stand-alone birth centre, is not necessarily associated with an increase in risk for the mother or the baby. After all, as Gail pointed out, the cases that had occurred in the acute site, where the backup of intensive emergency services was at hand, were far worse. It would seem reasonable to suggest, therefore, that this could have been quite a confirming, all be it solemn, moment, where midwifery commitments to practices which privilege normality might have been reaffirmed. But, instead, the incident operated in quite a different way, amplifying risk to such an extent that the midwife involved was unable to imagine any birth within a paradigm of normality. Rather than seeing an unwanted future – 'that thing, that happens' – as one of two possible futures, the other being the wanted future where mother and baby are both well, this midwife could only imagine her practice through a lens of risk, where discrete, and highly improbable, untoward events that had happened in the past map on to how both current and future activity can be imagined.

Conclusion

In their everyday practice, midwives working in the birthing environment are faced with two possible imagined futures: one, where the baby is born as a result of an adequate mechanism of spontaneous delivery and where any unnecessary medical intervention poses an unacceptable risk of iatrogenic harm; the other, conversely, is where spontaneous birth fails, threatening the health of mother or baby, or even worse both, and where serious harm would occur without the timely intervention of technocratic procedures. Importantly, both of these imagined futures are value laden; the former being the most desirable to both mother and midwife (Newburn 2006). As the evidence presented suggests, the latter, although less desirable, represents the more persuasive of the two within the current birthing climate where Caesarean section rates show a sharp rise in rates both nationally (Mander 2008; NHS Information Centre 2009) and globally (World Health Organization 2009) and where 97% of women choose to give birth within a hospital environment 'just in case' (DeVries et al. 2001; NHS Information Centre 2009).

By looking at normality in relation to risk it has been possible to build on the analysis presented in the previous two data chapters. The discussion in this chapter has introduced the importance of the interface between understanding of normality and risk in relation to: firstly, language; and secondly, contingency. That is to say, by illustrating how normality lacks any language or temporal space of its own through which midwives can defend its boundaries, it has been possible to illustrate how and why normality becomes so easily subsumed by the linguistically more secure notion of risk. Through close scrutiny of midwifery social action, represented through both published texts and through individual activity, this chapter has been able to give an indication of how midwives are positioned to the ever closing window of normality. Within a linguistic context, where normality and unassisted safety can only exist as the non-occurrence of unwanted futures, imagined futures where things go wrong take on a very real existence in the present through a process of temporal sandwiching, thereby impacting on how birth can be conceptualised and how it can be managed. As such, midwifery activity can be said to function, not to preserve normality in the present but to introduce the notion of birth as normal, only when it is over. Moreover, it is this way of conceptualising midwifery activity in relation to normality which is both novel and disturbing.

Chapter 8: The Uneasy Triangle of Choice, Normality and Risk

Introduction

The previous data chapters used key statements, said by three of the participating midwives, as a way of framing and directing the analysis of the interpretative work midwives do when making sense of risk. The first data chapter looked at the scare factor of risk, particularly in relation to organisational risk management. The second explored the swan effect of risk in relation to health surveillance; while the third chapter unpicked in more detail some of the complexities involved in the interface between normality and risk in birth and how this interface operates to close the ever narrowing window of normality. In this chapter, risk and normality will be located against another key component of current health policy and midwifery rhetoric – choice. By adding an analysis of choice to the multidimensional sets of statements through which midwives must make sense of risk, this chapter builds upon the preceding analysis to help give a sense of the complexly situated context in which risk is embedded within midwifery talk and practice.

According to Lindi, a midwife participating in my research, responsibility, blame and informed choice come together in a package that coalesces around a notion of risk. By that I mean, as she explained to me:

> "I think that is where sometimes informed choice can fall down, is when people are ... where they are not prepared to actually go to the bottom line and say: Okay, I understand that is a risk and *if anything happens I will not blame you.*'

In keeping with the previous chapters, the analysis to be presented here will be driven out of the task of understanding what Lindi means by this account. The discussion to follow, therefore, is an attempt to unpick the interrelationships between risk, informed consent, professional responsibility and accountability. However, it is

important to note that risk and choice do not simply run in one direction and, while the quote above illustrates one of the predominant themes, the picture is complicated by the fact that risk and choice cut across one another in complex and divergent ways (Symon 2006). This chapter, therefore, will focus upon two particular intersections between risk and choice in relation to birth performance in the UK. Drawing from two distinct theoretical threads from the risk literature, previously outlined in Chapter 3, this chapter will look at risk in relation to choice, firstly, from the moral dimension, which will include the issue of professional responsibility and accountability. The chapter will then go on to consider choice in this context from a different perspective, as an instrument of surveillance. The principal aim of the chapter is to present empirical evidence to unsettle some prevalent representations of midwifery identity and activity in relation to choice and normality, which can be found in the professional literature.

The first part of this chapter, therefore, which follows on from a brief background section, will be focused upon the tension potential which occupies the space between midwifery perceptions of risk and client choice. In particular, I want to look at tensions that arise out of the way midwives choose to utilise risk when dealing with, what I called in my thematic coding, 'deviant' clients, that is, women who refuse to conform to midwifery ways of knowing about birth and risk, but at the same time are apparently perceived as 'not being prepared to actually go to the bottom line and say: Okay, I understand that is a risk and if anything happens I will not blame you'.

In this section of the chapter, detailed descriptions of how midwives deal with choice will be presented in an attempt to challenge some of the prevalent assumptions underpinning the way midwifery is represented within the literature – as women's advocate and as 'being with women' – providing a glimpse of the complexities involved in negotiating a professional, midwifery identity where competing demands, which, as indicated in Chapters 6 and 7, often coalesce around understandings of risk, jostle for supremacy (Devries 1993, 1994). Leading on from this, a second assumption prevalent in the midwifery literature will be interrogated. That is, the assumption that choice will inevitably operate to confine the

medicalisation of birth, empowering women to reclaim their birthing experience, thereby enhancing personal freedom. Further data will be presented to show that such an understanding of choice and risk fails to capture the complexities involved in the way midwives negotiate the meaning-making process in their day-to-day working lives. While this challenge does not intend to refute that choice has become a prevailing mantra in our late-modern health care system, the second part of the chapter will draw more widely from the social theory of risk to give an indication of how midwifery advocacy of women's choice can interface with risk to both intensify the medicalisation of childbirth performance and confine personal freedom.

8.i Some background

By way of introduction to the discussion to follow, I will briefly explore some of the literature surrounding the notion of informed choice. Drawing from both the sociology of health and midwifery literature, I introduce informed choice within maternity care from the wider social and political context of informed consent.

From informed choice to the politics of informed consent

It has been suggested that with the development of the notion of informed consent in health care, a major shift occurred (Alaszewski 2007). Health professionals, who up until the 1970s had tended to adopt paternalistic attitudes in an effort to protect their clients from the harsh realities of their situation, were suddenly no longer able to withhold information or make decisions on behalf of those they were responsible for. Informed choice might be said to represent an intensification of this process; not only must the health professional now gain consent from their clients, they must go one step further, consulting them at every stage of the decision making process so that the implementation of a care pathway is mutually negotiated and decided upon through an ongoing partnership between the practitioner and the patient/client. Thus issues of risk, informed consent revolves around the rational construction of risk, with the professional being the risk communicator and the patient being the risk taker/decision maker.

Such privileging of lay, service user involvement in the health service is not confined to the client/health professional interaction but infiltrates every aspect of service and policy planning. Neo-liberal administrations since 1979 in the UK targeted paternalism in health care with reforms encouraging a more active consumerist ethos within welfare services (Winkler 1987). Policy documents such as the *Patient's Charter* (Department of Health 1992), driven by the language of consumerism and marketisation, place patient choice and client autonomy at the heart of the NHS organisation. Similarly, in maternal health, since the publication of *Changing Childbirth* (Department of Health 1993), the ideal of service user autonomy and informed choice has been privileged in the maternity policy agenda. The more recent *Maternity Matters* (Department of Health 2007) policy, for example, coalesces around what has been called 'the choice guarantee', offering women choice on place of birth which, according to the Department of Health, was achieved by the target date of 2009.[40]

Health policy throughout the 1990s and 2000s gave the public unprecedented levels of representation at all levels of decision making (Alaszewski 2007). Public or patient consultation and verification has therefore been courted, not only in relation to issues of direct care, but also in the policymaking process itself (Giddens 2000). It is not surprising, therefore, that at the 2001 RCM Conference the then Secretary for Health, Alan Milburn, pledged £100 million for maternity services to 'ensure that pregnant women have more choice and access to improved maternity services' (House of Commons Health Committee 2003 p. 4);[41] while in the 2007 *Maternity Matters* White Paper the word 'choice' dominates, appearing no less than seven times

[40] Although this claim made by the Department of Health was contested by the NCT with the publication of their *Location, Location, Location* report (National Childbirth Trust 2009), which argued that 95% of women across the UK have no choice regarding where they give birth.

[41] Interestingly, the Department of Health letter calling for bids for the fund makes very little reference to choice (Department of Health 2001). The fund was never ring fenced for this purpose, and discussion at the 2008 University of Central Lancaster's Celebrating Birth Centres Conference (University of Central Lancashire 2008) suggests that very little of these monies went towards improving choice in maternity services.

in the short preamble address written by the then Secretary of State for Health, Patricia Hewitt.

There is no doubt, therefore, that choice has become one of the mantras of today's health service, and Lane (2006) goes so far as to argue that the emergence of principles of consumerism in the maternity care service, where service user choice is privileged:

> 'has revealed that professional boundaries are not enclaves organized around a specific object of knowledge. Rather, they are contested spheres of practice – cultural artefacts produced by a "labour division"' (Lane 2006 p.341).

This shift has been described in terms of a wider decline in deference towards the expert, where individualism deepened its hold on the Western imagination and where, through the emergence of reflexivity, people took on responsibility for building their own personal autobiographies, carefully considering how to manage their own lives, their health (Beck 1992; Beck et al. 1994; Giddens 1991) and, importantly for me, the precise manner in which to birth their babies (Davies 2007; Possamai-Inesedy 2006; Symon 2006a).

Informed choice and midwifery discourse

According to many of the descriptions of midwifery, which permeate much of the professional literature, midwifery discourse interacts with the issue of informed choice in a very particular way. On the one hand, midwives are described as politically and ethically aligning themselves with the concept of informed choice and woman-centred care (Walton and Hamilton 1995). That is to say, in their role of being 'with women', midwives are simply assumed to do their best to preserve their client's autonomy in order to facilitate and support woman-centred care. Or, as the RCM put it in their position statement:

> '"Woman-centred care" is the term used for a philosophy of maternity care that gives priority to the wishes and needs of the user, and emphasises the importance of informed choice, continuity of care, user involvement, clinical effectiveness, responsiveness and accessibility' (Royal College of Midwives [RCM] 2001).

Concurring with this, Crabtree suggests that: 'The midwifery model of care... is grounded in supporting women's choice' (Crabtree 2008 p. 106), while Pairman (1998) uses the term 'professional friend' to describe how midwives go about supporting women to give birth in the way they have chosen and believe to be right for them and their babies.

On the other hand, by facilitating this process of informed choice, midwives are assumed to be in the business of encouraging both client autonomy and, notably, normality within the performance of birth (Edwards 2006; Graham and Oakley 1981; Newburn 2006; Oakley 1992; Walsh and Newburn 2002a; Walsh and Newburn 2002b). The data collected during this study, however, suggests that both of these assumptions tend to obscure the complexities involved in the interface between choice and risk, failing to capture multiplicity of meaning-making involved during everyday professional talk and practice. It is the intention of this chapter, therefore, to provide detailed descriptions of midwifery activity, as was revealed during this study through the ethnographic discourse analysis of published regulatory text, talk and practice, in order to unsettle both assumptions. Thus, having provided a brief overview of how the political development of choice within the context of health care policy in this country has been described within the sociological literature, the chapter will now move on to interrogate precisely how this policy is translated into meaningful action through the day-to-day activity of the midwife.

8.ii Informed choice and midwife's responsibility – a tension potential

The NMC position

In the NMC Council's *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* (Nursing and Midwifery Council 2008), the idea of supporting informed choice is centrally positioned in the midwife's professional duty of care in relation to respect, dignity, consent and collaborative care models. It reads:

> '1. You must treat people as *individuals* and respect their dignity.
>
> 2. You must not discriminate in any way against those in your care...

4. You must act as an *advocate* for those in your care, helping them to *access relevant health and social care, information and support...*

8. You must listen to the people in your care and *respond to their concerns and preferences.*

9. You must support people in caring for themselves to improve and maintain their health.

10. You must *recognise and respect the contribution that people make to their own care and wellbeing...*

13. *You must ensure that you gain consent before you begin any treatment or care.*

14. *You must respect and support people's rights to accept or decline treatment and care.*

15. You must uphold people's rights to be *fully involved in decisions* about their care' (Emphasis added).

According to the Council, therefore, a practising midwife has a responsibility to respect and facilitate informed choice and informed consent. Indeed, this concept appears to be a cornerstone in their statutory duty of care, as it is represented in the code, implying that any evidence suggesting the contrary, that is, if a midwife was found to have failed to fulfil this duty, would result in the offending party being removed from the register. This ethos echoes the individualised impulse that has underpinned maternity health policy since the early 1990s, suggesting that power has indeed devolved within health care, and that paternalist attitudes, which depended upon public deference towards health professionals, have been replaced by a partnership model of care where service users are at the centre of the decision making process. It is important to establish to start with that this picture was consistent with how the midwives involved in this study described their professional role and reflects how midwifery is described in the professional literature. In Cindy's, a participating midwife, description of midwifery, for example, she told me that, as a midwife:

> 'your *whole* role is to support women and be the women's advocate' (Emphasis added).

Similarly, when explaining to me how informed choice works in practice, Gail said:

'I think informed choice is exactly what it says it is. That women... have the right to choose what they want to choose and believe. And if you have given them all the facts and all the information and they still choose their way of doing things. Their method of birthing or their decision, then more power to their elbows. You know.'

While, on the same topic, Andrea said:

'I think the midwife's role really is to give as much information as possible and for them to make that decision and support them somehow in the decision that they make.'

What these midwives seem to be suggesting is that they take their professional code of conduct very seriously in their work and recognise that informed choice, as it is now recognised within current health policy and the Council's documentation, is an issue which they are professionally bound to respect and preserve. Women have the ethical right to choose what they do with their bodies while they are pregnant and birthing, and the midwife is present during these physiological processes in order to support and facilitate women in exercising that fundamental right.

The professional containment of choice – translation of the tension potential into meaningful practice

To flesh out the precise nature of how service user choice operates within midwifery discourse in more detail, an interrogation of another of the Council's texts, the *Midwives Rules and Standards* (Nursing and Midwifery Council 2004a), will follow.[42] The first point of note is that the word 'advocacy' is conspicuously absent from this document. Similarly, and equally surprisingly, the word 'choice' appears just once, where it refers to a woman's right to self-administration of medicine. This absence of interest in the words 'choice' and 'advocacy' is unexpected given the discursive context in which this document was published. That said, however, it would be wrong to suggest that the document ignores these issues completely. The notion of choice is indeed alluded to through a set of very different words:

[42] The statutory document which constrains and defines all midwifery practice.

'education', 'preparation' and 'decision making'. Importantly, as I shall argue below, these words tend to evoke quite different political implications.

In Rule 6 *Responsibility and Sphere of Practice* it states that the midwife: 'should respect the woman's right to refuse any advice given' (Nursing and Midwifery Council 2004a p. 17).

This is followed by a more detailed explanation, in the additional guidance section, of how this rule should be interpreted. Here, the Council goes on to explain:

> 'If you judge that the type of care a woman is requesting could cause significant risk to her or her baby, then you should discuss the woman's wishes with her; providing detailed information relating to her requests, options for care, and outlining any potential risks, so that the woman may make a fully informed decision about her care.
>
> If a woman rejects your advice, you should seek further guidance from your supervisor of midwives to ensure that all possibilities have been explored and that the outcome is appropriately documented. The woman should be offered the opportunity to read what has been documented about the advice she has been given. She may sign this if she wishes.'

In this extract, an interface between choice and risk emerges. Moreover, it is possible to see how this interface appears to operate, confining women's autonomy through what might be described as an urgent, and certainly very busy, midwifery activity profile. The midwife should 'discuss', 'provide' and 'outline' and in the next paragraph 'advise' and, although these activities do not appear to effect any material change, according to the Hallidayian Systemic Functional Grammar model (Halliday 1996) they do function to grammatically reduce the agency of the woman by positioning her as the goal of the processes. According to the theory of functional grammar, such grammatical structure demonstrates that the social actors represented in a text should not be thought of as being evenly placed politically (Fairclough 2001). If one party is positioned as a goal of the other then they are not being ascribed with agency or control over the interaction (van Leeuwen 1995). Furthermore, the Council go on to say that all these midwifery activities should be

carried out 'so that the woman may make a fully informed decision about her care'. This wording implies that the woman herself is incapable of making an informed decision about how she wants to behave in relation to her pregnancy and birth without recourse to midwifery expertise and, as such, the midwife is positioned as the gatekeeper of the decision making process. Informed decision making is not about accessing information; it is about accessing particular information and it is the midwife's role to ensure that the right kind of information has been taken on board. Any discussion involving one party 'providing', 'outlining' or 'advising' does not indicate a balanced relationship where mutual exchange is facilitated; rather, it assumes that the midwife's understanding of the risks involved is privileged. These grammatical observations are significant for two reasons: firstly, as already illustrated in Chapter 5, the overlap between risk and harm is firmly grounded within taken-for-granted midwifery knowledge; secondly, such a grammatical structure functions to relegate those women holding a different perspective from that of the midwife responsible for her care, to the position of being either misguided or wrong.

Such an interpretation of the midwife's role in relation to service user choice is further endorsed in the legislation which can be found at the back of the Rules. Here, it states that:

> 'The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care' (Nursing and Midwifery Council 2004a p. 43).

In this statement, the woman, her family and community are again the goals of material processes, which clearly belong to the midwife. This, as noted above, means that the actors represented in the clause are not evenly placed (Fairclough 2001), those parties being positioned as the goal of the process, that is, the women and their families, are given the passive role. Although this statement is all about service user choice, the grammatical structure in which this is embedded is such that the social actor with the power is the midwife and not the service user. The midwife

is represented as being the active agent in the relationship. It is questionable, therefore, whether this statement can be said to support a partnership model of care. By examining such grammatical structure in detail, the Council's political positioning towards the notion of choice appears to be complicated by the existence of a concordant discourse, which aspires towards a firmly paternalistic model of midwifery care, where it is the midwife's responsibility to take on an active role in educating the woman and her family, who remain largely passive to this process.

A fully-informed decision, it would appear, involves listening to the midwifery interpretation of risk, which, as noted above, coalesces around the avoidance of harm. Apparently, without this information the woman's understanding would be incomplete; she simply would be unable to make a choice. This positions ways of knowing in a rigid hierarchy, where midwifery understanding of birth, while not absolute, has authority over lay perspectives. Through the analysis of the language choice adopted by the Council, the boundaries within which informed choice can operate begin to emerge. Informed choice does not appear to be so much about facilitating service user autonomy as securing their compliance; furthermore, failure to gain this compliance has some serious repercussions for both midwife and client. At the point when a woman chooses not to accept the advice given to her by her midwife, the midwife's professional autonomy is compromised. She is no longer available to support the woman in her choice; rather, she must put into place a busy activity profile aimed at seeking professional support in order to correct the mother's misguided judgment, enabling her to make *right* choices for herself and her baby. Paternalism, it would seem is, is patently evident within bureaucratic guidelines aimed at regulating midwifery practice despite the rhetoric of informed choice. Or, as Hope, a senior midwife, puts it:

> 'Some of the constraints... I mean there are criteria... and no matter what the woman chooses she won't be allowed, if it isn't thought to be appropriate. The midwife doesn't have any control over that or any say in that nor does the woman.'

Within this context, choice can only be tolerated when it is defined by a pre-existing and paternalistic menu in which midwives are active agents.

The moral menu from which choices can be made

When talking about their professional role in relation to education and advice offered to clients in their care about choices around their pregnancies and births, all of the midwives involved in this study stressed the importance of two recourses:

- Evidence-based practice and NICE guidelines.
- NHS protocols.

While there was, in many cases, overlap between these two, this was by no means seen to be inevitable. And, put simply, where the two did not concur, the midwifery voice tended to echo local protocol. As Hope explained:

> *Hope*: 'There is a risk to going to unnecessary intervention and the cascade of intervention, erm, of being in an obstetric unit when actually there is no need to be there. Or even if you have a need to be there, there is still risks of unnecessary intervention and the consequences involved in that.'
>
> *Mandie (Researcher)*: 'And is it the midwife's role to explain those risks to the woman?'
>
> *Hope*: [long pause] 'Mmm, it probably should be but, erm [pause], I don't know whether it is. The thing is, there is just so many risks, there is risks to everything so you have to balance it all out and make sense of it all, it is like, oh I don't know, if you think about it too deeply [pause]. I think risk management is about more check-ups, more scans, that sort of thing.'

Hope appears to be aware that there is evidence to suggest there are iatrogenic risks associated to giving birth in a hospital environment; risks which affect all women but which are presumably taken unnecessarily by those women who have no clinical reason for birthing in a high-risk obstetric environment but choose to do so nonetheless. Despite this understanding however, this midwife clearly does not consider it to be her responsibility to alert the women in her care to these risks inherent in choosing this birthing environment. The role midwives play in the interface between choice and risks simply does not work in that way. Informing the woman about the evidence of the iatrogenic risks associated with unnecessary

hospitalisation, which may include major abdominal surgery,[43] is not part of risk management, which is instead orientated towards mitigating women's failing bodies and/or their unreasonable and irrational decision making. Risk is all about enhancing those choices, which coincide with increasing care and surveillance, and seemingly cannot operate in ways which might reduce medical intervention. According to Hope, such a notion simply does not make any sense.

Midwifery agency and the choice menu

By contrast, it is interesting to note that all the midwives in my sample insisted on the importance of making those women who chose to have their babies at home, or in one of the low-risk birthing centres, aware of the risks involved in their choice, and the occasions that would make transfer necessary. This routine conversation between midwife and every pregnant woman choosing to birth away from the high-risk, obstetrically-run birthing environment, takes place even when such a decision does not contravene Trust risk management policy. Moreover, each midwife stressed the importance of recording this discussion (which coalesced around things that might go wrong in either the mother's or the baby's body) in the mother's hand-held maternity notes. Interestingly, this formalised discussion and documentation was not a professional responsibility which I could locate anywhere in the Trust's protocols or guidelines, as Mary explained to me:

[43] The recent WHO publication reiterated there is no concrete evidence as to optimal Caesarean section rates but speculate a rate between 5-15% might be appropriate. This is in contrast to the Trust's rate, which is 25%. It should be noted that this calculation includes all births across the Trust, capturing those that take place in places where a Caesarean section cannot be performed, that is, at home or in a birth centre. Since Hope is talking about the risks involved in having a baby at a high-risk unit, the 'low-risk' numbers should be removed from the calculation. When these low-risk birthplace numbers are removed the rate is even higher and is nearer 30%. This rate is double the maximum threshold rate recommended by the WHO in 2010.

> 'We usually write on their birth plan words to the effect: Aware no doctors, no epidurals, reasons for transfer... I don't think there is any formal guidance on this and now you mention it I don't know how I know to write that!'[44]

There appears to be quite a sharply divided risk selection process going on here. The midwives I spoke to during this research were very keen to explore the risks associated with the physical process of birth with the women in their care and actively used this information to guide women through their decision making. These were the risks which evoked notions of professional responsibility and accountability and, ultimately, fear of blame. By contrast, those risks associated with the hospital environment remained predominantly unvoiced. These risks seemed to have, at most, tenuous links to understanding of professional responsibility and accountability. Indeed, many of the midwives in my sample were uncomfortable talking about such matters with their clients. The moral loading of risk involved a systematic bias, with some risks being amplified, while others were obscured through midwifery activity. Midwives were careful to select those risks which coincided with Trust protocol priorities, the first-order risks associated with birth, leaving other more controversial man-made risks unvisited in their conversations with their clients about choice. This moral guiding of maternal choice through selective risk amplification, however, does not appear, as some have suggested, to be a case of midwives passively submitting to protocols over which they have little control, or as Kirkham and Stapleton put it, just 'going with the flow' (Kirkham and Stapleton 2004). Rather, this is a practice those involved in this study actively pursued out of a consciousness that such careful risk selection was seen as being part of their role as a responsible midwife. This practice was an important part of being a competent midwife. Confining choice by educating mothers and their families, about institutional risks posed by high-risk birthing practices and environments

[44] This comment was supported by evidence collected during observations. Indeed, I came across one woman who had these details recorded in her notes twice because she was not sure which low-risk unit she wanted to have her baby in. Although both units came under the same Trust, the midwives involved did not think one risk assessment and consent regarding the risks was sufficient and so went through the entire procedure twice, once in each unit.

demanded much less, if any, of the midwives' attention. This was not considered to be part of their professional responsibility and was certainly never recorded in the mother's maternity notes as having been discussed. Thus, those women choosing to birth within an acute, obstetric unit without any medical or obstetric indication, rarely, if ever, had their choice discussed or even clarified by the midwife involved in their care.

It should be stressed, however, that this is not an expression of professional ignorance of the risks associated with hospital procedures. My observations indicated that all the midwives involved in this study were well versed in the iatrogenic risks associated with the medicalisation of birth, and it was a topic that commonly came up in group conversations, which took place in staff spaces where only midwives were present. The midwives were aware of the filter they put into place when confining choice through their discussions about risk with their client. Furthermore, they appeared to think that this filter was both an appropriate and justified part of their professional persona. In midwife-to-midwife interactions, however, conversations could be more candid, as one participant explained:

> *Gail:* 'People can see that doctors can cause problems by over intervention, lack of communication, etc... that is, causing, introducing risk and I think everybody would accept that. Or I don't know if everybody would but I think that would be accepted [sigh]. I think, I think yeah. I don't think that idea is too marginalised... I think that amongst midwives, I think that's perhaps the predominant. No, I don't know, I don't know, mmm. You will find out [laughs]. I think it is probably a widely held view and I think that the majority of midwives think, see that, that iatrogenic risk and they understand that.'
>
> *Mandie (Researcher)*: 'Where would you hear that? Would it be expressed to the women?'
>
> *Gail*: 'Probably not. They might express it to each other in the coffee room mightn't they? Sort of [pause], you know. I think in the coffee room. They might at labour ward forums. I think that could be I think a lot of it would be unexpressed and taken as a given. Unexpressed or to colleagues really.'

This evidence suggests that the intersection between risk and choice operates in a very particular way. The midwife's role in relation to giving information about choices is not a simple matter of alerting women to the risks, nor is it necessarily about informing her about the available evidence surrounding her choice. The midwifery position in relation to this task is not as politically neutral as that.

Although midwives may be aware of a variety of risks associated with the choices women make, they tend to be selective about which ones they choose to talk about with their clients; the menu of choice they offer to women is morally loaded in a way which ensures significant overlap between Trust protocols and evidence-based, expert advice. This means that, on the one hand midwives might perceive their primary role in terms of, as Cindy explained to me:

> 'imparting knowledge, bring our knowledge to bear on pregnant women being able to identify whether they are at risk and if so what the risk is.'

This knowledge is never impartial and is constrained and facilitated by a complex set of, sometimes competing, discourses. As Douglas (1985) points out, the cultural context in which risk is made sense of impacts upon which risks are chosen out of an array of risks that exist. In this case, risk selection very much depends upon which risks had been privileged within the NHS Trust's protocols and clinical care procedures. This element of the organisation's risk management culture, unlike that which has been described earlier in relation to clinical governance in Chapters 4 and 5, tended to focus upon those risks which reside within the mother's and/or the baby's body, the first-order risks, rather than those that reside with the institutional culture. Put another way, it was those risks which operated to unsettle the possibility for normal birth which were selectively amplified by the midwives. Those hospital sourced risks, which might contain the medical management of birth discourse, by contrast attracted relatively little midwifery attention. The midwife's responsibility in relation to risk and choice of place of birth, therefore, is to make a woman aware of all the things that might go wrong with her body during her birth, especially if she chooses to have the birth at home or in a low-risk birthing unit. If a woman chooses to birth away from the hospital environment, midwives make every effort to draw

attention to the imperfect nature of birth and to ensure that the woman is patently aware of her own potential physical inadequacies.

The gulf between choice and support – deviant cases

It is important to stress that the evidence collected during this research project suggests that the selective amplification of some risks and exclusion of others was not confined to the choices surrounding place of birth. This example was chosen simply as a topical illustration of the complexities involved in the interface between choice and risk. Having explored how the midwives in this study chose to position themselves in relation to this interface and place of birth, I now want to move on to look at some of the wider implications this had for midwifery practice. Although all of the midwives I spoke to were fluent in the rhetoric of midwifery advocacy in relation to supporting women's choices and women-centred care, the tensions that arose out of the way risk operated through midwifery activity suggests that this sense of professional identity was embedded within a concordant discourse in which other professional concerns predominate. Importantly, this tension meant that those women choosing to birth in the low-risk environment against midwifery advice had to be subjected to an intensified process of education, which inevitably involved not only the midwife but several other members of the multidisciplinary team. As we saw from the NMC's rules, these include a midwife 'outlining any potential risks' (selectively chosen) to a woman and, on the occasions where this tactic fails, the woman is referred to a higher authority. The NHS Trust protocol advises that:

> 'Women who are recommended to have their babies in an obstetric unit or who require individual assessment but who wish to remain under midwifery-led care should be referred to a Consultant Midwife, Community Managers, Birth Centre Co-ordinators or a Consultant Obstetrician as appropriate.'[45]

Thus, the decision not to follow midwifery advice marks a symbolic boundary within the midwife-client relationship. At this boundary, responsibility instantly shifts from

[45] The reference for this protocol has been excluded from the thesis bibliography to protect the anonymity of the participants who took part in the research.

the midwife upwards through the NHS chain of authority. The necessary deference to higher authority in these situations applies to both client and midwife alike. As we saw above, the NMC considers this cause for 'seek(ing) further guidance from your supervisor', meaning that the agency of mother and midwife is compromised since both have to defer to a higher authority. Furthermore, the midwifery capacity to adopt the role of supporter is severely challenged. In what follows, I will be using further interview data to give an illustration of how choice can operate within the midwife-client relationship and how it can, as occurred in some instances in my dataset, lead to a sense of woman being perceived as a deviant.

8.iii Choice, accountability and the medicalisation of birth

At the beginning of the chapter, Lindi introduced the notion of blame as key to the choice-risk interface. This quote was taken from a conversation where Lindi had been reflecting upon a particular case that had caused her some irritation. The case she was referring to involved a woman who was booked to have her baby at home but who had subsequently spontaneously ruptured her membranes prior to labour.[46] This event instantly threatened her chances of having the home birth she had planned because according to the Trust's 'Transfer' guidelines:

> 'Women should be risk assessed throughout pregnancy, at the commencement of midwifery care in labour and in the postnatal period. Risk assessment should be documented in the woman's notes on arrival/admission at a birth centre, midwife-led unit or on arrival at the woman's home...'

This statement is followed by a long list of situations where transfer should take place and this includes:

> 'Intrapartum:
>
> - Unsuitable to deliver at home/birth centre/MLU...

[46] When in utero the baby is encased within two layers of membranes. These membranes, the chorion and the amnion, usually stay intact for the duration of the pregnancy, breaking at some point during the labour. For 10% of women, spontaneous rupture of membranes occurs prior to the onset of labour.

- Prolonged rupture of the membranes >24 hours unless birth imminent'[47]

Interestingly, in another Trust guideline which deals exclusively with management of spontaneous rupture of membranes (SROM) and where place of birth is not overtly considered, the description of management is slightly more liberal, saying that:

> '60% of women will go into spontaneous labour within 24 hours of rupturing their membranes. The rate of spontaneous labour after this is 5% per day. The risk of infection is increased the longer the interval between rupture of membranes and the onset of labour and also by the number of vaginal examinations...
>
> Unit policy is to encourage expectant management for at least 24 HOURS. (It must not exceed 96 hours)'[48]

Here, the 24-hour period is subtly but significantly different. Unlike in the Transfer guidelines, this timeframe is no longer used as a cut-off point but is used instead as a positive indication that spontaneous labour will take place without the need for medical intervention. Furthermore, the 24-hour period represents a minimum length of time women should be given to go into spontaneous labour after their waters have broken; the maximum time being 96 hours.[49] Lastly, this guideline not only draws attention to the risks that lie within the mother's body but also the iatrogenic risks involved in performing a vaginal examination after the membranes have ruptured; a risk that presumably can be avoided by a woman choosing to stay at home without midwifery care.

This disconnect between these two NHS protocols reveals the interplay between risk, normality and surveillance discussed earlier in the thesis; that is to say, care may be

[47] This protocol reference has been omitted from the thesis bibliography to protect the anonymity of the participants involved in this research.

[48] The reference for this protocol is absent from the thesis bibliography to protect confidentiality.

[49] What is not written in the guidelines is the evidence that suggests that 90% of women at term who have SROM go into spontaneous labour within forty-eight hours.

open for negotiation provided women concede to a regime of increased surveillance, which may include abandoning plans to birth away from the hospital environment. However, for the purposes here, I draw attention to it purely as an indication of how protocols are drawn on in relation to service user choices which are considered to be unconventional. Although there appears to be a potential semiotic slippage between these two protocols, which might enable the midwife to support the woman's wishes to stay at home to deliver her baby, this opportunity in this case was never realised nor indeed does it appear to be explored as a possibility. As Lindi explains:

> 'What I don't like is when, we had an incident not so long ago when somebody was, erm, wanting a home birth had had rupture of membranes, all explained to her, she decided she didn't want to go into the high-risk unit, which is fine. I have got no problem with that but then we were trying to send midwives in to check that everything was okay and she was pretending not to be at home. So she wasn't, so she didn't actually call them until she was in labour. Now I feel that woman had every right to make that decision; what makes me cross is that when we were running round like idiots after her whereas if she had said to us: "Go away, I do not want to see you until I am in labour".'

When I asked Lindi to explain why she thought the woman had chosen to reject midwifery input so overtly, she struggled to reply and instead reinforced the issue of blame and responsibility by telling me:

> 'My line would then be: "I am more than happy for you to have your home delivery, I am more than happy to leave you alone. If you take that decision and something happens to your baby would you ever forgive yourself?"
> And I think that makes somebody really think about it so that that would be my way of dealing with it.'

Although Lindi shares, with those midwives quoted at the beginning of this chapter, a commitment to respecting the woman's right to choice, this is manifest through the midwife-client relationship in a very particular way. It is as if Lindi's professional sensitivity to risk, taken from a conservative reading of the NHS protocols, functions to splinter and, in this case, break down, the relationship she can have with her client. The fact that the mother involved responded by physically withdrawing from

midwifery care altogether, suggests that she was only too aware of these feelings of animosity towards her. But, rather than understand or sympathise with the woman's predicament, Lindi finds this act cause for further condemnation. The woman's choice to refuse midwifery surveillance is simply intolerable because at the end of day Lindi is convinced that if things did go wrong and the outcome was not good for mother or baby, then it would be the midwife who takes the blame. Or, put another way:

> *Lindi:* 'They (the deviant parents) are not prepared to actually go to the bottom line and say: "Okay, I understand that is a risk and *if anything happens I will not blame you*"' (Emphasis added).

Lindi's story illustrates the unsettled ground upon which the client's right to choice is placed within the maternity care setting. Although service user autonomy has been endorsed through health policy for almost twenty years, how this is allowed to be expressed is strictly policed through routine midwifery practice, which revolves around the selective amplification of risk as harm. Those women who choose options that are not on the presubscribed menu of choices that have been carefully set out by the midwife, create, through their choices, a site of tension where professional understanding of human rights and risk collide and where professional commitment to the possibility of normality is undermined. It is at these points of collision that the moral loading of risk crystallises into a discourse of deviance and, once loaded in this way, operates to fracture relations between the midwife and her client.

It should be understood that Lindi's story is by no means exceptional; rather, my thematic analysis reveals this to be a densely populated theme that ran through both my observational and interview data. Take, for example, Cindy's experience of caring for a woman who had been diagnosed as morbidly obese.[50] Having had two

[50] The social construction of obesity as a risk category in pregnancy is problematic, particularly since CEMACH acknowledge that as an independent variable it cannot be said to impact negatively on neonatal death rates. Although it is beyond the scope of this chapter to go into this in any detail, I

normal vaginal deliveries before in a hospital setting, this woman decided, largely for personal reasons, to opt for a home birth. Following her NHS Trust protocol, which states that women with a 'body mass index at booking of greater than 35 kg/m2 should be excluded from delivering at either a midwifery-led birth centre or at home', Cindy tried her best to persuade this mother to have her baby at an acute, obstetrically-run site. When the mother refused to acquiesce to this advice, tensions arose within the relationship. As Cindy explains:

> 'She, erm she, understood that but she was very, well [pause] very adamant that she was going to have a home birth and nothing was going to stop her. She was very challenging in that she was defensive, argumentative, rather than sort of going through the risks with me, and us making a plan together that we were both happy with. She was making clear that it was her that she was going to do exactly what she wanted to do...
>
> I mean usually women, if you explain to them the reason why they need to do that and the other they, they are happy to do that because they want to do what is right for them and the baby. But for this case it was really difficult because I knew what I was suggesting according to policies and guidelines was, erm [pause] was the right thing for her, erm [pause] and she was just disagreeing with me at every moment.'

Cindy appears to be confident here that she had provided this mother with all the information she needed in relation to her weight. In her professional opinion, therefore, this mother was in a position to make a fully-informed decision about where to give birth to her baby. Clearly, Cindy had fulfilled her professional duty of care as it is set out by the NMC and the Trust's protocols in relation to the risks this mother was choosing to take. Ironically, it was precisely because Cindy had fulfilled her duty of care in relation to the NMC and NHS protocols that she struggled to maintain a satisfactory midwife-client relationship. As she went on to explain:

> 'The way she reacted made me feel like she didn't care what I thought as a professional. Erm, it almost made me feel like I didn't know why she was coming

think it is important to note that targeting obesity can be seen as part of a wider neo-liberal policy agenda of shifting responsibility for health away from the state. The implications of this policy for women using the service who fall within this category are significant.

> to see me! It felt like she wasn't listening to any of my advice, she didn't want any of my advice and it made me feel a bit, erm, useless, I suppose.'

The tension within the midwife-client relationship in relation to choice described here does not appear to be founded upon a sense of blame or responsibility, as was the case above with Lindi, but is more explicitly attached to a power struggle over the right of definition. Cindy expected to have authority over what and how risks should be understood, and these, in her professional opinion, should reflect her Trust's policies and protocols. This meant that when her client refused to accept her authority the relationship became almost pointless in her eyes. The tension created by her deviant client's assertiveness seemed to make Cindy feel uncomfortable, vulnerable even, suggesting that professional identity and her right to authoritative knowledge heavily coincide. When her recommendations were ignored, the basis of her professional confidence fractured. At that point, her role as a midwife was severely compromised, since this role depended upon her maintaining a status gap between them, where she was placed in a position of authority. As Cindy explains:

> 'When you feel... that everything you're advising, it is very hard then to be that woman's advocate because you don't understand what she, what she wants, and what she is saying. You don't understand where she is coming from and it is really hard to go to support her in her decision.'

From moral loading to the intensification of medical surveillance

So far in this chapter I have explored some of the complexities involved in informed choice and risk in midwifery talk and practice. Drawing from two propositions found within the literature – namely, that choice is a mantra of contemporary maternity care where paternalistic health professional-client relationships have been displaced and more evenly balanced partnership models of care where power and authority are equally shared by both parties now prevail; and that midwives are naturally placed to support and facilitate this informed choice – I have used data to show that while both these propositions offer some insight into understanding how informed choice works in the context of risk, neither succeed in capturing the complexities involved. It is true that client choice has been at the top of the policy

agenda since the 1990s. How this is translated into meaningful action, however, is far from straightforward. The fragility of the client's right to choice within the context of maternity care becomes most apparent at those moments when women try to assert their right to choice despite the work midwives do in the amplification of certain risks, namely, those that reside in the woman's body. The data presented so far in this chapter suggests that these moments represent a point rupture in the midwife-client relationship, where struggles over responsibility, power and autonomy are fought. The midwifery task of supporting and facilitating informed choice is not an easy one but, importantly, the findings from this study suggest that, despite the rhetoric, midwifery practice does not inevitably endorse women's rights to informed choice. If and when a woman's choices coincide with how a midwife chooses to understand the risk, then the task of advocacy is relatively straightforward; on those occasions where this is not the case, however, midwives do not give up their professional authority easily and are active agents in trying to get the woman to conform to expectation.

The main theoretical driver behind the analysis thus far presented in this chapter originates from the cultural theorists' work on risk. Although governmentality in relation to surveillance and the disciplined body has been implicit in the discussion, this element has been, as yet, underdeveloped. The final section of this chapter, therefore, will look in more detail at choice as a mechanism of surveillance. First, it is important to revisit the assumption upon which debate surrounding the policy privileging of informed choice has been largely based. As observed at the beginning of this chapter, *Changing Childbirth* (Department of Health 1993), The National Service Framework for Children, Young People and Maternity Services (Department of Health 2004), and *Maternity Matters* (Department of Health 2007) all form part of a wider health policy agenda emphasising personal responsibility, personal autonomy and choice. This policy agenda has predominantly been warmly received within the midwifery press. Evidence-based, informed choice has been understood to be a mechanism which would inevitably promote the personal interests of women by expanding the normal birth agenda and confining the medicalisation of birth

(Bryar 1995; Newburn 2006; Sandall 1995; Walton and Hamilton 1995). As Fay explained to me:

> 'You see where I've been banging on about things, like not putting women on monitors, mmm, just not going down that cascade of intervention – you know, that sort of thing, making it all abnormal – well, now all the evidence is coming out to support all that.'

What mother would subject her own, and her baby's, body to the risks associated with medical interventions, if those interventions were not in her best interests or in the interests of her unborn child? Logically, through accessing information, it was assumed that women would rightly refuse any intervention that was not necessary and in so doing be proactive in the campaign to reclaim birth performance as being a normal physiological process. Trends in birth performance, however, suggest that such professional optimism is both misplaced and inaccurate. Resilient hospital birth rates suggest that interface between choice and risk is more complexly negotiated. The evidence above provided an indication of how the boundary work around choice can operate to intensify emotive risk amplification within midwifery discourse. The proposition in what follows is that women, as well as midwives, can, and do, position themselves to choice in such a way that is instrumental in the medicalisation of birth performance by actively seeking out medical surveillance, as the following extract from my field notes indicates:

> 'When (I was) working in a high-risk, obstetric unit a mother was admitted in early labour. On admission, the midwife, Miranda, explained the observation procedures she would have to carry out as part of her routine care and assessment. The mother, however, was not satisfied with the list of surveillance procedures and questioned Miranda, saying:
>
> "What about the fetal monitor? I want to have my baby monitored just for peace of mind."
>
> Miranda responded to this by reassuring the mother that continual fetal monitoring was not necessary in her case as she was low risk.
>
> "If anything happened and there was a clinical indication," Miranda explained, "then, of course, the baby would be monitored."

"But I cannot possibly do this without the monitor. I just need to know everything is Okay... I couldn't relax otherwise," protested the mother.

Miranda acquiesced, leaving the room to discuss the request with the midwife in charge of the shift and returning with the appropriate equipment to carry out a continual electronic fetal monitoring, in line with the mother's request' (Field Notes SM 1).

This tension potential, which arose out of the divergent opinions between the midwife and her client here, is quite distinct from that discussed earlier in this chapter for several reasons. Firstly, unlike above, this mother's choice is embedded within an anxiety about the process of birth. She is concerned that her baby might be threatened by, might be at risk from, normal physiology; she is afraid her own bodily function will harm her baby and insists on the application of technology in order to reassure herself that she is not inadvertently damaging her unborn child. Secondly, it is the midwife, in this instance, who maintains a confidence in the possibility for normality in this situation. Lastly, the moral loading involved in the midwife's understanding of this interaction is nowhere near as intense as that described above. Although Miranda sought professional approval by informing the senior midwife in charge of the shift, she was otherwise apparently unthreatened by the fact this mother chose to disregard her advice. Furthermore, discussion with Miranda in the staffroom later in the shift revealed that she was aware of the risks associated with continual fetal monitoring[51] but, despite this knowledge, she did not consider it was her responsibility to attempt to dissuade this mother.

'"It's not up to me," Miranda told me, "is it? I mean we live in a world where... well, women are entitled to choose, aren't they?"'[52]

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[51] Evidence suggests that continual fetal monitoring of low-risk mothers has had no impact upon improving neonatal outcome. However, using this technology has been associated with an increased risk of both instrumental delivery and Caesarean section. For this reason it is not recommended for low-risk mothers (National Institute for Health and Clinical Excellence 2007b). Increasing the use of this technology has been questioned even in high-risk obstetric care (Alfirevic et al. 2006).

[52] Legally of course women are not entitled to choose clinical interventions which are not professionally considered to be appropriate – as was the situation in this case. Women, like all

Although all three cases – Dianna's, Cindy's and Miranda's – involved mothers making choices which contravened professional recommendation and local protocol, it was only Miranda's situation that was resolved with little if any threat to the attending midwife's professional identity and integrity. In other words, it was only when choice was used to amplify risk through a request for increased medical surveillance that the midwife was able to support the mother's right to autonomy with relative ease.

Conclusion

In this chapter I have used text analysis, interview transcript and observational data to give an indication of how risk and choice interface within the maternity care setting. Through this presentation of empirical data and analysis I have attempted to unsettle several assumptions which permeate the literature.

Firstly, I have suggested that, despite the policy rhetoric privileging choice, professional interest in traditional, paternalistic models of care persist, especially at moments when women attempt to resist midwifery efforts to amplify risk. What this evidence seems to suggest is that midwives are not necessarily as woman-focused as much of the literature would have us believe and that concerns for professional responsibility and accountability in relation to risk and normality can function to erode the core midwifery principal of 'being with women'.

Secondly, the evidence presented suggests that the premise that choice functions to contain the discourse of risk is misplaced. Quite conversely, using the material generated through this study I have been able to identify ways in which choice can intensify midwifery activity in relation to selective risk amplification. Furthermore, this data suggests that midwifery tolerance of choice is more robust when women opt

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patients, are entitled to refuse care but this was a case of a mother demanding extra medical care and technology despite the fact that there was no clinical indication.

for increased, rather than decreased, medical surveillance. Put another way, several of the midwives involved in this study felt more secure when asked to support women's choices, which operated to intensify the medicalisation of childbirth rather than the other way around. Midwives make sense of maternal choice through a multidimensional process of negotiation, where different kinds of choices are not evenly placed. Choices which overlapped with medicalised activities, even when countervailing local protocol, tended to be less emotively considered. It was predominantly those choices which emerged from a resilient commitment to the possibility of normality in childbirth which evoked the most intense fear of personal and professional blame.

Chapter 9: 'If it isn't documented, you never done it.' Work at the Margins of Risk

Introduction

While emphasising the complexities involved when midwives make sense of risk and the multidimensional interpretative processes this involves, the main focus so far in the thesis has been on how this operates to unsettle midwifery notions of normality, autonomy and women-centred care. However, it is important to note that, although frequently unsettled, these professional priorities were by no means made redundant through the operations of the discourse of risk. When there was an ontological overlap between institutionally-driven risk amplification processes and these professional priorities, as has been described in the previous chapters, no tensions arose. In contrast, when being a midwife, that is being the expert of normal physiology and being 'with woman', appeared to diverge from such risk amplification processes' margin work, what Goffman (1961) called 'primary adaptations' could and in some cases did begin to emerge. In this chapter, I explore the mechanisms involved in this margin work that is a constant undercurrent to what has been described so far in this thesis.

While observing a group of midwives during a staff training session, the issue of documentation was raised by the senior midwife who was the session facilitator. The general tone of the discussion was punitive in that, from the outcome of a recent risk assessment audit, it was assumed that all the midwives in the room could be accused of what the facilitator called 'poor documentation'. While this was interesting talk in itself,[53] for the purposes of this chapter, this staff training session was significant

[53] I was struck by how it both amplified sensitivity to concerns with paperwork (which can have a significant, and not necessarily positive, impact upon how maternity care can be legitimately imagined), while indicating a wider cultural system where hierarchical, chastising managerial styles were the norm.

because of the space it opened up for activities to take place at the fringes. As Maria, the senior manager, noted: 'If it isn't documented, you never done it' (Field Notes ES 3).

In the previous chapters of this thesis, the discussion has coalesced around the discursive power of risk and how it operates to shape how midwives can imagine birth, and how, in turn, their professional activities help to sure up the discourse of risk. Maria's observation, by contrast, offers an opportunity to deviate away from this theme to look at the work midwives do at the margins of risk. This chapter represents an attempt to capture that activity, which unsettles the seemingly impenetrable preoccupation with risk within midwifery talk and practice. Although Maria said the above statement in the context of a wider narrative, where she described midwives having to defend their practice at NMC hearings,[54] her statement also alluded to the opportunity midwives have to engage in activities which might not fit with the local risk-averse protocols and practices but which could take place beyond the scrutiny of the institutional radar.

This chapter will focus upon midwifery activity which has a potential to confine what has been described as the dominant/technical paradigm in Chapter 3 of this thesis. That is to say, the discussion to follow will centre on the midwifery talk and practice at the margins of the more dominant maternity care discourses. Such margin work should not be conceptualised as necessarily being oppositional in nature; rather, it is best understood as representing a sense of slippage, a space created through everyday midwifery activity, where alternative possibilities can quietly exist.

In contrast to the previous chapters, therefore, the data presented here represents a shift in focus from what has so far been reported. Instead of looking at dominant themes that run through the dataset, largely identified through thematic coding and analysis, I will now take a different approach and interrogate those exceptional cases,

[54] Maria's purpose appeared to be about driving home the institutional demand for what the CNST risk assessment tool deems to be adequate record keeping by alluding to personal incentives.

the dissonant data, to look at the space potentials which exist within the meaning-making process of risk. The object of this chapter is, as Hope, a participating midwife, put it: 'the unofficial communication'.

The chapter is divided into three parts. Part one will open with be a brief theoretical section to introduce the academic debate underpinning this idea of work at the margins of risk. This will be followed by observational and interview data to explore the tensions arising out of margin work. In part two the costs paid by individual midwives will be explored. The third and final part of the chapter will examine some of the circumstances which can open up the necessary opportunity for resistance discourses to be expressed. In particular, I will be looking at the opportunities presented by: under-documenting; what Weber described as charisma; and; finally; by physical space in relation to where midwifery practice takes place.

9.i Work at the margins of risk

Some social researchers interested in risk have criticised Beck for underestimating the diversity of responses to risk. Weir, who uses a Foucauldian biopolitics approach to researching risk in pregnancy in Canada, notes:

> 'voluminous social science literature on the proliferation of risk judgment. There has been little curiosity about possible objections to risk reasoning and their significance' (Weir 2006 p. 76).

She argues that:

> 'Exactly how risk governance has been limited or rejected deserves treatment, partly as a corrective to the social scientific writings that assumes risk runs unchecked over the plains of the present' (Weir 2006 p. 5).

Similarly, Heyman claims that:

> 'Attitudes towards risk differ more than Beck's concept of the Risk Society might suggest' (Heyman 1998 p. 19).

This view is supported by Lupton and Tulloch:

> 'In the sociological literature dominated by the writings of Beck and Giddens, the human actor is portrayed as anxious about and fearful of risk, eager to acquire knowledge so as to best avoid becoming the victim of risk' (Lupton and Tulloch 2002 p. 114).

As I noted in Chapter 2, I would like to contend that such criticisms underestimate the subtleties of Beck's thesis. My own reading of this material suggests that the risk meaning-making process is complex. Beck's theoretical proposition rests upon notions of dis-embedding, reflexivity and fragmentation, which would inevitably lead to multidimensional understandings of risk. His thesis of risk, therefore, can be understood to offer insight into the complexity of the social construction of risk.

That said, however, I do think this literature raises an important point in relation to the operations of risk, and it is this that forms the theoretical basis of this chapter. Like any powerful discourse, the technical/dominant paradigm of risk, no matter how persuasive, exists alongside other ways of knowing. As Foucault et al. famously stated:

> 'There is no power without potential refusal or revolt' (Foucault et al. 1990 p. 84).

Although the dominant/technical paradigm of risk might be described as being powerful, the very production of its power creates multiple points of contestation, which might be local and discontinuous, but they are resistance all the same. Goffman, for example, shows how, even in total institutions such as asylums and prisons, resistance to the organisation's official demands (what he called the 'primary adaptations') can always be found in spaces outside or in-between institutional surveillance, providing that is, that the research instrument is sensitive enough find them (Goffman 1961). These spaces outside the surveillance of the panopticon include the proverbial cycle shed of the school playground. As pointed out in Chapter 3, Goffman (1961) showed that authority is neither absolute nor permanent. Resistance may not be covert; it may exist in ways that are unexpected, at the fringes of the organisation, but that does not mean that it does not exist at all. Davies (1995)

in her study of nurses in the NHS shows how, in bureaucratic systems where organisational structure function to mute subversive voices, in this case female nurses working in a patriarchal bureaucracy, dissonances can still be heard in the informal channels of interaction and communication. In this chapter, I focus on these less formal moments and the possibilities they create for alternative views of risk.

Risk adversity revisited

It should by now be clear that all the midwives involved in this research were uneasy with the idea of risk taking.

As I have already pointed out, although I expected to find midwives conceptualising risk as an opportunity to embrace professional priorities such as client autonomy and normality, rarely was such an understanding overtly expressed when they talked to me. This meant that when I asked the question: Is there a place for risk taking in midwifery? the almost universal reply was: No. As I indicated in Chapter 5, risk was overwhelmingly seen as something bad; a potential harm. Moreover, it was the midwife's responsibility to anticipate and reduce that potential harm.

Midwives reducing risk: How should it be done?

How midwives went about the business of achieving the professional aim to reduce risk, however, was not necessarily as straightforward as it might seem, and this represents one point where fractures in the dominant/technical paradigm can begin to emerge. While, as I have already shown, this midwifery activity often operated to amplify the risks associated with birth (see Chapters 6 and 8), this was not always the case. Midwives had different strategies for managing risk, and these differences could, and often did, become the site of inter-professional tension, as the following field note extract taken from a participant observation of a mandatory staff training session suggests:

'During a skills drills session on management of the breech,[55] seven midwives were practising the delivery manoeuvres in a small classroom with the help of a synthetic pelvis, vulva and thighs and plastic baby. All the demonstrations and practical participation took place with the 'woman' lying flat on her back with her legs up and hips abducted. Moreover, the 'dummy' was designed with a flat back, representing the female body in a permanent supine, and therefore passive, position.

One midwife, Sharon, brought up the fact that the only occasion she would be likely to manage a breech would be in the community, at a home birth or a 'born before arrival' (BBA).[56] She went on to say how she would, therefore, want to promote the normal physiology of birth by encouraging the woman to be upright or in the all fours position. It should be noted that this caused a certain amount of 'raised eyebrow' looks from the rest of the group. They seemed interested but no one else agreed with this or offered this midwife any support in her challenge.

The proposition appeared to make the group facilitator, Phyllis, a senior midwife from the Trust, uncomfortable. She explained that such a management would contravene Trust policy guidelines. She went on to say that there was no research evidence to substantiate such an approach and that she was therefore unable to teach it or condone it. It would seem that there was no room in this classroom for a demonstration of a faith in normal physiology; the breech had to be perceived as an abnormal event – a risk – and as such had to be managed using proactive and encoded obstetric techniques' (Field Notes SD1).

It would appear that both the midwives involved in this interaction conceptualised breech as hazardous, and both wanted to explore ways of managing the risks associated with this situation. In this respect, the two midwives involved in this teaching session, Sharon and Phyllis, were conforming to the technical/dominant paradigm of risk. Where the tension arose, however, was the knowledge base they

[55] Breech presentation is when a baby enters into the maternal pelvis bottom first and this presentation accounts for between 3-4% of births at full term.

[56] This term refers to an unplanned home birth, where the baby is born before the midwife arrives or before the mother gets to her planned place of birth.

chose to use to achieve this goal. The group facilitator, Phyllis, was in the business of ensuring that institutionally defined protocols were both understood and implemented in an effort to ensure that care would be standardised across the Trust and in all working environments. She was trying to ensure all the midwives used encoded midwifery knowledge (Alaszewski 2007), whereby evidence-based frameworks (classically drawn from random controlled trials) could be used to standardise future clinical management. Sharon was effectively challenging this when she drew on her tacit practice knowledge, using it to privilege an alternative professional priority – a commitment to the facilitation of spontaneous, physiological birth.

The tension presented in this extract does not appear to originate so much from the fact that these midwives had different attitudes towards risk or risk taking as such, nor indeed does it necessarily suggest that they have different levels of commitment to the process of reflexivity. It is not that one is engaging reflexively and the other not; on the contrary, their dilemma might be described as being an illustration of the very process of reflexive modernisation in relation to risk, as it has been described by Beck (Beck et al. 1994). Both midwives are using their understanding of expert technologies to imagine ways to mitigate a risk which only has a virtual reality in the present (Heyman et al. 2010). What is clearly different about the two midwives' approach to risk mitigation in this field note extract is the way they go about this task. Importantly, this difference has significant ramifications both for midwifery and for women more generally.

The importance of this difference of approach to risk can be seen in a further extract from the same observation:

> 'When some of the midwives later got together and flipped the dummy vulva over, to simulate the all fours position (with great difficulty considering its lack of arms and flat-back design), in order to practise delivering the breech the other way round, everyone, including Phyllis, the group facilitator, appeared to get confused. This is neither a remarkable nor unexpected observation; doing something upside down for the first time is bound to be disorientating. What was interesting, however, was the way Phyllis reacted to this situation: she simply withdrew from the group, hastily

leaving the room, which left the rest of the group (including myself) feeling confused and uncomfortable. In the face of this challenge, essentially a midwifery challenge based upon an understanding of, and conviction in, the mechanics of normal labour, this senior midwife acted as if her authority had been undermined' (Field Note SD 1).

Although Phyllis is, as far as she is aware, appealing to scientific evidence to state her case for the standardisation of care of undiagnosed breech births,[57] she is doing this in a very particular way. Phyllis is representing the CNST's understanding of risk, thereby privileging what might be described as an 'institutionalised' sense of reflexivity, where expert knowledge and standardised guidelines, set out both nationally through NICE and CNST and locally through the Trust, can be confidently used to make sense of risk. That is to say, Phyllis' commitment to the process of reflexivity closely coincided with the bureaucratic goals of the institution. This means that Phyllis inevitably should and does perceive her role in the clinical governance initiative as ensuring that all practitioner embodied tacit knowledge is supplanted by institutionally endorsed, encoded knowledge. As described in Chapter 4, such encoded knowledge places a premium on explicit guidelines, directives and universal standards with the aim to generate 'unified and predictable pattern[s] of behaviour and output' (Lam 2000 p. 492). Such an approach to risk is an intrinsic part of what Flynn (2002) has described as the 'machine bureaucracy', where a high standardisation of knowledge ensures that individual autonomy is replaced by strong organisational control.

Scientific-bureaucratic model of medicine

To help understand this midwifery activity in theoretical terms, I feel it is appropriate to revisit Harrison's analysis of the scientific-bureaucratic model of medicine (Harrison 2002). According to this model, Phyllis' activity can be seen as evidence of

[57] The professional debate in the literature on management of breech birth is vibrant. Impartial clinical evidence is both controversial and scarce. However, this has not prevented the interested parties adopting very strong positions in relation to this issue.

the operation of this system of health care (Harrison 2002). According to Harrison, scientific-bureaucratic medicine denies the possibility that personal experience can legitimately inform professional practice. In this context, not only does Sharon's suggestion (that her experiential knowledge of normal birth physiology could be capitalised upon in order to facilitate the spontaneous birth of the breech and thereby reduce the risks associated with that presentation at delivery) present an ontological tension, it fails to fulfil the criteria for credibility.

Feeling midwifery

It is my contention to suggest, therefore, that the tension arising out of the interaction recorded in the above field note extract can be seen not only as a power struggle between different ways of knowing about risk but also as a much wider, gendered struggle upon which the nature of legitimate professional knowledge within midwifery is determined. According to the feminist scholars, Dalmiya and Alcoff (1993), current scientifically-orientated rationality, such as that described by Harrison and Flynn, leaves little room for female ways of knowing about the world, which are said to include more intuitive and experiential understandings of normal birth. In their discussion of midwifery knowledge they argue:

> 'Contemporary epistemological theories have validated this practice of what might be called "epistemic discrimination" by developing definitions of knowledge and stipulating requirements for justification that traditional women's beliefs have generally not met and, in fact, cannot meet... the delegitimisation of traditional women's knowledge is not only politically disturbing but also epistemologically suspicious' (p. 217).

It proved quite difficult to capture how the midwives involved in this study thought of this idea of embodied, intuitive knowledge, as Andrea one of the NHS midwifery participants explains:

> 'It is a kind of intuition or gut feeling... I think knowledge and experience and a bit of intuition... so when I see them (labouring women) it doesn't actually take me long to work out what they are about and what is going on, kind of thing. So I don't think it is just... it must be the midwifery that you know that I have learnt and practised for a long time that I kind of just know it, feel it.'

What was easier to establish, however, was that this 'feeling midwifery' was both important and provided a potential point of departure from the dominant/technical paradigm of risk. By rejecting the possibility that personal experience can be accepted as a source of valid knowledge, the scientific-bureaucratic logic appears to trivialise what have been traditionally thought of as quintessentially female ways of knowing. As Fox Keller (1990) points out, there is nothing more masculine than the language of science, and, importantly, for many of the midwives who participated in this study, like Sharon, less scientific and more intuitive, embodied ways of understanding birth formed an important part of their midwifery skill base and identity. In this scientific-bureaucratic context, however, such ways of knowing appear to lose credibility. For some midwives, therefore, just as Sharon found in the above field notes extract, expressions of embodied midwifery care could only take place at the margins of daily activity, as they were neither valued nor welcomed within the more dominant discourse of maternity health care. As Davies noted:

> 'Because of the nature of the masculinist vision and of masculinity itself, women's work in the organisation – some of it called nursing (arguably also midwifery) – has to be ignored, or trivialised and devalued' (Davies 1995 p. 62).

Undocumented and marginalised

It is not surprising, therefore, that even those midwives who openly talked about relying upon intuitive and embodied knowledge in their daily work were all clear that such knowledge was ambivalently placed within the organisation. For example, Silvia, another NHS participant, described to me how she manages some labours, explaining that she just knows:

> 'That baby is just going to come. And that is intuition. We do use intuition but we know... if someone sat in front of me, when a mistake has been made and I say: "I used intuition," they are going to say: "What are you talking about?"
> So that is the world we live in, isn't it? I suppose official midwifery can be quite different from actual midwifery?'

Similarly, Andrea explained:

'You know she is getting ready to labour, kind of symptoms or she has got her nesting kind of instincts that is telling me she is you know, she is going. They all form part of the picture... I know that but I didn't actually write it down as such, I wouldn't document it.'

Such knowledge could only exist beyond the institutional risk management radar. It could only take place at the fringes in the potential opening provided by: If it isn't documented, you never done it.

9.ii Evidence-based midwifery, protocol-based midwifery – tensions and costs

The gendered scientific-bureaucratic mechanisms within maternity services place certain limitations on what evidence-based midwifery practice can look like. Because of the privileging of the masculine logic within the organisation, midwives tended to go about collapsing institutional guidelines and protocols and the notion of evidence into one ontological concept. This is an issue already explored elsewhere in this thesis in relation to both informed choice and the scare factor of risk. While it is not the main concern of this chapter, it is worth noting that this was an attitude that was not limited to the more senior, managerial midwifery participants involved in this research; nor, moreover, was it something that was confined to any particular working environment. For example, independent midwife, Hannah, who works as a midwife exclusively in the mother's home talked about NICE guidelines and evidence as if they were the same thing. She told me:

> 'I don't think NICE guidelines actually, erm, because they do tend to talk about evidence, don't they? So, erm, you know, I am quite confident that, erm, I deliver evidence-based care.'

For Hannah, evidence-based care is equated with implementing national guidelines. Within the NHS, this ontological collapse not only incorporates the national NICE guidelines but also includes local interpretations of those guidelines. Dianna saw her practice bound by protocols:

> *Mandie (Researcher)*: 'So in some respects protocols can restrict your better judgement?'
>
> *Dianna*: 'I think in some respects they are, they can. We are always told that protocols are there for guidelines they don't have to be abided by. Having said that, if you go against the protocols people are likely to haul you up on it. Every time.'

Hilary also explained:

> 'Erm, just because, because I signed a contract with them that I feel duty bound to adhere to the variety of different protocols and guidelines that have been put in place for me to work by. I don't agree with a lot of them... I just think, I can't. I just have to go along with what they say even if I don't agree with it.'

According to all of these NHS midwives, therefore, what is expected of the individual as a midwife and as an employee is a privileging of the evidence as it is represented in institutional guidelines, even if this evidence does not coincide with what the midwife believed to be good practice. The field note extract above, describing Phyllis and Sharon, can be seen as a powerful illustration of how this expectation, which demands that midwives confine their understanding of evidence-based care to specific types of encoded knowledge, works in practice, and the power struggles the voicing of marginalised resistance excites.

In this incident, Sharon appears to be in the business of refusing to accept the logic of the scientific-bureaucratic model of evidence which her colleague Phyllis is so eager to preserve. Instead, she actively disturbs the assumption that risk in birth is best managed through the uncritical acceptance of institutional, and in this case, medicalised, protocols. This is important because it has implication on how she is able to conceptualise not only risk but midwifery and birth itself. In suggesting that her professional understanding of the normal physiology of birth may be used to facilitate breech birth, Sharon is refusing to accept the institutional operations of risk in three separate domains.

Firstly, she is refusing to accept the image of herself as a potential liability, delivering suboptimal care which needs to be reined through the enforcement of the scientific-bureaucratic approach to managing risk. Secondly, she refuses to acknowledge that the birthing woman is incapable, choosing not to see her client as a site of risk, even in such exceptional circumstances. Lastly, Sharon is demonstrating her confidence in her own personal understanding of normal physiology, which is embedded, partly at least, in the experiential knowledge gained through simply being a midwife and working with women in labour. Through her resistance to the institutional operations of the dominant/technical paradigm of risk, Sharon endorses a world view which does not appear to originate out of an interest in controlling birth through the introduction of encoded medical interventions; instead, it stems from a quiet, nebulous professional confidence in women's 'natural', perhaps even essential, ability to bear children without interventionist techniques. As such, Sharon's statements function to unsettle the preponderance of the scientific-bureaucratic model of risk technology, as it is defined through clinical governance in the NHS. This resistance, however, should not be confused with a risk-taking approach. On the contrary, like Phyllis, Sharon is eager to reduce the harm which may come from a breech presentation birth. It is her distinctive approach to hospital protocols and her confidence in other kinds of knowledge which make her understanding of this risk so unsettling. As is the case with all power struggles, particularly those with a gendered component, such unsettling comes at some cost (Davies 1995).

The cost of work at the margins

In this section, I will further illustrate what can happen when midwifery activity which usually takes place outside of the institutional radar becomes visible. According to her interview data, Helen managed to conduct physiological breech births, as they were imagined by Sharon in the above, while practising in the NHS. The incident transcript below describes the occasion when Helen's, hitherto unnoticed, practice came to the attention of the risk management team in the NHS Trust.

'And everything was fine and the fetal heart was fine... And then all of a sudden, whoosh! I was like: "Oh, we've got a breech," so I buzzed and this midwife came and the breech was advancing...

I told the woman: "You have got a breech baby and it is best for you to stay in the upright position."

Anyway, Shellie (senior midwife), walked in and by this point I had put a pillow underneath her. And by this point, we must be up to about there (indicating her chest area), I think, so it is all coming out, it is very lively and then basically we were waiting for the head. *Because that is what I have always done and I have never done anything else.* I was just like: "Right we will just wait then, we will have another contraction, the baby will be born and everything will be fine."'

Just as Sharon had been suggesting that a midwife should be able to manage a breech presentation using a combination of her experiential knowledge of birth and her understanding and faith in the woman's own ability to birth her baby spontaneously, Helen went about the business of setting up a spontaneous birth with the woman in what she understood to be the optimal position for facilitating spontaneous vaginal birth. Importantly, her rationale was based around her own personal experience; she did it that way because that was how she had always done it. What is interesting about this story, as the next extract illustrates, is the tension this confidence in her own professional abilities and in the woman's capability raised and the impact this tension had on her future practice.

'Well, in the interim this midwife had to call the consultant... So he came in and because she (the mother) was kneeling and because the body, the front of the baby was facing outwards, he thought she had an OP[58] but all he did was, he was just hysterical, he was just hysterical and he went: "Turn her over now! What do you think you are doing?"

[58] OP means occiput posterior, which is not actually the correct terminology for what she is trying to explain here. The correct abbreviation would have been SP, which means the sacrum of the baby's pelvis is lying against the back of the mother's pelvis. This is important because there is no physiological mechanism for a baby to delivery breech in the SP position. To achieve a vaginal breech, the baby's back must be at the front of the maternal pelvis and not the back.

> I was like [snort]: "God! Don't clench the anal-rectal muscle because otherwise we are stuffed!" because he was so hysterical. So we gently turned her over, basically. If he had just left her she would have delivered and I think, well, he put his finger in baby's mouth and the baby delivered. He was hysterical and wanted to know what I was doing and then I ended up in this situation where, erm, I said: "Well, I have never done anything else."'

Up until this point in her career, Helen's breech practice had somehow slipped beyond the institutional radar. Because it had not been documented as an untoward event, near miss or clinical incident, Helen had been able to develop an experiential knowledge base for facilitating physiological breech births, which itself had been based upon her understanding of women's abilities to birth spontaneously. This situation had caused little tension within the organisation because the outcomes of her work at the margins had been good. It is only when events go wrong, when the potentiality of risk translates into actual harm, that the mechanism of the institutional risk management system clicks into action. However, on this particular occasion this mechanism was activated by tensions caused between two professionals working in the same clinical setting but choosing to take quite diverse approaches to how they understood and dealt with the risks associated with the case. At this point, the cost of Helen's resistance was paid. As Helen went on to explain:

> 'I was taken aside...
>
> "What would I have done if the baby's head hadn't have come?"
>
> And I said: "Well, why wouldn't it have come? The whole of the labour suggested that she was going to deliver."
>
> And I didn't give them the answer they wanted...
>
> And they said: "You didn't know what to do if the head hadn't have come. You couldn't give the right answer so that is going on your file."
>
> And, erm, but this person who interviewed me just said: "You know we have a policy here that they have to go into the lithotomy[59] for the second stage?"

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[59] A lithotomy position is used to enable the medical management of birth, e.g. the use of forceps for an instrumental delivery. It involves the mother lying on her back with the hips and knees flexed and the thighs apart. Her legs are held into position with stirrups, which are attached to the side of the bed.

> And I said: "That it is all about a medical approach, an obstetric approach to delivering breech!"
> "Well, we don't do breech."
> And I said:
> "Well, I don't know anything else. I don't know about a lithotomy breech. Why would I want to do that? Why do you put women at the most disadvantaged for the most high-risk birth? You want it to come, how could she deliver like that? I just think that is bizarre! If it, if it is advantageous for women to be upright for the cephalic, it must be for the breech. I just don't understand this. It just doesn't add up, it just doesn't make sense to me. I just can't get it into my head."
> So I had my hands firmly slapped about that... I think it has just been flagged up that I didn't adhere to policy.
> And they said: "Unless you practised it a lot you shouldn't be doing that."
> I went: "Right, I don't want to be involved with any breeches then.'"

Given that long-term benefits of Caesarean section birth for breech babies have never been established (Glezerman 2006; Whyte et al. 2004) and that one of the issues at stake in this area of care is the loss of practitioner skill (Association of Radical Midwives 1998; Royal College of Obstetrics and Gynaecology, Royal College of Midwives 2006), a midwife having experience of managing twelve physiological breech births successfully (which was Helen's level of experience with this practice) might have been seen as an opportunity for the Trust. Helen never claimed that her experience extended to complicated breech births where the after coming head was entrapped; what she did want to assert was that she was confident and skilled in managing normal vaginal breech births. This confidence and competence, however, fell outside the institutional protocol; it went beyond the boundaries of the Trust's scientific-bureaucratic model of medicine, where all practice has to be controlled and standardised. For this reason, not only were Helen's skills trivialised, she was officially chastised and ordered never to repeat such a management style.

Work at the margin: an alternative perspective

In the previous section of this chapter, dissonant data was presented to help capture some of the complexities involved in making sense of risk in midwifery talk and

practice. It is important to note that, although this material demonstrated how midwives can and do react to risk in different ways, ways which are not necessarily consistent with institutional risk management objectives, the underpinning ontological connection between risk and harm and the consequential professional priority of risk avoidance remained undisturbed. That is to say, while the interpretative work which exists at the margins of risk described in this chapter may operate to unsettle institutional risk procedure – in that it often relies upon ways of knowing which fall outside the organisation's accepted notion of evidence – this work should not necessarily be taken for evidence of the inadequacy of Beck's reflexive modernity thesis. Instead, such complexity in risk meaning-making might best be understood as an illustration of the limitations of the gendered dominant/technical paradigm of risk, as was described in Chapters 2 and 4.

Despite the empirical evidence presented in this chapter, which demonstrates concordant understanding of risk existing side by side within midwifery discourse, the multifaceted interpretative work midwives do when making sense of risk has not been taken to be an indication of the limitations of Beck's work. Quite conversely, it is the proposition of this chapter that such material can be understood as being consistent with a reading of Beck's Risk Society, where multiplicity of meaning is characteristic of the dis-embedding and re-embedding of social forms through the process of individualised reflexivity. This claim is made on the basis that the fundamental aversion to risk and the intent to amplify risk, or put another way the scare factor of risk (see Chapter 5), remains constant even at the fringes. In this final part of the chapter, dissonant data of a different character will be explored in order to examine some of the situated processes which appeared to operate as fertile ground for the emergence of more divergent professional understanding of risk management.

The material to follow is dissonant in that it evokes ideas towards midwifery practice which are at odds with many of the principal themes identified through the thematic coding of the dataset and already described in this thesis (see Chapters 5 to 8). Despite being tenuously placed, however, as will soon become clear, these practices were often surprisingly widespread.

9.iii Opportunity for resistance to risk

Under-documenting and the 'midwife's VE'

Helen's and Sharon's approach to breech births shows how some midwifery ways of knowing about birth rest upon a particular understanding of women's bodies, where experiential knowledge of normal physiology and intuitive confidence in women's capabilities can be privileged. Furthermore, this quintessential midwifery way of knowing can, in some instances, function to disturb other more institutionalised ways of imagining risk and how it should be best managed. However, this data suggests that this arguably more feminine-orientated way of knowing is undervalued, making the personal costs in many situations prohibitively high.[60] At this point I think it is necessary to stress that the management of the breech, while providing interesting insights into the work midwives do at the margins, should not be thought of as representing the only ground on which such power struggles take place. Far from it; there were many areas of practice in which potential fractures in the 'iron cage' of the scientific-bureaucratic approach inherent in dominant/technical paradigm of risk management were evident.[61] Perhaps one of the most noteworthy being what one of my participants called 'the midwife's VE'.[62] Noteworthy because of its apparent prevalence, I observed this practice being carried out in all three clinical settings and by midwives of all grades. The only exception I observed, the only group who did not appear to do the midwife's VE, were student midwives. This may be a practice which can be described as being at the margins of the organisation in terms of its ontological assumptions but the fact that I came across it almost routinely suggests that it is a technique which holds significant, all be it covert, currency within midwifery discourse.

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[60] In some cases it can even cost them their licence to practice (Nursing and Midwifery Council 2009).

[61] A more detailed discussion of Weber's notion of the iron cage can be found in the policy discussion in Chapter 4.

[62] VE means vaginal examination.

When talking about trying to provide individualised care within the prohibitive time constraints set by hospital protocols, Donna told me:

> *Donna:* 'Well, you can always do a midwife's VE of course' [laughs].
>
> *Mandie (Researcher):* 'What is that?'
>
> *Donna*: 'I'm not sure I should say [laughs]. Oh well, you know, it is a time when you have to be a bit... you know, liberal with how you record your findings.'

What Donna is talking about here is a mechanism midwives employ: the '*If it isn't documented, you never done it*', or, more precisely, 'If you haven't documented it, *it* hasn't happened mechanism', to avoid certain timing watersheds written into both national and local protocols for the management of normal labour. The first watershed is marked at the point when established labour is diagnosed. With the diagnosis of the onset of labour, discussed in more detail in Chapter 6, a stopwatch is set and a battery of seemingly benign intensive surveillance technologies are routinely employed to ensure, in part, that the parameters, set by the stopwatch, are not breached. The second watershed moment comes at the point where the labour is said to have progressed from the first stage to the active second stage.[63] Once diagnosed in second stage of labour, a second stopwatch is set and a further set of more intensive surveillance techniques come into play.

Notwithstanding a few exceptions, I found relatively little evidence for covert or explicitly expressed objections to limits imposed by hospital protocols when talking to midwives. Even those midwives who spoke most overtly about using intuitive knowledge, when asked directly, spoke very positively about both the national and local protocols. As Andrea explained:

> 'If I think: Now this woman can do this on her own. Just give her another half an hour, everything is okay. So then you negotiate at the point I think rather than sweep

[63] A standard definition of the first stage of labour would be that it starts with the onset of regular painful contractions accompanied by cervical dilatation, and ends when the cervix is fully dilated. The second stage follows on from this and is used to describe the period from full dilatation where active pushing results in the delivery of the baby.

everyone along with the guideline. I understand the need for protocols and guidelines because otherwise you wouldn't know who was who and what was what. So I think you need those boundaries but within I think you need to assess each individual on their own merit and make their particular plan based on the whole picture.'

Despite this largely positive view of protocols in particular situated contexts, several of those involved in this study appeared to consider the parameters they set to be restrictive, confining women's opportunity to birth spontaneously in their own time, and much activity took place to protect women from this perceived restriction.

Thus, Miranda told me:

> 'When they are four centimetres[64]... and then in which case I will try to make them three and not four and then they are not in established labour. Well if I re-examined her (four hours later) if she is not in established labour... so she could be the same and so I could say to her: "Well, actually, this is, you have not laboured. You are about the same so we can wait a bit longer for you to get into established labour."'

If Miranda had chosen not to record her initial findings liberally, if she had avoided doing what Donna called 'a midwife's VE', her clinical observation would have to be recorded in the hospital partogram,[65] as shown in Figure 6 below.

---

[64] This refers to birthing women. Four centimetres refers to the dilatation of the cervix during labour which marks the official onset of labour.

[65] Based upon the internationally used Friedman curve, a visual estimation of normal progress in labour curve taken from an aggregate study of one hundred primigravida women in 1954 (Groeschel and Glover 2001).

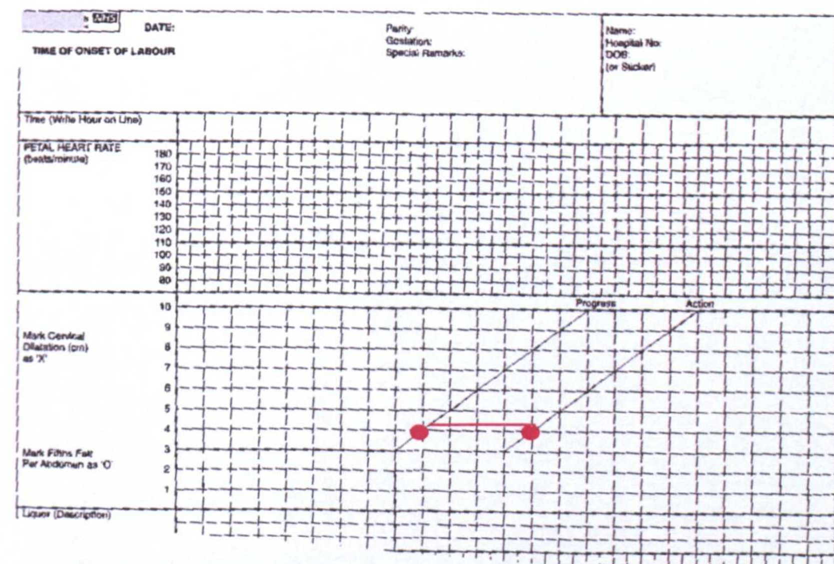

Figure 6: Trust Partogram for measuring Progress in Labour

The figures at the lower left represent centimetres of dilation; the bottom line is time progression in hours. Thus, once the 'clock starts ticking' at four centimetres dilation, the mother is expected to reach full dilation in six hours. The slanted progress line represents the expected progress rate, at one centimetre per hour, and the parallel line on the right marks the time when, if progress has not been made, action should be taken to either speed up or end the labour.

As can be seen, the midwife's VE saved Miranda from having to record a progress which would have crossed the action line and would have invited a cascade of intervention. Miranda talks quite clearly about resisting diagnosing the onset of labour by under-recording her findings. This is done to avert having to visually plot 'failure to advance' in the first stage of labour in the maternity notes. Provided

women in labour are never seen to have reached the four centimetre mark, then they escape being diagnosed as being 'in established labour' and, as such, the commencement of the partogram, with its inherent watersheds, can be suspended.

Such creativity in the documentation of clinical findings was particularly prevalent with regards to vaginal examinations and was most evident at those moments where increased surveillance was at stake. Through the mechanism of 'If it isn't documented, you never done it', midwives were able to disrupt the tight time constraints associated with the intensification of surveillance. The following field note extract is a further example and refers to a discussion between Jane and a labouring woman, Samantha, following a vaginal examination that took place shortly after her admission:

> 'Jane told her (the mother) that she had done well but that she was in the early stages of her labour.
> "Between you and me," she said, "your cervix can stretch right up to five centimetres but we shan't write that down just yet; there is no need. It will only mean a load of hassle."
> Jane recorded in the notes that the cervix was two to three centimetres dilated; importantly, Samantha (the mother) was not diagnosed in labour...
>
> Later, during handover, Jane described Samantha as being five centimetres dilated, but explained to the midwives who were taking over care that she hadn't bothered putting it in the notes like that. None of the on-coming staff reacted to this and nodded in approval' (Field Notes GT 4).

The reaction of the other midwives in the staffroom during this handover (Kerr 2002) is particularly interesting as it suggests that the underestimating of examination results in relation to cervical dilatation of the cervix was common practice. Indeed, this practice has been recorded elsewhere in the professional literature, indicating that this may well be the case (Russell 2007; Stewart 2004). The rationale for postponing the onset of intensive surveillance appeared to justify this covert practice and was spoken about freely during midwife-midwife, and even midwife-client, talk. By underestimating Samantha's dilatation, Jane was able to avoid having to commence

labour care monitoring, allowing Samantha to labour at her own, individual, pace, which may or may not fall within the partogram trajectory.

Charisma above the margins: How do they get away with it?

So far in this chapter I have looked at the ways midwives' activity which takes place at the fringes of the organisation can operate to unsettle the prescriptive and potentially restrictive logic of the dominant/technical paradigm of risk, where birth has to be managed through the application of encoded knowledge and intensive surveillance. I have suggested that perhaps one of the most prevalent strategies employed by midwives to disturb institutionalised risk management discourse is through their creative documentation of vaginal examination findings. However, strangely, not all of the midwives involved in this research had to resort to such convert methods. For some, and it should be stressed that it was only a few, resisting the constrictions set by the organisation was something that could be done openly. As Hilary succinctly puts it:

> 'There are certain colleagues that you, when they talk about methods and practices, you, you just believe them. That sounds really lame again but you have faith in what they are telling you. That their knowledge is trustworthy somehow just because they are the ones saying it.'

Hilary explains, when describing a fellow midwife, Carina, that not all midwives are alike:

> 'I mean Carina is extremely well known and respected for what she does and she had chiselled out that role for herself but it has taken a long time... Even the doctors are quite scared of her! She doesn't need, she doesn't seem to care whether doctors are appreciative of her skills or not; she has got huge, very, very high self-esteem. And I think that is another thing that a lot of midwives lack, oh yeah. But her self-esteem is really high and there is no knocking her off her perch. Erm, she would argue with William Bright (consultant obstetrician) until she is blue in the face, that she is doing one thing and that he can clear off, erm, and he kind of goes with it. She can get away with that; it is all part of her.'

Given the nature of my research design, I was able to use this interview to structure my sample and had the opportunity to work with this apparently formidable midwife and, I have to confess, I too was enamoured by her apparent ability to bend the rules of the organisation and disregard professional expectations enshrined in policy, at will, without apparently suffering any repercussions. I should stress that her practice was not a catalogue of rule breaking; far from it. She adhered strictly to many of the accepted institutional procedures and protocols. However, if she chose to resist a particular parameter set by the organisation she was rarely, if ever, challenged. But Carina was not the only midwife I came across during this research who seemed to have the authority to shape their personal practice in ways that in some cases flaunted the parameters set by the protocols.

When I suggested to Andrea that midwifery management of the breech was restricted by hospital protocols she strongly objected:

> *Mandie (Researcher)*: 'I have been told that this Trust does not support anything other than a lithotomy breech.'
>
> *Andrea*: 'That is rubbish... a particular standard is actually taught so, for all midwives attending the skills drills, they should know how to do a breech birth with a woman in a lithotomy position or her legs up. So that is how it is taught so midwives who attend are familiar with the process of actually delivering a breech but we do also talk about, because I teach at skills drills, so I also bring that up.'
>
> *Mandie (Researcher):* 'What would you do if a woman was at home?'
>
> *Andrea*: 'So then we kind of say to midwives, then you have to be aware that this can happen and *if you are not confident* in actually doing a birth with the woman in another position then, you may have to ask her to be in the position that you then are confident in that to be doing that process because it is back to front. But, er, *if you were confident in what you are doing and you know in your head how this works and if she is standing the baby would fall out anyway; there is nothing to do*' (Emphasis added).

This interview data is in sharp contrast with the skills drills study I witnessed, where Sharon tried to introduce the notion of spontaneous physiology in the management of breech. At first, I was confused by this apparent contradiction but, as the interview

with Andrea progressed, I realised that I was talking to one of those midwives who held sufficient authority to be able to bend the rules without exciting attention. It is not that Andrea had to avoid documenting her rule bending, nor did she seem to need to make any attempt to hide her activity from powerful members of the maternity care team. Like Carina, she had carved herself an identity within the organisation, which allowed her more professional autonomy than most of her midwifery colleagues, as the next interview extract illustrates:

> *Mandie (Researcher)*: 'Have you had a situation when you managed a case in a way that is not set by protocol, using perhaps more of what might be understood as a midwifery approach in the hospital context?'
>
> *Andrea*: 'I have done a water birth on someone who had had a previous section...[66] And it didn't have any repercussions... But the remit was that, how am I going to have IV[67] access if she has got a trial of scar in labour and, of course, continual monitoring?[68]
>
> *Mandie (Researcher)*: 'How did you negotiate that with whoever was in charge?'
>
> *Andrea*: 'It was okay. I didn't have any battles. I don't know. You see, now, again, it's knowing the women... and gaining the staff's confidence. I suppose they know me and knowing me and how I practise that actually helps because I don't take unnecessary risk. So, it is a calculated risk, and I knew this woman would have a vaginal birth. From my perception. So I put her in the water...'
>
> *Mandie (Researcher)*: 'And the doctors didn't come in?'
>
> *Andrea*: 'No, they didn't. They knew. I told them, I informed them, I informed them... It just wasn't an issue. And I suppose again it was because they knew me, so they said: "Yes, okay, you carry on." I mean they don't even say: "Call us if you need us," because they know if I call them I need them. So, no, it wasn't an issue so

[66] She had had a previous baby by Caesarean section.

[67] IV means intra venous.

[68] The Trust protocol for a VBAC reads: 'Delivery should be planned at an Obstetric Unit with availability of an obstetric theatre and on-site blood transfusion... IV access should be obtained and blood taken for FBC and Group & Save and the samples sent to the laboratory... Continuous CTG monitoring. Fetal distress has been reported to precede uterine rupture.'

> we didn't have any repercussions because she was fine afterwards; she had a physiological third stage'.[69]

This idea of being known, of being a trusted member of the team, seemed to be very important. According to Andrea, her reliability, her trustworthiness, meant that she could legitimately stretch the institutionally prescribed boundaries of risk without being challenged. Andrea saw herself, and was confident that others saw her, as a midwife who did not take chances.

What this evidence suggests is that some midwives occupy a privileged position in relation to risk. They can pick and choose when to follow hospital protocols, aimed at standardising care through the scientific-bureaucratic model, but equally they can pick and choose when not to. This right to define their own practice comes through the reputation they have forged within the organisation. In this respect, these midwives might be described as having what Weber called 'charismatic authority'. That is, they are able to be self-determined and set their own limits, their actions operating to transform values and break rational norms (Weber et al. 1968). This authority is in stark contrast to the iron cage set by large bureaucratic organisations such as the NHS, which stifle creativity and aim to standardise practice. According to Weber, charismatic authority can be a revolutionary force in that:

> 'Charismatic authority... is specifically outside the realm of everyday routine... In this respect it is sharply opposed to... rational, and particularly bureaucratic, authority... Charismatic authority is specifically irrational in the sense that it is foreign to all rules (Weber and Parsons 1997 p. 361).

Once such a charismatic reputation has been established, therefore, it is hardly surprising that it can be translated into practice, which operates to unsettle the dominant/technical paradigm of risk. Furthermore, the possession of such a reputation appears to enable certain midwives to openly privilege other professional

[69] Deciding to go for a physiological third stage on a scarred uterus again is in direct contradiction to both protocol and accepted practice.

priorities that may otherwise be confined within the dominant/technical paradigm of risk. This means that, in contrast to the findings and analysis in the previous chapters, women can be legitimately conceptualised in novel ways, where their bodies no longer have to be imagined to be a site of risk but, rather, are assumed to be capable, even admirable. Similarly, midwifery skills which may otherwise be marginalised, those skills gained through hands-on experience, personal relationships with women and even intuition and, importantly, those skills which have, in the feminist literature, been described as being more feminine ways of knowing (Davis-Floyd and Davis 1997; Grosz 1993; Jacobus et al. 1990; Wajcman 1991; Wickham 2009), in this context can be openly embraced and trusted, even though they are not measurable, remain undocumented and are largely unproven.

Unsettling territories

So far, this chapter has unpacked some of the ways midwifery practice can operate to disturb the dominant/technical paradigm of risk. I have suggested that, despite the ubiquitous nature of risk aversity within maternity services – structured into every level of the organisation through mechanisms such as the national and local protocols and CNST standards, all aimed at standardising care and mitigating risk through encoded and scientific-bureaucratic, evidence-based practice – midwifery activity at the fringes of the bureaucratic organisation, particularly that activity which evades documentation, can and does unsettle the accepted norms. As I have illustrated, personal charisma can be an important component to this unsettling activity but, for those lesser mortals, other specific situations and locations can offer the same kind of opportunity. The final part of this chapter will look at some of those specific situations; in particular, I want to look at midwifery work at the fringes in relation to peer support and location of practice.

Space: colleague support

The experience of feeling professionally supported appears to give a protected space, providing midwives with the confidence to use their professional discretion even if this discretion was at odds with the recommendations prescribed within the protocols. As Hilary explained:

'I did a water birth with Christine [another midwife]... it was just one of those, we waited. Funny, every now and then, every couple of seconds, she would look at me and every few seconds I would look at her and then the baby was born. And afterwards we did... a very long, interesting debriefing about the whole birth situation...

She said to me: "Every time I thought, oh my god, I am going to have to pull this baby out!"

She said she looked at me and: "You were holding your nerve but I was aware that you were then looking at me."

And then I was holding my nerve at that point. You know. Thinking: It's fine, it's fine, it's fine."

You know the baby was born and it was fine' [laughs].

Seemingly, both these midwives experienced moments when their faith in the process of spontaneous birth began to crumble. As they waited beyond the timeframe set by the protocol, their resolve became less certain. It was only because they never experienced these moments of uncertainty in synchrony that they were able to offer each other the necessary support to allow this mother to birth spontaneously in the water without disruption or intervention.

Similarly, Maggie told me a story about a woman she had been working with whose progress had fallen outside of that set by the hospital protocols:

'She was a normal primip,[70] low risk... in the pool and was pushing. And she pushed for an hour and, erm, generally our guideline is that an hour of pushing with no progress means that they are no longer considered to be normal... Well, the midwife who was on with me was the community midwife, who is a Band Seven... and, er, I asked her to come and have a look, to see what she thought because it was obvious she (the mother) was not going to deliver in the next five minutes... So we got the lady up and swinging her hips round and got her down... we went on for another quarter of an hour, and then another quarter of an hour and we just kind of kept on going. I know on my own I would not normally have been able to hold out that long but... between us, we both decided that, Yes, it was definitely okay to keep going.

[70] First-time mother.

She delivered; I think she pushed for over two hours in the end but everything was fine and she (the mother) felt really proud of herself after all that.'

In this story, Maggie talks about being able to respond to the deviation from what she believes to be the expected trajectory, in a way that can preserve the possibility for normality. Through the accessing of professional support she was able to introduce midwifery interventions such as change in maternal position and rotation of the hips, to enhance the spontaneous birth process rather than having to resort to more invasive intervention technology. However, Maggie is quite certain that she would 'not normally have been able to hold out that long' without the support she gained from a fellow midwife. Importantly, this supporting midwife was someone Maggie knew and respected. Within this context of professional encouragement and support, Maggie felt able to stretch the boundaries of what is considered to be normal progress or, more precisely, she was able to confine the boundaries of risk. Even though this mother's clinical profile failed to stay within the boundaries set by the prescriptive trajectory of the hospital's protocol, Maggie was able to resist resorting to medical intervention in the physiological process her birth.

Location, location...

It may not be insignificant that both these interview extracts describe births which took place away from the high-risk clinical setting. Certainly, this appeared to be an important consideration for most of the midwives I spoke to. In my interview data at least, working in a low-risk environment provided more opportunity for professional autonomy. Observational evidence to support this claim, however, was not very convincing with fear of inter-unit staff relations operating to enforce the limits defined in the protocols and standards. Attitudes such as the one described by Dianna below, can have a powerful effect, constraining practice in all clinical settings:

> 'But if we transfer somebody who has been in second stage for too long we tend to get questioned on it... you get pulled over the coals. I mean, one of my colleagues did precisely that just the other day, who had quite a set-to with the doctor when she transferred, who said it was a total mess, which it wasn't.
>
> "Why have you waited so long? blah blah blah".
>
> Accusations, always accusations. It can be quite horrible, really.'

However, for several of the midwives I interviewed, working in a low-risk environment provided opportunities which simply do not exist in acute clinical settings. As Cindy points out:

> 'I also think that if you are working in one of the other high-risk units there always seems to be somebody looking over your shoulder. It might be the next person up in the hierarchy; it might be the labour ward coordinator; it might be the doctors. But, if you go into a labour ward room with somebody, there will be people around asking what are you doing, asking you to justify what you are doing ... But at the same time (at the birth centre), we think we have that opportunity to try and make that pace of life just a little bit slower and I think because of that we are prepared to give people a chance...
>
> Basically if you have seen it work once, it gives you the encouragement to try it again.'

Emma expressed similar sentiments when describing the possibility for normality, telling me:

> 'And that is what I really noticed here in the birth centre, where it was quite low risk, it was all sort of midwifery focused and where women birth quite normally. But at the acute site, well, they're women who, you know, had had normal babies before, they came in there and it all went pear-shaped. Everything was managed in that way, that high-risk way, so everything became high risk, really.'

For other midwives, however, the restraints set by the NHS are considered to be too restrictive regardless of the working environment, as independent midwife, Heather, explained:

> 'The midwives that are independent are individuals. They are not part of the culture, the sheep culture that just fall in... It isn't just a job to them. I'm not saying, that isn't, the fact is in the NHS as well there are a lot of good midwives in the NHS, erm, many, many brilliant midwives who stay and, and they make small changes. If you're a 'now' person, like I am, it, it would have worn me down. It would have worn me out. I couldn't keep my principles there. Without a shadow of a doubt, no.'

For these midwives, working outside of the scientific-bureaucratic structure of organised maternity services is seen as being their only option. Although independent

midwifery is still subject to the rules and regulations set by the NMC and the NICE guidelines, the independent midwives I spoke to were keen to emphasise that their practice was less restricted, less confined than those working within the NHS. For Grace, for example:

> 'I think, I guess that maybe you make, at some point, you make a decision; whether it is a conscious decision or not is another matter. You either decide to acquiesce and just go along with, whatever makes life easier. There are times when I have definitely done that as a newly qualified midwife. But I think, erm, latterly, you know, that was it, I'd had enough of keeping my head down. It wears you down in the end, so I went independent. To escape all that, really.'

This understanding of independent work appeared to be mutually shared by independent and NHS midwives alike, as senior NHS midwife, Silvia, explains when talking about the restrictions on practice imposed by protocols within the NHS:

> *Silvia:* 'Guidelines never allow people to be individual because they look at the whole population and a number of other things that help them bring together, what would be the safest form of care. That's not individual; it never will be.'
>
> *Mandie (Researcher)*: 'No, so how do you balance that tension between giving women individualised care and following set guidelines?'
>
> *Silvia*: 'Well, I don't think you can. I don't think the midwife can actually. Certainly there are groups of midwives who can do that. For example, our independent midwifery practitioners probably can do that. But for, for a midwife that works within the NHS, I don't think she can.'

The ability to provide individualised, women-centred care even if this care demanded midwifery practices which contravene accepted protocols, was a notion that was held very dear to the independent midwives involved in this study. As Grace explains:

> 'You hear such horror stories in this job. "Oh you've got to do this, you've got to do that and the other." Well, no actually. She (the mother) hasn't got to do anything! It is her choice and my job as a midwife is to support her in that choice. I didn't come into this job to force women to do things, to scaremonger them into things. No way. Why would I want to do that? That's not midwifery. Not my kind of midwifery anyway.'

By practising in this way, beyond the confines of NHS protocols and procedures, the independent midwives I spoke to saw themselves as being able to achieve two professional goals. The first was that by practising independently they felt able to offer women-centred care that was not restricted by the limitations set by the large bureaucratic organisation of the NHS through set policies and protocols and inadequate staffing. In fact, as the next extract demonstrates, Hannah's confidence in her own skills at managing cases that transgress the parameters set by accepted opinion far exceeded my own:

> **'I've had one woman, who was having baby number nine, and I looked after her on baby number nine at home. Yeah, yeah [laughs]. So what, why do you look like that? It is still there somewhere, that prejudice, because of your reaction. Look at your face! Do you see what I mean? There is no evidence at all and in actual fact in my, in my experience, it is that actually multips[71] bleed less. Primips are the ones that bleed the most and that as you go on having more babies the bleeding gets less and less and less. And that's what I've seen; that's what I have seen in practice.'**

This description is important because, according to national and local protocols, such a case should have been classified as a high risk and as such would have been managed within a high-risk, acute unit. A home birth would have been strongly discouraged if the midwifery management in this case had been provided through the NHS. The justification of this care pathway would be based upon the number of pregnancies and births this mother had previously had and the risk of a massive bleed associated with an obstetric history of this nature. Hannah, on the other hand, is able to justify offering this mother her services at home because she does not see her body in relation to hypothetical risk. Instead, by drawing from a combination of an understanding of the mother's personal obstetric history, her own experiential knowledge, along with a selective reading of the literature pertaining to post-partum haemorrhage risk, Hannah is able to conceptualise normality where others working within the NHS might only see risk.

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[71] Mothers who have had more than one pregnancy and birth.

Which brings the discussion directly on to the second professional goal which independent midwives felt able to privilege: these midwives felt able to practise in such a way that assumes normality rather than being preoccupied with the possibility of pathology. Through this refocusing, the independent midwives appeared to be more confident about using a broad knowledge base, which could include ways of knowing that are largely excluded from the scientific-bureaucratic model of midwifery found in the NHS. Although I never witnessed them openly documenting this kind of knowledge in the notes, they certainly talked more candidly about drawing from experiential knowledge and 'gut feelings'. Furthermore, they were able to work with an underlying assumption that the women in their care were capable of birthing their own babies with minimal intervention or even guidance. As Silvia, the NHS midwife, explains:

> 'It is whether they (independent midwives), it is the way that they practise. Their perception of what is normal compared to what our perception of what is normal. We are very risk averse, aren't we? We, we will say, within the NHS, the majority will say, it is normal after the event?[72] Now, I'm not an independent midwife and I might be speaking completely out of turn but my impression on my, my idea of the way they practise is they will assume that everything is normal right up to where something abnormal happens.'

Conclusion

In this chapter I have explored the multiplicity of meaning and meaning-making which surrounds risk in midwifery discourse. That said, however, it is important to reaffirm that it is not my contention to question the ubiquity of the risk-harm connection in this context. Nor am I meaning to suggest that any of the midwives involved in this study saw risk-taking as a legitimate or desirable part of midwifery practice. In this respect, then, the data I have presented in this chapter does not concur with the claims made by many risk theorists, who criticise Beck for assuming that reactions to risk in our post-modern society are homogenous. The evidence

[72] This is an extension of a quote used previously in section 7.vi.

produced in this chapter shows how reactions to risk can be both at once uniform and multifaceted. I do not, as a consequence, believe that this data needs to be understood as undermining the validity of Beck's reflexive modernity thesis; rather, I think this marginal work might be seen as a very particular kind of sub-politics, where concerns with risk drive forward new ways (or in this case perhaps it is old ways) of knowing, where dominant and institutionally prescribed sets of statements about risk can be unsettled. Moreover, the apparent resilience of the dominant/technical paradigm of risk within midwifery discourse and the significant price paid by some midwives for daring to think outside of this paradigm, appear to confirm Beck's claims that medical technologies, and the authority these technologies beget, are likely to remain resilient to the processes of modernisation.

By following Foucault's warning that theorists should be cautious of concentrating solely on the dominant forms of power and knowledge at the expense of lesser sites of power, where possibilities for new ways of knowing can emerge, I have been able to look at the social construction of risk in midwifery discourse as part of a multidimensional, complex and socially embedded process. Just as Kelly et al. argue that:

> 'Diagnosis concerning the nature of the present... does not consist in a simple characterization of what we are but instead – by following lines of fragility in the present – in managing to grasp why and how that-which-is might no longer be that-which-is. In this sense, any description must always be made in accordance with the kinds of virtual fracture which open up the space of freedom understood as a space of concrete freedom, that is of possible transformation' (Kelly et al. 1994 pp. 126-7)

I have been able to look at how risk works in midwifery talk and practice at the fringes and have therefore have been able to illustrate how small fractures within the dominant/technical paradigm of risk operate to create space where other professional priorities can be, all be it tentatively, voiced.

Chapter 10: Conclusion

Introduction

In this thesis I have explored the interpretative work midwives do in the social construction of risk. Through the detailed analysis of midwifery talk and practice in various working environments, I have scrutinised the way in which midwives go about making sense of risk and how this is translated into practice in the labour room. In this conclusion I will take an overview of the analysis presented in this thesis in an effort to defend its contribution to two academic areas of debate: the birth performance debate; and the risk debate. The chapter will fall into four sections. First, I will revisit the polarised debates within the critique of birth performance and describe the contribution this thesis makes to understand these debates. This section will be followed and complemented by a discussion of how the analysis of risk can help offer a new dimension to the analysis of the midwifery contribution to today's birth culture. The chapter will then revisit the research questions as they were proposed at the beginning of the thesis to offer evidence on how the analysis has engaged with these research questions. In the final section, some of the limitations of the study will be identified and explored.

10.i The polarised debates within the critique of birth performance

In 1996, Annandale and Clark noted that the critique of birth performance had lost sight of contemporary social theory (Annandale and Clark 1996). Because of this, they argue, midwives and midwifery practice have tended to be unhelpfully represented as being in binary opposition to obstetrics and the practice of active medical birth management. This, they suggest is problematic because:

> 'feminist thinking which is premised upon binary division... reinforces women's oppression rather than emancipates them' (Annandale and Clark 1996 p. 38).

These observations certainly resonate with what was found by the House of Commons Health Select Committee, which in 1992 reported that:

> 'Much of what we have heard appeared to be concerned with which group should have control over the maternity services...There is ... considerable difference of opinion among professionals... Differences of opinion... appear to stem from divergent philosophies of management of pregnancy and childbirth, between what has frequently been described as a 'medical' and 'non-medical view of the process' (House of Commons 1992 p. XXXV).

It has been the intention of this thesis to concur with the Annandale and Clark position. In particular, it has been proposed that midwifery understanding and operationalisations of risk can operate to 'smudge' the professional boundaries which have been used to distinguish midwifery ways of knowing about parturition from obstetrics in the literature (for example, van Teijlingen et al. 2004b). The proposition being made, therefore, is that the descriptions of dichotomous professionals, each privileging opposing and mutually exclusive interests, which, in the professional literature some appear to have surprising resilience (Boden 2010; O'Neill et al. 2008; Sinclair 2009; van Teijlingen et al. 2004a), are limited in that they fail to capture the complexities involved in how we (women and midwives) choose to make sense of and perform birth.

Notable developments have been made in relation to this ontological restriction. Since the publication of Annandale and Clark's paper, successive attempts, largely from work either published within the midwifery press or written by midwives and aimed at tackling the binary oppositions between the two most prominent professional stakeholders involved in providing maternity care in the UK, midwives and doctors, and, by association, normal birth and medicalised birth, have contributed to the debate (Downe and McCourt 2008; O'Neill et al. 2008; Walsh 2009). Most notable in these efforts has been the drive towards collaborative working operating under the auspices of the safety agenda (O'Neill et al. 2008; Royal College of Obstetrics and Gynaecology, Royal College of Midwives 2007; Sandall et al. 2011; Smith et al. 2009), which, as I argued at the beginning, is closely intertwined with risk and perceptions of risk. While this thesis can be understood as overlapping this material

in its theoretical orientation, it is distinguishable from much of the work in this area in one important respect. Despite an ontological interest in the dismantling of the somewhat theoretically blunt polarised and dichotomous paradigms previously used to describe maternity care in the UK (through an interest in the discursive formations and practices of risk) this thesis simultaneously attempts to preserve, and moreover, make further contribution to, the critique of birth performance. This concern to problematise current birth practices is a point I shall revisit in more detail below.

Research design

The work presented here locates the material act of giving birth, and midwives' contribution to that act, within the wider socio-political theoretical critique of late-modern society. Rather than conceptualising birth performance as taking place within a cultural microcosm of competing professional interests, this thesis has set out to understand birth in a broader social context using the social theory of risk to highlight the key elements of that context. This analytical paradigm has been applied in a way that centres a methodological interest in discourse. By scrutinising the interpretative work midwives do in relation to risk, using an ethnographic discourse analysis approach it has been possible to move away from the limitations of the dichotomous approach to the empirical analysis of the routine medicalisation of birth, towards an analytical approach, which captures the complexities, while not losing sight of the underlying power struggles involved in those complexities.

Through the detailed examination of midwifery everyday talk and practice, I have mapped how these professionals go about translating risk into meaningful action and how this impacts upon how birth can be imagined within our birthing culture. Through a research design which combined methodological interest in ethnography and discourse with an analytical interest in the social theory of risk, it has been possible to see how midwifery activity is both constituted by, while at the same time, constitutes, the discourse of risk. This is a relatively novel approach to understanding midwifery talk and practice since the analysis of risk within intra partum care practice is surprisingly underdeveloped within the current critique of birth performance. For instance, a review of the titles and abstracts of *Risk, Health and Society*, one of the

highest impact journals in the social analysis of risk in health, reveals that risk in birth is very rarely discussed and, on the rare occasion this topic does reach the pages of this journal, the meaning of risk tends to be assumed to be universally shared and consistent across all social contexts (for example, Lankshear et al. 2005). Despite its relative underdevelopment, however, I suggest that this approach has proved invaluable and has produced some pertinent data to answer the principal research questions underpinning this investigation.

Smudging but not eliminating the boundaries

It is important to point out that, while the theoretical interest in risk in this thesis has helped to show how risk can operate to erode the possibility for denotative and segregated 'midwifery' activity within the labouring room, it is not my intention to suggest that the midwives involved in this study did not see themselves as a distinct professional group defined by a particular set of priorities which, above all, privileges normal birth and women-centred care. Furthermore, nor am I claiming that such representations of midwifery practice have disappeared from the midwifery literature; far from it. They co-exist, both within and alongside other more multifaceted interpretations of midwifery activity (for example, Boden 2010; Crowther 2010). The symbiotic relationship between midwifery and normal birth, as outlined in Chapter 7, gives an indication of the resilience of such interpretation of midwifery practice. The descriptions here of the work midwives do when making sense of risk must be understood as being intertwined with a notable valorising of normality in birth performance, voiced particularly within the interview data. However, how such professional priorities could be expressed within the wider sensitivity to risk, where organisational risk management procedures prevail, is far from straightforward, meaning that disconnects soon emerged within the data, which suggested that a complex, embedded dynamic was at work.

Thus, while a polarised analysis of birth performance may fail to capture the complexities involved in midwifery talk and practice, this conceptualisation still holds tenancy in relation to how midwives describe themselves and their activity both in the literature and in the birthing room. In other words, my claim for the theoretical

smudging of the dichotomies, which have been, and in some instances are still, used to critique birth performance, should not be mistaken for an attempt to suggest that these dichotomies no longer have any relevance within our birth culture. Although it is the intention of this thesis to refute the usefulness of the polarisation of the paradigm for describing and analysing birth performance, it should be understood that this is done with a certain amount of caution in an effort to preserve the sentiments of the midwives involved in this work. The majority of midwives I spoke to were keen to orientate their professional identity around a fundamental belief that women are capable of birthing their offspring both spontaneously and successfully. An underlying concern of this thesis has been an effort to preserve this quintessentially midwifery and feminist perspective.

10.ii Risk theory and birth performance

There is an academic consensus that risk and, importantly, peculiarly late-modern sensitivities to risk, operate to shape contemporary life in particular ways (Beck 1992; Gabe 1995; Power 2004; Zinn 2006). It is the proposition of this thesis that midwives can be understood as drawing upon and sharing this particular socio-historic contingent with the other stakeholders involved in birth – obstetricians and women and their families. That is to say, the findings of this research concur with Beck's reflexive modernity thesis in that sensitivity to risk can be seen to cut across the boundaries which may have once separated the social actors involved in birth into distinct groups with prescriptive roles and defined boundaries (see van Teijlingen et al. 2004a). It is not, therefore, that risk sensitivity is the preserve of one professional group and not the other. According to the data presented here, risk operates to smudge boundaries between the different professional stakeholders involved in delivering maternity care in such a way that makes all the practitioners involved agents of risk.

The wider social components of risk

The smudging mechanism of risk, which formulates a principal theme in this thesis, is complicated by another set of neo-liberal statements, associated with Beck's reflexive modernity thesis, which centre on the privileging of individualised care and choice.

As I argued in Chapter 8, the way these two concordant discourses interface is neither politically neutral nor straightforward, as they are at once antagonistic and harmonious. The proposition being made in this thesis is that it is across the turbulence of this discursive tension within risk that midwifery talk and practice precariously lies. The diversity between the data presented in Chapters 6 and 9 is a persuasive illustration of how midwifery articulations of risk depend very much upon where and when these articulations are situated. As I have pointed out, this is not a simple case of hospital environment versus midwifery-led environment leading to divergent understandings of risk; the socio-political context of midwifery talk and practice is far more complexly negotiated than that. What this does mean, however, is that the meaning-making of risk in midwifery talk and practice inevitably involves a process of slippage. The interfaces between potentially competing professional demands, such as risk avoidance and individualised care, do not necessarily produce a consistent articulation of risk practice. Although the operations of clinical governance within maternity care engender the dominant/technical paradigm of risk understanding, as described in Chapter 4, this understanding, no matter how persuasive, should never be assumed to exist in isolation. Instead, it is best to conceptualise the dominant/technical paradigm as being constantly and creatively reformulated within the context of other ways of knowing about birth, where the birthing woman does not inevitably have to be imagined to be a site of risk.

10.iii From a multidimensional soup to a precarious web

It is not my intention to suggest that the concordant sets of statements, described in this thesis, which operate to shape the meaning-making of risk within midwifery talk and practice, are evenly placed within a kind of multidimensional cultural soup. Instead, the proposition here is that such discourses are suspended within specifically located power relations. A better explanatory metaphor, therefore, would be one of a web, where particular strands are more securely placed while others are fragile and where individuals can easily come adrift when they chance upon a less well-established strand.

This more useful metaphorical framework provides the possibility for making sense of midwifery talk and practice in a way which allows for midwives to be attributed with a sense of agency within today's birthing culture, without losing sight of either the political dimension of this agency and the work done at the margins of risk (see Chapter 9). It is at this point where I would like to suggest that this thesis makes its most novel contribution. On the one hand, such an approach overcomes the supposition that midwives play little part in the intensification of the medicalisation of birth. Such a position I suggest, is not only unhelpful in that it fails to capture the complexity of how birth performance is negotiated. Moreover, it is rather insulting in that it reduces this group of (usually) women to being hapless victims in a process over which they can have no control. On the other hand, this approach allows for an analytical sensitivity which does not descend into another equally unhelpful supposition that all stakeholders enter the meaning-making of risk and birth on equitable terms.

What I am proposing by way of conclusion is that this thesis offers new and fertile ground for understanding some of the gaps posed by the existing literature. Firstly, I posit that the literature concerned with the politics of birth, in particular that which criticises the politics of the routine medicalisation of birth, is inadequate, precisely because it fails to capture the critical role played by the most prolific professional stakeholders within the maternity services and the most senior practitioners present in the majority of births. Such an oversight is at the very least theoretically suspicious. The data and analysis have been presented here in such a way as to move beyond this suspicious oversight towards a theoretical engagement with the problem.

The second posit is that, despite this overriding interest in capturing the multidimensional nature of midwifery talk and practice, this has been achieved in a way which is analytically sensitive enough to preserve a critical standpoint. Analysing risk using a research design which centres both the ethnographic method and discourse, has provided the opportunity to scrutinise the midwifery activity which operates to dismantle professional boundaries without losing sight of the power

relations in which this dismantling is embedded, and without losing sight of the routine medicalisation of birth as a case for concern.

The risk web and problem with collaborative practice

Through the detailed scrutiny of midwifery talk and practice it has been possible to show how midwifery activity can operate to unsettle normality (see Chapters 6 and 7). By introducing this line of analysis, the political implications of current midwifery practice can begin to be considered. This is important, particularly in the light of new professional collaboration drives within the maternity services mentioned above. Within the move away from the polarised critique has been a shift towards the idea of collaborative practice, where midwives and obstetricians are conceptualised as working together within a united and equitable team. Thus, the Royal College of Midwives and the Royal College of Obstetrics and Gynaecologists (2007) suggest:

> 'A central theme is the need to improve communications between healthcare professionals and between professionals and women. Units should foster a *team approach, based on mutual respect, a shared philosophy* of care and a clear organisational structure for both midwives and medical staff, with explicit and transparent lines of communication.' (My emphasis) (p. 1).

Appealing though this proposition is, I suggest that it can be considered to be problematic in that it fails to pay due attention to the power struggles upon which these alliances rest. The basis of this concern is an understanding that mutual collaboration functions when, and only when, the collaborating parties enter into the arrangement on an equal footing; where professional interests are equally valued. Through this investigation, it has been possible to engage with some of the power struggles and discursive tensions within which midwifery agency is embedded.

The empirical evidence collected during this project indicates that, within the current climate, midwifery interests are easily subsumed by concerns with risk, which arguably operate to marginalise understandings of birth as a normal physiological process. That is to say, midwifery activity in the birthing room is most secure when it coincides with the risk management of the organisation, what Harrison (Harrison

2002) calls the scientific-bureaucratic approach to care. Given that feminists have argued that both science and bureaucratic structures are gendered in ways which marginalise the interests of women (Davies 1995; Fox Keller 1990; Fox Keller 1992; Harding 1991; Rose 1994), the articulations of risk can be seen to operate within gendered power relations. According to Evans:

> 'often the only viable form of participation for women in public life is the replication of male behaviour' (Evans 1997 p. 134).

This observation resonates with much of the findings presented in this thesis. When the midwives involved in this study translated risk into meaningful action in ways which expressed the scientific-bureaucratic interest in clinical governance and the standardisation of care, they placed themselves upon the more securely placed strands of the discursive web. When midwifery agency operated to replicate the masculine nature of the organisation by assuming that the physiological process of birth should be categorised as a site of risk, as not yet pathological, then the midwives enjoyed the relative safety of a sheltered position; they were protected from the scare factor of risk. However, when, and if, they ventured into the territory where women were simply assumed to be competent and where birth could be imagined as being essentially reliable and where the outcomes were presumed to be good, then the strand upon which they were positioned was more likely to be less stable in nature.

The dominant/technical paradigm of risk and normal, spontaneous birth

In Chapter 6, I was able to show how midwifery activity within the birthing room borrowed so heavily from surveillance medicine, in an effort to ensure the standardisation of care, that it introduced risk even where none was apparent. In their efforts to hunt out abnormality, midwives dismantle the differences which can be used to distinguish the healthy or normal from the pathological or abnormal. Through such dismantling practices, all labours, whether spontaneous or medically managed, had to be categorised as being 'at risk'. I went on to show in Chapter 7 how this meant that the notion of normal birth, the very thing the midwives involved in this study identified themselves and their practice with, existed in the present only as a sense of absence of the more securely placed discourse of risk. Normality had neither a

language nor a positive activity profile of its own; instead, it was constantly overshadowed by an imagined risk virtual object. Given such lexical privileging of the abnormal, coupled with a preoccupation with an imagined future colonised by potential risks, it is not surprising that midwifery talk and practice can operate in the opposite direction to that expected (or at least what I had expected when setting out on this research project). That is, midwives can be seen to actively confine normality and privilege risk through both what they say and what they do. Thus, in Chapter 8, I was able to show how those midwifery practices and women's preferences which were aligned more obtusely to a medicalised and interventionist approach to birth management were easier for midwives to deal with. This had the unfortunate consequence of those mothers, who, refusing to accept such an alignment, those women who refused to see their birthing bodies as a site of risk, being regarded with suspicion and even resentment.

By breaking down midwifery activity in relation to risk into distinct components through the various chapters of the thesis, each drawing from the theoretical literature in a slightly different way, it has been possible to explore the complexities involved in the interpretative work midwives do, through their talk and practice, in relation to risk, and how this impacts upon the way birth can be imagined and performed. In particular, I have shown that, despite a potentially unique professional position in relation to risk, which, arguably, could have engendered a broader and more positive attitude to risk, the midwives involved in this study all shared a common understanding of risk which is consistent with Beck's reflexive modernity. That is, participants drew from expert interpretations of risk, particularly those expressed through published guidelines and protocols, to position themselves as risk avoiders (see Chapters 5 and 8).

A principal responsibility for the midwives I spoke to during this research was the mitigation of risk. Risk was universally considered to be something bad. For this reason, risk was heavily morally loaded and those practitioners who had been associated with risk, apart from in exceptional circumstances, felt the full ferocity of this moral loading. Risk was something that could contaminate a midwife's

reputation, since bad outcomes, no matter how unusual, had to be traced back through the mechanisms of robust clinical governance in order to, on the one hand, establish an individual who can be held responsible, while, on the other hand, hold that person thought to be responsible to account (see Chapters 4 and 5). The institutional mechanisms of risk management appear, therefore, to work as a form of moral justice, meaning that rare events from the past can be held up, by both the institution and individual practitioners, to plan and shape future care. Thus, risk and probability have at times tenuous links. It is almost as if the likelihood of a risk occurring was irrelevant to how risk is translated into meaningful action in maternity care. The danger of this, of course, is that, without recourse to this element of risk, that is the likelihood of a risk actually happening, risk-taking can only ever be embraced at the margins of professional practice even when it might operate to facilitate normal birth or woman-centred care (see Chapter 9).

This conclusion has important implications for the collaborative working project, so popular in today's maternity care working environment. Not only might the gendered working environment operate to stifle a uniquely midwifery contribution, the uneven footing upon which a midwifery voice can rest is further undermined by the interpretative work of risk towards which midwives, somewhat ironically, are avid contributors. Since risk, as I have suggested, operates to unsettle the very thing midwives orientate their identity upon – the possibility for women to birth their babies spontaneously without recourse to medical intervention, that is, normal birth – and since sensitivity to risk is, as Beck suggests, so prevalent within the operations of late-modern society, midwives hold what might be described as a 'precarious position' within such collaborative working partnerships. Moreover, this unsettled position is in part maintained by midwifery talk and practice itself.

10.iiv Revisiting the research questions

In Chapter 3, I set out a list of research questions, claiming that the research design was well suited to answer these questions. By way of conclusion to this thesis, I would like to reiterate this claim by revisiting these questions in relation to how they have been answered through the thesis. Questions 1 and 2 were:

- In what way does risk enter into professional discourses and influence professional practice?
- How do midwives define and make sense of risk? How does this impact upon practice behaviour?

By looking in detail at the things midwives do and the things they say, I have been able to show how risk enters into the midwifery discourse and how it influences practice (see Chapters 6 to 8). I have shown how the translation of risk into meaningful action is embedded within a multifaceted weave of concordant and potentially competing professional interests that are not evenly placed within the existing power relations (see Chapters 7 to 9). In answer to Questions 3 and 4:

- Is there more than one risk discourse at work among midwives? If so, what is the political dynamic at work and what are the social conditions that engender these different meanings?
- Is there a tension between risk talk and risk practices?

I have been able to illustrate how, in some marginal circumstances, different approaches to risk might be articulated, while still maintaining that, even at the margins of risk, attitudes towards risk remained consistent (see Chapter 9). That is to say, risk, regardless of how it manifested in talk and practice, was uniformly assumed to be bad (see Chapter 5). Midwifery understanding of risk revealed through this research was at once ubiquitous and congruent, in that it centred around risk being a bad that needed to be avoided (see Chapter 5); while at the same time, understanding was multidimensional in that in certain situations the specifities of the location of risk

could be challenged, allowing other concordant professional interests to be voiced (see Chapter 9). Instead of accepting women as a site of risk, for instance, some midwives chose to use their conviction in the possibility of spontaneous birth to mitigate what they saw as the iatrogenic risks associated with the routine medicalisation of birth. Finally, in answer to the last question:

- **Do working environments affect how risk is perceived and dealt with?**

while physical space was one of the factors which influenced how risk could be articulated through midwifery activity, this was by no means a presiding factor. Risk and place did not interact in as straightforward manner, as some of the literature would have us believe. Concerns with the dominant paradigm of risk, which coalesces around an amplified sensitivity to risk and risk avoidance, dis-embedded both social and physical boundaries. In Chapter 9, I was able to use the ethnographic method to provide insight into some of the complexities involved in the work at the margins of the dominant paradigm of risk. While in Chapters 5 and 6 I demonstrated how midwifery activity, in various physical settings, was constituted through a sensitivity to risk, which operated to disturb other professional commitments to a unique identity, suggesting that midwifery activity in the birthing room is not inevitably compatible with the notion of birth as a normal, spontaneous physiological process.

Having explored how this thesis can contribute to the birth performance critique and how concerns with how risk operates within midwifery discourse can facilitate an understanding of the active role midwives play in how birth can be imagined, I now want to move on to the final section of this conclusion chapter. In this section, some of the limitations in this research will be explored.

10.v Limitations of the study

The limitations of this study, I would suggest, rest largely upon issues of research design. By way of conclusion to this thesis, I will briefly visit some of these. The first is an issue of theoretical orientation, and this applies to the theoretical and methodological centring of both risk and discourse. The second applies more to the data collection process with problems of validity, reliability and generalisability.

Researching risk

According to Henwood et al. (2008), the preponderance of risk in the academy presents the researcher with both an epistemological and methodological dilemma. In their paper, the authors highlight that researchers interested in interrogating how risk operates tend to go into the research process with a set of theoretical assumptions about risk which can interfere with the investigation. They warn against what they call 'risk framing' (Henwood et al. 2008) due to the inherent

> 'danger of researchers defining research situations from the outset in terms of some presumed universal notion of 'risk,' thereby unreflexively importing to the research process a priori constructions of what that term might mean' (p. 422).

Henwood et al. are not alone in this caution. For example, in his critique of the reflexive modernity thesis, Heyman suggests that, by overestimating the importance of risk sensitivity, Beck fails to consider the possibility of diversity in attitudes towards risk (Heyman 1998). Similarly, Weir challenges Beck's assumption that risk, and society's anxiety towards it, 'roams unchecked over plains of the present' (Weir 2006 p. 5). A perfect example of this, but rather an unfortunate one for my purposes, would be to 'over frame' the analysis of midwifery activity and thought in terms of risk. While such a theoretical strategy might be considered to be legitimate, given the current political climate in the NHS with its attention to risk management, as pointed out above, midwifery rhetoric rests upon another set of assumptions that coalesce around normality; assumptions which might be thought to be juxtaposed against the idea of risk and risk adversity as it is described in the literature (Beck 1992; Beck

1998; Furedi 1997). In the context of researching how risk operates in midwifery talk and practice, therefore, Henwood et al's apprehensions are particularly pertinent and are therefore considered to be a very real limitation of this study. While every effort has been made, through the application of a sensitive methodological toolkit, to ensure that my research was not over framed by the concern to find risk, it is a problem that I fear I did not manage to fully overcome. A solution to this particular limitation of the research might be overcome by an attempt to replicate the study. However, with the ethnographic research design this in itself is problematic.

Researching discourse

The limitations of applying discourse to the analysis of birth performance in relation to the application of governmentality theories of risk have already been discussed in Chapter 2. However, since this is a very serious flaw in this research design, in that it cuts to the very essence of midwifery identity, I think it is worth revisiting in this section.

The methodological centring of discourse has proved to be invaluable for unsettling the taken-for-granted operations of risk as they are played out through the dominant/technical paradigm. The problem is, however, that in this unsettling there is a tendency to lose sight of the corporeal body. By understanding risk as only fixed through discourse it is possible to imagine birth performance in ways which are not inevitable, thus opening up the potential for criticism and change. What is fixed through discourse, equally can be unfixed through discourse. But, through the logic of the same argument, women's ability to birth their babies spontaneously without recourse to technology or technicians can also be lost. It has been my intention to use a discourse approach in order to interrogate how midwifery agency impacts upon birth performance. However, in this endeavour I am arguably guilty of deconstructing the very thing that midwives say that they orientate both their identity and practice towards – normal birth. Thus, midwifery priorities and women's physical abilities are in danger of being trivialised through the analysis.

As with the limitation above, it is difficult to envisage a solution to this dilemma. My defence rests upon the socio-political positioning of the competing discourses I have

endeavoured to analyse. Risk, I have argued, is secured through powerful social and cultural mechanisms within the Risk Society. Normal birth, on the other hand, seems to lack any form of representation within this context (see Chapter 7). Furthermore, the amplification of risk appears to beget a birthing culture where birthing women are subsumed by intensive technocratic surveillance and interventions which have done little to improve maternal and fetal outcomes but have done much to reduce women's autonomy and agency. As such, the routine medicalisation of birth 'just in case' has been conceptualised as being both a political and physical violence against women; a violence which includes ever increasing numbers of women undergoing major abdominal surgery for no apparent improvement in clinical outcome. Much has been written about this from within the feminist canon, particularly within the second-wave feminist account. It has been my intention to use this feminist position as justification for adopting a soft constructionist approach to the analysis of birth performance. That is, a partisan commitment to women's ability and the need to promote this ability within the patriarchal system in which risk in birth performance is constructed has afforded me a certain amount of analytical licence, where women's bodies have been envisaged as possessing both corporeality and ability and, as such, have been inserted into this discourse analysis of birth.

Validity, reliability and generalisability

Validity, reliability and generalisability are central tenets in establishing the credibility of a research project within the social research literature. Both validity and reliability impact upon generalisability in distinct ways and, moreover, both are problematic within the context of the ethnographic discourse analysis approach to social research. This is the third and final limitation of this study to be explored in this chapter.

Validity, according to Cook and Campbell (1979), can be defined as the 'best available approximation to the truth or falsity of a given inference, proposition or conclusion.' Truth claims, therefore, lie at the centre of this concept. However, as pointed out in Chapter 3, the ethnographic discourse analysis approach is useful in its very refusal to accept the possibility of approximation to truth. Instead, what is

proposed by this approach is that multiplicity of truths should be contemplated and within this multiplicity the ethnographic account should positioned as one of the many. While this challenge to the convention of validity has led many to question the ethnographic contribution to the academy, in this instance it has proved to be an invaluable quality. Indeed, it has been the very thing which threatens to undermine the credibility of the ethnographic discourse analysis approach to social research, in terms of proof of validity, which has turned out to be one of this method's greatest strengths.

Because of my research interest in sets of statements which are not evenly placed and where resistance to power is being constantly expressed at the fringes of the more dominant discourse, I required a methodological toolkit which was sensitive enough to unsettle the irresistible logic of the truth in the scientific account of birth as it is expressed through the dominant/technical paradigm of risk. This unsettling of the possibility of truth, however, comes at a cost. This cost is serious limitation to this project since the validation of the findings is so difficult to defend within the context of the research design adopted. The generalisability of any inferences is, as a consequence, difficult to justify.

Reliability is equally difficult to defend in the context of an ethnographic discourse analysis account. Reliability, as a measure of consistency, that is, the replicability of a research project using the same research methods, is undermined by the centrality of the researcher in the process of building the ethnographic account. The reflexive turn within both feminists' and ethnographic social research has meant that aspirations towards impartial social analysis have long since been abandoned (see Chapter 3). Instead, the researcher has been recognised as being pivotally embedded within each stage of the research process from its inception to its final writing up. Thus, a study carried out by one researcher will never have consistent tools of measurement with another carried out by another researcher since each individual researcher is him/herself recognised as being an integral part of the research instrument.

In the case of this study, for example, I chose to use a snowball sampling technique in keeping with an interest in ethnographic methods. This technique relied upon me, as

a unique individual, building up relationships within the field and exploiting these relationships to develop a network for participant access. Who I talked to and, importantly, who I happened to build a rapport with during my participation, strongly influenced who I approached to be involved in the study. Such is the nature to this approach to sampling. However, this strongly undermines the possibility of achieving a representative sampling frame introducing what might be described as sampling bias and undermining generalisability of the findings.

Rigour – What the ethnographic discourse analysis approach to social research can offer, however, is rigour, and it is on this ground which I want to defend the credibility of this account of midwifery talk and practice. Due to the methodological flexibility afforded by my choice of research design, I was able to mobilise an array of both analytic and data collection techniques (see Chapter 3) to help me drill down and capture key themes which arose out of my research. As soon as themes began to emerge, I was able to interrogate these themes with further analysis and data collection. For example, if I witnessed a certain pattern of behaviour during an observation episode, my research design was such that I could follow this up, to test it out by incorporating it into my subsequent participant recruitment, ethnographic interviews and detailed text analysis until a point of saturation on the particular theme was reached. Because analysis formed an intrinsic part of the data collection process, I was able to visit and revisit the themes, checking the patterns which were arising out of data as they arose. It was a synthesis of devices afforded through an ethnographic discourse analysis research design which facilitated both a rich and dense analysis of the research problem. While the data presented here cannot make claims to generalisability under the criteria of validity and reliability as they are described in much of the research literature, this, I suggest, should be thought of at the same time as both a limitation and a strength of this thesis. The rigour provided by the research design is the very thing which limits the study's validity and reliability.

Final comment

In much of the professional literature, midwives have been set up as being the guardians of birth as a normal and spontaneous physiological event. While this is arguably the case, detailed analysis of what midwives do during their everyday working lives reveals that other professional concerns, concerns which coalesce around understanding of risk, cut across such guardianship responsibilities in complex and, in some cases, contrary, ways. Furthermore, it is theoretically unhelpful to assume midwifery talk and practice will operate in a particular way to risk and the medicalisation of birth. In this regard, this thesis has much in common with the work of Allen (Allen 2007), who, in her analysis of the work nurses do, argues that that there is a

> 'discrepancy between the image of nursing which currently dominates the profession with the realities of nursing practice... current nursing mandate has been driven by professional concerns... about what nursing ought to be rather than on empirical studies of the work that nurses actually do' (Allen 2007 p. 46).

Like Allen, it has been the ethnographic method which has provided the necessary sensitivity to uncover the nature of this discrepancy. If, as the recent maternity health policy seems to assume, midwifery care can be used as a mechanism for the curbing of the routine medicalisation of birth, then it is important that we understand how this group of professionals is currently positioned in this process. Midwives are the most senior health professionals present at the majority of births in the UK and, as such, they are well positioned to constitute how birth can be imagined and performed. In this thesis, I have suggested that how midwives make sense of risk is an important part of the routine medicalisation process. While this work represents only a small sample of midwives working in a particular area in the UK, meaning that it is impossible to make any generalisations from the findings, this micro analysis of midwifery talk and practice offers a detailed description of the operations of risk in midwifery discourse, indicating that this is an area which deserves more empirical investigation. It is the intention of this thesis to suggest that to ignore how midwives

make sense of risk is to ignore one of the most forceful drivers behind contemporary birth performance.

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Appendix one

Title of Document: **Sponsorship confirmation letter**

FTAO National and local ethics

Research Services

Nicole Palmer
Research Ethics and Governance Officer

Dialling code for Canterbury:
01227 (UK) or +44 1227 (International)
Tel: 824797 direct line
764000 switchboard (ext. 4797)
Fax: 823998
Email: N.R.Palmer@kent.ac.uk
URL: http://www.kent.ac.uk/research

To whom it may concern

22 May, 2008
Ref: ResGov 70

RE: Mandie Scammell – An investigation into the social and political dynamic of risk within midwifery discourse and practice: how perceptions of risk impinge upon midwifery-based, maternity health care services

This is to confirm that the University of Kent will accept the role of Sponsor for the above project, according to the requirements of the Department of Health's Research Governance Framework, (RGF), dependent on ethical approval of the project by the NHS National Research Ethics Service.

As Sponsor of this research and employer of the student's supervisor, Professor Andy Alaszewski, who acts as Chief Investigator for this study, the University of Kent will take responsibility for ensuring the following aspects of the project are carried out:

- Ensuring scientific and ethical review
- Conducting risk assessments
- Conducting this study in accordance with legal requirements, guidance and accepted standards of good practice
- Preparing and providing information for participants and obtaining informed consent – or ensuring appropriate decisions are taken in respect of individuals who lack the capacity to consent
- Ensuring participants' welfare while in the study
- Arranging to make findings and data accessible
- Arranging for feedback of research results to participants, as appropriate
- Putting in place arrangements to initiate and manage the study
- Ensuring that arrangements are in place for monitoring and reporting, including prompt reporting of suspected unexpected adverse events
- Ensuring that researchers understand and discharge their responsibilities
- Providing written procedures, training and supervision
- Taking action if misconduct or fraud is suspected.

University of Kent
The Registry
Canterbury
Kent CT2 7NZ
United Kingdom

The organisation providing care for this project (ref. sections 3.10, 3.11, 4.4 of the RGF), will remain responsible for the following:

- Arranging for an appropriate person to give permission, on behalf of the organisation, for this research to take place before the project starts
- Ensuring any such research is conducted to the standards set out in the RGF
- Requiring evidence of ethical review before allowing any research that affects the duty of care
- Retaining responsibility for the care of participants to whom the organisation has a duty.

Insurance arrangements are in place for the study, as evidenced by the enclosed certificates.

If you have any queries about this letter or arrangements for the research governance please do not hesitate to contact me, Nicole Palmer, in the University of Kent's Research Services department on 01227 824797 (N.R.Palmer@kent.ac.uk).

Yours sincerely

N Palmer

Nicole Palmer
Research Ethics and Governance Officer

2

Appendix two

Title of Document: **Participant information letter**

Purpose of document: **To inform midwives about the research**

Distributed to: **All midwives (acute unit, birthing centers, community and independent based) working in the targeted clinical areas**

1

Centre for Health Services Studies

Dear Colleague,

This letter is to inform you about a research project that is to be carried out a [redacted] , and to ***invite you to be actively involved***.

The study, I am inviting you to be part of, builds on a growing interest in clinical governance and risk within health service research. The aim of the project is to examine what midwives think about these concepts and how they manage to incorporate these within their professional role of being 'with woman'. Importantly, I am interested in ***what you think and how you feel*** about working within today's NHS culture.

In this letter I hope to provide you with information about exactly what will be involved, should you decide to take part in this research. I therefore ask that you read the following information carefully and raise any questions you may have with me (details below).

What is this study?

This is a small scale qualitative project which is sponsored by the Centre for Health Service Studies (CHSS) at the University of Kent at Canterbury, is funded by the Economic and Social Research Council and has had national and local ethical approval. The principal investigator is both a registered midwife and qualified researcher. The project supervisor has extensive experience researching health and is the Professor at CHSS.

What is the research about?

As a practising midwife myself, I have grown used to working with government initiatives aimed towards establishing clinical governance, which have included things

1 Mandie Scamell MA, BA, RM Centre for Health Service Studies, UKC

WHO COLLABORATING CENTRE

University of Kent
George Allen Wing
Canterbury
Kent CT2 7NF
United Kingdom

like Evidence Based Practice, the National Institute of Clinical Excellence (NICE) guidelines, Clinical Negligence Scheme for Trusts (CNST) standards and the National Service Frameworks. These have all become part of our daily working lives. However, there has been little research on what this means for midwives, how it affects the way they see themselves as autonomous practitioners and what impact it has upon their practice. In this project I would like to find out as much as possible about how such health policy initiatives have impacted upon your working life.

What will be involved?

If you would like to take part in this research I would be asking for **your help with the collection of data** using two techniques

- Participant observation - where I will join you in the intra partum care setting to observe midwifery life from your perspective. During this time I will observe you speaking to clients, fellow midwives and other staff team members. My aim is to impact as little as possible on the care you provide, however, I will be available to provide support to you and to the clients under your direction and at your discretion. It is important that you should know that I am **not** there to monitor your practice in any way, moreover, participation is not compulsory but is done on a purely voluntary basis. Please note that you will be free to withdraw your consent at any point during your participation in this project. I will be keeping field notes of these observations which will be stored in a locked filing cabinet for a maximum of two years from the date of the observation and will then be destroyed.
- Informal interviews – these interviews will take place at your convenience, outside of working time, if appropriate, and will take between one hour and two hours to complete. During these interviews I will ask you questions about how you feel about working as a midwife. I will also be interested in your reflections on incidents that may have occurred during observation episodes in which you were involved. I will invite you to between 1 – 4 such interviews during the projects duration (2 years). Consent to take part is entirely voluntary and can be withdrawn at any point. All interviews will be taped, the

tapes will also be kept in a locked cabinet and will similarly be destroyed at the end of the project in 2010.

Confidentiality

All the data collected during this study will be kept confidentially. Your name and any identifying details will be removed, whilst I may use direct quotes from the data, the identity of the speaker will never be revealed. The only possible exception to this will be if you reveal information that may suggest a risk to the public of serious harm, in which case the incident would have to be reported to management and the supervisor of midwives.

How do I find out more?

If you have any queries about this project then please do not hesitate to contact me on the address below, by email ajs65@kent.ac.uk. or by phone on 07901646123. If you have questions regarding the research funding or academic department then please visit their websites at http://www.esrc.ac.uk/ESRCInfoCentre/index.aspx , http://www.kent.ac.uk/chss/ respectively.

How do I take part?

A consent form is enclosed. Could I ask you to sign and return it to me via the internal mailing system to Mandie Scamell [redacted] Co-ordinator, KCH. I hope to be contacting you very soon. If you do decide to take part and would like to be kept informed about the study findings, please let me know at the time of the observation/interview.

May I take this opportunity to say thank you very much for your interest in this study and I hope very much that I will have the pleasure of working with you soon.

Yours sincerely

Mandie Scamell (MA BA Dip MW)

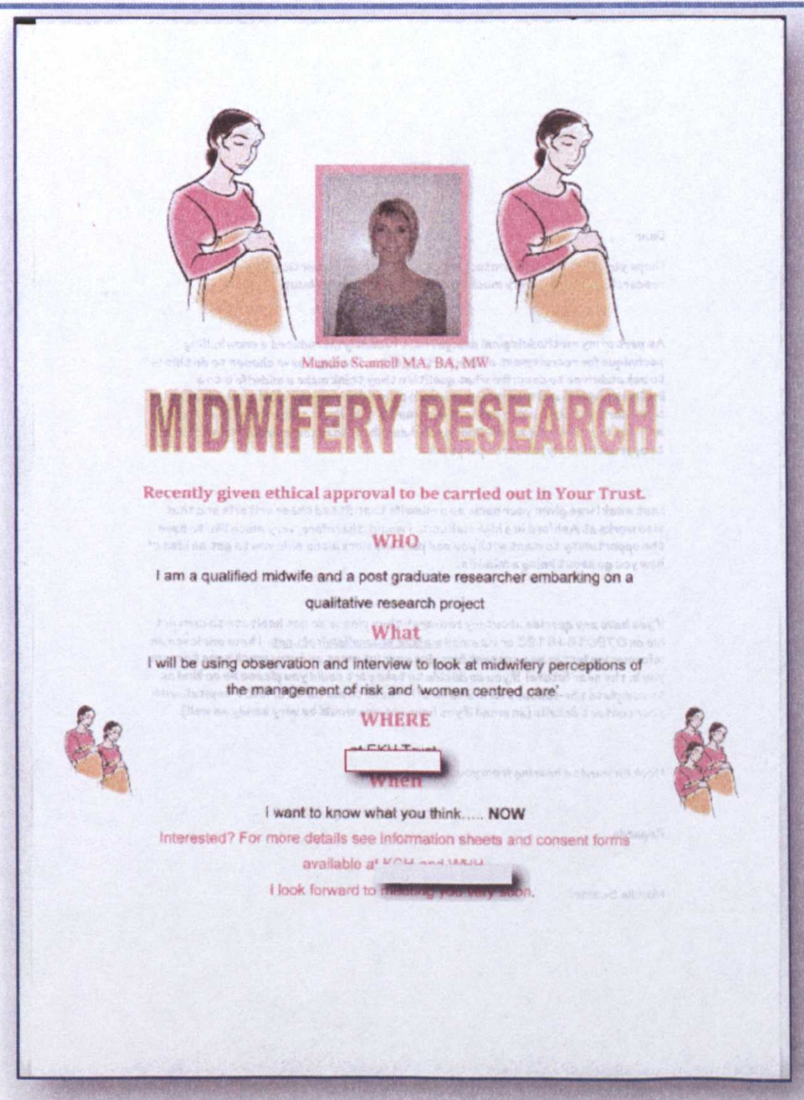
Independent information about being a research participant and what it involves, is available through the local NHS Research & Development Office. [redacted] Research Ethics and Governance Office at University of Kent. Rm 105, The Registry, University of Kent at Canterbury, CT2 7NZ Tel. 01227 824797

Appendix three

Title of Document: **Participant information poster**

Purpose of document: **To offer information about the research project**

Displayed: **On staff notice boards in all relevant clinical areas, staff toilets and coffee areas and all antenatal clinic areas in hospital and community.**



Appendix four

Title of Document: **National Research Ethical approval letter**

Purpose of document: **Confirmation of ethical approval**

National Research Ethics Service
West Kent Research Ethics Committee

South East Coast Strategic Health Authority
Preston Hall
Aylesford
Kent
ME20 7NJ

Telephone: 01622 713048
Facsimile: 01622 885966

10 February 2009

Ms Mandie Scamell
14 Falmouth Place
Five Oak Green
Tonbridge
Kent
TN12 6RD

Dear Ms Scamell

Full title of study: **An investigation into how midwives make sense of the concept of risk: how do midwifery perceptions of risk impinge upon maternity care services?**

REC reference number: **08/H1101/72**

Thank you for your letter of 21 July 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Participant Consent Form	1	16 June 2008

This Research Ethics Committee is an advisory committee to South East Coast Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Letter of invitation to participant		
Letter from Sponsor		22 May 2008
Summary/Synopsis	1	
Protocol	1	
Investigator CV		
Application		25 May 2008
Letter from University of Kent		21 April 2008
Supervisor CV		
CV of Kirstie Coxon		
Interview Schedules/Topic Guides	1	
Midwifery Research Advertisment	1	16 June 2008
Invitation letter to Participants	1	
Midwifery Manager approval		15 January 2009
Honorary Contract		09 January 2009
Response to Request for Further Information		
Letter from Head of Midwifery		28 July 2008
Letter from Head of Midwifery		21 July 2008
Information re Honorary Contracts Procedure	1	01 November 2007
Response to Request for Further Information		21 July 2008
Participant Information Sheet	2	21 July 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document 'After ethical review –guidance for researchers' gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H1101/72	**Please quote this number on all correspondence**

An advisory committee to South East Coast Strategic Health Authority

With the Committee's best wishes for the success of this project

Yours sincerely

pp

Jim Armstrong
Chair

Email: Hollie.Brennan@nhs.net

Enclosures: 'After ethical review – guidance for researchers' *SL- AR2 for other studies*

Copy to: *Prof Andy Alaszewski*
Art Artinou – R&D

West Kent Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	08/H1101/72	**Issue number:**	0	**Date of issue:**	10 February 2009
Chief Investigator:	Ms Mandie Scamell				
Full title of study:	An investigation into how midwives make sense of the concept of risk: how do midwifery perceptions of risk impinge upon maternity care services?				

This study was given a favourable ethical opinion by West Kent Research Ethics Committee on 10 February 2009. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

Principal Investigator	*Post*	*Research site*	*Site assessor*	*Date of favourable opinion for this site*	*Notes* (1)
Ms Mandie Scamell	PhD Candidate	East Kent Hospitals NHS Trust	East Kent Local Research Ethics Committee	10/02/2009	

Approved by the Chair on behalf of the REC

[signature] .... (Signature of Chair/Co-ordinator)

(delete as applicable)

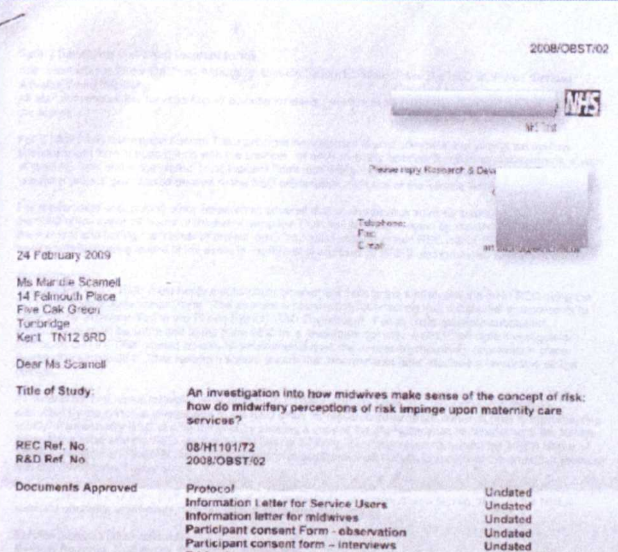
Hollie Brennan .... (Name)

(1) *The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.*

Appendix five

Title of Document: **Trust's Research and Development ethical approval letter**

Purpose of document: **Proof of local approval to conduct research**



2008/OBST/02

NHS

Please reply Research & Dev

Telephone:
Fax:
Email:

24 February 2009

Ms Mardie Scamell
14 Falmouth Place
Five Oak Green
Tonbridge
Kent TN12 6RD

Dear Ms Scamell

Title of Study: **An investigation into how midwives make sense of the concept of risk: how do midwifery perceptions of risk impinge upon maternity care services?**

REC Ref. No. 08/H1101/72
R&D Ref. No 2008/OBST/02

Documents Approved		
	Protocol	Undated
	Information Letter for Service Users	Undated
	Information letter for midwives	Undated
	Participant consent Form - observation	Undated
	Participant consent form – interviews	Undated
	Ethics favourable opinion letter	05/09/2009

Thank you for submitting the above referenced protocol to the R&D Department. I am pleased to confirm that your study has now been approved by the Trust provided that you comply with the conditions of Trust R&D approval which are attached.

We advise you to study this letter and the attached Conditions of Trust Approval carefully.

All research undertaken within the NHS requires both management approval from R&D offices and approval from an NHS REC, research may not commence at any NHS site until these have been obtained. Research that requires site-specific assessment (SSA) may not start until the ethical opinion has been extended to this site.

You must ensure that you are fully aware of your responsibilities and that your activities are conducted in line with the Local Research Governance Framework for Health and Social Care 2nd Edition, Research Ethics Committee conditions, The Medicines for Human Use (Clinical Trial) Regulations 2004 and Amendment Regulations 2006 and the Medicines for Healthcare Products Regulatory Agency for Clinical Trials Involving an Investigational Medicinal Product (CTIMP).

Good Clinical Practice
Pharmaceutical clinical trials involving an investigational medicinal product shall be conducted in accordance with the conditions and principles of International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH GCP).

The conditions and principles of GCP (Amendment Regulations 2006) shall be complied with if the trial is a CTIMP.

The Conditions and principles of GCP (Amendment Regulations 2006) are a requirement by law for CTIMPs. However, investigators of other research should be conducting their activities to similar standards and good clinical practice systems.

2008/OBST/02

Safety Reporting and Trust incident forms
Staff must always follow the Trust 'Managing Adverse incidents Protocol' and the R&D SOP No7 'Serious Adverse Event Reporting'
All staff are responsible for reporting all adverse incidents, whether or not related to research in accordance with the above.

For CTIMPs and multicentre Clinical Trials principal investigators should complete and submit the serious adverse event form in accordance with the protocol. In addition to the Sponsor's reporting requirements, a copy of the SAE form and a completed Trust Incident Form identifying both the nature of the incident and ticking the 'research project' box should be sent to the R&D office within 24 hours of the serious adverse event.

For researchers undertaking other research all adverse events and serious adverse events should be notified to the R&D office within 24 hours of the event using the Trust Incident Form, again by identifying both the nature of the incident and ticking the 'research project' box. You must notify the main REC within 15 days of the principal investigator becoming aware of the event in the format prescribed by NRES and published on the website.

Amendments
The sponsor of a CTIMP must notify a substantial amendment both to the MHRA and the main REC using the EU Notification of Amendment form. The sponsor is responsible for ensuring that substantial amendments to the proposal are submitted to the PI and EKHUT R&D Department. For all other research substantial amendments must be submitted to the main REC for a favourable opinion. EKHUT principle investigators participating in a CTIMP should ensure all amendments have the necessary regulatory approvals in place. Researchers involved in other research should ensure that amendments have received a favourable ethical opinion.

All substantial and non-substantial amendments to CTIMPs, Clinical Trials and other research must be submitted by the principal investigator to the R&D office for research governance approval prior to implementing locally. Please notify R&D of amendments by sending a copy of the EU Notification of Amendment, the MHRA Acceptance letter and the REC favourable opinion for CTIMPs. For other research submit the NRES Notice of Amendment form and the REC favourable opinion. In addition we will require one copy of the amended protocol and any other revised documents.

Further guidance and examples of substantial and non-substantial amendments can be found in the NRES standard operating procedures, NRES website www.nres.npsa.nhs.uk

Service Support Departments –
Medical Records, Radiology, Pathology, Pharmacy
Principal Investigators participating in a CTIMP are responsible for identifying trial patients in the study on all referral requests to service support departments such as Pathology, Radiology, Pharmacy and medical records are marked for retention. This will enable the necessary archiving in compliance with the Medicines for Human Use (Clinical Trials) Regulations [SI 2004 1031] & Amendment Regulations 2006 [SI 2006 1928].

Service Support Departments (SSDs), (if supporting the study) should be notified immediately of any amendments to the study and provided with a current version of the protocol. R&D will require evidence of continued support from SSDs before substantial amendments are approved.

Monitoring
The sponsor should ensure that the study is monitored and audited within 6 months of commencing and that reports are sent to the EKHUT R&D department.

Progress reports
Please note that in addition to complying with the REC Standard Conditions of Approval, MHRA (IMP and Medical Devices) and the Sponsor requirements researchers' should complete 6 monthly progress reports from the date R&D approval was given. Researchers are also required to submit an end of study report. Regular reports and information on the dissemination of the results are in compliance with the Research Governance Framework for Health and Social Care.

End of Study Reports
Researchers must submit End of Study reports to R&D when all study activity, including recruitment, follow-up etc. have ended.

Accrual
It should be noted that PIs who participate in CTIMPs and other Multicentre Clinical Trials are required, in addition to the above, to provide quarterly reports on total number of patients recruited locally into the trial

2008/OBST/02

Sponsorship, Indemnity, Insurance
The sponsor must ensure that indemnity arrangements and insurance are in place and adequate to cover the whole period of the trial.

The sponsor shall ensure that it notifies R&D of the trial end date when all activity, including recruitment and follow up, has ceased.

Training
You agree to attend Good Clinical Practice training updates annually for the period of the study. The sponsor is responsible for ensuring that the PI and team are appropriately qualified and trained in GCP, particularly in completing CRFs and reporting of SAEs.

Breach of approval conditions
Failure to comply with these conditions or failure to provide the information when requested will result in the study being suspended and may lead to Trust approval being withdrawn.

Yours sincerely

BSc, MSc, PhD, PG Dip, CBiol. MIBiol, CSci, FIBMS)
R&D Manager

Attached: Conditions of Trust Approval

Copy to: Lindsey Stevens
Professor A Alaszewski, CHSS, University of Kent
Ms Nicole Palmer, Research Ethics and Governance Officer, University of Kent

Appendix six

Title of Document: **Research protocol**

Purpose of document: **For NHS ethics**

Distributed to: **National Ethics Committee, Local Research and Development Directorate, Trust's Risk, Assurance, and Legal Services and Department Manager**

The research concept:

Risk management strategy in the maternity services is a direct response to the governmental call for the NHS to become an 'organisation with a memory' (1), where clinical errors, resulting in poor outcome (or near misses) are learned from. This governance initiative is part of a much wider proliferation of, what Horlick-Jones calls, 'a technical discourse of risk' (2). Social theorist of risk suggest that ideas of risk and risk techniques now form the basis of governance and administrative practice, not only in the health sector, but in most private and public sector organisations across the Western world (3,4,5).

The basis of the NHS risk strategy is to adequately protect the public from potential hazards that may arise out of risks in the future (6). While it is easy to assume this strategy is self-evident, a product of common sense management, such assumptions overlook the importance of how risk is conceived by practitioners. It ignores the process of risk construction and in so doing underestimates firstly, the role of the practitioners responsible for the implementation of risk management policy and secondly, the impact risk has upon care.

The efficacy of any health policy is known to rely heavily upon those people directly responsible for the delivery of health care (7). This is further complicated, with regards to risk health policy, by the fact that risk is known to be, not only morally loaded (8,9), but its meaning is strongly contested and far from straight forward (10,11). How health care providers, make sense of risk is, therefore, crucial, since the success of risk management initiatives depend upon it.

Since obstetrics is perceived as a high risk area (12,13,14), responsible for a 'significant proportion' of the NHS' liability claim (15), one might expect to find midwives attitudes to risk, as the most senior practitioner present at 70% of births in the U.K., to be high up on the risk and health research agenda. But not so, a broad literature review and previous post graduate research on risk within midwifery, carried out by the researcher, reveals that the understandings of risk held by midwives, who make up the bulk of the work force in maternity care, have never been subjected to sustained analysis? Indeed to date, within both the academy and the profession, the midwifery position in relation to risk has simply been accepted as a common sense, exciting little critical analysis. It is both the extent of the influence of risk in health care generally and the high

Research Protocol by Mandie Scamell Page 1

risk profile of obstetrics, which makes this research deficit particularly surprising. This project aims to make a contribution to the health literature on risk by addressing the lack of research in this particular area.

The research will explore the midwifery construction of risk and how this impacts upon practice by examining:

In what way does risk enter into professional discourses and influence professional practice?

How do midwives define and make sense of risk? How does this impact upon practice behaviour?

Is there more than one risk discourse at work? If so, what is the political dynamic at work and what are the social conditions that engender these different meanings?

Is there a tension between risk talk and risk practices?

Do working environments affect how risk is perceived and dealt with?

Theoretical background:

Previous, related studies in the social construction of risk in the medical care setting, which have helped inform this project, include research carried out by Alaszewski et al (2000) (16). This study revealed that professional understandings of risk, held by nurses working in the community were, not only, thought to be self evident demanding no particular concern, but assumed a hazardous focus. This, Alaszewski et al argue, leads to unreflexive models of care, where client autonomy is compromised in the pursuit of hazard/risk avoidance. While the scope for theoretical inference from this project is limited, as nurses and midwives make up two very distinct professional groups, each with a unique philosophy to care, these findings raise some interesting research questions which this project aims to explore. In particular it raises the theoretical problem behind taking the meaning of risk for granted and shows how this can adversely affect clinical practice.

What is particularly interesting about risk in the area of maternity health care is, firstly, the fact that this area of care is considered to be the highest risk area in relation to litigation burden within the N.H.S.. Whilst secondly, the unique position midwives hold in relation to risk within

Research Protocol by Mandie Scamell Page 2

the health service. Unlike most health professionals, midwives are not dealing with illness, on the contrary, much of the professional literature adamantly professes that neither pregnancy nor childbirth should be thought of as pathological (17). The normal physiological process of reproduction is not perceived to be harmful, as a risk to be manipulated or even managed (18,19). Rather, midwives see it as something to be embraced and preserved (20). As Margret Jowitt puts it

'midwifery is essentially a 'hands off' profession dealing with a population of healthy women performing their natural function where the aim is to prevent the need for any 'treatment' at all but instead to empower women to give birth to their own children.' (21) The theoretical question is how does such a discourse sit within the risk avoidance preoccupation apparently so prevalent within contemporary health care ?

What these professional references indicate is that midwives practise upon an injunction of at least two concordant, and in many ways divergent, professional priorities. On the one hand, the midwife must be mindful of her professional duty to minimise harm and protect her clients from the possibility of hazardous situations, in other words she must avoid risk; an obligation endorsed in both health policy and professional regulation. Whilst on the other, a midwife practices with a tangible commitment to the normality of childbirth; a commitment which, it would not be unreasonable to assume, drives a broader definition of risk, where positive risk taking might be conceived as a step towards achieving a physiological birth, in a home birth for example.

The question is how do midwives manage these potentially competing professional priorities? How does this apparent contradiction impinge upon their practice? What effect does this dynamic have upon professional confidence? How do midwives protect client autonomy whilst avoiding harm?

There is some empirical evidence to suggest that this balance is struck by midwives abandoning their commitment to the normality of childbirth in favour of a more cautious or even defensive approach to practice, one that prioritises risk avoidance (22,23,24,25) Indeed, work carried out by Lankshear et al (2005) (26) on midwifery autonomy in the labour ward setting in relation to

risk, showed midwives being enthusiastic instigators of the reclassification of labour from a low risk, normal category, to a high risk, pathological one, which called for technological intervention in the form of caesarean section, rather than the other way around. It is not surprising, therefore, that some have suggested that defensive midwifery practice is a major contributory to the rising caesarean section rate, which continues unabated despite policy aimed at curbing it (27). Furthermore it may help explain why government initiatives set out in Changing Childbirth (1993) (28) and more recently in Maternity Matters (2007) (29) struggle to make any impact upon maternity care statistics.

Midwifery is an essential part of maternity services in the U.K. Unlike many other countries, midwifery here has always enjoyed a central role in the delivery of maternity care. And yet, despite this, the medicalisation project is as tenacious here as it is in those countries where traditional midwives have been excluded from mainstream birth management (30). This project aims to assess the role risk and risk management policy has played in the contemporary birthing culture in this country. In particular, the common sense understandings midwives hold of risk will be analysed to see how these impact upon professional confidence in core midwifery philosophies such as physiological childbirth and woman centred care.

Summary of aims

This research seeks to develop a robust theoretical understanding of the influence midwifery held understandings of risk, have upon maternity services. By examining risk from a midwifery perspective, the project aims to provide evidence that can translate into meaningful indicators for professional development. An understanding of how midwifery discourses of risk operate, will help to explain the current birth management culture where incidence of technocratic interventions continue to escalate, despite both international and national policy aimed at attenuating this trend.

Research design and methods

The nature of the problem being researched demands a penetrating methodological tool. In order to make explicit the common sense assumptions about risk, held by midwives, a qualitative, multi method (31,32) will be adopted using ethnographic discourse analysis (33). Within this design framework, data on contextualised midwifery practice and talk will be collected using:

a) *Non participant observation & Participant observation* (34,35,36) to examine professional behaviours and institutional practices. (The researcher is a qualified and registered midwife)

Using ethnographic analysis (37,38), along with more detailed conversational analysis (39), the finer details of midwives interactions in different social settings will be looked at. To see precisely how the language of risk works in various situations, each demanding its own distinct social language (40), midwives will be observed interacting with

a) Other midwives
b) Maternity care service users or clients
c) Other health professionals particularly doctors

These observations will be carried out on 'labour ward' and behind the scenes at two NHS sites:

an obstetric lead unit –

a midwifery run unit –

b) *Ethnographic interview* to interrogate individual practitioners (41,42)

Taking a narrative approach (43), that is using an open interview schedule to encourage respondents to tell their personal story about being a midwife working within a risk sensitive organisation; interviews will be carried out in three phases.

Phase 1 : up to 6 orientation interviews with midwives from various levels of seniority and experience. These will take place at the beginning of the field work in conjunction with initial non participation observation. The aim of these interviews will be to 'get a feel' of the working environment (34) and to ascertain important themes in midwifery talk about risk.

Research Protocol by Mandie Scamell Page 5

Phase 2: up to 30 interviews will be carried out as part of a mutual validation process of the participant observation and non participant observations that will take place during this phase of the project. A narrative approach will be taken to collect data from individual midwives of various levels of seniority, who have been involved in observation episodes. Using this broad methodological approach will facilitate ongoing data validation, where the researcher will be able to verify findings using different research methods, thereby ensuring a robust research instrument.

Phase 3: up to 10 interviews will be carried out for clarification purposes

c) *Archival analysis*, of hospital protocols, staff memos, patient notes and government health policy to examine the political dynamic of risk within text (44,45,46).

Ethical considerations

There are four main areas of ethical concern in the research project:

1. *Sensitivity of the subject*

Since risk is known to be a morally loaded concept and, in this particular context, revolves around core professional competencies, the inquiry may provoke strong feelings or at the very least has the potential to make participants feel uncomfortable. It is anticipated that the ethnographic research design will help negate this difficulty by providing the opportunity to employ what Parker calls an 'ethico-ethnographic method' (47). In this approach priority is given to building sequential research relationships, where informed consent is constantly revisited and renegotiated and where participants are afforded every opportunity to manipulate the conditions of their involvement or to withdraw their consent.

2. *Informed Consent*

Such informal, ongoing informed consent procedures will be carried out in conjunction with written consent of participants. All potential participants will be given an information letter about the study which will include details on the aims and objectives of the project; participant anonymity and how the data will be stored.

Research Protocol by Mandie Scamell Page 6

Informed consent forms will be collected from all those involved stating that they have read and fully understand the information letter.

3. *Service user participation*

Whilst service users are not the focus of this study, they will be involved during episodes of observation. Moreover, these episodes will entail the observation of intimate birthing events. During this phase of the project the researcher will be mindful of attitude and manner with which she interacts with the service users and staff. Every effort will be made to minimize any loss of dignity caused by the process of observation suffered by the service users through active participation as a midwife, whereby the researcher (a qualified midwife) will offer support and reassurance whenever appropriate.

Using active midwifery participation to blend into the normal environment, is a particularly important part of the research design, as it is widely acknowledged that birth attendants can have a significant impact on birth outcome. A passive observer, or non-participant observer, may impact negatively on the labour by making the woman feel awkward or uncomfortable. As a qualified midwife the researcher will be able to reduce this sense of being watched and so invoke a more conducive birthing environment.

4. *Ethical approval*

Comprehensive liaison will be set up with the relevant NHS Trusts and PCTs, Ethics Committees and staff involved in the project. The commencement of the project will be on condition of National and Local Ethical approval.

Time line

1st year:

- submit research proposals to appropriate NHS Trust, PCTs and Ethics Committees
- literature review
- Phase 1 of data collection
    a) Establish access and orientation

b) Publicise study and instigate initial recruitment
c) Non participant observation
d) Ethnographic interview (n6)
e) Archival analysis – Critical Discourse Analysis (CDA)

2nd year:

- Phase 2 of data collection
    a) Ethnographic thematic analysis of phase 1 data set to guide data collection process, ongoing analysis
    b) Participant observation
    c) Non participant observation
    d) Conversational analysis
    e) Ethnographic interviews (n30)
    f) Narrative analysis
    g) Archival analysis - CDA

3rd year:

- Phase 3 of data collection
    a) final analysis of all data using various techniques
    b) Ethnographic interviews (n10)
- writing up of thesis
- dissemination of findings – professional and academic journal publication
- development of recommendations for best practice

Appendix seven

Title of Document: **Licence to Operate for both years**

Purpose of document: **To gain access to research area and secure vicarious liability and Indemnity insurance cover.**

A Licence to Operate is used to cover individuals not employed by the Trust but present on Trust premises as part of a clinical attachment, further professional education and examinations, on the job training or as an observer to gain experience. If the individual is actually performing work on Trust premises they must be professionally registered (if appropriate) and have professional indemnity insurance (if appropriate).

A Licence to Operate for Ms Amanda Scamell as a Researcher/Maternity Care Assistant in the maternity Department [redacted] reporting [redacted] This document sets out the conditions of your Licence to Operate.

During your Licence to Operate you have agreed to work as a Researcher/Maternity Care Assistant in consideration of the Trust providing you with specific work experience.

You shall through the currency of this Licence to Operate ensure that you are registered with the NMC.

You are required to ensure that you take reasonable steps to achieve the safety of yourself, work colleagues, patients or other visitors to the Trust's premises. You must at all times abide by the safety practices and codes of the Trust. You are expected to exercise all reasonable skill, care and diligence in the work you carry out.

Although you are not an employee of the Trust you are required to observe the standards of behaviour which the Trust sets both in terms of relationships with colleagues and with patients.

You will have access to see or hear information of a confidential nature. All information concerning patients and staff within the Trust is strictly confidential and must not be disclosed to any unauthorised person. Any breach of confidentiality or misuse of data may result in legal action or disciplinary action by your substantive employer (if appropriate).

You will be required to return to the Trust before the end of this Licence to Operate, or otherwise on request, any property or documentation belonging to the Trust. Failure to do so could result in an appropriate charge being made.

In the event of sickness or other absence you should notify [redacted] the first day of your absence giving the reason for your absence and its probable duration.

This Licence to Operate is for a period of one year commencing on 14th April 2010.

This Licence to Operate may be terminated earlier by either party providing the other with one week's prior written notice. In appropriate circumstances the Trust reserves the right to terminate the Licence to Operate without notice.

You are covered by NHS Indemnity. It is a condition that you obtain and keep in force appropriate indemnity insurance as may be necessary for the work you are undertaking for the Trust and in any event sufficient to cover acts or omissions in the course of your practice. You are required to indemnify the Trust against any claim made against it in respect of your acts and omissions. A copy of your insurance policy or policies must be provided at the Trust's request.

Putting patients first

Where you are covered by the NHS Indemnity, the Trust accepts vicarious liability for damages arising from your clinical negligence where this occurs in the course of the work that you carry out for the Trust and provided that you are not in breach of the terms of this Licence to Operate.

You may wish to consider obtaining your own cover for other liabilities which you may incur. If however you have substantive employment with another NHS Trust, then liability for your clinical negligence will remain with your substantive employer.

The Trust does not accept responsibility for the personal property lost or damaged on Trust property and recommends that this is insured.

In the course of your work for the Trust, you may generate Intellectual Property. You will find this defined in the Trust Intellectual Property Policy. Any Intellectual Property so generated shall belong to the Trust, and you agree to affect such assignments and documentation as may be necessary to invest the same in the Trust forthwith upon demand. In the absence of completing the relevant documentation, you appoint the Trust as your attorney for completion of the relevant documentation to achieve this purpose. We will agree a system of revenue sharing with you as an incentive dependent on the circumstances of each particular case.

The Trust manages all research in accordance with the requirements of the DH Research Governance Framework. You must comply with all reporting requirements, systems and duties of action put in place by the Trust to deliver research governance.

Nothing in this Licence to Operate shall be regarded as creating a contract of employment between you and the Trust. No remuneration is payable by the Trust to you and no expenses or fees will be met save in exceptional circumstances and where the Trust's prior written approval has been given.

I accept the conditions of this Licence to Operate and will keep a personal copy for my own reference.

Signed.......................... Signed..........................
(on behalf of the Trust)

Name.......................... Name..........................

Date...15/4/2010 Date...14/4/2010.......

NHS Trust

A Licence to Operate is used to cover individuals not employed by the Trust but present on Trust premises as part of a clinical attachment, further professional education and examinations, on the job training or as an observer to gain experience, or as otherwise authorised by the Trust. If the individual is actually performing work on Trust premises they must be professionally registered (if appropriate) and have professional indemnity insurance (if appropriate).

A Licence to Operate for Mandie Scammell, as Maternity Care Assistant in the Maternity Department at [illegible] reporting to [illegible] Head of Midwifery and Gynae Nursing.This document sets out the conditions of your Licence to Operate.

During your Licence to Operate you have agreed to work 37.5 hours per week in consideration of the Trust providing you with specific work experience.

Your role and responsibilities are as set out in the attached job description for a Maternity Care Assistant.

You shall through the currency of this Licence to Operate ensure that you are registered with the NMC.

You are required to ensure that you take reasonable steps to achieve the safety of yourself, work colleagues, patients or other visitors to the Trust's premises. You must at all times abide by the safety practices and codes of the Trust. You are expected to exercise all reasonable skill, care and diligence in the work you carry out.

Although you are not an employee of the Trust you are required to observe the standards of behaviour which the Trust sets both in terms of relationships with colleagues and with patients.

You will have access to see or hear information of a confidential nature. All information concerning patients and staff within the Trust is strictly confidential and must not be disclosed to any unauthorised person. Any breach of confidentiality or misuse of data may result in legal action or disciplinary action by your substantive employer (if appropriate).

You will be required to return to the Trust before the end of this Licence to Operate, or otherwise on request, any property or documentation belonging to the Trust. Failure to do so could result in an appropriate charge being made.

In the event of sickness or other absence you should notify [illegible] on the first day of your absence giving the reason for your absence and its probable duration.

This Licence to Operate is for a period of one year commencing on 12th January 2009

This Licence to Operate may be terminated earlier by either party providing the other with one week's prior written notice. In appropriate circumstances the Trust reserves the right to terminate the Licence to Operate without notice.

You are covered by the NHS Indemnity. This means that, provided you are not in breach of the terms of this Licence to Operate, the Trust accepts vicarious liability for any negligent actions or omissions arising from the work that you carry out for the Trust resulting in a clinical negligence claim.

The Trust does not accept responsibility for your personal property lost or damaged on Trust premises and recommends that this is insured.

Acceptance of this licence to operate implies your agreement to abide by the Trust's policies in relation to Intellectual Property.

The Trust manages all research in accordance with the requirements of the DH Research Governance Framework. You must comply with all reporting requirements, systems and duties of action put in place by the Trust to deliver research governance.

Nothing in this Licence to Operate shall be regarded as creating a contract of employment between you and the Trust. No remuneration is payable by the Trust to you and no expenses or fees will be met save in exceptional circumstances and where the Trust's prior written approval has been given.

I accept the conditions of this Licence to Operate and will keep a personal copy for my own reference.

Signed.............. Signed ....

(on behalf of the Trust)

Name.............. Name..................

Date....20/01/09.... Date....9/1/2009....

Appendix eight

Title of Document: **Participant consent form for observation and interview**

Purpose of document: **To gain formal written consent for participation**

Distributed to: **All participating midwives and mothers**

Research Consent Form

'midwifery perception of management of labour process' - observations

I understand that the research in which I am consenting to participate in is sponsored by the Centre for Health Service Studies (CHSS) at the **University of Kent** and is funded by the **Economic and Social Research Council**. I am aware that the chief investigator is qualified in **Midwifery** and **Research** and is interested in midwifery perceptions of the management of the birthing process.

The nature of my involvement in this study has been fully explained to me:

- I am to be involved in one/several [*please delete if appropriate*] observation episode[s] which will take place at the time of intra partum care delivery (the birth of the baby).
- I understand how and for how long the data will be stored
- I am assured that my confidentiality will be protected.
- I am aware that my participation in this project is voluntary and that I can withdraw my consent at any point during my participation
- I know where I can get independent advice about my participation

I (name)

Address

Tel: **email:**---------------------

give my consent to take part in the research, described above, being carried out at East Kent Hospitals Trust by Mandie Scamell from CHSS.

Date:

I understand that the research in which I am consenting to participate in is sponsored by the Centre for Health Service Studies (CHSS) at the **University of Kent** and is funded by the **Economic and Social Research Council**. I am aware that the chief investigator is qualified in **Midwifery** and **Research** and is interested in midwifery perceptions of the management of the birthing process.

The nature of my involvement in this study has been fully explained to me:

- I am to be involved in one/several interview[s] that will take place at a time and place that is convenient to me and are not anticipated to take place during work time
- I understand how and for how long the data will be stored
- I am assured that my confidentiality will be protected.
- I am aware that my participation in this project is voluntary and that I can withdraw my consent at any point during my participation
- I know where I can get independent advice about my participation

I (name)

Address

Tel:

give my consent to take part in the research, described above, being carried out at East Kent Hospitals Trust by Mandie Scamell from CHSS.

Date:

Appendix nine

Title of Document: **Participant information letter**

Purpose of document: **To inform service users about the research**

Distributed to: **All mothers due to give birth during the research period in the targeted clinical areas**

Centre for Health Services Studies

Hello,

I am a researcher and midwife and I am writing to you to inform you about a research project that is to be carried out and am ***inviting you to be personally involved***.

During the time that your baby is due to be borne, a small scale qualitative project will be being conducted which may, should you choose to become involved, affect you. The purpose of the study is to look at what midwives think about today's working environment and how this affects the care they deliver to you. In particular the aim is to investigate clinical governance and risk, to examine how midwives incorporate these concepts within their professional role.

I would be most grateful if you could take the time to read the information below carefully if you are interested in taking part in this study.

<u>What is this study?</u>

The project is sponsored by the Centre for Health Service Studies (CHSS) at the University of Kent at Canterbury, is funded by the Economic and Social Research Council and has had national and

WHO COLLABORATING CENTRE

University of Kent
George Allen Wing
Canterbury
Kent CT2 7NF
United Kingdom

local ethical approval. The principal investigator is both a **registered midwife and qualified researcher**. The project supervisor has extensive experience researching health and is the Professor at CHSS.

What is the study about?

We all know about governmental efforts to implement a health service that is based upon clinical excellence, evidence based practice and efficiency. Most people have also heard about the policy drive within maternity to facilitate maternal choice, continuity and women centred care. These initiatives have had a huge impact upon the working environment in which midwives practice and I am interested in how this has impacted upon the service they offer you at that crucial time when you come to give birth to your baby.

What will be involved?

If you would like to take part in this research I would be asking for **your help with the collection of data** using the research technique of:

- *Participant observation –*

this will involve my joining you and your birthing partner during your labour to observe the midwife who is looking after you. I will be looking at how she speaks to you and how she explains things to you, as well as how she speaks to her fellow professional colleagues.

My aim is to impact as little as possible on the care you receive, however, I will be available to provide extra support to you should you wish it.

During these observations I will be keeping field notes, these will be stored in a locked filing cabinet at the University for a maximum of two years from the date of the observation and will then be destroyed.

I would also like to have a look at your notes to see exactly what is recorded

- **Confidentiality**

All the data collected during this study will be kept confidentially. Your name and any identifying details will be removed, whilst I may use direct quotes from the data, the identity of the speaker will never be revealed. The only possible exception to this will be if I uncover evidence that suggests you might be at risk of serious harm, in which case the incident would have to be reported to management and the supervisor of midwives.

How do I find out more?

If you have any queries about this project then please do not hesitate to contact me on the address below, by email ajs65@kent.ac.uk. or by phone on 07901646123.

If you have questions regarding the research funding or academic department then please visit their websites at http://www.esrc.ac.uk/ESRCInfoCentre/index.aspx , http://www.kent.ac.uk/chss/ respectively.

The Centre for Health Service Studies, University of Canterbury, George Allen Wing, Canterbury, Kent CT2 7NF

How do I take part?

I have enclosed a consent form for you with this letter which I invite you to have a look at. It should be completed and returned to me when we meet (keep it in your maternity notes). It is important that you realise that participation in this study is in no way compulsory and that even if you agree to be involved, you can withdraw your consent to participate at any point.

Hopefully I will be meeting you very soon. If you do decide to take part and would like to be kept informed about the study findings, please let me know at the time of the observation.

May I take this opportunity to say thank you very much for your interest in this study and I hope very much that I will have the pleasure of working with you soon.

Yours sincerely

Mandie Scamell (MA BA Dip MW)

For further independent advice about what is involved in volunteering to be a research participant contact: 1. Research Governance Co-ordinator,

2. Research Ethics and Governance Officer at the University of Kent, Nicole Palmer, Room 105, The Registry, University of Kent, Canterbury, CT2 7NZ, Direct dial: 01227 824797 Email: N.R.Palmer@kent.ac.uk