Risk within the Confines of Safety:
An Analysis of Current Pregnancy and Birthing Practices of Australian Women

Submitted by

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SUMMARY

The following thesis seeks to inquire whether the recent phenomenon of women seeking out and indeed actively engaging with a medicalised birth stems from a shift in not only perceptions of risk, but also how a shift in responsibility, choice and control has impacted on the birthing women of Australian society. The thesis examines sociology of risk employing the work of both Beck and Giddens, although an emphasis will be placed on the work of Ulrich Beck. The three major themes that underpin the work of Beck, namely his risk society thesis, reflexive modernization and individualization are employed to explore some of the issues that concern the relationship between risk and society, the ramifications of this form of society on its inhabitants and specifically in relation to its impact on those experiencing pregnancy and childbirth. The Risk Society as an explanatory framework was empirically tested by conducting 45 interviews with women who had recently given birth from three separate birthing environments: private birth mothers, birth centre and home birth mothers. The argument is put forward that whilst previous research into the area of childbirth is clearly important in shedding a critical light upon childbirth practices, it does nevertheless neglect some important current social changes. In this respect, the application of Beck and Giddens work to the area of sociology of reproduction captures more adequately the ideological shift which this thesis examines. It is argued, through the scrutinizing gaze of the public, that the pregnant woman is the least able to escape the consequences of risk society where changed notions of health and responsibility have created a cultural acceptance of medical intervention of childbirth.
STATEMENT OF AUTHORSHIP

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis presented by me for another degree or diploma.

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

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

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I am thankful to the 45 women who allowed me access to a very personal time period of their lives. The time spent with these women is one that I hold very dear to my heart. It was during this time that my connection and admiration for women was greatly strengthened.

This thesis would not have been possible if it were not for my family. I thank my mother Claudette for her constant emotional support. I would also like to thank my stepfather Phillip. Although he passed away when I was young, his passion for knowledge and life greatly influenced my path into academic research. I thank my children Natasha and Cameron for bringing me through the rite of passage of pregnancy and childbirth and into my life as a parent. I would also like to express my
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**PREFACE**

For the last four years I have been researching women’s experiences of pregnancy and childbirth within Australian society. The results of that research appear before you in the form of a thesis. To begin, I offer a brief glimpse into my life which situates my stance on the research at hand and simultaneously fleshes out the various concerns of the theoretical approaches to childbirth within Western Societies.

I felt drawn into this area of research, not only because of my own personal experiences as well as the very similar experiences held by my close friends, but also because of the perceptible shift in attitude, held by some within our society, from medical and technological avoidance to one of its active engagement within pregnancy and childbirth. Recently, the World Health Organization (WHO) provided an outline of recommendations for childbirth which included the demedicalisation of care for normal pregnancy and birth (Chalmers, Mangiaterra & Porter, 2001). Yet, in the most recent Senate Committee Inquiry into Childbirth Procedures (Commonwealth of Australia, 1999) it was revealed that although 80% of all pregnant women fall within the category of low risk pregnancies and births close to 90% of all births in Australia include some form of medical intervention.

This led me to seek the story behind the statistics. Do these statistics reveal a picture of medical dominance within the field of pregnancy and childbirth, where the medicalisation critique can be applied to understand this mass rate of intervention? Or perhaps the newly applied label of consumer or client to the pregnant woman has led her to pick and choose medical intervention to the extent the statistics are demonstrating. Does the intervention stem from the desire of the woman? Has there been a shift in women’s attitude from avoidance towards medical intervention? If we were to pay attention to the media reports within mainstream magazines and newspapers we would answer with a resounding and wholehearted 'yes'. For beyond the various articles revolving around the phenomenon of demand medical intervention, including the induction of labour and caesarean sections (Mould, Chong et al., 1996; Quinlivan, Petersen et al., 1999), there are articles devoted to “fear of
childbirth” (Steyn, 2001) and the embracement of pre-genetic testing (Gibbs, 2002; Tormey, 2005).

Attempting to understand the various components at play within the field of reproduction within our society has led me to move away from investigating the impacts of variables such as socioeconomic and education levels and to question the basis of this stark increase of medical intervention during pregnancy and childbirth. Does it stem from women’s desires or men’s constructs? And why does most literature neglect the seeming paradox, that many women feel positive about medical control of the process in which they create new life?

To make the water murkier I will share a glimpse of my own personal journey into motherhood. My first child was born in 1991, a nine hour labour that started out with the breaking of my waters and ended with haemorrhaging and many internal and external stitches—leaving me unable to care for my daughter in her first few days of life. After the birth of Natasha, I was confined to my birthing bed for a period of 5 hours. It was during this solitary confinement, for my daughter had been whisked away by the medical team and her father was off somewhere signing forms and making phonecalls, that I received experiential confirmation of the reality of the Cartesian mind body dichotomy; the very first time in my life that I existed with a feeling of detachment from my body. Through the haze of pain and the remnants of the gas I attempted to examine what had just happened. Throughout my pregnancy I felt that I had always done the responsible thing. My childhood friend had sent me three books on pregnancy and childbirth, and these books were just the beginning of my library. Soon I began to change many aspects of my life to accommodate for the growing life within me. My exercise routine became gentler; I made sure to avoid all of the foods that were said to cause damage to my baby; and I took the multivitamins that were recommended by my pregnancy and childbirth books as well as by my doctor. The end result was a constant monitoring, not only of my self, but also of my environment.

My involvement with the pregnancy and impending birth involved all aspects of my life. Although I never questioned the use of an obstetrician as my primary carer, I did question my obstetrician. Following the advice of one of the many books I had read, I
created a list of questions for my obstetrician. It was important to me to avoid medical interventions such as an episiotomy, epidurals and the ultimate intervention of the caesarean section.

As my pregnancy advanced I excitedly began to prepare for the birth of my child. The approach that I undertook was that birth was not just going to happen to me, but rather that I was going to be completely involved in the process. I began to develop ideas of what I felt would be a ‘good’ birth. My partner and I practiced various birthing techniques, such as the American based Bradley Method. In the end we both felt the mixture of feelings of excitement and anxiety that seems common to most first time expectant couples.

My due date came and went as did two more weeks of waiting. Finally, my doctor informed me that we could no longer wait for my baby to arrive in his or her own time, rather I had to be induced. Although I had read about some of the negative side effects of being induced I fully trusted my doctor and his advice on the risk to my baby or myself by allowing the pregnancy to continue. On the day of my daughter’s birth I arrived at the hospital early to have my waters broken in our first attempt at instigating labour. Unfortunately, after hours of walking nothing was happening – this child was not ready to come into the world. The next step was having an IV administered with the synthetic hormone syntocin – a synthetic oxytocin which affects the uterus’ ability to contract. Nothing could prepare me for the effects of being induced. The contractions I had prepared for were meant to operate like a wave. I had read that as the contraction was hitting its strongest point it would soon be over and I could ride the remaining contraction until the slow build up to the next peak. Unfortunately, with the aid of syntocin every contraction was extremely intense. I found myself saying over and over again “the whole thing is a peak”. Not only did the contractions operate on a completely different level than what I had expected, but the second stage of labour left me feeling completely out of control. All of my attempts at working with the contractions failed, I couldn’t work with a contraction that did not have a peak, as all of my literature had told me to expect. Yet I refused to have any pain relief. All of the self-monitoring that I had carried out during my pregnancy continued into the birth. I knew the possible risks to myself, but more importantly my baby in having an epidural or being administered pethedine.
When my labour progressed into the second stage, my body started to convulse – I had no control over pushing or stopping the involuntary muscle contractions. I told the midwife that I was in the pushing stage; she told me that I wasn’t. What contributed most to the feeling of a mind/body split that I described above was that during the critical stages of my labour the medical staff in the room spoke over me and to each other, not to me. They were caring for my body, but not paying attention to my ‘self’. It was during this time that I had a distinct impression of being a stomach or vagina rather than being a human being. Whatever else I expected of the birth of my first child, a de-humanizing experience was never contemplated.

In hindsight, I can see how I ended up on that table with a gas mask forced onto my mouth and very hard working and committed individuals attempting to stop the haemorrhage. I entered the hospital, not so much as an earth mother, but a young woman who had read every mainstream book and magazine on the issues of pregnancy and birth that I could get my hands on. My pregnancy had begun with a scare; 2 months into it I had started to bleed, my family and friends were in America so I had no one to really turn to except my GP. It seemed that from that time onwards I turned to my ‘self-help’ pregnancy manuals and the medical profession whenever I had a concern. I felt that I had learned everything that I needed to know- ranging from preconception to labour to post labour care. Whenever I would attend a social function, other pregnant women or mothers seemed to gather around each other – it was there that I could see the similarity of experiences. The insecurities, the fears and excitement, but where many other women were apprehensive about their impending labour I felt confident. I knew the consequences of medical intervention and I was preparing myself for the natural birth of my child. For instance, I had read in one particular book about what it termed the cascade effect. I knew that if I were to become induced and given intravenous syntocinon that this would create strong contractions where I might require some form of pain relief which in turn would greatly reduce the sensation in my lower body, confine me to my bed, slow my labour, reduce the effect of my pushing reflex and most likely lead to a forcep or a vacuum delivery, which in turn could lead to an episiotomy. With this one example of the cascade of intervention-I could quickly see how the autonomy of the woman, her control over her childbirth and her body is quickly taken away.
So how did the birth of my daughter turn from the natural childbirth that I had planned to one of medical dominance? Why didn’t I question the birthing environment that I was entering into as a medicalised one? Was there anything that could truly prepare me for the reality of this ‘rite of passage’? Or perhaps I was acutely aware of the double-edged nature of the advancements within science and medicine. Should I be questioning or thanking the obstetricians and medical staff who had ‘saved my life’? These questions came to the surface once more with the birth of my second child. My son Cameron was born almost two weeks early with the aid of syntocin. My obstetrician had decided that starting my labour prior to the due date would be a proactive measure in avoiding the problems that occurred during the first birth. Yet this birth ended with a more severe haemorrhage that necessitated three transfusions. It was on my arrival home that I began to ask questions. Why didn’t I question the artificial stimulation of labour. I knew the research that indicated that being induced brings on severe contractions for the labouring woman and contributes to further medical intervention. Why did I feel secure within a medical environment regardless of my knowledge? Why did I only want my previous obstetrician as a primary carer? Why was my first reaction to a negative outcome, such as a post partum haemorrhage, directed towards my body as opposed to medical intervention? I could see that in many ways the medicalisation of childbirth had made childbearing safer for women and their infants, but it had also brought some new dangers in its wake as well. It is these experiences, as well as the countless conversations with many friends who told of similar experiences, that led to this research.

This thesis is based on interviews conducted with 45 pregnant women and mothers within the state of NSW. I centred my research within two separate hospitals; a private hospital, and midwifery led hospital and also interviewed home birth mothers. When I began my search for pregnant women to query about their expectations and desires of birth I did not specifically seek out women who believed in a certain type of birth, I simply followed what Davis-Floyd (1994) would term the “mother trail”.

During my research I grasped the reality of the statistics, I found that indeed women are subjected to a series of obstetrical interventions so routinised that they are
difficult to avoid in most hospitals, under the care of most obstetricians. For although some women do seek out a natural birth with a midwife as her primary carer, the indemnity crisis faced by Australia and indeed the Western world is quickly limiting women’s options in their choices. A recent study of 171,000 births in NSW found that of low risk first time mothers, labour is induced or augmented with syntocin for one in three public patients and half of all private patients. Between a quarter (public) and a half (private) use epidural anaesthesia. Forceps procedures or vacuum extraction are used to deliver one in every five babies born in a public hospital and one in every three born in a private hospital. One in three public women and half of all private women receive episiotomy. Overall, less than one quarter of public first time mothers and one fifth of private patients give birth without obstetric intervention of any sort. These interventions are not always clinically indicated or in accordance with evidence based best practice. With the acknowledgment that over one-fifth of all women giving birth in Australia is by caesarean section, we can indeed see the technological level of intervention women are faced with.

Of course we can see that Australian women's birthing options are becoming more limited. Yet there are still choices available. Choices, according to the above statistics, that could lead to an increase of medical intervention. It is quite clear that private patients are subject to higher intervention rates than women of the public system. Within Australia there are birthing centres available and hospitals which provide a predominantly midwifery led model of care. Home birth is still an option, though a very limited one—with only a few private practicing midwives willing to operate without indemnity coverage.

From this scenario of constrained choices, which appears to be becoming narrower, mass medical intervention and indeed active engagement appears to be the norm rather than the exception. This shift in attitude requires an analysis- or rather we can seek to connect what C. Wright Mills(1959) identified as the public sphere of structure with the personal realm of experience.
INTRODUCTION

I think women are more anxious about birth today because their expectations are so much higher. They want perfection – an emotionally wonderful experience; an easy, painless delivery; a perfect baby; instant bonding. But in the back of their minds, they know it can go wrong. With more information and new technology, women expect to have the perfect labour, and it’s a huge disappointment if it doesn’t go well. (Saunders cited in Steyn, 2001: 23)

A portrait of an extremely expectant and wealthy young woman hangs on the walls of the Tate Britain gallery of London. The recently acquired Portrait of an Unknown Lady (c. 1595) by the Elizabethan artist Marcus Gheeraerts II is one of many ‘pregnancy portraits’ which reveals to the modern day observer not only the ‘dynastic pride’ of the family but also what Karen Hearn, the curator of the Tate gallery, has called a “haunting anxiety […] which expresses the real possibility that a beloved partner may be about to die” (cited in Kennedy, 2002). These 17th century Elizabethan portraits often depict women who wear expressions of fear and anxiety. In fact, Ms. Hearn has revealed that records demonstrate that some portraits were commissioned by pregnant women who had premonitions of their death through childbirth. This was discovered by the literary parallel of these paintings in the many ‘mother’s legacy’ letters that were written by pregnant women to their unborn children.

The statistics for death in childbirth for that particular place and time were approximately one in a hundred women, a stark contrast to that of today where the Australian mortality rates are approximately 13 per 100,000 confinements (Madden, 2003). Even so, women in the Western world seem to be just as anxious about pregnancy and birth as their 17th century counterparts. Take for example the quote
which began this introduction. Doug Saunders, professor of obstetrics and
gynaecology within the University of Sydney, provides us with an insight into the
possible attitudes of the birthing women of Australian society. The article itself
centred on Tokophobia\(^1\), an emerging trend within Australia, and indeed Western
societies, which sees women frightened of pregnancy and childbirth.

Surely we must question whether the hopes, anxieties, risk and uncertainties of each
period are merely a carbon copy of previous eras. Are the fears and anxieties of
today’s Western mothers different to those of Gheeraerts’ subjects, or for that matter
mothers from less than one century ago? Again we can turn to Britain to find
possible answers. In 1914 the 32,000 strong Women’s Co-operative Guild fought a
battle for the improvement of maternity and infant services available to women,
specifically to women from lower socio-economic classes. During this time, the
Guild asked for their members to share their personal experiences of childbirth:

I do not know that my experience of childbearing has differed much from the women
of my class. I was a factory girl, and an only child. I was married at twenty, and the
mother of three children by the time I was twenty three…

I was weak and ill, could not suckle my second baby…and to crown my misfortune
my husband fell out of work, and I had to do shirt work at home in order to keep a
roof over our heads. My third baby was very tiny and thin when born. I put this
down to the worry and the shortness of food which I had to put up with, and though
he lived till he was three years old he died from diptheria…

I do not think I was very different in my pregnancies to others. I always prepared
myself to die, and I think this awful depression is common to most at this time…

After the first three living children, I had three stillborn children. I was six months
advanced when I fell downstairs over a stair-rod, which killed the child, which was
born after forty-eight hours’ labour, and perhaps it seems wicked to you, but I was
glad, because it left my hands free for a time to look after the other two, for I was
fearfully weak and ill. After a lapse of two years I had another seven months baby
born dead, and again, after another two years, a five months stillborn child, all three
stillborn children being boys. I had a miscarriage after this of two months, and when
I was thirty-five years old had my last baby, who is now living, nine years old.
I do hope you will not feel that his letter is morbid, and that I delight in writing horrors, for I do not, and had you not asked for information I should never had written this all down…please do not think I am miserable, for I am not, for I believe – in fact, I know – that there is a brighter day dawning for the mother and child of the future. (Davies, 1978: cited in Oakley, 1981: 187-188.)

During this particular time period maternal mortality rates were somewhat better than the 17th century statistics, yet, they were still quite high at 1 in every 250 births. Therefore, the fears and anxieties of these particular populations of women were bound within their living reality. Negative outcomes of pregnancy were expected and attributed to fate, nature or the ineffable intentions of the Diety. Yet, today when we are living in the “brighter future for mothers and children” we find women, and in particular Australian women, just as anxious, possibly more so. However, it will be argued in this thesis that the fears stem not from a lived experience but rather from speculation about risks. In various hospital and obstetric waiting rooms women are confronted with dozens of leaflets and posters which warn them about all kinds of hazards which they face during their pregnancy and impending birth. These women are told about invisible killers lurking in their ignorance. Yet blame, as it will be shown, is allocated to those who fail to inform themselves about the risks that they face.

Risk Society and Childbirth

The world of risk for the childbearing women of Western society, and also for the general population, is full of hazards and risks that are not as clear cut as previous generations. In theorising these changes, Beck (1996b:28) coined the term ‘Risk Society’ to refer to a new stage in the life of individuals residing within developed countries. Risk society is an inescapable structural condition of advanced
industrialization where the produced risks of that system undermine and/or cancel the established safety systems that nation states and large companies were seen to be able to provide (Beck, 1996b: 31).

Because of this Beck et al. (1994) argue that the central problem of Western societies is not the production and distribution of goods such as wealth and employment in conditions of scarcity, but the prevention or minimisation of risks. Individuals are daily bombarded with debates and conflicts, which proliferate over these risks. Bauman (1998: 65) illustrates this point well when he states:

> it [risk] is now dissolved in the minute, yet innumerable, traps and ambushes of daily life. One tends to hear it knocking now and again, daily, in fatty fast food, in listeria-infected eggs, in cholesterol rich temptations, in sex without condoms, in cigarette smoke, in asthma-inducing carpet mites, in the dirt you see and the germs you do not.

Accordingly individuals, and of special concern here – the expectant woman - living in these societies have moved towards a greater awareness of risks, deal with them on an everyday basis, and are far more sensitive to what they define as ‘risks’, or threats to their health, economic security or emotional wellbeing than they were in previous eras (Lupton, 1999b).

Risk, accordingly has become a force of social change (Beck, 1992; 1995; 1997; 2000a; 2000b; Giddens, 1990; 1991). It can be seen to actively shape our concept of health, desire for perfection, and our relationship to technology and responsibility. It is these themes which are noticeably absent from previous research in the area of sociology of childbirth and can provide insight into the agency of women who seek
medical intervention during pregnancy and childbirth. This thesis will concentrate on middle class women; a particular population of women which have presumably more control over their pregnancy care and birthing options (Barker, 1998). By focusing on this specific group, the cultural influences, which impact on these choices, will be highlighted.

The perception of risks faced by previous generations of childbearing women, as outlined above, entailed a relationship to an unknown future whose likelihood of transpiring could be calculated on the basis of drawing on past occurrences. Risk assessment and behaviour of this kind is thus a question of mathematics irrespective of whether the risk is explicitly or implicitly calculated (Adams, 1995). We could say that this world of risk assessment belongs to the realm of rational action and scientific certainty, a realm where there are clear distinctions between danger and safety, falsity and truth.

This thesis will argue that the world of risk for the childbearing women of my study is not of this kind. Rather, their world is full of hazards and risks that are not as clear-cut as was the case for previous generations. The invisibility of many of the risks as well as their insidious nature cannot be encompassed by traditional conceptions of risk. ‘Risk society’ argues Beck (1996:28) “is not an option which could be chosen or rejected […]”. Rather, it is an inescapable structural condition of advanced industrialization where the produced risks of that system “undermine and/or cancel the established safety systems of the provident state’s existing risk calculation” (Beck, 1996:31). Beck uses the examples of chemical pollution, genetic engineering
and nuclear power to highlight this point. These contemporary risks cannot be limited in time and space, cannot be grasped through the rules of causality, and cannot be safeguarded, compensated or insured against. “Industrial society, which has involuntarily mutated into risk society through its own systematically produced hazards balances beyond the insurance limit” (Beck, 1996:28)

Specifically for the conceiving or pregnant couple, these multifaceted risks are in a permanent state of virtuality and are actualized through anticipation. It makes no difference then whether they are actually or objectively ‘safe’; if the risks are anticipated then they call for the couple or the woman to respond. This ‘becoming real’ aspect of risks within high modernity may placate sentiments of absurdity relating to living in a risk society (Petersen, 1997). After all, our world appears so much safer than that of previous times. We have learned to control most contingencies, for example relating to diseases, accidents or violence. As Van Loon (2002) indicates, even natural hazards appear less random than they used to be. Although we cannot stop the hurricane or earthquake we can reasonably predict, and therefore make the necessary structural arrangements as well as emergency planning. Further examples can obviously be cited here, however, it is safe to summarize that life in modern western societies is now safer than ever. Whilst this form of sentiment is quite sensible it does miss the obvious point outlined above. The risks of high modernity are not ‘real’, they are ‘becoming real’ (Beck, 1992, 2000b; Van Loon, 2000).
To adequately describe the ‘risk society’ environment that not only my respondents but indeed all of us within Westernised societies experience we can turn to the creator of the thesis, Beck:

We no longer choose to take risks, we have them thrust upon us. We are living on a ledge – in a random risk society, from which nobody can escape. Our society has become riddled with random risks. Calculating and managing risks which nobody really knows has become one of our main preoccupations. That used to be a specialist job for actuaries, insurers and scientists. Now we all have to engage in it, with whatever rusty tools we can lay our hands on – sometimes the calculator, sometimes the astrology column. The basic question here is: how can we ignore it and possibly get hurt or killed? Or should we be alarmed and stop or exclude all likely causes? Which course of action is ‘rational’, the first or the second option? (Beck, 1998:12)

Indeed, what expectant mother disregards the possible threats, hazards and risk that are constantly highlighted as a threat to not only herself but that of her unborn child? Recent examples include the media coverage on studies such as child cancer being linked to exposure to environmental pollution while in the womb (BBC News, 2005) and separate research on the possibility of breast milk being toxic for newborn children because of exposure to various pollutants such as paint thinners, dry-cleaning fluids, wood preservatives, toilet deodorizers, cosmetic additives, gasoline by products, rocket fuel, termite poisons, fungicides and flame retardants (Williams, 2005).

Beyond these environmental risks women must also deal with hazards which extend as far as her emotional state. Lay childbirth literature as well as media reports highlight the effects of stress on not only the pregnant woman’s body but also that of the foetus and the ongoing effects into that child’s future health. These warnings are reminiscent of the Victorian era, when women were advised by medical experts and maternity handbooks to avoid strong emotions during pregnancy for fear of affecting
the health of the unborn child. More recently, a report has disclosed that high stress experienced by the expectant woman within her first trimester is connected to the development of high blood pressure in the life course of the unborn child (Tormey, 2005). Further research reported within *The Australian* states that stress is directly connected to miscarriages (McDonald, 2004). Although the article also highlights previous research that connects the majority of miscarriages to foetal abnormalities, it also reminds us that “how women feel and their mental states are as important as the fact they don’t smoke while pregnant” (McDonald, 2004.) Paradoxically, such exhortations to women to control their emotional states for the sake of their unborn child may indeed have a counter-productive effect, as Shuttleworth (1993/94: 38) argues they “necessarily engender the very state of emotional agitation that they are warning against”.

This thesis seeks to examine the ideological shift which Saunders, the author of the opening quote to this introduction, speaks of. *To inquire whether the recent phenomenon of women seeking out and indeed actively engaging with a medicalised birth stems from a shift in not only perceptions of risk, but also how a shift in responsibility, choice and control has impacted on the birthing women of Australian society.*

The emphasis of the thesis will not lie in debating whether or not there is an increase in medicalized pregnancies and births – the statistics reveal that story plainly enough. Of interest, rather, is the trend toward actively seeking and employing an overtly medical model of care for pregnancy and childbirth by many women. The
statistics reveal that unnecessary intervention is likely and to some extent unavoidable during hospital obstetrical care – the question is why is there an increase in the numbers of women who find comfort and security through this model?

Accordingly, this research will employ the work of theorists such as Anthony Giddens and Ulrich Beck who provide us with insight on the contours and existential parameters of life in what they term ‘late’ modernity or risk society. It will be argued within Chapter one that previous research into the area of childbirth, whilst clearly important in shedding a critical light upon childbirth practices, does nevertheless neglect some significant recent social changes. In this respect, the application of Beck and Giddens’ work to the area of sociology of reproduction might capture more adequately the ideological shift which this introduction speaks about. It will be argued, through the scrutinizing gaze of the public, that the pregnant woman is the least able to escape the consequences of risk society where changed notions of health and responsibility have created a cultural acceptance of medical intervention of childbirth.

Contents

The subsequent chapters discuss the cultural shift that is taking place for many birthing women of Australian urban society. The first chapter of the thesis provides the contextual framework for the research. The current crisis of pregnancy and childbirth within Australia are outlined with an emphasis on questioning how some meanings of pregnancy and childbirth come to function as official definitions with a majority embracing that definition, and importantly question who is defining the risks that surround the event and how they are doing so (Reiger, 1999).
Chapter two provides an overview of the history of maternity services within Australia as well as providing a timeline for the recent indemnity crisis. Here it is argued that the medicalisation of pregnancy was achieved over time, more through ideological claims to greater medical expertise (Oakley, 1980), than through any demonstrable benefits to women. There is a further emphasis that the medical system, in the person of obstetricians, deliberately set out to frighten women, by exaggerating the dangers of childbirth, into believing that a medical environment was necessary for a successful pregnancy and birth (Donnison, 1977). This chapter concludes with an overview of the medical indemnity crisis that arose within Australia in mid to late 2001. A defensive medical culture and diminishment of choices in relation to primary care giver and birthing environment for the women of Australia are examined as consequences of the crisis. In essence the chapter portrays the emergence and maintenance of a ‘risk society’ within maternity services and practices.

The Methodology chapter follows. Ulrich Beck’s ‘risk society’ thesis is employed as a possible explanatory tool for the cultural shift which has been outlined. However, sociological knowledge about ‘risk society’ as an explanatory framework for the escalation of medicalised pregnancies and births remains under-developed because it lacks empirical evidence related to the ways that individuals respond to and deal with risks on the everyday and intimate level. Indeed, as Alexander (1996: 134) has contended of Beck’s work: “Broad tendential speculations are advanced about infrastructural and organizational processes that have little grounding in the actual processes of institutional and everyday life”.

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The empirical testing of the risk society thesis, neglected by its founder, has nevertheless been undertaken by various authors. For instance, I have previously explored the notion of risk society and ontological security within an analysis of postmodern religion/spiritualities (Possamai-Inesedy, 2002). Tulloch and Lupton (2003) examined the ubiquitous nature of the risk society and its impact in Australian and English society. The current thesis investigates women’s approach to pregnancy and childbirth empirically using a qualitative ‘multimethod’ study (Morgan, 1998). The methods used were a thematic textual review of pregnancy and birth lay texts, and 45 birth narratives (Zadoroznyj, 1999) stemming from in-depth interviews with women who had just recently given birth. These data were analysed using an iterative process which utilised coding for the purpose of theory generation (Miles and Huberman, 1994).

The use of multiple methods of data collection and an iterative analysis are the defining characteristics and strength of this research. The use of multiple methods “overcomes some of the limitations of each method and permits a comparison” of findings (Rice and Ezzy, 1999: 89). Furthermore, each method provides a different perspective on the phenomenon being studied and thus facilitates a complex and descriptively rich interpretation (Morgan, 1997).

Chapter four is an exploration of the theory that underpins this thesis. This Chapter examines the sociology of risk employing the work of both Beck and Giddens, with primary emphasis given to the work of Ulrich Beck. There are three major themes
that infuse the work of Beck – these include his risk society thesis, reflexive modernization and individualization. All three components are central to the research at hand. This particular chapter provides an overview of these areas as well as a cursory examination of the various approaches to the analysis of risk environments in contemporary society. The aim is to explore some of the issues that concern the relationship between risk and society – the ramifications of this form of society on its inhabitants and specifically in relation to its impact on those experiencing pregnancy and childbirth.

Chapter five is the first of three chapters which formally presents the empirical basis of the research. These chapters examine the accounts of the women of this research and explore the impact that risk has played in their pregnancies and childbirth. The chapters are presented in chronological order, from preconception to the eventual birth of the child. Chapter five addresses how risk impacted on preconception and early pregnancy practices. Chapter six emphasises the consequences of risk society, with a stress on individualization, on the decisions made during pregnancy relating to prenatal screening and testing.

The final chapter of the three examines the narratives of the respondents and their expressed experiences of labour and birth. Within Chapter seven, there is an emphasis on the agency of women who accept medical management during their labour and births, an element that is missing from the critique of medicalisation. Indeed, the central component of the medicalisation critique is the consequence of the power imbalance that is characteristic of the doctor-patient relationship, namely the
loss of control and disempowerment for the birthing woman (Fox and Worts, 1999). Accordingly, the chapter examines concepts such as control, trust and responsibility.

Chapter eight provides an analysis of the most cited, by the respondents of this research, pregnancy and childbirth self-help text: *What to Expect When You’re Expecting* (Murkoff et al., 2003). It is argued that in addition to the increasingly reflexive nature of modern social life and the salience of risk, living within the confines of high modernity, becomes a socially mediated experience; one in which the media and systems of mass communications play a key role. From the news coverage to advice on healthy lifestyles, people are continually bombarded with media messages; processes which have a crucial bearing upon the knowledgeability and reflexivity of the lay populace in contemporary Western societies.

Almost two decades ago, Barbara Katz Rothman observed that many North American women “take pregnancy as a reading assignment” (1986: 45). Rothman’s sentiment is readily observable within the many respondents that I have interviewed, as will be demonstrated within Chapter five. This along with the abundance of literature in the form of magazines, pamphlets and books available for the expectant woman or couple upholds this claim.

This particular chapter attempts to analyse the role that pregnancy and childbirth self-help literature plays in defining risk knowledges for its audience. It argues that the accessibility of knowledge, within a risk society, of the various risks that women face during their pregnancy and birth opens up not only more spheres of action on their
part, but also creates new types of risks as well. The expectant woman now has decisions to make with consequences for not only herself but also that of her unborn child. The argument will be put forward that one consequence of living in a society where more and better knowledge is available, knowledge which most people assess in unreservedly positive terms, is the proliferation of new risks (Beck, 2000b). Because we know more about how the body operates during pregnancy and childbirth as well as how the foetus develops we create not only more spheres of action and creation of risks as discussed above, but also more spheres of responsibility.

The fact that there is an increasing number of women who not only feel positive but also actively engage with a medicalised birth is the driving force behind the research at hand where there is an attempt to empirically test the risk society thesis through an investigation of Australian women’s pregnancy and birthing practices.
CHAPTER ONE:

THE CURRENT CRISIS IN CHILDBIRTH WITHIN AUSTRALIA

Whatever else a culture does or does not do, if it wishes to reproduce itself, it must produce new members. Because cultural reproduction depends upon human reproduction, questions of childbearing are invariably significant in the life of a culture, and significant changes in childbearing patterns often signal broad cultural change. (Treichler, 1990: 113)

It can be argued that the cultural context within which women experience pregnancy and birth reveals much about the society’s core values (Davis-Floyd, 1994), about the playing out of the various power relationships between the various types of birth attendants (Ehenreich & English, 1973; Willis, 1983; Annandale, 1988) and about the power position of the birthing woman herself (Oakley, 1980; Rothman, 1986). In Australian society, childbirth has become a medical event where the age of the consumer and the environment of fear of litigation have led to an unprecedentedly high intervention rate.

This is reflected in the most recent report (NHMRC, 2001) on maternal deaths in Australia published by the National Health and Medical Research Council (NHMRC) and the Australian Institute of Health and Welfare (AIHW). The report, the 11th in the series, was based on statistics derived from 1994-96. There were 102 deaths reported to the Advisory Committee, of which 100 deaths satisfied the definition of maternal deaths\(^1\) during pregnancy and the puerperium. This presented an increase of 19% in the number of deaths compared with the 1991-93 triennium, and a reversal of
the trend of declining maternal deaths seen over the previous 15 years (NHMRC, 2001).

The report, which was released on the 21\textsuperscript{st} of September 2001, expresses concern for this rise in maternal deaths, especially the number of direct deaths, the category of deaths resulting from obstetric complications of the pregnant state (of the 100, there were 46 direct, 20 indirect and 34 incidental). The reason for this increase is not clear\textsuperscript{2} with the report claiming that it is difficult to determine if the results indicate the beginning of a new trend or are just a normal statistical fluctuation of a very rare event, a maternal death. However, in a recent interview, Professor Lesley Barclay (NHMRC representative) stated:

> The safest thing is for women to give birth with little intervention […]. At each stage of intervention you slightly increase the risk of complications. For example, if a woman is induced she’s more likely to have an epidural for pain relief because of sudden contractions, and in turn she’s more likely to have a caesarean. (Steyn, 2001: 43)

Barclay continues, “[…] we should think twice before performing elective Caesareans on healthy women with straightforward pregnancies. And also look at whether doctors intervene too hastily during labour, practicing defensive medicine for fear of being sued” (ibid.). Here, Barclay may be commenting on the fact that of the 66 direct and indirect deaths investigated, the majority were related to blood clots on the lung and the leaking of amniotic fluid- both complications associated with caesarean birth.
Barclay’s comment closely aligns itself with the recommendations put forth by a recent Senate Community Affairs References Committee’s Inquiry into Childbirth Procedures (Commonwealth of Australia, 1999) and with the World Health Organisations (WHO) principles of perinatal care (Chalmers, Mangiaterra and Porter, 2001). Both reports suggest that unnecessary medical intervention and overuse of technology during perinatal care continue to be practiced widely despite the acceptance of evidence-based principles and care. Of the various points listed within the two reports, many are identical including; reduction of Caesarean Section (CS) rates, care for normal pregnancy and that birth should be demedicalized, should be multidisciplinary, and should be based on the use of appropriate technology.¹

In fact, prior to the Senate Inquiry into Childbirth Procedures (Commonwealth of Australia, 1999) five other comprehensive reviews of maternity services in Australia have made repeated calls that bring into question the medical hegemony that govern childbirth. Key recurrent themes have been echoed in these reviews since the Shearman report, a ministerial review of obstetric services in New South Wales, which was completed in 1989. The Shearman (1989) report identified that the obstetric services system was failing to effectively use the skills of general practitioners and midwives in the care of women who have low to moderate risk factors in their pregnancy and recommended that additional shared care arrangements involving general practitioners and midwives in the provision of antenatal care be introduced in metropolitan and selected rural hospitals. These included the introduction of midwives’ clinics, appointment of visiting midwives (independent midwives) to public hospitals and an accreditation process for practitioners to provide antenatal care.
However, regardless of these recommendations, childbirth practices in Australia remain predominantly hospital and medically centred. The Senate Committee Report (Commonwealth of Australia, 1999) revealed high medical intervention for pregnant women in Australia. Some of the interventions performed during childbirth were minimal, however the Committee report disclosed that close to 90% of all births in Australia include some form of intervention. This fact is mirrored in the most recent publication of *Australia’s Mothers & Babies* (Laws & Sullivan, 2004). This particular release of national perinatal statistics revealed that nationally there were 63,448 CS performed in 2001. This demonstrates a continuation of the steady trend of the last 10 years continuing with the proportion of women having CS now at 25.4% compared with the 18% recorded in the 1992 statistics. There are of course variations from State to State and between the public and private sectors (Roberts et al., 2000). Furthermore, the report disclosed that CS rates also increase with age. The statistics reveal that CS rates ranged from 146.5 per 1,000 confinements in mothers aged less than 20 years to 395.9 per 1,000 confinements of mothers aged 40 and over (Laws & Sullivan, 2004: 28). Considering that the report also highlighted the average age of first time mothers was rising to age of 29.2 years, this most likely indicates a continuation of the trend. Many explanations have been advanced, including better survival prospects for very preterm infants; the threat of litigation leading to earlier intervention in labour, and the subsequent cascade of intervention; fewer operative vaginal deliveries; and routine abdominal delivery for breech presentation. The widespread use of electronic foetal monitoring and epidural analgesia, and the need for repeat CS, have also been presented as evidence. Conversely, there is also evidence emerging that non-obstetric factors may contribute
to the high CS rates; for example, by the woman’s demand or request for the procedure (Mould, Chong, Spencer, Gallivan, 1996; Wilkinson, McIlwaine, Boulton-Jones, Cole, 1998; Graham, Hundley, McCheyne et al., 1999; Quinlivan, Petersen, Nichols, 1999; Turnbull, Wilkinson, Yaser et al., 1999).

With the release of the Senate Committee’s Inquiry Report childbirth has moved beyond the various academic reports available and from the confinement of women’s magazines and parenting magazines to the more mainstream public domain. It is presented on television, radio and in the press as a subject about which we should all be concerned. Newspaper articles such as “Attempts to reduce Caesareans ‘doomed’” (Robotham, 2001a); “Home births in peril as midwives lose insurance cover” (Robotham, 2001b); “It’s not all plain Sailing for Water Babies” (Stuttaford, 2005); “Too much to bear; What happens when a world renowned feminist becomes a mother” (Viner, 2001); “Caesarean births reach record level” (Kearney, 2002); “Express Delivery: Is Nature’s Way of Giving Birth Becoming Obsolete?” (Hamilton, 2003) and “Why Mums are Turning their Backs on Nature” (Picard, 2001) – with stories about pop stars and other celebrities who opted for elective Caesareans. The same theme was duplicated within the radio and television medium. Lateline released a program at the end of 1999 on “should women be able to choose a caesarean?” A similar program was available through A Current Affair in 2001 and 2002. In early December of 2003 the Today Show broadcast the birth of the 20 millionth citizen of Australia. Of course the filming of a birth on a morning talk show must be timed effectively. The birth of Australia’s record-breaking citizen was by caesarean section.
Birth has also found a place in the political agenda, and is coming to be seen as integral to public health policy. Within the 2001 election campaign the Labor Party’s platforms discussed issues relating to safe and dependable maternity care. In particular, the Labor party platform called for a more holistic approach to maternity care with the call for professional indemnity for midwives. This pattern was repeated in the more recent 2004 election.

In here lies the crux of the problem; regardless of the governmental enquiries, subsequent recommendations, policy proposals within election campaigns, and the various media attention revolving around the issue of birth, the ‘medicalised birth’ is actively sought by women. As mentioned above the most recent Senate Inquiry into Childbirth Procedures in Australia (Commonwealth of Australia, 1999) concluded that close to 90% of all births involve some form of medical or surgical intervention to either initiate, alleviate, accelerate or complete the birth experience (1999: 119). The Senate Inquiry Committee in summarising the Australian intervention rates proposed that “many appear to be almost routinely undertaken without any scientific evidence of their benefits as against their costs, in terms of perinatal and maternal morbidity” (1999: 120). Australian birthing outcomes also directly contradict international evidence indicating that in any given culture approximately 80% of women are physiologically capable of giving birth without medical intervention (WHO, 1999).

These few examples of representations of birth within the public sphere such as the media and governmental inquiries and policy proposals provide us with an example
of the discourse that surrounds this issue. This thesis seeks to establish the social, institutional and discursive constructions, such as the contrasting meanings of risk and safety, choice and control and responsibility and care. We need to approach these patterned systems of discourse not only as simple messages but also as Lupton (1992: 145) states “the elements and influences in the discourse process as a whole”.

Therefore, this thesis seeks to move beyond the above mentioned evidence and seeks to examine the cultural influences which impact on birthing women. For birth is an intrinsically intense and socially important event which seems to draw out cultural understandings that are usually unspoken and implicit (Monto, 1997). As Kitzinger (1987) argues, in any society the way a woman gives birth and the kind of care given to her and the baby points as sharply as an arrowhead to the key values of the culture.

**Cultural influences on the pregnant and birthing woman**

Accordingly, we must ask ourselves what cultural influences within Australia are impacting on women in this way? Why do the vast majority of women within western societies, and of interest here Australia, not only experience a medicalised birth, but seek one out? As argued, constant recommendations on the de-medicalisation of birth have been put forth within Australia since 1989 with the publication of the Shearman report. Yet, when we look beyond the various advances made, we find that there is a crisis affecting maternity care within Australia. Defensive medicine practices, CS rates and medical defence premiums are increasing. New options for the care of pregnant women (eg. birthing units) may fail because midwives, general practitioners and smaller hospitals may be unable to afford
adequate insurance to continue their services. A closer examination of the link between defensive medicine, litigation fears and medicalized pregnancies and birth will be examined in chapter two. The following section provides insight into some of the problems faced in applying previous research into the field of childbirth to the current practices of birthing women within Australia.

Georgie’s birth stories

Georgie is the mother of two girls, both of whom were born through the private system with a private obstetrician that was chosen through the advice of an aunt who works within the medical field. Although she did not have any clear ideas or desires about the qualities she wanted in a primary carer, Georgie developed a strong trust in her obstetrician, often referring to him as ‘my man’. Throughout her pregnancy Georgie read various books but most of her information was from Murkoff et al.’s (2003) text *What to Expect When You’re Expecting*. She attended prenatal classes with her husband which she found useful, but more so in relation to familiarising herself with the hospital and its services as well as providing a locale to meet new friends. Throughout her interview Georgie discussed both of her pregnancies and births. The following is a representation of her two birth stories.

Anyone who conducts qualitative research will attest to the uniqueness of individual interactions with respondents. Although an interview schedule is developed with a specific structure in mind, interviews often take the form of conversations and develop a life of their own. This was particularly the case with Georgie who spoke at length about her experiences, with little provocation needed from the researcher.
Quite early within the interview Georgie began to discuss the birth of her first child and her feelings, regardless of the reading she had done and classes she had attended, of how nothing could prepare her for labour and birth:

It’s all so different. It might have been good for a couple of people [the classes], but for me, I didn’t really get to use anything, because when my contractions start, and it happened both times, they start at every second minute. So I got to the hospital as soon as I could both times, to get an epidural. The first time I got it, it was pretty much, it must have been within half an hour, 45 minutes, I think. So I only had that short time.

A: So how did you find the epidural, did it help you, did it take away the pain, or?

G: Yeah, it was very good. They had to top it up, because it started to get a little bit more, I could feel it, and the midwife came in and said ‘oh, you were breathing a bit then, is it wearing off, would you like a bit more?’, and I said ‘oh yes please!’ so that was good. Actually it was quite strong when they wanted me to push, and of course you can’t really feel anything, you don’t know that you’re ready, they tell you you’re ready. I had to have the drug to induce it a bit more, to bring it on, so that she could be delivered, she was forceps in the end. Because you don’t really know, and you can’t feel, you’re just doing what you’re told. My Aunt arrived, but she got there after I had my epidural, so she missed all the chaos at the beginning. It was actually quite good, she brought some mints, and I had my bag of lollies and stuff and we were having a party. It was quite festive actually.

A: Through your labour?

G: Yes, it was quite relaxing, it was like a party atmosphere and we were up all night, having a chat. I think it’s the first night in my life where I’ve been up all night with no sleep. Anyway, with the epidural I did actually feel the birth. I said to him [the obstetrician], I didn’t feel when he cut me with the episiotomy, my husband said there was blood everywhere, he said it was awful, but I didn’t feel that. I was pushing, not knowing what I was doing. I couldn't feel pushing, and he was pulling with the forceps. My husband said he was pulling, pulling, pulling. I felt something, and I said, ‘I felt something then, what happened’, and he said ‘oh your baby’s been born, you can look down’. Her head was out, and I said ‘oh’, and I think the rest of her came without too much drama.

It is evident that the labour and birth of Georgie’s first child involved unnecessary medical intervention. The cascade of intervention which began with the administration of an epidural led to the need to administer syntocin as well as an episiotomy and forceps delivery. Yet, far from being upset about circumstances which, according to recent literature, should have left her feeling alienated from the
birthing experience, Georgie expressed sentiments of satisfaction. This became clearer when she discussed the birth of her second child.

I was wanting an epidural, because I’m all for drugs, but it was the same thing. My waters break, a little bit of nothingness, and then the contractions start at 2 minutes. I got to the hospital and I was already 7 centimetres, and I said to her ‘I want an epidural’, and she said ‘we’ll get the anaesthetist, I’ll call him in for you, but he might not make it in time’. She was preparing me, I had prepared myself before, I knew with the first time, because it started out so quickly, that I might find myself in a bit of trouble. So I knew. I was saying ‘I want an epidural, I want an epidural’, but I knew all along that there was a chance I mightn’t get one, and it happened. I got to the hospital at 11 o’clock when I walked in the door, and I thought they would have an anaesthetist somewhere within the hospital, that they could just pull out, that there’d be one on the ready within 5 minutes. It was 11 o’clock in the morning. So I thought, the last one was at night, he took half an hour to come, and I kept saying ‘where’s that bloody anaesthetist’, but I thought in the day time they’d have one there, but that wasn’t the case, she said he’ll be at least half an hour, and he might not make it. I thought ‘oh my god’, so she’s getting me ready, I wanted to have the spa, but I missed out on that the first time, and I wanted to have it the second time, but I missed out on it again.

I didn’t want to have pethidine, because I know it can be put through the placenta, I don’t know about an epidural, I’ve heard both, I thought it wasn’t meant to go through, but apparently it does. My cousin drove from Wollongong that morning and she just made it with 15 minutes to spare, and I said ‘I can’t believe I’m doing it without drugs,’ and she said ‘I can’t believe I’m doing this without drugs’. But I said to them ‘maybe I should have some pethidine,’ because I knew it was getting close. She said ‘oh, you’re 9 centimetres now’, and when I said to her, because I was worried about what it was going to be like, and I said ‘can I have some pethidine?’ She said ‘look it’s too late for pethidine now’. I didn’t realize it takes 15 minutes or something to have an effect, and she said ‘I don’t think you’ll make pethidine either, now.’ I thought ‘oh my god’, so I just had the gas.

A: So what were you feeling apprehensive about?

G: Because I hadn’t had it natural the first time, I didn’t know really what it was like, and you hear that it’s the most painful thing in your life ever. And it’s sort of ‘oh Jesus, I don’t know if I really want to have the pain, too much’. But actually, in the end, when I think about it, it wasn’t as bad as I thought it was going to be. I don’t know if I’m just that kind of person that has births that are a natural one that’s not as bad as what somebody else could have. But it wasn’t really as bad. No, I remember it all quite clearly cause I actually felt, she said ‘have you felt any pressure in your bottom’, and I was, the doctor wasn’t here yet, and I was denying, I knew within myself that I had felt pressure before I’d left the house, and it’s sort of ‘oh no, no, that’s fine’. It got to the stage and I was in transition and I hadn’t thrown up, and I remembered in the class they tell you, when you throw up that’s really good, because it’s happening, and I hadn’t thrown up, but I had felt just a tiny little bit of a heave and bit nauseas, and I thought, I knew then exactly what was happening. So I had the bowl, and that’s when my cousin came in, a bit after that, and she said ‘are you feeling a bit of pressure now’, and I said ‘just a little bit’. She asked me a couple of times and I still said ‘no’, but towards the end, when I knew, and I said ‘is the doctor coming, I think he’d better get here now’ because I knew I couldn’t hold off any longer, and I was breathing like hell on the gas. I was literally holding my legs together, pressing down hard on my feet, my right foot was over my left foot, and I was pressing down like this, on my feet with each contraction, trying to hold her in, waiting for the doctor to come. And then he came and the midwife said ‘if you push once that will make you feel more comfortable, it will move her down the birth canal’,
which I didn’t know. So I pushed once, and I did, I felt more comfortable, which was strange, because it’s sort of, how can you feel comfortable when you’re in labour? It was weird, but she was right, so that was good. And then the doctor was there, and we’re ready to push now, and I think everything happened a lot quicker than what he thought too, because with the second push she was there, her head and one shoulder were out. He didn’t have his gloves on, and he’s saying ‘just wait, wait, wait’. I was so busy concentrating on pushing I didn’t know what was going on, and she said ‘pant, pant,’ and she’s showing me what to do, and I said ‘oh, okay’. Zane, my husband, was on the other side, but it wasn’t until she told me to stop pushing that I realized what to do. The doctor decided he’d better put his gloves on now. And then the next one she was out, so it only took 3 pushes, I got to the hospital at 11 o’clock, and she was born at 11.45.

It is apparent from the above extraction that Georgie not only trusted her obstetrician but also derived a great sense of security by his presence – to the extent that she was attempting to not give birth in his absence. Furthermore, she felt she had the right to choose and demand certain forms of intervention. Although she expressed knowledge of the possible implications of pharmaceutical aid during labour this did not stop her from requesting it. Her fear of the pain involved in the last stage of labour overrode the possible complications she was aware of. This was most likely aided by her trust in science and medicine that she expressed throughout the interview. As presented, she did not end up with an epidural or pethidine; this was not due to the midwives rejecting her requests, rather it appears to be due to the anaesthetist not arriving on time as well as the speed of the actual labour. Another matter of interest was Georgie’s sentiments of dissatisfaction with this birth in comparison to her first. Although this birth occurred within a hospital setting in conjunction with the aid of gas to diminish the pain of contractions, it did not involve the amount of medical intervention that the birth of her first child did.

A: So comparing the two births, how do you feel about the two, which do you feel was a better experience for you?

G: Basically I think the epidural was good, in that everything was so calm and party like in the room, and we were really happy, and oh, okay we’ll have the baby now, and it was all quite civilized. Whereas the second one was a lot quicker, but it was just hell and chaos from one end to the other, because it was contractions every two, three minutes.
Georgie’s sentiments reflect those of the private birth mothers, this particular group represents all of the respondents of this research who chose a private obstetrician as a primary carer as well as a private hospital for their birthing environment. Of course, the respondents tell different stories, with different emphases; these differences will be discussed thoroughly within Chapters five, six and seven. Nevertheless, these women all clearly trusted and felt secure with their primary carer, as well as with the institutions of science and medicine. Rather than feeling alienated by their experiences, they frequently expressed feelings of contentment within the interviews. There was also a demonstration of the need for control, over their own birth experience as well as control of their bodies. When reviewing their birth narratives, it slowly became clear that previous research was largely silent on these matters, and provided limited explanatory power.

The never ending research trail

*How informed can our choices be when the information we receive reflects only one way, the technomedical way, of looking at the world and at our bodies? From the new genetic model of medicine now taking hold to the older germ theory of disease, this technomedical approach is mechanizing, fragmenting, deconstructive, and expensive, and its widespread cultural credibility, while opening new options, is closing down others at a rapid pace.* (Davis-Floyd, 2000:277-278)

Research within the area of childbirth is extensive, stemming from a wide array of fields including anthropology, feminist studies, sociology, philosophy, psychology, social work and health policy, midwifery led research as well as obstetric literature. Yet, many of the accounts presented are polarised. This was again brought to attention with the recent review of maternity services in Queensland (Hirst, 2005). The report disclosed that many maternity care environments are characterised by conflict. Hirst categorises the conflict into two distinct cultures: the organic, where
there is a call for less interventionist and more humanistic models of care and the mechanic culture that stresses the need for the medical model. Here pregnancy and birth are seen as inherently risky and laden with unforeseeable consequences that only the medical model could cater for. These cultures have been apparent for decades with both vying for dominance in the field. Yet it is the medical model which is prominent. Medical hegemony in maternity care exists despite the evidence which consistently finds that maternal mortality and morbidity rates are much higher when obstetric interventions are used (Tew, 1998).

The mechanic approach, which sees birth as a pathological event, is often counterposed to the more humanistic or holistic experiential interpretation of birth as a natural process. What is clear from the bulk of the literature is that the medical or technological approach to childbirth proposed by modern obstetrics has dominated the social practices associated with birthing to the point that they have become firmly entrenched into this particular stage of life. This was clearly demonstrated in the case of Georgie with her desire to only give birth with her obstetrician present. When asked toward the end of the interview why this was so important to her, Georgie replied that whilst she liked her midwives, they would not have been able to help her if an emergency arose.

It is also quite evident that the dominance of modern obstetrics is highly gendered as well as implicated in class and race associations (Nelson, 1983). The theoretical chapter (Chapter four) of this thesis will argue that the critical analysis of a field which is characterized by its contestation over definitions, knowledges and power
struggles, as demonstrated in the recent Queensland Maternity Services Review (Hirst, 2005), can be more thoroughly understood with the employment of the risk society thesis.

When attempting to understand the current pregnancy and birthing practices of the respondents of this study, existing literature provided useful but limited information. For instance, Reiger (1999) presents a comprehensive overview of various feminist approaches to the area of childbirth. She argues that most feminist analyses centre on the historical project of the domination of the medical model of birth and its corresponding effects. Reiger argues that within the literature there is an overarching tendency to place women into an undifferentiated category of being under the authority of the male obstetrician. This is readily seen in the works of Ehrenreich and English (1973), Donnison (1977) in her work on *Midwives and Medical Men* and Rothman (1982). Yet there are others who have concentrated on the necessity, for the takeover of birth, of the abolition and or domination of the midwifery profession. Arms (1975) work *Immaculate Deception: a New Look at Women and Childbirth in America* is a good example of this approach. Further research, such as Tew’s (1990) *Safer Childbirth?*, explores the hegemonic domination of the medical model of birth, often drawing attention to the exaggerated claims of medical science.

Social and Marxist feminists have offered important critiques of the uneven distribution of maternity services and the problems of policy formation within capitalist societies (Garcia et al, 1990; Taylor, 1979). Moving toward the social sciences, there are numerous accounts of research which provide us with accounts of
women’s reproductive experiences (Oakley, 1980; Rothman, 1982; Crouch & Manderson, 1993; Brown et al, 1994). Within this abundance of literature is also the political tradition of women’s activism which has asserted the rights of women, arguing for improved maternity care (Ruddick, 1989; Belenky, 1987; Reiger, 1999b; 2001).

Anthropological accounts of birth in other cultures demonstrate a wide variety of potential understandings and definitions of birth. Bates and Turner (1985) argue that the symbols of birth in so-called ‘traditional cultures’ bind the woman’s individual experiences with a culturally meaningful set of beliefs, allowing her to labour not in isolation but in harmony with the rest of her society. Jordan (1993) contrasts birth in four cultures – the Yucatan, Holland, Sweden and the United States. Of particular interest are Jordan’s contrasts of birth in the three Western countries, which differ greatly despite being similarly modern, wealthy, and economically developed. Jordan contrasts the United States’ definition of birth as a medical procedure with Holland’s definition of birth as a natural process, and Sweden’s definition of birth as an extremely fulfilling personal achievement.

In an attempt to better understand the experiences and desires of the respondents of this research, an enquiry into the cultural themes or key values reflected in these birth practices is necessary. Australia aligns itself predominantly with the United States model of childbirth, that is it employs a medical model. What does this reflect about our key values? Rothman (1989) argues that they reflect three dominant cultural themes; capitalism, patriarchy and technology. Davis-Floyd (1992) argues that the
way we give birth in our society reflects a technological worldview. Martin (1989) argues that birth is managed according to a production metaphor in which women’s bodies are treated as machines: Arms (1975) also identifies a machine metaphor in U.S. birth practices. Monto (1997) argues that childbirth procedures can be related to the Weberian concept of rationality. She argues that birth in our society is governed by a highly bureaucratized set of procedures and policies, which, as in the Weberian understanding, are inflexible to particular individual needs and leave individuals feeling alienated from one another.

This particular approach is echoed within the work of Ritzer (2004) particularly his McDonaldization thesis. Although his work is not empirically directed toward childbirth, he does offer in both his first and second edition of *The McDonaldization of Society* an insight into childbirth practices. Ritzer sees the increasing control over childbirth being as manifested in the decline of midwifery, the increase of control by professional medicine, and the increase of the bureaucratization of childbirth. Ritzer claims that hospital chains and birthing centres have emerged, modelled after his paradigm for the rationalization process – the fast food restaurant. Although Ritzer is speaking about an American context, these statements can readily be applied to Australia. The McDonaldization of birth offers great insight into the main concerns of this research. Ritzer’s theory offers the explanations of control, predictability, efficiency, and calculability to a process that is expressed as being high risk by many medical experts.
In addition to these larger cultural themes, others have identified particular birth related themes. Armstrong and Feldman (1990) argue that birth in our society is treated as a ‘great emergency’. Arney (1982) argues that the obstetrical profession in the United States treats all births as potentially pathological and in need of constant surveillance.

While these alternative viewpoints influence the contemporary debate over childbirth practices, no single one can adequately grasp the complexities at play in the contestation of birth. Perceptions of risk, notions of trust and security in the medical establishment as well as control through that system are noticeably absent. Theorists such as Anthony Giddens (1991) and Ulrich Beck (1992) provide us with insight on the contours and existential parameters of life in what they term ‘late’ modernity or ‘risk society’. Previous research into the area of childbirth, whilst clearly important in shedding a critical light upon childbirth practices, does nevertheless neglect some important current social changes. In this respect, the application of Beck and Giddens work to the area of sociology of reproduction might capture more adequately the ideological shift which this thesis seeks to question.

Whilst due credit should be given to the above mentioned research into childbirth practices, what seems to be missing is any examination of the agency of women who seek medical intervention during pregnancy and childbirth. Much medical technology has no doubt been of physical benefit to women and their infants, particularly (in the case of the woman) in terms of pain relief, but this has been underemphasised in the literature, which is highly critical of hospital-based obstetric
practices. This view equates the increased use of technological intervention with a corresponding loss of women’s power and control over her child’s birth. The history of obstetrics then can be seen as the history of oppression of women by science and medicine. In many accounts (see Oakley, 1984) it is insinuated or stated that pregnancy and childbirth, prior to the advent of male medical control, was a safe, non-alienating and purely biological or physiological process; that women midwives and relatives attended in a purely supportive role - this romanticised version of childbirth can be seen in many fictional accounts, for instance the work of Anita Diamant (1998) in her acclaimed novel *The Red Tent*.

However, as alluded to in the review of the anthropological literature, childbirth is socially controlled in all societies. As Jordan (1993) found, far from women being in control, childbirth in the societies within which she conducted her fieldwork is invariably surrounded by a multiplicity of rules, customs, prescriptions and sanctions. For example, Jordan (1993) states that Maya women will only go into the hospital in extreme situations, and sometimes when it is already too late. A major reason for this opposition to hospitalised care during childbirth could be the attendance of young male physicians, the shame associated with genital exposure, the routine occurrence of episiotomies, and a separation from midwife and family. All of these factors violate the traditional assumptions about the proper management of birth to these women of the Yucatan (Jordan, 1993).

Given the obvious social and cultural factors involved in any birth experience, we should perhaps avoid speculating on issues of what childbirth was or might be like
outside of the controls of the technologies of reproduction. Rather, we should examine the social context in which the new reproductive technologies have developed and examine why the technologies take the form that they do. Further, we should attempt to understand the recent shift from avoidance to utilization of these technologies by the pregnant and birthing woman.

For the purpose of this thesis, I wish to acknowledge the above-mentioned themes of analysis, but will concentrate specifically, as does Davis-Floyd, on the technological aspects of medical intervention and their acceptance within our society. For Davis-Floyd (1992; 1994) and Davis-Floyd and Dumit (1998) the core value system of any particular society is visible in many areas of cultural life, yet it is nowhere more evident than in the treatment of the human body – especially when that body is giving birth to the next generation of social members. The future of a particular society, Davis-Floyd argues, depends not only on its physical continuation but also on the continuation of the belief system that shapes the way its members understand their social world. She classifies American society as a technocratic one which accordingly employs a technocratic model of birth. It is this technocratic hegemonic model which functions as a powerful agent of social control, shaping and channelling individual values, beliefs and behaviours.

Davis-Floyd’s analysis of what she calls the technocratic birth within American society is based on the work of Rothman (1982) and Martin (1989). Rothman’s comparison of the medical and midwifery models of birth supply much of the basis to Davis-Floyd’s work and parallels Martin’s analysis of medical metaphors and
reproductive imagery. Davis-Floyd’s earlier work (1987a, 1987b, 1990) viewed birth as a ‘technological model of birth’. It is only in her later work that she narrows this overly broad label to that of a technocratic model of birth. Inspired by the work of Reynolds (1991) who used technocracy to imply the use of an ideology of technological progress as a source of political power, Davis-Floyd based her work on the definition of “management of society by technical experts” (1992: 319). It is this label that offers much to the current research. For it is obvious that within Australian society birth is similarly defined by its management by technical experts, and hence the hegemony of the technocratic model extends into the cultural treatment of birth. What should be highlighted is that a medical definition and approach to pregnancy and childbirth is inevitable once a social group follows a path that rewards technological definitions of human functioning, adopts a managerial approach to healing, and institutionalizes practices based on fear and risk.

Whilst Davis-Floyd has contributed much to our understanding of the ‘technocratic birth’ and has provided the reader with an outline of the differing cultural models for women’s birth choices, this thesis seeks to address the larger cultural contexts which surround the process of birth. Her models of the technocratic body and the organic body models for women’s birth choices builds on the work of Martin (1989) who demonstrated that middle and working class American women hold contrasting images of the body and of birth that centre around the issue of control. Interestingly, in Martins’ (1989, 1990) study the middle class women sought control over their birth by wresting it away from the medical establishment. This particular population of women sought not only control over their choice of birthing environment and primary carer but also that of themselves as they laboured and gave birth. In the meantime,
the working class population in this study rejected the ‘middle class’ notions of control.

Paradoxically, Davis-Floyd found that women, rather than resenting and resisting the increasing number of impersonal intrusions of technology into birth and consequent loss of power (according to researchers such as Arms, 1975; Haire, 1977), were actually embracing technological intervention. It was found that 70 women of the 100 that were interviewed by Davis-Floyd were comfortable with their highly technologised obstetrical experiences, and were not interested in resistance. Of these 70, it was found that 9 seemed to have especially sought out and were personally empowered by the technocratic interventions in their birth. Significantly, these nine women were all high-powered professionals in positions of prestige and authority: when they hired an obstetrician they were hiring another professional to perform a service. As Davis-Floyd (1994: 1128) notes:

They seemed to see technology as integral to all areas of American life, and they fully expected that the very best in the modern technology of the body would be brought to bear on their pregnant bodies and the babies within them in order to ensure that their births were competently managed and controlled and therefore safe.

Davis-Floyd’s respondents, as well as many of the respondents of this research, are turning toward the ‘safety’ of a technologically dominated pregnancy and birth in what Ritzer might call the “irrationality of rationality” (2004: 134). Here Ritzer (2004) argues that the pursuit of rational systems can lead to inefficiency, unpredictability, incalculability and loss of control. For although the media generates many messages about the safety of medicine and technology there are also numerous accounts of how too much technology can bear negatively onto the mother and her baby. If we think back to Professor Lesley Barclay’s earlier comment that “ [t]he
safest thing is for women to give birth with little intervention […] at each stage of intervention you slightly increase the risk of complication” (Steyn, 2001: 43) - this could well lead to the unpredictable outcome that Ritzer speaks of. We could conclude from Barclay’s opinion that interventions such as induction or a Caesarean Section (CS) for non medical reasons should be avoided at all costs, however, as Davis-Floyd found in her research and what can be argued to be the situation for many Australian mothers – this is far from the case.

The innovative quality of Davis-Floyd’s (1994) work was the realisation that rather than the women seeing themselves as passive victims of technocracy, all were active agents in their birthgiving. Although many women find value in the ideal of surrendering to the natural process of childbirth, this particular group of women experience the hospital and its technology as a liberation from the tyranny of biology, as empowering them to stay in control of an ‘out of control’ biological experience. This was clearly demonstrated by many of the private birth mother respondents of this research and was clearly indicated within the introductory case study of Georgie. Georgie expressed a preference for a birth and labour that was pharmaceutically controlled and thus more ‘civilized’.

Davis-Floyd’s work provides a basis to move beyond the literature which has been analysing childbirth practices within developed and developing countries since the 1960’s. She demonstrates a break away from the dichotomy of medicalisation and consumerism which is present in most literature. The present thesis seeks to continue with this break from dichotomous thinking with the aid of the risk society thesis.
As demonstrated, research into the field of reproduction is vast, particularly over the last three decades. The following section reduces this broad range of sociological inquiry into the categories of medicalisation and consumerism. Prior to this, there will be a further examination of Martin’s (1989) concept of the ‘faulty body’. These areas contribute a great deal to the research at hand, but as stated above these particular perspectives neglect certain aspects of the consequences of living within a reflexive modernity. The notion of the faulty body is one that was often expressed by many of the respondents of this research. Furthermore, a closer scrutiny of the medicalisation critique as well as the consumerism approach, which begins to explore notions of agency, is necessary.

**The Risky Body: The womb is a dark and dangerous place**

*Pregnancy and childbirth are rife with hazards. (Brody, 2002)*

The technocratic model views the female body as abnormal, as inherently faulty, unpredictable and full of hazards. During pregnancy and birth, the unusual demands placed on the female body render it constantly at risk. This belief is often reflected within obstetrical literature. There are numerous accounts by anthropologists and sociologists alike on the thorough job the medical system has done in convincing women of the defectiveness and dangers inherent in their specifically female functions (Corea, 1985; Ehrenreich and English, 1973; Mendelsohn, 1981; Oakley, 1984; Martin, 1989; Lay, Gurak, Gravon and Mynitti, 2000).
Within Australia, current provisions of maternity services is dominated by a hospital based obstetric model which sees birth as a pathological condition to be controlled. The argument that there is a climate of fear which pervades Western society is further illustrated by the view that birth is a pathological condition fraught with pain and danger. Take for example the words of the late Joseph Fletcher, professor of medical ethics at the University of Virginia School of Medicine: “The womb is a dark and dangerous place, a hazardous environment” (cited in Rifkin, 2002). These words began the Guardian article on the creation of the artificial womb from Cornell University’s Weill Medical College (Rifkin, 2002). The artificial womb lining which has been designed for the purposes of infertile couples has the potential to facilitate genetic corrections and modifications- creating designer babies, where mothers could spare themselves the rigours and inconveniences of pregnancy, retain their youthful figures, avoid the dangers that lurk in all pregnancies and births and bring the baby home when it is ‘done’ (Rifkin, 2002). Although the technology is designed for the infertile woman, Fletcher’s emphasis on the faulty body and the dangers and negative consequences of pregnancy and childbirth are aimed at all women.

This example highlights the view of the medical model, which, as outlined, seems to dominate the event of pregnancy and childbirth within Western societies. The model assumes that the body is inherently faulty, even in ostensibly ‘low-risk cases’. To use the language of risk within the setting of reproduction is an interest in itself. As the social anthropologist Mary Douglas (1992) has argued, risk is not a neutral term. Doctors do not talk about a ‘good’ risk. The term is used negatively- and with negative consequences for women.
To understand the medical treatment of birth, and its consequent view of the ‘faulty’ body, we must recognise that in the development of western thought and medicine the body came to be viewed as a machine (Martin, 1989). The origins of this particular metaphor began in the 17th and 18th century, however it is argued that it still dominates obstetric practice today. This is an example of our readiness to apply technology to birth and for the initial intervention in the process. As Rothman (1986: 34) points out:

The Cartesian model of the body as a machine operates to make the physician a technician or mechanic. The body breaks down and needs repair; it can be repaired in the hospital as a car is in the shop; once ‘fixed’, a person can be returned to the community.

Though there are some who would argue that the metaphor of the body as a machine is too simplistic, it allows us to understand the view of the ‘faulty’ body and the corresponding language of ‘risk’ which seems to dominate discourse surrounding childbirth. In the case of childbirth it is argued that the imposition of a risk category on all women acts as a form of micro-social regulation bringing about acquiescence to medical intervention (Lupton, 1999). It is true that the majority of women are classified as medically low-risk cases, but the very term ‘risk’ implies the probability of mischance. Douglas (1992) argues that the term ‘risk’ has a forensic dimension. It is either employed retrospectively to explain a misfortune or it is used to forewarn of immanant disaster. The rhetoric of risk is further augmented within maternity discourse. Unfavourable events are not only seen as inevitable, but their timing seems to be capricious and unpredictable. Accordingly, all women are subject to obstetric control and surveillance, for all women are deemed to be at risk (Lane, 1995).
When attempting to understand the rate of medical intervention during pregnancy and childbirth we need to study the effect of technology. However, it is difficult to see how our current scientific ideas are infused by cultural assumptions; it is easier to see how scientific ideas from the past or from other cultures might have been or are affected by cultural ideas (Martin, 1989). In other words, it is difficult as a sociologist to find an objective stand from which to view what is happening. As a researcher I can see how solidly entrenched my cultural presuppositions are and how difficult it is to dig them up for inspection. Berger and Luckman (1979) have expressed this problem as trying to push a bus in which you are riding.

Within this thesis, as highlighted previously, there is an attempt to convey a sense of those underlying cultural assumptions about the events of pregnancy and birth, a sense of their implicit meanings. As Brigette Jordan (1993) points out, childbirth is an intimate and complex transaction whose topic is physiological and whose language is cultural.

Accordingly, the physiological and the cultural must be considered together for any holistic analysis of birth. When examining births cross-culturally we find that there is no known society where birth is treated by the people involved as a merely physiological function. On the contrary, it is everywhere socially marked and shaped.

As stated above anthropological literature in relation to childbirth reveals cross-cultural evidence that birth is universally treated as a marked life crisis event (Jordan, 1993). As such this period is everywhere a candidate for consensual shaping and
social patterning. In fact, in most societies, birth and the immediate post-partum period are considered a time of vulnerability for mother and child. It is often seen as a time of danger. In order to deal with this danger and the existential uncertainty associated with birth, people tend to produce a set of internally consistent and mutually dependent practices and beliefs that are designed to manage the physiologically and socially problematic aspects of parturition in a way that makes sense in that particular context (Jordan, 1993).

Evidence of the faulty body

As further evidence of the medical view on the ‘faulty’ nature of the female body, we only need to look at the high rate of caesarean sections performed in Australia today. As stated previously, the caesarean section rate varies from state to state and from hospital to hospital, but overall Australia is revealed to have a CS rate of over 25%. This contrasts sharply with what the procedure was originally intended to be – a procedure to be carried out only in the direst emergency. Whilst we can see that today the procedure continues in many cases to be a life saving surgery, sparing women and infants from death, suffering and damage, we do need to question whether a 25% CS rate be entirely justified by life threatening situations.

Numerous media reports and journal articles explore the issue of the patient demand for CS. Yet there is little emphasis on the view of the primary carer. Recently The Australian quoted the president of the National Association of Specialist Obstetricians and Gynecologists, a Dr. David Molloy, as stating: “Caesarean sections are no more dangerous than vaginal births”. He continued: “They are equally safe for
mother and under a wide range of circumstance it's more safe for the baby” (Pirani, 2003: C13). There are three factors, according to Molloy, that create a ‘level playing field’ between the caesarean section and a natural birth: “When caesareans are performed in the private sector where there are no trainee doctors, and the patient is covered by antibiotics to reduce the risk of infection and it's done without a general anaesthetic, in other words under a spinal block or an epidural, with the patient awake and protecting their own airways” (Pirani, 2003: C13).

Not surprisingly, this idea of the superiority of a technocratic rather than natural birth is also common within America. On June 20th of 2001, Dr W. Benson Harer the president of the American College of Obstetricians and Gynecologists, spoke on the Good Morning America program. Harer suggested to millions of viewers that morning how a demand caesarean is in fact a safer option for both baby and mother. Harer described that the risks for the baby are far higher for a vaginal delivery than for an elective caesarean section at term. For the mother, the longer term risks of pelvic dysfunction, urinary incontinence, and anal incontinence are higher for vaginal birth and over the long term. Furthermore, a 1997 survey of British obstetricians published in the Lancet found that 31% of female obstetricians, given a scenario of an uncomplicated full-term singleton pregnancy, said they would prefer a Caesarean delivery for themselves (Al-Mufti et al., 1997).

Dr. Walters, the author of Just Take it Out! The Ethics and Economics of Caesarean Sections and Hysterectomy (1998) states that the disadvantages of vaginal delivery, which can include faecal incontinence, sexual dysfunction and ruptures of the uterus
are often underplayed. His argument is that there are indications that more women are becoming candidates for caesarean deliveries. Maternal and fetal weight have been increasing and women are continuing to delay childbirth. He argues that while trying to reduce the caesarean delivery rate we are ignoring the fact that nothing is being done to make vaginal birth easier. What we are actually choosing between, according to Dr. Walters, is either elective caesarean delivery or attempted vaginal births, followed by emergency caesarean delivery if that fails. Here Dr. Walters is underlying what he sees as the intrinsic failure of the birthing woman. That if we had to choose between an elective CS and an emergency CS, for that it seems is where we will all eventually end up, it is only ethical to provide the elective CS, for they are, statistically speaking, twice as safe as the emergency procedure. All women, regardless if they are pregnant or not, are confronted with statements such as these. Over a morning coffee, whilst watching a television program or perusing the daily newspaper, women are confronted with or reminded of the inherent faultiness of their bodies.

A further interest within the media reports is the choice given to women in relation to embracing the technocratic model of care. Not only is it clear that the above mentioned reports of the ‘experts’ opinion demonstrates a clear view of pregnancy and birth as intrinsically risky and the woman’s body as faulty. It also outlines that women have choice when they are confirming the technocratic notion that the female body is inherently faulty.  

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Medicalisation and Consumerism

In November of 2004 the *British Medical Journal* released a study that found the likelihood of a mother having a no-indicated-risk caesarean was almost 50% higher in 2001 compared to 1996 (Barclay, 2004). Although the study was undertaken in the United States, Australia’s statistics for caesarean delivery are very much in line with those of the United States. The study was not conclusive in its findings of why this is happening – in the end the authors felt that these changes may be a reflection of the physician or patient choice, though they could not determine that with any certainty (Declerq, Menacker, & MacDorman, 2004).

The significant increase in primary caesareans in such a short period of time is one of the driving forces behind this research. We already know that the overall and primary caesarean rate is growing rapidly in not only the United States, but worldwide, including Australia where recent reports reveal the average CS rate at just over one quarter of all births (Laws & Sullivan, 2004). Furthermore, the likelihood of a caesarean is strongly related to the age of the mother. With the increasing age of first time mothers documented in developed countries we must surely begin to question the basis of these changes. Is it defensive medicine practices, as highlighted in the previous section? Or is it consumer driven?

For the last few decades, the ‘consumer’ movement in health care has grown in Australia and overseas and has become increasingly significant for areas such as obstetrics (Grace, 1994; Reiger, 2001). It has been argued that the movement has had an impact on both the macro level in relation to health policies, but also on the micro
level – to the extent of disrupting the dominance of medicine (Gabe et al., 1994; Zadoroznyj, 2001).

Before further analysing this concept of consumerism, it is useful to examine medical dominance or medicalisation. For we must consider the extent to which the doctor-patient relationship can be constructed as simply an exchange of services between a provider and a ‘consumer’ – regardless of the shifting of labels.

**Medicalisation**

Medicalisation describes a process by which nonmedical problems become defined and treated as medical problems (Conrad, 1992). It is therefore concerned with defining a problem in medical terms, using medical language, and adopting a medical framework to understand a problem or using a medical intervention to treat it (ibid.). Essentially, the concept of medicalisation refers to the ways in which medical jurisdiction has expanded and now encompasses various problems which previously were not defined as medical issues (Williams & Calnan, 1996).

As Nye states “medical models have influenced standards of pathology and norm, therapeutic philosophies and techniques, strategies for social intervention, and theories of deviance and punishment” (2003: 115). In the past two centuries various behaviours from alcoholism to homosexuality have been placed under the scrutiny of the medical gaze. The advancement of science, medicine and technology in the area of gene therapy – locating genetic precursors of illnesses, diseases, disabilities and
even behaviours such as alcoholism, means that scientific medicine has made further
inroads into defining ‘normality’ and the limits of the deportment and control of the
human body (Lupton, 1994; Williams & Calnan, 1996). Thus, medicalisation has
figured importantly in the history of the human sciences.

As in the case of childbirth, research in the area of medicalisation has been underway
for several decades. It can be found to have its origins in the Marxist perspectives
and the liberal humanism that underlay the emergence of the various social
emancipatory movements of the 1960’s and 70’s. Despite this, writers vary
considerably on their approach to the causes of medicalisation. For instance Freidson
(1970) saw medicalisation as an outcome of the medical professions’ attempt to
extend its professional dominance. This can be counterposed to authors such as
Conrad & Schneider (1985) and Gabe & Calnan (1989) who believe that
medicalisation is represented as a form of social control which serves a diverse array
of interests responsible for controlling deviance as well as particular segments of the
medical profession. The notion of medicalisation has also been approached by many
feminist scholars who have stressed the ways in which the bodies and lives of women
have been increasingly medicalized and controlled (Ehrenreich & English, 1973).

Beyond the apparent factions within this tradition of scholarship is the important
realization that has been produced. Namely, that the histories of medicalisation are
not necessarily histories of scientific triumph. As Barker (1998:1067) argues:
“[m]edicine’s cultural authority is not dependent on efficacy alone, but on the ability
to reconceptualize a phenomenon as “medical” and an acceptance of that conceptualization by the public”.

The redefining and acceptance of pregnancy and childbirth as a medical event has been highlighted by various academics (cf. Ehrenreich & English, 1973; Oakley, 1980; Rothman, 1989; Treichler, 1990). The medical view of birth as potential pathology, in which something could go wrong at any time is a dominant and accepted model in most Western societies. Scholars within this tradition have also highlighted the alienating experience of pregnancy and childbirth as the outcome of being coerced into accepting the use of various obstetric techniques without being told why they were necessary (Oakley, 1980; Rothman, 1982, 1989). Also, the discourse that surrounds reproduction is often full of negative metaphors and images which contribute to the notion of the ‘faulty body’ as well as implying the ‘deviant’ female body over the ‘norm’ of the male body (Martin, 1989; Oakley, 1980, 1984; Tew, 1990).

During the naissance of the concept, the work of R.D. Laing, Thomas Szasz, Irving Goffman, Ivan Illich and Michel Foucault (although not strictly part of the medicalisation thesis) provided various theories suggesting that the process of laying down the boundaries of pathology and norm in bodies and behaviour was a social construction depending heavily on medical expertise and discourse (Nye, 2003). At the base of these approaches was a critique of the way that society was structured, including calling into question the social role played by members of powerful and high-status occupational groups. One of the most prominent proponents of the
medicalisation critique was Ivan Illich (1975), who contended that rather than improving individual’s health, contemporary scientific medicine undermined it.

The idea that individuals should not have their autonomy constrained by more powerful others is central to this approach. Followers of the critique generally take a negative view of the medical profession, seeing doctors as attempting to enhance their position by presenting themselves as possessing the exclusive right to define and treat illness, thereby subordinating the opinions and knowledges of lay people.

The solution to medicalisation, according to most critics, includes challenging the authority of medicine to make claims about its powers to define and treat illness and disease and encouraging the state to exert greater regulation over the actions of the medical profession so as to limit its expansion and ‘deprofessionalise’ it (Lupton, 1997). Most critics also advocate the notion of the consumer and its according ‘empowerment’, encouraging the individual to take back control over his or her own health. This will be further explored in the upcoming section of this chapter.

A failure of the medicalisation critique can be seen in various areas, stemming from the black and white portrayal of the western medicine profession as detracting from rather than improving the lay public’s health, to the negligence of recognition of the ways that medicine may contribute to good health, the relief of pain and the recovery from illness (Lupton, 1997). As Atkinson (1995: 33) points out “the asymmetry of the relationship is exaggerated to the point that the lay client becomes not the beneficiary but the victim of the consultation”. Furthermore, the orthodox
medicalisation critique fails to take into consideration the complex nature of the feelings and opinions that many people have in relation to medicine, or the ways that individuals willingly participate and indeed seek out medicalisation (Lupton, 1995).

Foucault, on the other hand, seems to argue for the seductiveness of power in modern societies, where power can be seen as productive rather than simply confining:

What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression. (Foucault, 1984: 61)

Foucault, as well as the social constructionist perspectives on medical knowledge, has accordingly been influential in drawing attention to elements of social control and surveillance which medicine exerts over our bodies and lives. The transformation of the body as something docile, that could be surveilled, used, transformed and improved was an outcome, for Foucault, of the broader social changes and processes of rationalization that were occurring towards the end of the 18\(^{th}\) century (Foucault, 1975).

Beyond Foucault’s *The Birth of the Clinic* (1975) and *Discipline and Punish* (1977), Foucault wrote several essays that addressed the issue of medicalisation. In one noteworthy lecture Foucault spoke of the ‘medical intervention’ into biohistory that first occurred in the 18\(^{th}\) century:

Starting in the 18\(^{th}\) century human existence, human behavior, and the human body were brought into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape. (Foucault, 2000: 135)
Now on the surface this argument does not seem to extend the orthodox medicalisation critique to any degree. However, Foucault differs in various ways. According to Lupton (1997), the main difference is in his contention that there is no such thing as an authentic human body that exists outside of medical discourse and practice. Rather, the body and its various parts are understood as constructed through discourses and practices, through the clinical gaze exerted by medical practitioners (Armstrong, 1994).

If we were to analyse the development of his argument in relation to medicalisation we can see the distinctive quality of his work. From his early work, mentioned above, to his incorporation of governmentality in the late 1970’s, Foucault’s unique approach to power provided great insight. Ultimately, Foucault’s main interest was in a biopolitical power that relied on autonomous citizens who embraced their social duties as individuals than in an authoritarian regime that ruled by violence or force alone (Nye, 2003).

Power, not through coercion, rather by persuasion, is a disciplinary power that provides guidelines about how we should understand, regulate and experience our bodies. Foucault argues that society is medicalised in a profound way, serving to monitor and administer the bodies of citizens in an effort to regulate and maintain social order as well as promoting good health and productivity. Through this analysis we can see that medicalisation is evident in the ways in which warnings about health risks have become common events. As Mary Douglas has argued, we have moved from a probabilistic calculus of chance to a politics of risk as danger (Douglas, 1992: 63).
22-25). People are constantly urged to conduct their everyday lives in order to avoid potential disease or early death. As a result, “Sociologically speaking, everyone lives under the medical regime, a light regime for those who are not yet patients, stricter according to how dependent on doctors one becomes” (De Swaan, 1990: 57). This is easily seen to be the case with populations such as the elderly, the chronically ill, and maternity care patients.

While it is clearly important to trace the discourses and practices of medicine and to demonstrate shifts as well as continuities over time, we should keep in mind that it is also important to investigate the ways that members of the lay population respond to the clinical gaze. We should remember that the lay population is ‘alive’ and should not be represented simply as docile or passive bodies constrained at every turn by the hegemonic discourse. As Shilling contends (1993: 64) “it is necessary to allow for lived experience, for the phenomenology of the body. Bodies may be surrounded by and perceived through discourses, but not irreducible to discourse”. Shilling continues by stating “…the body needs to be grasped as an actual material phenomenon which is both affected by and affects knowledge and society” (1993: 64). Understanding this allows us to understand the various choices women make in relation to their childbirth plan. With this we are speaking about the split between the women who choose the natural birth or home birth rather than the medical birth, or as Davis-Floyd (1994) would distinguish the organic body versus the technocratic body.

In an attempt to understand the crisis of maternity care within Australia we can build upon Foucault’s notion of productive power and situate the medicalised birth setting
as a ‘cultural field’ in the Foucauldian sense. We can think of a field as a piece of territory, or a space within society, that gets used in particular ways. Each field lays down rules and procedures, assigns roles and positions, regulates behaviours and produces hierarchies (Danaher et al., 2000). It is through the languages employed within the cultural field, or as Foucault would term them ‘discourses’, that shape our understanding of ourselves, and our capacity to distinguish the valuable from the valueless. From this we can theorise that the institution of science and medicine dominates the ‘cultural field’ of the ‘medical birth’. We may therefore understand the mother’s experiences of pregnancy and birth and shortly afterwards as a product of the discourses and values of this particular field.

Laying this foundation we are able to explore the next area under investigation, that of the development and acceptance of technology within the realm of birth. Technological research in the social sciences frequently focuses on the relationship between technological change and social change. Roughly summarised, two positions have initiated the debate. On the one hand there is technological determinism which sees technology as destiny; technology dictates whether and in what way it will be applied. In relation to childbirth, this can be linked to the orthodox medicalisation critique expounded by such authors as Illich (1975) or more in relation to childbirth Oakley (1980; 1984) and Katz Rothman (1982). On the other hand there is the position of social reductionism. Here it is the users who decide whether and in what way technology will be applied, as the consumer movement argues. Cultural influences, social norms and interests play a crucial role in the shaping and use of technology.
Meanwhile, the deficiencies and lacunae of both positions have become evident. Both perceive only segments, not the whole, as sociologist Peter Weingart (1997) puts it: “they are the two great traditions of one-eyedness” (cited in Beck and Beck-Gernsheim, 2002:139). For example, in relation to the medicalisation critique, research shows that although some women are alienated by their experience of medicalised birth, many women across all social classes welcome medical intervention, if not management, and are quite satisfied with medical deliveries (Fox & Worts, 1999; Davis-Floyd 1992, 1994; Lazarus 1994; Sargent & Stark 1989). What this literature is overlooking, and what the proposed thesis will address, is the agency of women who accept medical management of their births. We need to question how women might be using medical intervention and what they might accomplish in becoming patients. Relative to the consumer movement, the weakness lies in the failure to acknowledge the emotional dimension of the patient-doctor relationship, specifically the trust relationship (Lupton, 1996). Consequently recent research focuses on the relationship between the cultural prerequisites of technology and what it offers. Here technology may be seen as a spiral-shaped process (Beck-Gernsheim, 2000). It appears as both the product and the instrument of social needs, interests and conflicts. Technology is effect and cause at the same time (Reynolds, 1991).

**Consumerism**

The outline of the medicalisation approach to childbirth depicts the archetype of the passive or dependent patient. As highlighted, the placement of individuals into this category negates notions of agency. The undesirable implications of dependency and unquestioning compliance to the expert deviates from dominant notions within
Western societies about the importance of the autonomous self (Lupton, 1997), the self who governs through rationality rather than through emotion. Hence, the archetype which is set up in opposition is the model of the patient/consumer.

Consumption has become increasingly important and expanding in its ability to infiltrate into all aspects of individual lives, and as Edwards (2000) argues, the entire development and direction of contemporary society, nationally and internationally. We could argue that there are few areas of everyday life that are not affected by or limited to the practices of consumption – from advertising to policy making. Consumerism has even infiltrated into the issues of provision of health, welfare and education (Cahill, 1994; Keat et al., 1994). The end effect sees the development of arguments since the 1970’s that the lay population is gradually moving towards a consumerist approach when seeking health care.

Recent years have seen a steadily increasing interest in the area of consumption – this is readily seen in academic research as well as popular discourse. The mass media provides numerous reports on spending patterns and consumer confidence as well as directing and advising their readers in matters of style and taste. This is readily extended to the area of health with the various television shows and magazines dedicated to issues of health and fitness. For instance, Foxtel provides to its cable subscribers a station dedicated solely to issues of health. This is easily broadened to the area of pregnancy and childbirth with television shows such as Birth Day and Babies Story – both aired on Discovery Health - and magazines such as Pregnancy and Birth and Mother and Baby. Likewise, we have seen a swift expansion in
academic research in the area of consumption across various disciplines of the arts and social sciences (Featherstone, 1991; Fine & Leopold, 1993; Lury, 1996; Miller, 1998, Ritzer, 1999)

The various theoretical approaches of the social sciences all converge with similar concerns, namely the consequences for society as a whole and for the individual on the significance and importance attached to consumption. Regardless of this convergence the diversity in perspectives raises questions concerning the role and function of consumerism. Is consumption a means of empowerment and expression or is it a source of manipulation and exploitation? This query is easily applied to the area of health in general and maternity care specifically. It has been argued that maternity care has become a commodity in our society with the advent of deregulation and privatization of health services (Lane, 2000), and the expectant couple has become the consumer. The question remains – are they empowered or manipulated and exploited?

Draper (1997) highlights the significance of the shift in role from ‘patient’ to ‘consumer’. This supposed shift represents a revolution in the way that individuals approach health services as well as their status. Draper argues, the term ‘consumer’ has positive connotations: it denotes someone who has a right to receive a service (instead of someone who is grateful to receive a gift) and it denotes a collective right of consumers to have their interests met (cited in Lane, 2000). The pregnant woman now has the right and entitlement of information, choice, safety, fair treatment and redress. This is a large shift from previous generations where the hierarchy of power
within the obstetric patient relationship did not leave room for questioning or battles over control. As one of Kerreen Reiger’s (2001: 22) obstetric respondents points out “There never was much criticism of medical treatment or anything. It was just accepted and that was it; you were the boss. The patient didn’t ever have much say at all really”.

This particular obstetrician was speaking about obstetric practices around the time period between the 1930’s and 1950’s. The present situation may be somewhat different, but does having the entitlement that Draper discusses necessarily equate to the reality of the situation? For, as Lupton (1996:146) asks: “[w]hat [does] participation mean in a context dominated by expertise, competitive individualism, and neo-liberal democratic structures and values.” For this shift in terms from patient to consumer also highlights the shift from the Keynesian welfare state to that of the market state. In Australia we are steadily moving away from the notion of an individual who has the right to equality in health services to the rational consumer who as Gardner (1995) points out is intrinsically empowered to pursue their own interests.

This ‘empowerment’ of the maternity service consumer can be placed under the general heading of economic rationalism, which in turn is underpinned by rational choice theory (Lane, 2000). Rational choice theory assumes that “humans are motivated in their political and economic behaviour to maximise self-gain…the individual is deemed as unitary, calculating, egoistic, motivated solely by the economic end of accumulating wealth by means of profit maximisation” (Hancock,
Accordingly, power now “resides in the hands of those who control databases from which rational decisions can be made and by which they can be justified. Comprehensive information gathering is therefore critical to the process” (Gardner, 1997:208). In essence responsibility has now shifted to the private sector and to the individual consumer. Further analysis of this neo-liberal approach to health care will be explored in Chapter four of this thesis.

Karen Lane (2000) examines this rational choice theory in relation to the delivery of health services and examines through various State commissioned studies whether consumers are indeed empowered. The Department of Human Services Victoria and the Health Services Policy Review are both examined to determine the extent of consumer control. The Duckett report (1999) (Health services Policy Review) reveals that the “market for health services is distorted because of information asymmetry between providers and consumers.” According to the report, “[t]his asymmetry handicaps consumers in making informed choices about the services available to them in the market” (99). According to Lane, the Health Services Policy Review views the consumer as a unitary, stable and rational individual with an underlying assumption of generalisability.

This is mirrored by previous research on the doctor-patient relationship where the notion of the rational, autonomous subject is privileged. Meredith (1993:599) highlights this: “[p]atient satisfaction surveys implicitly rely on a conception of the patient as a ‘rational evaluator’ who is willing, wishing and able to judge all aspects of hospital care relatively dispassionately and reasonably reliably”.

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Yet as previous research has demonstrated (Calnan & Williams 1992: 1994) the lay population’s relationship with medical experts is anything but unitary and stable. Rather this relationship is a very ambiguous one where the lay population are seen as critical reflexive agents who are active in the face of medicine. The relationship is also based on a shifting dialectic of trust and doubt, certainty and uncertainty, and finally reverence and disillusionment in the face of high modernity.

This shift has often been attributed to not only the redefinition of patients as ‘consumers’ but also processes of proletarianisation and deprofessionalisation. Proletarianisation is a process whereby organisational and managerial changes divest professions of the control they have enjoyed over their work. This is mirrored in current debates over ‘cybermedicine’ where it is argued that new technology is being used by administrators to restrict doctors’ autonomy (Slack, 1997). Deprofessionalisation relates to the demystification of medical expertise and increasing lay cynicism about the health profession that is highlighted in the works of both Beck (1992, 1994) and Giddens (1994). Expert knowledges are being challenged on the part of the lay population due to an increasing awareness of their uncertainties (Beck, 1994). Patients as consumers has reinforced these two processes.

A central theme in the move towards consumerism in the area of health is the need to provide clients, no longer patients, with information; a theme which dominates Giddens’ work on life within ‘late modernity’. Giddens (1991) argues that we live in an information rich society in which life plans and strategies have to be negotiated via
a potentially confusing mass of competing and sometimes contradictory sources of information. Giddens highlights this through a fictional account of a woman’s search for information about her back pain, for example, he describes how she finds information from various sources that provide a diversity of material from which she can make a “reasonably informed choice” (1991: 141). Giddens’ fictional subject was engaged in core activities of the reflexive consumer of evaluating and at times challenging expert knowledge (Lupton, 1997). However, we should not fail to realise that in an expert-dominated culture, it is inevitable that many ‘knowledge problems’ will be attributed to the scientific ignorance or naivety of ‘participants’, or to problems with lay knowledge or lay rationality or both (Lupton & Petersen, 1996:153). It can be further argued that the assumption of a generic lay population ignores the role played by issues such as gender and culture. As Lupton states: “There is little understanding of the consumption of health care qua commodity as a dynamic and intersubjective sociocultural process rather than as an outcome of an individualized calculation” (1997:374).

**Conclusion**

Beck contends that we are living within a time period where the proliferation of risks as well as the growth in lay knowledge and public perceptions of risk are established against the resistance of scientific rationality. In other words, as Beck suggests: “the history of the growing consciousness and social recognition of risks coincides with the history of the demystification of science” (1992: 59). It seems that our awareness of the increase of dangers and hazards that surround us are not allayed by official announcements of risk and safety. We have begun to question the experts.
Can we relate this to women’s interactions with their primary carer during pregnancy and childbirth? Numerous studies have been conducted on lay perceptions of medicine (Watson, 1970; Adams, Chancellor & Kerr, 1971; Hibbard & Weeks, 1987; Steven & Douglas, 1988; Dunt, Oberklaid & Temple-Smith 1988; Lupton, Donaldson & Lloyd, 1991; Williams & Calnan, 1996) some expounding a consumerist approach and others expressing the difficulties in labelling the lay populations approach to health care and medical professionals. Research by Lupton, Donaldson and Lloyd (1991) reveals that the assumptions that Australian patients are behaving as consumers are inappropriate. They found that the majority of their respondents did not approach their choice of GP as consumers; rather they demonstrated a need to feel protected from the effects of the free market. Notions of trust and faith were central to these particular respondents. According to Lupton, faith in modern medicine becomes a sort of ‘creed’. However, there is an underlying ambivalence. Lupton highlights in her later work that:

There is a set of expectations surrounding health and the body prevailing in western societies: we expect to feel well, without pain or disability, long after middle age, we expect all children to survive birth and infancy, all women to give birth with no complications, all surgery and medical treatment to be successful. And for the majority of individuals these expectations are indeed met, serving to reinforce them even more strongly. However, although medical authority may confer an image of reassuring competence and control of the situation, the construction of the medical practitioner as omnipotent inevitably leads to disappointment and disillusionment when things go wrong, resulting sometimes in legal action against doctors…Furthermore, while we continue to look to medicine to provide help when we are ill, we also express resentment at the feelings of powerlessness we experience in the medical encounter. (Lupton, 1994: 1-2)

This form of ambivalence was echoed in the research of Williams & Calnan’s 1996 study where it was found that there was a considerable degree of ambivalence towards modern medicine and that views appeared to differ on its relative merits
according to which specific forms of technological intervention were being considered. They found that most criticism appeared to be levelled at low-level forms of medical technology such as tranquilizers, whereas the high tech forms of medicine were not uncritically received. Briefly, the work of Calnan and Williams reveals that the structure of lay thought and perceptions of modern medicine is complex, subtle and sophisticated. Indeed, they highlight that individuals are not simply passive consumers who are duped by medical ideology and technology. More accurately they are critical reflexive agents who are active in the face of modern medicine and technological developments.

If we were to bring the findings of these two studies together we could see that the lay populations approach to medicine and medical experts does not fit as neatly into the rubric of medicalisation or consumerism as previous research has implied. Both perspectives, whilst clearly important in shedding a critical light upon modern medicine and its role in society, are nevertheless neglecting important changes which have and are taking place in the relationship between medicine and the lay population. With this in mind we can turn to the works of Giddens (1990, 1991, 1994) and Beck (1992, 1994, 2000b). Their approach to life in ‘late’ modernity and ‘risk society’ provide valuable insights into the research at hand.

Anthony Giddens conceptualizes contemporary western society in a novel way. He acknowledges the many shifts that are taking place within western societies yet fails to fall into the dichotomy of modernity and postmodernity. We are not living in a post modern age according to Giddens – rather we are within a period that both he
and Beck refers to as high or late modernity (Beck, 1992; Giddens, 1994). Within this post traditional order the consequences of modernity are becoming more universalized and radicalized. Giddens and Beck both draw attention to the importance of reflexivity. There is an emphasis on the interaction of individual and institutional social forces. What comes through clearly in both theorists bodies of work is the concern for the ways in which self, society and knowledge intersect in the present day.

Employing both of the work of Beck and Giddens allows us to capture more accurately the changing and dynamic nature between medicine, medical experts and the lay population. For the purpose of this research, the emphasis will be on the specific field of maternity care. The theoretical chapter (Chapter four) of the thesis will examine certain key themes of their work – emphasizing general social trends and tendencies within late modernity.
CHAPTER TWO

THE EMERGENCE AND ENDURANCE OF A RISK SOCIETY WITHIN AUSTRALIAN MATERNITY SERVICES

*Medicine has become like a secular religion, a view reinforced by the knowledge that belief in its powers is based on myths about the past and faith in the present.*

(Hart, 1985: 17)

The following chapter provides an overview of the steady rise and prominence of biomedicine as well as the gradual decline of status in the profession of midwifery. The chapter provides further context to the cultural shaping and defining of pregnancy and childbirth as a medical event which is seen as intrinsically risky. It ends with an overview of the medical indemnity crisis which began to affect Australia in late 2001. The crisis itself mirrors an intensification of rationality and its many measures where consequences such as the diminishment of choices available in maternity services as well as a reported increase in defensive medicine practices are unavoidable.

The subordination of midwifery and the rise of the hospitalized birth

Researching the history of maternity care practices provides an abundance of literature for the researcher. There are numerous articles, book chapters and books devoted to the subject. However, in the case of the history of childbirth practices within Australia, the scale is somewhat more limited. The following section attempts to provide an overview of the development of maternity care in Australia, greatly assisted by the works of Willis (1983), the NSW Midwives’ Association’s publication (Adcock, 1984), and Kereen Reiger (2001).
As previously argued, Australia is very similar to the United States in relation to current maternity care services and practices. However, Australia is unique to countries such as America and especially the UK, as maternity care practices were developing during a time period where biomedical dominance was already firmly established. The attempt to uncover the initial trends of a dominant midwifery led care is further hampered by the fact that the history of childbirth practices within Australia has been written overwhelmingly by obstetricians who provide a particular ‘reading’ of its development (Willis, 1983). This is especially true of the colonized Australian history where midwives left few records and wrote no accounts of their work.

The relevance of British history to the Australian birthing scene and particularly to that of midwives is discussed within the work of Willis (1983). Underpinning his work is an examination into the historical development of the medical and nursing professions’ dominance of the once autonomous occupation of midwifery which provides a context of the present relationships between these professions.

Conflict has characterised many of the historical accounts of midwives and midwifery practice. For example, the Middle Ages saw the struggle between women healers and the medieval church culminating in midwives inclusion as the victims of vicious witch hunts (Forbes, 1966; Ehrenreich & English, 1973; Chamberlain, 1981; Donnison, 1977). The early seventeenth century ushered in the man-midwife, which doubtless contributed to the establishment in the mid-eighteenth century of the lying-in hospitals (Towler & Bramwell, 1986). These hospitals, Versluysen (1981) argued,
set an important precedent in the history of childbirth since they provided a model of childbirth conveniently managed by man-midwives within an institutional setting. This trend towards male control over childbirth met with vigorous opposition from female midwives as there was little place for them to continue their autonomous practice within these lying-in hospitals. Employment was commensurate to subordination by the male-midwives (Versluysen, 1981; Willis, 1983; Tew, 1990). Australia inherited this past, just as this country inherited the people of Britain absorbed with such a past, and as Strauss and Corbin (1990) emphasise history has consequences for present action/interaction; with past and present becoming part of the future

The emergence of medical dominance

An historical study by Chamberlain (1981) traced the growth of the medical profession in relation to the rise of the middle classes. According to Chamberlain, the institutionalisation of medical knowledge promoted the concept of expertise as an institutional status, rather than a capacity of practice. This expertise was jealously guarded and protected from those considered unable to comprehend its complexities. The wise and cunning women, once experts, were relegated to caring for those women who were unable to afford the services of the rising medical profession. The increase in the number of medical practitioners was closely linked to the expansion of the middle classes alongside their deference to the experts. Thus diagnostic and prescriptive practices became the prerogative of the physician rather than the women healers and midwives. The incentive for middle class women to practice healing decreased as the ideology of the day promoted idleness as a status symbol for the middle class women, which in turn reduced the status of the working woman healer
and midwife. At the same time, the popularity of the medical practitioner grew as their ministrations to the wealthier were not hampered by many of the communicable diseases and poverty related illnesses adversely affecting the outcomes of the urban poor (Chamberlain, 1981; Tew, 1995).

Furthermore, where it had been usual for the medical practitioner to be called in by midwives for abnormal cases, they now moved into direct competition with midwives for attendance at normal births. By the middle of the eighteenth century there were about several hundred men-midwives practising in London and its surrounding locales (Donnison, 1988). The trend towards male involvement was greatly accelerated by the development of the midwifery forceps, which were restricted for use by male practitioners. This enabled the male practitioner to deliver live infants, where previously either mother or child may have been lost. The distinction of the great men-midwives, such as Richard Manningham, Fielding Ould, William Smellie and William Hunter, also reflected credit on every male practitioner of medicine, deservedly or not (Donnison, 1988). Accordingly, medical control of the birthing business effectively transferred pregnancy and birth from the domestic arena to the public: “from the hands of women to the control of men” (Nettleton, 1995: 199).

Midwives were concerned about their declining opportunities to practice. This concern, according to Towler and Bramwell (1986) prompted Mrs Sarah Stone in 1737 to publish her Complete Practice of Midwifery in the hope that it would enable women to deliver their patients successfully. She believed that unless women showed themselves capable of delivering difficult cases, the public would bypass them in
favour of a man-midwife. Midwives’ access to instruction in dealing with difficult cases, however, remained guarded by male practitioners. According to Donnison (1988) Thomas Dawkes in 1736 wrote *The Midwife Rightly Instructed*. This was a question and answer book which had the surgeon refusing to tell the midwife how to deal with a haemorrhage. Rather, the author warned the midwife not to aspire beyond the capacities of a woman (ibid.).

The expansion of male midwifery practice was not entirely welcomed by the ranks of medical practitioners who believed that the surgeon alone should be involved in difficult cases. This initiative was promoted by John Douglas, a London surgeon, who demanded the establishment of lying-in hospitals in all the principal cities of England. Events such as this were significant in allowing the medical profession to attain a prominent position in controlling the training and practice of midwives, both in the community and in the hospitals.

By the 1850’s, despite repeated proposals for the regulation and training of midwives, little had been achieved. In fact, such was the stigma attached to the occupation that educated entrants were a rarity. In comparison, the social recognition afforded the emergent general practitioner within the specialty of obstetrics continued to rise. With the position of the midwife at an all time low, her demise was imminent. As Donnison (1988) states, without external help the downward trend would have continued, with midwives becoming monthly nurses trained to satisfy the needs of the well-to-do in society, and to perform the routine functions surrounding childbirth that were seen as time wasting to the attending medical practitioners.
Colonial influences

The social reforms that occurred in England as a consequence of the appalling conditions in the crowded workhouses and infirmaries coincided with, and contributed to, the assisted emigration of the poor to the open spaces of England’s new colonies. Burchill (1992) describes the far-reaching effects of these inter-woven events on the early development of nursing in Australia. In particular, the international influence of Florence Nightingale and the impact of the Nightingale Nurses on the way nursing and midwifery were to develop within Australian society. Her account of the work performed by bush nurses, border nurses, district nurses and infant welfare nurses, indicated the historically unquestioned need to be able to provide care in all situations. Midwifery and infant welfare qualifications were seen as necessary adjuncts to general nursing. Once gained all were used to provide the multi-faceted needs of the pioneering communities, urban, rural and remote (Durdin, 1991).

There is little information available about the early immigration of midwives to Australia. However, Durdin (1991) refers to the lowly status of midwives as portrayed in an analysis of the assisted immigrants who arrived in the colony between 1836 and 1840. Midwives were among the miscellaneous category of ‘domestic servants’, along with nursemaids, laundresses, housemaids and charwomen. Durdin describes the role of the ‘granny midwife’, who went from home to home, assisting at the birth and staying on to care for the mother for four weeks after the birth. A few midwives, usually widows needing to support their own families at home, opened one
or two rooms in their homes to provide a rudimentary cottage hospital. Accounts of women assisting one another in childbirth feature in early pioneer history (Teale, 1978) however; little has been recorded of the actual role of the midwife.

Recognizing the paucity of material on early midwifery history, a chronological account of midwifery practice in the different Australian states was prepared by the Western Australian Branch of the National Midwives Association of Australia, for the 20th Congress of the International Confederation of Midwives, held in Sydney in 1984 (McDonald & Davis, 1984). Members of the College from each state compiled a concise description of midwifery from the time of the early convict era (1788-1850) and the early settlers, to the time of writing. Adcock et al. (1984) recorded the New South Wales experience within four time dimensions; the convict era (1788-1850); colony to nation (1850-1900); early nationhood (1900-1950); and the era of increasing technology (1950-1984). It was found that early settlers were reliant upon each other for assistance, with some women becoming recognised for their knowledge and experience in assisting at birth. The infirmaries for convict women were the beginnings of institutionalised confinements, with female convicts who became pregnant being sent to the female factories for lying-in. These patterns of midwifery were reminiscent of the early British era.

The trend to hospitalisation
Training for midwives had commenced in maternity hospitals within each of the cities by the early 1900’s. These teaching hospitals catered for the poor and destitute. In New South Wales and Victoria training schools were established before the commencement of the 20th century. The turn of the century saw increasing concern with the high levels of infant mortality and the falling birth rates. A Royal Commission Report in 1904 encouraged hospitalisation for confinement. It was not long before teaching hospitals were overflowing, and new hospitals were built. Private cottage hospitals were also opened by midwives who had graduated through the teaching hospitals.

Willis (1983) refers to the period from 1910 through to the late 1930’s as the takeover period. He argues that with the growing concern over high infant mortality rates and falling birth rates, midwives became the scapegoat to blame. This, Willis states, was the case in the New South Wales 1904 Royal Commission, despite the fact that the more affluent middle class women attended by doctors were at greater risk of infection than the poorer women attended by the midwife. With continued claims that puerperal fever was the result of the practice of midwives, there was a call for the exclusion of midwives from attendance at childbirth. The state was also invoked to control the practice of midwives. At the same time state patronage for the medical profession consolidated the profession’s dominance over other health occupations. “The subordination of midwifery was formally achieved through its limitation in various midwifery registration acts from 1915 to 1920, and its final and formal incorporation into nursing in 1928” (Willis, 1983: 111).
This subordination was occurring simultaneously with the rise of the hospitalized birth. As early as the 1930’s recognition for the need of medically supervised antenatal care was developing. Willis (1983) relates this to the medical profession expanding the roles of the obstetrician in one of its final moves towards subordination of the midwife. Home birth through an independent midwife was seen as dangerous and irresponsible, and it seemed that the state supported this through the ‘Maternity Allowance’ or ‘baby bonus’ with encouraged women to use the services of doctors rather than midwives (Reiger, 2001).

Concurrently, it is argued that women were seeking out the larger hospitals, which had advanced technology and had developed new standards of care. As Reiger argues:

> Mothers seem to have supported the hospitalisation of childbirth which occurred in the interwar years partly because they accepted the doctors’ arguments concerning the safety model of birth, and also because they appreciated the care and attention afforded by a stay in hospital, away from normal domestic responsibility. (2001: 18)

Reiger’s interviewees, who gave birth between the 1930’s through to the 1950’s, also spoke about the confidence and trust they had in the staff to manage a safe birth. It seems these particular respondents accepted the idea that childbirth was risky and that the safe model the hospital birth provided brought them security. Of course these women were also giving birth during a time period where medical dominance was prevalent. As one of the obstetricians interviewed by Reiger commented: “There never was much criticism of medical treatment or anything. It was just accepted and that was it: you were the boss. The patients didn’t ever have much say at all really” (2001: 22). This comment also parallels Reiger’s interviewees comments on their sense of lack of control over the pregnancy and childbirth.
Unlike today, women who gave birth during this time period had very little information available to them outside of the hospital and obstetric care that they received. This most likely contributed to the lack of expectation or desire to ‘have a say’ in the type of care given during their pregnancy or childbirth. For whilst women’s organizations were being used to develop the standard of maternity care – issues of concern revolved around increased medicalisation rather than a desire for increased autonomy in the pregnancy and birthing process.

Maternal and infant morbidity and mortality rates building up to the 1950’s most likely affected the acceptance and use of technical solutions such as antibiotics, blood transfusion and developments of antenatal care to manage conditions such as toxaemia. But at the same time the effect was to create the new illness category of pregnancy, categories of risk, as well as expounding the discourse of the faulty body. Again we can turn to the valuable work of Reiger (2001). In many of her interviews with obstetricians who practiced during this particular time period the notion of the hazardous pregnancy was voiced.

**The crisis of birth, the need for obstetrics**

The honour for bringing about the decline in death rates after 1870, rightly or wrongly, was given by the grateful public to the medical profession. The epidemiological explanation for the decline in mortality disclosed in the 1950’s and 1960’s (McKeown, 1979) was greeted with general surprise and scepticism, revealing how deeply ingrained was the popular (mis)conception of the powers of doctors.
These attitudes towards health and illness are seen by Tew (1990) as contributing to society’s belief that “although reproduction is not a disease, its problems are better solved by medical intervention than by environmental improvement and healthy life styles” and adds Tew (1990: 5) “since the prosperity of doctors concerned with maternity care is vitally dependent on this belief, it is understandable that they should make great efforts to propagate it”.

A new age was ushered into the history of maternity care by the 1950’s. Overall the medical model dominated, defining birth as a crisis event and the postpartum period as needing rigorous professional supervision (Reiger, 2001). It was described by Hayes and Bayliss (1984) as the era of increasing technology. The new technologies were being implemented at the same time as developments in the management of pain relief. It was this combination, according to Reiger (2001), that set the scene for the emergence of the reform movements in relation to maternity care.

The emergence of the technologically safe birth

Maternity care within and from this time period forward was shaped by a social context which valued the ‘modern’ and ‘scientific’. ‘Progress’ continued into the 1960’s and 70’s, where technological advances and techniques enabled inductions and caesarean sections to be safer and more commonly used. The training and practices of obstetricians and midwives was greatly affected by this as well as the strong memories of the horrors of high maternal mortality of previous decades (Reiger, 2001). It was during this time period that the full impact of the equation of a pregnant and birthing woman being like any other ‘patient’ came to fruition.
The impetus in technological advances continued into the following decades. Ultrasound and electronic foetal monitoring was under way by the 1980’s. Initially, both were used primarily for the category of the high risk pregnancy, both are now commonplace. Although a variety of literature on alternative approaches to childbirth was available from the 1930’s, following the publication of *Natural Childbirth*, the work of the English doctor Grantly Dick Read, they were not widely available or sought after until at least the late 1960’s with the introduction of birthing techniques such as Lamaze and later the Bradley Method in the 1980’s.

Although much lay literature from this period expounds the notion of expanding options for the pregnant and birthing woman, with an emphasis on autonomous choice, it was often expressed within a medicalised perspective. The impact of this form of advice literature will be further analysed in chapter eight.

**The normalization of the medicalised birth**

Michel Foucault (1990:140) calls bio-power an expression of law’s interest in the management of life, both at the level of individual bodies and at the level of populations. The practice of pregnancy and childbirth as a medical event has created standards for judging individuals as ‘normal’ or ‘abnormal’ and has developed techniques for reforming those that fall outside the range of ‘normality’. The absence of support for private practicing midwives by the federal government and the continued negotiations and support for obstetric led services has normalized the use of obstetric led based care of the pregnancy and birthing woman.
As argued within Chapter one, the constant rise of caesareans and the marked decline of vaginal births marks a crisis era of maternity services within Western societies. Australia continues to demonstrate an increase in caesarean delivery with recent reports (Laws & Sullivan, 2004) claiming that 30% of all births within major centers are now by caesarean. In the United States the caesarean delivery rate reached 26.1 percent in 2002 (Hamilton et. al., 2003) its highest rate ever, and there are similar increases in other countries (Donati et. al., 2003; Leung et. al, 2001; Chan et. al. 2001; Murray & Pradenas, 1997). As discussed within Chapter one, there are many explanations put forth for the marked increases. Along with a technologically driven society, a supposed anti-vaginal birth movement within the obstetric community (Young, 2003), and demand caesareans, there are higher rates of electronic fetal monitoring, induction and epidural analgesia. This in combination with the stark increase in ultrasound and pre-genetic testing can be seen to be part of a relatively recent trend of defensive medicine. As the practice of defensive medicine is often claimed by obstetricians as justification for stark increases in intervention during pregnancy and childbirth, the following section will outline two of the more important historical and contextual factors that make defensive medicine so prevalent and often unavoidable within a hospital setting.
Defensive Medicine and Pregnancy and Childbirth Care

Defensive Medicine is usually defined as clinical care in which:

the threat of medical malpractice may lead physicians to order medically unnecessary tests and procedures to protect themselves against a future lawsuit. (Bassett et al. 2000: 524)

We live in a society in which technological definitions of human functioning are rewarded as well as approached managerially. Our society encourages a dependency on medical authority which in turn institutionalizes practices based on fear of failure and risk categorization. Accordingly, it should not be seen either in isolation of these processes or relegated solely to the field of obstetric care (Bassett et al., 2000).

Defensive medicine has received considerable attention in academic literature, varying from medical to legal. During the recent indemnity crisis within Australia, various publications suggested that clinical care is in a defensive medicine ‘crisis’. There were numerous ‘How to avoid litigation’ publications and the last Royal Australian and New Zealand College of Obstetrics and Gynecology conference had several sessions dedicated to the issue.

Additional research has been devoted to measuring defensive medicine by calculating the extent to which litigation concerns influence clinical outcome, particularly during obstetrical care (Sloan, Whetten-Goldstein, Githens & Entman, 1995). Recent clinical studies found no evidence of a direct correlation between either litigation experience or fears and any measurable aspect of subsequent clinical outcome
It seems evident then that the issue of the actual extent of defensive medicine is controversial at best. Despite the difficulties in ascertaining the causal link between fear of litigation and defensive medicine practices doctors are being quoted that they indeed practice defensive medicine. For instance, in the climax of the medical indemnity crisis, Obstetrician and AMA executive member Dr Keith Hollebone argued:

> [t]he problem is we are being forced to practice defensive medicine now. I now have to do so many extra tests on patients to be able to cover myself from a medico-legal perspective, even if we feel every test now is not absolutely necessary. If we are sued and the test has not been done, it is a point that can go against us. This is preventing us from practicing proper clinical medicine. (Hollebone, 2001: 26)

What is missing is the interplay occurring between a cultural shift in approaches to health, responsibility, notions of perfection, risk and the advancement of technology. These issues will be developed more thoroughly within the theoretical chapter (Chapter four) as well as demonstrated within Chapters five, six and seven.

As Bassett et al. (2000) portray the probability of defensive medicine during the employment of obstetrical care can be understood through the historical and contextual factors of (1) the fetus as the patient and (2) the active management of birth, initially explored by social researchers such as Oakley (1987). Both of these factors have both played considerable roles in the shaping of reproductive medicine. The progression towards the fetus as a patient is directly linked to the development and use of various technologies which were seen to offer objective proof of the fetus’ health. The ‘active management of birth’ has been explored by various sociologists (Oakley, 1984; Rothman, 1986; Tew, 1995) to try and unravel the reasons for
increase in intervention during childbirth, here it provides a logical connection to the increase in defensive medicine practices.

The fetus as the patient

Understanding current defensive medicine practices leads us to examine the process whereby the obstetrician and other physicians have come to act as what has been termed ‘fetal champions’. This has been previously researched by Franklin who identified the historical process of the “medical-scientific construction of fetal personhood” (Franklin, 1991: 191). Franklin explored issues as far reaching as the detailed images of the fetus employed within the abortion debate, especially within the United States, as well as the development of a ‘belief system’ for women to fit with the “technocratic model of reality dominant in the hospital” (Davis-Floyd, 1992: 155).

The justification for a “technocratic model of reality” as the one that best provides for the wellbeing and safety of the individualized foetus, is in sharp contrast to earlier conceptions of the foetus as the anatomically hidden and physiologically dependent maternal organ. Bassett et al. (2000) provide an historical overview of this shift explaining that prior to the 1960’s typical approaches to pregnancy and birth viewed the experience as something that only a woman faces. Birth was the physiological process whereby the foetus was expelled from the woman. Accordingly, the foetus was seen as a passenger in a woman’s body and was passively affected by her powers and her birth passage. Bassett et al. (2000) contextualize this by providing an excerpt from a popular obstetrical text which describes the foetus as “but another, albeit

Obstetrical researchers began to move away from the adage “healthy woman, healthy baby” and began a quest to improve foetus health directly, by intervening on behalf of the foetus, rather than indirectly, by continuing to improve maternal health (Pritchard et al., 1985: 267 cited in Bassett et al., 2000: 530). This is evidenced by the advent and constant use of the electronic foetal monitoring device (EFM). From the early 1950’s researchers led by Dr. Hon used the continuous EFM recordings of the foetal heart to make intensive study of the oxygen needs of the foetus during labour. The obstetrical researchers led by Hon reversed the above credo and in stark contrast declared that behind a mother who appears healthy there may lurk a distressed or dying foetus. Here we can see a shift in pregnancy and birth happening solely to the woman. In Dr. Hon’s view obstetricians must learn to be more distrusting of maternal appearances and more vigilant about the status and health of the foetus (Bassett et al., 2000).

The use of the monitor has diffused steadily from the ‘high risk’ to ‘low risk’ obstetrical care. Indeed, within my research 83% of my private patients experienced the use of this device. Clinicians and researchers alike felt that the EFM was a device that helped practitioners help the foetus. Although the device is strapped to the woman and is used to determine patterns and durations of contractions as well as the foetal conditions, it is called and used as a foetal monitor.
The standardized use of the EFM is not because it has demonstrated an improvement in foetal and maternal outcomes, rather research has demonstrated the opposite. From the 1970’s research has shown that the use of EFM has provided no benefit to fetal or maternal outcome versus the use of nurse or midwife attendants. As research continued it became clear that there was a large percentage of false positive rates known to exist in EFM interpretation which has consistently been shown to relate to the increase of CS (Thacker, 1987; Notzon et al., 1994). Recent research demonstrates that up to 50% of false positive results are indicated with a demonstration of doubling the CS (Notzon et al., 1994). Indeed, recent research has indicated that concerns over the efficacy and safety of EFM has led expert panels in both the United States and Canada to recommend that its use be applied to only high risk pregnancies (Thacker & Stroud, 2003). Results such as these surely would indicate to clinicians the need to reduce the use of the EFM. However, the monitor continues to become standardized - most likely because of the technocratic approach to pregnancy and birth that Davis-Floyd (1992) highlights. Pregnancy and birth are medicalised and actively managed in the name of foetal health. At the same time the use of the EFM provides objective data and records in the case of possible litigation cases for the obstetrician. What is also of interest is the development of new electronic foetal monitors such as the oxygen monitor. Therefore, the continuation of the widespread use of the EFM and those like it are reflections of societal needs rather than woman centered needs. This is evidenced by the constant emphasis on not only obstetric responsibility but also on individual responsibility for health outcomes, as well as issues of control and perfection. These themes will be discussed more fully within Chapters four through eight.
The active management of birth

Ann Oakley (1980, 1984) and Oakley and Houd (1990) conducted various studies on the medicalisation of childbirth and found that there has been a widespread adoption of statistical knowledge to manage the duration of birth. Childbirth, an event which can be experienced by women in vastly different ways – has become normalized and set to a timetable. Both the private birth and birth center mothers often expressed this during their interviews. However, this sentiment was more commonly expressed by the private birth mothers, this will be further demonstrated within Chapter seven.

Statistics related to the ‘normal’ pregnancy and birth have been present, according to Hacking (1990) at least from the time that statistical methods were applied to human conditions in the middle of the last century. This particular time period that Hacking points to correlates to the time where political will and bureaucratic mechanisms were established such that populations and population characteristics could efficiently be counted.

Various authors have highlighted the abundance of public health information in this century with the resulting measuring of all aspects of population characteristics. Obstetrics, specifically, and medicine in general were at the forefront of these statistical developments (Arney, 1982). The development of categories such as normal, low risk and high risk are very important in relation to the conduct of obstetricians as well as the expectant woman. Oakley (1984) contends that it is only through the technological developments of the last several decades that obstetricians
have been able to apply statistical knowledge to birth and use it to justify interventions.

Time frames are placed on the expectant woman from the moment that her pregnancy is first confirmed by her general practitioner. A due date is estimated, although it is often expressed as the date the baby is due. Appointments are set for the following trimesters and much of the information that the woman reads relates to pregnancy and birth being broken down into stages. Each stage relates to what is expected for the normal pregnancy and birth. During the birth process the birth attendants and obstetrician are very aware of the various stages, with the obstetrician having most of the responsibility at the last stage. Time becomes central. The woman’s body, whether she is aware of it or not, must comply with a predetermined schedule. The following quote derived from Bassett et al. (2000) is a demonstration of how stages and time are central in a maternity ward:

You want to know what is the biggest problem with having a baby in this place? Look up there. See that round thing? There is one in every patient’s room, in every hall, and in every part of the nursing station. Everything we do is dominated by that. We act, we record, we defend ourselves in relation to it. Get rid of those clocks and you’ll get rid of most of our stress, our arguments and our fears. (cited in Bassett et al., 2000: 532)

These issues can be related again to Robbie Davis-Floyd’s technocratic model. As discussed previously, it encapsulates a dominant belief system in which “technologies have developed in a hierarchical social context that supervalues them and the individuals who control them” (1992: 47).
An outcome of the time frames that is placed on the birth process is the increased rate of interventions and CS. The development of Clinical Practice Guidelines, also known as Best Practice Guidelines in Australia, often leads to defensive actions being taken in the case that labour has exceeded the given time frame. The outcome of the development and broad application of the EFM and other interventions such as CSs has been to develop a particular form of obstetrical care, which reflects among many other things defensive medicine practices (Bassett et al., 2000). Best practice guidelines, based on quantitative measures, gives priority to meaning developed through medical scientific constructions of physiology (Ginsburg & Rapp, 1995).

The Medical Indemnity Crisis of Australia

In 1999 The Senate Inquiry into Childbirth Practices found that many practitioners and other witnesses raised concerns about the impact of litigation on birthing service practice and provision. It was here that many spoke of their practice of ‘defensive medicine’. Many spoke of their apprehension in refusing a demand caesarean and an increase in use of screening technology. For instance, Professor Chamberlain stated: “It is certainly a not uncommon statement from physicians that no one gets sued for doing a caesarean section” (Commonwealth of Australia, 1999: 393)

The issues that were raised within the Senate Inquiry had previously been discussed in some depth within the Review of Professional Indemnity Arrangements for Health Care Professionals. The review was established in April 1991 by the Federal Government to look at the adequacy of compensation and funding arrangements for
health care misadventures in Australia. The Report, which came to be known as the “Tito” report after the Chair, initially sought information on how many adverse patient outcomes arise from health care services, how severe they are and the impact they have on those services (Tito, 1995).

The difficulty in researching this area, then and now, is the lack of information or data available to answer questions such as these. No Australian studies had been undertaken up to the commencement of the review and only limited information was available from standard health and other statistical collections and from claims data held by insurers, medical defence organisations and State Government bodies. The Review decided, therefore, to collect new Australian data. The preferred approach was that which had been taken by the Harvard Medical Practice Study.

The Harvard study, which issued its main report in February 1990, was carried out to inform the policy debate which was occurring in New York and elsewhere about how society can best deal with its medical injuries and malpractice. It focussed strongly on the issue of negligence in adverse events. It analysed the records of 30,121 randomly selected admissions to 51 acute care, non-psychiatric hospitals in New York State in 1984 to describe the incidence of adverse events. An adverse event was defined as an unintended injury caused by medical management which resulted in the prolongation of hospitalisation or temporary or permanent impairment or disability in the patient.

In summary, the Harvard study concluded that: 1) malpractice was frequent in the hospitals studied, 2) a high toll of avoidable medical injury nationwide can be
inferred from this frequency rate; and 3) relatively few of the injured patients actually sued.

These findings were mirrored by the Australian Professional Indemnity Review’s (PIR) Final Report. In the Final Report, the issues of professional indemnity, negligence actions and adverse outcomes were described as surrounded by myths and assertions, supported by little hard data. Much of the information relating to the ‘litigation crisis’ was anecdotal: "evidence for a so-called claims crisis is scant", said the Report, concluding that a crisis mentality has been fostered by some medical defence organisations to deflect attention from their own "irresponsible financial management" (Tito, 1995: 14). What the PIR did reveal was a crisis not in the number of legal claims; rather it was in the incidence of medical negligence within Australia. More specifically, the PIRs research concluded that there were very many adverse patient outcomes which arose out of health care in the Australian system – considerably in excess of 400,000 per annum, with around 230,000 being preventable with current knowledge. Of such outcomes, 20% resulted in permanent disability or death. With the 230,000 adverse patient outcomes there appeared to be fewer than 2,000 tort claims commenced each year where health care negligence is alleged. Many of these conclusions were supported 18 months later by the report of the Victorian Law Reform Committee in 1997.

The flawed nature of the ‘claims crisis’ was also reflected within the work of the Subcommittee of the PIRs case study of Birthing Services within Australia. The motivator for the extensive research in the area was the widespread public concern
about whether professional indemnity issues were affecting birthing services. The subcommittee was established in 1993 and the members included representatives from State Governments and Commonwealth Governments, all relevant professional and industrial groups, consumers, medical defense organizations (MDOs) and the insurance sector.

The subcommittee’s main goals were to explore issues such as whether practicing specialists and general practitioners are ceasing to provide obstetrics services because of increasing indemnity premium levels, and that wider use of midwives is being discouraged because of the difficulty in obtaining adequate professional indemnity cover. The subcommittee also explored medical indemnity contributions, contingent liabilities of MDOs, Statutes of limitations and the issue of causation (Tito, 1995).

At the time of the report it was found that whilst indemnity premiums had increased, analysis of Medicare data undertaken by the PIR did not indicate that practitioners were shifting from obstetrics to gynaecology or other sub-specialties. This has slowly changed over the years, as I will discuss shortly. In a research paper stemming from the PIR (Hancock, 1993) it was found that Australian doctors are very aware of the threat of litigation. The research conducted a mail questionnaire sent to a national stratified random sample of doctors, chosen proportionately to State/Territory and medical specialty by the Medical Statistics and Analysis Section of the Commonwealth Department of Health. This created a representative sample size of 1,158 doctors. The key objective was to identify doctors’ perceptions of the relationship between medical litigation and clinical practice. The doctors’ awareness
and fear, it was found, led to a significant proportion of doctors adopting defensive medical practices. Significantly, for this thesis, it found that obstetricians and gynaecologists were influenced to change their clinical practice most frequently. The study concluded that doctors’ fear of litigation is generally far greater than the actual likelihood of being sued or having a complaint made against them. However, a recent poll carried out by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) found that of its 1300 members, 53% of the more than 1,000 who responded had been contacted by a patient’s lawyer (cited in Robotham, 2001b).

This background of increasing litigation, or fear of litigation among health care professionals can be seen to have a direct connection to the behaviour of doctors and others in the health system, with defensive medicine being one outcome. This can be one explanation put forward for the high rates of intervention mentioned throughout this thesis. As seen above it is reflected within various inquiries and also reflected within various accounts from obstetricians portrayed within the media and furthermore found within the fieldwork of this research. For instance, one Sydney obstetrician recently stated “with the costs being so great for us we of course do become very careful about who we treat and how we treat them. We are obliged not to take any risks at all” (Whelan, 2000: 10).

This fear of litigation within the medical arena has led to claims of positive developments. For example, further development and implementation of medical
practice guidelines by Medical Colleges and Government departments. This was highlighted within the PIR report:

While there appeared to be many practice changes because of fear of litigation, many of these changes were probably beneficial for patient care. These included better record keeping, spending more time explaining things to patients, seeking second opinions and a range of other practice changes which may, in fact, have enhanced quality of care, even where it has possibly led to additional costs to the health system. (Tito, 1995: 129)

However, the negative effects of defensive medical practice are also significant, and outweigh the suggested positive effects. Patients are routinely refused access to their personal medical records on the advice of doctors' insurers. An example of how pervasive this advice has become is in the use of ultrasounds in gynaecology and obstetrics. A recent medical study revealed that doctors in this area have been advised to withhold copies of ultrasounds from patients to limit their potential exposure to liability for negligence (Woodrow, Crespigny & Gillies, 1999).

Arguing that clinical care is in a defensive medicine ‘crisis’ and stems from perceived or actual threats of legal action implies that the defensive medicine problem can be solved by improving the legal defenses available to physicians, by restricting claim frequency and award size or by removing the potential for lawsuits altogether. As is being outlined, defensive medicine understood in this way has received considerable attention in the medical and legal literature as well as in the media. The literature is vast emphasizing avoidance of litigation within publications from medical organizations and insurance companies and associations to measuring defensive medicine by calculating the extent to which litigation concerns the clinical outcome. What seems to be the uniting theme amongst all of the literature is the examination of
defensive medicine almost exclusively as the influence of law on medicine. The extent to which defensive medicine results from technological innovation and accordingly affects law is absent.

A Timeline of the Medical Indemnity Crisis

Various key events have impacted on the environment of birthing services within Australia. Following is a brief overview of some of these events including the provisional liquidations and exodus of key players within the insurance industry in Australia.

In November 2001, Calandre Simpson won her 14-year legal battle against UMP and obstetrician Robert Diamond for negligence. The $12.9 million dollar payout was justified by Justice Tony Whealy by Simpson’s disabilities which were so severe and sweeping that she required assistance with every aspect of her life, 24 hours a day, 7 days a week. Although UMP, who insured Simpson’s obstetrician, was on notice to plan for such a large payout 14 years ago, it caused shockwaves within the Medical profession. The fear was the increase in medical indemnity premiums with the result of more doctors leaving the profession.

The state government responded by announcing a detailed scheme to limit the burden on medical defence funds to $1 million in some public hospital cases. This was on top of the Health Care Liability Bill developed earlier that same year where capping maximum levels for past and future earnings compensation and for non-economic losses, including the abolishment of punitive damages from medical negligence cases
was the outcome. Set by NSW State Government, it also made indemnity coverage compulsory and increased the regulation of the medical indemnity industry.

It was the Health Care Liability Bill, which according to UMP, added to the financial pressures of an already struggling industry. The rush of litigation in an attempt to avoid the tort law reform added to the financial instability partly created by the collapse of HIH\textsuperscript{5}. Following the collapse, Guild insurance pulled out of Australia leaving Australia’s 70 registered independent midwives without medical indemnity cover. The situation of the midwife within Australia will be explored more closely within the following section including the independent midwives inability to acquire indemnity coverage or be included within the Medicare system.

By mid 2001, UMP acknowledged that it had $550 million of known claims covered by funds of over $650 million; however, it had a further $455 million in anticipated claims which it had not included – leaving a balance of $350 million in under funded liabilities. This in conjunction with the Calandre Simpson payout, September 11 and the exodus of the insurance company St Paul\textsuperscript{6} in December of 2001 led to the further demise of the indemnity industry.

In the midst of this Nation wide crisis, NSW was experiencing an additional crisis. In late 2001, the NSW Government was confronted by a threatened walkout of specialists from public hospitals and rural areas over the high cost of professional indemnity. It became apparent that NSW was the only state of Australia which did not provide Visiting Medical Officers with indemnity coverage, leading to the threat
of mass resignations. In the end the State government provided cover for the doctors through the NSW government treasury managed fund.

By the beginning of 2002, the indemnity crisis was mounting. The Australian Prudential Regulation Authority (APRA) gave UMP until June 30th, 2002 to double its capital reserves. APRA investigated UMP after an alarming deterioration in its financial position which saw UMP’s capital reduce from $118 million on June 30th, 2001 to $38 million by December 31st, 2001. The end result was the provisional liquidation of UMP which witnessed 32,000 medicos without coverage.

The escalation continued with various closures including the Family Planning Association on May 31st, 2002 because of its inability to secure indemnity insurance. Furthermore, various rural obstetric services were threatened because of staff shortages. This eventuated in instances of total shutdown of services. For instance, in August 2002 Port Macquarie Hospital announced it would end private obstetrics treatment from the beginning of 2003. It was the first instance of loss of an entire service resulting from the medical indemnity crisis.

Closures, service shutdowns, walkouts, and threatened mass resignations led both the Federal and State government to instigate actions to alleviate the crisis. In October 2002 the NSW government created further tort law reforms in a bid to curb the crisis. The reform largely restored the ‘Bolam Principle’ which finds a doctor cannot be found negligent for following accepted medical procedures. The Law of Negligence Review found that a medical practitioner is not negligent if the court is satisfied that
the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the relevant field, unless the court considers that the opinion was irrational.

In the words of Fiona Tito, author of the PIR, the legal system is far from a perfect place for consumers with a medical injury. The disadvantages are many - the chances of getting compensation are limited, the amount awarded unpredictable, the delays in receiving it, and the expense of engaging lawyers. The PIR (Tito, 1995: 174) concluded that patients face the greatest challenges in gaining satisfactory outcomes from litigation. The complex and specialized nature of health care raises particular hurdles for patients. They are faced with trying to support their claims against practitioners and their defence funds that often have ready and permanent access to specialised advice and opinions.

The various reforms which have taken place since the publication of the PIR makes Tito’s comments a harsh reality. Yet, support for the reforms dominate. Where the shift of responsibility lies even more with that of the individual. For instance, the then Minister for Revenue and Assistant Treasurer Helen Coonan found that the:

Commonwealth, and all States and Territories, are grappling with ways of implementing responsible reform which will take the pressure off insurance premiums while providing adequate protections for consumers. The review of the law of negligence provides a range of significant proposals and outlines a principled approach to reforming tort law which impose a reasonable burden of responsibility on individuals to take care of others and to take care of themselves. (Coonan, 2002)

As mentioned above, this form of support is not extended to the midwife or to such organizations as Family Planning. In September 2002 the Federal Government
announced a rejection of the National Maternity Action Plan in its bid to extend Medicare to midwives – despite the growing literature on the reduction of costs and mortality and morbidity statistics available through midwifery led care (Roberts et al., 2000; Tracy & Tracy, 2003). This is later magnified by the growing increase for obstetricians with the announcement of payouts averaging $15,000 a year more to each country obstetrician to ensure the medical indemnity crisis does not trigger a further decline in bush maternity services.

Despite the lack of governmental support, midwifery led services are beginning to operate in areas deficient of obstetricians, although their future is insecure. For example, Shellharbour hospital announced in June 2003 a midwife only birth plan. The local Area Health Service operates Wollongong Hospital and Shellharbour Hospital as a single entity spread over two campuses (Shellharbour being a 25 minute drive from Wollongong). The local area health service has operated a very obstetrically dominated maternity service for many years, especially after the Birth Centre at Bulli and smaller units at Kiama and Port Kembla were closed to consolidate obstetric care in one centre. The Birth Centre at Wollongong was also closed not long ago as part of the ‘renovation’ of the hospital.

Shellharbour has previously employed a midwifery model of care, but as stated above the hospital was unable to fill its obstetric roster with the announcement that obstetricians would no longer travel to Shellharbour. Initially, the Region’s Administrators announced the maternity service would therefore have to close down. Yet, an opportunity was seen for the establishment of a midwifery unit, along the
lines recommended in the NMAP Report. Representations were made to the relevant authorities and the State Government indicated that this would be a pilot region for the new models of midwifery care. With the approval from the Maternal and perinatal committee from NSW Health the midwives began their program. Unfortunately, as of January, 2004 obstetricians have announced they would not provide any backup for the new unit and the local Regional Administrators have bowed to the pressure and said the Shellharbour unit would operate as a midwifery unit but only offering pre and postnatal care - the women would have to give birth in Wollongong itself.

As changes such as midwifery led units in 2003 began to emerge it was revealed in August 2003 that almost half of the country’s obstetricians were planning to abandon private practice in the following five years\(^8\), affecting – they argued – the delivery of up to 17,000 babies by 2008. The threat of litigation, the cost of medical indemnity and the constant pressures of practice and its impact on family life were the reasons put forth. Doctors were warning that the public hospital system would be increasingly struggling to meet the demand created by the exodus of private obstetricians. This finding followed the new indemnity legislation in July 2003 which required doctors to pay any difference in liability cases after their insurance cap.

It was in this environment that a mass resignation of doctors (72) from NSW public hospitals had forced the Federal Government to announce an 18-month moratorium and a review of a levy which covers possible future lawsuits. On October 3\(^{rd}\), 2003 government representatives met with the President of the Australian Medical
Association, the president of the royal Australian college of surgeons, the president of
RANZCOG and representatives of other doctors’ organizations about doctors’
concerns over the impact of Incurred but not Reported Claims (IBNR). Tony Abbott
the new Health Minister concluded that all levy notices in excess of $1000 a year will
be rescinded for the next 18 months. The Federal government was aware that the
levy, due to be paid on November 1st, was one of the key factors leading to the
announcement of the doctor’s intention to leave their work in the public system for
the private system to fund their indemnity costs.

This announcement does little to abate the fears of doctors. On October 8th of the
same year staff specialists from seven of the twelve main teaching hospitals,
including Westmead voted to withdraw all services except emergency duties from
October 27th. At Mona Vale Hospital about 20 Visiting Medical Officers (VMOs)
(approximately 81% of the hospitals VMOs) voted to resign. Their decision came the
same day as 55 specialists from Royal Prince Alfred voted to hand in resignations on
October 31st, effective three months from that date.

On December 16th 2003, Tony Abbott unveiled the recently passed Federal
Government medical indemnity package. The package does not meet the
expectations of both Abbott and many doctors where the taxpayers would meet the
entire cost of the $460 million Government guarantee to prevent the collapse of the
doctor controlled indemnity insurer, UMP. Instead doctors will pay up to 7.5% of
their gross income on the levy, with the Government picking up 80% of the costs
above that threshold. Furthermore, the threshold, or the point at which the
Government meets 50% of damages claims against doctors will be lowered from $500,000 to $300,000. The new measures that have been adopted will cost an extra $181 million over 4 years. That is on top of the previous commitment of about $438 million over the same period.

For the time period, despite many seeing the medical indemnity package as only a bandaid, the threat of mass resignations seems to be abating. Within NSW over half of the 140 who said they would walk out over medical indemnity costs have committed to staying in the health system. Figures from the NSW Health department show 71 doctors have officially withdrawn their resignations, which were due to take effect between Christmas and the first week of January 2004. Of the 66 doctors whose resignations were still pending, 24 have told health officials they intend to stay in the system. Northern Sydney and Western Sydney areas show nearly all doctors withdrawing their resignations. This is significant because these two areas comprise the largest numbers of VMOs.

Yet, despite the gains in the medical indemnity crisis, specialists such as obstetricians, neurosurgeons and orthopedics are still in crisis. Perhaps this is due to the long tail risks that are open to these groups. For example, obstetricians are open to lawsuits up to 18 years after a birth. As one obstetrician put it to me: “The disturbing reality is that some medical procedures in Australia are now virtually uninsurable”. This aspect of the ‘uninsurable’ fits in well with the work of Ulrich Beck. As Beck (1992) contends the risks of high modernity are invisible, uninsurable, systematic, generic and democratic.
The consequences of the indemnity crisis not only contribute to the practice of defensive medicine but it also contributes to policies based on risk categories. As we have seen above there are closures of birth centres, and obstetricians rejecting patients or carrying out procedures they might not have in the past. What are hidden are policies that are employed within various institutions, such as birth centres which work on the basis of the risk category. For instance, birth centers have the right to reject a client based on conditions such as age, medical conditions or a previous caesarean section. Furthermore, beyond the impact of a governmentally backed definition of pregnancy and birth as being in need of obstetric care, the indemnity crisis greatly reduced the choices available for the pregnant and birthing women of Australia. Homebirths are becoming almost obsolete, as independent midwives do not hold indemnity coverage. Birth center births are available, however, the number of women able to take up these services will gradually decline as the age of first time mothers continues to increase.

In the end, the medical indemnity crisis is an important example of the unintended consequences of modernity which Beck (1992) speaks of. ‘Unintended consequences’ denotes a conflict of knowledge or rationalities. In Beck’s reflexive modernity we see the claims of different experts collide with not only one another but also with claims of lay knowledge and of the knowledge of social movements (Beck, 2000b). This can be readily applied to the situation at hand. Yet, for Beck, the last two forms of knowledge can be argued to stem from expert knowledge. However, because of notions of status and social credibility they are not acknowledged as expert knowledge and consequently are not valued as such by institutions such as law,
politics and business (Beck, 2000b). This will be further explored within Chapter four.
CHAPTER THREE

METHODOLOGY

The positivist – subjectivist dichotomy

*Sociology . . . is a science concerning itself with the interpretive understanding of social action and thereby with a causal explanation of its course and consequences. We shall speak of 'action' insofar as the acting individual attaches a subjective meaning to his behavior--be it overt or covert, omission or acquiescence. Action is 'social' insofar as its subjective meaning takes account of the behavior of others and is thereby oriented in its course. (Weber, 1921/1968: 4)*

Before exploring the methodological approach employed throughout this research, the following section will examine one of the core problems facing the active social science researcher – regardless of their discipline; namely, the positivist –subjectivist dichotomy. To begin this brief analysis, Weber’s notion of Verstehen will be discussed.

For Weber (1949), the construction of a definitive and exhaustive system of concepts is impossible and therefore an illusion. Reality is a dynamic stream of events that is in a state of perpetual flux. Sociocultural disciplines are therefore endowed with eternal youth because culture in its endless progressions invariably leads these disciplines to novel problematics. Following a *Verstehen* approach limits a tendency to ascribe characteristics to these actors and therefore reduces what Weber calls a ‘dogmatic’ conceptual construct. Indeed, all analytical concepts are specific to a particular historical and cultural environment. It is therefore necessary to search for less ascribed concepts, that is those found in ‘local realities and meanings’ and minimise the cultural gap between insider and outsider accounts. Therefore, this research is
understood to be a study conducted by an outsider, but as a mother of two children I am also included in the ‘local reality and meaning’ of these actors. However, while following a *Verstehen* approach, the researcher tends to also distance herself from the participants to gain an overall view. For this reason, a ‘synoptic approach’ is adopted. A discussion of this follows.

In the current academic world, it is impossible for a sociologist or an anthropologist to be a ‘scientist’, following the positivist illusion of the social world as completely amenable to objective study. On the other hand, the method of subjectivism faces problems as well. J.P. Olivier de Sardan (1992: 8) compares this method as ethno-ego-centrism in which the ‘I’ of the researchers dominates the literature through their feelings or “by cloaking their involvement in intrigue”. According to the author (1992: 161), “subjectivism does not avoid ethnocentricity any more than positivism does” and “the positivist approach which regards the involvement of the researcher as unproblematic, and the subjectivist approach which regards the first-person narrative as some of miracle solution often achieve similar results”.

The solution does not lie in either of these extremes. What this research follows is a ‘synoptic approach’ (Hanford 1975) in which objectivist and subjectivist orientations are not seen as opposites, but as complements. As Geertz wrote, the symbolic universe of the actors is to be the point of departure, not the final destination (quoted by Karcher et al. 1981: 22). Emic data (subjectivist) have to be strongly taken into consideration, not as an end, but rather as part of the process of obtaining valid etic categories (objectivist). As Karcher et al. (1981: 100) state:
an objective viewpoint demands continual motion, back and forth between immersion in emic data and construction and reconstruction of etic categories.

This synoptic orientation does not exclude the approach to ‘differences’ in favour of unity; it includes both. This principle means that, in this case, my participants approach to their pregnancy and birth can be studied both from the inside as well as from the outside because that approach “includes the rigour of empiricism without its reductionism and includes the challenge of the phenomenologists without their insufficient means for validity” (Hanford 1974: 219).

**Researching Risk Society**

Human beings reflexively monitor their conduct via the knowledge they have of the circumstances of their activity. (Giddens, 1979: 254)

Since the publication of Ulrich Beck’s translated work *Risk Society* in 1992 there has been a plethora of research into individual’s perceptions and understandings of risk knowledges. Within the social sciences much of this research is of a quantitative nature, focussing on attitudes and behaviours that can be measured and later statistically analysed (Tulloch & Lupton, 2003). This quantitative approach is common within the field of psychology and tends to portray the lay individual as deficient in his or her ability to judge risk situations. The research is largely carried out in laboratory settings with the use of surveys or matrixes. Whilst this form of research has demonstrated that perceptions of risk form certain patterns and are influenced by social and cultural factors, such research tends to portray the individual
as a “universal, rational agent who is focused on avoiding risk, or else is ignorant in her or his assessment of risk” (Tulloch & Lupton, 2003: 8).

In contrast, we find a body of sociological research which seeks to understand and locate the existence and logics of risks within particular historical and sociocultural settings. Various research has demonstrated that risk knowledges tend to be highly contextual (for instance Wynne, 1996; Lupton, 1999a; Caplan, 2000). Cultural and social backgrounds are seen to act as partial determinants in the construction and meanings of risk that lay people attribute to them (Tulloch & Lupton, 2003). Accordingly, this research will also employ various sociocultural theorists’ writing on risk to explore the various levels of meaning, from the social structural to the cultural and symbolic. The insights of these theorists will aid in analysing various facets of the issues surrounding the medicalisation of pregnancy and childbirth and will extend the previously mentioned research in the area of sociology of childbirth.

The theoretical underpinnings can be said to follow a constructionist perspective; from this perspective all knowledge about risk is bound to the sociocultural contexts in which this knowledge is generated. Risk, therefore, is not a static, objective phenomenon, but is constantly constructed and negotiated as part of the network of social interaction and the formation of meaning. Accordingly, it is argued that we can only ever know and experience risks and security through our specific location in a particular sociocultural context. As Beck (1996: 4) states “…risks are social constructs which are strategically defined, covered up or dramatised in the public sphere with the help of scientific material supplied for the purpose”. 
The social constructionist perspective understands people as reflexive subjects who experience and respond to risk via communal, aesthetic and shared symbolic meaning (Lupton, 1999a). The term reflexive is defined here as not merely self-monitoring but also self-interpretation and evaluation of social processes, conducted through hermeneutic understandings, or those that seek to understand the deep meaning and significance of actions, words, deeds and institutions (Lash, 1993).

An important aspect of understanding an individual’s perception of risk is to recognise individuals as reflexive subjects whose perception and response to risk is shaped and constrained by the particular framework or setting in which it occurs. Therefore, the emphasis of analysis is placed on social action and social setting. More specifically, the methodology employs a qualitative perspective which explores issues of discourse and of the micro and macro context in which risk is experienced and given meaning.

The Research

The research includes 45 interviews in the form of birthing narratives with women stemming from three separate birthing fields; namely the private hospital, the midwifery led birth center, as well as homebirth mothers. Women were recruited into the study by a combination of methods. Private hospital and birth center respondents were approached through information sheets and posters posted throughout the maternity section of the institutions. This was problematic at times as I remained a faceless researcher to the women, where the only appeal lay with the interest of topic.
For this reason, a limited snowball sampling was also employed for these particular fields. In relation to the homebirth mothers, I contacted various independent midwives found on the Internet and asked them to disperse the information sheets. I also sent out an appeal on various listservs that were aimed at the homebirth mother. Again, snowball sampling was implemented to recruit this particular population.

The Senate Inquiry into Childbirth Practices (Commonwealth of Australia, 1999) provided the impetus for investigating these particular fields. The report of the Inquiry indicated that there was a marked difference in the rate of medical intervention among women who are public patients and those who are private patients. For instance, it was found that in “1997-98 18% of public admissions were delivered by caesarean section against 27% from women with private status” (1999: 81). Roberts et al. (2000) mirrored this finding in their research which found variations amongst private and public patients but also variations between States.

The birthing narrative inquires into women’s constructions of their ideal births and their actual experiences (Zadroznyj, 2001). This approach, as Robinson (1990) contends, allows for the framing of events in a temporal and causal sequence and as such constructs a particular type of account. This approach brings into view the respondent’s reflexivity as well as highlighting shifts in their subjective and lived experience (Zadroznyj, 2001). The birth narratives were constructed through a semi-structured in depth interview, developed during a pilot study, with women soon after their birth experience, from 3 birthing fields which represent the middle class socio-economic areas of New South Wales.
This research centres on women of a white, middle class, English-speaking background. It seems that women from this particular background, given the reality of the Australian health care system, could be expected to receive the best that the Australian health care system has to offer. It is a well documented sociological phenomenon that poor women giving birth in hospitals must accept prenatal care from the public system, have no choices in regards to their primary carer or birth environment, are assigned for birth to whatever obstetrician happens to be on duty, and are usually given little or no choice as to how their births are managed, and that women of various ethnic or racial backgrounds often receive unfavourable medical treatment (Davis-Floyd, 1994; Lazarus, 1994; Martin, 1989; Nelson, 1983; Scully, 1980; Shaw, 1974). This can be seen within Australia by the higher maternal mortality rate among Indigenous childbearing women as well as women from Cultural and language diverse backgrounds (NHMRC, 2001). In relation to this issue Martin writes of the “differing treatment of women in labour,” concluding that whether the dominant mechanism is race or class “both profoundly affect birthing” (1987: 155). She continues:

For a white middle-class woman, the salient issue may be to stall going to the hospital so the clock cannot be started or to organize and demand that all hospitals in the region install birthing rooms; for a white working-class woman…lurks the larger issue of finding a way to pay for prenatal, obstetrical, or infant care; for a black working-class woman, the issue of stalling and paying may be crucial, but even if she contends with them, she still may have to find a way to avoid downright mistreatment or to manage to have matters explained to her at all. (Martin, 1987: 155)

Nelson (1986) provides one of the most revealing instances of this problem with her research which was specifically designed to examine class differences in childbirth.

In her conclusions she argues that another model is needed for “working-class women
who have fewer opportunities for making choices; even pregnancy often appears to be outside their control” (1986: 171).

Three Representations of the Cultural Field of Birth

Australian maternity care has features of the British and American systems; all women are covered by national health insurance, which provides free maternity care for patients in public hospitals, but about one third take out private medical insurance or pay for private obstetric care (Roberts et al., 2000). For private patients, antenatal care is provided by obstetricians chosen by the woman and delivery may occur within a private or public hospital. It is through this system that a woman is provided with continuity of care, however she is also subjected to a highly medicalised approach to pregnancy and birth. The public patient on the other hand receives antenatal care and birth care at public hospitals. Care is provided by rostered midwives, residents, registrars and staff obstetricians. Continuity of care is not provided for, but if the woman finds herself in a primarily midwifery led hospital she is less likely, than the private patient, to have medical intervention during delivery. Furthermore, within Australia, and especially within NSW, home birth is no longer a viable option. Whilst this does provide the woman with the much needed continuity of care and the autonomy needed for a successful birth, the eradication of indemnity coverage for private practicing midwives has meant the option of homebirth is quickly disappearing.

In a recent study (Roberts et al., 2000) research was carried out to compare the risk profiles of women receiving public and private obstetric care and to compare the rates
of obstetric intervention among women at low risk in these groups giving birth in NSW. It was found that indeed there was a higher rate of intervention among women in the private sector, which has been linked in this study to fear of litigation, financial reward, time pressures, and widespread use of electronic fetal monitoring and epidurals. Fisher et al. (1995) found that in addition to private insurance, women who are well educated, assured, and have mature personalities face an increased possibility of obstetric intervention.

The Parliamentary inquiry (Commonwealth of Australia, 1999) whose mandate was to explore the differences between public and private care, heard repeated submissions that high caesarean rates in the private sector are probably because large numbers of women at high risk take out private health insurance for pregnancy care. However, there is no data to support this assertion. In fact one must and should question the different rates of obstetric intervention amongst the two fields of private and public patients. However, rates of intervention cannot be simplified to just these two areas. In fact there is a difference in rates of intervention amongst three separate forms of hospital or what I would call three distinct representations of the cultural field of birth; namely the private hospital, the public tertiary hospital and the public midwifery led hospital. Although this research initially sought out women who undertook their care through the public tertiary system as well as the others mentioned, the investigation of this particular population ceased when it was found that the women of a middle class background were poorly represented in the area health system studied.
The Interview and Introduction of the participants

The research took the form of semi-structured interviews. As stated above there were 45 women interviewed in total, 18 private birth mothers, 14 homebirth mothers and 13 birth centre mothers. All interviews, with the exception of 8 homebirth mothers, were conducted face to face and recorded on an audiotape. The exception of the 8 homebirth mothers was solely due to distance. As it is estimated that less than 1% of the population gives birth at home, it was difficult at times to find women to interview within a 2 hour driving radius, therefore, these particular women (who still resided within NSW) were interviewed over the phone with the aid of an audio tape. These interviews lasted from 90 minutes to 3 hours and were later transcribed in full. They were carried out from mid 2002 to late 2003. The interview questions were designed to be open-ended, allowing all of the participants to expand upon their own experiences and opinions. Among other issues the participants were asked to explore the practices that they undertook during pregnancy - such as change in diet or exercise as well as reading material and classes they explored for the preparation of the upcoming birth. Some questions were framed in direct relevance to the risk society thesis. Therefore, notions of risk, responsibility, security, trust, and relationships to experts were highlighted.

Presentation of the Participants

Qualitative research does not aim at being representative, rather it provides a much more holistic account of person’s lives, stories and behaviour (Strauss & Corbin, 1990: 17). With this research, the participants gave their views of what they
understood and believed and how they made sense of their experience. Employing a qualitative approach enabled the researcher to examine the interpretations and experiences of the women in great depth. Furthermore, as the interview schedule questions were open-ended in form, this allowed the respondents to raise issues and topics which may not have been included by the researcher. Accordingly, although this research is not representative of all women’s expectations and experiences of pregnancy and birth – the data collected is rich in depth and scope. Following is an introduction of my respondents: the private, birth centre and homebirth mothers. The respondents are presented in this chapter within the order that they were interviewed.

**Tania:** Tania was 29 years old at the time of the birth of her first child. She had been with her partner for 10 years and had planned the pregnancy. She is a nurse by occupation. Tania has a previous medical condition relating to her kidneys. She also had 1 miscarriage prior to this pregnancy. Her approach to health care is geared toward Western medicine. She and her husband both actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Tania gave birth within a private hospital with the services of a private obstetrician who was referred to her by her GP. She demanded an induction for the birth of her baby. She does not plan on changing the mode of care for subsequent pregnancies and births.

**Millie:** Millie was 22 years of age when she gave birth to her child. She had been with her partner for 1 year prior to falling pregnant and they did not plan the pregnancy. Millie is a midwife by occupation. Her approach to health care is a mixture of Western and alternative. She often approaches a naturopath for advice rather than a general practitioner. Both her and her partner actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Millie chose to give birth at home with the services of an independent midwife who was referred to her by a friend. She does not plan on changing the mode of care for subsequent pregnancies and births.

**Sonia:** Sonia was 33 years of age when she gave birth to her first child. She had been with her partner for 5 years prior to falling pregnant and they planned the pregnancy. Sonia is a manager for a large corporation. Her approach to health care is a mixture of Western and alternative. Both her and her husband actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Sonia chose to give birth through a birth centre which she researched because of her strong desire to birth within that environment. She does not plan on changing the mode of care for subsequent pregnancies and births.

**Helene:** Helene was 30 at the time of the birth of her first child. She had been with her partner for 10 years prior to falling pregnant and they had planned the pregnancy. Helene is an art historian. She had a previous medical condition relating to her reproductive system and had experienced 1 miscarriage in between the birth of her first and second child. Her
approach to health care is a mixture of Western and alternative. Both her and her husband actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Helene’s first birth was at home and her second birth was through a private hospital through the services of an obstetrician. After her first birth in Holland she always planned on giving birth at home. However, returning to Australia she realized that the system did not allow for this in terms of financial reimbursement or infrastructure. Helene plans on seeking out an independent midwife for a home birth for any subsequent pregnancies and births.

**Jen:** Jen was 33 years of age at the birth of her first child. She had been with her partner for 10 years prior to falling pregnant and they had planned the pregnancy. Jen is a Childhood Education Consultant. Although she was an avid reader in preparation for her pregnancy her husband did not participate. He did, however, attend all antenatal classes. Jen’s birth was at a private hospital through the services of an obstetrician who was suggested by her GP. She does not plan on changing the mode of care for any subsequent pregnancies and births.

**Natalie:** Natalie was 30 years of age at the birth of her first child. She had been with her partner for 3 years prior to falling pregnant and they had planned the pregnancy. Natalie is an Independent Childhood Educator. She developed a liver condition during her first pregnancy which affected the subsequent 3 pregnancies (all pregnancies were planned). She has not experienced any miscarriages. Her liver condition drove her to exploring more alternative approaches to medicine. Both her and her husband actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Natalie gave birth to all 4 of her children at home. She does not plan on changing the mode of care for any subsequent pregnancies and births.

**Wendy:** Wendy was 32 years at the birth of her first child. She had been with her partner for 7 years prior to falling pregnant and had planned both her first and second pregnancy. She is a technician by occupation. Her approach to health care is geared toward Western medicine. For her first pregnancy and birth both her and her husband actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. The second pregnancy saw less involvement from the husband. Wendy planned to give birth to her first child through a birth centre, however, she was transferred to the hospital. She gave birth to her second child within a private hospital setting. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Kylie:** Kylie was 32 years of age at the birth of her first child. She had been with her partner for 5 years prior to falling pregnant and they had not planned on falling pregnant. Kylie works as an administrative personnel within a hospital. Her approach to health care is a mixture of Western and alternative. Both her and her husband actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Kylie gave birth within a birth centre setting based on the location of the hospital and advice she had received from friends. She does plan on changing her mode of care to a private setting for any subsequent pregnancies and birth.

**Gabrielle:** Gabrielle was 36 years of age at the birth of her first child. She had been with her partner for 1 ½ years prior to falling pregnant and they had planned the pregnancy. Gabrielle is an academic researcher, prior to this she was a nurse. She has had a previous medical condition but has not suffered any miscarriages. Her approach to healthcare is significantly Western. She actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Her husband did attend some antenatal visits and some prenatal classes. Gabrielle gave birth within a private hospital setting with the assistance of an obstetrician. She does not plan on having any further children.
Merlene: Merlene was 35 years old at the birth of her first child. She had been with her partner for 5 years prior to falling pregnant and they had planned the pregnancy. Merlene is a chiropractor. Her approach to health care is more alternative. Both her and her husband actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Merlene gave birth at home with the assistance of an independent midwife which she found through an information session. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Laura: Laura was 31 years old at the birth of her first child. She had been with her partner 4 years prior to falling pregnant and they had planned the pregnancy. Laura is an administrative assistant. Her approach to healthcare is both Western and alternative. Both her and her husband actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Laura gave birth at home with the assistance of an independent midwife who she found through her own research. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Tracey S.: Tracey was 30 years old at the birth of her first child. She had been with her partner for 2 ½ years prior to falling pregnant and they had planned the pregnancy. Tracey is a sales manager. Her approach to healthcare is Western. She actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Her husband did attend some antenatal visits and some prenatal classes. Laura gave birth within a private hospital with an obstetrician she had found through her GP and friend’s advice. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Josie: Josie was 28 years old at the birth of her first child. She had been with her partner for 2 years prior to falling pregnant and they had planned the pregnancy. Josie is a physiotherapist. Her approach to health care is both Western and alternative. Both her and her partner actively participated in the preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes. Josie gave birth within a birth centre with a doula present. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Tracey: Tracey was 29 years old at the birth of her first child. She had been with her partner for 2 years prior to falling pregnant and they had planned the pregnancy. It took Tracey and her husband 1 year to fall pregnant. She is a sales manager by occupation. Her approach to health care is Western. Both her and her husband actively participated in the care and preparation of her pregnancy and birth. Tracey gave birth within a private hospital with an obstetrician she chose because of friend’s advice and the location of the hospital. Tracey also requested a social induction. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Jo: Jo was 30 years of age at the birth of her first child. She and her partner had been together for a period of 5 years prior to falling pregnant. The planned pregnancy took 2 months for conception. She is a teacher by occupation and she largely employs an alternative approach to health care. Both her and her partner were heavily involved in the care and preparation of her pregnancy and birth. Jo gave birth at home with a private practicing midwife who was the same midwife that her partner had used in the birth of their first child. Both Jo and her partner do not plan on changing their mode of care for any subsequent pregnancies and births.

Kate: Kate was 31 at the birth of her first child. She and her husband had been together for a period of 5 years prior to falling pregnant. Both her and her husband were heavily involved in the care and preparation of her pregnancy and birth. Kate’s 1st pregnancy was not planned and took place within a hospital setting. Her second pregnancy was planned and took place at
home with an independent midwife who she found through a homebirth network. Kate does not plan on changing their mode of care for any subsequent pregnancies and births.

**Heidi:** Heidi was 25 years old at the birth of her first child. She and her partner had been together for a period of 5 years prior to falling pregnant. Her approach to health care is both Western and alternative. They had not planned the pregnancy. Heidi was heavily involved in the care and preparation of her pregnancy and birth, her husband to a lesser degree. Heidi’s birth took place within a birth centre; she chose this centre because of the research she conducted and her strong desire to give birth within that particular setting. Heidi does not plan on changing her mode of care for any subsequent pregnancies and births.

**Cathy:** Cathy was 26 years of age at the birth of her 1st child. She had been with her partner for 4 years prior to falling pregnant. Cathy is a secretary. They had planned the pregnancy and were both actively involved in the care and preparation of the pregnancy and birth. Her approach to health care is both Western and alternative. Cathy has had a serious skin condition for many years which becomes difficult to manage during pregnancy. The birth of Cathy’s two children was within a birth centre environment. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Anitra:** Anitra was 24 years old at the birth of her child. She had been with her partner for 4 years prior to falling pregnant. Anitra is a Respite coordinator. They had planned the pregnancy and both were heavily involved in the care and preparation of the pregnancy and birth. Anitra’s approach to health care is very Western. She gave birth within a private hospital setting with an obstetrician whom her GP had recommended. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Megan:** Megan was 34 years old at the birth of her 1st child. She had been with her husband for a period of 5 years prior to falling pregnant. At the birth of her 1st child, Megan was a hairdresser, since then she has undertaken a degree to become a midwife. Her approach to health care is both Western and alternative with an emphasis on the latter. For both of her pregnancies she was heavily involved in the care and preparation for the impending birth, her husband to a lesser degree. The birth of her 1st child took place within a private hospital setting. The birth of her 2nd child took place at home with an independent midwife that she found through a private prenatal class. Megan does not plan on changing her mode of care for any subsequent pregnancies and births.

**Michelle:** Michelle was 26 years old at the birth of her first child. She had been with her partner for 2 years prior to falling pregnant. She immediately fell pregnant after the decided to have children. Both her and her husband were actively involved in the care and preparation of the pregnancy and birth. Michelle’s occupation is within the IT industry. Michelle gave birth at home with an independent midwife she found over the Internet which she then interviewed over the telephone. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Louise:** Louise was 28 years old at the birth of her first child. She had been with her partner for 4 ½ years prior to falling pregnant. They had planned the pregnancy and it had taken them just over 2 years to conceive. Louise has a skin condition which she has been on medication for. Her approach to health care is both Western and alternative. Louise works with the retail industry. She was heavily involved in the care and preparation of the pregnancy and birth. Her husband to a lesser degree. Louise gave birth within a birth centre environment because of the research she had conducted and her strong desire to birth within that particular environment. She does not plan on changing her mode of care for any subsequent pregnancies and births.
**Philipa:** Philipa was 25 years old at the birth of her child. She had been with her partner for 4 ½ years prior to falling pregnant. They had planned the pregnancy and Philipa was actively involved in the care and preparation of her pregnancy and birth with her husband only attending prenatal classes. Philipa is a sales manager. Her approach to health care is Western. Philipa gave birth within a private hospital setting with an obstetrician who her sister in law (midwife) recommended. She plans on changing her obstetrician for her next pregnancy but still plans on giving birth within a private hospital.

**Cheryl:** Cheryl was 33 years old at the birth of her child. She had been with her husband for 5 years prior to falling pregnant. They had planned the pregnancy and were both actively involved in the care and preparation of the pregnancy and birth. Cheryl is a police detective. Her approach to health care is very Western. Cheryl gave birth within a private hospital setting with an obstetrician who was recommended to her by her GP. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Angela:** Angela was 35 years old at the birth of her child. She had been with her partner for 3 years prior to falling pregnant. This was a planned pregnancy and they were both actively involved in the care and preparation of the pregnancy and birth. Angela’s approach to health care is largely alternative. Angela gave birth at home with an independent midwife who she found through the home birth association. Angela does not plan on changing her mode of care for any subsequent pregnancies and births.

**Hope:** Hope’s first pregnancy and birth occurred when she was 24 years of age. Her first birth eventuated through a caesarean section in a private hospital setting. Her next pregnancy occurred when she was 34 years old. This was not a planned pregnancy. Both Hope and her husband were actively involved in the care and preparation of the pregnancy and birth. Her approach to health care evolved over time to a more alternative approach. The birth of Hope’s second child occurred at home with an independent midwife whom she found through a friend. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Joanna:** Joanna was 40 years old at the birth of her child. She had been with her partner for 4 years prior to falling pregnant. Joanna is a manager within Quantas sales. The pregnancy was not planned, it occurred just after a miscarriage. Joanna has also had multiple health problems involving her reproductive system as well as her back. Joanna’s approach to health care is largely Western. Joanna was heavily involved in the care and preparation of her pregnancy and birth, her husband attended prenatal classes. Joanna gave birth within a private hospital setting with an obstetrician who was referred by her family GP. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Rebecca:** Rebecca was 32 years old at the birth of her child. She had been with her partner for 1 year prior to falling pregnant and they had not planned the pregnancy. Rebecca is an editor for a magazine as an occupation. Her approach to health care is both Western and alternative. Both her and her partner were heavily involved in the care and preparation of the pregnancy and birth. She gave birth within a birth centre environment. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Bronte:** Bronte was 33 years old at the birth of her first child. She had been with her partner for 5 years prior to falling pregnant and it had taken them 18 months to conceive. Bronte is a sales manager for a fashion retailer. Her approach to health care is both Western and alternative. Both her and her partner were heavily involved in the care and preparation of the pregnancy and birth. She gave birth at home with an independent midwife she found through the home birth association. She does not plan on changing her mode of care for any subsequent pregnancies and births.
Angie: Angie was 26 years old at the birth of her child. She had been with her partner for 1 year prior to falling pregnant and they had not planned the pregnancy. Angie works within sales. She has had numerous problems relating to her reproductive system, largely relating to ovarian cysts. Her approach to health care is both Western and alternative. Both her and her husband were actively involved in the care and preparation of her pregnancy and birth. Angie gave birth within a private hospital setting with an obstetrician who was referred to her by her GP. Angie would like to employ a private practicing midwife for her next pregnancy with the hope of birthing at home.

Danielle: Danielle was 34 at the birth of her 1st child. She had been with her husband for 6 ½ years prior to falling pregnant. They had planned the pregnancy and it had taken them just over 6 months to conceive. Danielle is a legal secretary and part time student. Her approach to health care is very Western. Danielle avoided reading pregnancy and childbirth books and attempted to avoid prenatal classes although both her and her husband did attend the hospital run classes. She gave birth within a private hospital setting with an obstetrician who was referred to her by her sister. The birth involved a caesarean section. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Sylvia: Sylvia was 31 at the birth of her child. She had been with her partner for 5 years prior to falling pregnant. They planned the pregnancy and it took them approximately 8 months to conceive. Sylvia is a gym instructor. Her approach to health care is both Western and alternative. Both her and her husband were actively involved in the care and preparation of her pregnancy and birth. Sylvia gave birth within a birth centre largely at the recommendation of a friend. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Elizabeth: Elizabeth was 32 years old at the birth of her child. She had been with her partner for 4 years prior to falling pregnant and it had taken them 1 year to conceive. Elizabeth works within the fashion retail industry. Her approach to health care is largely Western. Both her and her husband largely depended on the obstetrician and prenatal classes for information about the pregnancy and birth. Elizabeth gave birth within a private hospital setting with an obstetrician who was referred by her GP. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Georgie: Georgie was 30 years old at the birth of her child. She had been with her husband for 3 years prior to falling pregnant. The pregnancy was planned. Georgie is a stay at home mother. Her approach to health care is very Western. Georgie and her husband largely depended on her obstetrician and prenatal classes for information, although Georgie also made reference to at least one book as well as magazines. Georgie gave birth within a private hospital setting with an obstetrician who was referred by a family member who is a nurse. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Anne: Anne was 35 years old at the birth of her child. She had been with her partner for 6 years prior to falling pregnant. The pregnancy was planned and it took Anne and her husband approximately 8 months to conceive. Anne had suffered 1 miscarriage prior to this pregnancy. Her and her partner own and run a restaurant. Anne’s approach to health care is both Western and alternative. Anne gave birth at home with an independent midwife that she found through a friend. She does not plan on changing her mode of care for any subsequent pregnancies and births.

Tina: Tina was 25 years old at the birth of her first child. She had been with her husband for 5 years prior to deciding on falling pregnant. Other than some back problems Tina has had no health issues and has not suffered any miscarriages. Both Tina and her husband own and run a hair salon. Tina’s approach to health care is very Western. She and her husband attended prenatal classes and antenatal visits, however, Tina tended to rely on her obstetrician
for advice rather than her own research. Tina gave birth within a private hospital setting with the aid of an obstetrician whom her GP had referred her to. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Christine:** Christine was 33 years old at the birth of her child. She had been with her husband for a period of 6 years prior to falling pregnant. They had not planned the pregnancy, however, because of Christine’s experience with her first pregnancy and birth within a private setting she was determined to give birth within a birth centre. Her occupation is an academic researcher. Her approach to health care is both Western and alternative. Christine does not plan on having any further children.

**Denise:** Denise was 27 years old at the birth of her child. She had been with her husband for a period of 3 years prior to falling pregnant. The pregnancy was planned. Denise’s approach to health care is Western. Denise actively participated in the care and preparation of the pregnancy and birth by conducting reading, attending antenatal visits and prenatal classes, her husband to a lesser degree. Denise gave birth within a private hospital setting with an obstetrician who was referred to her by her GP. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Christina:** Christina was 25 years old at the birth of her first child. She had been with her partner for a period of 1 year prior to falling pregnant and they had not planned the pregnancy. Christina works within sales. Her approach to health care is both Western and alternative. Christina and her partner actively participated in the care and preparation of her pregnancy and birth. Christina gave birth at home with an independent midwife whom she found through her yoga classes. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Ann:** Ann was 26 years old at the birth of her first child. She had been with her partner for a period of 4 years prior to falling pregnant and they had not planned the pregnancy. Ann works within the banking sector in a managerial position. Her approach to health care is very Western. Ann has suffered some reproductive health problems. Ann actively participated in the care and preparation of her pregnancy and upcoming birth, her husband to a much lesser degree. Ann gave birth within a private hospital setting with an obstetrician referred to her by her GP. She does not plan on changing her mode of care for any subsequent pregnancies and births.

**Mary:** Mary was 27 years old at the birth of her first child. She had been with her partner for a period of 14 months prior to falling pregnant and they had not planned the pregnancy. Mary works within the travel industry. Her approach to health care is both Western and alternative. Mary and her partner actively participated in the preparation of her pregnancy and upcoming birth. She gave birth within a birth centre setting due to the large amount of research that she had conducted. Mary does not plan on changing her mode of care for any subsequent pregnancies and births.

**Natalie:** Natalie was 33 years old at the birth of her child. She had been with her partner for 6 years prior to falling pregnant and they had planned the pregnancy. Natalie is a stay at home mother who is actively involved with the home birth movement. Her approach to health care is both Western, and alternative, with an emphasis on the latter. Natalie and her partner actively participated in the care and preparation of her pregnancy and upcoming birth. Her first birth was within a birth centre environment and her subsequent three births were at home. Due to health reasons Natalie does not plan on having any further children.

**Natasha:** Natasha was 28 years old at the birth of her first child. She had been with her partner for 2 years prior to falling pregnant and they had not planned the pregnancy. Natasha works within the education system as a teacher of primary school students. Her approach to
health care is both Western and alternative. Natasha and her partner actively participated in
the care and preparation of her pregnancy and upcoming birth. She gave birth at home with
an independent midwife whom she found through her Mother’s friend. Natasha does not plan
on changing her mode of care for any subsequent pregnancies and births.

Ruth: Ruth was 32 years old at the birth of her first child. She had been with her partner for
5 years prior to falling pregnant. They pregnancy was planned, as were her 3 subsequent
pregnancies. Her approach to health care is Western. This approach to health care was
accentuated during her 3rd pregnancy when the foetus developed Osteogenesis Imperfecta,
commonly known as brittle bone disease. This pregnancy was induced at the 24-week mark,
it resulted with a stillborn. Ruth gave birth to her children within a private hospital setting
with an obstetrician referred to her by a friend. After the birth of her first child she changed
obstetricians and remained with him for her subsequent 2 pregnancies. She does not plan on
having any more children.

Sandra: Sandra was 42 years old at the birth of her first child. She had been with her partner
for 7 years prior to falling pregnant. They had planned the pregnancy but it took the couple
over 2 years to fall pregnant. Sandra has had some reproductive health problems and back
troubles. Her approach to health care is both Western and alternative with an emphasis on the
latter. Both her and her husband actively participated in the care and preparation of her
pregnancy and upcoming birth. Sandra gave birth within a private hospital setting with an
obstetrician referred to her by a friend and her GP. She would have preferred to give birth
within a birth centre but was unable to because of her age and previous health problems.
Sandra and her husband do not plan on having any more children.

Mel: Mel was 32 years old at the birth of her first child. She had been with her partner for 8
months prior to falling pregnant and they had planned the pregnancy. Mel has had various
health problems relating to her reproductive system as well as back problems. Her approach
to health is both Western and alternative. Both her and her husband actively participated in
the care and preparation of her pregnancy and birth. Mel gave birth within a birth centre
environment because of the research she had conducted as well as advice from a friend. She
does not plan on changing her mode of care for any subsequent pregnancies and births.
CHAPTER FOUR

THE EXPLORATION OF THE RISK SOCIETY THESIS

In my opinion, the history of mankind, its endangerment, and its tragedy, is just beginning today. So far, there have been altars of saints and the signs of archangels behind it. Chalices and baptismal fonts bathes its weaknesses and wounds. Now the series of great insoluble disasters itself is beginning. (Gottfried Benn cited in Beck, 1999: 108)

The contemporary experience of childbirth is determined by the contemporary context and a central feature of that context is the presence of risk. This has been explored within Chapter two, where the emergence and endurance of a ‘risk society’ within maternity services was outlined. We live in a world that we have grown to understand as increasingly more risky; a world in which technological change is rapid, people and places are more intricately connected and in a time where there appears to be even more of which to be afraid. We only have to glance at a newspaper to see headlines of terrorism or new deadly viral outbreaks. Globally, we are not only concerned with health epidemics such as AIDS and SARS and health issues such as the overuse and misuse of antibiotics and the growing resistance of infectious agents to them, but also to environmental issues such as El Nino and global warming. The list can of course be extended to concerns over crime, toxins and carcinogens in the food we eat, bacteria in the water we drink, reproductive technologies and the increase in multiple births and reported birth defects, radiation, malnutrition, overeating, driving, flying, taking a train or ferry, mass production and pollution, the return of diseases such as tuberculosis; and the list goes on and on.

Since the time of the initial publication of Risk Society (1986, translated into English: 1992) through to World Risk Society (1999) Ulrich Beck has consistently argued that
the concept of risk is increasingly becoming a central concern to not only Western society but also the global society. It has become a generic feature of modernisation.

Beck argues:

The historically unprecedented possibility, brought about by our own decisions, of the destruction of all life on this planet…distinguishes our epoch not only from the early phase of the Industrial Revolution but also from all other cultures and social forms, no matter how diverse and contradictory. If a fire breaks out, the fire brigade comes; if a traffic accident occurs, the insurance pays. This interplay between before and after, between security in the here and now and security in the future because one took precautions even for the worst imaginable case, has been revoked in the age of nuclear, chemical and genetic technology. In their brilliant perfection, nuclear power plants have suspended the principle of insurance not only in the economic but also in the medical, psychological, cultural and religious sense. The ‘residual risk society’ is an uninsured society, in which protection, paradoxically, decreases as the threat increases. (1991: 22-3)

The risk society thesis, therefore, depicts a world whose inhabitants are exposed to not only high technological innovation and scientific development but also to the ramifications of them – positive and negative. Furthermore the implications of such a world – the global risks and dangers that are faced- seems not to be fully understood by its citizens.

This chapter examines the sociology of risk, employing primarily the work of Ulrich Beck but also that of Anthony Giddens. Giddens (1990) agrees with Beck (1992) that late modernity is characterised by transformations in traditional habits and customs, bearing an extreme effect on the conduct and meaning of everyday life. In fact there are major convergences between Beck’s and Giddens’ conceptualisations of risk. For example, both see the concept of risk as a central concern in contemporary western society, emerging from the process of modernization. Both are interested in the political aspects of risk, singling out reflexivity as a primary response to uncertainty and insecurity. They also emphasize willingness on the part of the individual, within
the contemporary era, to challenge experts, governments and industry in relation to risk concerns. However, there are points within their respective theories where they differ considerably. This will be examined in the upcoming sections.

There are three major themes that underpin the work of Beck – these are his risk society thesis, reflexive modernization and individualization. The analysis of risk environments in contemporary society in relation to these three themes is reviewed below. The aim is to explore some of the issues that concern the relationship between risk and society – the ramifications of this form of society on its inhabitants and specifically in relation to its impact on those experiencing pregnancy and childbirth.

**The Risk Society**

Beck’s theory of risk creates a new periodisation of modern history that is divided into traditional society, simple modernity and high or reflexive modernity. Simple modernity saw the industrialisation of society, which involved the unequal creation of wealth, the formation of social classes and a hierarchy of risks (Elliot, 2002). High modernity, by distinction, involves the distribution of ‘bads’, that is, new patterns of status inequality and the democratisation of risks. The risks of reflexive modernity are invisible, uninsurable, systematic, generic and democratic (Turner, 2001). Beck argues that there has been an introduction of global risk parameters that previous generations have not had to contend with. This reality is due to the failure of modern institutions in their attempt to control the risks that have been created. A clear example is the ecological crisis, a negative by product of the progress of modernity. The creation of risks, according to Beck, is a defensive attempt to avoid the creation
of new problems and dangers. Yet, if we turn to the first chapter of this thesis and revisit the work of Reynolds (1991) we see that these attempts create rather than fend off new hazards and risks.

Rather than viewing the contemporary world as a move toward postmodernity Beck views it as an extension of modernity. We can see this through his creation of a distinction between the two epochs listed above: simple and high modernity. In simple modernity, the class society’s main concern is the visible satisfaction of material needs. Here, those who have and those who do not are in direct confrontation with each other. Poverty is in direct and visible correspondence to the material evidence of wealth and power. As Beck states: “the certainties of a class society are the certainties of a culture of visibility” (1992: 44).

It is the quality of ‘visibility’ that is no longer tangible within the risk society. For what escapes our perception no longer denotes the unreal, rather it can possess a higher degree of ‘hazardous reality’ (Beck, 1992). For instance, we are all exposed to global warming; to the hole in the ozone layer; to the unintended consequences of pollution and genetically modified foods; and to the contemporary health scares of HIV/AIDS and SARS. These contemporary risks are not local or class problems; rather, they have become global epidemics.

This distinction is made more clear when contrasting pre-industrial society to that of the risk society. When turning to Beck’s work we can see that his analyses are based on a three stage periodization, of pre-industrial, industrial and risk societies. Each of
these societies contains risks and hazards of their own, but as Lash and Urry (1994) point out there are qualitative differences between the types of risk involved in each. Turning to pre-industrial society, we can see a clear demarcation between the concepts of risk and hazard. Beck does not imply that the lived experience of the risk society is intrinsically more hazardous than in the pre-modern world. What he does suggest however is that the notion of risk in pre-industrial societies was viewed as pre-given. Risks were not man made, they were seen as natural and if they were constructed, such as wartime casualties, they did not follow from technology or economic progress.

The concept of risk during the Middle Ages seemed to exclude the idea of human culpability and responsibility. “At that time, risk designated the possibility of an objective danger, an act of God” (Luhmann, 1993: 226). Risk was perceived to derive from natural events such as a storm, flood or epidemic rather than a human creation. Here, risks were seen to come from some ‘other’ – gods, nature or demons. Accordingly, individuals could do very little but to take steps to reduce its impact. The key difference between this time period and the present is social accountability and responsibility. The hazards experienced by pre-modern societies were from the outside and attributable to an ‘other’ – whether that is a God or nature itself. Within a risk society responsibility is firmly placed with individuals – it becomes politically charged (Beck, 1992).

With the beginning of societal attempts to control the unforseen and move towards a future of predictable security, risk – as stated above – becomes a political issue. For
Beck, this point is crucial. Through processes such as decision making – society intervenes and transforms hazards – which on the whole are incalculable – to calculable risks. At the base of risk society lays one of the central tenets of modernity, instrumental rational control – which is to be applied to all spheres of life, from the private to the public (Elliot, 2002). This emergence of social accountability and the politicisation of risks will be further explored in our overview of reflexivity and individualization.

**Risk Society and the Insurance Principle**

*Society has become a laboratory where there is absolutely nobody in charge. (Beck, 1998: 9)*

This particular approach to risk has changed with the emergence of modernity, beginning in the 17th century and gathering force in the 18th century, where uncertainty is brought into every niche of existence (Giddens, 1999). It was with the underlying ethos of modernity, namely that the key to human progress and social order as objective knowledge of the world through scientific exploration and rational thinking that the responsibility of risk moved away from an omnipotent God to that of human kind. In this disenchanted world, hazards and risk were no longer externalized into the hands of God or fate. Slowly but surely, accountability swayed toward the individual. This new understanding of risk represented a new way of viewing the world and its chaotic manifestations, its contingencies and uncertainties. It assumed that unanticipated outcomes might be the consequence of human action rather than expressing the hidden meaning of nature or the ineffable intentions of a Deity. As Giddens (1990: 111) states:

*A world mainly structured by humanly created risks has little place for divine influences, or indeed for the magical propitiation of cosmic forces or spirits. It is*
central to modernity that risks can in principle be assessed in terms of generalisable knowledge about potential dangers – an outlook in which the notion of fortuna mostly survive as marginal forms of superstition

Reddy (1996: 237) continues this argument by stating: “Moderns had eliminated genuine indeterminancy, or uncertainty, by inventing risk. They had learnt to transform a radically indeterminate cosmos into a manageable one, through the myth of calculability”. In other words risk can be understood as constituting a metanarrative in an age of ‘manufactured uncertainty’ (Giddens, 1994).

This structured calculation of risk in modernity as a strategy for securing the world is identified by Beck as the insurance principle. This seems common sense given that the risks faced by society within this time period were no longer seen to be attributable to external agency. Accordingly, industrial societies needed to develop institutions and rules for managing the unforeseen and unintended consequences they were producing. Central to the insurance principle is an understanding that hazards are “systematically caused and statistically describable” (Beck, 1992a: 33-34) and that this “creates present security in the face of an open uncertain future” (Beck, 1992b: 100-1).

The idea of reacting to uncertainties in this way can be related back to insurance contracts which had their beginnings in early intercontinental navigation. But as Beck illustrates, with the expansion of industrial capitalism – insurance was continually expanded into all areas of life. As Beck states:

Consequences that at first affect only the individual become ‘risks’, systematically caused, statistically describable and in that sense ‘predictable’ types of events, which
can therefore also be subjected to supra-individual and political rules of recognition, compensation and avoidance. (1992: 99)

Beck’s aim is to not only demonstrate the infiltration of risk calculus into all areas of social action – but to also highlight the survival of it. The calculus of risks can connect such disparate events as employment, manufacturing, traffic accidents, smoking, diet and life events such as pregnancy and childbirth – and according to Beck it does so with a technological moralization – a “mathematical ethics of the technological age” (Beck, 1992: 99).

The endurance of risk calculus, according to Beck’s thesis, is intrinsically tied to obvious fundamental advantages – hence its survival. The advantages discussed deal with the emergence of political regulation over our lives as well as the ability to sideline legal battles over causation due to insurance guidelines. The important advantage is that the industrial system is able to deal with its own unforeseeable future. Through the creation of the calculation of risks as well as insurance liability laws – the future becomes the basis of present action. Present action revolves around “prevention, compensation or precautionary after-care” where “modernity […] finds its counter-principle in a social compact against industrially produced hazards and damages, stitched together out of public and private insurance agreements” (Beck, 1992: 100).

According to Beck a consensus was created which functioned as a security pact against industrially created dangers and hazards. At the basis of the consensus was insurance, particularly two forms of insurance – the private insurance company and
the public – which is linked to the welfare state. Accordingly, Beck argues that the social pact for the containment and distribution of the consequence of modernity is situated somewhere between socialism and liberalism; first because it is based on the creation of hazards and second because it involves a shift in responsibility toward the individual in preventing and compensating for the same hazards (Beck, 1992b: 100).

The uninsurable society

Since the middle of last century, with the advent of the nuclear age, the social institutions of industrial society have been confronted with the unprecedented prospect of the destruction of our planet, through our own decision making. The precautions that we have set up are being revoked in the age of nuclear, chemical and genetic technology (Beck, 1992b). As Beck states:

In all the brilliance of their perfection, nuclear power plants have suspended the principle of insurance not only in the economic, but also in the medical, psychological, cultural and religious sense. The residual risk society has become an uninsured society, with protection paradoxically diminishing as the danger grows. (1992b: 101 emphasis in the original)

The destruction of this insurance society unleashed a destruction of the calculus of risks by which modern societies had developed an agreement on progress (Beck, 1992b; Elliot, 2002). At first, argues Beck, risks and hazards were externalised – attributable to an other – fate or fortuna combined with the fact that social life was coordinated by tradition left much as a ‘given’ (Giddens, 1991; Beck, 1992, 1998). This moved to the first stage of risk, where risks seem no more than calculations aimed at sealing off boundaries as the future is invaded (Beck, 1998). As time progressed and nature became infused by industrialization and tradition began to dissolve we moved into the second stage of risk, a stage where risks become
The changing nature of risks outlined by Beck negates risk calculation for purposes of insurance. Beck emphasizes that the risks that we are exposed to today threaten irreparable global damage which is not limited, thus monetary compensation is impossible. With the worst case accident, for instance nuclear or chemical, any monitoring of damages fails; accidents, such as the Chernobyl disaster, highlight the delimitations in space and time which is of central importance for insurance. Finally notions of accountability within a risk society collapse – Beck highlights this with his concept of organized irresponsibility.

Organized irresponsibility refers to a political contradiction of the self-jeopardization and self-endangerment of risk society. This is a contradiction between an emerging public awareness of risks produced by and within the social institutional system on the one hand, and the lack of attribution of systemic risks to this system on the other. There is, according to Beck, a constant denial of the suicidal tendency of risk society – ‘the system of organized irresponsibility’ – which manifests itself in technically orientated legal procedures designed to satisfy rigorous causal proof of individual liability and guilt. This self-created dead end, in which culpability is passed off on to individuals and thus collectively denied, is maintained through political ideologies of
industrial fatalism: faith in progress, dependence on rationality and the rule of expert opinion (Elliot, 2002).

Risk society, as seen above, is a society in which risks become the central organizing principle as well as taking on a new form. The risk society sees events such as Chernobyl, global warming, mad cow disease, the debate about the human genome, the Asian financial crisis and the September 11th terrorist attacks. These examples depict risks which are incalculable, uncompensatable, unlimited and unaccountable (Lash and Urry, 1994). Accordingly, the insurance principle is not viable in high modernity. We are now residing in an uninsurable society where previous protection is diminishing.

In Beck’s thesis we live in a world where it can be argued that tradition and nature are dead. As stated above, the stage of risk society that we have entered began with not only the demise of ‘fortuna’ but also the end of tradition. Various social theorists argue the death of tradition – where we see that in all spheres of life we can no longer take traditional certainties for granted (Beck, 1998). We are no longer born into the preconditions of tradition. It is argued by authors such as Beck (2002), Beck and Beck-Gernsheim (2002), Giddens (1991) and Bauman (1998, 2002) that we no longer have the biography of earlier time periods. Rather we have an elective biography or reflexive biography (Giddens, 1991). The preordained, unquestioned, often enforced ties of earlier times are replaced by a call to action. We must now create our own boundaries on a day-to-day basis. As Bauman argues:

Nowadays, everything seems to conspire against…lifelong projects, permanent bonds, eternal alliances, immutable identities. I cannot build for the long term on my
job, my profession or even my abilities. I can bet on my job being cut, my profession changing out of all recognition, my skills being no longer in demand. Nor can a partnership or family provide a basis in the future. In the age of what Anthony Giddens has called ‘confluent love’, togetherness lasts no longer than the gratification of one of the partners, ties are from the outset only ‘until further notice’, today’s intense attachment makes tomorrow’s frustration only the more violent. (1993: 17)

The collapse of tradition in combination with notions such as organized irresponsibility leads us to the next areas of Beck’s thesis, reflexivity and individualization.

**Reflexive Modernization**

The pervasiveness of risk as a central organizing principle of our lives is the central component of risk society, which in itself is part of the process of reflexive modernization. According to Beck, the latter involves a critical approach or questioning of the consequences of modernity. It is a world in which public debates, more often than not, feature discussion of risk and its effects. This trickles down to the private where our everyday lives are dominated by concerns about risks. As Beck argues: “Everyone is caught up in defensive battles of various types, anticipating the hostile substances in one’s manner of living and eating” (1994: 45).

This everyday consciousness of risk emphasises current practices and necessitates a more self critical or reflexive approach to life. Within this society both Beck and Giddens argue that individuals begin to question the institutions of modernity such as science and medicine. They approach these institutions with a critical eye no longer accepting expert opinion at face value. For Beck, “society becomes a problem for itself” (Beck, 1994: 8). He continues:
In risk issues, no one is an expert, or everyone is an expert, because all the experts presume what they are supposed to make possible and produce: cultural acceptance. (1994: 9)

**Reflexive modernization unpacked**

Knowledge is intrinsically tied to the notion of reflexivity, in the use of both Beck and Giddens work – although their approaches to this particular concept is different. For Giddens (1994), reflexive modernization is tied to knowledge on foundations consequences and problems of modernization processes. For Beck (1992,1994, 2000), reflexive modernization is essentially tied to the unintended consequences of modernization as well as an aspect of unawareness. The difference is not a large one and often their two approaches converge. As Beck argues: “the concept of unintended consequences ultimately does not contradict the understanding of knowledge in reflexive modernization; instead it opens an expanded and more complex game involving various forms and constructions not just of knowledge, but also of unawareness” (2000b: 110).

Giddens’ approach to knowledge in reflexive modernization is to view it, in a generalized sense, as the impetus of change. For Giddens, the modernization of societies exists simultaneously with the increase and generation of knowledge about its foundations, structures, dynamics and conflicts (Giddens & Pierson, 1998). The increase of this form of knowledge and its application leads to the breaking up of traditionally defined constellations of action within structures which is replaced by a “knowledge-dependent, scientifically mediated global reconstruction and restructuring of social structures and institutions” (Giddens & Pierson, 1998: 110).
Reflexive modernization says something about late modernity, reflecting on the limitations and difficulties of modernity itself. That relates to key problems of modern politics, because simple or linear modernization still predominates in some parts of the world [...]. In the West and the developed industrial societies, there are conditions of reflexive modernization, with the key problem of modernization being what modernization itself is all about. (Giddens & Pierson, 1998: 110)

The drive for change stems from knowledge. “Knowledge forces decisions and opens up contexts for action” (ibid.).

As stated above, Beck does not negate this understanding of reflexivity, rather, he builds upon it. Beck broadens the understanding of reflexivity from reflection of knowledge to also include reflex – or the “effect or preventive effect of non-knowing” (Beck, 2000b: 109 emphasis in original). Therefore, the main distinction between the work of Beck and Giddens in relation to reflexive modernization is the notion of unawareness. For Beck, the medium of reflexive modernization is “not knowledge, but more or less reflexive-unawareness” (Beck, 2000b: 119).

Beck’s approach to reflexivity and reflexive modernization can be roughly summarized in the following way: as a society becomes more modern it produces more unintended consequences, as these consequences become acknowledged they in turn call the foundations of modernity into question. Secondly, these consequences are part of the knowledge base of society. The important question is who knows them and on what basis? ‘Unintended consequences’ denotes a conflict of knowledge or rationalities. In Beck’s reflexive modernity we see the claims of different experts collide with not only one another but also with claims of lay knowledge and of the knowledge of social movements (Beck, 2000b). For Beck, the last two forms of
knowledge can be argued to stem from expert knowledge. However, because of notions of status and social credibility they are not acknowledged as expert knowledge and consequently are not valued as such by institutions such as law, politics and business (Beck, 2000).

The knowledge of ‘unintended consequences’ therefore opens up a battleground over rationality claims. This is readily seen with the case at hand as we saw in the subsection on the medical indemnity crisis. This battleground could be easily analysed as a case study for Beck’s thesis. The opponents of this battleground were numerous, however, the two main players were obstetricians under the guild of RANZCOG, and the private practicing midwives. The midwives do not have a guild but, much of their argument was supported by the National Maternity Action Plan, which was formulated by the National Maternity Alliance, an organization comprised of not only midwives but also politically active lay individuals. Of course we can extend this to not only the battle of medical indemnity coverage but also the contestation of definitions of birth and subsequent practices which surround it.

For Beck, there is an ultimate objective over this conflict of rationalities. What is at danger is the defeat of institutional expert constructions of knowledge tied with the implied inability of others to have this knowledge. As Beck states:

Can the dams constructed around the unawareness of the foundation-endangering and foundation-changing consequences of industrial modernization be upheld, or will the recognition in its own centres of the consequences of knowledge-based industrial modernization change the basis of business, the social contract of industrial modernization, so that modernity becomes political? That is to say, the foundations and basic norms in business, science, politics and the family must be renegotiated and re-established. (2000b: 120)
Reflexive modernization and unawareness concluded

The usurpation of unawareness over knowledge in the construction of reflexive modernization leads us finally to the “preventative effect of unawareness” (Beck, 2000b: 120). Unintended consequences “[…] are constructions of (ir)relevance in an anticipatory defence against uncomfortable challenges […] which intrude along with the recognition of the consequences and thus the responsibility for them” (Beck, 2000b: 122). Thus, intrinsic within his thesis is a contradiction between an emerging public awareness of risks created by modernity on the one hand, and the lack of attribution on the other.

It is plain to see that foundational to Beck’s thesis is a critique of theories of modernity. According to Beck (1998), in the age of global risk, the theoretical and political philosophy of simple modernity is doomed to failure. These theories and politics are tied intrinsically to the notion of progress and benign technological advancement. Not surprisingly, he also argues that the belief that risks can still be approached and dealt with effectively by 19th century models of hazards and safety needs to be examined and remodelled. This, in combination with the dissolution of institutions of modernity such as the nuclear family, gender roles, social classes and stable labour markets, leads us to the notion of reflexive modernization (Beck, 1998).

For Beck, as outlined above, there are clear distinctive periods within modernity – the simple and the reflexive. In view of these two stages and their sequence, the concept of ‘reflexive modernization’ may be introduced. This does not mean reflection (as the adjective ‘reflexive’ seems to suggest), but above all self-confrontation. The
transition from the industrial to the risk epoch of modernity occurs unintentionally, unseen, compulsively, in the course of a dynamic of modernization which has made itself autonomous, on the pattern of latent side-effects. One can almost say that the constellations of risk society are created because of the self-evident truths of industrial society (the consensus on progress, the abstraction from ecological consequences and hazards dominate the thinking and behaviour of human beings and institutions). Risk society is not an option which could be chosen or rejected in the course of political debate. It arises through the automatic operation of autonomous modernization processes which are blind and deaf to consequences and dangers. In total, and latently, these produce hazards which call into question – indeed abolish – the basis of industrial society.

It is the autonomous, compulsive dynamic of advanced or reflexive modernization that, according to Beck, propels men and women into ‘self-confrontation’ with the consequences of risk than cannot adequately be addressed, measured, controlled or overcome, at least according to the standards of industrial society.

**Individualization**

Scott Lash (2001a), when discussing the works of Beck and Giddens and the notion of reflexivity, points out a key distinction between individuals of the first modernity and those of the second modernity. Employing Beck’s approach to these two periods of modernity, Lash contends that the individuals of the first modernity are reflective and those of the second are reflexive. Reflective, it is argued, belongs to the
philosophy of consciousness of the Enlightenment and accordingly to the first modernity. Lash contends, echoing the sentiments of Habermas, that to reflect is “to subsume the object under the subject of knowledge” (Lash, 2001b: ix). Dualisms, inherent within the scientific rational discourse of modernity, represent the activity of reflection, the subject in one realm, the object of knowledge in another (Lash, 2001b). Beck’s presentation of reflexivity, as outlined above, is a critique of such dualisms. As Lash contends “[…]the objectivity of simple modernity individualism is replaced by the intentionality of knowledge in the second modernity” (2001b: x).

Its fast pace, its realm of choices and the need for quick decision-making characterize the world of Beck’s subjects. Reflexivity comes to mean and has to mean reflex rather than reflection. This is in stark contrast to individuals residing in Beck’s notion of a first modernity. Here there was a fundamental assumption that certain boundaries were beyond an individual’s control. Boundaries existed in an unshakable and unalterable fashion based on various essentialist paradigms. These paradigms, or ‘world pictures’ as described by Beck, Bonss & Lau (2003) could be based on biological arguments such as sexual differences; on society and culture, such as class differences or family structures; or technological development for differences between industrial and non industrial countries. Here the individual had a limited sovereignty, action stemmed from the pre-given patterns of systems, ranging from the private to the public. As Beck et al. (2003) argue, the subject of the first modernity “was conceived of in terms of limited sovereignty and calculable subjectivity […] Subjectivity develops within the boundaries assigned by the life situation accompanying a given social position” (2003: 23-24). Here there is security within
the confines of society’s structures. The individual emerges with a well defined unambiguous social identity (Beck et al., 2003).

In reflexive modernity these boundaries are undermined and overthrown leaving the individual without the firm boundaries that their predecessors experienced. Accordingly, Beck’s individualization does not allude to notions of loneliness or alienation but rather the requirement of individuals living within a reflexive modernity to create their own biographies. This becomes necessary in a world where there is an absence of fixed and traditional norms and certainties. Rather there is a constant emergence of new ways of life that are endlessly subject to change (Beck, 1994: 13). Bauman eloquently summarizes the position of the reflexive subject:

[to put it in a nutshell, ‘individualization’ consists in transforming human ‘identity’ from a ‘given’ into a ‘task’ – and charging the actors with the responsibility for performing that task and for the consequences (also the side-effects) of their performance: in other words, it consists in establishing a de jure autonomy (although not necessarily a de facto one). No more are human beings ‘born into’ their identities; as Jean-Paul Sartre famously put it: it is not enough to be born a bourgeois, one must live one’s life as a bourgeois. (The same did not need to be said, nor could it have been, about the princes, knights, serfs or townsmen of the pre-modern era!) Needing to become what one is is the hallmark of modern living – and of this living alone [...]. Modernity replaces determination of social standing with compulsive and obligatory self-determination. (emphasis in original 2002: xv)

Therefore, the arrival of high or reflexive modernity is not only about risks; it is also about expansion of choice and consequently an increase of responsibility. Beck’s argument of the disintegration or disembedding of aspects of life from the hold of tradition presupposes choice. This, in conjunction with the expansion of risk and risk monitoring, as discussed in the earlier sections of this chapter, points to not only an increase in choice but also agency and responsibility.
For Beck (1992), one of the central components of reflexive modernity is the freeing of accepted social roles such as social class and gender roles. He argues that traditional structures of society lose their influence in the formation of personal identity. This is readily seen when contrasting the present situation of Western societies to that of earlier periods. In early modernity or pre-modernity structures such as sex differences and class distinctions were considered facts of nature and accordingly near impossible to avoid. Bauman (2002) illustrates this point when speaking of classic modernity: “[c]lass and gender hung heavily over the individuals range of choices; to escape their constraint was not much easier than to contest one’s place in the ‘divine chain of being’ (xvi). Accordingly, individualization means “the disintegration of the certainties of industrial society as well as the compulsion to find and invent new certainties for oneself and others without them” (Beck, 1994: 14).

Accordingly, individuals living within reflexive modernity are confronted with the need to be actively engaged with both the private and public aspects of their lives. Parts of their lives that were once governed by tradition or what Bauman has emphasised as ‘taken for granted norms’ are becoming problematic. The consequence is the compulsion to daily invent and choose a path for ones’ life. This necessitates an active engagement with the self, the body, with relationships with partners, family and friends, with notions of gender and with careers (Elliot, 2002).
Individualization and fertility

We will now turn to the example of gender roles. We have slowly seen the disintegration or disappearance of the previous existing social form of fixed gender roles. Within one century, and especially within the last several decades, immense and rapid changes have occurred in the context of women’s lives. History is witness to the change from women living for others to slowly living for themselves. Ehrenreich and English’s classic text bears witness to this shift:

With the collapse of the traditional social order a glimmer of something like freedom of choice appeared – for most women, of course, still very distant…Inclusion in the market as a female worker might bring low wages and wretched working conditions, loneliness and insecurity. But it also brought a chance that was inconceivable in the traditional social order – the chance of freeing oneself from the clutches of the family. (1973: 12)

This excerpt highlights a central theme of individualization, namely: the disintegration of traditional roles which in turn forces individuals into making decisions about their own lives and future course of action.

Decisions about relationships, marriage and family are an obvious extension of this. The recent debate on the fertility crisis that is affecting Western countries can be argued to be a consequence of reflexive modernization. Currently, Australia is facing a population crisis with women reproducing at an all time low of 1.73 – 1.76. Population replacement in developed countries requires that women have an average of 2.06 babies (Weston et al., 2004). The question of why we are not reproducing ourselves is becoming a central issue to many countries throughout the world as well as being a central issue for international conferences as well as governmental inquiries. Recently the Australian Institute of Family Studies in conjunction with the Australian Government Office for Women undertook research to examine factors
influencing individuals to have fewer children if any at all – the project was entitled 
the ‘Fertility Decision Making Project’ (Weston et al., 2004). The title of the project 
can lead us to argue that in reflexive modernity fertility is the outcome of a process of 
the self-questioning and self-confrontation by possible parents that is an intrinsic part 
of individualization. Questions can be asked about the impact on the partnership of 
the parents, career prospects and limitations and resource availability. This 
theoretical perspective can surely enlighten the current debate on the fertility crisis 
that is hitting many Western countries including Australia.

The fertility crisis is also impacting on pregnancy and childbirth practices. Many 
women are now having their first child later in life. Although this opens up new 
possibilities for many women in relation to aspects such as their career and 
availability of financial resources it also closes certain possibilities in relation to 
certain childbirth practices. The most recent release of *Australia’s Mothers and 
Babies 2001* demonstrates a delay in childbearing for many women with the average 
age of all mothers in 2001 being 29.2 years (Laws & Sullivan, 2004). Furthermore, 
of the 41% of first time mothers the percentage of women aged 35 years and older 
was 10.7%. This is a demonstrated increase of the 1992 figures with the mean age of 
28.1 years. The report attributes this to various factors including “social, educational 
and economic factors, increased access to assisted reproductive technology and 
longer reproductive life expectancy” (Laws & Sullivan, 2004: 12). The report 
demonstrates a direct correlation between the increased ages of first time mothers 
with caesarean sections. It was argued that although reasons for women having 
caesarean sections were not collected, characteristics such as giving birth to twins, 
being 35 years and over, or giving birth within a private hospital setting greatly
increased the likelihood of having a caesarean (Laws & Sullivan, 2004). Furthermore, just under one in two women giving birth following assisted reproductive technology also had a caesarean section (Laws & Sullivan, 2004). It should also be noted that many birth centres have policies which automatically place women over a certain age into a high risk category which then excludes these women from making use of their services. Indeed, at a recent Australian conference entitled *Future Birth* held by Birth International, Sally Tracy a leading Australian midwife, presented on midwifery led maternity services. Within her presentation she provided the conference attendees with a profile of low risk women – among other factors was an age bracket of 20-34 years.

**Voluntary compulsion**

The operation of individualization is, therefore, governed by a dialectic of disintegration and reinvention that is not without its problems (Elliot, 2002). Although Beck (2002) sees individualization as the base to his vision of a ‘new modernity’ he recognizes that the constant renegotiation of one’s life path can create both progressive and regressive elements. In other words individualization produces side effects. These side effects exist on many levels, as Beck et al. (2003) argue: “[…] what for one individual is the overstepping or overthrowing of boundaries is for another the setting of new boundaries and the changing of the probabilities of various outcomes” (2003: 24-25).

In two earlier publications with Beck-Gernsheim (1995, 2002) the two authors demonstrate this side effect by highlighting how individualization creates a new
distribution of possibilities, while simultaneously creating a distribution of impossibilities. Based on the work of Beck-Gernsheim, there is an investigation into the role of technological innovation in medicine and of how this impacts on pregnancy choices and family life. Beck and Beck-Gernsheim highlight new realms of responsibility that are the unforeseen consequence of technological advancements. Through the advancement in diagnostic and genetic testing on the unborn child new realms of choices are highlighted for the soon to be parents. However, because of the emphasis on responsibility towards one’s own health as well as notions of perfection, parents – the two authors argue – are rapidly becoming faced with an obligation to use these technologies, not only for the future of their child but also to secure their own future. What is of essence in their argument is that the obligations and responsibilities towards one’s life path that Beck’s notion of individualization highlights also a voluntary compulsion to actively engage with science and technology to fulfil these obligations. As Beck-Gernsheim (2000) argues when discussing gene technology and what she terms preventative compulsion: “[t]o put it paradoxically, it is a pressure most people will submit to voluntarily, again for the sake of that magic word: ‘health’” (2000: 129). This sentiment echoes Beck when he states that “[h]ealth oils voluntariness, makes it submissive to ‘necessity’” (1988: 57 cited in Beck-Gernsheim, 2000: 129). With the advancement of technology within science, and of interest to this research – medicine, new options are constantly opened up – but at the same time responsible behaviour is widened. This compulsion to actively engage with technology and science and the effect on notions of responsibility will be addressed in Chapter six.
It is no wonder that Beck argues “people are condemned to individualization” (1997: 96). The act of making oneself the centre of the conduct of one’s life necessarily equates the expansion of responsibility for the crises that befall one during the course of a lifetime. We have the freedom to choose, but as highlighted by Beck and Beck-Gernsheim (1995, 2002) and Beck-Gernsheim (2000), that freedom also carries the crushing responsibility to make the right life choices. Individuals are now expected to seek knowledge about the various facets of their lives such as education, family formation and employment and also the risks that affect them. Interestingly, in Beck’s risk society, blame for risk is projected both outwards and inwards; outwards as part of the process of reflexive modernization, and inwards as a part of individualization (Tulloch & Lupton, 2003). However, it could be argued that in the case of pregnancy and childbirth where it has been claimed that the pregnant body has been constructed as doubly at risk and doubly responsible (Lupton, 1999:63), blame for risk befalling the pregnant woman and the unborn child is predominantly projected inwards.

Risk, Responsibility and neo-liberalism

The climate of risk is fundamental to the way that experts and also the lay individual organize their social spheres (Giddens, 1991). The contemplation of risk pervades everyday life; present behaviours are acted out, often with future consequences in mind. The future has changed from a path of clarity to one of contingency – a path that must be negotiated daily in the face of plurality of choices – each with the potential of unintended or undesirable consequences. It only makes sense then that risk assessment and management dominates a wide range of current political programs and professional practices, not least of all within the health field. For
instance, within Australia there have been various governmental reports and inquiries which support the implementation of preventative health promotion programmes which use as their base risk profiling (Hancock, 1993). Further evidence within the specific field of maternity care is in the recent RANZCOG release on best practice guidelines in areas such as “Obstetricians and childbirth responsibilities” and “Guidelines on Antenatal Screening” (both available at: http://www.ranzcog.edu.au/publications/collegestatements.shtml)

Individuals residing within a risk society are constantly confronted with information in the form of expert opinion based on actuarial data. Confronted with this information the individual is urged to design or constrain their behaviours to avoid the negative consequences that have been statistically connected to particular behaviours. In the area of health, we are urged to maximize health promotion and disease prevention (Murphy, 2000). In the specific area of pregnancy and childbirth, the mother is urged to protect and maximize her own health as well as, and some would argue more importantly, the health of her unborn child. For as Weir states: “[…], the main object in the population-based risk management of pregnancy, the foetus has become implicated in a remoralization of pregnancy” (1996: 373).

Experts and the illusion of security

As discussed above, the discourses which surround contemporary maternity practices in reflexive modernity, see the claims of different experts collide with not only one another but also with claims of lay knowledge and of the knowledge of social
movements (Beck, 2000). Yet, because of notions of status and social credibility the last two forms are not acknowledged as expert knowledge and consequently are not valued as such by institutions such as law, politics and business (Beck, 2000). Therefore, whilst knowledge and discourses surrounding pregnancy and childbirth practices as well as the risks that surround them emerge from both the lay sphere as well as experts, it is the experts who hold the most influence.

The assumed ‘scientific’ and ‘neutral’ character of the expert’s knowledges is portrayed to the expectant woman or couple in two forms- the clinical risk and the epidemiological risk. The actuarial data portrayed as clinical risk derives from the characteristics of case studies of individuals, whereas the epidemiological risk is calculated through the observation of patterns within populations of disease (Lupton, 1999). As Lupton argues, these approaches beyond acting as normalizing agents, “serve to render the risk attendant upon pregnancy as calculable and governable, thus bringing them into being as problems that require action” (1999: 63). In other words, the constructed disease categories of pregnancy and childbirth act as elements of moral control for the individual and the population as a whole. Furthermore, the collective results of the diagnostic tests that have been developed for the disease of pregnancy and childbirth create a benchmark of normality for the pregnant woman and her unborn child. Any substantial deviation from this benchmark is labelled as ‘high risk’ – with the end result being further medical surveillance and intervention (Lupton, 1999).
An irony of this form of risk discourse is that while it conveys the notion of security, in the free market of neo-liberalism (discussed below) it also promotes uncertainties (Petersen, 1999). As clearly illustrated within Chapter two, different groups have different interests in promoting their own risk narratives. This creates different sources of expert advice which greatly affect the ability of the individual to abide by a coherent set of norms when caring for themself. The creation of multiple truths creates an ever-changing definition of risk. The nature of risk profiling, predicting and controlling necessarily becomes a tentative one. For instance, at one time the recommended age for amniocentesis for the pregnant woman was initially 40 years of age. This has moved down to 35, with speculation of it coming down to 30 (Condit, 2000). Similarly, Giddens (1991) highlights the shift in medical advice in relation to smoking, once regarded as a relaxant, and foods such as red meat, butter and cream once regarded as healthy food staples. The individual residing within the ‘risk society’ is faced, therefore, with not only conflicting advice on risk but also changing advice. It is the aspect of changing advice which can often be a challenge to the consumer of expert advice – for how is the individual to know for certain whether any specific set of advice is more likely to provide security than any other (Petersen, 1999).

The rise of neo-liberalism

From the argument put forward to this point there is a clear indication that the uncertain, contingent, flexible and risky aspects of high modernity have had a profound effect on the field of health. As Turner argues: “The traditions of centralised mechanisms for the provisions of social security has been replaced by the
logic of internal markets, competitive tendering and devolved budgets” (1997b: xvii). Turner goes on to argue that the notion of security is difficult to establish in a world where the discourse of entrepreneurship and the culture of risk dominates.

This is a far cry from earlier forms of modernity where citizens of advanced societies were offered the benefits of modernity with few risks. Risks such as diseases were eradicated or limited, progress was enjoyed as freedoms or insured by the state. As Turner comments the stabilized networks of organized risk management, threatened and in slow retreat\(^5\), left states to explore ways of shifting costs and responsibilities.

This led the way for the conception of the self as a ‘neo-liberal’ citizen. The shift from ‘welfarist’ to ‘neo-liberal’ politics in health care emphasizes the concept of the active subject or citizen. This shift is especially noticeable in the language that surrounds the subjects of health care – from the patient to the consumer or the client – the latter denoting action – including the action of decision making and a readiness to put information to use (Henderson & Petersen, 2002).

The expectant woman as a neo-liberal subject must exercise caution in the face of these risk assessments and accordingly monitor her behaviour as a responsible and rational response to the information. Failure to act responsibly invites charges of irresponsibility, as we have seen with media representations of ‘monster mothers’. The most recent example of this is the Queensland case where a woman was reported to child welfare authorities after refusing a caesarean birth, recommended on the basis that she had one previously, because she wanted a natural delivery. Although she
gave birth to a healthy baby girl, the woman of this case became the subject of a child abuse notification after she cancelled a caesarean booking and later gave birth vaginally in a different hospital. It can therefore be argued that charges of irresponsibility can be more strongly applied to the expectant mother – as she is not only responsible for her own health but that of the unborn child which is typically presented within expert frameworks as highly fragile, vulnerable and susceptible to a multitude of threats which can affect its future health (Lupton, 1999).

This privatisation of risk management that the expectant woman is confronted with highlights again the need to be actively responsible. As Rose (1996) argues, neo-liberalism calls for the individual to exercise his or her individual obligation to “bring the future into the present” (57). To accomplish this the neo-liberal citizen must be:

educated in the ways of calculating the future consequences of actions as diverse as those of diet and home security. The active citizen thus is to include within his or her obligations the need to adopt a calculative prudent personal relation to fate now conceived in terms of calculable dangers and avertable risks. (Rose, 1996: 58).

According to O’Malley (1996), the foundation of neo-liberalism, namely the act of government through individual responsibility, celebrates prudence and circumspection. These defining qualities of neo-liberalism echo the concept of individualization. We see individualization as the active engagement with both private and public aspects of the individual’s life, for the creation of new certainties for oneself. We see the neo-liberal subject with similar responsibilities, for instance Gordon (1991) discusses the tasks of the neo-liberal subject in the following manner: “one remains always continuously employed in (at least) that one enterprise, and that it is part of the continuous business of living to make adequate provision for the
preservation, reproduction and reconstruction of one’s own human capital” (1991: 44).

Responsibility for securing health for oneself and for those to whom one owes allegiance is devolved on the individual actor, who is required to exercise prudence in the light of expert assessments of risk (Petersen, 1997). However, the clear distinction that once existed between the healthy and non healthy citizen has quickly evaporated in the ‘risk society’, as everything can be seen to be a potential source of risk and everyone can be seen to be at risk. The evaporation of this dichotomy blurs the dichotomy of the medicalised body from the unmedicalised body. As Harding argues:

[…] owing to the medicalisation of life generally and the promulgation of medical statements about symptoms and diseases and their treatments, in the clinic and in the media, as news and entertainment, it is hard to isolate examples of medicalisation from its absences, and to distinguish a medicalised body from an unmedicalised body. (1997: 145)

This is not an attempt to advocate the medicalisation critique – the limitations of this particular argument were highlighted within Chapter one, rather it is to highlight the impact of the discourses of risk in every aspect of our lives. Pointing to the example of health and specifically pregnancy and childbirth – we can see that the limitless potential of risk as well as its inescapable quality creates problems that are promoted as calculable and governable and accordingly necessitate action. In the case of maternity care, as argued above, it is medical advice which holds the most influence, and it follows that the action undertaken by the responsible pregnant or birthing woman would most likely be a medical one. Whilst it is clearly important to highlight the conditions of ‘risk society’ and its impact on health discourses and
practices it is equally important to investigate empirically the way that individuals respond to them. Accordingly, rather than represent the pregnant and birthing women of Australian society as a ‘singular female body’ (Harding, 1999) or in other words a homogenous group with common interests and relations to medical encounters, the following chapters seek to examine the lived experiences of my respondents. For as Shilling contends:

> It is necessary to allow for lived experience, for the phenomenology of the body. Bodies may be surrounded by and perceived through discourses, but they are not irreducible to discourse. The body needs to be grasped as an actual material phenomenon which is both affected by and affects knowledge and society. (1991: 664)

Accordingly, this thesis is interested in the consequences of a ‘reflexive’ or ‘risk’ society upon individuals and their subjectivities (Fox, 1998). Prior to this exploration there will be a cursory examination of various critiques of Ulrich Beck’s approach to risk and an emphasis as to why there has been an implementation of his theoretical model for the purposes of this research.

**Beck’s sociology of risk and its critiques**

As discussed above, the concept of risk – in the sense that it is now understood – is a modern concept. Prior to the period of modernity risk was a neutral term, absent of the political connotations it is imbued with today. Various understandings of the term during this time period have been linked to maritime adventures (Lupton, 1999a; Lupton & Tulloch, 2002). Accordingly, it was primarily concerned with probabilities, of losses and gains. These probabilities – whether positive or negative – were directly connected to notions of fate (Giddens, 1990) or to an act of God,
placing notions of control firmly out of reach of the individual where accordingly the individual “could not be imputed to wrongful conduct” (Ewald, 1993: 226). As time progressed the control of Fortuna and Deities over our lives readily gave way to actions being controlled by the individual. Slowly, risk lost any positive connotations and grew to encompass negative consequences alone. As Douglas asserts: “the word risk now means danger” (1992:24).

The negative connotations of the word are often expressed through the actuarial tables of life and health insurers as well as economists. The individual residing within the risk society is confronted with the end result of this actuarial data – the expert opinion, expressed to connect negative consequences that have been statistically connected to particular behaviours. Risk assessment in these cases reminds one of Weberian rationalisations of modernisms (Fox, 1991, 1998). At the same time, they tend to ignore the socially constructed nature and historically specific character of ‘risk’.

Ulrich Beck’s formulation of the theory of risk links with other sociological approaches to the analysis of risk environments in contemporary society (Douglas & Wildavsky, 1982; Giddens, 1990, 1991; Luhmann, 1993). However, it can be argued that his approach and application are more sophisticated in detail (Elliot, 2002; Fox, 1998). Beck’s sociology of risk (1992, 1994, 1999, 2000b) has been highly influential and implemented in areas concerned with understanding the complex time and space figurations of many of the invisible hazards that have been argued throughout this thesis.
Although his work has been highly praised (for instance Lupton, 1999a) it has at the same time been criticized for his demonstration of a realist approach when defining risk. For many, this kind of analysis, based in realism or ‘scientism’ where the term risk can be readily exchanged for terms such as hazards and dangers, is too simplistic. Within his seminal work *Risk Society: Towards a New Modernity*, Beck does give credence to these critiques. For example, within the early sections of his work he claims that the “risks of modernization” are “irreversible threats to the life of plants, animals and human beings” (Beck, 1992: 13). This led many of the commentators of his work to argue that Beck does not address the impact of culture on the construction of risk as a concept (Lash, 1994: 199-200). Yet, further analysis of this particular work, as well as later publications demonstrates Beck’s emphasis on the social and cultural construction of risks – as has been emphasized throughout this thesis. For example, within the same text we find Beck stating that there is a difference between ‘a risk itself’ and ‘public perception of it’. He continues by pointing out that: “it is not clear whether it is the risks that have intensified, or our view of them” (1992: 55, emphasis in original). This is backed up in his later publications where Beck addresses the realism-constructivism debate by arguing that risks are “social constructs which are strategically defined, covered up or dramatized in the public sphere with the help of scientific material supplied for the purpose” (1996:4). He continues this trend in later works (for instance Beck et al., 2003) arguing the fact that risks are mental constructs.

In the end he argues for an integration of realism and social constructionism into what he calls the “sociological perspective” (1995: 92). In essence Beck argues that ‘real’
risks do exist, but he argues at the same time that the nature and causes of risks are thought about and dealt with differently in various time periods. Finally, Beck directly addresses the critiques of his ‘realist’ tendencies with the following statement:

Some of the discussions in this volume, which accuse me of being a ‘realist’ therefore, are the result of a misinterpretation of my arguments. What strikes me about them is the inability of constructivist thinking to criticize and renew the frameworks of modern and post-modern sociology. Let me explain. I consider realism and constructivism to be neither an either-or option nor a mere matter of belief. We should not have to swear allegiance to any particular view or theoretical perspective. The decision whether to take a realist or a constructivist approach is for me a rather pragmatic one, a matter of choosing the appropriate means for a desired goal. If I have to be realist (for the moment) in order to open up the social sciences to the new and contradictory experiences of the global age of global risks, then I have no qualms to adopt the guise and language of a ('reflexive') ‘realist’. If constructivism makes a positive problem shift possible and if it allows us to raise important questions that realists do not ask, then I am content to be a constructivist. [...] I am both a realist and a constructivist using realism and constructivism as far as those metanarratives are useful for the purpose of understanding the complex and ambivalent ‘nature’ of risk in the world risk society we live in. (Beck, 2000: 211-212)

It is within this response to his critics that Beck clarifies his position on risk.

In direct response to Lash and his attempt to displace Beck’s ‘risk society’ with that of ‘risk culture’ Beck again emphasises the cultural aspect of his work. Lash attempts to displace the idea of ‘society’ which presumes, for Lash (2000:47) a “determinate, institutional, normative, rule bound and necessarily hierarchical ordering of individual members in regard to their utilitarian interests with ‘culture’ which would necessarily mean by contrast not a determinate ordering, but a reflexive or indeterminate disordering”, stemming from non-institutional or anti-institutional sociations. For Beck, the distinction is moot. He argues that his approach to defining risk, as argued above, incorporates the cultural. Interestingly, he begins with the statement that “risks do threaten destruction” (2000: 212). When trust in our security and in notions of progress end, the discourse of risk begins. It ends when the
potential catastrophe is realized. Therefore, for Beck, risk is characterized by the intermediate stage it holds between ‘security’ and ‘destruction’ (Beck, 2000: 213). What is being argued accordingly, is this stage. It is here that the perceptions of the threatening catastrophe –whether it is environmental, economical or health focussed – determine the thought and actions of the individual. This is what the present research is focusing on, the thoughts and actions of the pregnant and birthing woman in the face of her perceptions of pregnancy and birth. In the next chapter it will be suggested that many of these women do indeed see this period of their life as one full of potential risks and for some, of potential catastrophes. Ultimately for Beck, it is the cultural perception and definition that constitutes risk. ‘Risk’ and the “(public) definition of risk are one and the same” (Beck, 2000: 213).

This brings us to another common critique of Beck’s work, that of the true extent of the relevance of risk to the contemporary individual. One of the central critiques of Bryan Turner (1994) on the work of Beck questions, from a social-historical perspective, whether life in society has become more risky. Turner argues for instance:

‘[A] serious criticism of Beck’s arguments would be to suggest that risk has not changed so profoundly and significantly over the last three centuries. For example, were the epidemics of syphilis and bubonic plague in earlier periods any different from the modern environment illnesses to which Beck draws our attention? That is, do Beck’s criteria of risk, such as their impersonal and unobservable nature, really stand up to historical scrutiny? The devastating plagues of earlier centuries were certainly global, democratic and general. Peasants and aristocrats died equally horrible deaths. In addition, with the spread of capitalist colonialism, it is clearly the case that in previous centuries many aboriginal peoples such as those of North America and Australia were engulfed by environmental, medical and political catastrophes which wiped out entire populations. If we take a broader view of the notion of risk as entailing at least a strong cultural element whereby risk is seen to be a necessary part of the human condition, then we could argue that the profound uncertainties about life, which occasionally overwhelmed earlier civilizations, were not unlike the anxieties of our own fin-de-siècle civilizations. (1994: 180-181)
Turner’s critique basically asks, as was asked within the introductory chapter of this thesis, whether the hopes, anxieties, risks and uncertainties of each period are merely carbon copies of previous eras. However, Turner neglects many of the central aspects of Beck’s thesis, especially Beck’s notions of reflexivity and individualization.

Further critics attack Beck for what they call his cognitive realism, moral proceduralism and lack of attention to aesthetic and hermeneutical subjectivity (Lash & Urry, 1994); his failure to acknowledge the embodied nature of the self (Turner, 1994, 1997; Petersen, 1996, 1997); and his neglect of the psychodynamic and affective dimensions of subjectivity and intersubjective relations (Elliott, 1996; Hollway & Jefferson, 1997). Elliot argues that many of the criticisms of Beck focus on his supposed inability to grasp the “forms of meaning-making within socio-symbolically inscribed institutional fields” (Elliott, 2002: 301). However, Elliot concludes his critical approach to Beck’s social theory by arguing that the “concepts of risk, hazard and uncertainty, when couched within the framework of reflexive individualization and advanced modernization, are significant and provocative ideas that go a considerable distance in resolving some of the central problems and dichotomies within contemporary social theory” (Elliott, 2002: 312).

It is Beck’s emphasis on the social construction of risks and the according impact on the individual’s subjectivity which is of great significance when trying to understand current practices of pregnant and birthing women of Western society. Beck’s reflexive risk society can be seen as one in which individuals live according to a sense of all pervading risk. In relation to health in general it can therefore be argued
that any action or practice contains the potentiality of risk to one’s health or well
being (Petersen, 1997). This all pervasive aspect of risk is amplified in the time
period of pregnancy and birthing – as the risk is a potentiality for not only the mother
but also the unborn child. In a time period where children are being represented as
“precious entities entrusted to adults’ care” where they are seen to “deserve the very
best from us” (Nippert-Eng, 1996: 203) the pregnant woman needs to demonstrate the
capacity to look after herself and her unborn child not only as an indicator of how
responsible she is but also as an indicator of her moral worth.
CHAPTER FIVE

THE INTERRELATION OF RISK SOCIETY AND CHILDBIRTH PRACTICES

Since the release of Ulrich Beck’s translated *Risk Society*, the intervening years have provided us with enough examples of the centrality of risk in contemporary societies to cast Beck as a visionary. The expeditious progression of globalization increases the number of examples, with environmental, economic and health dilemmas becoming permanent backgrounds to our everyday life. This ‘climate of risk’ presses in on our daily activities, and as reflexive individuals we are aware of how it impacts on our relations with the self, with others and with society as a whole. It seems that we have become experts in adapting to these risks, whether this is through active engagement, resigned acceptance or simply denial (Giddens, 1991). The following chapter will examine these contentions through the voice of the respondents. First, there will be a brief examination of the recent research undertaken by John Tulloch and Deborah Lupton (2003) in relation to risk.

A difficulty with the contentions of Beck, and indeed Giddens, is that neither of them has empirically tested their theories, which thus relegates them to the status of ‘grand theories’. Indeed, as Alexander argues in relation to the work of Beck: “Broad tendential speculations are advanced about infrastructural and organizational processes that have little grounding in the actual processes of institutional and everyday life” (Alexander, 1996: 134).
Tulloch and Lupton engage in this challenge in their most recent publication on the ‘risk society’ thesis (2003). The intention was to build on previous research that has investigated the ways in which individuals make sense of and respond to specific risks by extending it to include an inquiry into the ways in which people broadly conceptualize and define the concept of risk. The research was carried out in both England and Australia with a total of 134 respondents being interviewed (60 in Britain and 74 in Australia). It was found that the participants’ definition and categorization of risk was negative. As Tulloch and Lupton highlight: “The emotions of fear and dread were associated with interpretations of risk as danger and the unknown. Uncertainty, insecurity and loss of control over the future were associated with risk, as was the need to try and contain this loss of control through careful consideration of the results of risk-taking” (2002:325). The assertion, by Beck and Giddens, of the pervasiveness of risk into the daily activities of Western citizens was also confirmed by these respondents who saw risk as an inevitable part of their life. Tulloch and Lupton conclude that risk was represented as an ever-pervasive part of life that was also strongly tied to individuals’ life situations, which were seen to not only expose the individual to certain risks but to also influence the perception of the phenomena as risks or not.

Although their respondents frequently conceptualized risk as a highly negative phenomenon, many of them also evinced the view that there were positive aspects to risk taking (Tulloch & Lupton, 2003: 33). These particular individuals portrayed risk as positive in the sense of voluntary risk taking for purposes of personal gains. For Tulloch and Lupton this is in direct contradiction to Beck’s notion of the risk aversive individual (2002, 2003).
Furthermore, Lupton and Tulloch challenge Beck’s contention of the loss of ‘logic of control’ within high modernity. For Beck (2000b: 215) individuals of early modernity sought to exert control over the conditions of life through rational processes which he terms ‘logic of control’. Beck argues, conditions of high modernity and the accompanying nature of contemporary risks necessarily erode this ‘logic of control’. Lupton and Tulloch (2003) contend that many of their respondents still apply the early modernist beliefs about control over risk and aspects of their life.

Although there is scope for further evaluation of Lupton and Tulloch’s conclusions, the purpose of this overview is to provide a broader context to the exploration of my respondent’s voices. The research undertaken within this thesis takes as an axiomatic that the activities surrounding pregnancy and childbirth, indeed the life events themselves, are socially constructed. Central to this construction is the ‘specialness’ that is attributed to this life stage as well as to the unborn child, who it can be argued are seen as particularly cherished beings (Tsing, 1990; Beck-Gernsheim, 1996; Jackson & Scott, 1999). Because of the protected state of the event the mother and the child both become the focus of risk discourse and anxiety. As Jackson and Scott (1999) argue in relation to children, risk anxiety helps to construct the event as well as create the boundaries of the event. Accordingly, it is worthwhile to examine the accounts of the women of whose experiences inform this research and explore the impact that risk has played in their pregnancies and childbirth.
Researching Risk

It is often expressed that the fieldwork and empirical findings of research are the most challenging and valuable aspects of undertaking qualitative work. My fieldwork was no exception. Being given access to these women’s life stories, their journey through pregnancy and into motherhood, was an immensely rewarding experience. These women and their stories reaffirmed my connection with women and with myself. Without diminishing the individual aspects and experiences each pregnancy and birth journey held, it quickly became apparent to me that similar themes were emerging throughout the interviews.

Interestingly, although the interview schedule did not address the ‘risk society’ thesis specifically, as did Tulloch and Lupton (2003), the discourse of risk was dominant through all interviews regardless of various factors such as age, pregnancy care choices and birthing environments. Accordingly, the following sections will emphasize the themes which emerged throughout the interviews and which can be seen to stem from the ‘risk society’ thesis which has been outlined within the preceding chapter. These themes include anxiety, fear, notions of trust, security, perfection and responsibility, control, life as a planning project and Beck-Gernsheim’s concept of voluntary obligation. The following three chapters examine the accounts of the women of this research and explore these themes through the chronological order of childbirth, from preconception to the birth itself.
The risk averse pregnant and birthing woman

As discussed above, the work of Lupton and Tulloch (2003) revealed risk as both a positive and negative concept that they argue is a critique of Beck’s conception of the risk averse contemporary individual. It could be argued that in terms of health, and especially pregnancy and childbirth, risk is not seen in positive terms. As argued in the previous chapter, indeed implied throughout the whole of the thesis, the pregnant body has been constructed as doubly at risk and doubly responsible (Lupton, 1999:63) where blame for risk befalling the pregnant woman and the unborn child is predominantly projected toward the woman. Accordingly, the findings of this thesis, in line with previous research, include that the pregnant woman’s understanding of risk is highly negative.

Indeed, a 1996 study conducted within a major Melbourne hospital revealed a high level of anxiety and fear amongst the pregnant women surveyed and interviewed (Searle, 1996). This particular study addressed concepts of risk directly by concentrating on aspects such as the potential for abnormality to the unborn child. It was found across socio-economic groups, yet was particularly high amongst first time mothers, that fear and anxiety were pervasive aspects of their pregnancy. Interestingly, more than half of the participants were concerned and felt anxiety about abnormal aspects of their pregnancy, with many worried about negative consequences which might place their unborn child at risk. These women were found to place the health of the foetus above their own; this mirrors previous research such as Dawn Johnsen’s (1986) claim that pregnant women will typically go to great lengths and
risk significant harm to their own health in the interests of their future child’s well being\(^1\). They also regarded the availability of prenatal tests as a positive thing which offered reassurance, regardless of the anxiety they felt whilst waiting for the result. This is reminiscent of Rothman’s (1986) notion of the ‘tentative pregnancy’, yet at the same time critiquing her central tenets.

As previously stated, the women of this research were never directly asked questions about risk, yet the women’s accounts often expressed their pregnancy and birth experiences as risk-related issues. For instance, although the question of preconception care was not directly asked within the initial interviews, it quickly became apparent that many women saw this as an important aspect of their motherhood journey. In fact, of the 45 women interviewed 33 had planned their pregnancies, and well over half of these women saw prenatal care as an important aspect to having a successful pregnancy and birth. Of course the extent of care was of varying degrees amongst these particular respondents. For some preconception care involved a heightened awareness of diet and exercise, for others it involved further implications. For instance Tania, a mother of two who had just recently given birth to her second son spoke of her approach to preconception care:

For three months prior to falling pregnant, I had been like no caffeine, and watching my diet, no alcohol, and no going to pubs with a smoking environment, and that sort of thing, for the three months prior to falling pregnant.

Tania took extreme care in both of her pregnancies, although she does reflect the findings of Searle’s 1996 study in that she seemed more relaxed in her second pregnancy, even with a miscarriage occurring between the first and second births:

This time was the same, I started taking vitamins that are specific for pregnancy, you know the ones that help safeguard against conditions like Spina Bifida, and decaffeinated products
again, but apart from that I still had a bit, maybe a glass of wine, three times a week or something. I wasn’t quite so stringent this time.

Many of the women who undertook preconception care expressed similar sentiments to Tania, but few took this form of care to a more extended level. An example of an exception is found through the narrative of Tina. A mother of two girls, Tina felt that undertaking preconception care safeguarded her health during pregnancy and also the future health of her unborn child.

When Tony and I decided to have a baby I knew that I had to make sure that I was as healthy as possible before we fell pregnant. I am pretty healthy anyway, you know, but I made sure that I didn’t have any alcohol, foods with preservatives and stuff like that. In fact I even became careful about where I went, I didn’t want to be around people who smoked. I even stopped going to my friend’s house who has a cat. I tried to minimize my stress levels, but that is kind of hard when you are running your own business. It was so important to me to be as healthy as possible to give my baby the best start and you know the best future too. So on top of my diet I also took the multi vitamins that are for pregnant women. I took them for three months before we started to purposely fall pregnant. I knew that I was doing the right thing for my baby.

The choice of undertaking preconception care is becoming more and more popular. Not only have various media reports expounded on the benefits of preconception care, or rather the dangers of not undertaking it, but they have also highlighted the responsibility of doing so. For instance, a recent newspaper article began with the following statement: “preconception care is the most loving and responsible choice you and your partner can make together, not only for you and your child’s health, but also for future generations” (McDowell, 2005). The increased popularity of preconception care is also evidenced by the implementation of it within American health policies, the acknowledgement of its importance within publications of RANZCOG, the publication of books such as The Natural Way to Better Babies (Naish & Roberts, 1996) and The Natural Way to Better Birth and Bonding (Naish &
Roberts, 2000) as well as the creation of Australian clinics which specialise in preconception care and natural methods for increasing fertility\(^3\). The understanding that taking folate vitamins to help safeguard your baby against health problems such as Spina Bifida was common knowledge to all of my respondents. In fact, not only is the information readily available through pamphlets at the general practitioner’s office and within health food stores, but all pregnancy tests have folate pamphlets within them informing women of the benefits of taking them within the first trimester of pregnancy.

The idea that pregnancy was ‘risky’ was also expressed through various women’s accounts of insecurity during their first trimester. Many of the respondents expressed anxiety about the feasibility of the pregnancy within the first few months. This was expressed by their choice to not tell anyone about the pregnancy until after this time period. For instance, Joanna and her husband Craig did not tell anyone outside of their parents about their pregnancy until the third month was completed:

I guess because we had suffered the miscarriage before falling pregnant with Tiana. I was so scared about anything happening and then having to tell everyone that we had lost the baby again.

This sentiment was echoed by all of the women who had miscarriages prior to their successful pregnancy. Tania conveys her feelings in the following way:

The first time we had a very awful bleed, when we thought we were 11 weeks along, and that was terrible, but it was just an eruption of the placenta, and everything was fine. I guess I had the miscarriage prior to falling pregnant with Lloyd, made me a little bit more concerned until we got to the 12 week mark. We told everyone, with Lachlan we told everyone we knew straight away, and with the miscarried pregnancy we told everyone as well. But just having that experience of, and it wasn’t so much that we didn’t want to tell everyone, we just didn’t want to put other people through the whole thing again of grieving for us anyway, so we didn’t tell anyone till 12 weeks. So that whole time was really tentative this time round. Then we had a very small bleed with Lloyd when I was about 28 weeks and that was scary,
even though it was very small, we went into the SAN and everything was fine. That was really the only scary times.

The notion of a ‘risky’ pregnancy was also expressed by women who had no history of miscarriages or health conditions. For instance, Natasha, a 28 year old woman who had decided to give birth at home with the aid of an independent midwife expressed similar sentiments:

My husband and I decided that we wouldn’t tell anyone about the pregnancy. Not only did we want to get our heads around it without anyone giving us advice, but we also wanted to make sure that everything was normal. A month into the pregnancy I had some bleeding and I was really scared, that is when I called my Mum to let her know, I just wanted her support and she was great. The midwife helped us through it and obviously everything was ok.

**Risk and Individual Biography**

The impact of previous pregnancy and childbirth experiences on women’s conception of their current pregnancy and impending childbirth as ‘risky’ were significant. Although this appears to contradict Searle’s 1996 study, the instances of anxiety expressed by these particular respondents related to issues of miscarriage, specific illnesses which are unique to pregnancy, and labour and birth outcomes such as haemorrhaging, rather than cases of foetal abnormality which is specific to Searle’s study. As outlined above, a previous experience of a miscarriage often left these particular respondents with feelings of anxiety and a sense of tentativeness.

With some of my respondents their previous pregnancies involved complications such as the contraction of cholestasis⁴. Although the condition itself is relatively rare, with instances of its occurrence stated as 1 out of 1,000 pregnancies, its reoccurrence can be as high as 90%. Furthermore, the stated implications for the foetus can involve
risks of foetal distress, preterm births and stillbirths. Accordingly, in the two cases
within my fieldwork, both women were quite aware of the ‘risks’ that surrounded
their pregnancies and births and attempted to exert control over the situation.
Interestingly, one of these women was under the private care system and the second
woman gave birth to her children at home. Although both women discussed their
conditions and aspects of their pregnancy in terms of ‘risk’, the activities they
undertook in hopes of controlling the condition were strikingly different. For
instance, Danielle discovered she had the condition, as is typical, in the last trimester
of her pregnancy. At first, she was tentative to acknowledge her symptom of extreme
itchiness as anything outside of the ordinary:

I was in the obstetrician’s office on a Wednesday, at 36 weeks and everything was fine. She
did the heart rate and all was good, and she was saying ‘fantastic, we’re on target with
everything.’ By that Friday night, Saturday morning, I didn’t realize it yet, but I’d started to
scratch, (much laughter). We went to watch my nephew play cricket, and my parents were
there, and we were all standing around, and I didn’t realize it, but I was scratching my arms
and legs, and outside of the thigh. My mother, being a mother, went ‘what are you doing,
scratching so much?’ and I said ‘oh yeah, I’m really itchy, I don’t know why, it’s just
started.’ And then I thought in my naïve, I’ve never been pregnant before, I said to her ‘it’s
probably some pregnancy thing.’ So many changes happen and you’re not really sure if it’s
normal or not. She said ‘no love, I really don’t think that’s normal, I think you should speak
to your doctor.’ I went ‘I’m not phoning my doctor and saying I’m itchy, honestly mum,
come on.’ I was embarrassed. I said ‘I’m going to the doctor on Wednesday I’ll ask her
then.’ She said ‘it’s a long time away,’ and of course as mothers do, planted that seed of ‘I
bet she’s right.’ Because within me, I’d started to think is this right, something could be
strange.

Danielle was soon diagnosed with cholestasis and was informed by her obstetrician of
the stated risks implicit within the condition. Danielle expressed sentiments of fear
and guilt over her feelings of irresponsibility of not taking the condition seriously:

She just picked up the phone straight away and put me in for some blood tests, she said this
could be really, really serious. So then I went in to this panic of ‘oh my god, I’m a bad
mother,’ this whole guilt thing that starts before you even have your baby. She sent me for
blood tests and they confirmed I had this cholestasis thing, which affects your liver, and I
do’t even know why but it makes you itchy. It’s a deficiency of something. If it goes
undiscovered it can affect the baby, it can kill the baby, so she laid it down for me really
seriously, ‘you have to rest more, you have to do this, you have to do that,’ it was awful.
Anyway they also decided to induce the baby early because I had it, and they said as soon as I got to 39 weeks they said she’s ready, we may as well bring the baby on. That’s why we were in hospital early.

At no point did Danielle question the authority of her obstetrician. Once her doctor expressed to her the stated seriousness of the condition, Danielle was quick to surrender all autonomy to her obstetrician. In fact, earlier within the interview Danielle discussed her relationship with her obstetrician and the reasons for choosing a private hospital and private care as opposed to public, shared, birth centre or homebirth. She expressed feelings of security towards and trust in her obstetrician as well as viewing her as an expert:

I believe in paying professionals to do their job, and because I knew nothing about having babies, I think I felt safer. Most of my friends and my sister had had an obstetrician for their first baby, so it seemed like the logical thing for me to do, to have one as well, which turned out to be for the best.

In contrast, Natalie who with the same condition has had four children, gave birth to her first child within a hospital setting but chose to give birth at home with an independent midwife for the subsequent three pregnancies. She contemplated giving birth at home for her first child but when at 32 weeks she was diagnosed with cholestasis, she accordingly followed the advice of her midwife and gave birth within a hospital setting:

Yeah, I saw her [the midwife] every month until 30 weeks, then I started itching, and she’d had a midwife friend that had cholestasis before, so it triggered that maybe it was that. I was seeing her every week, and by the time we got the test results back, I was 34 weeks, so we saw the Professor at Nepean Hospital, and he said it was cholestasis. We decided I would be induced at 37 weeks, that’s what I thought I needed to do then.

Natalie, most likely due to her reoccurring exposure to the condition, was very knowledgeable about it and the stated risks it involves:
There’s no rash, it’s just itching, manic itching on your hands and feet particularly, and vomiting. I was vomiting a lot. They say it’s over production of oestrogen, is one of the things, and the bile duct closes, so the toxins start coming out through the linings and in to the blood. Eventually they get in to the baby, and there’s a one in four chance of stillborn over 38 weeks. The toxins get in to the placenta.

However, during her first pregnancy her determination to not be induced saw her trying various home remedies to induce labour naturally rather than be induced within the hospital setting. Through the advice of her independent midwife as well as a network of natural birth advocates, Natalie began to take raspberry leaf\textsuperscript{6} in the form of tea, had acupuncture sessions, her husband stimulated her nipples for production of oxytocin which is responsible for the contraction of the uterus, and they increased sexual intercourse. In the end, Natalie gave birth within a hospital setting but through a spontaneous labour, rather than an artificially induced one.

Despite her awareness of the chance of the condition reoccurring in later pregnancies, Natalie and her husband decided to fall pregnant 10 months after giving birth to their first child. It was important to Natalie to give birth with as little intervention as possible, in her mind this could only occur within a home birth environment. With the subsequent pregnancies she undertook a change of diet as well as consulting an acupuncturist and homeopath:

Basically I’m a vegetarian anyway, but I took out all fats, no dairy products at all, cause they’re oestrogen forming, and also really hard for the liver to process. I had fresh juices, 20 minutes before every meal, the liver cleansing ones, parsley, celery, beetroot, apple, to try and flush the toxins out of my body. Herbs, I was taking herbs throughout the pregnancy, I was having acupuncture through the pregnancy. Anything, and everything during the pregnancy to help.
This approach was successful for the second pregnancy but for the third pregnancy Natalie became quite ill. Regardless, she was determined to continue with her chosen path of care:

Yeah, I’d been having liver function tests throughout the whole pregnancy, but I could bring them down. I’m the first person that they’ve known, that’s ever brought their results down once they got as high as mine. I could bring them down with my diet, but every now and again I’d slip with something. I’d have to have a whole block of chocolate or whatever, then they’d go back up, and I’d be itching more. I could bring my results down, but I couldn’t stop the itching, but I was able to get them back in to a safer level. They thought I was going to get fatty liver disease at 34 weeks, and that’s when I really changed a lot more things. We changed my herbs; I started drinking seven to ten litres of water a day. Not that I needed that much but at that point that’s what I thought I needed to do. I was only eating organic fruit and vegetables and juicing all day long, trying to flush everything out of my body. At 36 weeks I couldn’t take it any longer, that was it, and I said I had to bring this baby on. So we started then, just with preparation, like sex, and acupuncture to try and stimulate the uterus. Everything I could do to prepare first, cos I wanted to build it up slowly, and then at 37 weeks we had to pull the uterus down, and the lip of the cervix down, and that sort of thing, but it triggered labour off. I had her after three days of labouring, I birthed her. So she was born, and she was 8 pounds, she was really healthy when she was born. The children were there at the birth, and my sister. Once I went in to labour the itching died down and I was able to labour really well. I was just so exhausted from the two months of not sleeping.

The doctors who had been involved with her throughout her previous pregnancies, because of the condition, informed Natalie that if she were to fall pregnant a further time she could actually die from a condition called fatty liver disease. Natalie and her husband through much careful consideration had decided to not have any further children. Yet just over three years after she had given birth to her third child, Natalie fell pregnant once more. The pregnancy was unplanned and Natalie had many negative feelings about it:

I was totally traumatised to start with. It’s funny because after I had Emma, my third, I was in two minds, should we, shouldn’t we, should we, shouldn’t we do it again, and I think because I’d moved a lot more in to the birth scene, co-ordinated the home birth groups, and involved in homebirth axis Sydney, and I’d supported many women around the world who’d had cholestasis, when I found out I was pregnant I was absolutely traumatised. I’d met many more women who had had still birth babies, and miscarriages, and were sick, and it was really, really a shock for both of us. I cried throughout the whole pregnancy, just in the anticipation of what was going to happen to me. And being sick and having migraines, and just caring for my other children it was huge.
Natalie began to show signs of the condition early within the pregnancy and was fearful of what the rest of her pregnancy would bring. Expressions of fear from family, friends and medical staff weighed heavily on Natalie and her husband. Nevertheless, she continued with her choice of birthing environment. Fortunately, the condition was more controllable in her final pregnancy than was the case in her third. The key difference for Natalie was that the birth of her last child was at home, but it was unattended. Natalie felt uncomfortable employing the same midwife she had for her last pregnancy and childbirth. Although she was not explicit in the reasons surrounding this decision it became clear that there was an issue of trust:

I got to know this midwife, more professionally, in a different capacity, and decided that I wouldn’t have her this time, I wasn’t happy with some of the things that she’d said. Nothing to do with my birth, she was great at the birth, but I wasn’t happy with her any more. I wasn’t comfortable with her to be at the birth.

She did approach several other midwives yet because of the indemnity crisis and lack of insurance for independent midwives, these women had to reject Natalie as a homebirth client. Nevertheless, they did offer to support her within the hospital system. Natalie rejected this offer, she felt that being in a hospital system would not be the most responsible approach for herself or her unborn child:

I think they would have seen me as high risk and I think even if I knew deep down what was right, that they could have persuaded me by making it sound more dangerous, or whatever, that I was taking too big a risk, and I’d probably end up with whatever, I didn’t want to go down a path where I was accepting things being done to my body or to my baby that I knew were not good for us, just because they had convinced me in a time when I was weak.

In the end, Natalie gave birth at home unassisted with a support team comprising of her husband, children, a close friend who had home births as well and contact numbers of an obstetrician who was unaware that Natalie was giving birth unassisted. If Natalie were given the opportunity to birth at home with a midwife she would have
preferred that alternative, unfortunately, the indemnity crisis and its consequences left Natalie with no options in her opinion. Trust in her primary carer was imperative for Natalie, this was clear throughout the interview. However, it was also clear that she felt the responsibility for what happened during the pregnancy and birth lay squarely on her shoulders. When asked about her relationship with her primary carer as well as what she desired from a midwife, Natalie almost provided a checklist:

To let me birth the way that I choose, at the time, to pretty much lay low, and let Jason and I be, until we needed her. To basically respond to anything that I need throughout the pregnancy and birth, whether it was a bit of research done, or just to support my decision, someone to talk to, someone to listen to me. Someone to care for my children through the birth, if there were any complications to be able to cope with those complications. Basically, I wanted my midwife just to be there if there were any problems. Because I had problems already, my expectations were a lot greater, but then again, what I wanted them to do during the birth, wasn’t a lot.

It becomes quite evident that the sense of responsibility that Natalie has towards the outcome of her pregnancies has led her to become her own expert. Her involvement in the homebirth movement and the Internet community which deals with the condition of cholestasis is an extension of this. The themes of risk, responsibility, control, trust and security are present in both of the cases that we have just examined, although they are approached at almost polar viewpoints. Further examination of this will be conducted shortly; first it is worthwhile to revisit the case of Danielle.

Danielle is the only respondent of the study that I was able to interview on two occasions. The second interview was more informal than the first as I found out by chance that the respondent had just given birth a second time. What is worth drawing attention to is Danielle’s turn towards a more medicalized pregnancy and birth for her second child. This was alluded to during the first interview, as one of the last questions asked to Danielle revolved around change of care for any subsequent
pregnancies and birth. Danielle’s sense of pregnancy and especially birth as ‘risky’ as well as her trust of the medical system and security derived from it was obvious:

Nope, I’d do the same, same doctor, same hospital. On my six-week check up I said to her ‘if I had another baby, do I have to have a Caesar, or what’s the story?’ She said this cholestasis thing that I had, it’s not a guarantee that you’ll get it in the second pregnancy, but it’s a high risk, and she said ‘if you develop it again, I would recommend that you have a Caesar, book yourself in, don’t put yourself through what you went through, but there’s no guarantee that you’ll get it. You could just go ahead and see what happens and it may all just happen naturally, but you might get in to the situation where you’ll have an emergency Caesar.’ I said to her ‘if there’s any remote risk of that happening I will just book myself in, and bad luck, if I never give birth naturally I don’t care, because I couldn’t go through that risk again.’ I was going to say nightmare, but I’ve never had a nightmare about it. Yeah, I’d do the same.

Just as in the case of Natalie, Danielle experienced cholestasis within her second pregnancy. Although she was concerned about its reoccurrence she did not undertake any major dietary changes as we saw in the case of Natalie. Although she did speak about a diet it revolved more around her concerns about gaining unnecessary weight than having any impact on the condition itself. Her tendency to release her autonomy and responsibility to her primary carer continued into this second pregnancy and birth, to an even greater degree.

Although Danielle was experiencing the condition for the second time her knowledge of it was still limited. Her main source of information was her obstetrician, What to Expect When you are Expecting, a lay pregnancy and childbirth book and a pamphlet provided to her by her obstetrician. Danielle felt that to be a responsible mother and have the best outcome for her child, the safest route was a medical one. This was emphasised in Danielle’s response to my question relating to a possible change in activity or diet because of her condition:

While we were trying to get pregnant I went on a full on low carbohydrate, zero carbohydrate diet, to lose some weight, because I was really worried that when I got pregnant I’d get hugely fat and I’d never lose the weight. After we were pregnant I really began to think
about the chance of getting cholestasis again. On my 6 week check up my obstetrician told me I could get it again, she was kind of blunt about it actually. It was comforting to have her advice though. She gave me a pamphlet about the condition, which you wouldn’t believe it I don’t really remember the advice that much, isn’t that awful. But we also spoke about a Caesarean section to keep the baby safe. I decided in the end that I was going to have a caesarean. I couldn’t stand the thought of going through labour again, and considering we needed to get this baby out early so that she would be safe, a caesarean was obviously the safest choice.

The social construction of pregnancy and childbirth as a pathology and intrinsically risky are inherent within Danielle’s interviews. It is obvious that Danielle believes that her obstetrician’s medical knowledge is the best thing for her health as well as that of her baby’s health. This is very similar to the recent research of Straten et al. (2002) who found that the public trust that the lay population has for health care is heightened in the case of women, whom they found expressed confidence to be adequately taken care of when in need. Furthermore, Danielle’s view that a caesarean section was the safest mode of delivery mirrors the conclusions of Zanetta’s et al. (1999) research. This particular research analysed an Italian tertiary hospital’s maternity records over a 14 year period under two different obstetric management teams. Although they did not interview the women involved, they provided a cultural view of birth:

Vaginal delivery is symbolically related to the fear of possible risks to the fetus, and nonhealth professionals may believe inaccurately that intervention procedures will reduce maternal and neonatal risks. In addition, caesarean delivery is often perceived as a painless mode of delivery. Compared with the “terrible” pain related to vaginal delivery. (Zanetta et al., 1999: 146)

This particular approach to childbirth can be readily applied to many Western countries as is evidenced in various research. For instance, the work of McClain (1990) highlights that caesarean birth is viewed by some women as a ‘cultural good’ (1990: 208), where the procedure is seen as “having rescued the fetus from some
menace, usually brought about by their own maternal deficiency” (1990: 208). McClain’s research involved the issue of vaginal birth after a previous caesarean delivery. Her research involved interviewing 100 women and it was found that of those who ended with a caesarean birth the experience did not signify a loss of control over the body and birth, rather many of the respondents felt they were controlling an experience brought about by ‘biological deficiencies’ which could not be controlled by other avenues (ibid.). Control and empowerment are important themes of not only McClain’s study but also the present one.

In the case of Australia, recent research in women’s role and satisfaction in the decision to have a caesarean section (Turnbull et al., 1999) revealed that out of the 278 women who participated in the study, 171 women reported being involved in the decision to have a CS. The survey used for this research incorporated open-ended questions, including “What led you to make the decision to have a CS?” (Turnbull et al., 1999: 581). Here the researchers found through a content analysis of this question that women framed their responses in terms of medical risks and benefits as well as issues of non-clinical personal issues. This was further clarified in the questions with forced-choice responses which found that among various reasons women were influenced to choose a caesarean because of considerations about pain and previous negative experiences of childbirth. Furthermore, about four times as many women with an elective CS reported that they had been influenced by family and friends during their pregnancy (ibid.). Subsequent research within Australia found that Australian women, independent of socio demographic variables such as age and education levels, felt that caesarean sections were an easy and convenient way of giving birth (Walker et al., 2004).
As argued within Chapter one, there has been a copious amount of research undertaken in a quest of understanding the recent trend of active engagement with a medical birth (for example Davis-Floyd, 1994; Lazarus, 1994; Zadroroznyj, 1999; Zanetta et al., 1999). For many of my respondents, medical intervention during their pregnancy and childbirth – even to the extent of undertaking a caesarean section – provided them with a sense of control that they found empowering. Indeed, many of my respondents who actively engaged with a medicalized pregnancy and birth expressed control more as a matter of their active participation with their pregnancy, such as diet, exercise, preparation for birth through classes and reading and also following the growth of their baby through information from books, internet sites, and feedback from tests such as ultrasounds. This very much mirrors the work of Campero et al. (1998) who suggest that control for women who seek out a medical experience during this time period are more likely to see it as “a matter of having participated in and having followed the evolution of their labour” (1998: 402). Davis-Floyd (1992, 1994) demonstrated similar patterns in her study of middle class American women who purposely chose, what she termed, the technocratic model of birth as means of controlling the uncertainties they felt were intrinsic within pregnancy and birth.

Beyond the case of Danielle, this was expressed within all of my private birth mothers as well as some birth centre mothers. As we have seen with the case of Danielle, there are instances where the active engagement with a medicalised birth is quite extreme, yet this was not always the case. This was apparent with the example of Georgie, the private birth mother whose story was presented as a case study within
Chapter one. A further example is Phillipa. Within the interview, she often expressed her desires for her pregnancy and birth to be as natural as possible. Here she speaks about the plans she had for the birth of her first child:

I wanted to give birth naturally. I wanted to be amongst people that I knew and I loved. I had my support group picked out. I wanted to be active, I wanted to be able to get in the bath. I wanted to do it without drugs if I could. I knew that if I was going to have anything, I would have gas, and then I would skip pethidine, and go straight to the epidural. I didn’t want pethidine, because I didn’t want the effect on the baby. Those were the main things that I wanted, I wanted to be able to do it myself.

Although Phillipa’s intention was to give birth naturally, indeed her first desires involved a water birth, she ended up with a caesarean section. Phillipa was quite happy at exploring various avenues for a natural birth experience, yet she was receptive to what Davis-Floyd (1994) would call a technocratic birth. What is curious with Phillipa’s case is that her desire for a natural birth experience was strong to the extent that she was planning on becoming a doula. However, when asked about her birth experience it became evident that the medical environment provided her with security during an event she found to be an ‘out of control’ experience. Indeed, when asked if she would change her mode of care for any subsequent pregnancies, Phillipa’s response indicated her alignment with the medical model:

I would do it much differently. First of all trying to achieve a VBAC [vaginal birth after caesarean] is something that you need support with. I would pick a lot more carefully my obstetrician. I would still want to have a doctor’s care, simply because they can tell me what’s happening with the baby so that I can prepare for that. I can do what’s necessary at the time. If I have the same OP again, then I can prepare for that. I know that I’m probably not going to be able to deliver that. But I would certainly, next time, look at having something like a doula, who can work me through.

The combination of a natural childbirth desire with the acceptance of a medical model of birth was present, as stated above, within many of the birth centre respondents as well. Kylie, who works within the hospital system in the area of administration,
chose the birth centre option not only because of her desire for a natural birth, but also because of her knowledge of the hospital system:

They [her friends] who had birthed within the birth centre unit also presented it being quite non-clinical, and working in a hospital that was quite an attractive option for me. I’ve had enough of hospitals, I know what hospitals are like, and I know there’s risks with medical intervention. Partly because you don’t know the level of expertise of the health professional who’ll be looking after you, and decisions can be made that are good, and decisions can be made that aren’t so good. So if I didn’t need any extra intervention then I was happy to go without it.

Kylie was quite happy to give birth within the birth centre, with its ‘non-clinical’ environment. Yet, this was mostly due to the fact that it was not a freestanding unit, the closeness of the hospital system with its avenues for dealing with emergencies provided security for Kylie. When asked about her expectations of and preparation for labour, Kylie’s acceptance of necessary medical intervention was clear:

What I wanted was to jump in the spa, and to use the heat and to be able to get through it as I had anticipated, practicing the breathing that I had been taught, using the heat packs, the warm water, the massage, getting in different positions. Different positions that might help alleviate pain, and help with gravity and all of that sort of stuff. But at the same time I was aware that there’s the potential for things to be unexpected. The midwives weren’t going to know if this child was far too huge for my anatomy to fit out, and it wouldn’t be until after I’ve been pushing and it wasn’t coming out, that they would say ‘okay plan B, we’re going to wheel you down the corridor, and we’re going to have to pull it out with a caesarean.

The desire to give birth within a system that advocated natural birth with the safety of the medical model ‘down the corridor’ was succinctly expressed by Josie in the following manner:

I felt really secure giving birth in the birth centre, not only was Chris there [her doula], but I knew I would have drugs if I needed them. I chose the birth centre because I liked the environment, I mainly liked this big bath that they had, and it was in the hospital anyway, so I knew if I needed drugs I would go upstairs and have them. I was trying to get the best of both worlds, having a nice birth environment, but also knowing there was pain relief and support if there was an emergency next door if I needed it.
This is in sharp contrast to women such as Natalie, who do not relinquish their autonomy to the medical experts, it appears to any degree; rather their rejection of medical intervention is a demonstration that they are able to manage their bodies responsibly. Accordingly, the sense of control and empowerment is from the act of refusing medical intervention and the self-management of their bodies during pregnancy and childbirth. This is expressed throughout all of my respondents who gave birth at home as well as some of the birth centre mothers, mirroring the research undertaken by authors such as Martin (1992) and Lazarus (1994).

Millie, a student midwife and the youngest respondent of the study, gave birth at home to her daughter at the age of 22, passionately expresses this form of control:

That’s really the paradox in life. By control I mean, taking control of, don’t expect somebody else to take control and to care for you. You’re in control of your body, your own health, your own growth of your baby, and accepting the responsibility and your role in the outcome, and your part in it. It’s as good as you make it. The thing is with the control is, you can have control as much as you like, you can have continuity as much as you like, but if you don’t have a choice, either of them go out the window, both of them go out the window. If you don’t know you have a choice, either of them go out the window, both of them go out the window. If you don’t know you have a choice, you can have control with an obstetrician, you can have continuity with an obstetrician, but if you don’t have choice, you don’t know your choices, so your control isn’t really informed. It’s not informed, it’s not your own, then that’s what I would urge people to do.

Other homebirth respondents mirrored similar sentiments, at times it was about maintaining autonomy throughout their pregnancy and birth experiences and actively avoiding any medical intervention. At other times it was as simple as controlling their birthing environment. Helene expressed why birthing at home was important to her in the following way:

I think, at home because I felt safe, I felt secure, I could do everything at my own pace. I had a little bath, so I could bath whenever I wanted. We had the cats around, we could put on music, we could put on candlelight, we could do whatever we wanted, and I felt that was the place I wanted to be really.
What has been presented by these women is not only the expression of a consciousness of risk in relation to their pregnancy and birth experiences, but also the more self critical or reflexive approach to the decisions they make about their care. It is apparent that many of the respondents of this research were questioning the institution of medicine. Yet at the same time, there was still an acceptance of obstetricians as the experts and the medical birthing environment as the ‘safest’ place to give birth.

Even within the homebirth respondents there was a lingering presence of medical definitions amongst their birthing narratives. As we saw in the case of Natalie, a woman who became her own expert about pregnancy, childbirth and the condition of cholestasis, there was a persistent acceptance of the medical model. When asked why she did not want to give birth within the hospital system when she had the pre-existing condition of cholestasis as well as a history of haemorrhaging during birth, she highlighted her fear of accepting the medical model that she felt would be imposed on her:

I think they would have seen me as high risk and I think even if I knew deep down what was right, that they could have persuaded me by making it sound more dangerous, or whatever, that I was taking too big a risk, and I’d probably end up with whatever, I don’t really go there.

Natalie’s sentiments of fear in relation to accepting medical intervention within a hospital setting are common amongst the homebirth mothers. This also reflects the research of Monto (1997) who argued that although cultural opposition shapes alternative models of childbirth care, women who oppose the dominant medical understandings are at a disadvantage in the definitional contest. Monto found,
through the 31 interviews that she conducted, that despite women’s conscious commitment to alternative definitions of pregnancy and childbirth, “vestiges of the medical definitions remained internalized, only to surface during times of crisis” (1997: 305).

The presence of opposing definitions and understandings of pregnancy and birth in Monto’s respondents and the present research are obvious. Monto questions not the existence of these opposing definitions, as she explains this through the use of Erickson’s (1976) ‘axes of variation’, rather than the influence of some over others. For Monto the prevalence of a medical definition over the life event of pregnancy and childbirth is because it is legitimated by powerful societal institutions and comprehensively embedded in our cultural ideas (1997: 313).

Whilst this is obviously the case and has been expressed by various researchers in a multitude of ways (to list just a few: Arms, 1975; Jordan, 1978; Arney, 1982; Kitzinger, 1987; Davis-Floyd, 1987b; Martin, 1989; Rothman, 1989; Armstrong & Feldman, 1990; Davis-Floyd & Davis, 1996) it neglects historical and societal processes that have led to the elevation of one definition as authoritative. Returning to the work of Beck in relation to his approach to reflexivity and reflexive modernization, we see two phenomenon occurring. As previously outlined, the first phenomenon is the production of unintended consequences as a result of the increased modernity of a society which in turn call the foundations of modernity into question. The second highlights that these consequences are part of the knowledge base of society. The important question, according to Beck, is who knows them and on what
basis? ‘Unintended consequences’ denotes a conflict of knowledge or rationalities. In Beck’s reflexive modernity we see the claims of different experts collide with not only one another but also with claims of lay knowledge and of the knowledge of social movements (Beck, 2000). As argued in the previous chapter, for Beck, the last two forms of knowledge can be argued to stem from expert knowledge. However, because of notions of status and social credibility they are not acknowledged as expert knowledge and consequently are not valued as such by institutions such as law, politics and business (Beck, 2000). The knowledge of ‘unintended consequences’, therefore, opens up a battleground over rationality claims. This is readily seen with the case at hand, where the contestation of definitions of birth and subsequent practices which surround it are constantly debated.

Beck’s emphasis of knowledge of ‘unintended consequences’ is especially pertinent in the childbirth debate. Beck (1992) highlights the transient nature of risks and how society approaches and defines them. For Beck, risks “only exist in terms of the (scientific or anti-scientific) knowledge about them. They can be changed, magnified, dramatized or minimized within knowledge, and to that extent they are particularly open to societal definition and construction” (1992:23 original emphases). The malleable nature of risks, therefore, argues that there are winners and losers in the construction of risk definitions. Accordingly, Beck argues that power and access to and control of knowledge thus becomes paramount in a risk society. As argued throughout the thesis, the current definition of pregnancy and birth as a medical event is the authoritative one. Accordingly, it has become very difficult for the pregnant woman not to become caught up with the discourses of risk that surround her.
The Imperative of Avoidance: Risk Discourse in Pregnancy and Childbirth Narratives

It has been argued that we now live in a world that has become more risky. By this it is not meant that day-to-day living has become inherently more risky than in previous eras, rather that the individual, whether they are lay or expert, think in terms of risk and risk assessment becomes an ever-present exercise (Giddens, 1991). Beck’s (1992) concept of individualization, as argued in the preceding chapter, involves the nearly constant reflexive monitoring of risk which pervades our sense of how to manage ourselves and the world. It has been argued that the social construction of pregnancy and childbirth as medical events, which necessitate medical intervention, makes it almost impossible to avoid notions of risk that surround the event. Furthermore, because of the ‘specialness’ that is attributed to this life stage and the unborn child, who it can be argued are seen as particularly cherished beings (Jackson & Scott, 1999), the event and the child both become the focus of risk discourse and anxiety. Indeed, Nippert-Eng argues that children are represented as “precious entities entrusted to adults’ care, deserving the very best from us” (1996: 203). This common sentiment is referred to by Nippert-Eng as the discourse of the ‘sacred child’ (1996: 203).

It became clear, throughout the process of interviewing the respondents that the dominant definition of pregnancy and birth as a risky event was impacting on them and their perception of the event. For example, the birth centre mothers in their expressed desire to birth within an environment that was connected to a hospital demonstrated their belief in the inherent risk of childbirth. As found through the case
of Natalie, the lingering presence of medical definitions relating to pregnancy and childbirth was evident within the homebirth mother population. This was found to directly relate to perceptions of risk relating to the event. However, the sentiment of pregnancy and birth as an inherently risky event was most strongly found within the private birth mothers. For instance, one of the respondents, Sandra, a 42 year old woman who provided therapy through reflexology, remedial massage, Bowen therapy and kinesiology expressed how the classification of herself as a ‘high risk’ patient because of her age affected her negatively:

I would have loved to go to a birth centre, but I was told that I was too old. I was told that I was in a higher risk category because of my age. Can you imagine? I hate that they said that to me because I was already thinking that in my head a little, you know. I feel that I have so much trust in my body, I have learned Bowen therapy and I am a trained masseuse, I know how important it is to have trust in your body. But I guess all of the things you hear around you, things in the news and in the newspaper and then you are told you are in a higher risk section because of your age, it just gets to you even if you don’t normally think like that – do you know what I mean? All I can say is thank God for my yoga class they kept me in a good place. When I was doubting myself I thought about them and all of the conversations that we had and that I could do this and that age was not a factor. But I’ll tell you something it was a battle sometimes.

For Sandra, the category of ‘high risk’ became a label she found hard to escape. The term itself meant to her that she might be doing unintentional harm to her unborn child as well as to herself. As previously argued, to use the language of risk within the setting of reproduction is in an interest in itself. As the cultural anthropologist Mary Douglas (1992) has argued, risk is not a neutral term. Doctors do not talk about a ‘good’ risk. The term is used negatively- and with negative consequences for women. As Lupton (1999b) argues, even the woman who is seen as ‘low risk’ remains the object of a high level of ‘expert’ surveillance and intervention as well as expected to exercise self surveillance over her own body. Accordingly, there can be no such thing as ‘no risk’ in pregnancy (Lupton, 1999b).
Many of the respondents demonstrated that the medical environment not only provided them with a sense of security, but also communicated to them the possibility of ‘things going wrong’. As we see in the case of Sandra, the classification of ‘high risk’ communicates to her that her pregnancy and birth were inherently risky. In the case of Helene, her second birth was in a hospital setting. It was this environment that conveyed to her the possibility of a negative outcome for her pregnancy and birth. Helene is the only respondent who gave birth in two separate countries. With her first birth she was living in Holland. This birth took place at home, and according to Helene this was not out of the ordinary:

It’s the most common way in Holland to go, so everyone else has the same experience. It’s nothing special really; it’s just the way you go. It’s a different system really, it’s the environment that I was in. The system has great appeal really, I think even statistically wise, the Netherlands do very well. There’s no hassles, or no deaths, or nothing, so I think it proves itself.

When moving to Australia, Helene found herself pregnant and unable to find an independent midwife to birth at home. She decided to go through the hospital system where the feelings of security she had from birthing at home turned to fear with her initial interactions with the maternity services in Australia:

I had one show around the maternity ward, so they showed you where you stayed, and where you could have pain relief and your caesarean. I was very frightened because they started this, it’s like a day, and you go there with a few pregnant women, and they start to show you what they can give for pain relief. I really thought that was such a bad thing to do. That’s my personal opinion. I really think, still, perhaps I should tell them, that without fighting the system, but I think that’s how you keep the fear in. That’s actually how you say ‘okay yes, we are afraid, but this is what we offer, its very scary, but this is what we offer.’

The expression of risk was not only found within the medical environment, indeed it was found in all spheres of life. For instance, Mary, a birth centre mother who made
sure to exercise on a regular basis during her pregnancy, expressed real concerns over a pamphlet she found within her swimming pool centre:

I was swimming at the pool, if I happened to see a brochure about pregnancy and exercise then I’d grab it and think okay, I’ll start to see what I’m supposed to be learning. That in itself turned out to be quite detrimental, because of the information I was given. For example, that little brochure was quite specific and I took it to the midwives and said ‘this is the information that they’re saying about the risk factors with exercise.’ It was to the point where you should be measuring your heartbeat so that you’re not going above 23 beats per 10 seconds. If you’re in an indoor pool, which I was through winter, your body temperature is going to be increased and that’s putting risk on the foetus. You shouldn’t be exercising on your back, and I was doing backstroke. I was saying to the midwife is backstroke bad for me. She was just saying ‘you have far too much information. This is not what I would be encouraging you to read. I didn’t even know about this 23 beats per 10 seconds, so why should you be worrying about that.’ In a sense she said ‘look use common sense, and don’t be so worked up about what precautions other people are going to put on you.’ It made me feel that I was going to have to be really stringent and pedantic about what you do, and making sure I had a watch so that I could count 10 seconds, and how many heartbeats I’d had. It was just over the top.

The respondents often communicated this heightened awareness of hazards and risks that had been represented in printed material such as pamphlets or magazines and newspapers as well as images from television and films. Heidi, a mother of one who chose to give birth within a birth centre expressed her concerns about a magazine article that she had read during the second trimester of her pregnancy:

I was so into this pregnancy, you know. Even though we hadn’t planned it, once I knew that I was carrying a baby inside of me I was so excited. I started reading everything that I could get my hands on and that included magazines and books and the odd newspaper article. Well you know I didn’t find out I was pregnant until I was about 6 weeks pregnant. I just thought I was really late, which sometimes happened to me. So during that time I was drinking wine sometimes and having the types of food that a pregnant woman is supposed to avoid, you know things like soft cheeses. Just after I started visiting the midwives for my monthly consultation I read this article that has really stuck in my memory. It went through all of the things that we were supposed to avoid eating and drinking as well as talking about emotions to avoid! That’s just crazy isn’t it? Anyway, even though the article annoyed me there was one thing that just stuck out. This article said that the most dangerous time for the unborn baby was around the five to seven week mark. That was the time when the baby was most vulnerable in terms of being affected by alcohol and things like that. Well what was I doing at the 5 to 7 week mark? I was drinking some wine. So for the rest of my pregnancy I kept on thinking, what if I did something to my baby!
It seems that the respondents of this study were constantly engaging with their pregnancy and impending birth within a ‘risk’ context. Drawing on the interview material, it appears that all of the women involved in the research dealt with this by obtaining information and relying on the expert knowledges of their primary carer, their personal biography and that of their friends and family members as well as the concepts of risk that were presented to them in their cultural context. The information related to them within the media was not often directly addressed, as we have seen in the case of Heidi, however it is surely worth analysing.

The care that was undertaken by these women during their pregnancies and births was based on what Beck calls an ‘imperative of avoidance’ (2000: 217). For Beck “[t]his is how a society based on knowledge and risk opens up a threatening sphere of possibilities” (ibid.). For instance, reviewing a recent edition of Sydney’s Child\textsuperscript{13}, a popular publication that is provided free to parents and has a stated readership rate in excess of one million parents, the researcher came upon an article entitled “You are what your Mother ate” (Ladd, 2005). Not only does the article reflect on the need to improve the diets of pregnant women but it also expounds on the need to avoid stressful situations. For example, if the mother does not consume enough folic acid during her pregnancy there is an increased risk of neural tube defects such as spina bifida (Ladd, 2005). If your baby is born with a low birth weight there is a “higher incidence, as adults, of a number of chronic cardiovascular conditions, including heart disease, hypertension, diabetes and raised cholesterol” (Ladd, 2005: 26). In relation to stress, an Australian researcher, working with sheep, stated that exposure to stress could relate to later development of insulin resistance and diabetes within the offspring. Dr Quinlivan states, for all mothers and expectant mothers to read:
Basically, if you have a single exposure to stress hormones the body is very resilient. But if you have repeated exposure to stress, it affects the number of brain cells in a foetus’ brain, the growth of the baby, and the development of the thyroid and the immune system, so it has multiple effects. (cited in Ladd, 2005: 27)

It is as Beck argues, “everyday life thus becomes an involuntary lottery of misfortune. The probability of a ‘winner’ here is probably no higher than in the weekly lottery, but it has become almost impossible not to take part in this raffle of evils where the ‘winner’ gets sick and may even die as a result of it” (2000: 217, emphasis in original). The pregnant woman who is argued to be doubly at risk and doubly responsible surely must experience and act on this ‘imperative of avoidance’.

When reviewing Beck’s theory of reflexivity we can see that the mass media plays a fundamental role in its process. The malleability of risks, the fact that they can be “changed, magnified, dramatized or minimized within knowledge” and therefore are open to the forces of “social definition and construction” mean that the key social and political positions in charge of defining risks are the mass media and the scientific and legal professions (Beck, 1992: 22-23). The central role of the mass media and its impact on the construction and perception of risks will be further analysed in Chapter eight with an overview of the role that pregnancy and childbirth self-help literature plays in defining risk knowledges for its audience. Although this particular chapter would be most suited to follow the present one, there is a desire to keep the voices of the respondents uninterrupted through Chapters five, six and seven. The following chapter, therefore, begins with the decisions made by the respondents in relation to prenatal testing. We now move our analysis from risks solely associated with the organic body to risks associated with the organic and the technocratic.
CHAPTER SIX

LIFE AS A PLANNING PROJECT

27 is the age at which a woman's chance of getting pregnant begins to decline. At 20, the risk of miscarriage is about 9%; it doubles by 35, then doubles again by the time a woman reaches her early 40s. At 42, 90% of a woman's eggs are abnormal; she has only a 7.8% chance of having a baby without using donor eggs. (Gibbs, 2002:44)

Conceiving a baby at the age of 20 carries a risk of a chromosomal abnormality of about one in 500. That risk rises steeply to one in 200 by the age of 35 and can be as high as one in 65 by the age of 40. And these figures do not include the ‘single-gene’ disorders such as cystic fibrosis or Huntington's disease. (Tormey, 2005: 23)

The above quotes from *Time* magazine and *Sydney Child* respectively, demonstrate that the language of risk in relation to pregnancy practices is available to and invoked by not only women who are contemplating pregnancy, the currently pregnant, and mothers, but also the never to be pregnant. The quotes demonstrate not only the concepts that were explored above, such as Beck’s notion of the ‘imperative of avoidance’. They also emphasize what Beck and Beck-Gernsheim (1995; Beck-Gernsheim, 1996) term the ‘planning project’. According to them, life, within a risk society has developed into a planning project where constant work and attention on the part of the individual is required. This project of the self requires planning, rationalization and depends on Beck’s concept of individualization. This can readily be applied to the emphasis of the risk discourse which surrounds pregnancy and birth.

As outlined within Chapter four, Beck explains individualization as the breaking down of traditional norms, beliefs and their according expectations which in turn frees the individual from these ‘constraints’ and allows more flexibility in a life
course, at the same time it burdens and shackles the individual with choices and responsibilities. As Beck-Gernsheim argues: “on the one hand, that means an expansion of the radius of life, a gain in terms of scope and choice. Life becomes in many respects more open and malleable. But it also means that new demands, controls and obligations fall upon the individual” (1996: 140). Our lives are supposedly full of diverging paths and a multitude of choices. With the disintegration of traditional norms, the responsibility now falls on the individual to choose their life path – often on a daily basis. With this new found responsibility comes new forms of blame, negative outcomes as a consequence of our choices come to be seen as our own ‘fault’. The harshness of this reality is expressed by Beck:

In the individualized society, the individual must learn, on pain of permanent disadvantage, to conceive of himself or herself as the centre of action, as the planning office with respect to his/her own biography, abilities, orientation, relationships and so on. (1992: 135)

The increase of variables such as: age of first time mothers, New Reproductive Technologies such as IVF, genetic screening and testing, medical intervention during pregnancy and childbirth, and the decline in fertility rates in developed countries in relation to the concept of life as a ‘planning project’ becomes clear when reviewing literature and the narratives of the respondents of this research. Increasingly, an active and self-directed approach to life is expected from the individual of the ‘individualized society’, and this implies a skilful handling of and reaction to all that it entails (Beck-Gernsheim, 2000). As Kohli argues: “life is no longer … a “Wonderful Gift of God”, but rather an individual property, to be defended continuously. Even more so it becomes a productive task, an individual project” (Kohli, 1986: 185 cited in Beck-Gernsheim, 2000: 123).
Changes in the public sphere in relation to women’s opportunities for participation in the labour market as well as expectations which surround their societal role are a part of Beck’s ‘individualized society’. As Lupton (1999) argues, many women with high levels of education and professional careers no longer see their lives as devoted solely to the family. Beck-Gernsheim (1996) sees motherhood as an option which has become a risk for the woman in this ‘privileged’ situation. With historical shifts which have seen women ‘living for others’ to a bit of ‘a life of one’s own’ (Beck and Beck-Gernsheim, 2002: 74) she argues that: “having children is today the structural risk of a female wage-earning biography: indeed, it is a handicap measured by the yardstick of a market society” (1996: 146, emphasis in original). For many women of today, pregnancy and motherhood are a risk and a financial handicap. This was explicit in several of the respondent’s biographies, especially those women who worked within a male dominated field. For instance, Cheryl, a police detective, explained the impact of her pregnancy on her career in the following way:

The part that I found different was that I had to within myself make sure that my pregnancy did not affect me in the workplace. Because they, I felt that they had the mindset that if you are at work then you should be working and pregnancy should not be interfering with that. I had heard the previous complaint that some people were not pulling their weight when they were pregnant- I wanted to make sure that I was not accused of not doing my job because I was pregnant. I think I put in a little bit more pressure on myself- because you do get so caught up in being pregnant and trying to look after yourself and you are getting heavier and more cumbersome to move around- but I think in some situations I did push myself beyond what would have really been healthy for me.

The sentiment of not changing your work patterns when pregnant was expressed by a number of respondents. Yet for some women, pregnancy as a ‘handicap’ was even more evident. This was most strongly indicated by Ann, a mother of one who has a senior position within the banking industry. She expressed her anxiety over the physical signs of her pregnancy in the following manner:
Being pregnant was hard for me much of the time. That in itself was a hard thing to deal with. You are expected to be so excited about the whole thing, but when you aren’t its like you are a bad mother or something. You see, at my work I am the manager of many men. There aren’t many women who I work with, and the ones who I do work with are generally older. Anyway, I was really concerned when I started showing. All of a sudden the status of my position was gone. I had men, who were my subordinates, approaching me and speaking to me in totally different ways then they used to. When I went back to work when Stephen was 3 months old I actually had one of my male colleagues say to me “It was the first time I viewed you as a woman”. To tell you the truth I found that threatening.

If Beck-Gernsheim (1996) argues that a pregnancy and the birth of a healthy child are a handicap for women in a market driven society, the argument can be forwarded that the pregnancy and birth of an unhealthy child or disabled child would be even worse in terms of a woman’s prospects in the labour market (Lupton, 1999).

Part and parcel of this argument is the elevated status of health in high modernity. Lupton (1995) labels it the ‘imperative of health’ – where public health institutions are seen to emphasise self-regulation through discourses on health and risk. For Beck-Gernsheim the individualized task of health has evolved from sickness being seen as part of the “eternal cosmos, a task allotted by God in order to lead man toward purification” (2000:123) to salvation being dethroned with healing taking its place (2000: 124). She argues:

Health is no longer so much a gift of God but rather the task and duty of the responsible citizen. S/he has to safeguard, control and care for it, or else s/he must accept the consequences. For if one’s health is being impaired, one has fewer chances in the labour market, or even none at all. This is the danger potentially threatening everyone. It creates a climate of latent but widespread insecurity which, in turn, gives health a high priority in public opinion and media. Or to paraphrase Oscar Wilde: ‘the importance of being healthy’ is a characteristic of modern society. (2000: 124)

The question should be raised, what is the task and duty of the responsible pregnant woman? What practices should she perform to ensure not only her own health but also that of her unborn child? It is clear from the above argument that the individual
who ignores their health care is deemed irresponsible, however, what of the pregnant woman? For her, she is not only irresponsible, but some would argue criminal. This is highlighted within various media representations of ‘monster mothers’ who supposedly place the health of their foetus at risk when giving birth outside of the medical system or against the expert opinion of obstetricians. In the United States women can be charged with ‘foetal abuse’ or ‘prenatal child abuse’ if, for instance, they are found to be using drugs that are not authorized medically or if they give birth vaginally when they had been ordered by their doctors to have a caesarean (Tsing, 1990). As reported in Chapter five, we find the most recent example of this is the Queensland case where a woman was reported to child welfare authorities after refusing a caesarean birth because she wanted a natural delivery. Although she gave birth to a healthy baby girl, the woman of this case became the subject of a child abuse notification after she cancelled a caesarean booking and later gave birth vaginally in a different hospital (The Australian, 2005).

To this point we have raised pregnancy practices such as informing oneself on the best care to take through preconception diet, pregnancy diet and exercise and a proper preparation for birth through regular checkups with a primary carer. As Beck comments there is an elastic nature about the risks that we face, and it has become apparent that the risks that the pregnant and birthing woman face have changed throughout history as well as across cultures. In conjunction with this is the malleable nature of health. As discussed above and in the preceding chapter the concept of health has significantly expanded. This expansion is due to the various concepts that have already been explored, but also importantly by the development of technology. As the medical writer Michael Crichton argues:
The physician as lifestyle expert, as wellness adviser, has already begun to appear. And as genetic profiles and other predictive tools improve, the art of prevention will grow far more sophisticated. Physicians will administer tests as they now dispense medication...Even more fundamental will be gene-replacement therapy, in which missing or defective genes are supplied by the physician. Such procedures are now being developed to treat serious illness, but they will even be used to boost enzyme levels and hormone production to retard aging and to increase vigour...What all this means is that our present concept of medicine will disappear...Medicine will change its focus from treatment to enhancement, from repair to improvement, from diminished sickness to increased performance. (1990: 58)

It has been noted that the responsible active citizen will safeguard his or her health through preventative care. What practices does that entail in a society which is slowly being dominated, as Crichton alludes to, by the new genetics? Importantly here, what practices does the pregnant woman enact? As we have seen, preventative care, in the case of the reproductive woman, has centred on her physical, mental and emotional wellbeing. Preventative care, which has become an element of self-management expected of the modern individualized person (Daele, 1989 cited in Beck-Gernsheim, 2002: 144), is also performed through genetic technology. Genetic testing provides a predictive dimension that is far different from those conventional diagnostics available through medicine. With this tool, potential illnesses can be identified long before they begin. Genetic testing, it could be argued, brings new questions to the issue of what constitutes preventing or controlling diseases. Applied to the field of maternity care, genetic medicine involves prenatal testing and termination if the foetus is found to carry the ‘wrong’ gene. Preventative care in this sense equates to abortion, which in the current biomedical language is seen as treatment.
Prenatal Screening and Testing within the Australian Context

The implications of the Human Genome Project have been variously examined by sociological researchers. For example, there have been several accounts on the general implications of the project (Conrad, 1997; Rothman, 1994, Conrad & Gabe, 1999). There has also been emphasis on how it has been reported within the media (Henderson & Kitzinger, 1999; Petersen, 2001, 2002) as well as the implications of the project on public health (Willis, 1998; Petersen & Bunton, 2002). Further, there has been an emerging thread of literature which critically analyses certain genetic illnesses (Hallowell, 1999; Petersen & Bunton, 2002).

However, much of the attention which surrounds the new genetics has been geared toward prenatal screening and testing (a few examples include: Rothman, 1986; Rapp, 1988, 1993; Lippman, 1989, 1991, 1992, 1999; Beaulieu & Lippman, 1995; Ettore, 2000). The lurking connection between current practices of genetic screening and testing and eugenics is most definitely a contributing factor. As stated above, the preventative aim of antenatal screening and testing is the termination of an existing pregnancy. This brings into focus different social and ethical implications than the other applications of new genetic technologies. This has led to critical analysis of the way programmes are designed, implemented and put into practice (Pilnick, 2004).

With the completion of the Human Genome Project, the ability to test prenatally for serious diseases will be combined with testing for less serious conditions and could eventually be used to identify elevated risks for diseases such as heart conditions and
non health conditions such as eye colour and height (Pilnick, 2004). Eugenic overtones are becoming apparent; this has led many to question “How perfect does a foetus, on the basis of prenatal diagnosis have to be before the “tentative pregnancy” is allowed to proceed to term?” (Willis, 2000). Indeed, until relatively recently, IVF providers within Australia have been marketing the use of pre-implantation genetic diagnosis (PGD) as a ‘family balancing’ device (Tormey, 2005). The National Health and Medical Research Council recently made a ruling banning the use of PGD to select the sex of a child, stating that selecting a child based on gender offends the unconditional acceptance at the heart of the parent-child relationship (Tormey, 2005).

The following section outlines, on a superficial basis, the use of prenatal screening and testing within the Australian context, utilising existing research as well as the experiences of the respondents of this thesis. The present research did not attempt to understand how women approached these tests. Through the women’s birth narratives, it quickly became apparent that prenatal screening and testing was a part of their landscape of pregnancy care. Although one of the themes of the interview schedule addressed the use of screenings such as ultrasounds, all respondents addressed the issue of prenatal screening and testing, whether that was to discuss their decision to make use of them or not to. This fact reinforces Beck and Beck-Gernsheim’s notion of reflexivity and individualization and its useful application to understanding current pregnancy and childbirth practices for certain populations.
Screening and Testing

The terms screening and testing are often used as though they refer to the same procedure, however, there are important differences between the two (Pilnick, 2004). Willis (2000) makes use of Khoury’s (1996) distinction between primary, secondary and tertiary prevention in the case of genetic medicine. Primary prevention is said to focus on stopping the illnesses before they occur. Applied to the case of prenatal diagnostic tools, it is testing which is seen as primary prevention. Secondary prevention, or screening, targets clinical manifestations of the disease by early detection. Tertiary prevention, according to Khoury, minimises the effects of the disease by preventing complications and deterioration (Willis, 2000). As argued above, prevention in the case of prenatal screening and testing can only mean termination. A further distinction between screening and testing is the indication of use. For instance genetic testing is often employed when the individual being tested is in a high-risk category³. Indications such as family history of genetic abnormalities, age categories and negative results of a screening are examples of this. Screening, on the other hand, has largely become routinized in many parts of the western world. Here, the individual is tested often without any of the risk indicators that are listed above.

The screenings and tests that are available to the pregnant woman of Australia are varied⁴. The prenatal ultrasound has become commonplace. All of the respondents, bar some of the home birth mothers underwent routine ultrasound scanning. Often, the pregnant woman can have several ultrasounds within one pregnancy, some are even being used for ‘entertainment’ purposes. This will be explored shortly. Other tests include Nuchal translucency Ultrasound, carried out during the first trimester,
which can include testing the mother’s blood. For this screening test, an ultrasound is facilitated to determine the depth of the fluid in the space at the back of the baby’s neck. This measurement is used to calculate the risk of the baby having certain genetic disorders such as Down syndrome. As this is a screening test, the results are not definitive; it only demonstrates a risk of certain problems.

Further screening tests include maternal serum testing (maternal serum alpha-fetoprotein it is commonly referred to as the AFP blood test) and the triple test. The AFP test is commonly used around the fifteen to seventeen week mark and is used to assess the likelihood of a Neural tube defect in the baby. The triple test is slightly more involved than the AFP, in addition to measuring the alpha-fetoprotein (AFP) for neural tube defects, it also measures two other hormones called 'unconjugated oestriol' and 'human chorionic gonadotrophin' (or HCG). These two hormone levels are combined with the woman's age to calculate a 'risk figure', or the chances of the baby having Down Syndrome. Again, both of these techniques are screening tests and do not provide a definitive result. Rather, the results are expressed to the expectant mother in ratios or percentages. For example, with the triple test the three test results are combined with the woman's age and expressed as either 'low' or 'screen negative', meaning the baby is probably not affected, or 'screen positive' or 'high' if the baby is thought to be at risk of having a disorder. Alternatively, you may be given a specific figure expressed as an 'odd'. A 'low risk' is usually more than 1:300 (for example, 1:400) and a 'high risk' is less than 1:300 (for example, 1:30).
Around the eleven to twelve week mark the diagnostic test of chorionic villus sampling or CVS is available. The test is quite common and requires the collection of some foetal cells early in the pregnancy by inserting a fine needle into the placenta. From 15-19 weeks an amniocentesis can be carried out in much the same way, although the foetal cells are collected from amniotic fluid rather than the placenta. Both tests are recommended to women over the age of 35 and carry with them the risk of miscarriage (stated at around 1%). Furthermore, the tests take from one to two weeks for analysis. It is factors such as: stage of pregnancy when tested, duration of time for test results and prevention via termination which all contribute to what Rothman (1986, 1994) calls the tentative pregnancy.

It has been reported that in 2004 at least 9000 women within Australia had an amniocentesis (Pirani, 2005), it could be argued as the age of first time mothers increases as well as the routinization of such screenings and tests, so will the number undergoing primary and secondary preventative tests such as these. In fact a recent Australian newspaper article cited research which indicates that a growing number of women under the age of 35 are terminating pregnancies because their foetus had Down syndrome. The research suggests that prenatal screening is occurring widely, even in younger age groups (Robotham, 2004). Availability of statistics that represent use of prenatal diagnostic tests as well as the birth of a baby with birth defects is limited within New South Wales. Unlike Victoria, which has a long-standing collaborative arrangement with four cytogenetic laboratories that process all prenatal diagnostic tests (Webley and Halliday, 1999), NSW has limited collaboration as well as only recent 1998 legal requirements to report birth defects. However, in 2004 the New South Wales Chief Health Officer released a report on prenatal
diagnosis which concentrated on women over 35 years of age. Of the two most common forms of prenatal testing, namely amniocentesis and CVS, it was found that between the time period of 1994 and 2002 rates of use had dropped. The number of tests carried out for prenatal diagnosis among women aged 35 years and over in NSW rose from 4,549 in 1994 to 5,795 in 1998. However, it has since declined to 5,302 in 2002. This pattern of change was apparent for both forms of test; furthermore, amniocentesis remained about twice as common as CVS throughout the period, most likely due to the higher risk incidence of miscarriage within CVS. It was reported that the recent decline is presumably due to greater use of less invasive procedures such as ultrasound examination of nuchal translucency (Population Health Division, 2004).

An alternative test to amniocentesis has recently been developed within Australia. This new technique will allow foetal DNA sampling via a cervical swab that is similar to a Pap smear; this obviously carries a lower risk of miscarriage than CVS or amniocentesis. The test is carried out at six weeks instead of the usual eighteen weeks that the amniocentesis is performed. A further reported advantage includes the test being able to be carried out by a GP which will allow women living in remote and regional towns access to the technology. The advantages are clear, however, does the fact that the tests are carried out earlier in the pregnancy with a reduced chance of miscarriage erase the tentative nature of the pregnancy during the testing time? The test does not relinquish the possibility of a positive result or the preventative action which should take place. The ‘improved’ nature of the test will only result in a higher employment of it, with consequences that are not yet contemplated. For instance, in the United States there are health insurers who are
refusing to insure babies that were not aborted after a genetic disease was identified. It is argued, by these insurers, that these babies have been born with a pre-existing condition that makes them uninsurable. ‘Elective disability’ is the term employed, as if having a child with a genetic disorder, such as Down syndrome, was a lifestyle choice (Tormey, 2005). Not only does this expand the concept of health, as discussed above, but also that of responsibility. Responsibility, as Beck-Gernsheim (2000) argues, is being expanded and adapted along with the increasing options of technology. What this means, what the concept of the expansion of responsibility includes, will be examined shortly.

**Voluntary Obligation and Prenatal Testing**

Genetic screening and tests are examples of New Reproductive Technologies (NRT) that are supposedly providing the very best of care and range of possible choices in maternity care. The introduction of these new technologies, which are used for determining the ‘normality’ of the foetus, introduces and forces upon the pregnant woman of the 21st century a broad range of risks and decisions to make based on risk statistics, such as those illustrated in the opening quotes of this chapter. What is of interest is the reaction to these tests expressed by the respondents of this research. For a minority, the screening procedures and tests were avoided, for some they were hesitantly employed and for others actively pursued. Yet all respondents engaged with the screening and testing on some level and for those who did employ the technology, many expressed feelings of security once the results were in. All negotiated the new responsibility that has been slowly but surely forced upon the pregnancy and childbirth environment.
The Ultrasound

Ultrasound, developed as a diagnostic tool for exploration on the ventricular spaces in the brain in the 1930’s (Yoxen, 1987), expanded into military use in World War II (Duden, 1993). It eventually found its way into the realm of obstetrics in the 1950’s and 1960’s. Initially employed to screen for suspected abnormalities, the ultrasound is now routinized and has become part and parcel of maternity care. The emergence of the ultrasound into routine pregnancy care has been critically examined by various social scientists as the ‘technomedical takeover’ of pregnancy and childbirth (Davis-Floyd and Sargent, 1997: 12). The unintended consequences of routine antenatal ultrasonography are manifold. Providing visual access to the hidden foetus has transformed it into a “media spectacle” (Petchesky, 1987: 58). As Boulter (1999) argues, the foetal image is “no longer simply a medical projection but a cultural symbol which has become part of the public imagination” (1999:1 cited in Draper, 2002: 778); one that can be manipulated in social, cultural and political ways (Casper, 1998).

This has led to the development of the two patient model of pregnancy in which the foetus is treated as a patient in her or his own right (Mattingly, 1992), separate from and privileged with its own identity and development of its civil rights. Furthermore, the normalization of ultrasonography has contributed to a change in women’s and men’s experiences of pregnancy and their relationship to their unborn child (Sandelowski, 1994). With the advancement of technology the ultrasound has developed from a two dimensional image to three dimensional as well as four-
dimensional ultrasound, resulting in what many term the ‘entertainment’ ultrasound. For these scans, the normal 20 minute session is extended into at least a 1 hour long process where surface details of the foetus are visualized with remarkable clarity. With 4D ultrasound the single still image of 3D is now superseded and the expectant couple are now able to view live ‘video’ of the foetus in the womb. In NSW, both the Royal Hospital for Women at Randwick and the Nepean Hospital at Penrith, as well as many private hospitals, including the hospital where part of my research was carried out, offer this service and provide a DVD for private viewing. The argument for employment of such technology is primarily for bonding purposes. As Dr Challis, acting director of obstetrics of the Royal Hospital for Women at Randwick states: “I don’t think it makes a huge deal of difference with the diagnostic information. But it’s a huge difference for patients. It’s common to have a mum and dad in tears the first time they see their baby sucking its thumb, stretching, yawning. It’s an emotional experience” (Teutsch, 2003: 46).

It can be seen by this that prenatal screening technologies have the ability to shape emotional responses of the pregnant woman and her partner to their unborn child. Ultrasounds carried out within the early stages of the first trimester indicate to expectant parents, the ‘realness’ of the foetus. Prior to feelings of quickening⁹ that the pregnant woman feels around the 18-21 week mark, the ultrasound tells both her and her partner that the foetus is a ‘real’ entity. For example, Sonia a mother of two who had chosen to give birth within a birth centre, spoke of her pregnancy coming into ‘reality’ through the scan:

This pregnancy was funny, I felt that I knew I was pregnant from the time that John and I conceived. But at the same time it feels unreal. The ultrasound really brought it into reality for both of us. I had to have a scan a little early because I had some spotting and there on the
screen was this little being jumping around. The technician asked me what I had for breakfast because this little one was just going crazy with so much energy. At the twelve week mark you don’t feel the baby moving, but there she was dancing on the screen. It really made it real.

This can be seen to have a two-fold effect. On one level research has indicated the rising use of ultrasounds has increased the involvement of the expectant father in pregnancy. For instance Sandelowski (1994a: 232) argues that for men, ultrasound is ‘a prosthetic device’, giving them entry into a physical dimension of pregnancy that has eluded them due to a ‘deficit of the body’. In a further study, Sandelowski (1994b) suggests that the ultrasound was being used as a mechanism to include men into the pregnancy experience. This sentiment was expressed by many respondents. For instance, Denise who had been exposed to several ultrasounds prior to the eighteen-week scan spoke about her feelings in the following way:

D: My doctor had a little ultrasound machine in her office. She did a few, not every visit. We did the 18/19 week thing at a centre, where you can see the whole spine and everything, Adam came to that, that was quite confronting.

A: How did he feel about that?

D: That was his first real acknowledgment of something’s moving around in there, but he was quite chuffed. He was quite happy during it because one of the first things that they looked at was her legs, and the technician said the baby’s got quite long legs. Adam’s six feet, three, so he went ‘she takes after me,’ so I think that was the beginning of his daddy kind of feelings. Whenever we said to people we had the ultrasound, ‘how was it?’ he’d say ‘oh the baby’s got really long legs,’ and I thought that was quite cute, he’s getting a bit paternal.

A: How did you feel about the ultrasound?

D: It was fantastic, it was a little bit surreal cause you can feel something moving on your tummy, but on the screen there’s this, it looks like a picture of a fossil or something. It was exciting, it was lovely.

This increased sense of ‘being paternal’ was expressed throughout all of the respondents who had undergone an ultrasound with their partner present. This echoes the sentiment of Mitchell and Georges (1997) who argue that the use of ultrasound to promote bonding, which was formerly considered ‘natural’ and ‘an instinct’ has expanded beyond the mother to encompass fathers as well. They argue that ‘family
centred sonography’, has been promoted as a means of enhancing both maternal and paternal attachment to the foetus (1997: 382). This builds on the research of Ann Oakley and others who have argued that ultrasound is one of “a long line of other well-used strategies for educating women to be good mothers” (1984: 185). This increased attachment to the foetus is argued to not only stimulate a woman’s natural mothering ability but to also reduce her anxiety as well as increase her compliance with such things as medical advice and surveillance of her body through diet and exercise (Mitchell & Georges, 1997).

Many of the respondents communicated a sense of security and an according decreased anxiety due to the ultrasound. Seeing ‘ten fingers and ten toes’ and ‘a smile on the technicians face’ was enough for respondents such as Louise who expressed great joy at the memory of her ultrasound. For her this was the first time she was able to see her baby and the experience was ‘very emotional’ as well as providing her with ‘comfort that everything was all right’. This sentiment was mirrored by many mothers who undertook an ultrasound who found justification for the use of the technology because of the positive emotional experience. For instance, Jennifer expresses why she wanted to undergo an ultrasound in the following manner:

*I guess that’s become a pretty standard thing to do. Although because it’s so lovely, you just go along with it, and I guess too, it does give you that extra bit of confidence that everything, as much as can be seen, is okay, all the systems are working and everything’s growing fine, at that extra closeness to due date.*

For others the security stemmed from a need to make sure that previous medical conditions or previous pregnancy experiences were not being repeated. For instance, Megan, whose first pregnancy resulted in a caesarean due to a condition called placenta previa, chose to give birth at home for her second pregnancy. However, she
and her husband decided to undergo an ultrasound for the pregnancy. She describes the process that they went through in making this decision:

With our first pregnancy we had quite a few ultrasounds and some of them I felt were really unnecessary. I felt like my obstetrician wasn’t skilled at feeling the baby and he always turned to technology to figure out things I could have told him. Like when I was about 30 weeks along he told me that I wasn’t growing enough. He felt my stomach and said there might be a problem. So I went and got an ultrasound and it ended up being that the baby was lying transverse, so of course she takes up less space. When I fell pregnant again I had to decide what to do, especially with the complications I had with the first and the fact that we were going to have this baby at home. But, I guess talking about, looking again at whether to have tests, and we chose to have an ultrasound done with the second pregnancy as well. We discussed whether we would or not, and she [the independent midwife] was very open about the information, gathered some stuff to read, and we still thought that perhaps information was necessary. We had a scan done, but I wasn’t as clear on my dates with this pregnancy. So it really helped on different levels.

Megan’s first ultrasound for the second pregnancy was undertaken too early to determine if placenta previa was occurring. Accordingly, her and her husband had to decide whether to undertake a second one. Her reflexive approach to the use of the technology as well as her sense of security through the ultrasound is expressed in the following way:

I think we felt that the information was still useful. I have to say it was we did it for the first so we may as well as do it for the second, and we have the photo, and we have the video. I have to be honest and say that probably played a role. Lot’s of women say it, we’ve got it for the other two, so we’ll do it for this one. I’m sure it played a role, not a big one, but I think in all honesty that we believed that information that it provided was useful. Perhaps even more useful in birthing at home, perhaps it could assist in our choice of birthing at home. Particularly with births when they have the low lying placenta, our midwife was quite happy for us not to have the second ultrasound, she was still happy for us to birth at home, without knowing whether or not there was placenta previa. We did talk about this, there was bleeding and all of that, but I guess there was still that slight mistrust of how things work, and perhaps this information would be good to have.

This reflects evidence which suggests that the use of ultrasounds during pregnancy promotes psychological benefits for both parents (Cox et al., 1987; Johnson & Puddifoot, 1998; Rothman, 1994). From the above it appears that the experience for the father to be is always enhanced but at the same time the experience of the expectant mother may be enhanced or lessened (Sandelowski, 1994a). Rothman
(1989) argues that foetal ultrasonography is a disabling mechanism that disrupts the privileged access to the foetus that only being ‘with child’ confers (1989: 90). This argument has been demonstrated through many respondents implying that the ultrasound undermined their experiential knowledge, yet none of the respondents explicitly expressed this.

The cited research indicates that the consequences of ultrasound use are not clear-cut and unidirectional, rather it can appear that the consequences are opposing. Not only can two different tests provide different emotional responses, such as the feeling of bonding through a routine ultrasound and the feeling of emotional detachment whilst waiting for a genetic testing result, but the same test can result in different emotional responses. As we have seen above, these respondents derived security through the knowledge that was provided to them through the objective and scientific ultrasound. Yet many others expressed this same security occurring simultaneously with feelings of anxiety, detachment or insecurity. This was expressed by Rebecca in the following manner:

R: He [obstetrician] didn’t do it, he sent it off. He said it was to check for normal growth and to confirm the due date. With both ultrasounds I was quite looking forward to them because you get to see the baby.

A: What did you find with the first one at 12 weeks? Could you see her?

R: Yeah, I was so amazed at how human she was. I didn’t know it was a girl at all throughout the pregnancy, but thought, on the side, the little formed face and all that, it was amazing. It was very real from then. I think it was at that point that it became very real for Gary.

A: I was going to ask how Gary felt about it.

R: Yeah, he was there, and he was quite emotional about it. I wasn’t emotional, I was a bit removed, I was still trying to get used to the idea. It made me feel ‘oh yeah this is really happening’, but I still felt a little bit distant, a little bit removed from it.

A: What do you mean?

R: Well, it was quite a detaching experience actually, that’s a good way of looking at it. She was wriggling around, flipping about, and Gary was saying ‘you must be able to feel that?’
and I was going ‘I can’t feel it’, which in a way made it more detaching. But then it was nice to have the photos and I looked at them a lot, to try and get my head around it all.

Rebecca’s sentiments mirror those of Rothman’s (1989) argued above. The ultrasound is obviously undermining her experiential knowledge, however, at the same time she also enjoyed the experience, as she was able to ‘see’ her baby. For many women the use of the ultrasound is an empowering experience as having visual knowledge of their unborn child provides them with security in the normality of their foetus as well as creating feelings of intimacy with it. Interestingly, visual knowledge has been linked to concepts of surveillance and control by authors such as Jenks (1995) who argues that the privileging of vision within the West served as a mechanism for social control. Surveillance in this sense can be seen to be occurring at two levels, surveillance of the self and medical surveillance. An obvious connection is Foucault (1975) and what he called the surveillance of the body. Here medicine is able to determine what is in need of being visually explored and simultaneously securing a monopoly of interpreting and treating the visual image. Indeed, Mitchell and Georges (1997) argue that not only are women monitored during an ultrasound for foetal anomalies or physical conditions which can complicate labours, but they are also monitored for their own shortcomings. The pregnant woman, according to Mitchell & Georges, is being monitored for: “failure to monitor their bodies and behaviour, failure to be compliant and selfless – in short, for failing to be ‘good mothers’” (1997: 381).

Further evidence of divergent consequences to the employment of screenings and tests was made evident by Tracey, a 29-year-old mother of two who spoke about her feelings of anxiety and responsibility over the use of ultrasound as a screening device:
When I had Luke, I had the same ultrasound at the same weeks, you didn’t have to sign any
documents, three years later you had to be signing all these documents to say that you’d been
instructed that you had so many percentage chance of having a Downs Syndrome baby. Then
you had to sign another document to say that you refused to have the amniocentesis. I’m not
even in the age group for having them. I spoke to my obstetrician this time about it, I said
that I felt really uneasy about all these forms being signed, I said ‘is there a chance that the
baby is going to be Downs Syndrome?’ He said ‘no, it’s mandatory now, so people can’t
come back and say my baby’s got Down Syndrome, I wasn’t told, or didn’t know that I had a
32% risk chance’. But that uneasy feeling then went through my whole pregnancy, that
maybe it is Downs Syndrome, and I don’t even know. Maybe I should have an
amniocentesis.

It became apparent that many of the respondents of this research were confronted
with very similar scenarios. The ultrasound which is carried out at 18 weeks was
used as a screening test; the women were then approached in a very similar fashion to
what Tracey was exposed to. When asked if she had undergone an ultrasound during
her pregnancy Tania expressed her experience in the following way:

T: We had the first ultrasound at 12 weeks, I also had the blood test that follows up the
ultrasound, I can’t remember what it’s called now. That was the only test that I probably
asked for.

A: Was there a reason you requested that test?

T: I was a little bit goaded into it, in the fact that when we had had the 12 week ultrasound,
which of course was fine, this didn’t happen with Lachlan. We went in to see the doctor, who
looked at the ultrasound, and she sat us down and she said ‘look the chances of Downs
Syndrome from the ultrasound are such and such’, and they were very low, but she said ‘but
we cannot guarantee that, and you need to sign this piece of paper to say that you don’t want
to have a amniocentesis. This was all a bit, ‘I have to sign this bit of paper to say I DON’T
want amnio, that I’ve been informed, and I have declined to have an amniocentesis’. This
started the wheels turning in the mind, and she said ‘but of course you can have the follow up
blood test to see how that correlates’. And that is what we did.

It seems as technology develops, responsibility is expanding. The concept of
responsibility has been adapted to the new options of reproductive medicine and
prenatal diagnosis. Now it is interpreted in the way of a qualitative selection taking
place before birth, perhaps even before conception (Beck-Gernsheim, 2000: 130-
131). As we can see from the voice of the respondents, the terms used here often do
not spell out the goal directly, rather they use the technological, administrative
language, or as Barker (1998) calls it ‘biomedical rhetoric’. For example, the words ‘prevention’, ‘risk’, and prophylactic measures’ abound. As Beck-Gernsheim (2000) argues: Prevention and prophylactic measures have positive meanings within modern society, they are rational and sound like they are for the good of the patient. “They point to goals which are widely accepted because they serve the interest of the individual (maintaining health, avoiding pain) as well as the interests of society (cost savings)” (2000:131).

Beck-Gernsheim’s (2000) investigation into the role of technological innovation in medicine and its impact on pregnancy choices and family life, in conjunction with the new realms of responsibility that Beck and Beck-Gernsheim (2002) highlight as an unforeseen consequence of the technological advancements, is of great value. It is clear that through the advancement in diagnostic and genetic testing on the unborn child new realms of choices are available for the soon to be parents. However, because of the emphasis on responsibility towards one’s own health as well as notions of perfection, parents, argue the two authors, are rapidly becoming faced with an obligation to use these technologies for not only the future of their child but, as argued above, also to secure their own future. What is of essence in their argument is not only the obligations and responsibilities towards one’s life path that Beck’s notion of individualization focuses on, but also a voluntary compulsion to actively engage with science and technology to fulfil these obligations. As Beck-Gernsheim (2000) argues, when discussing gene technology and what she terms preventative compulsion: “[t]o put it paradoxically, it is a pressure most people will submit to voluntarily, again for the sake of that magic word: ‘health’” (2000: 129). With the advancement of technology within science, and of interest to this research, medicine,
new options are constantly opened up, but at the same time responsible behaviour is widened.

This becomes even more evident when discussions with the respondents turned to screening tests such as the triple test or tests such as amniocentesis or CVS. As stated above, in Australia all women over the age of 35 (in some states this is 37) are offered amniocentesis or CVS to check for any genetic abnormalities of the foetus. All of the respondents who were in either the private system or birth centre system over the age of 35 were confronted with these tests. Each of them spoke about the difficulty of either contemplating undergoing the test or the consequences of doing so, although it should be noted that some employed the test more as a matter of course rather than actively deciding to do so. Helene underwent the tests with her second pregnancy and found the experience quite distressing regardless of her original reasons to do so. Here she succinctly expresses the tentative nature of her pregnancy during this time period:

I decided to have the ultrasounds, and I think because I was 35 at that time you had to do other tests. Blood tests, and something with the neck, so they could combine that. I decided to do this because of my age and the risks that it carries, so I went along with all the tests that they wanted, but I wasn’t really happy because they, for me I felt like it put on a lot of stress on your pregnancy, because you always had to wait for tests to come out, and it could always be wrong. I felt that was very hard for me. I felt thrown away from myself, feeling that I knew what I was doing, and all those tests would sort of barge in to me, that’s what I felt.

Although it is noted that tests are offered to woman over a certain age group it quickly became apparent that these screening and tests were being offered to women at even earlier ages. Angie, a 26-year-old mother of one, describes her interaction with her obstetrician over screening for Down syndrome:
A: So the obstetrician mentioned Downs Syndrome, but you said you were 26 when you fell pregnant.

AN: Well that’s the thing, I said, he asked if I wanted to test for Downs, or this is the test for Downs, and I said I wasn’t in the high risk group, and he said ‘well you don’t know whether or not you’re in the high risk until you have the test’. I said ‘don’t you have to be older’, and he said ‘well your risk does increase with age, but there’s other risk factors as well, age is only one of them’. It kind of freaked me out, because I had believed that I wasn’t high risk Downs because of my age.

A: How did that interaction make you feel?

AN: Really insecure, so then I thought I’d better get the tests done. The tests go something like, the standard is you’ve got one in 875 chance of having a Downs baby, and then after they do the test the odds change, either higher or lower. So, you either then say you’re one in a hundred, and then you might want to get more testing done, or they’ll say you’re one in 4,000 or whatever, which is what I was. It’s very odd, because there’s a doctor at the ultrasound place who then explains the results to you. He was very, because they test for other things as well, I don’t even know what now, but they did other things, I think there were four things, and he was very clear to say ‘this is your chance, but it’s only a chance, it doesn’t mean you’re not going to have a Downs baby’.

As Beck-Gernsheim (2000, 2002) argues the language that surrounds these practices is of central importance. The language used within these interactions, as expressed by the respondents, constitutes their lived reality. From these interactions they reflexively manoeuvre their way through this particular stage of pregnancy. What is important to note, as we can see clearly in the case of Angie, is that the choice of particular words shapes thinking and action. Prior to this interaction Angie was secure in her knowledge that she was ‘low risk’ in relation to her baby having a condition such as Downs Syndrome. However, her obstetrician’s emphasis on the inability to know this for certain without the objective scientific evidence provided by the screening test directed Angie down one particular avenue of thought and action. Because of this particular interaction, Angie’s experience and perceived reality of her pregnancy shifted from her carrying a healthy baby to her carrying a baby that could potentially have Downs Syndrome. It could be argued that because of the expansion of health and responsibility, other avenues of thought and action were simultaneously
closed. Again this highlights the significant change in notions of health and responsibility.

Indeed, some respondents emphasised the language employed during these interactions. For example, Tracey indicated that the language used by the technician and staff that undertook her initial ultrasound were perceived as judgemental:

I never thought that with James [to have an amniocentesis], it didn’t ever come in to my head. That was the worst thing about those ultrasounds. It was as though they tried to, I had the ultrasound at the SAN where I had Luke, and I felt like I was trying to be pushed in to having it. I felt like I was being made to have it, or go one step further and have a blood test, and just check again. I felt like they were saying that if I didn’t have the tests done than I wouldn’t be doing the best thing for my baby. That I was a bad mother or something! I felt as though you should be having it, even though I was only 32, I’m only 32, there’s no real need to have it. I spoke to my doctor about it, this is with Luke, and he said there was really no need to be having it, and he said they do that, and they will push you in to doing things like that. Whether they make money on it, I don’t know, they must, by doing these tests. But isn’t that sad, to even think that they do that, and all these poor crazy women that are walking around and feeling insecure. I felt that with Luke, not so much with James, I never felt like that, I was never asked to have these tests, or sign these forms.

With the birth of her second child, Tracey was exposed to a new realm of decision-making that did not exist in her first pregnancy which was only three years prior to her second. As indicated at the beginning of this chapter, life has become a planning project. This new dimension of prenatal screening and testing, which has grown exponentially in the last couple of decades and has potential for greater expansion, demonstrates one aspect of the decision-making that must be carried out in this ‘do it yourself biography’. This is applied to not only the women who make use of the tests but also those who actively decide against it.

There were a relatively small number of women in this research that refused to undergo any prenatal screenings or tests. This is indicative of the research carried out
by Rapp (1990) in her study on the employment of amniocentesis in New York City. Rapp found that of all of the women who were offered amniocentesis, because of their age, it was the white, middle-class women who were more likely to agree to have the test and to have an abortion if the foetus was found to be abnormal. Motherhood and the added risks of having a child with any form of disability was problematic for the middle class women of Rapp’s study. These women had postponed motherhood for the advancement of their careers. As we have seen it is not only the child’s future at stake but also the mother’s which is directly at stake, a fact that is due to the multiple far reaching changes that have occurred within women’s lives over the last few decades (Beck-Gernsheim, 2002).

Even for the small group of women in this research who decided against screening and testing, there was a clear demonstration of a reflexive approach in their decision-making, perhaps to an even greater degree than the respondents who did undertake them. As we can see above, many of the respondents who undertook the various screenings and tests did so because the routinization of the tests either did not make them question it fully or they felt ‘goaded’ into it by the language used by their primary carer. Of course, there were respondents who actively sought the tests out. For instance Tracey S. indicated her desire for employing screening tests:

My husband and I started discussing screening tests pretty much as soon as we knew we were pregnant. We really went through everything and thought out what we could handle or couldn’t handle. We both realized that we just couldn’t have a child with something like Down syndrome so we knew we would have any test that our doctor suggested. I think even if we decided not to have an abortion if there were something wrong, the test would at least prepare us.
However, there were also women who equally decided early in their pregnancy that they would carry their pregnancy to full term regardless of any conditions their unborn baby may have. When discussing the possibility of screening tests for conditions such as Downs syndrome with their primary carer, many women noted that one of the first questions their carer would ask was ‘what would you do if the test came back positive?’ If the respondent indicated that they would proceed with the pregnancy, there were instances where the primary carer indicated that there would be no need to undergo the test. For instance, Elizabeth recounted her interaction with her primary carer over various screening tests:

At the first visit, he talked about the ultrasound, about getting an ultrasound done, and explained what they were looking for in that first ultrasound. He said to me ‘there’s no point in getting an ultrasound done if you wouldn’t do something about it if you got a bad result’. He wrote me out a referral to have one done and then said to go away and think about it, and decide whether you want to have it done, but bear in mind the fact that if you get a bad result it’s either going to cause you a lot of worry during the rest of the pregnancy, or you may decide that you need to do something about it. You may want to terminate the pregnancy.

However, of the small number of women who rejected the screenings and tests outright, they were more often than not confronted with antagonism rather than respect for their decision. After much research and consideration, Gabrielle decided against the tests:

G: First of all I read of the investigations and the things like that the GP had given me about the tests that could be done on the foetus, for chromosome disorders and stuff like that. I did some reading and I felt that there wasn’t enough evidence to say that the tests that could be done at that point were accurate enough to make the risk worthwhile.

A: How did your primary carer react to your decision?

G: Well because of my age, everyone became very anxious. I had various staff basically tell me that I was being irresponsible. But I felt strong about my decision. It even got to the point that I had an appointment with a genetic counsellor. I sat through all of the reasons why I should be having these tests. I then asked if there was a real likelihood that there would be something wrong. She then said that looking at my profile and my husband’s profile, bar my age, no there was no real likelihood. But she still suggested that I do it. Well I didn’t and he is fine.
From the various experiences recounted by the respondents of this study, it is apparent that the discourse that surrounds the use of prenatal screening and testing, is emerging as one imbued with a technological moralization. To be a responsible citizen and parent one must submit to the process of these tests. The onus of health is increasingly being placed on the shoulders of the expectant couple, but more centrally on women. The genetic form of medicine assigns women substantial duties for ensuring the health of their children. Women are supposed to undergo the anxiety producing process of prenatal testing (Rothman, 1994). If the tests find that there is a genetic deficiency in the foetus, women are supposed to abort their pregnancies, facing the loss of a wanted child as well as the reality of a later term abortion (Condit, 2000).

It is no wonder that Beck argues “people are condemned to individualization” (1997: 96). The act of making oneself the centre of the conduct of one’s life necessarily equates to the expansion of responsibility for the crises that befall one during the course of a lifetime. We have the freedom to choose, but as argued by Beck and Beck-Gernsheim (1995; 2002) and Beck-Gernsheim (2000) that freedom also carries the crushing responsibility to make the right life choices. As Davis-Floyd argues: “Choices come and choices go: as we gain the choice to travel the promising but perilous paths of bio-technology, seeking to conceive, to bear babies that we know in advance to be healthy, to give birth to babies that remain so, we lose the choice to travel other paths” (2000: 280). Surely we must question not only the path that we are currently travelling, but also the paths that are slowly but surely being closed to us.
CHAPTER SEVEN:

THE BIRTH NARRATIVE

Take a highly successful natural process, like salmon swimming upstream to spawn. Punch One: In the name of progress and improvement, render it dysfunctional with technology – dam the stream, preventing the salmon from reaching their spawning grounds. Punch Two: Fix the problem created by technology with more technology – take the salmon out of the water with machines, make them spawn artificially and grow the eggs in trays, then release the baby salmon downstream near the ocean. This One-Two Punch – destroy a natural process, then rebuild it as a cultural process – is an integral result of technocratic society’s supervaluation of science and technology over nature. Reynolds articulates this technoscientific de- and re-construction of nature as a process of mutilation and prosthesis. (Dumit & Davis-Floyd, 1998: 10)

I woke up that morning, at 6 o’clock, and my water was leaking, so I rang the hospital and they said ‘come in’. He arrived and said ‘oh yeah, they’re just leaking, they haven’t broken. We’ll put a drip up, let’s get started’. I remember saying to him ‘can we wait and see what happens, if I can go in to labour naturally?’ I remember he went, sigh, almost rolled his eyes and said ‘I’ve delivered a lot of babies, and basically you can sit around this hospital for three days with the risk of infection, or I can put the drip in now and you can have a baby by this afternoon’. I remember thinking ‘okay, I really don’t have a choice when you put it like that. This is all so new to me’. So that’s what he did. I still remember, he shoved the needle in to my hand, the canella, and said to the nurse ‘fix that will you’, and off he went. She couldn’t hide the fact that she found that quite rude, that he didn’t even stay around or do it. So then I was in labour all day I suppose, till Oliver was born at five to four. He just came in and out very rarely, I don’t remember seeing him much at all, and then at the end, I had gas during the day, and that was all, and then at the end, at a quarter to four, I was pushing for an hour, and he wasn’t coming. A new midwife came on, and she was very organised, she was one of the head girls there, and she checked him, and said ‘look the baby’s in distress, you’re in distress, I’m going to call the Dr. now’. He was just about to do a Caesar, and she said ‘I want you to come up, the baby’s in distress, I think we should get this baby out’. He said ‘I’ll just do this Caesar first’, and she said ‘no I want you to come now’. So he came in, in all his green scrubs, basically catheterized me, gave me two local anaesthetics, gave me an episiotomy, and yanked him out with the forceps. It was all pretty dramatic and horrible. I remember afterwards, I just lay back and let it all happen, and afterwards saying to the midwife, ‘tell me again, what happened there at the end?’ She said ‘look, it was pretty yucky, and he was pretty forceful, but there was a lot of meconium, and the baby was quite distressed, so I’m really glad I told him to come when he did.’ (Sara)

Sara, a mother of three, expressed what many social scientists would cite as a prime example of a medicalised birth. Indeed, we can see from the Dumit and Davis-Floyd quote which proceeds Sara’s birth narrative a possible explanation for what transpired...
during the birth of Sara’s first child. The application of Reynolds' notion of the One-Two Punch in the realm of pregnancy and childbirth sees the mutilation of the ‘natural rhythms of birth by multiple interventions in every phase’ (Dumit & Davis-Floyd, 1998: 10). It is quite apparent that Sara’s primary carer placed more confidence in technology and science than her ability to birth naturally. From this one example we can see that the medicalisation critique still has place in understanding current maternity care practices. However, as indicated previously, the approach has limitations.

As we have seen, researchers such as Davis-Floyd (1992, 1994) and Lazarus (1994) have argued that some women are indeed alienated by their experience of a medicalised birth, however, many women across classes express satisfaction with medical intervention and management of their births. For example, Sara expressed relief at the actions of her obstetrician:

Oliver was fine, that was the bottom line, one minute he was in distress and it was all horrible, and the next minute you’ve got this perfectly healthy little baby, and it all really doesn’t matter. I was a little miffed at the behaviour of my doctor and I decided not to go back to him with my next pregnancy. But I was glad that he was there when he was needed.

The fact that there is an increasing number of women who not only feel positive but also actively engage with a medicalised birth obviously calls for further analysis.

This sentiment is the driving force behind the research at hand where there is an attempt to build on the works of researchers such as Davis-Floyd (1992, 1994) and Martin (1989) who examined the structural and cultural context of childbirth. The present chapter examines the narratives of the respondents and their expressed experiences of labour and birth. There is an emphasis on the agency of women who accept medical management during their labour and births, an element that is missing
from the critique of medicalisation. Indeed, the central component of the medicalisation critique is the consequence of the power imbalance that is characteristic of the doctor-patient relationship, namely the loss of control and disempowerment for the birthing woman (Fox & Worts, 1999). Accordingly, the following chapter will examine concepts such as control, trust and responsibility.

**Birth within Australia**

In Australia, childbirth has become medicalised to the extent that having your pregnancy confirmed by your doctor is practically universal. In fact, all respondents bar one had their pregnancy confirmed by a general practitioner. The one respondent who did not attended a family planning centre for confirmation of her pregnancy. Many participants expressed the need to have their pregnancy confirmed for reasons ranging from not trusting the home pregnancy test to need of further information. For instance Mel, a birth centre mother, spoke about the day that she took the at home pregnancy test:

I remember the day; I remember being in shock, thinking ‘no!’ It was a Sunday, and then I went to the GP the Monday week after that, just to make sure. I wanted to launch into ‘right I’m pregnant,’ but my husband and I just couldn’t believe it, we had to have the GP doing a test, but it’s funny they do the same test anyway, the urine test.

This sentiment of disbelief which could only be suspended by confirmation from a medical expert was expressed by many respondents across the three fields. However, it was most represented in the private birth mothers with only two of the homebirth mothers stating this. Angie, a private birth mother of one, states:

It was funny because Gary and I were looking towards the doctor telling me, as confirmation, like it wouldn’t be real until a doctor had said ‘yes you are pregnant’. I knew they did the same test that I’d done.
It is with this initial contact with the medical system that many women receive their first information about the services that are provided for them during pregnancy and childbirth. In some instances, general practitioners provided information on various forms of care such as shared care or midwifery led care. More often than not, this only occurred due to the fact that the doctor was directly involved with these services. As the respondents represent women from middle to upper class socio-economic background, the avenue of publicly funded maternity services was never given as an option. Rather, the majority of the respondents were often given a list of obstetricians to contact. In fact, when asked why they had chosen this particular form of care, 8 out of the 18 private birth respondents argued that they were not aware that there were other services available.

On the other hand, many of the respondents who had a private obstetrician commented on the desire to have someone that they trusted. This was succinctly expressed by Cheryl:

I think, um, being 33 and being in private health insurance, I had friends who had just had a baby in a birthing centre and who ended up having to go into the maternity section anyway because um, because they decided they would do all of these things- they had this birthing plan worked out and it completely went by the wayside. So I figured that I would rather than, um have these ideas- I would let these people who are the professionals do it instead of me having to dictate what needed to be done. I figured that since they had all of the training and um they knew what they were doing- then I would just let them do that. I also wanted to be in a private hospital where I could receive the best care. I just wanted to make sure that if anything should happen I would be in the best hands possible.

Ann similarly argues:

Well, to tell you the truth we had never considered any other option. Both my husband and I have good jobs and earn a pretty good living, so we have private health insurance. Besides the whole tax thing we would have had the health insurance anyway, because eventually we did want to have children. We always wanted to go down the private path, with our own doctor and own private hospital because it was right for us. We have total trust in our doctor and really trust in the medical profession. They are the experts; they studied for so long surely we should trust them.
This implicit trust in an obstetrician, who has been culturally constructed as the ‘expert’ in pregnancy and childbirth by society, is more fully understood in the context of the risk society thesis. According to Beck (1992), one of the unintended consequences of modernity has been the gradual erosion of public confidence in modernist institutions; such as governments, industries and corporations and at the same time raise doubts about the notion of progress. Drawing on this work, Reddy (1996) has argued that these very conditions posit the expert as a crucial focus of trust in a process that may seem less than trustworthy. In essence, the role of the ‘expert’ in a risk society is to claim knowledge, expertise and an ability to control that which seems to be out of control.

The sentiment of pregnancy and childbirth being an out of control experience was interestingly expressed by 10 of the private birth mothers, 5 of the birth centre mothers and none of the homebirth mothers. For instance, Kylie who made use of the birth centre at her local hospital spoke about her pregnancy in the following manner:

I was almost grieving because I had no concept of being a person who had made this choice, and been in control. It was not an issue, my body was taking over, and my body was doing strange things. I was feeling sick and yuck, and I hated it.

Pregnancy is a time period where women often express feelings which are very ambiguous. Sentiments of fear, anxiety and happiness as well as unhappiness were often expressed by all respondents when they reflected on their reaction to finding out they were pregnant. Yet, the notion of pregnancy and childbirth being an out of control experience was not expressed by the home birth mothers. This most likely
stems from the fact that instead of them relegating their trust to the medical expert, they trusted their bodies as well as the process. This will be further explored shortly.

In terms of the birth itself being seen as an out of control experience, the private birth mother, as stated above, expressed this most often. For these particular women, although they had prepared for the birth by at least going to prenatal classes, labour was an intense experience they felt ill prepared for. For instance Philipa expressed on more than one occasion the unexpected intensity of labour:

I guess I expected that I would be able to be in control. I expected that I would, I fully expected that I would be able to achieve what I wanted. I expected there to be pain, I didn’t expect it to be unbearable. I expected to probably have to use the gas.

Tina expressed similar sentiments:

But then having those few contractions without drugs at all I was thinking again that I couldn’t ever have done this without drugs. I don’t know how women ever did it in the olden days. Because it was such a trauma at the time, whenever I think about it, it upsets me, so I don’t think about it. Having to sit and actually talk about it, I’m thinking is that how it happened?

What these excerpts neglect to inform us is that often the private birth mother was being exposed to a cascade of intervention, which most likely contributed to this out of control feeling. Being induced by syntocin does increase the intensity of labour making it very difficult for the women to work with contractions. In fact, the carers that surrounded the private birth mothers often prepared them for this. Tracy presents an interesting case:

Yeah, they had a lot of babies. That’s why the woman, before she gave me the drip to make me dilate, she said ‘why don’t I get you an epidural now, so that when it does get really painful, you’ve already got the epidural’. I thought ‘that’s sensible, yeah, okay’. When the anaesthetist came she said ‘don’t tell the anaesthetist you’re not in labour, can you pretend you’re in labour’. I was like ‘okay, I don’t know if I can do that’. So when the anaesthetist came, he said ‘are you in labour’, and the nurse cut in and said ‘yes, she is in labour, she’s ready to go, she’s a couple of centimetres dilated’.
The cascade of intervention and its contribution to uncontrollable bodily acts was most succinctly expressed by Danielle:

Yeah, well I was pretty out of it, cos they did the first epidural at whatever time, and they did a top up whenever they were meant to, but it was not long before they had to do the full on operation epidural, and that’s when the whole blood pressure thing went a bit haywire. I was so, and it’s why I think it’s such a trauma when I think back on it, cos I was out of control, I couldn’t control what I was saying or anything, cos there were so many drugs in my body. I’d never had that experience, I’m happy to say, before. I got hooked up to stuff, and wheeled through to the theatre, and it was like watching ER except it was me on the trolley, and I didn’t like it at all, the ceilings flying past, I was really freaking out.

For the birth centre mother, the intensity and uncontrollable feelings of labour was expressed by a minority. Wendy discusses why she felt ill prepared for the birth of her first child regardless of the reading that she had conducted as well as her attendance to prenatal classes:

After I had my first one and the experiences that I had I often thought about why it all seemed so out of control. I know I had a really long labour, but why couldn’t I handle it? We talked about this in that group I told you about – the one where we all spoke about traumatic birth experiences. Anyway, I thought about the classes I attended. I found those classes quite good, but they tended to glorify the whole labour process. It was like ‘this is how it’s going to be, it’s going to be fantastic, you’re going to have all these midwives around’. But when it comes to the actual labour it’s not like that. There was a huge emphasis, because I went through the birth centre, on drug free birth. I know they’re advocating that but it was like a successful labour is a drug free one, whereas the successful outcome is a happy healthy baby. They were pushing it, and also it was a very subjective course. It was like the midwives personal experiences. I had one midwife say ‘I’ve had three kids, and if I can do it any of you women can’. It’s like, how can she possibly know what all these women are going to experience.

The rhetoric of choice

The work of Davis-Floyd is a key piece of research in the critique of the medicalisation approach. She argues that birth is a rite of passage into motherhood. The purpose of the various hospital ‘rites’ organizing medicalised births, according to Davis-Floyd, is to socialise women to that culture’s main beliefs. In American culture, the aim is to impress the supervaluation of technology over nature. What is
key in her analysis is the emphasis of birth as a hazardous or risky event. In every society, danger is dealt with in a way that is specific to its culture, in America, and it can be equally argued to be the case in Australia, the construction of birth as a dangerous event is dealt with in a manner that underlines the importance of technology. Research such as this demonstrates that in most western countries current birthing practices are culturally defined as inherently risky events in need of medical management that are surrounded by rituals presented in the guise of rationality and science.

The technical or scientific discourses tend to make claims to objectivity; this can be seen to have a two-fold effect. On the one hand, claims to objectivity can be seen to negate subjective knowledges such as the experiential knowledge of the mother. On the other, the supervaluation of the technocratic in our society automatically deflates any knowledges in competition with it. This has been demonstrated quite clearly throughout the thesis in relation to the conflict between obstetricians and independent midwives as well as consumer and advocacy groups of natural childbirth. Furthermore, the advances of biomedical knowledges and technologies that are presented by these discourses supposedly present more choice and agency for the pregnant woman; yet, we have already seen in the case of prenatal testing, this can be readily contested. In other realms of pregnancy and birth, Katz Rothman (1984) discusses the complexity involved in making a ‘choice’ about whether or not to opt for a caesarean section when told that the foetus is in distress. This was evident in the excerpt of Sara’s birth narrative. There was ample evidence of this occurring to many of the private birth mothers. The discourse employed by the respondents primary care physician often emphasised notions of potential or immediate distress to the
unborn baby and the mother. As Katz Rothman indicates, choice in this context becomes extremely problematic.

This leads us to question, what choices do women really have in relation to the care they receive during pregnancy and childbirth? Relative to choice of primary carer we can see the options are quite limited. The lack of indemnity coverage for independent midwives places the home birth at risk of vanishing within Australia. The lack of free standing birth centre units and the existing policies of birth centres in relation to who qualifies as a ‘low risk’ pregnancy is quickly eroding choices of care for the gradually aging first time mothers. Regardless of this women are viewed as consumers of maternity services. The following section examines the consumerist behaviour of the respondents of this study in relation to their choice of primary carer.

Although many of the respondents demonstrated a reflexive approach when deciding on who was to be their primary carer, it was only the birth center and home birth mothers who were critical of the medical model of care. Of the 18 private birth mothers interviewed, only 7 chose their primary carer based solely on the advice of their general practitioner. The other respondents listed reasons such as the location of the obstetrician and hospital or advice from family members and friends. The comments of these particular respondents demonstrate a consumer approach in the choice of their primary carer, yet they were not critical of the medical model as a system of care.
In fact, of these 18 respondents, not one actively questioned their primary carer on matters such as caesarean section rate or episiotomy. This is not to argue that all women who employ a private obstetrician do not question their carer or are not critical of the medical system. Interestingly, it was found through the interviews that many did question the necessity of unnecessary medical intervention – yet they did not discuss these thoughts with their obstetricians. Angie provided insight into this in the following manner:

That’s the thing he didn’t really give me any advice. He said to me ‘are you going to pre-natal classes?’ and I said ‘yes’, and he said ‘that’s good’, and that’s about it. In terms of the birth the only thing he said to me was ‘have you thought about whether or not you want medication or drugs for the birth?’ and I said ‘I’d rather not’, and he said ‘well what if it’s painful?’ and I said ‘well I expect it will be’, and he said ‘okay’ and that was it, the whole conversation about the birth. Gary and I talked a lot about a birth plan, what we wanted, and Gary kept saying to me ‘you should talk about it with the Doctor’, but I didn’t really feel as though there was ever any opportunity to do that. I wasn’t brave enough to say ‘hey I want to talk about this’, because the sessions were quite rushed with him, he always had a really full waiting room, and I thought everything’s fine, I’ll just go along with it. I guess in a way, because I’m quite competent, that I knew what I wanted to do, but it would have been nice if I could have talked through that. It sounds crazy, because I can speak up, I’m an intelligent person, but then when you’re in this relationship, you think you’d better not.

This is not to argue that all obstetricians interacted with their patients in the same manner. There were many instances where a respondent expressed quite positive interactions with her obstetrician. Some spoke of their obstetrician treating them as an equal. Tania discussed this and felt that it was mainly because of her medical background:

I quite like obstetricians to be professional and straight down the line. Not like these gushy ones that have photos of babies all over the wall that they’ve delivered. I like the professional boundary. It wasn’t that I liked him, but I trusted him. If I had a question relating to how I was feeling or anything about the prenatal tests, he spilled out information. He wasn’t condescending at all. On the contrary, he did know I was a nurse, so he did speak medical lingo to me. I don’t know if he does typically.
It is worth noting that although Tania did discuss what qualities she preferred her primary carer to have, she did not base her choice of carer on this. Rather it was based on the advice of her general practitioner and the availability of obstetricians which was on the list provided. Others spoke about the obstetrician being paternal, rather than describing this as condescending, these particular respondents viewed this behaviour as endearing and a further quality which cemented their trust relationship.

For instance Joanna discussed her obstetrician in the following way:

He was an obstetrician that my mother’s GP, who was my GP, when I lived down there, and he’s also a good friend. She referred him to her family, her two sisters have both gone to him. He was also the obstetrician who looked after my sister in law when both her children were born, and he’s also another GP, she had her babies with him, so I felt I like this guy. I’d met him before and he was like a real father figure, and that was really important to me. He’s got four kids of his own, and that was really important to me, I know that’s stupid.

Jennifer expressed similar sentiments about her obstetrician and his caring manner as well as his demonstration of respect for her and her ability to make decisions for herself:

He treats me like a real person, not just another woman. Either he is an extremely good actor, or he genuinely enjoys telling somebody that they have a healthy baby. He’s been delivering for about 25 odd years, and you’d think he’d be getting tired of that by now. It feels genuine, whether it is or not I don’t know, but it certainly feels like it. He puts the sonar…. on and checks the heartbeat. He gets this grin, and he’s like ‘listen to that, oh that sounds good. That’s such a good sound isn’t it?’ He just seems genuinely pleased about pregnancy. And he’s gentle, he’s very caring, in his touch and his manner. As well as that, he treats me like a woman with a brain. I’ll ask him a question and he’ll say ‘there have been three studies done on that, one found this, one found the other, and one found the other. The first two really weren’t very well done, because they were’ blah, blah, and he goes in to the methodology, or the sample size or whatever. He gives me all the information that he has. Whether it’s all the information he has I don’t know, but he certainly gives me an overview of the information without dumbing it down, and he doesn’t make decisions for me. We talked about testing. He raised all these different tests that we could do, and I said ‘I’m not really sure that if I found out the baby had Down syndrome, for example, I don’t think it would change the outcome of the pregnancy.’ He said ‘if that’s how you feel then there’s no point in doing the test and putting you in a state of worry for the next six months, let’s have a happy pregnancy.’

Accordingly, the development of a trust relationship with a primary carer eventuated for different reasons among the private birth respondents. For many it was based on
the personality of the obstetrician, some enjoyed a warm and paternal obstetrician, others one that remained professional and distant.

Beck’s (1992) emphasis on the importance of the expert within the risk society is further complimented by the work of Giddens and his exploration of trust. For Giddens (1990, 1991), trust can be understood in two separate ways. One is based on the actual interaction between individuals. Giddens calls this form of trust ‘facework commitment’, here the ‘trust relations which are sustained by or expressed in social connections established in circumstances of copresence’ (1990: 80). As can be seen from the above accounts of the respondents ‘facework commitment’ was clearly demonstrated in their relationship with their obstetrician.

Beyond this form of commitment, it seemed for all of the private respondents of this study that there was an intrinsic trust in the medical care of pregnancy and birth. As we can see from the comments of Ann and Cheryl there was a demonstration of trust with this model of care. When asked why they chose the private system for the care of their pregnancy and birth, many of the private mothers simply stated that it was ‘better care’. They often related it to private health insurance, equating the high cost of the insurance to the quality of private care. This form of trust with an expert can be further understood by Giddens second concept of trust, namely ‘faceless commitment’. Giddens defines this second form of trust as one which “concerns the development of faith in symbolic tokens or expert systems” which when taken together are termed abstract systems (1990: 80). Although past research has stipulated that this form of trust or faith in abstract systems was more likely to be
present among the working class population (Zadoroznyj, 1999) it was clearly evident in quite a few of the private birth mothers. Many of the private birth mothers as well as some of the birth centre mothers mirrored Cheryl, a tertiary educated detective, and her sentiment of letting “these people who are the professionals do it instead of me having to dictate what needed to be done”. In essence, the obstetrician became the face of this expert system. His or her qualities represented, to the private patients, the characteristics of an expert system that the respondents already trusted.

A demonstrated trust in the medical system did indeed also exist in the birth centre population. For instance, when discussing complications that arose during the birth of her baby that caused her to move from the birth centre to the maternity section of the public hospital, Wendy stated:

At one point the baby’s heart rate was dropping a lot, that was the thing that everyone seemed concerned about. I was just happy to be free of pain, I didn’t understand the implications of that really, and I just felt like that was the obstetrician’s and the midwife’s problem. They know what they’re doing, and I was relying on them to make the decision about whether the baby had to come out super fast via caesarean or whether it could endure the long labour. I was fine, I felt great once I had no pain, and just tired, and I didn’t feel capable of making those decisions.

Wendy continued:

The doctor said I’m going to give you an episiotomy, and I said is that necessary, because we didn’t really want one. He said ‘yes, otherwise you’ll tear’, so I was relying on him to make the best choice.

This reflects the sentiments of many of the birth center mothers. Of the 13 birth center mothers interviewed, 9 expressed very similar sentiments to those of Wendy. Although they were in that particular system because they wanted to avoid unnecessary medical intervention, these particular respondents welcomed the idea of being ‘down the corridor’ to the hospital. This form of trust in an abstract system is
readily understood when further examining Giddens' concept of faceless commitments. In a later publication (1991) Giddens unravels some of the consequences of our security and trust in these abstract systems. According to Giddens, abstract systems deskill. He argues that the intrusion of abstract systems, especially expert systems, into aspects of our day-to-day life undermines pre-existing forms of local control. Pre-modern times were characterised by individuals developing many skills and type of local knowledges relevant to their daily lives. However, with the expansion of abstract systems high modernity bears witness to the ‘sieving off’ of these local knowledges to the expert systems (1991: 137-138). With the development of professional obstetrics, as discussed in Chapter 2, there was indeed a gradual ‘sieving off’ of knowledge and power from the layperson and midwife to the obstetrician. ‘Doctors’, as part of the rise of abstract systems, “derive power from the knowledge-claims which their codes of practice incorporate” (Giddens, 1991: 138). It is important to note that Giddens does not see that as an exhaustive process. He argues that a reappropriation of knowledge and control on the part of the lay actor is possible; this reappropriation is a basic aspect of what he terms the ‘dialectic of control’:

Whatever skills and forms of knowledge laypeople may lose, they remain skilful and knowledgeable in the contexts of action in which their activities take place and which, in some part, those activities continually reconstitute. Everyday skills and knowledgeability thus stands in dialectical connection to the expropriating effects of abstract systems, continually influencing and reshaping the very impact of such systems on day-to-day existence. (1991: 138)

It is for this reason that we now turn to those respondents who valued a non-technocratic pregnancy and childbirth.
The non-technocratic childbirth

It is worthwhile exploring the voices of the respondents who subscribed to a non-technocratic construction of childbirth. For these women, the dependent patient/doctor relationship was surpassed by one in favour of shared responsibility. We have seen this demonstrated by Natalie, within Chapter five. It was clear that despite the many health problems that Natalie faced, she did not view pregnancy as inherently risky or as an illness. Viewing pregnancy in this manner was expressed by quite a few of the private respondents. Whilst some clearly viewed their pregnancies and eventual births as being rife with potential complications others simply saw it as an unknown and at times an ‘out of control’ experience which needed medical management. This was obviously more the case with first time mothers and it appeared to be even stronger with older first time mothers. Joanna, who was 40 years old at the birth of her first child, expressed it accordingly:

I was really concerned about my age. I thought that it was going to be such a difficult pregnancy. I also have back problems, and I thought I need help. I was really, really scared about being pregnant, about how my body was going to cope with it at my age. She said [GP] ‘what do you mean, you’ll just have an average pregnancy’. I said ‘I don’t think I will’. I really thought I was going to have trouble. I really thought I wouldn’t be able to cope with it. Also my mother had some difficult pregnancies, and my mother was much younger than me when she was first pregnant, over 10 years younger than me. She had two pregnancies, and one still born, in between my brother and I, and I had a lot of problems with blood pressure. I used to have high blood pressure as well. I thought that was going to be a problem through my pregnancy, I was convinced.

In contrast, all of the homebirth mothers viewed pregnancy and birth as a natural event. They had a strong belief in their bodies’ ability to carry a healthy baby and to have a positive birth experience. Many mirrored the words of Merlene who found “If I trusted my body it would do the work, as it has done for a million years, for all women. There was a lot of trust there!”
All homebirth respondents had a great depth of knowledge about pregnancy and birth process. As we saw through the narrative of Natalie, the homebirth mother becomes her own expert. All of these respondents discussed the myriad of books, lectures and events on birthing that they were exposed to. For instance, Kate a mother of two, whose first birth was in a public hospital and eventuated into a caesarean section spoke about the research she conducted when deciding what form of care she wanted for her second pregnancy:

I did lots of homework, I had read and read and read, I’d spent a year just reading endless stuff. I’d gone to a homebirth support group before I’d fully committed in to it. This was when I was pregnant, it was the first two months, I was full on intense trying to work out where am I going to have this baby, I really wanted to have him at home, but I knew that I had so much homework to do.

Her feeling of needing to educate herself for a better informed decision in choosing a primary carer seems to stem from her difficult first birth:

I had a room that had a big spa bath in it, it was THE birth room in the whole hospital, all the rest were just tiny little rooms with showers. I was lucky I got this good room. I was in the bath, and going really well, 9 centimetres, everyone was excited; they were lying out towels, saying ‘the baby’s going to born, it’s going to be half an hour’. And that was it, it got stuck, it didn’t progress from there. The midwives, who were really good, except they were still coming in and out, and I didn’t know them from a bar of soap of course, but they were pretty good. They tried, I had an anterior lip, so they were sort of pushing that back, quite a few examinations to see what was going on, to see where the baby’s head was, so a fair bit of prodding and looking, and trying to work out what was going on. I was in labour for, I think, about midnight when they thought he was going to be born, and then 7 o’clock the next morning I still hadn’t had him. That was all the time of just trying, it went on and on and on. I didn’t have any drugs, I had some gas, a little bit of gas in the end, cos the obstetrician who was on was a female, and she was pretty nice, and she tried putting a cup on his head, to try and suck him out. That didn’t work, they couldn’t get it on his head. I think he’d sucked back up a bit. So then they decided I’d have to have a caesarean. I’d spent hours pushing and I was delirious by then, exhausted. I didn’t care if I lived or died at that point, I actually thought I was going to die, I didn’t care, I was too tired, ‘I don’t care what’s going on, just cut the baby out, as long as he’s okay, let him live, and sweep me under the bed’, the stuff that goes on in your mind. But then I had an epidural, I was on the operating table, and he’s giving me the epidural, but my leg, I was still having labour pains on and off in that time still, and my legs were twitching and really flicking. I was yelling ‘I’m getting shocks down my leg,’ and I could hear him swearing ‘fuck!’ and ‘shit!’ and swearing because he’d put the epidural in the wrong place. So then he was yelling at these people to come and block up the hole, a (blood patch), they basically patch up where the hole was so that it doesn’t seep up to your brain, because it’s in the wrong spinal space, so it’s really dangerous. People are paralysed from it, so that was terrible. Meanwhile my husband was out in the corridor, it was supposed to be about five or ten minutes to get the epidural and then he was coming in, then
this was like 45 minutes later, so he was off his head outside, in tears, and worried, and thought I was dying. Anyway they did the blood patch, and then decided they had to give me a full spinal block, so I had that from my neck down, and when they cut him out they handed him to me, but I couldn’t lift my arms, I couldn’t move. They’re trying to bring him over, and I’m saying ‘give him to Kell, I can’t do anything’. I’m off my head on drugs, delirious, I don’t know what’s going on, and they’re trying to hand him to me, and I can’t move my arms.

Kate’s reaction to what happened to her during this birth is expressed as follows:

I felt fine at the time, because I thought ‘that’s how it had to happen, we’re alive, we’re fine, he’s okay’. I had a caesarean, everyone was saying ‘oh you had a hard time’, and I was ‘oh it wasn’t that bad’. Obviously all the hormones kick in, and I just moved on. It wasn’t until I was pregnant with my second that all those emotions came up, and then I felt that I was really disappointed that my body let me down, and I don’t know if I can do it naturally, so doubts of my own body’s ability.

Interestingly, Kate did not automatically critique the system; rather she turned her attentions on to her own bodies’ ability, a common sentiment amongst private birth mothers who were subject to a cascade of medical intervention. This changed with the amount of information that she gained from her reading and from the support group that she attended. Slowly Kate felt differently:

I can honestly say after my first birth I felt there was still something missing, like there was a gap, I didn’t know what it was. But it was, I didn’t feel fully a woman, because I hadn’t had a baby come down the birth canal, like we’re meant to. That was like a whole rite of passage once I’d had my second and it was life changing.

This change of attitude reached its height when Kate and her independent midwife had sessions together:

Once I fell pregnant again all of those old emotions came flooding back. But this time I felt differently. It wasn’t about my body anymore it was about the system. That really became more intense once my midwife and I were getting together. I sat down with my midwife, she’d come to my place to do the visit, and we’d sit and talk, and sometimes she might have been there for two, three hours. We’d talk and she’d ask me all about my previous birth, about how my mother birthed me, and we’d go through things, and sometimes I’d cry if she’d press a particular button that I didn’t even know was there. It really healed my first birth, and helped me to understand the process that I can do it. I did lots of journal writing and affirmations. We talked about the power of the mind, the body will go where the mind is.
Although there is a group of women who choose homebirth after having difficult medically managed previous births, there were several instances of a respondent choosing a homebirth for their first pregnancy. For instance, Merlene, a mother of one who had taken part in what is called a ‘better babies programme’, speaks about why she wanted a homebirth:

We decided prior to conception that we wanted a homebirth. Because it was very planned, we’d read a lot of stuff and talked to a lot of people, and the more and more I read about homebirth, it was like, yeah, that’s my head space, that’s where I want to be. We’d pretty much decided. The thing that held us back for the final decision was the fact that we couldn’t find, it was very hard to find home birth midwives, so until I was actually pregnant I didn’t go in to that detail. I didn’t want to find a midwife and then not fall pregnant for two years. We’d decided that was the way we were going to go if we could. You see my husband and I are both chiropractors, so I’ve always questioned mainstream medicine, and been very non intervention as far as the human body, and healing and all that sort of stuff, it’s like don’t muck around with it too much. I’ve always been a bit cynical of mainstream medicine as well. That coupled with all the statistics that we’d read on how doctors can interfere in the normal birthing process and that can cause problems, that’s why we went that way. Both of us have always had that mentality, even though my father in law is a GP.

The decision for a homebirth is often fraught with adversity. In Kate’s case her general practitioner confronted her once Kate informed him she was interested in a homebirth:

The doctor told me when I went in to have the pregnancy test. He gave me all the rules and regulations, ‘well you’ve already had a caesarean, so you’re high risk’. There’s a low risk unit birthing centre at Wyong, but they said ‘no you can’t go there, you have to go to Gosford, and you’d have a monitor on, and they’d give you about four hours if you’re lucky’. I went ‘no, I don’t think I can have the baby in a hospital. I’m going to go in there, I’m going to have fear from my previous experience, there’s got to be another way.’ I can’t remember what he said exactly, but he did, he said something like, ‘you’re a high risk patient, and that’s not advisable, how can you?’

This type of comment was often expressed to the homebirth respondents, it could stem from doctors, friends and family. In fact, many of the homebirth mothers informed me that they often did not tell people they were planning a homebirth in fear of their reaction. It was commonly expressed by these respondents that they only told
close family and friends one or two weeks prior to the due date. If we return to the
idea of what it means to be a responsible pregnant woman within high modernity and
what is deemed as responsible actions we can better understand the response of these
respondents’ social circle.

**Trust and the non-technocratic birth**

I was really quite confident in Angela, quite confident in my body, but mum was
really eroding my confidence. So when I spoke to Angela about a week after Eve was
due, she asked me how things were going, we talked about mum, she asked me how
things were going with Sam. She really made sure that all my emotional and I guess
my soul, was looked after as well, and that was a really big difference from the first
time around, that somebody actually cared to stop and say ‘hey what are you
feeling’, and ‘are you okay with that’, and that was really cool. She just made it
perfectly okay to be that overdue, and restored all my self confidence and faith again.
(Michelle)

I would like to say then that I choose a midwife for the continuity of care. That Jan
was able to meet my physical, emotional and spiritual needs. That is the only way
that I could trust her. I couldn’t go to a birth centre knowing that I could have one of
up to eight or nine women there that day, particularly if I’d met them previously and
didn’t particularly get along with them. I could not labour efficiently having
someone in the room that I didn’t like, or worrying if they were going to bother me,
or if what I was doing was acceptable to them. That’s why a midwife is so important
to me. (Rachael)

Choice, control, continuity, they are the three things that you have to have. The
continuity with your midwife can really last a lifetime. The relationships you build is
amazing, if ever you’ve got something you want to ring and talk to them about,
they’re there. (Millie)

I think a lot of people have to have a birthing plan when they go to a birthing centre
or whatever, because they have to let the midwives know what their ideals are,
whereas my midwives, I knew that they already knew exactly how I wanted it. I
wanted it as natural as possible, I wanted them to leave me alone, so I didn’t really
have to plan that aspect of it. They were on the same wavelength as me, and I trusted
them to let it happen. (Merlene)
If we return to Giddens’ concept of trust in abstract systems and his notion of dialectic of control, we can further understand the homebirth mothers’ position. It is quite clear that the homebirth mother develops a deep relationship with her primary carer through facework commitment and that she also rejects the expert system of medicine for her pregnancy and birth. Giddens’ notion of dialectic of control does aid in explaining the rejection of the medical model by these respondents. Giddens (1991) argues that a characteristic dilemma of high modernity is that often there is no overarching authority in many situations and conditions of day-to-day life. Pregnancy and childbirth practices are representative of an arena where there are a variety of discursive constructions of what is the best form of care. Some argue (see Lane, 1995; Zadoroznyj, 1999) that childbirth is a discursive domain characterized by a lack of an ‘authoritative truth’. It is within these instances that Beck (1992) and Giddens (1990, 1991) argue that this lack of foundational truths in conjunction with risk and uncertainty calls for the reflexivity which is typical within the condition of high modernity. In relation to pregnancy and childbirth practices women can choose between the medical model or the natural. These models obviously approach pregnancy and childbirth practices in different ways. Both apply different concepts of risk to the events with an according different approach to what constitutes the best form of care. There are also different implications for the extent of the involvement of the pregnant and birthing woman.

Yet, as has been continuously argued throughout the thesis, the dominant definition of childbirth is the medically managed one. As demonstrated, the construction of pregnancy and birth as a risky event is related to the erasure of uncertainty with respect to women’s knowledge about their body during this time period and their
according experiential knowledge. It can be argued that knowledge specific to this
time period is then reconstructed via the medical expert. It is evident that this expert
knowledge has been contested; indeed, Lane argues that “obstetrics is not immune
from general and growing consumer criticism which is itself substantially reflexive”
(1995: 89). Yet, the discourse which surrounds the medical expert, such as those
found within the media and mainstream pregnancy and childbirth texts, serves to
confirm it and spread its effects. This demonstrates the adversity that homebirth
mothers must confront in their abandonment of trust in the medical expert system.

Giddens emphasises that no one can disengage completely from the abstract systems
of modernity, yet lifestyles, he argues, can be “tailored to navigate a course between
the different possibilities offered in a world reconstituted through the impact of
abstract systems” (1991: 142). Interestingly, he comments on the saliency of these
forms of decisions which occur during fateful moments of an individual’s life.
According to Giddens, these fateful moments can be felt as a crossroads for many
individuals. Do we turn to the more traditional authorities in these highly
consequential moments in our life or do we take this moment as an opportunity to
reskill and empower ourselves? He argues that these are the moments when we have
to:

Sit up and take notice of new demands as well as new possibilities. At such
moments, when life as to be seen anew, it is not surprising that endeavours at
reskilling are likely to be particularly important and intensely pursued. (Giddens,
1991: 142)

It is obvious that the life stage of pregnancy and childbirth is a fateful moment. It is
seen as a time period of great change and responsibility. In contrast to the private
birth mother, and to a degree the birth center mother, who can be argued seek refuge in familiar and socially acceptable modes of behaviour, the homebirth mother intensely pursues the path of becoming her own expert. In a society where thinking in terms of risk becomes an inevitable part of day-to-day life, individuals even become aware of the risk of not thinking in these terms (Giddens, 1991). For the private birth mother as well as the birth centre mother the potentiality of a troubling occurrence during their pregnancy and birth is blocked off by the protective cocoon of trust they have in the medical system. For the homebirth mother it is the trust that she has in her body and the process itself.

Conclusion

Chapter One outlined the various critiques of medical management and intervention of childbirth that have been developed to this date. It is quite clear that these critiques are derived from a large wealth of research and disciplines, ranging from medicine to the popular press. Yet, despite this broad range of fields and orientations involved, these researchers unanimously critique the involvement of medical professionals and their according control over pregnancy and birth within Western society. If we were to represent the various arguments of the decades of research into childbirth practices, we may conclude that the construction of childbirth as a hazardous event has eventuated in the unnecessary medical intervention occurring within a natural event.

On the whole, it has been argued that this needless intervention and medical management of childbirth has resulted in several consequences. Sociological
research has emphasized the loss of control and feelings of alienation from the birth experience that women experience with a medicalised birth. For instance, sociologists such as Ann Oakley (1980, 1984) and Barbara Katz Rothman (1982) have argued that a medicalised childbirth disempowers women. There has also been a multitude of arguments against the increased improvement of physical and emotional outcomes of a medicalised birth. For example, researchers such as Tew (1998) have found that perinatal mortality is much higher when obstetric interventions are used.

As previously discussed, the research is vast and as time progressed the valuable contributions of the initial investigation into childbirth were gradually developed. It was found that variables such as the socio-economic background of women could impact on their expectations, goals and desires of childbirth (Nelson, 1983; McIntosh, 1989). Increasingly it was found through later empirical evidence on the actual experiences of childbirth expressed by women was contradictory to the critique of medicalisation (Davis-Floyd, 1992).

As we have seen, this has led researchers to examine childbirth practices through various lenses including the lens of consumerism. The dichotomous model of medicalisation versus consumerism arose simultaneously with a model of conflicting cultures in relation to childbirth practices. For instance, the recent Queensland review of maternity services (Hirst, 2005) disclosed that many maternity care environments are characterised by conflict. Hirst categorises the conflict into two distinct cultures: the organic, where there is a call for less interventionist and more humanistic models
of care and the mechanic culture that stresses the need for the medical model. Here pregnancy and birth are seen as inherently risky and latent with unforeseeable consequences that only the medical model could cater for. These cultures, which are argued to be present within maternity care providers as well as the consumers of the services, have been apparent for decades with both vying for dominance in the field. Yet it is the medical model which is prominent. As we have seen, the critical analysis of a field which is characterized by its contestation over definitions, knowledges and power struggles can be more thoroughly understood with the employment of the risk society thesis. Furthermore, the employment of the argument and its valuable components of individualization and reflexivity aid in understanding the active engagement by an increasing population of Western women with the medical model of pregnancy and childbirth.
CHAPTER EIGHT:

LEARNING TO BE PREGNANT IN A RISK SOCIETY

All words have the "taste" of a profession, a genre, a tendency, a party, a particular work, a particular person, a generation, an age group, the day and hour. Each word tastes of the context and contexts in which it has lived its socially charged life. (Bakhtin, 1981 cited in Treichler, 1990: 113)

Giddens (1991: 126) adage that ‘the body is in some sense perennially at risk’ provides an entry to the following chapter on the analysis of self-help literature relating to pregnancy and childbirth. His statement carries double implications of external agency and personal insurance. Two themes which meet in the body and carry the implication that it is capable of not only action but also resistance. Giddens highlights this when he quotes Goffman: “a body is a piece of consequential equipment, and its owner is always putting it on line” (1972: 166, cited in Giddens, 1991: 126). Goffman’s ‘putting it on line’ and Giddens highlighting of resistance imply agency and accordingly the making of decisions. Decisions, it can be argued are mediated through discourse.

The following chapter argues that the accessibility of knowledge, within a risk society, of the various risks that women face during their pregnancy and birth opens up not only more spheres of action on their part, but also creates new types of risks as well. The expectant woman now has decisions to make with consequences for not only herself but also for her unborn child.
Since the advent of the risk society thesis and subsequent explorations of the consequences of living within high modernity, there has been an abundance of research on how various populations are affected by media reports about risk information (eg. Kitzinger & Reilly, 1997; Tulloch & Tulloch, 2001; Blood & Holland, 2004). The work of Giddens and Beck highlight that the new risk society is characterized by our preoccupation with the management of risks in our everyday lives and that the mass media are seen to play a key role in this sociocultural transformation (Kitzinger & Reilly, 1997). Surely we must question not only the role of the mass media in defining risk knowledges for audiences but also the significance of self help literature, and specifically for this research, mainstream pregnancy and childbirth literature.

A focus of this chapter will be on the politicization of the risks that are presented to the childbearing woman. As discussed in Chapter four, Beck constantly emphasises the political aspects of risk society, his approach is aided by the anthropologist Mary Douglas. Despite her culturalist analysis, which seeks to demonstrate that risks are perceived in a social context, her exploration of various health issues such as AIDS lead her to emphasise that “the dangers are only too horribly real…this argument is not about the reality of the dangers, but about how they are politicized” (Douglas, 1992: 29). This is a valuable point for the research at hand. There are some intrinsic dangers within the process of pregnancy and birth. Miscarriages, foetal abnormalities, and ailments such as cholestasis, hypertension, stillbirths, and maternal deaths - these are real threats which no one is suggesting are imaginary. However, the overemphasis of their occurrence, in a time and place where maternal and infant morbidity and mortality rates are so low, could be argued to be the politicization of
maternity care. While the hazards are real the argument can be made that both hazards and risks can be seen as cultural products. For example, what a health risk means to various audiences develops through the continuing and often changing representations of that risk in media content, as well as through other social and cultural practices. Risk knowledge results from the interplay between expert and lay discourses as well as media discourses. As Blood and Holland (2004) argue, the contestation of risk knowledge is a public battleground in which each stakeholder attempts to persuade others of the validity of their interpretation of a given risk. Yet as Beck (1992) argues, it is only the culturally recognized stakeholder’s approach to risk that is seen as the valid one. However, these multiple meanings of risk, he continues, can be managed through situated negotiation among an individual’s values and experiences.

It would seem that these themes of risk and body management, highlighted by Beck and Giddens respectively, are crucial concepts in exploring women’s experiences of pregnancy and childbirth. The following section of the thesis attempts to understand the above mentioned processes of negotiation by the respondents of this study by initially exploring narratives of risk and self-surveillance within the most cited pregnancy text of this research, as the background against which women manage their pregnant and birthing bodies. The pregnant woman, it has been argued, is more sensitive to notions of risk. For she is no longer a single body, but one harbouring the potentiality of another human being. Indeed, the active management of the pregnant body is one with which we are all familiar, as these bodies are represented as ones that need to be carefully managed, not only by themselves but also by the medical expert. As previously argued, those who do not partake in this personal care and self-
surveillance are often accused of acting irresponsibly (Lupton, 1999b). This seems to be even more so in the case of the visibly pregnant woman, as it is quite difficult for her to avoid the fascinated scrutinizing gaze of the public. The more obviously pregnant a woman becomes, the more she is rendered the subject of others’ appraisals and advice. As Lupton (1999b: 64) states:

Risk is a central discourse among those that surround the pregnant woman. Much of the appraisal and advice she receives is directed at containing risks, both those threatening her own health, but even more intensely, those threatening the wellbeing of the foetus that she carries.

This was found to be the case amongst many of the respondents of this study. One section of the interview was dedicated to how the respondent felt about being pregnant. Questions relating to the experiences of being pregnant, from bodily changes to the publics’ interaction with her were asked. It was quite common for the respondents of the study to express feelings of being ‘public property’. As Heidi pointed out:

There is no other time when a complete stranger feels that he or she has the right to come and touch your stomach or to tell you to stand up so they can tell you if you are having a boy or a girl. Sometimes I was happy for it to happen, but other times I just felt invaded. It’s funny because I am guilty of doing it now. It used to annoy me at times, but now if I see someone that is pregnant the least I will do is smile and sometimes I will start a conversation. Pregnant women are just so beautiful you know.

Gabrielle expressed similar sentiments and mirrors Lupton’s comments on advice being directed at containing risks:

I hated being pregnant. There is really nothing less sexy in the world. And I hated how invasive people were about the whole thing. Once I was at a dinner party. The people who were throwing it always have such great wine; I was over my morning sickness so I was up to having a mouthful. Not only did I not have a wine glass set next to my plate but when I took a sip of my husbands wine this colleague of my husband’s came up to me to lecture me on why I shouldn’t drink whilst being pregnant. I was not impressed.
Reading Pregnancy

She didn’t feel pregnant yet, not really. She read about the feelings she might have at this stage. She might, she read, have increased sensuality. She looked that up in Darren’s dictionary and that wasn’t how she felt at all. She might feel like she was in love: no way. She might feel great excitement — no.

She was sitting between Jimmy Sr. and Veronica a few days after she’d told them the news.

-What’s perception? Sharon asked.

-Sweat, Jimmy Sr. told her. Why?

-It says my perception might be heightened when I’m pregnant.

-What’s the buke about?

-Pregnancy.

-Jaysis, d’yeh need a buke to be pregnant these days?

She struggled through her book. She read forwards into the weeks ahead. Parts of it terrified her.

So much could go wrong. Even when it was okay there seemed to be nothing but secretions and backache and constipation. And she’d thought there was no more to it than getting bigger and then having it and maybe puking a few times along the way. (Doyle¹, 1990 cited in Gardner, 1995: 30)

Pregnancy and childbirth are mainly taken care of by the medical system. Indeed, many feel that the only ‘natural’ place to give birth is within the hospital system. As reflected by one of my respondents when asked how she would have felt if she had not made it to the hospital in time to give birth:

Do you mean give birth at home? No, I definitely would have made it to the hospital in time. You give birth in the hospital not in your home where you can have so many germs and you don’t have the necessary technology if something happens to you or your baby. It would have been totally irresponsible of me not to be at the hospital in time. (Joanna)

This response was quite common amongst my private birth mothers. Indeed, recent statistics demonstrate that just over 97% of Australian women birth within the hospital system, with 2.2% birthing in a birth centre environment and 0.3% birthing at home (Laws & Sullivan, 2004: 11). These statistics are identical to the previous
Australian Institute of Health and Welfare release of *Australia’s Mothers and Babies 2000*, demonstrating a consistent trend documented in the last 4 publications.

Yet at the same time, health care undertaken during pregnancy is also identified outside of the institution of the hospital and medical bureaucracies and found within various other settings such as private prenatal classes and pregnancy yoga. The maintenance of one’s health during pregnancy and for many prior to conception involves the consumption of a range of goods and services which are being increasingly advertised for their health-giving properties, such as specific foods to eat and others to avoid, vitamins and supplements used to avoid disorders such as spina bifida and exercise classes promoted to ease the discomforts of pregnancy but also to prepare the woman’s body to birth in a more efficient and enjoyable manner. The list of consumer products aimed at and available to the expectant woman and couple would not be complete without self help literature aimed at guiding her through the hazardous terrains of pregnancy and childbirth. The following section will underline how various texts on pregnancy and childbirth, but especially *What to Expect When you are Expecting* (Murkoff et al., 2003), are emblematic of contemporary approaches to health care as well as the risk society. It will be argued that contemporary handbooks for the expectant woman make it clear that responsibility for a good pregnancy and production of a normal infant remains with the mother, with many tending to highlight the most extreme views on the risks that face the expectant woman and her unborn child.
The increased emphasis on the responsibility of the mother to be has been evidenced throughout the thesis. There is little room for negotiation; the pregnant and birthing woman must be seen to do the right thing. But exactly what actions one must undertake to be seen to be doing the right thing? From the voices of the respondents, as seen within Chapter four, five and six, it seems that this involves issues of self-surveillance, exertion of control over one’s own body, the seeking out of expert advice as well as to subscribe to it and of course the practice of self sacrifice for the sake of her unborn child. This was practiced by all respondents regardless of their approach to pregnancy and childbirth practices. It became apparent through the various birth narratives of the respondents that the key differences lay with the definition of these terms, such as who is exactly viewed as the expert.

The seeking out of expert advice is one avenue worth pursuing. As Carol Brooks Gardner states: “[p]art of the way in which women can “train” themselves to be pregnant is to seek and absorb the knowledge of experts, especially experts in print” (1995: 31).

What to Fear When you are Expecting

I was pregnant, which about one day out of three made me the happiest woman in the world. And for the remaining two, the most worried. Worried about the wine I’d sipped nightly with dinner, and the gin and tonics I’d downed more than a few times before dinner in my first six weeks of pregnancy – after two gynaecologists and a blood test convinced me that I wasn’t pregnant. […] Worried about the coffee I’d drunk, and the milk I hadn’t; the sugar I’d eaten, and the protein I hadn’t. Worried about the cramps in my third month, and the four days in my fifth month when I felt not even a flicker of fetal movement. […] Worried, even about feeling good “But I’m not constipated…I don’t have morning sickness…I’m not urinating more frequently – something must be wrong!” (Murkoff et al., 2003: xxvi; emphasis in original)
The above quote derives from the most widely referred to pregnancy and childbirth texts for not only my respondents but also within Western society. Indeed *What to Expect When you are Expecting*, initially printed in 1982, has recently been revised into a third edition. It has been translated into 11 languages and it is advertised as selling over 11 million copies. Every one of my respondents mentioned this book. Over 90% of my private birth mothers and 75% of my birth center mothers stated that they used this as their major reference point, above and beyond that of friends and family and often obstetricians themselves, although it can be stated that this was due to the short duration of their checkups. As we saw in the previous chapter, many private birth mothers felt there wasn’t the time to ask questions or they quite often felt that they were not in a position to ask.

The excerpt is the voice of Heidi Murkoff, who just as most of my private birth mothers, was consumed with concerns during the pregnancy of her first child. Concerns she felt unable to voice to her doctor as she “was either afraid [her] worries would sound silly or afraid of what [she] would hear” (2003: xxvi). What she found in her quest for expert advice through various texts was that firstly, according to her there was no sufficient advice in the books that she had, and secondly, she was not alone in her concerns. Murkoff found that worry is one of the most common ailments of pregnancy “affecting more expectant women than morning sickness and food cravings combined.” According to her research, “ninety four out of every hundred women worry about whether their babies will be normal, and 93% worry about whether they and their babies will come through delivery safely” (2003: xxvi).
Accordingly, Murkoff and her colleagues created the book to address all of these normal concerns about the risks that the pregnant woman and her unborn child face. In fact, one chapter is dedicated solely to the risks that the pregnant woman is confronted with on a daily basis throughout her pregnancy. According to Murkoff et al. (2003) once a woman has her pregnancy confirmed she may be concerned by issues such as alcohol consumption, direct or passive cigarette smoking, marijuana use, caffeine and herbal tea consumption, the use of sugar substitutes, the family cat, participating in sports, the use of hot tubs and saunas, microwave exposure, the use of electric blankets and heating pads, the impact of mobile phones and x rays, household hazards, air pollution, occupational and occupational hazards. It is apparent just from this example, that the book’s portrayal of the unborn child is one which is infused with endangerment and its portrayal of the mother to be is one who needs to be aware and responsible.

This mirrors contemporary approaches to health care where there is a privatization of risk management. As argued within Chapter four the risk society and neo-liberalism calls for the individual to act ‘responsibly’. For the pregnant woman responsibility is emphasised and she is obligated to “bring the future into the present” (Rose, 1996: 57). To accomplish this she must be educated in a manner which enables her to calculate the future consequences of her actions, such as her diet and exercise routine. As Rose argues, “the active citizen thus is to include within his or her obligations the need to adopt a calculative prudent personal relation to fate now conceived in terms of calculable dangers and avertable risks” (1996: 58).
The following section of this chapter analyses the self-help literature of pregnancy and childbirth in relation to the risk society thesis. Notions of reflexivity and individualization are central to the employment of such self-help literature. Indeed, Giddens has described self-help books as “a kind of on-the-ground literature of our reflexive engagement with our everyday lives” (Giddens & Pierson, 1998: 141). Accordingly, the following section will highlight the underlying factors on how What to Expect When You are Expecting is symbolic of contemporary approaches to healthcare as well as the risk society thesis in a number of ways.

First of all, although they are not meant for the public at large, it can be argued that pregnancy and childbirth mainstream literature can appeal to a large proportion of the population, if not directly, often indirectly as a friend or family member who acts as a support person for the expectant woman. Perusing the bookshelves at a major inner city bookstore, one is struck by the sheer number of books on maintaining health, and specifically for this research, on guiding the expectant couple through pregnancy and childbirth. Taking into consideration the above mentioned sales records and stated use from the respondents of this study, it is obvious the public is eager to engage with these issues. It seems that the existence of not only the books themselves but also the diversity and quantity highlights the need to have a book which informs one on how to be pregnant. As Carol Brooks Gardner (1995) argues popular magazines and self help literature relating to pregnancy and childbirth are informative but also recursive. There is a need for this form of literature to justify its own existence by demonstrating that there is a wealth of information and advice available which a woman is unlikely to know. However, as has been argued, the pregnant woman
needs to acquire this valuable information to enable her to safeguard the health of herself and her unborn child.

Secondly, the information of *What to Expect When You are Expecting* is set out in a manner where the readers can make their own choices and tailor the various information supplied to their specific needs. The 450 page book is presented in 5 sections and incorporates a comprehensive index. “In the Beginning”, the first of the 5 sections, covers, amongst others, issues such as “Are you Pregnant?”, “Choosing (and Working with) Your Practitioner”, the “Pregnancy Diet” and a sub-section entitled “About Prenatal Diagnosis”. The second section provides month-by-month descriptions of the various physical and emotional changes the woman can expect during this time period. “Nine Months and Counting: From Conception to Delivery” opens each chapter with “What you may be concerned about” as well as “What You can Expect at this Month’s Checkup” providing information on the tests and examination a woman should expect. The third section involves problems faced by the postpartum mother. Issues such as recovery from a caesarean section, excessive bleeding, fever, baby blues and depression as well as issues of getting back into shape, breastfeeding basics and the concerns a new father may have are covered. “Of Special Concern” is the title of the fourth section. This covers topics such as getting sick during pregnancy, coping with a chronic condition, living with a high-risk pregnancy, pregnancy complications such as miscarriages and ectopic pregnancies as well as more uncommon pregnancy complications such as molar pregnancies and knots and tangles in the cord. The final section discusses preparation for the next baby. Here there is an emphasis placed on preconception care for both the mother and the father where the authors are suggesting to ‘plan ahead’ so that your good
planning and pre pregnancy care will “benefit not only your own children but your children’s children” (2003: 530).

The readers are encouraged to tailor the information for their own needs and desires. For example, in relation to the form of care that one wants to undertake during their pregnancy and childbirth various information is provided, emphasising a language of choice, personal preference and women’s control over her experiences of pregnancy. The information is presented in such a manner that the woman can tailor it to her own needs. Yet, although these books advocate notions of choice and control they simultaneously promote extreme self-monitoring that increases notions of risk and anxiety which in turn supports a compliance with medical regimes of maternity care. For instance, when providing information on the various choices of maternity care that are available for the pregnant women, Murkoff et al. ask “What Kind of Patient are You” (2003: 9). The labelling of the pregnant woman as a ‘patient’ infers that pregnancy is an illness in need of medical attention. Regardless of the emphasis of choice presented by the authors where “there are almost as many choices in childbirth – yours for the choosing – as there are doctors in the yellow pages” (2003: 9) there is a clear bias towards medical authority for the ‘illness’ of pregnancy and childbirth. When presenting the different forms of care available for Australian women it was private care which was promoted as the “option that provides the most freedom of choice” where “you’ll be able to select the caregiver of your choice and the hospital or birth centre in which you will deliver” (2003: 11). This is contrary to recent research carried out within Australia which indicates that it is the women who choose
private care that end up with the highest intervention rate, including caesarean sections (Roberts et al. 2000).

Thirdly, although there is an emphasis on medical and technological intervention there is considerable attention placed on the expectant couples’ ‘lifestyle’. The emphasis of the inescapability of the risks associated with pregnancy, especially risks that the unborn child faces, is placed firmly within the body, history and activities of the pregnant woman (Georges & Mitchell, 2000). Accordingly, recommendations about lifestyle changes are prevalent in this text, for example the authors dedicate a chapter to what they call the ‘Best Odds Diet’. Consider the following excerpt:

**Every bite counts.** You’ve got nine months of meals and snacks with which to give your baby the best possible start in life. Try to make them count. As you raise fork to mouth, consider: “Is this a bite that will benefit my baby?” If it is, chew away. If it isn’t, see if you can’t find a bite more worthy. Though most bites should count for good nutrition, some can – and should – count for pure pleasure. If a food you’ve chosen doesn’t measure up nutritionally, it should at least be one you truly enjoy. (Murkoff et al., 2003: 82; emphasis in original)

According to this book, self-surveillance, control and self-sacrifice are central components of the responsible mother, who is interested in doing the best thing for her unborn child. The expectant mother must be constantly aware of dangers that lurk in her presence, dangers which in other contexts are seen as benign. For as Beck states: “Calculating and managing risks which nobody really knows has become one of our main preoccupations” (1998:12). As demonstrated within Chapter five, the sense of managing risks through changes in lifestyle was a widespread response among my interviewees.
There is a clear emphasis on responsibility and self-monitoring placed upon the mother to be. The inescapability of the woman’s new found role is accentuated by the particular depiction of the foetus. As seen above, this particular book emphasises the fragility of the unborn child where it is presented as highly vulnerable and susceptible to many threats. It also emphasises the preciousness or special place the unborn child holds, often above that of the mother. For instance, at the opening of each chapter within section two, Murkoff et al. provide a drawing entitled “What You May Look Like”. Here the pregnant woman is portrayed as a headless transparent being who contains a vagina, bladder, spine, uterus and foetus. Below this representation of the pregnant woman is a further enlarged depiction of the foetus accompanied by a paragraph or two emphasising its individuality and subjectivity. For instance:

As muscles strengthen, nerve networks expand, and the skeleton continues to harden, the fetus is much more active and coordinated – capable of numerous gymnastic feats (including somersaults) that help baby grow and develop motor skills. These movements are also – finally!- strong enough for you to feel. Ears are well developed now, and can start to recognise sound; baby also has regular periods of wakefulness and sleep, and can make a variety of faces, including frowns and grimaces. (Murkoff et al, 2003: 199)

The woman has been reduced to a mere baby container and the foetus has been elevated to a distinct being in need of protection.

A further example of the book’s representation of the central tenets of current approaches to health care and risk society is the care in expressing the ‘expert’ status of all authors involved. As pregnancy and childbirth are predominately viewed as a medical event, information and recommendations to the expectant mother or couple often comes in the form of scientific news. As previously argued, information about pregnancy and childbirth presented in scientific discourse projects objectivity. In
What to Expect When You are Expecting there is an emphasis on the authors being experts as ‘consumers’ of maternity care. If we were to doubt a consumer’s ability to provide scientific and objective fact, we are quickly put at ease by the foreword which is entitled “A Word from the Doctor”. In the most recent edition of the publication “Another Word from the Doctor” has been added as well as an Australian foreword which is written by a practicing obstetrician and senior lecturer of the University of Melbourne. Both doctors highlight the preciousness of the foetus as well as the need to protect this precious life the expectant couple are bringing into the world. For instance, Richard Aubry, M.D. argues that there is a “fundamental importance of healthy childbearing to the health and vitality of society. These precious new lives, when nurtured by loving parents, become healthy, contributing members of a new generation.” He continues by stating “[t]here is no book that better prepares parents for that important job of nurturing those young lives – a job that begins even before sperm meets egg – than What to Expect When You’re Expecting” (2003: xix).

A presentation of two experts in the medical field, one in the United States and one in Australia, supporting the information within the book implies all ‘suggestions’ will be objective and based on scientific knowledge. This highlights a difference in what is perceived as scientific knowledge. This can be counter posed to the other often cited pregnancy and childbirth book Up the Duff (1999). The Australian author fully acknowledges within her introduction her lack of ‘expert status’ beyond her experiential status. It is relevant to add that throughout the book Kaz Cooke provides not only literary sources for ‘expert’ advice but also specific services provided by health professionals throughout Australia.
Finally, this text holds the assumption that it is possible for the pregnant woman to be in control over not only her health during pregnancy and the kind or ‘style’ of birth that she will have, but it also highlights the possibility of controlling the destiny of her unborn child. For example, when promoting “The Pregnancy Diet” Murkoff et al. emphasise that a proper diet can give your baby not only the “healthiest possible start to life” but also “make it more likely that your child will grow to be a healthier adult” (2003: 81).

Texts such as this emphasize the very important shift in the meaning of ‘responsibility’ living within a risk society. It is a further demonstration of the process of individualization that Beck (1994) argues exists within a risk society. Where:

‘[i]ndividualization’ consists in transforming human ‘identity’ from a ‘given’ into a ‘task’ – and charging the actors with the responsibility for performing that task and for the consequences (also the side-effects) of their performance. (Bauman, 2002: xv)

Therefore, there is a shift in responsibility away from the primary caregiver, whether that is the obstetrician or midwife, toward the individual. Constantly the expectant couple are reminded that they are the ones who are best able to effect change to make the pregnancy, labour and health of the unborn child ‘better’ (Nettleton, 1997).
Conclusion

Joost van Loon (2000) highlights how risks cannot be understood outside their materialization in particular mediation, be it scientific, political, economic or popular. He highlights how the invisible risk becomes visible to the consumer, with the end result being responsibility. It can be seen that the ‘becoming real’ of all of the ‘risks’ associated with pregnancy and childbirth for the infant and mother is directly related to its mediation. Now that ‘we’ know that there are possible risks, ‘we’ face a responsibility. This responsibility takes the form of a decision whether, for example, to eat deep-sea fish, soft serve ice cream or deli meats, or refrain. Therefore, for example, mercury poisoning is no longer a hazard for the pregnant woman, as there has been a direct link between deep-sea fish and high levels of mercury and miscarriages. Mercury poisoning has become a risk.

The women from my research felt they had many decisions to make in relation to all of the aspects of their pregnancy and the impending birth of their child. The accessibility of the knowledge of the various risks that they faced during their pregnancy and birth opened up not only more spheres of action on their part, but also created new types of risks as well. This knowledge transformed the potential hazards into risks. The expectant woman now has decisions to make with consequences for not only herself but also that of her unborn child.

We are living in a society where more and better knowledge, which most people assess in unreservedly positive terms, is becoming the source of new risks (Beck, 2000). Because we know more about how the body operates during pregnancy and
childbirth as well as how the foetus develops we create not only more spheres of action and creation of risks as discussed above, but also more spheres of responsibility.
CONCLUSION

Are the hopes, anxieties, risk and uncertainties of today’s Western mothers merely a carbon copy of previous eras? Are their fears and anxieties different to those women who were the subjects of the 17th century pregnancy portraits discussed in the opening section of the Introduction? Gheeraerts’ clients were apparently so fearful of death during childbirth that they created a literary parallel of their portraits in the form of ‘legacy letters’ for their unborn child (Kennedy, 2002). As discussed the possibility of death during childbirth, during this time period, was embedded within the reality that the statistics for death in childbirth were approximately one in a hundred women. This is in stark contrast to the reality faced by the respondents of this study where Australian mortality rates are approximately 13 per 100,000 confinements (Madden, 2003). Yet, fear and anxiety of death during pregnancy and childbirth has become prominent to the extent that it has been termed to be a phobic state labelled tokophobia (Hofberg & Brockington, 2000).

This thesis has empirically examined the consequences of residing within a risk society upon Western mothers and their subjectivities. It has explored the aspect of the social construction of risk relating to pregnancy and childbirth where the emphasis of certain kinds of risks not only allocates responsibility but also supports certain public moral judgements.

Accordingly, the risks faced by the childbearing women of Western society, and also for the general population, are not as clear cut as previous generations. The
calculable risk has been replaced by the risk which is “dissolved in the minute, yet innumerable, traps and ambushes of daily life” (Bauman, 1998: 65). Risks have pervaded our everyday consciousness and have left us far more sensitive, than our 17th century counterparts, in what we define as ‘risks’.

This relationship to risks has been demonstrated to actively shape the relationship that the childbearing women of this study have toward the concepts of health, desire for perfection and their relationship to control, technology and responsibility. As demonstrated within Chapter one, it is these themes which are noticeably absent from previous research in the area of sociology of childbirth and which provide insight into the agency of women who seek medical intervention during pregnancy and childbirth.

 Acknowledging that risks are a social construction, it has also been recognized that there are some intrinsic dangers within the process of pregnancy and birth. Miscarriages, placenta previa, stillbirths, and maternal deaths are real threats, which no one is suggesting are imaginary. However, the overemphasis of their occurrence, found for example in the media and popular lay texts such as Murkoff et al.’s (2003) *What to Expect When You Are Expecting*, in a time and place where maternal and infant morbidity and mortality rates are so low, could be argued to be the politicization of maternity care.

Reports on maternal deaths through the National Health and Medical Research Council (NHMRC, 2001) attest to the reality of these hazards. However, the argument can be made that hazards and risks can be seen as cultural products. For
example, the risk of alcohol consumption to a developing foetus means different things to different audiences. Moderate drinking during pregnancy within France is socially acceptable, whilst countries such as the US, Canada and Australia advocate abstinence (Maley, 2005). Accordingly, what health risks actually mean is developed through the continuing and often changing representations of that risk in media content, such as the continual link of alcohol consumption to foetal disorders such as attention deficit hyperactivity disorder, nervous system damage, neurological impairment, low birth weight or the extreme case of foetal alcohol syndrome.

As discussed throughout the thesis, risk knowledge results from the interplay between expert and lay discourses as well as media discourses. Yet as demonstrated within Chapter two and Chapter four, it is only the culturally recognized stakeholder whose approach to risk is seen as the valid one. The status and social credibility of the medical profession allows their approach to and definition of the processes of pregnancy and childbirth to be the culturally dominant one. Accordingly, the medical view of pregnancy and birth as potential pathology, in which something could go wrong at any time is a dominant and accepted model in most Western societies.

This leaves the conceiving or pregnant couple faced with multifaceted risks, which has been argued, are in a permanent state of virtuality. It makes no difference then whether they are actually or objectively ‘safe’; if the risks are anticipated then they call for the couple or the woman to respond. This was demonstrated throughout Chapters five, six and seven where respondents spoke about their fears and anxieties relating to their pregnancy and birth and the activities they undertook to counteract
them. The respondents of this study spoke about experiences where they actively avoided situations they viewed as risky. For example, Tina not only avoided certain foods and drinks but also avoided any undue stress as well as interaction with possible contagions such as toxoplasmosis from her friend’s cat. This form of activity was followed throughout many of the respondent’s pregnancies and birth where they subjected themselves to medical tests and invasive procedures in an attempt to ‘control’ the ‘out of control’ event.

As Beck (1992) has argued, the statistical probability of a particular event occurring may be less important than its “catastrophic potential” (29). Indeed, what expectant mother disregards the possible threats, hazards and risk that are constantly highlighted as a threat to not only herself but that of her unborn child? All of the respondents of this research identified these possible threats, and spoke about the need for a healthy diet, the need to avoid substances such as caffeine and alcohol. This awareness, at times, began prior to conceiving. For example, Jennifer, a private birth mother, felt that:

In planning this pregnancy I knew that I wanted to be as healthy as I could be before conception, so we had a lead up time of about three or four months, before we actually started trying. There was a three or four month period where we knew, okay we’re going to have to be really careful with everything we come into contact with.

What is of interest is that all of the respondents discussed pregnancy and birthing practices through a risk discourse. Prior to beginning the field work of this research, there was an assumption on the part of the researcher that there would be a marked difference between the narratives of the private and homebirth mothers with the birth centre mothers falling somewhere in between. Indeed, there was an expressed difference in the trust they had in their body, with the homebirth mothers displaying a
much stronger trust. As we saw in the case study of Natalie within Chapter five, the homebirth mothers also displayed different approaches toward responsibility and the need to have autonomy over their pregnancy and birthing experiences. However, the similarity was found in the discourse of risk which surrounded the event. For some, their fears and anxieties were allayed by medical supervision. For the home birth respondents, medical supervision was often portrayed as the risk. This was succinctly expressed by Hope in the following manner:

The thought of giving birth in a hospital scares me because I don’t think, there’s a whole lot of reasons, but first of all, you’re not sick, and a hospital is a place for sick people, and there’s sick people in hospital. I’ve also read way too much about things that happened to babies and mothers in hospitals. I don’t cope with labour well, I’m a real whinger, I beg for, if there were drugs anywhere near by I’d have given them to myself. I don’t think I could have a natural birth in hospital because the proximity of people who are willing to offer me pain relief and stuff is too tempting. I need to be somewhere where it’s not even available. I know people who have beautiful births in hospital but I don’t know if I could. Basically, I know that when I am in the middle of giving birth, the things they would say to me would make me scared. They would make me feel like I needed to have the things they would say I needed. Does that make sense?

Regardless of their choice in primary carer and birthing environment, all respondents approached their pregnancy and birth as one that needed to be constantly monitored to avoid the potentiality of a virtual risk. All of the respondents of this study felt that their approach to pregnancy and childbirth, in the face of the multitude of threats that they were facing, was the most responsible course of action.

Accordingly, the social construction of pregnancy and childbirth as inherently risky has led many of the respondents to express fear and anxiety in relation to the event. On one level, this can be seen to be irrational as statistics reveal low morbidity and mortality rates for both the woman and her child. However, these women’s responses are eminently rational given the risk discourse of both medicine as a social institution and broader society in general. The fears and anxieties expressed by all of the
respondents of this study are only explicable and rational within this context. These findings help to explain the agency of women who actively engage with a medicalised pregnancy and childbirth.

It has been argued that the accessibility of the knowledge of the various risks that the respondents faced during their pregnancy and birth opened up not only more spheres of action on their part, but also created new types of risks as well. It was found that the women of this research had decisions to make with consequences for not only themself but also that of their unborn child, decisions that hold a moral accountability. Furthermore, moral accountability is not merely a function of the magnitude of the risk but also of the value of that put at risk. As argued, the events of pregnancy and childbirth are socially constructed as ‘special’ with children accorded the label of ‘cherished beings’ (Tsing, 1990; Beck-Gernsheim, 1996; Jackson & Scott, 1999). Accordingly, two main themes have emerged throughout this thesis, first, there is the different types of knowledge which inform perceptions of risk, and secondly, the moral dimension and according responsibility to these risks.

Therefore, it can be seen that reflexive modernity’s emphasis on rationality and scientific knowledges, or the supervaluation of the technocratic over nature, establishes humans as subjects of a multiple systems of knowledge which impinge upon all aspects of life. Beck’s (1992) risk society can be seen as one in which people live according to a sense of all-pervading risk: accordingly, for example health promotion in relation to pregnancy and childbirth suggests that any action or practice may possess inherent risks to health or well being (Petersen, 1997). For the pregnant
woman, a demonstration of her ability to look after herself and her unborn child does not only denote responsibility, it is also indicative of her moral worth (Petersen, 1994). As we have seen the woman who does not fall prey to the technological moralization of the current dominant maternity care practices is seen as immoral or a ‘monster mother’.
APPENDIX I

INTERVIEW SCHEDULE

Occupation of woman and that of her partner/ husband.

How long the couple has been together.

How did you know you were pregnant? How did you feel when you first found out? What did you do then?

Tell me about the experience of being pregnant. Did you like being pregnant? How did you feel about the changes in your body? How were you treated by others? Any differently than usual? How did you feel about that? What did you do about being pregnant (alter diet? Read books? Stop drinking or smoking etc. How did you feel about that?)

What sort of prenatal care do you have? What do you think/ how do you feel about it? How did you select your obstetrician or midwife? What sort of relationship do you have? Have you had any interactions with your obstetrician or midwife that you feel are significant?

What were your expectations of pregnancy? Were they fulfilled? Why or why not?

Did you take prenatal classes? Why or why not? Where? What kind? What did they teach you? What did they do for you? Did they make a difference to your birthing experience?)

What were your expectations for the birth? What did you want/ hope/dream it would be like? What were you planning for? What did you actually think it would be like? Did you have any fears? Why/ why not/ of what?
Tell me about your labor and birth.

Just in case I get little response the following questions could be asked.

When did you go into labor? How did it feel? How did you feel about it? Who was with you? What did you do? How did you decide when to go to the hospital? Tell me about getting there. What happened when you got there? How did you feel about that? Etc.

How soon did you see the baby? For how long? How soon did you have care of him or her? Was that all right with you?

(When applicable) What do you think would have happened if you hadn’t had access to a hospital? How did you feel about being in a hospital? Why?

How do you feel about your birth experience?

How would you rate your overall birth experience - positive or negative? On a scale of 1-10?

What did you like best about the birth? Least? Is there anything about the birth that you wish had been different? Will you plan to do anything differently if you have another child?

Is there anything special you would like others to know about what you have learned about being pregnant and giving birth?

What do you believe birth will be like in the future?

The Interview Schedule was largely influenced by the work of Davis-Floyd (1992)
APPENDIX 2

ETHICS AND HIERARCHICAL ORGANIZATIONS

In this appendix I would like to outline some of the methodological and ethical issues that confront the fieldworker attempting to gather data on an event as sensitive and intimate as birth, and second, to include some stories of personal experiences in the field.

My research has been conducted within Australia, specifically within the suburbs of Sydney. As argued throughout the thesis, birth is considered a medicalised event within Sydney, an event which a woman finds difficult to manage without the technological and pharmacological resources of modern scientific obstetrics. My sociological approach and involvement with birth revolved around qualitative analysis. My approach, as outlined within Chapter three, centred around the woman’s birth narrative.

In this appendix, I would like to address what it was like for a woman sociologist to undertake research in the area of birth, a male dominated scientific cultural field. I have chosen to concentrate on the experience of entry into the field and the question of interference and the dilemmas that thereby arise for the researcher.

I first became interested in the area of sociology of childbirth as an undergraduate student. This interest, I believe, stemmed initially from my own personal experiences and those of my friends, but it soon took on a different level of interest as my studies
continued. With my interest first being “why is it that so many different women, who are all experiencing the very individual experience of giving birth, have very similar stories?” to the interest of culture specific management of a universal biological process, and in our case the medical management of birth. My interest was so intense that I in fact decided to shy away from the research altogether, hoping to avoid the pitfalls of bias as a researcher. During my honours year I concentrated on the field of sociology of religion. Yet the interest in the field of sociology of reproduction always remained. It was during a sociology conference that the spark was truly re-ignited. Listening to various papers brought my sociological imagination back into fine tune—that is in relation to childbirth issues, rather than what my task at hand was—namely my honours thesis. It was then I began to map out my research plan which I have undertaken for my PhD thesis.

Little did I know during that time the obstacles I would have to overcome to be able to actually begin my fieldwork. It was only after a thorough literature review and a pilot study that I realised that I wanted to have as my sample mothers soon after they gave birth. At the same time I came to the conclusion that there were three main types of hospitals available to the birthing woman, that of the private, the tertiary led and the midwifery led. Yet for reasons explained within the Methodology chapter of this thesis, it was decided that the areas for investigation were to be limited to the private and midwifery led hospitals and home birth mothers. It was obvious that since I desired to interview my respondents soon after they had given birth that I would need to approach a representative of each of the models.
I searched through various literature in hopes of finding advice on who to approach when one wishes to gain access to a hospital birth, all to no avail. Most research carried out did not speak about their methodological approach in relation to them gaining access to respondents. Overall they spoke about the snowball effect, or in relation to anthropological research— the obstacles of undertaking participant observation. So there I was with all of this research to do and not quite sure how to approach it. After establishing representatives of the three hospital models mentioned above I took the next logical step and completed an ethics application from my University. I then approached the two hospital environments and was directed to their Internal Ethics Committees. Finally I thought, all I have to do is complete the ethics and I am on my way.

I couldn’t have been more wrong. From that time I have encountered various entry problems. At times I was pleasantly surprised by the courtesy and professional cooperation I have encountered, at other times I was faced with the obstacle of such heavy gate keeping I eventually turned to another hospital. Overall the experience was one of a bureaucratic paper war, which often left me disheartened and exhausted. Rejections to my research stemmed mostly around a dismissive attitude towards qualitative research. In fact my interaction with one head of obstetrics led to his dismissal of my research based on my methodological approach not producing valid data. It seemed that most of the time I was facing a field which was inaccessible and very protective over its territory.
If I were to give advice when dealing with a hierarchical organisation such as a hospital it would be as follows: Start at the top. Before beginning your ethics application do your research, find out who is the head obstetrician and the senior midwife. Without their consent your ethics application is useless. You might find the head midwife is much more approachable to this form of research than the head of obstetrics. A qualitative study is not unfamiliar to a midwife, where obstetricians on the whole deal with quantitative research. There was on the whole a condescending and protective attitude from most heads of obstetrics that I had dealt with, with one actually stating “this should be very interesting, I wonder what women do want”. I should also state, prepare yourself for the time it takes to make the connections and to have the ethics application go through the proper channels. Overall it has taken me 1 and a half years to receive approval from the three of the four hospitals that I had approached.

Ethics clearance unfortunately is not the last obstacle to overcome. Each hospital has its own system when dealing with external research, especially I have found of the qualitative form. In many instances I was not able to make contact with women, except in the form of my information sheets and later information posters. Without the benefit of introducing myself to these women I remained a faceless researcher whose only appeal lay with the interest of topic. So one must keep in mind the time it can take to undertake research of this kind.
Hi, my name is Alphia Possamai-Inesedy. I am undertaking research at the University of Western Sydney in the area of sociology of reproduction.

My research centres on the choices women make during pregnancy and childbirth.

If you would like to share your thoughts and feelings, in the form of an interview, about this very important time in your life, please see the Information and Consent Sheets that are provided for you.

Thank you

This research has been approved by both the UWS. Feel free to contact me on 9772-6628 or A.Garrety@uws.edu.au if you have any questions or would like to participate.
Hi my name is Alphia Possamai-Inesedy. I am undertaking research at the University of Western Sydney in the area of sociology of reproduction.

My research centres on the choices women make during pregnancy and childbirth.

If you would like to share your thoughts and feelings, in the form of an interview, please see the Information and Consent Sheets that are provided for you.

Thank you

This research has been approved by UWS Ethics Committee. Please contact me on A.Garrety@uws.edu.au or 9772-6628 if you have any questions or would like to participate.
NOTES

Preface

1 This statistic is based on the Health Department of Victoria’s report *Having a baby in Victoria. Final Report of the Ministerial Review of Birthing Services in Victoria* (Lumley et al., 1990).

Introduction

1 A specific anxiety or fear of death during parturition preceding pregnancy. The fear becomes so intense that childbirth (*tokos*) is avoided whenever possible, even despite the desire to have a child. This phobic state has been termed tokophobia (Hofberg & Brockington, 2000).

2 Please see Chapter one and two for a demonstration of this.

Chapter 1: The Current Crisis in Childbirth within Australia

1 Maternal mortality as defined by the World Health Organization (WHO) is the death of a woman while pregnant or within 42 days of the termination of the pregnancy, irrespective of the duration or the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management. This definition includes deaths of women from terminations of pregnancy, spontaneous abortion, miscarriage and ectopic pregnancy. Excluded are deaths from assisted reproductive technologies where pregnancy has not occurred (1999).

2 However they did state that the leading causes of direct maternal deaths were found to be pulmonary embolism (8), amniotic fluid embolism (8) and pre-eclampsia (7).


4 In reviewing the outcomes for birth it is worthwhile looking at the rates for induction. For it can be argued that induction can be seen as the starting point for a cascade of intervention that can end with an instrumental or caesarean birth. Within N.S.W. the rate of spontaneous onset of labour with no further intervention varies between 18.4% at Kareena Private Hospital to 66.6% at Broken Hill Base Hospital (where they have caseload midwifery). Amongst the big city teaching hospitals, the rates are 51.5% at King George V (now the Royal Prince Alfred Women and Babies Unit), 44.7% at Royal North Shore, 45.1% at The Royal Hospital for Women and 50.5% at Westmead. Once labour starts, many women are then augmented with either ARM or oxytocics, but again there are wide variations: 13.5% augmented at King George V, 17.1% at Royal North Shore, 21% at Royal Hospital for Women and 18.7% at Westmead. Kareena Private augments 17.1% and Broken Hill Base 11.6%.

5 For example, a recent report disclosed that an obstetricians indemnity bill has recently shot up from $35,000 to $58,000 in one year (Wroe, 2002).

6 Place here the abundance of literature on the difficulties of homebirths and also VBACs which are fast becoming illegal.

7 This is a new category created by Declercq, Menacker and MacDorman for the purpose of their 2004 study on a rise in primary caesareans. No indicated risk denotes mothers with singleton, full term, vertex presentation births who were not reported to have any medical risk factors and for whom no complications of labour or delivery were listed on the birth certificate.
"Discovery Health describes its programs in the following way: “Health is aimed squarely at women, to satisfy their desire to make their lives better – to be fully in charge of their own and their family’s health and well-being, in every way – spiritual and emotional, as well as mental and physical” (http://www.foxtel.com.au/channel/channel_3936.html).

Chapter 2: The Emergence and Maintenance of a Risk Society within Australian Maternity Services

1 This resulted in the halving of the births attended by midwives in the decade following 1923 (Willis, 1983: 113).

2 The oxygen monitor, developed to measure the amount of oxygen in the fetus’ blood stream in an attempt to reduce CS, was recently tested in Sydney, Brisbane, and Melbourne with 600 women in a world first trial (Ryan, 2002).

3 Adverse events were counted if they occurred and were discovered in the index admission or if they occurred before the index admission but were first discovered during it. While adverse events which occurred in the index admission but were not discovered until after discharge were recorded, they were not included when calculating the frequency of adverse events.

4 3.7% of hospital stays involved an adverse event; 1.0% of discharges (or 27.6% of adverse events) involved negligence; and most adverse events resulted in minimal impairment; 56.8% of patients recovered completely in one month, 13.7% recovered in under six months, and 2.8% had no permanent impairment but took longer than six months to recover. Permanent impairment with less than 50% disability occurred in 3.9% of adverse events, permanent total disability in 2.6% and death in 13.6%. Disability could not be judged in 6.6%.

5 HIH possessed 20% of the professional indemnity market. Until late 1999 it provided reinsurance for UMP. Insurance companies shift about a quarter of their risk by taking out their own insurance policies with other companies known as reinsurers. In the case of professional indemnity policies there is about 40% that is reinsured.

6 St Paul, the world’s largest medical malpractice insurer and the underwriter for UMP states that all policies are to expire on June 30th, 2002. The US based company said its medical indemnity business was headed for an underwriting loss of almost $US1 billion.

7 FPA Health provided reproductive and sexual health services for more than 66,000 people. It contained 154 staff including 80 employed directly in clinical services. The clinical services provided by FPA were funded by the Commonwealth.

8 Of the 1162 specialists practising obstetrics and gynaecology around the country, less than half practice obstetrics and only 300 are in private practice only. Already, 150 specialists have quit private practice in the past three years, and 55 said they intended to stop private practice in 2003. Over the next five years another 150 will cease practice. While medical indemnity was not nominated as the main reason for leaving the profession, 10% of those surveyed reported paying premiums of more than $98,000 in 2001-2002.

Chapter 3: Methodology

1 Please see Appendix 2 for an overview of some issues that were raised working with Hospitals and gaining ethics clearance. Appendix 3 contains the information sheet, consent sheet and posters.

2 All fieldwork was given clearance by the University of Western Sydney’s Internal Ethics Committee.

3 The homebirth field is placed within this context by the fact that expenses related to a homebirth including the independent midwife fee is not reimbursed by Medicare nor most of the private health insurance coverage. In fact, Medibank, which is the largest carrier of health insurance, does not provide any form of rebate for the cost of a private practicing midwife. Covers such as Australian unity, NRMA, SGIC, NSW teachers health insurance fund, provide $500 for the cost of a private midwife in a hospital birth setting. Reimbursements for homebirth settings within NSW, it seems, is
non-existent. However, HBF within WA will provide a $1400 reimbursement for a homebirth, although the Western Australian government supports the practice of homebirth through various initiatives. Whilst enquiring about the possibility of reimbursement one fund informed me that it was not possible as “it’s a lesser level of care than you would receive in hospital to have a home birth”. Exploration of the costs involved reveals expenditures upward of $2000.

4 For the sake of anonymity all names have been changed.

5 The initial aim was to interview 15 respondents from each birth setting. However, it was very difficult attaining respondents from the homebirth and birth centre setting. In regards to the homebirth mothers, it was difficult because of the small population that exists within NSW. In relation to the birth centre mothers this was most likely the case because of the lack of awareness of the research. The private hospital placed my information sheets within information all patients receive when booking into the hospital. The birth centre placed my information sheets as well as my posters only within the waiting room.

6 In the case that the respondent had more than one child the interview was primarily concerned with the last birth and the setting of that birth. However, previous pregnancies and births were discussed as they often had an impact on the choices of care and birth environment of future births.

7 Please go to Appendix 1 for a detailed interview schedule.

Chapter 4: The Exploration of the Risk Society Thesis

1 Beck states quite clearly his definition of high modernity and how this contrasts with the concept of postmodernity in his work (Beck et al., 2003). Beck argues that despite the fact that there are many meanings to the word ‘postmodernity’ and many of them overlap with the concept of reflexive modernity, there is still a clear distinction between the two. Beck’s understanding of high or reflexive modernity maintains that there are new rules of the game for our political and social systems. Whereas many theorists approach the term postmodernism as the issue of de-structuration of society and he adds the de-conceptualization of social science, for high modernity it is a matter of re-structuration and re-conceptualization (2003: 3).

2 Luhmann (1993) claims that the work ‘risk’ appeared in German in references in the mid sixteenth century and English in the second half of the seventeenth century. He notes, however, that the renaissance Latin term riscum had been in use long before in countries such as Germany. Most commentators link the emergence of the word and concept of risk with early maritime venture in the pre-modern world (Giddens, 1999; Turner, 2001).

3 In 2001, the average age of women giving birth after ART treatment was 33.3 years, 4.1 years older than the average age of all Australian mothers (29.2 years) (Laws & Sullivan, 2004: 58).

4 Tracy also included: no medical complication, no obstetric complication, singleton, 31-41 completed weeks as well as presentation of normal size.

5 Crook (1999) argues that although the welfare state is in retreat and neo-liberalism is part of the current political programme, we must remember that organized risk management of the welfare state does not simply disappear. He makes the important point that there are key differences between the experiences of advanced societies. Rather than arguing for the homogenizing effect of neo-liberalism on all developed countries – he highlights the varied approaches and balance between state, individual and employer provisions among various developed countries. Furthermore, he highlights limits to the process - for example with the case of public health care in countries such as Canada, Britain and Australia.

6 For instance Skolbekken (1995) has reported that there has been an increase in the use of the term ‘risk’ within the medical journal of Britain, the USA and Scandinavia – to ‘epidemic’ proportions (1995: 296). The study examined journals between 1967 and 1991. It was discovered that for the first five years the number of risk articles published was around 1,000 and for the last five years there were over 80,000.
Chapter 5: The Interrelation of Risk Society and Childbirth Practices

1 Johnsen’s tendency to situate all women’s lived experiences under one umbrella is argued by various researchers. For instance Reichman and Teitler (2003) argue that independent variables will have an impact on the approach the woman has to the care she undertakes during her pregnancy. These variables are coded as psychosocial risk factors and include the wantedness of the pregnancy.

2 The U.S. National Health Promotion and Disease Prevention Objectives for the year 2000 included the implementation of preconceptual care for all women (Wallace & Hurwitz, 1998).

3 For instance the authors Naish and Roberts are the founders of one of Australia’s first clinics dedicated to offering the best in natural methods of fertility management (contraception and conception), comprehensive preconceptual care, natural remedies for reproductive and fertility problems.

4 Cholestasis of pregnancy is a condition in which the normal flow of bile in the gallbladder is affected by the high amounts of pregnancy hormones. Cholestasis is more common in the last trimester of pregnancy when hormones are at their peak, but usually goes away within a few days after delivery. The implications and symptoms for the pregnant woman are: itching, particularly on the hands and feet (often is the only symptom noticed), dark urine colour, fatigue or exhaustion, loss of appetite, depression and less commonly: jaundice, upper right quadrant pain and nausea. The stated implications for the unborn child are: increased incidence of fetal distress, preterm birth or still birth. The rational behind this is that the fetus relies on the mother’s liver to remove bile acids from the blood, therefore the elevated levels of maternal bile cause stress on the baby’s liver. Quite often it is suggested that women who have contracted the condition be induced prior to their full confinement.

5 Raspberry leaf is argued to ensure efficiency of uterus contractions. It may be taken as an infusion or by tablet. Recent research involved a double blind randomised trial through Westmead Hospital, Sydney. Midwives there have already run a pilot study. They believe tablets are best as the dose is more accurate than herbal infusions. This paper was presented at the 11th Biennial Australian College of Midwives’ Conference, Hobart, Tasmania in September 2002.

6 A more serious liver disease encountered during pregnancy is that of acute fatty liver. It is an extremely rare condition affecting less than 1 in 10,000 patients. The symptoms are that of a rather sudden onset in the last four weeks of pregnancy of rapidly deepening jaundice, somnolence, and in short order, coma, bleeding dyathosis, and hepatorenal failure. The usual time course from onset of symptoms to hepatorenal failure is approximately 2 weeks. The maternal mortality rate from acute fatty liver of pregnancy approaches 30%.

7 Results included: 1. All women were very likely to have been influenced in their decision by information from their doctor. 2. Women who had an elective CS were influenced by factors such as their recovery and the ability to plan. 3. Women who had an emergency CS were influenced by the physical stress of labour, as well as their partner’s reaction in the labour ward. 4. Pain and previous negative experiences in childbirth were also factors. (Turnbull et al., 581). We must keep in mind that these results stem from questions with forced-choice responses.

8 This particular research involved a sample of 148 women who delivered at a tertiary referral public maternity hospital in metropolitan Adelaide, South Australia. The research was conducted through a survey and employed the likert scale for assessment of responses.

9 A Doula is a professional labour assistant, usually a woman, who provides emotional, physical and sometimes spiritual support to the labouring mother. Doulas are known for being natural birth advocates.

10 A Mentum anterior presentation meaning the babies chin is facing towards the mothers spine during labour. This is often associated with extreme pain in the lower back area during labour with women often expressing that their contractions were in their back.
Free standing units are not connected to hospitals. At this point there are no running free standing birth centre units within Australia. This was made even more difficult with the indemnity crisis where independent midwives were unable to get coverage. There is the exception of the Natural Birth Education and Research Centre of Lismore NSW. However, they do not define themselves as a birth centre, rather as a venue for innovative research and education.

By cultural opposition, Monto was arguing that Erickson’s (1976) ‘axes of variation’ could be applied. In other words, culture, Monto argued, includes not only those forces that promote uniformity of thought and action but also those forces that organize the character of opposition (1997: 295).

Sydney’s Child is part of the ‘Child’ family of publications produced by Copeland Publishing. These five monthly publications cover Sydney, Melbourne, Adelaide, Canberra and Brisbane with readership figures in excess of one million parents, 11 times a year. The target population is for parents or caretakers of children aged 0 to 12 years of age. The publication is available free of charge wherever parents and children may go, for instance schools, education and health centres, playgroups and businesses that cater to families (http://www.sydneyschild.com.au/home.asp).

Chapter 6: Life as a Planning Project

The malleable nature of pregnancy and birthing risks throughout history has been highlighted throughout the course of this thesis. The reality of this was brought to the researcher’s attention recently when viewing a favourite movie on a rainy Sunday afternoon. In The Way we Were, a 1973 film starring Barbara Streisand and Robert Redford, Streisand’s character finds herself pregnant. Beyond the obvious joy that the couple shared at the impending birth of their child, they also shared cigarettes and alcohol. In just over three decades, the consumption of cigarettes and wine during pregnancy went from a societal norm to a societal taboo. The different approaches to pregnancy and birth across cultures has been discussed, for example, in Jordan’s (1978) work Birth Across Four Culture, as well as deVries (2001) edited volume Birth by Design: Pregnancy, Maternity Care and Midwifery in North America and Europe and Kitzinger (2000) in her recent publication Rediscovering Birth.

In preimplantation genetic diagnosis, DNA is sampled from the embryo while it is still in the laboratory waiting to be implanted in the womb. According to Tormey (2005) approximately one thousand babies worldwide have been born subsequent to this procedure, with no apparent medical problems.

The Human Genetics Society of Australia and the Royal Australia and New Zealand College of Obstetrics and Gynaecology jointly endorsed and released a statement on prenatal diagnosis policy. It included among various recommendations that prenatal testing should be available for the following: all women of 37 years and over (although it recognizes that some States and Territories offer prenatal diagnosis tests at 35 years and over); all women who have a screening test for chromosomal abnormalities; all women who have a high risk of a foetus with a diagnosable defect et. Ultrasound-diagnosed abnormality; maternal infectious diseases (2004).

Current recommendations on antenatal screening by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists are: blood group and antibody screen; full blood count; rubella antibody status; syphilis serology; hepatitis B serology; hepatitis C serology (if significant risk); HIV serology; and cervical cytology. In addition, the doctor should discuss: the availability of maternal serum screening for Down's syndrome; ultrasound examination at 18-20 weeks' gestation.

The blood test measures two proteins in the mother’s blood taken at the same time as the ultrasound. It reportedly can give a more accurate risk result.

Amniocentesis involves sampling the amniotic fluid surrounding the baby by aspiration of fluid through the mother’s abdomen. CVS involves taking a sample from the placenta either through the vagina or the abdomen.

Surveys within Australia demonstrate the routinization of ultrasound scans during pregnancy. In 1992, 97% of pregnant women had at least one ultrasound scan and 46% had two or more (Yates et
al., 1995). A 1994 survey demonstrated that 99.5% of the respondents had at least one ultrasound scan (Commonwealth of Australia Senate Committee Report, 1999: 45). The same report disclosed that the use of scans such as the ‘nuchal translucency’ is being used by an increasing number of women, despite concerns about its efficacy.

8 For instance, in 2003, Florida Governor Jeb Bush appointed a guardian for a 22 year old severely retarded woman’s foetus. The woman, who had been raped whilst in state care, had been forced onto the center stage of the abortion debate. Governor Bush’s actions fly in the face of both the US Supreme Court and the Florida state Supreme Court which have both found that a foetus does not count as a person under the 14th amendment. Although Bush was not successful in his attempts to appoint a guardian, the young woman later gave birth to a girl by caesarean section who was then placed into custody of the state Department of Children & Families. Within Australia, the 2001 road rage car crash that eventuated in the still born son of Renee Shields, resulted in the creation of Bryon’s Law, where the legal rights of an unborn child are recognized and it is deemed an offence to kill an unborn child.

9 Quickening is defined as the moment during pregnancy when the baby is first felt to move. For first pregnancies, woman usually experience quickening between the 18 and 24 week gestation. If this is not their first baby women can expect to feel their baby earlier.

10 Ultrasounds can be performed at any stage during the pregnancy. It is most commonly done at the 8-10 week mark to check the dates of the pregnancy and the number of babies present. It is also employed at the 18 week mark for a detailed scan to pick up any physical problems present. This ultrasound is often used as a screening device to indicate if any further tests need to be carried out.

Chapter 7: The Birth Narrative

1 On an anecdotal note during my pregnancy I created a list of questions which covered topics such as the incidence of episiotomies that my obstetrician performed as well as his CS rate. Discussions with close friends revealed similar tendencies. Yet, none of us questioned the ability to birth without medical intervention in a private setting.

Chapter 8: Learning to be Pregnant in Risk Society

1 Roddy Doyle’s The Snapper (1990) is presented by Gardner condensed from the following pages: 14,17, 32-33.

2 21 of my 45 respondents undertook preconception care. Furthermore, recent publications demonstrate an increasing trend toward this form of care as well as the advent of businesses which are designed specifically for this purpose.

3 Indeed all pregnancy kits now contain information on what supplements should be taken to avoid any genetic disorders. Accordingly, it is not only the pregnant woman who is confronted with information on genetic disorders but also the woman who finds she is not pregnant.

4 An abnormal mass, instead of a normal embryo, forms inside of the uterus after fertilisation. The layer of cells that line the gestational sac converts into a clump of clear vesicles instead of the beginnings of a healthy placenta. Without the support of a placenta the fertilised egg soon deteriorates. It is said to occur in a small percentage of pregnancies with variables such as age being predictive of its occurrence.
REFERENCES


