MODERN WOMEN

OR

TREE-HUGGING HIPPIES?

A FOUCAULDIAN DISCOURSE ANALYSIS OF THE NEW ZEALAND MEDIA'S REPRESENTATION OF WATERBIRTH

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ABSTRACT

This study has identified the discourses surrounding waterbirth and analyses how these discourses are utilised by the media in New Zealand to represent waterbirth. The philosophical approach that underpins the study is that of philosopher Michel Foucault and his theory on discourse, power and the subject. His framework is used in a discourse analysis to reveal three main discourses: the scientific medical discourse, the natural birth discourse and the dive reflex discourse.

Data used for this study consisted of 30 newspaper articles containing the word 'waterbirth' collected over a five-year period (2000–2005) from New Zealand's eight main broadsheet newspapers. Analysis was a two-part process: Foucauldian discourse analysis and a media discourse analysis (Fairclough, 1995b).

Firstly, the discourse analysis showed the subject and the power positions each discourse offered women for positioning themselves in that discourse. The literature and texts revealed Foucault's theory on power relations and resultant subjectivity within institutions and how waterbirth within institutions is disciplined, surveilled, excluded and circulated.

The second part of the analysis revealed how the media chooses to deploy the three identified discourses that represent waterbirth in New Zealand. This textual analysis followed the framework of Fairclough's (1995b) media discourse analysis, showing media strategies that are used to promote the discourse deemed to be ideologically significant by the media outlet.

Textual analysis identified that the scientific medical discourse contests waterbirth as an unsafe, unproven practice that puts babies' lives at risk. This discourse categorises women who choose waterbirth as unsafe, irrational, alternative, tree-hugging hippies who favour perceived benefits of waterbirth for themselves above the safety of their baby.

The natural birth discourse contests that waterbirth is a safe practice that has encountered few problems since its emergence as a validated birthing practice in the late 1980s. It

promotes waterbirth as having multiple benefits for both mother and baby and as a way of enhancing the physiological process of birth through non-intervention.

The dive reflex discourse underpins the issue of babies drowning when born into water. This discourse details a reflex that suppresses the normal breathing mechanisms in neonates at birth. Literature debates its existence and troubles the overall trustworthiness of such a reflex to prevent a baby drowning when born into water. It is this discourse that sways people's views and positioning on the overall discourse of waterbirth.

ATTESTATION OF AUTHORSHIP

‘I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.’

Signed_____ Date_____

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CHAPTER ONE: INTRODUCTION

Can you say when he left one kingdom for the other?
It is so subtle; the eye can hardly catch it.
As subtle as stepping in,
Or out, of time,
To be born,
Or to die.

What of the tide,
Which imperceptibly,
Irresistibly rises,
Only to fall.
At what moment did it turn?
Is your ear sharp enough to hear the ocean breathe?

Yes, this birth,
This wave parted from wave,
Born from the sea
Without ever leaving her.
Don't ever touch it with your rough hands.
You understand nothing of its mysteries.
But the child,
The drop from this ocean,
Knows.

(Frederick Leboyer, *Birth Without Violence*, 1974)

In 1997 I nonchalantly attended the British Isles 'Home Birth in Practice' conference in London because I had thought that the line-up of International guest speakers that year looked particularly impressive – Marsden Wagner, Caroline Flint, Yehudi Gordon and Ina May Gaskin. Names familiar then and now, to midwifery and obstetrics in the western parts of the world. The conference was inspiring, I recall an emphasis emanating from each speaker, even back then, on the importance of midwives striving to maintain and keep birthing a normal experience for women. Midwives were being told they had a moral responsibility and social obligation, while working within a rapidly increasingly litigious environment with soaring obstetric intervention, to promote birth as a normal physiological milestone in a woman's life.

That lunchtime I sat at a table of strangers, all midwives, and listened as a Dutch midwife described the birth unit where she worked. This was the birth unit of St John's and St Elizabeth's in St Johns Wood, London. I sat stunned as she described a private institutional setting that incorporated homeopathic induction of labour protocols, aromatherapy massage to women in labour and postnatally, antenatal yoga classes, a place where 30% of all primigravidas had waterbirths, where there was a policy of absolutely no induction of labour for social reasons, where new mothers and fathers shared a double bed after the birth of their baby, and where siblings could stay too if they wanted. The women were given a menu each day, champagne was delivered to the birth room after every birth and visiting hours didn't exist.

Compared to the large public hospitals I had worked in previously, this unit simply sounded too good to be true. Was this midwife exaggerating? It sounded like a midwifery nirvana. Champagne in the delivery room!? I had a mental picture of the looks of sheer horror on the faces of some of the midwives I had worked with in the past at such an idea being put before them.

At this time I was employed as a staff midwife in a Kent hospital. The midwives still wore their red woollen capes to work and some still donned their peaked nurse's hats. This was 1997. Staff were all addressed as 'sister' or 'matron'. There was a hierarchical order as to whom could enter the tea room first for morning tea, i.e.; Matron first, students last. This hospital was one of the few in the British Isles that had signed the 'Dublin protocol' – a three-year research study at the time, which aimed to reduce the amount of time in which women laboured in the second stage of labour. Hospitals that signed up were paid for their data and involvement. 'Participation' involved laminated flow charts of how to manage the second stage of labour, which were stuck to the wall behind the labouring woman's head in each delivery room. The midwife conducting the labour was required to leave the room and summon the charge midwife when the woman reached full dilation. The charge midwife then set a timer outside the door and timed how long the woman pushed for. Primigravidas were 'allowed' 45 minutes, multips 30 minutes. If the labouring woman was not progressing to this time frame, a luer was to be inserted into her hand and an intravenous drip of syntocinon started, along with rupture of the membranes if this had not already occurred. Obviously, all three of these procedures are extremely painful, not to mention

when the woman was in the throes of second- stage labour. I witnessed dozens of women, particularly multips, 'lose it' as the syntocinon infusion hit their uterine muscle. Ask any midwife how many women she has looked after in labour that have had syntocinon infusions but no epidural? They are very rare indeed…

The Dublin protocol and it's influence on me personally and my practice as a midwife was very damaging, I found myself 'doing' things to women that I considered torturous and inexplicably cruel. After a short time I left and went to work as a staff midwife at the Birth Unit of St John and St Elizabeth in London.

During my three and a half years at the birth unit I witnessed and conducted many waterbirths. I personally wish every woman could birth, or would want to birth, in this way. For me, it is the ultimate way to give birth. I believe it is far less painful (I can thrice vouch for this myself), calm and quiet, the woman feels in control. Often babies that are brought to the surface have experienced such a gentle birth they are not acutely aware of their surroundings and seem dozy. Few scream. I have never witnessed any form of resuscitation following a waterbirth, although it does occur – as with land birth too.

The birth unit had a policy on conducting waterbirth, with which all staff were familiar and confident. Likewise, at University College Hospital in London where I also worked on the bureau, there was a list of midwives who were competent practitioners in waterbirth. I have not seen such lists in this country.

It was disheartening for me on returning to New Zealand to discover that waterbirth was not a mainstream practice. It seemed that only independent midwives behind closed hospital doors or at home births conducted waterbirths, but even then waterbirths weren't discussed in the tea room afterwards and were documented in the birth register as being a 'normal vaginal delivery', not a waterbirth. Hence, there is no data available on how often waterbirth occurs here. While it appeared that lip service was paid to women antenatally that they could indeed have a waterbirth if they so wished, this would involve the woman arduously seeking out an independent midwife who incorporated waterbirth into her practice, and the expensive hireage of a custom-made, portable birthing pool.

I am a midwife and a mother who has ‘waterbirthed’ three times. I therefore acknowledge and declare my bias towards waterbirth as a way to birth for low-risk women. I have embarked on this study with the assumption that the construction of waterbirth by the media in this country is largely dependent on the opinion of our medical profession. I do not claim that midwives know better. I am not pitting midwives against doctors. I am acutely aware that both doctors and midwives work collectively in this country in the business of keeping birth safe. I have always maintained that the relationship between midwives and doctors is symbiotic.

I felt that waterbirth was invisible in New Zealand. I wanted to explore why this was, and what or who the powers were that kept waterbirth hidden from women as an available option to them. This led to the formulation of my research question. It became apparent that for most New Zealanders their only exposure to the term or notion of waterbirth was through their usual broadsheet newspaper. I began to ask myself questions such as: how is waterbirth written about and represented in the media? Who seem to be the dominant speakers referred to? How are women and health professionals presented in the media?

1.1 The Philsophical Approach and Aims of the Study

Discourse analysis gave me the best platform from which to identify and explore subject positions and power relations available when one speaks or writes about ‘waterbirth’. Analysis will be a two part process using Foucault and Fairclough. From my experience as a midwife of waterbirth, I felt that it was a misunderstood birthing practice in New Zealand.

By choosing to adopt a Foucauldian discourse analysis of waterbirth, I was able to draw on Foucault’s concepts of power, knowledge and truth, since this configuration is essentially what constitutes discourse for him (Mills, 2004). In particular, I found Foucault’s concept of power most useful. His theory is that power is dispersed throughout social relations and that it produces possible forms of behaviour as well as restricting behaviour (Foucault, 1994). Foucault’s theory on discourse and its production of certain subject positions related well to how I wished to analyse how women and maternity practitioners are represented in the media.

Foucault's notions of discipline, surveillance, exclusion and circulation of discourses enabled me to identify how dominant discourses are used to ensure power relations are exerted and maintained in our society and, for the context of this study, particularly within maternity institutions.

Employing both Foucault and Fairclough revealed that both were complimentary to each other in the analysis of my research questions. While Foucauldian analysis exposes *what* power relations underpin waterbirth in New Zealand, Fairclough's analysis shows *how* these power relations are exhibited and maintained. Fairclough's analysis provided strength and clarity of how the media operates to represent waterbirth in New Zealand.

Fairclough's (1995a, 1995b) media discourse analysis enabled me to show how the media select a discourse on a topic that they (the media outlet) wish to convey as the 'truth' on that topic. Media strategies such as the order of discourse, intertextuality and linguistic analysis highlighted and emphasised how waterbirth is constructed within the New Zealand media. This analysis revealed the overall ideological significance of waterbirth promoted in our society.

1.2 Study Outline

The aim of my thesis is to show the reader the complexity of the three discourses I have uncovered that contribute to the meanings of waterbirth in New Zealand. I aim to expose the subject positions within each discourse and the power relations that uphold and maintain each of the discourses.

Chapter Two of the thesis begins with the outline of the philosophy of Michel Foucault – it is this philosophy that underpins the methodology of discourse analysis. I show Foucault's main notion of knowledge/power through my selection of his notions that analyse power relations: of these I chose the techniques of power, discipline, panopticon, exclusions within discourse and circulation of discourses to show how waterbirth is disciplined, surveilled and deployed as a knowledge or discursive practice. The second part of this chapter details Fairclough's critical discourse media analysis framework. The framework describes Fairclough's notions on the powers that regulate the media itself, the use of

discourses to promote ideology of preference, and media strategies used when constructing a topic for a newspaper article. The final section of this chapter describes the method used in the overall design of this research study. Steps involved in the data collection and analysis are described. I also explain the measures I have taken to ensure rigour throughout the study.

Chapter Three is an overall account of what the practice of waterbirth involves. The account draws on a review of the literature by means of identifying the discourses within the literature. The emergence of the natural birth discourse is explicated through a historical account of the political and social events of midwifery's history in New Zealand. The emergence of waterbirth as a relatively new birthing method is shown through a chronological account of birthing practices. This chapter also reveals the three discourses I have identified in relation to waterbirth in general. The emergence and origins of both the scientific medical and natural birth discourses are discussed. The physiology underpinning the dive reflex is detailed, and the contest regarding its validity is described.

Chapter Four shows the construction of waterbirth in the New Zealand media by way of Foucault's notions of discipline, panopticon, and exclusions in and circulation of discourses and how these impinge on people's views towards waterbirth. Excerpts from the newspaper articles are used to showcase each notion in operation. Foucault's notions show the boundaries that exist for waterbirth and how these are maintained.

Chapter Five shows Fairclough's media strategies in operation. Multiple excerpts from the newspaper articles are used to highlight his notions of order of discourse, intertextuality and linguistic representation. The actual construction of waterbirth within a text and how it is articulated and positioned and the grammar used to deploy the discourse of waterbirth is shown. The articulation used and its effect on women's subjectivity is explored.

Chapter Six, the final chapter, summarises both Foucault's and Fairclough's analyses and the findings made on the representation of waterbirth in the media. I detail the implications that these findings have for midwifery practice. Limitations and implications of the study are stated. I conclude with my overall feelings towards the findings of this research study.

This chapter has explained the research questions and the aims and philosophical approaches to analysis being employed. The outline and flow of the thesis has been detailed. In the following chapter I reveal the framework for the methodologies and methods used in this piece of research.

CHAPTER TWO: METHODOLOGY

2.1 Introduction

This chapter outlines the framework for this research and draws on two types of discourse analysis which will be described in detail. Foucault's theory on power relations and their production of subject positions related well to how I wished to analyse how waterbirth is constructed in the New Zealand media. In this chapter I will explain postmodernity and poststructuralism and show the influences of these paradigms on my research. I will review Michel Foucault, who he was, his main works, what he stood for, and what is meant by a Foucauldian discourse analysis. I also include criticism of Foucault.

2.2 Philosophical Underpinnings

While there are multiple methods of discourse analysis, this study draws on the postmodernist meaning of discourse in which it is historically positioned. Postmodernism is the grand narrative given to a reaction to the ideology of modernity. Modernity as a cultural phenomenon is usually traced back to the enlightenment period in the eighteenth century (1640–1798) of European history, often referred to as the 'enlightenment project' (Sim & Van Loon, 2004, p. 96). Modernity is the belief that reason can dominate the environment around us. In doing so, it can guarantee us material progress, stretching on into the indefinite future. Although Foucault and his theory of discourse analysis are situated both in the postmodern and in the poststructuralist paradigm, I feel it is pertinent to discuss the paradigms prior to the poststructuralist movement and how their influences shaped Foucault's way of thinking.

Structuralists conceived the world as a series of 'interlocking sign-systems' (Sim & Van Loon, 2004, p. 65), to which human beings respond in largely predictable ways. Structuralists argued that there were different ways to determine meaning; they saw language as a 'system with its own rules and constraints, and with its own determining

effect on the way individuals think and express themselves'. Structuralism signaled the break with past views of language (Mills, 2004).

The philosophical underpinnings of structuralism, however, reveal a deeper structure that dictates how systems operate. For example, Marx located an unconscious hidden in economic production. Freud uncovered a system in our psychic drives. For structuralism, 'the unconscious is located in linguistics itself' (Sim & Van Loon, 2004, p. 66).

The implications of the structuralism era for society and social sciences lie in the social meanings that are produced within social institutions and practices in which individuals, who are shaped by these institutions, are agents of change. Change may either serve hegemonic interests or challenge existing power relations (Weedon, 1987). Weedon (1987) also reasons that 'once language is understood in terms of competing discourses, competing ways of giving meaning to the world, which imply differences in the organisation of social power, then language becomes an important site of political struggle' (p. 24).

To up and coming new generations of cultural theorists, the world was not as 'orderly' as structuralism seemed to be claiming. What became known as the *poststructuralist movement* occurred in the late 1960s (Sim & Van Loon 2004, p. 87). The poststructuralist period covers a wide range of positions. Poststructuralists, perhaps unwittingly, introduced the concept of *skepticism* to our society. Skepticism has become a noteworthy characteristic of critical theory. Skeptics on whether or not waterbirth is a safe birthing practice exist in many New Zealand maternity institutions.

The most influential off-shoot of poststructuralism has been the practice of deconstruction. Deconstruction involves dismantling systems to reveal the gaps that, try as we may, we can never disguise. 'Deconstruction is a philosophy which very self-consciously sets out to deflate philosophical pretensions about our ability to order the world' (Sim & Van Loon, 2004, p. 89). Jacques Derrida was an influential poststructuralist who objected to structuralism's dependence on binary oppositions. One term of a binary always takes dominant priority over the other, e.g. man/woman, white/black, true/false. Deconstruction opposes the common notion of hierarchy, which remains embedded in a lot of societies

today. Deconstruction and binary oppositions are analytic measures that can be applied to the notion of waterbirth.

Michel Foucault (1926–1984) reacted against the formal rigidity of structuralism and its insistence that everything be neatly classified in terms of its system-bound role.Foucault's philosophy and the questions he asked of the world are examined in greater depth in the following analysis of who he was as a person.

2.3 Michel Foucault

The philosophy Foucault developed was a series of conceptual works in approaches to discourse, power and the subject. Foucault's philosophical thinking asks the basic questions of; who are we? And, who are we today? (McHoul & Grace, 1998). Unlike most European philosophers Foucault chose not to separate philosophy from history.

Foucault conceded that philosophy was not an inquiry into itself, but an application of philosophy to the human sciences, linguistics, psychology and sociology. He asked how it was that knowledge and experience were incorporated into an apparently objective view of man as an object. He questioned – ' if we cannot take experiences as a given truth, perhaps the questioning of scientific method can force us to ask, under which circumstances should we see any knowledge (of self or world) as tenable? What other factors apply?' (Horrocks & Jetvic, 2002, p. 22).

Foucault began to see that scientific knowledge was based on power rather than truth. His first writings 'reflected his attempts to resolve psychology's status as a science with its object – human existence' (Horrocks & Jetvic, 2002, p. 27). This led to his object being knowledge within institutions. He began to critique, in particular, psychiatry. In his writings *Madness and Civilisation* (1964), he said his object was 'knowledge invested in a complex system of institutions, authorities, their practices and opinions would be studied to

show madness not as a scientific or theoretical discourse, but as a regular daily practice' (Foucault, 1964, p. 65, cited in Horrocks & Jetvic, 2002, p. 37).

It could be said that Foucault began with the truism 'knowledge is power'; he took it to pieces, analysed it and reconstructed it. He was particularly interested in knowledge *of* human beings, and power that acts *on* human beings. He tried to reveal the mental force exerted by a powerful minority who are thus able to impose their idea of the right, or the true, on the majority (Horrocks & Jetvic, 2002). Foucault's works focused on a central mechanism of the social sciences – this being the categorisation of people into normal and abnormal. He chose to focus on the forms of abnormality (madness, criminality and perverted sexuality). Overall, he examines the rise of scientific discipline.

All his works describe the rise of the scientific forms of social control by the authorities governing them and how the lives of the individuals are to be strictly regimented. 'Episteme' is a key term in understanding Foucault's works. 'An episteme is the underground grid or network which allows thought to organise itself. Each historical period has its own episteme. It limits the totality of experience, knowledge and truth, and governs each science in one period.' (Horrocks & Jetvic, 2002, p. 65). It is also commonly known as a 'paradigm'. Foucault called his historical researches 'archaeologies' or 'genealogies' designed to bring light to suppressed discourses in western society. 'Foucault brought people what they needed – an eclectic synthesis to demonstrate the impossibility of historical reflection.' (Horrocks & Jevtic 2002, p. 78).

2.4 Discourse

There are multiple definitions of discourse. Fairclough (1998) states there is a conspicuous lack of agreement on the definition of discourse, while Payne (2002) notes that certain disciplines such as linguistics and social psychology employ the term discourse but in quite a different sense to Foucault. In Mills (2004) Foucault gives some general definitions of discourse. 'One of the most productive ways of thinking about discourse is not as a group of signs or a stretch of text, but as practices that systematically form the objects of which they speak' (Foucault, 1972, cited in Mills, 2004, p. 15). In this way, it can be seen that a

discourse is something which produces something else – an utterance, a concept, an effect. Fairclough (1998) prefers the following definition:

> …discourse… is not concerned with language alone. It also examines the context of communication; who is communicating with whom and why; in what kind of society and situation, through what medium; how different types of communication evolved, and their relationship to each other. (p. 3)

A discursive structure is recognised by the systematic flowing of ideas, opinions, concepts, ways of thinking and behaving that are formed within a particular context and because of the effects of those ways of thinking and behaving. Foucault focused on the mechanism whereby one discourse becomes produced as the dominant discourse, 'which is then supported by institutional funding, staffing, and provisions from the state, for example. The other discourse, the marginalised one, is treated with suspicion and is sited both metaphorically and literally at the margins of society'. (Foucault, 1978, p. 18).

Discourse is therefore useful in that it can allow the analysis of similarities across a range of texts as the products of a particular set of power/knowledge relations (Mills, 2004, p. 21).

Foucault's work and questioning can be fixed into three main concepts to arrive at his notion of discourse analysis. These are: firstly, the description of the discourse – or disciplines of knowledge; secondly, the political questions of power that arise from the discourse; and thirdly, the discovery of the theory of the self. Hence these characteristics of ourselves today can be put into questions that Foucault's work seeks to uncover. McHoul and Grace (1998) define these questions as 'who are we in terms of our knowledge of ourselves? Who are we in terms of the ways we are produced in political processes? Who are we in terms of our relation with ourselves and the ethical forms we generate governing these?' (p. 6).

2.5 Subjectivity

Subjectivity, as defined by Foucault in his work *'The Politics of Truth'* (1997), is the point where the interaction between two types of techniques occurs – the techniques of domination and techniques of the self. The contact point is where individuals are driven (and known) by others and is tied to the way they conduct themselves, and know themselves (Foucault, 1997, p. 181).

A more easily understandable definition of subjectivity in relation to discourse is that by Weedon (1987), 'ways of being, identities, desires, ways of behaving and so on, which are required by existing social institutions' (p. 33). Similarly, Weedon (1987) also concedes that subjectivity refers to 'the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world (p. 32).'

It should be noted that the poststructuralist approach to experience is different to western psychology's meaning. The poststructural approach assumes that all experiences we have are essentially linked to the language we accept as our own. Poststructuralism denies authenticity of individual experience. At the least, poststructuralists conclude that a person's subjectivity is the result of a milieu of conscious awareness, contradiction, political choice and exposure to differing discourses from which a person will find their own meaning. Most importantly, subjectivity is changeable. By this, a person can change their mind and reposition themselves within other or alternative discourses at any given time (Weedon, 1987).

There are multiple discourses in the world, each offering competing, and potentially contradictory, ways of giving meaning to the world. They do this by each offering the individual a 'subject position'. Individuals choose positions in accordance with the promise of power they will offer the individual.

> Discourses vary in their authority. The dominant discourses appear 'natural', denying their own partiality and gaining their authority by appealing to common sense. These discourses, which support and perpetuate existing power relations,

> tend to constitute the subjectivity of most people most of the time (in a given place and time).
>
> (Gavey, 1989, p. 464)

Waterbirth is currently limited by its power because it is marginalised and unavailable as a subject position to many women because of the power exerted on them by the dominant discourse, the scientific medical discourse. The contradictory nature of subjectivity means that a woman may align herself with the natural birth discourse and waterbirth as a discursive practice of that discourse when she is pregnant. However her experience in labour and childbirth may change her subjectivity to position herself among other discourses in her subsequent pregnancy and also through that journey.

It is now timely to show how discourses are analysed according to Foucault's notions and philosophy.

2.6 Foucault's Analysis Employed in This Thesis

The following are the key notions of discourse analysis that I have employed and highlighted in this thesis. These are just a select few of many of Foucault's notions of discourse analysis. These key theoretical concepts have been used as a framework on which to analyse the data I have collected on discourses pertaining to waterbirth in New Zealand media: power/knowledge, techniques of power, including discipline, panopticon, exclusions within discourse, circulation of discourses, and subjectivity.

2.6.1 Power/Knowledge

Power/knowledge was a notion Foucault developed in his 1977 work *Discipline and Punish.* By putting these two words together in this way he combines the connection he believes exists between the production of knowledge and power relations; power/knowledge (Shumway,1989). In short, Foucault believed that accumulated knowledge resulted in power. In western society today 'truth' is seen as the product of science or scientific 'methods'. Whilst we can be skeptical of science, it is much more difficult to ask *why* sciences are held in such high esteem. Foucault's work as a whole moves some way towards formulating this question. He did this by challenging not only what constituted 'truth', but he also examined what *conditions* were necessary for the production of such 'truth' (McHoul & Grace, 1998, p. 58). I identify and analyse the power

positions offered to the speakers of the two discourses, which I will call the scientific medical discourse and the natural birth discourse. I show what conditions enabled them to produce their version of truth on the object of waterbirth and what they have gained politically from positioning themselves in this discourse.

Foucault's analysis of power deemed that power is dispersed throughout social relations in society and that it produces possible forms of behavior as well as restricting behavior (Mills, 2004). Most theorists who have studied power have conceded that individuals are oppressed by power relations, but Foucault sees them as the effects or instances of power relations (Mills, 2004). Therefore Foucault insinuates that any knowledge we have is the result or the effect of power struggles. My explanation will show how power is seen to permeate and oil the discourses circulating in relation to waterbirth. I now show how power is exercised throughout our society, according to Foucault's theory on power relations.

2.6.2 Techniques of power

Foucault suggests that power is intelligible in terms of the *techniques* through which it is exercised. Common to all types of power that exist in our society is a shared reliance on certain *techniques* or methods of application, as most people will draw some authority by referring to scientific 'truths' (McHoul & Grace, 1998, p. 65). The four techniques that I have chosen to use as a framework for my data analysis that best show how waterbirth is dominated by the power of the scientific medical discourse in New Zealand are: discipline, the Panopticon gaze, exclusion within discourse, and circulation of discourse.

Technologies of power were Foucault's analysis of how the human sciences are analysed and applied by people in order to 'understand themselves' (Payne, 2002, p. 22). Each of these techniques is a form of domination.

2.6.3 Discipline

Foucault noted of the disciplinary society: 'discourse and surveillance serve to produce "docile bodies". Obedience becomes normal; disobedience becomes suspect and may be dealt with punitively' (Foucault, 1977, p. 218).

In his book *Discipline and Punish* (1977) Foucault describes how the disciplines of the seventeenth century that had long been in existence, for example, in monasteries, armies, schools and workshops, had developed into intricate general formulas of domination. Discipline has been part of other historical processes such as the economic, juridical-political and scientific fields (Barker, 1998, p. 61).

> The historical moment of the disciplines was the moment when an art of the human body was born… the formation of a relation that in the mechanism itself makes it more obedient as it becomes useful… what was formed was a policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviour. The human body was entering a machinery of power that explores it, breaks it down and rearranges it...
>
> (Foucault, 1977, p. 138)

This new form of power created ways that one could have a hold over another's body and people could be made to do what one person wished by use of techniques that ensured speed and efficiency. Foucault called this discipline the production of 'docile bodies'. 'Discipline increases the forces of the body (in economic terms of utility) and diminishes these same forces (in political terms of obedience)' (Foucault, 1977, p. 138). In other words, discipline can be both productive and yet repressive. In my analysis of texts I examined how discipline is applied to midwives who practice waterbirth.

Various forms of discipline are described by Foucault (1977a), of which I have chosen the concept of the panopticon to illustrate discipline in relation to waterbirth within the institution of a hospital.

2.6.4 Panopticon

The easiest way, according to Foucault (1977a), to make 'docile bodies', was discipline through observation. Foucault used the model of architect Jeremy Bentham's (1843) *Panopticon*, an apparatus for the observation of prison inmates to illustrate how observation can be used to discipline (Brown, 2000, p. 50). The prison was built in a circular fashion with a watchtower at its centre. The circular peripheral building was divided into cells, each with two windows, one facing the watchtower and the other the outside. The outside

window provided backlighting. With the effect of backlighting, one could observe from the tower the small captive shadows in the cells of the periphery. Each individual in his cell could be seen in front by the supervisor, but the side walls prevent the prisoner from seeing his companions. The guard tower was screened with Venetian blinds. For the inmate, he is seen, but he does not see; 'his is the object of information, never a subject in communication' (Foucault, 1977a, p. 200).

The constant surveillance guaranteed a sense of order. Hence, the major effect of the panopticon was to induce in the inmate a state of conscious and permanent visibility that ensures the automatic functioning of power (Foucault, 1977). The panoptican made its captives behave in a pre-determined and not spontaneous way. People who know they are being watched respond to the constraints of that power by complying and obeying. It was a clever invention because it involved non-corporal and non-confrontational forms of perpetuating power over individuals. The notion of the panopticon facilitates the identification of strategies which surveill the practice of waterbirth as they are made evident in the data.

2.6.5 Exclusions within discourse

Exclusion is, in essence, paradoxically, one of the most important ways in which discourse is produced (Mills, 2004, p. 60).

The process of exclusion operates on discourse to limit what can be said and what can be counted as knowledge. The first way this is usually done is by 'prohibition' or taboo (Mills, 2004, p. 57). It remains that there are certain subjects that are difficult to discuss within our western society, such as death and sex. Mills (2004) gives the example that in Victorian England it was difficult to talk openly about sex and remain respectable. So, too, it can be seen with waterbirth. Practitioners of waterbirth being excluded are shown in my analysis chapter.

The discursive and institutional limitation of a discourse becomes habitual within particular cultures at certain periods. Once tabooed, that status of a discourse begins to feel obvious. It is assumed that the ideas and views of 'rational' people such as doctors carry more weight

(Mills, 2004, p. 59). It could be said that the advent of articles about waterbirth, which first appeared in literature in 1992, saw the onset of what Foucault (1981) termed the 'will to truth' (p. 54). He detailed the historical division between knowledge that is perceived to be true and that is perceived to be false. The 'will to truth' 'imposed on the knowing subject, and in some sense prior to all experience, a certain position, a certain gaze and a certain function' (Foucault, 1981, p. 55).

According to Mills (2004), in western culture the transition between fact and fiction, truth and falsehood, began occurring within the eighteenth century.

> With the beginning of the production of 'news', that is texts which purported to be recent, accurate representations of noteworthy events rather than representations of events which had a moral, symbolic or wider religious significance, there began to be forged a division between truth and falsehood within the public domain which has been supported and enacted through government intervention, through the introduction of libel laws and stamp duties on certain types of publications.
>
> (Mills, 2004, p. 59)

Foucault demonstrates that this 'will to truth' is supported and perpetuated by institutions such as universities, publishing and legal companies, and libraries; so much so that it is now almost impossible to question 'what is the truth?'. Worldwide within academic study, there is now a concern to produce 'true' representations of external realities.

It is evident that exclusions within discourse produce what can be counted as legitimate knowledge on a topic. By examining the exclusions that are evident in relation to waterbirth in the media I am able to identify what is spoken about and what is not? What criteria are deemed 'the truth' on waterbirth? What do the media have to say on waterbirth? This validness of knowledge can be further strengthened by how a discourse is circulated. I now discuss how circulation of discourses occurs in our society.

2.6.6 Circulation of discourses

There are internal and external mechanisms which keep certain discourses in existence. Foucault (1981) notes the first of these mechanisms to be commentary. Discourses which we hear, speak or see regularly are the discourses which we consider to have validity and

worth. Repeated and regular commentary on a discourse ensures that it remains in circulation as legitimate knowledge. It can be seen that newspapers presenting medical journal publications on waterbirth are part of this circulation.

Mills (2004) states that critical analysts adopt strategies to attempt to articulate the 'true' meaning of a literary text. Critics try to create a better, more in-depth, interpretation of a piece of literature. Their argument is that the text already contains the meaning they have found – it was just waiting to be discovered.

I have examined the data to reveal the circulation of the discourses surrounding waterbirth by identifying commentary and the repetition of that commentary and by whom; also the place of publication and how frequently the discourse is spoken of and over what length of time. I identify whose voice is being documented the most often and which 'voice' is 'put out there' as the most dominant discourse on waterbirth in the New Zealand media.

The second aspect of what determines circulation of a discourse, according to Foucault (1981), is that of academic discipline. Academic discipline involves grand-scale grouping, which determines what can be regarded as factual or true within a given domain. A parallel example here is how the scientific medical discourse prefers randomised controlled trials over case studies or qualitative methodologies. Disciplines determine what methods are used, how data is classified, what constitutes an argument and the formation of distinct methodologies for analysis – all within certain discursive limits (Mills, 2004).

The final aspect in the circulation of discourses that Foucault examined in his work *The Order of Discourse* (1981) was that of rarefaction. Rarefaction is the notion that although one person could utter and speak infinitely on a subject, what that person would say would be repetitive and would always remain within certain socially agreed boundaries. Foucault proposed that what we find ourselves wanting to say falls within fairly predictable and restricted sets of parameters. Accordingly, we speak and act within the bounds of what discourses map out for us (Mills, 2004, p. 63). Foucault makes clear that discursive limitations such as these are sanctioned by an institution of some kind. My analysis shows the boundaries of the different discourses in relation to waterbirth, and the institutions that sanction or prohibit the practice of waterbirth.

Foucault (1981) concludes his ideas on the circulation of discourses by highlighting that people who attempt to express ideas that do not refer to past knowledge, and which are not expressed in a conventional way, are generally stigmatised and marginalised by our society. Thus it can be seen *how* discourses are maintained within our societies and how people choose to align themselves within certain discourses. It is now pertinent to critique Foucault's theories and concepts.

2.7 Critiques of Foucault

Foucault himself was a critic of our society and of its cultural history. Critics of Foucault are perpetually frustrated that he never offers any form of action or recommendations to solve the problems he so effectively demonstrates (Shumway, 1989). Unlike the works of critical theorists such as Marx and Habermas, Foucault does not provide an emancipatory intent to his work. This is partly due to his rejection of the deterministic notions of power (Mitchell, 2000). Foucault has been labeled a skeptic and a nihilist. Foucault's philosophy does not aim to provide truths, 'but for the freedom of withholding judgment on philosophical dogma, and so of acquiring relief from the restrictions they introduce into our lives and thoughts' (Shumway, 1989, p. 156). Hence the term common to works on Foucault: 'freedom of philosophy'.

'Ideology is often characterised as being false consciousness or an imagined representation of real conditions of existence; the position from which this falseness is apprehended is that of critique and stands outside ideology' (Mills, 2004, p. 29). Foucault's own critical position suggested within a discourse theory view all statements, whether theoretical or not, maintain the same status and validity. 'Foucault believed that all statements were determined by institutional pressures' (Mills, 2004). To critical theorists, there is the belief that power is binary and comes from centralised or politicised processes – which is contrary to what Foucault spoke of.

Critics of Foucault maintain that his analysis of power is simply a dead end that disallows any possibility of political action. But Foucault insisted that political resistance was not just

possible but a necessary part of the equation. Fillingham (1993) critiques Foucault's notion of power:

> You see if there was no resistance, there would be no power relations, because it would simply be a matter of obedience. So resistance comes first, and resistance remains superior to the forces of the process; power relations are obliged to change with the resistance. (p. 151)

Foucault's concept of power explains its diffuse nature throughout society on many different levels; it means that his notion of power is huge, intricate, and not simplistic. Critics can be answered by being told here that his work allows us opportunity to resist the effects of power within our own lives and influences. Without Foucault's works it could be argued that the diverse nature of power would remain invisible and today we could still believe that power was a binary notion (Mitchell, 2000).

Foucault deemed truth to be a category of power. His project asked questions about what it means to call something true. Critics of his theory of truth assume that if Foucault is asserting that truth cannot be separated from power, then there can be no designation of truth (Barker, 1998).

A common thread of criticism against Foucault is that he never gave the reader alternatives or other possibilities of expanding their problem-solving while using his philosophy. Margolis (1998) summarises that what is missing is the rationale for the redirection of human life, the grounds or norms (even if historicised) for favoring one vision of life over another. Of Foucault he says 'he had opposed structuralism's repudiation of historicity, but he had not directly addressed the incoherence of completely bypassing the role of human agents' (p. 47).

Foucault's notion of the subject was that individuals were agents with control over themselves. To much criticism, he believed the subject was simply an effect of power and preferred, especially in his later works, to ignore the subject altogether. He was more interested in examining the constitution of people's notion of subjectivity (Mills, 2004). However post-structuralist psychoanalyst theory questioned this use of self, 'describing a wide range of subject positions that individuals inhabit, sometimes precariously, sometimes

willfully adopting particular subject roles and sometimes finding themselves cast into certain roles because of their past developmental history or because of the actions of others' (Mills, 2004, p. 30).

Foucault largely ignored feminism, despite the fact that at the time he was working on his theory of docile bodies, feminists were working on the constructed bodies of women in parallel. The methodological tools available to him were ignored (Brown, 2000). Feminists also feel that important parts of history were ignored by Foucault when he developed the notion of the subject:

> Beauvoir argues that the subject is male and at the margins of history is a female consciousness who must adopt certain male characteristics to be recognized as a Subject in her own right. This double history, ignored by Foucault, would necessitate changes in his account of the coming to subjectivity of the autonomous individual.
>
> (Brown, 2000, p. 73)

I now begin the second part of the methodology employed for this thesis. This is the use of Norman Fairclough's (1995a) media analysis framework.

2.8 Fairclough's Critical Discourse Media Analysis Framework

Fairclough offers an innovative approach to studying the media. He demonstrates how changing practices of media discourse relate to wider processes of social and cultural change. These are vividly illustrated by the tensions between public and private and between information and entertainment that exist in many contemporary media texts.

Fairclough (1995b) explains the concept of intertextuality and shows how texts function by employing a multiplicity of voices, discourses and genres. Textual analysis can give access to the detailed mechanisms through which social contradictions evolve and are lived out, and the sometimes subtle shifts they undergo. The following excerpt from Fairclough (1995b) clearly relays why I have chosen to show my data according to this framework:

> Understanding how relations are constructed in the media between audiences and those who dominate the economy, politics and culture, is an important part of the general understanding of relations of power and domination in contemporary

> societies… Do the media constitute a substantive democratization, or do they primarily have a legitimizing role in respect of existing power relations? ... there are questions about whether and to what extent the media, in the ways in which they construct audience and reporter identities, operate as an agency for projecting cultural values – individualism, entrepreneurialism, consumerism – and whose values these might be. (p. 126)

This excerpt reiterates my original intention to analyse the construction of waterbirth in the media by revealing the complexities and strategies of media practice that shape what is said to construct the discourses that are deployed in relation to waterbirth. In parallel, this also highlights and demonstrates Foucault's notions of power relations and dominant speakers. The notions of Fairclough that will reveal these complexities and strategies are: analysis of the order of discourse, intertextuality, linguistic analysis and representations in text, including presuppositions, categorisation, foregrounding and backgrounding.

Undertaking a discourse analysis in the media was of interest to me because I feel strongly that waterbirth's image and reputation in New Zealand is largely fuelled by what New Zealanders read about it in our newspapers. The media are a source of readily accessible data for research and teaching. Media usage influences and represents people's use of and attitudes towards language in a speech community. Media use can tell us a great deal about social meanings and stereotypes projected through language and communication. In my opinion, the media reflect and influence the formation and expression of culture, politics and social life in New Zealand. By examining the media I was able to view my data in such a way that it showed me how discourse construction occurs and relates to so many facets of everyday life.

The notions I have chosen originate from the framework of Fairclough's (1995a) theory of critical discourse analysis. The framework is divided into specific operational analysis of specific texts. Of these, I have chosen the aforementioned three of order of discourse, intertextuality, and linguistic analysis.

Fairclough terms his philosophical approach as 'critical'; this is his recognition that social practices, and our use of language in particular, are bound up with causes and effects, which we may not be fully aware of under normal conditions (Bourdieu, 1997). An

example given by Fairclough (1995b, p. 54) is how society has become socialised to believe 'that it is legitimate for the reporter – as one who "speaks for" the public – to challenge the politician'. We can see that such practices are shaped, with their common-sense assumptions, according to existing power relations between groups of people. Critical discourse analysis explores the tensions between two sides of language use, the socially shaped and socially constitutive (Fairclough, 1995b).

2.8.1 Characteristics of mass media

A communicative event in the media, such as a newspaper article, involves major temporal and spatial disjunctions. The fundamental point is that the time and place of production of a mass communication text are different from the time and place of consumption, when an audience views or hears or reads it (Fairclough, 1995b, p. 36). Fairclough (1995b) alludes to the politicised nature of *who* in the world can have access to mass communication and *when.*

Fairclough (1995b) describes the mass media as a *chain* that connects the public domain to the private domain. For example, newspaper articles are produced in the public domain using predominantly public domain materials (e.g. political events) but they are consumed in the private domain, mainly in the home and within the family. Likewise, private events such as adverse birth outcomes have gained 'news' status and have become available for public consumption. A by-product of the bridge between public and private domains has been a communication style and ethos which adjusts towards the priorities, values and practices of private life. As a result, the media has developed its own 'public colloquial language', a public language for use in certain ways on certain topics e.g. the death of a child, or suicide (p. 38). The existence of waterbirth's own 'language', and when and where it is spoken of, is evident in the data texts for this study.

Indirectly, ownership of media institutions also shapes media discourse. Predominantly, large conglomerates own a country's media outlets. Consequently, the media become more fully integrated with ownership interests at the national and international economic levels. This intensifies an association between ownership and capital class interests…

> This manifests itself in various ways, including the manner in which media organizations are structured to ensure that the dominant voices are those of the political and social establishment, and in constraints on access to the media… it creates a persuasive pro-capitalist 'ethos' (Fairclough, 1995b, p. 43)

The meaning of genre is explained here because it is a term commonly used in Fairclough's (1995a) analysis. Genre in this sense refers to a way of using language, which corresponds to the nature of the social practice that is being engaged in; for example, a job interview is associated with the special way of using language we call the 'interview genre'. The newspaper articles used in this study contain multiple genres. Fairclough (1995b) states that there are no definitive lists of genres, discourses or any other set categories to which analysts must refer (p. 77). Intertextual analysis is an interpretative art that depends upon the analyst's judgment and experience.

Fairclough (1995b) states that any text is always simultaneously constitutive of social identities; social relations; and systems of knowledge and belief. Put concisely, it could be said that any text makes its own small contribution to shaping these aspects of society and culture. Therein lies the proof of how powerful the media can be. Fairclough suggests that media texts are sensitive barometers of cultural change which manifest in their heterogeneity and contradict the often tentative, unfinished and messy nature of change. Textual heterogeneity can be seen as a materialisation of social and cultural contradictions and as important evidence for investigating these contradictions and their evolutions. 'We are living through a period of rapid and continuous change in society and culture, the media play a significant role in reflecting and stimulating more general processes of change, and the practices of the media are correspondingly in constant flux' (p. 61).

I begin now with the first of the three notions of Fairclough that I have chosen to demonstrate with my data.

2.8.2 The order of discourse

The order of discourse refers to the positioning of the media between public orders of discourse and private orders of discourse, and the way in which the media transform their source into public discourse for consumption in domestic settings (Fairclough, 1995b, p. 63). The order of discourse mediates and shows how the media discourse has been shaped by the tension between its contradictory public sources and private targets, which act as contrary poles of attraction for media discourse.

> … the negotiation and renegotiation of the relationship between public and private discursive practices which takes place within the order of discourse of the media has a general influence on the relationship between these practices, and between the public and private in an overall sense, in other domains of social life. (Fairclough, 1995b, p. 63)

The point of 'order of discourse' is to highlight the relationship between different types in a set (e.g. in a hospital, the discursive types of midwives and doctors). It is whether a rigid boundary is maintained between discourses, or whether they can be easily mixed together in particular texts.

> These boundaries are also sometimes a focus of social struggle and conflict. Indeed orders of discourse can be seen as one domain of potential cultural hegemony, with dominant groups struggling to assert and maintain particular structuring within and between them. (Fairclough, 1995b, p. 51)

The key notion to understanding the order of discourse in the media is to recognise that the media influence private domain discourse practices, providing models of conversational interaction in private life. The issue is how the media's order of discourse chooses within, and appropriates, the potential available in adjacent orders of discourse. Internally, the issue is to describe the paradigms of alternative discursive practices available within the media's order of discourse and the conditions governing selection among them.

To summarise, it can be said that the relationship between institutions and discursive practices is not neat and simple. It is noted that different institutions share common

discursive practices, e.g. medicine and midwifery; however, these discursive practices may have a complex distribution across many other institutions.

2.8.3 Intertextuality

'Intertextuality is the term used to describe and show how texts function by employing a multiplicity of voices, discourses and genres' (Fairclough, 1995b, p. 215). It aims to unravel and expose the various genres and discourses – all of which are articulated together in the text.

Discourse practice is a term frequently used when discussing intertextual analysis. Discourse practice is to do with the various aspects of the processes of text production and text consumption. It is the point where the two perspectives within critical discourse analysis – the communicative event and the order of discourse – intersect.

Intertexual complexity in the mixing of genres and discourses is realised linguistically in the heterogeneity of meaning and form (Fairclough, 1995b, p. 61). To simplify, intertextual analysis is the interpretation of the discourses, while linguistic analysis is the describing of the discourses in the text. Intertextual analysis requires an understanding of the social and cultural influences surrounding the discourse in question.

2.8.4 Linguistic analysis and representations in text

The analysis of representational processes in a text is an account of what choices are made; what is included and what is excluded, what is made explicit or left implicit, what is foregrounded and what is backgrounded, what process types and categories are drawn up to represent events.

This analysis aims to reveal the social motivations for particular choices, and relations of domination. The ways in which I have chosen to demonstrate representation of a discourse in text are: presences and absences in texts; presupposition; categorisation; and foregrounding and backgrounding.

Relative foregrounding or backgrounding of aspects of represented social practices is an important part of their representation. This shows us that we need to be aware of not only what is represented, but what relative weight and importance are attached to different elements within a representation.

2.9 Summary of First Part of Chapter

In this first half of this chapter I have summarised my use of Foucault's main notions that I have applied to this research, and discussed critics of his works. I have also summarised Fairclough's critical discourse media analysis framework, from which I have chosen three main notions and their sub-themes to apply to my data. I have described how each notion contributes to the wider picture of social conditions that regulate media discourse and media texts and their social effects in terms of systems of knowledge and ideologies, social relations of power, and the positioning of people as social subjects.

In the next part of the chapter I describe the method and research design employed in this thesis.

2.10 Method

2.10.1 Introduction

Discourse analysis traditionally involves the careful reading of text; for example, interviews, conversations or newspaper articles. The aim is to reveal the discursive patterns of meaning, contradictions and inconsistencies that are present in the text. Discourse analysis is an approach which identifies and names the language processes people use to constitute their own and others' understanding of personal and social phenomena (Gavey, 1989). This chapter describes the research method used in this study, data collection and the process by which I analysed the data. Finally, I also describe the strategies employed for ensuring the trustworthiness of the research process as a whole.

2.10.2 Data collection

Firstly, while there is plenty of anecdotal evidence in New Zealand media about waterbirth it is often in publications that are not accessible to the general population. For example, *Little Treasures* magazine, a parenting magazine, regularly features articles on waterbirth and women's accounts of their waterbirths. However this magazine is targeted at a subset of our population: parents, mothers, women of child-bearing age. I wanted to concentrate on the general core of New Zealand media coverage so that I could analyse data that a large cross-section of New Zealand society would be reading. I also presumed that I would get a more equal distribution of opinion and perspective on waterbirth if I concentrated on mainstream New Zealand media. My aim was to ensure that I captured the perspectives that the general public were exposed to over the five-year period studied.

The three specific criteria I employed were; to find any article that contained the word 'waterbirth' and which was published in a New Zealand main broadsheet newspaper in the time frame of 2000–2005. New Zealand has 10 main broadsheet newspapers. These are *The New Zealand Herald*, *Waikato Times*, *Sunday Star-Times*, *The Evening Post* (Wellington), *Otago Daily Times*, *The Evening Standard* (Manawatu), *The Press* (Christchurch), *The Daily News* (Taranaki), *The Evening Post* (Auckland) and *The Dominion Post* (Wellington). Collectively, these papers are owned by Fairfax New Zealand Ltd. I also included one article (*Central Leader*, February 2, 2005) from a suburban newspaper, which was serendipitously published during my data collection period. This article was selected as it was rich in discourses and was the most recently circulated discourse on waterbirth for some time in the New Zealand media.

Fairfax New Zealand Ltd is New Zealand's largest media company. It was established in 2003 after the purchase of the publishing assets of Independent Newspapers Ltd. These include nine daily newspapers, two national Sunday papers, a stable of magazines with particular production in the lifestyle category, a magazine publishing business and an internet operation. Fairfax New Zealand Ltd also publishes over 60 community newspapers throughout the country. The parent company, John Fairfax Holdings Ltd, includes the *Sydney Morning Herald*, *The Age* and the *Australian Financial Review*. Its website states that 'Fairfax is a highly competitive media company with a strong performance ethic,

serving its communities through high quality independent journalism and dynamic venues for commerce and information' (www.fairfax.co.nz). It is of note that I could not find a mission statement or ethical code on this website. As I discuss in my media analysis chapter, the characteristics of mass media contribute politically to what news stories our country receives and when.

I collected a total of 30 articles during this period. I attempted to ensure that my data collection was thorough firstly by way of cross-searches using different search key words. Secondly, my search was greatly enhanced by a search performed for me by Media Masters who are employed by Dow Jones Reuters Business Interactive LLC in Sydney. This is a specific branch of the Reuters Law conglomerate that provides information to its employees for cases they are working on. This search accessed three additional articles. The articles I collected were sourced from the following:

Table 1. Media Sources	Number
The New Zealand Herald	8
Waikato Times	6
Sunday Star-Times	2
The Evening Post (Wellington)	1
Otago Daily Times	1
The Evening Standard (Manawatu)	3
The Press (Christchurch)	2
The Daily News (Taranaki)	1
The Evening Post (Auckland)	2
The Dominion Post	3
Central Leader (suburban)	1

Search engines I employed were www.theknowledgebasket.co.nz, www.stuff.co.nz, www.nzherald.co.nz , www.factiva.au, www.fairfax.co.nz, and www.otagodailytimes.co.nz.

2.10.3 Data analysis

Before commencing a media data analysis I reviewed the midwifery and medical literature on waterbirth, which enabled me to locate and identify the discourses and the speakers from those discourses in relation to waterbirth. This then framed the data analysis and research aim, which was to examine how the media deploys these discourses to represent waterbirth. For the literature review I read extensively about waterbirth, collecting all available articles I could on waterbirth from the midwifery and medical journals. The literature review revealed the seven main safety issues that are raised and are prominent in waterbirth literature: maternal and fetal temperatures during labour, perineal outcomes, delivery of the placenta and cord snapping, shoulder dystocia, infection, protecting midwives backs, and fetal hypoxia and water inhalation during waterbirth. A synopsis of this review is detailed on page 56.

From this review of the literature two main discourses, which I have termed the scientific medical and the natural birth were identified. A third discourse, the dive reflex discourse was identified as a discourse that underpins the claim of safety around babies being born underwater. This reflex is deployed as verifying waterbirth as a safe practice. I then read and re-read the 30 newspaper articles I had collected about waterbirth in New Zealand during the period of 2000–2005. Using a highlighter, I colour-coded each of Foucault's and Fairclough's notions and identified these notions in operation within the newspaper articles.

The framework for the analysis is divided into two parts. The data was firstly examined according to five of Foucault's concepts relating to his meaning of discourse: subjectivity, discipline, the panoptican, exclusion in discourse and circulation of discourses (Foucault, 1977).

Discipline was examined by searching for Foucault's notion of 'docile bodies'. I identified how discipline as a technology of power manifested itself on the practitioners of waterbirth

and the women themselves. Examples of ‘docile bodies’ were identified. By then examining the protocols on waterbirth of seven Auckland maternity hospitals/providers (see appendix 1) I was able to identify how an overall discipline is applied to the practice of waterbirth.

The notion of the panopticon was revealed by identifying the conditions that exist to ensure that waterbirth is kept permanently visible to the scientific medical discourse so its power over waterbirth can prevail. I asked ‘What processes are in place to survey waterbirth in New Zealand?’ ‘Who is surveilling waterbirth?’

Foucault’s (1977) notion of ‘will to truth’ revealed how exclusion within discourses dictates what is deemed legitimate knowledge on waterbirth. I asked ’What “truth” on waterbirth is perpetuated and by whom?’ ‘What strategies are used to state what is considered valid knowledge in relation to waterbirth and what is not?’ ‘What truth on waterbirth does the media choose to deploy?’

By examining Foucault’s (1977) notion of circulation of discourses I was able to question:
Which discourse provides repeated commentary on waterbirth? In what types of publications is this commentary repeated and whose voice is being documented as the legitimate speaker? How is academia cited as to what constitutes the argument on the safety of waterbirth?

Foucault’s notion of discourse allowed me to ask:
What representations of birth and waterbirth challenge waterbirth’s acceptance as a safe birthing practice in this country? Who are the speakers that relay fear to women who might be considering a waterbirth? What technologies of power are evident in these texts? What subjectivities are produced by each of the discourses? How are these discourses circulated and what conditions exist to ensure each discourse prevails?

Discourse analysis allows for the identification of other discourses and creates space to reveal other ‘truths’ that have been marginalised by the dominant discourse.

The data were then analysed following Fairclough's concepts of the order of discourse, intertextuality and linguistic representations in text (Fairclough, 1995b).

The newspaper articles in this study were examined for which discourse is given priority and the most positioning and volume within the individual text. Which discourse is made to 'stand out' the most and drive the overall communication about waterbirth in the text? I asked of each article 'What is the dominant discourse saying here about waterbirth in society at the time this article was published?'

The order of discourse is concerned with specifying what communicative events, internal and external, are chained together in this way, and the sorts of transformations that texts undergo in moving along such chains. Therefore when reading the articles I looked for what recognition the speakers of each discourse gave to the alternative or adjacent discourse on the topic of waterbirth ('lack of scientific research' is commonly cited here). I took care to reveal other internal and external influences that the media may have 'honed in on', such as the death of a baby, to advance one discourse over another. I aimed to show what adjacent discourses (for example, disciplinary action against midwives) may have been used to shape discursive practices and hence transform the original body of text into something more appealing to the private domain of consumption from that which has actually occurred in the public domain.

The question that intertextual analysis asks is 'What genres and discourses were drawn upon in producing the text, and what traces of them are there in the text?' It is important to explain the two underpinning notions of discourse practice and discourse type and relate them to the umbrella term of intertextuality. The researcher questions here how the communicative event draws upon the order of discourse (normatively or creatively) and what effect it has upon the order of discourse – whether it reproduces its boundaries and relationships, or helps restructure them. Creative discourse practice sees the mixture of a number of discourses but also examines the way they were put together. For example, documentary-style news bulletins can now involve combinations of genres – informing, persuading and entertaining.

Fairclough's (1995b) analysis of discourse type involves looking at the configuration of genres rather than a simple genre; for instance, a discussion on waterbirth in a newspaper article may draw upon and combine political oratory, interview, or a 'chat' between a woman and her midwife. All these genres articulate elements of conversation with elements of entertainment. The object in identifying types of discourse is to capture the distinctive discourse types that have emerged in the order of the discourse by the media. Fairclough uses the titles of *activity type, style, mode and voice* as cues for the reader to use when identifying discourse types (p. 76).

Linguistic analysis and representations in text were examined under the following sub-headings.

2.10.4a Presences and absences in texts; presupposition

Representation in the media generally means an analysis of what is 'there' in the text. It is also pertinent to be sensitive to absences from the text, to things that might have been there but are not (Fairclough, 1995b, p. 106).

The absence of historical context in a lot of news stories is noted; news is constructed in terms of events that are treated as more or less isolated from prior or subsequent events – isolated from history. If something is presupposed it is in a sense present in the text, but as part of the overall implicit meaning of the text. If something is explicitly present in a text, it may be informationally backgrounded, or informationally foregrounded.

Presuppositions act by positioning the reader. 'How a text positions the reader is very much a matter of the common-sense assumptions that it attributes to the reader. The presuppositions in a text are part of its intertextuality; presupposing something is tantamount to assuming that there are other texts (which may or may not actually exist) that are common ground for oneself and one's readers, which are now presupposed to be part of the 'said' (Fairclough, 1995b, p.107). Presuppositions also help establish represented realities convincingly. For example, the opening paragraph of a newspaper article needs to establish for its reader a world that carries conviction as being authentic.

The presupposed, the unsaid, the already said, are of importance in ideological analysis in that 'ideologies are generally embedded with the implicit meaning of a text rather than being explicit' (Fairclough, 1995b, p. 106).

2.10.4b Categorisation

Fairclough (1995b) stresses that when a person uses language to represent people, events, actions and objects around them the choice of words is always paramount. He states that it is grammar alone and its associated 'process types' and associated 'participant types' (p. 109) that make us choose the language we use to represent something. We either represent something as an action or an event. Fairclough suggests that newspapers systematically background the involvement of police/violence and other forms of undesirable social behaviour to represent practices which may have significant ideological effects. This is done by contrasting discourses, e.g. good people versus bad people. This is achieved by discourses that foreground, for example, casualties, responsibility and even conspiracy, and discourses that represent such problems and disasters as a matter of fate, happening beyond human control.

2.10.4c Foregrounding and backgrounding

Subsequently when reading the data texts I looked for the clauses that featured most prominently (foregrounded) and noted which speaker of which discourse they came from.
It is interesting to look at the relative positioning of different topics within the generic structure of the text. Topics which appear in the informationally prominent headline position in television or newspaper articles or in the lead (i.e. the first) paragraph are informationally foregrounded. Foregrounding involves using main sentences to foreground the information, whereas subordinate clauses generally background it.

Fairclough's media analysis framework allowed me to ask:
Are these discourses mixed together in the text or do they stand alone? What other adjacent discourses have been used here to transform this communicative event for private consumption? What social and cultural influences are evident in this article? What genre

has been used? What is the dominant discourse saying about waterbirth in New Zealand at the time this article was published? How is language used to articulate subjectivities on waterbirth? What information is presupposed or absent from this text and which information is positioned to attract the readers attention the most?

I examined the configurations of the discourses, selection among available discourses, and how overall articulation had occurred, to demonstrate and showcase the ideological significance or 'truth' on waterbirth being promoted.

I now explain how I ensured my study met the criteria of rigour in research.

2.10.4 Rigour

Rigour is the term used to describe the overall integrity and trustworthiness of research. When research is deemed 'rigorous' it implies that the reader can have faith in the findings and results of the research (Gbrich, 1999). By choosing postmodernism as my philosophical point of inquiry I acknowledge that the issue of validity is contestable. The aim of qualitative research is to obtain a comprehensive and truthful description of a particular phenomena, context or incidence. There are differences in language and criteria within the quantitative and qualitative paradigms. The criteria for rigour in qualitative research are listed by Lincoln and Guba (1985) as credibility, dependability, confirmability and transferability. Overall, the aim of qualitative research is to obtain a comprehensive and truthful description of a particular context.

Credibility in qualitative research is the truth-value of the study. It asks 'how true is the researcher's representation to the actual reality being told here?' Lincoln and Guba (1985) maintain that 'credibility is a trustworthiness criterion that is satisfied when source respondents agree to honor the reconstructions; that fact should also satisfy the consumer' (p. 329). Credibility is maintained by ensuring that the original research question 'fits' the design of the research.

The activities of prolonged engagement, persistent observation, triangulation and peer debriefing are cited by Lincoln and Guba (p. 301) as techniques to ensure findings are credible. I have honoured the criterion of prolonged engagement and persistent observation by collecting data published over a five-year time frame. Triangulation is not applicable to this study. My data searching methods attempted to be thorough and repeated several times over the space of a year. I enlisted the help of Media Master in Australia to assist me with my searches and I employed six different search engines. I contacted a newspaper clipping service but was advised by them that worldwide web searches would provide a better and more thorough coverage for data collection. By ensuring a prolonged engagement on data collection I learnt the 'culture' of how waterbirth is spoken about in the media in New Zealand, enabling me to monitor misinformation, distortions and to eliminate data that did not meet the three criteria of my search. During this period of prolonged engagement I was able to identify and decide upon my own preconceptions, while exposing myself to the multiple influences that impinged upon the scope of waterbirth in the media.

Persistent observation provides depth to the credibility of data. It aims to identify and assess salient factors and crucial unusual happenings (Lincoln & Guba, 1985, p. 307). By following closely the three data collection criteria, I was able to see when data was not relevant or attributable to my study. I was also then able to recognise when atypical, unusual or unexpected data on waterbirth might have been of some importance to the overall assessment. Detailed exploration of such salient factors was carried out in the 10,000-word literature review undertaken before commencing the study. By exploring the worldwide literature on waterbirth I was able to sort which information helped to form and represent each discourse in the most correct and up-to-date way. I have endeavoured to describe my methodology and link it whenever possible to the data I have collected. I have attempted to include dense description in my writings to illustrate my findings.

Minichello, Sullivan, Greenwood, & Axford (1999) suggest confirmability can be achieved by undertaking an audit trail to verify and confirm findings and conclusions. Trustworthiness may also be substantiated in this way. An audit trail involves the systematic review of the study by an external examiner. Such an auditor would judge how sampling, categorisation and core themes were generated and how the final analytic decisions were made. Auditability provides transparency that ensures the reader can follow

the decision trail on the researcher and that it is transferable research that can be applied to another group of people experiencing the same phenomenon (Allison, 2001).

Peer debriefing was carried out at discourse analysis forums held at Auckland University of Technology, where I presented my topic and findings to other students of discourse analysis and asked them to give feedback. This strategy ensured that the aspects of my study were laid open for discussion and input. Lincoln and Guba (1985) credit debriefing as a process that 'helps keep the inquirer honest, exposing him or her to searching questions by an experienced protagonist doing his or her best to play the devil's advocate… the inquirer's biases are probed, meanings explored, the basis for interpretations clarified' (p. 308). Furthermore, I shared my findings and ideas with numerous people throughout the time I have been writing my thesis. I presented my preliminary findings to a group of mainly midwives and nurses who were also undergoing post-graduate study. Throughout, my two supervisors read and gave written and verbal feedback on each chapter as it emerged, giving me further clarification and challenging my biases and overall interpretations as I journeyed.

The practice of sharing findings with others to gain their agreement contests the postmodern view that reality is partial and constructed and that multiple truths exist, and that subjectivity is changeable and contradictory. Foucault attempted to distinguish his work from structuralism, and thereby outlined the possibility of an analysis that is not dependent on referring back to the identity of an underlying continuous subjectivity (Barker, 1998).

From a postmodern perspective, validity and reliability in research are problematic issues (Gbrich, 1999). We can ask 'what is validity?' And whose version of truth is this anyway? The postmodern rejection of the grand theory as a singular explanation of 'reality' in favour of multiple perspectives and the development of small-scale contextual theoretical explanations adds great complexity to this debate (Gbrich, 1999, p. 9).

Reflexivity in qualitative research is an important process whereby researchers clarify to readers how their beliefs have been socially constructed and how their values may impact on the overall interpretation of the research study (Lincoln & Guba, 1985). Reflexivity

requires the researcher to undergo a self critique of her experience, empathy and objectivity. Such a process is viewed as instrumental in transcending differences of power, culture and class (Gbrich, 1999, p. 65). Reflexivity examines the extent to which the researcher's biases may have influenced the outcomes. Lincoln and Guba (1985) suggest strategies such as the researcher keeping a personal diary throughout the research may provide opportunity for catharsis, for reflection upon what is happening in terms of one's own values and interests, and for speculation about growing insights along the way (p. 327). A degree of measured explicitness about one's own analytical and naming practices is recommended by Sunderland (2004). This ensures the analysis is not solely the product of the analyst's particular interpretive proclivities.

I have declared in Chapter One my experiences of working at one time as a midwife in a birthing unit that actively promoted waterbirth and its benefits. However, from the outset, I have deliberately and methodically chosen to equally examine all discourses and subject positions on this subject. I have rigorously tried to contest and uncover all discourses regarding waterbirth. I have tried at all times not to allow my own subjectivity to dominate or permeate through into my findings.

2.11 Summary of Second Half of Chapter

In this chapter I have described my chosen methodology and its relevance to my research question. I have shown the research process and explained my research design. The process of data collection, rigour and the method of data analysis have been described in detail. I have demonstrated reflexivity by discussing my own subjectivity as the researcher in Chapter One. In the following chapter I describe the practice of waterbirth, its origins, history and the three discourses identified in the literature that contribute to the representation of waterbirth.

CHAPTER THREE: LITERATURE REVIEW

In this chapter I inform the reader about waterbirth. The notion of birthing underwater holds multiple representations for people. Proponents of waterbirth represent it as a practice that has played an important role in keeping birth normal in homes and hospitals throughout New Zealand. Critics of waterbirth trouble the practice by arguing that it creates the potential for neonates to drown in water, therefore its practice is contested in relation to birth. This chapter describes waterbirth and its pioneers. The chronological emergence of waterbirth as a practice in history and within New Zealand is detailed. The purpose of this chapter is also to clearly show the reader the three discourses I have identified in my review of the midwifery and medical literature on waterbirth. I have identified and labeled these as the natural birth discourse, the scientific medical discourse, and the dive reflex discourse. By identifying and comparing the three discourses as they are evident in the waterbirth literature I aim to show the reader the contested nature and construction of waterbirth.

Discourses need conditions in order to exist (Johnstone, 2002, p. 3). In this chapter I discuss the conditions of existence and aim to show how they enable the emergence of the discursive object that is waterbirth. Each discourse brings objects into our awareness. Discourses offer identities and subjectivities for the different speakers. Certain institutions and social contexts provide legitimacy for the speaker (Johnstone, 2002; Weedon, 1987). I begin now with the natural birth discourse.

3.1 The Natural Birth Discourse

The natural birth discourse that speaks on waterbirth is found mainly in midwifery journals, midwifery publications and parenting magazines. Women continue to write positively of their waterbirth experiences in the media. ‘Compared to women who have given birth out of water, waterbirth mothers report a higher level of satisfaction’ (Gordon, 1996, p. 3).

Waterbirth became a discursive practice more strongly associated with the natural birth discourse because it is a mode of birthing that declares the birth to have been a natural or normal physiological process. That is, one that has not involved pharmaceutical forms of pain relief, or medical intervention. It is seen as evidence of how a birth has happened truly

physiologically. Midwives who assist at waterbirths follow a set of unspoken ‘rules’ to maintain and not interfere with the normal ebb and flow of birth (Balaskas, 2004). What is a normal physiological birth? It is the belief that pregnancy and birth are normal and healthy events that most midwives use to construct their midwifery knowledge and practice. ‘Normal’ in this sense means the biological process of childbirth where pregnant women will achieve a successful outcome given support and patience (Department of Health, 1989; WHO, 1997).

Birth is socially and culturally constructed and as such midwifery is to ‘do’ with normal. The particular skill of the midwife is in recognising each individual woman’s boundaries of ‘normal’ (Guilliland & Pairman, 1995). These authors demonstrate how ‘normal’ is considered the basis for midwifery training:

> For a midwife to internalize birth as a normal life passage, she must witness the total childbirth experience within its social and cultural framework. Similarly for women to internalize birth as a normal life passage they must experience birth in their own way, unfettered by imposed belief systems. (p. 35).

The New Zealand College of Midwives *Handbook For Practice* (2002) states ‘The midwife promotes and supports the normal childbirth process.’ (p. 4). However, in a climate of increasing habitual intervention, the challenge to keep birth ‘normal’ presents the midwifery profession with a real problem. In the pervading medical culture that surrounds birth at the present, a paradox has been created ‘Where midwives may believe natural childbirth to be normal but do not really believe that normal childbirth has to be natural’ (Downe, 2001, p. 438). Normal birth is the domain of midwives. In a study that questioned student midwives’ perspectives and definitions of normal birth, Gilkison, Holland, Berman, McAra-Couper, Waller, Gunn, & Lennan (2004) found that student midwives constructed ‘normal birth’ from a multitude of reasonings:

> Normal is where labour is left to unfold on its own with no interference, not even the interferences of the midwife…

> What I count as normal things, are things that do not dramatically affect the baby, or which may help the mother to cope, they are interventions, but not a medical intervention…
>
> I think as long as you deliver vaginally, it does not matter what help you had to get there, it is classed as a normal delivery now… (pp. 11–12).

The study highlights that student midwives each construct their own definition for what is normal. They identified that midwives, women and culture influence the definition of normal birth.

Guilliland and Pairman (1995) created the New Zealand model of midwifery partnership. They discussed that over the past four decades the New Zealand midwife's role has become fragmented and her understanding of birth as a normal life event has become distorted.

The dominant subjects of the natural birth discourse are midwives and women. Waterbirth is attended by midwives rather than obstetricians (Beech, 1997; Birth Unit of St John and St Elizabeth 1999; Haddad, 1996; Odent, 1997). Obstetrics is the domain of medicine relegated to high-risk or complicated pregnancy, labour and birth. The natural birth discourse has a tendency to exclusively portray and construct birth as a predominantly normal and natural event that is regulated by hormones produced by the mother herself; the hormonal flow in labour is dependent on her emotional state, which in turn is affected by how she is treated and the atmosphere in the birthing room (Beech, 1997). The natural birth discourse opposes the scientific birth discourse on the basis that birth is an intrinsic, physiological life event and is safe. Waterbirth is promoted as an ideal mode for enhancing and supporting the physiology of the birth process (Charles, 1998; Fenton, 2004; Fitzgerald, 2003; Forde, Creighton, Batty, Hawdon, Summers-Ma, & Ridgway, 1999; Garland, 2000; Garland & Jones, 1994; Kitzinger, 1995; NZCOM, 2002; Odent, 1997, 1998).

The speakers within the natural birth discourse are predominantly from the midwifery profession, though not exclusively, and women who adopt this discourse on birth for themselves. It is noteworthy that not all midwives practicing midwifery would position themselves within the natural birth discourse. Payne (2002) found that some midwives will

move within and between both the natural birth discourse and the scientific medical discourse.

3.2 Definition of a Waterbirth

A birth is termed a waterbirth when the lower body of the labouring woman is immersed in water during the second (delivery) stage of her labour. The baby is born into the water. A true definition involves both the baby's head and body born underwater (Odent, 1984). Waterbirth in New Zealand is commonly conducted in a custom built, self assembled, rental pool or tub. Maternity units that incorporate waterbirth in their practice will often have plumbed-in custom built tubs or pools.

3.3 The Pioneers of Waterbirth

Waterbirth became an apparent and available way of giving birth through the writings of Michel Odent, a French obstetrician. Odent established a birthing unit in Pithiviers, France in 1970. He discovered that if allowed, women were naturally drawn to immersing themselves in water during labour as a means of pain relief. The first waterbirths began occurring unplanned, as women refused to get out of the water. Odent began experimenting with waterbirth and documented his findings. Garland (2000) states:

> Odent's emphasis on environment and caregivers revolutionized practice in western hospitals. He was one of the first to identify the importance of empowering women, to facilitate them to regain control over childbirth. His first tentative steps towards using water for labour and eventually delivery were from the apparent attraction that women displayed towards water during labour. (p.10).

Odent has written widely on his belief that water's physiological basis reduces adrenergic secretions, promotes endorphin production and reduces sensory input. His stance on waterbirth is from an overtly physiological base. He also advocates the premise that water provides a calm, reassuring environment, which stimulates and enhances normal labour. Water labour and waterbirth have become his trademark.

Of note and historical importance are two other pioneers in the development of waterbirth practice. They are Igor Tjarkovsky (Richmond, 2003b), and Frederick Leboyer, a French obstetrician.

In the 1960s Igor Tjarkovsky, a swimming instructor by profession, studied the behaviour of animals in water and discovered that some mammals could be trained to give birth and nurture their young underwater. It was his photographic book *Water Babies* (Sidenbladh, 1983) that brought the first visions of waterbirth to the west (Balaskas, 2004). When visiting the United Kingdom for the first time in 1989, he showed to health professionals a video he had made of the 'apparent trust that Russian women had in his ideas, allowing their babies to be submerged in ice-cold water' (Garland, 2000, p. 12). His ideology was that sudden exposure at birth to the full force of gravity places a huge insult of oxygen on the sensitive newborn brain functions. The United Kingdom banned him from re-entering the country on the grounds of cruelty to children. This basically ostracised him from further researching. Garland (2000), an important waterbirth pioneer in the United Kingdom and senior midwife at the Maidstone hospital birth unit (Balaskas, 2004), credits Tjarkovsky for his radical thinking.

Frederick Leboyer states in his work *Birth Without Violence* (1974) that new ideas about birth violence started in 1966. His belief was that the emotional environment of birth has a profound impact and life-long effect. He advocated separating the baby from the mother once the umbilical cord is cut and replacing the baby straight into warm water. Leboyer believed the transition from the intrauterine to extrauterine environment should be gentle, respectful and kinder to the baby. Leboyer's work would have been groundbreaking reading in 1974 when he advocated his straightforward attitude towards gentle birth and using water immediately afterwards. He stressed the need for a quiet, dimly lit environment at the moment of birth. Less stimulus to the baby's senses he believed was beneficial for all future development (Garland, 2000). Leboyer's thinking challenged opposing medical discourses and practices regarding birth. By highlighting the concept of mind/body and use of human intuition, Leboyer was valuing subjectivity; these concepts alone position Leboyer in the natural birth discourse.

Yehudi Gordon, a British obstetrician mentored by Odent, felt that by incorporating waterbirth into obstetric practice where he worked there was a mimicking of the skills and values of many practicing midwives within the United Kingdom. It was a way of retaining some traditional midwifery skills at a birth, e.g. having to verbally 'coach' a woman through each contraction. Retention of midwifery skills he believed was becoming more difficult in the ever-changing health service and within an increasingly litigious profession. Gordon pioneered the Birth Unit of St John and St Elizabeth Hospital in North London where women traveled (and continue to do so) from all over the world. In the late 1970s he was recognised as being an obstetrician who would advocate and support women opting for vaginal birth after caesarian section (VBAC); later he became well-known as one of the few remaining obstetricians prepared to let a woman with breech presentation labour and deliver vaginally. Gordon is responsible for the promotion, support and teaching of many midwives in the skill of waterbirth.

It can be seen that collectively Odent, Tjarkovsky, Leboyer and Gordon introduced new concepts and practices regarding birth, which have been embraced and implemented in many birthing institutions the world over. It was these practitioners of birth who first began to resist the medicalisation of childbirth that had dominated maternity care since the 1920s (Donley, 1986, 1998; Stojanovic, 2002; Tew, 1998).

3.4 A Return To Natural

The voice and subjects that became what I deem 'the natural birth discourse' began to emerge around 1952 with the formation of the Parents Centre. Hence, emergence of the natural birth discourse in New Zealand began in the 1950s. Women were reacting vocally against the increasing use of sedation in hospitals, which often resulted in forceps deliveries. They wanted more flexible routines, such as 'rooming in' and breastfeeding support. Grantly Dick Read's psycho prophylaxis method of 'Childbirth without Fear' (1954) was an influencing piece of literature at this time. His work would have been welcome reassurance for a lot of women who had been socialised to believe that birth was a life-risking event. Dick Read was the first person to coin the term 'natural childbirth'. His experiences as an obstetrician in the early 1930s had pondered him to write about women's

emotional experience of childbirth and motherhood; concepts utterly unheard of in these times. He questioned and investigated the part played by the emotions in the natural function of reproduction. 'Was the nature of labour responsible for the emotional state of the woman, or was the emotional state of the woman to a large extent responsible for the nature of the labour?' (Dick Read, 1954, p 6). To summarise Dick Read's theory of natural childbirth I include this excerpt:

> Superstition, civilization and culture have brought influences to bear upon the minds of women which have introduced justifiable fears and anxieties concerning labour. The more cultured the races of the earth have become, so much the more positive have they been in pronouncing childbirth to be a painful and dangerous ordeal… Therefore, fear, tension and pain are three evils opposed to the natural design, which has been introduced in the course of civilization by the ignorance of those who have been concerned with preparations for and attendance at childbirth… The implementation of my theory demonstrates the methods by which fear may be overcome, tension may be eliminated and replaced by physical and mental relaxation. (p.10).

The Natural Childbirth group began in Wellington in 1951; this group originated from the Christchurch Psychological Society and eventually became Parents Centres. This was a group of women who began to challenge the child birthing authorities of the time (Donley, 1986). The World Health Organisation's report of 1952 mentioned that while New Zealand gave a high standard of physical care to its mothers it showed 'relative neglect of the equally important emotional aspects of maternal and child care'; factors known to contribute to longer labours (Donley, 1986, p. 82). This statement at this time from such an authority would have expertly strengthened the Parents Centers' outright cause. From their inception, Parents Centres rallied for the empowerment of women in birth through antenatal education. They called for birth to be re-acknowledged as a natural life event. Alongside this was their desire to see more loving and enlightened parenting, improvements in parent-child relationships and a more permissive approach to childcare. This was a time of a strict parenting style, which involved rigid routines – a by-product of the teachings of Dr Truby King, founder of Plunket. His teachings were reinforced by Plunket nurses of the era. Parents Centres were instrumental in the introduction of antenatal classes for pregnant women, where relaxation breathing techniques were taught by physiotherapists. They also addressed widespread consumer dissatisfaction of the maternity services during the 1950s and 60s. Their effect as a pressure group saw the inclusion of demand breastfeeding and

rooming-in into hospitals (having the baby in the same room as the mother and not in the nursery).

The Home Birth Association was formed in 1978. Members who joined the association saw their aims as 'directly linked with maintaining the midwife in her full scope of practice and were the group which specifically aligned themselves to the midwife.' (Donley, 1992). To the more conservative groups within maternity care they became known as 'birth activists', whose ideas and ideals were often considered radical. In the following years, women seeking 'other' ways in which to birth would discover waterbirth for the first time; it was around 1982 that waterbirth began occurring in New Zealand (L. Williams, personal correspondence, 2006). The formation of the Home Birth Association revealed to the public the underhanded behaviors of obstetricians in New Zealand and their plans to achieve a complete monopoly of childbirth in New Zealand. Via newsletters and media broadcasts, this group has kept controversial obstetric developments in the public domain. In 1978 less than 2% of women had home births (Donley, 1986, p. 82). The years between 1978 and 1988 saw an acute shortage of domiciliary midwives nationwide. Factors that contributed to this were very low rates of pay – in fact they were still paid in accordance to the 1938 Social Security Act! - too frequent 'conflicts' with medical professionals, burn-out from being on-call 24-hours-a-day and often the isolation of being the only domiciliary midwife in an area. Ironically, and yet sadly, these years saw a surge in the demand for home births; the medicalisation of childbirth had become widespread, well-known and unacceptable to a lot of women. However, as most midwives worked within hospitals, there was a scarcity of experienced domiciliary midwives versed in home birthing. The 1983 Nurses Amendment Bill prompted the Auckland sect of the Home Birth Association to launch a 'Save the Midwife' campaign. This saw the improved remuneration for domiciliary midwives and improved relations and alleviation of growing tension between hospital-based and domiciliary midwives. The Home Birth Association would go on to lobby in support of the 1990 Nurses Amendment Act, which would allow for fully autonomous independent midwifery practice (Donley & Hinton, 1993, as cited in *Midwifery News,* (35), p. 14).

3.5 Waterbirth Emerges in New Zealand

New Zealand domiciliary midwives were instrumental in the initial changes to rigid authoritarian maternity care models of the 1970s. This saw the creation of an equal partnership between women who believed in their ability to give birth and the domiciliary midwives who supported them. Women in collaboration with their midwives began to explore other possible alternatives and options for their childbirth and parenting experience (Guilliland & Pairman, 1995). Waterbirth became one of these.

Women such as Balaskas (1998, 2004), Robertson (1994) and Kitzinger (1990, 1991) have written extensively from their experiences as childbirth educators and midwives on the importance of active birthing – that is, ensuring the labouring woman remains in an upright and mobile position so that she may labour naturally. A resurgence in active birthing had the effect of empowering women with the knowledge that they no longer had to 'obey' the birth attendant and commit an entire labour to lying supine on a bed.

The first evidence of waterbirth occurring in New Zealand was in 1982 *The New Zealand Women's Press* newspaper, announcing in an article (June 29, 1982) 'New Zealand's First Waterbirth.' It detailed the birth on March 17, 1982, at the Rainbow Dolphin Centre, Tutukaka, Northland. Founded by Estelle Myers, whose waterbirth philosophy was based on what she called 'attitudinal healing', the centre promoted and offered a place for waterbirth. Myers adopted the 'dolphin life-style philosophy' whereby when a dolphin gives birth it is surrounded by a circle of mother dolphines. It was Myers' philosophy that a birthing woman should be surrounded by family at the time of birth. She incorporated Fredrick Leboyer's main concepts into her births.

The following month (July, 1982) the *Evening Post* published an article about Wellington Women's Hospital agreeing to arrange a waterbirth for a woman who had requested one. It claimed to be the first hospital in the country to do so. However, the woman who had requested the waterbirth went into labour en route to Auckland and had the waterbirth at a house in Auckland, attended by Estelle Myers. During labour the woman presumably sustained a cervical tear. She was transferred to hospital for surgical repair and was given plasma infusions to counteract the heavy blood loss she had sustained after the birth. Estelle

Myers had been interviewed by *The Evening Post* about the waterbirth soon after it occurred. In the initial media interview she failed to disclose any such details and had instead heralded the birth as 'beautiful' and that it 'blew her away'. She was later lambasted for failing to disclose this information or keep notes on the birth and would not respond to calls from the medical profession to explain what had gone on at the birth.

Media coverage (*Evening Post* July 31, 1982; *Evening Post* August 3, 1982; *Evening Post* August 4, 1982; *Evening Post* August 13, 1982, *Evening Post* August 23, 1982; *Evening Post* August 27, 1982; *Whangarei Post*, September 17, 1982) on the topic of waterbirth in the months and years following this waterbirth debut were consistently negative and defamatory towards Estelle Myers and waterbirthing in general.

Lynda Williams, co-ordinator of the New Zealand Maternity Services Consumer Council since 1992, midwifery consumer representative and childbirth educator for 15 years, recalls that in 1980 she was aware as a childbirth educator that women were relaxing in the bath during labour and sometimes delivering in the bath. She saw the beginnings of waterbirth in this country linked to the emergence of the home birth movement. At this time she felt that women began reclaiming birth for themselves (L. Williams, personal communication, November 3, 2006).

Carolyn Young, independent midwife with over 30 years experience in domiciliary practice spoke about public opinion on waterbirth at the time of its emergence in New Zealand. She felt that in the beginning waterbirth was placed on the lunatic fringe, that it was perceived that there were no particular advantages in having a waterbirth, and that there was an element of lack of safety. Carolyn felt it appealed to a small fringe of people. She feels that today (in 2006) waterbirth is now condoned and it is accepted that you can have a waterbirth in a public hospital facility. However, she remains of the opinion that it is still considered to be on the lunatic fringe to a certain extent (C. Young, personal communication, October 27, 2006).

Waterbirth as a discursive practice of the natural birth discourse first began to emerge within independent midwifery care around 1994 (Maude, 2003). By 1997, it was openly discussed with women as an option for them.

I would suggest that waterbirth and hypno-birthing remain today (in 2007) as the newest of the alternative modes or methods of birthing. Foucault in his work *The Archaeology of Knowledge* (1970) describes his notion of 'the episteme'. He says that an episteme is the total sum of the discursive structures, which comes about as a result of the interaction of the range of discourses circulating and authorised at a particular time (Mills, 2004, p. 51). It could be said that waterbirth as a discourse has emerged from the episteme of discourses within maternity care in New Zealand since 1904 until now (Stojanovic, 2002). Within this period there has been a tendency to structure thinking about waterbirth in a particular way. There are multiple discursive practices that collectively contribute to our thinking when we regard the discourse of waterbirth.

3.6 The Politics of Waterbirth

Waterbirth is controversial. The main fear that exists today is that the baby will suffocate or inhale water and drown before it surfaces (Beech, 1997; Geissbuhler & Eberhard, 2000; Gilbert & Tookey, 1999; Limburg, Smulders, & Kloosterman, 1992; Nguyen, Kuschel, Teele, & Spooner, 2002). Waterbirth emerged as discursive birthing practice around the late 1980s; initially it challenged the dominant medical system of birth. However, it does not need to be validated by tradition (Kitzinger, 2000, p. 15). Whilst waterbirth cannot be supported phylogenetically (that is, relating to or based upon evolutionary development), or by ethnic examples, western women continue to write positively about it in the press (Richmond, 2003a). Waterbirth is attended by midwives rather than obstetricians. 'Few obstetricians want to wait kneeling on the floor at the side of the pool while a woman gives birth unmanaged, undirected and in her own time and her own way.' (Kitzinger, 2000, p. 214). Marsden Wagner, a world-renowned perinatal epidemiologist, neonatologist and ex-WHO director, gives his explanation for the controversy that has embraced waterbirth since its inception:

> Waterbirth like homebirth is controversial. Why? Because the Obstetricians are out of control. It's that simple. The water helps the woman but it sure doesn't help the birth attendant. It's the opposite of the lithotomy position, which helps the attendant but doesn't help the woman. With waterbirth the birth attendant has

> many dilemmas; do I roll up my sleeves? Do I get in the pool? Take off my clothes? What do I do here? You can't really attend a waterbirth and keep your sophisticated control and dignity. (Cited by Lawrence-Beech, 1996, p. 4).

Waterbirth, like homebirth, is an example of a non-orthodox, non-obstetric approach to birth; both of these phenomena use the natural birth discourse rather than a medical model of birth.

Waterbirth is largely constructed as being an unsafe and alternative birthing practice, yet large studies (Aird, Luckas, Buckett, & Bousefield, 1997; Alderdice, Renfrew, Marchant, Ashurst, Hughes, Berridge, & Garcia, 1995; Eberhard & Geissbuhler, 2000; Eriksson, Ladfors, Mattsson, & Fall, 1996; Forde et al., 1999; Garland, 1995; Gilbert & Tookey, 1999; Haddad, 1996; McCandlish & Renfrew, 1993; Pellantova, Verbera, & Pucek, 2003; Zimmerman, Much, & Huch, 1993), and the documented prevalence of women's positive accounts of their waterbirths (Richmond, 2003a) show otherwise. The dominant priority when waterbirth is spoken of is safe/unsafe, conventional/alternative.

In 1991 the British Parliamentary Health Select Committee commissioned a review of maternity care (The Winterton report). This report recommended that birth pools should be provided as an option for labouring women 'wherever this is practicable' (Balaskas, 2004, p. 17). This saw the first birth pools installed in NHS hospitals. This report provided legitimacy for waterbirth, on the basis that British women were voicing that they wanted to be able to access waterbirth facilities wherever they chose to give birth.

Negative media coverage on waterbirth in 1992 saw the UKCC (United Kingdom Central Council for Nursing and Midwifery) validate waterbirth by releasing a position statement. It states 'waterbirth is preferred by some women as their chosen method of delivery of their babies. Waterbirth should therefore be viewed as an alternative method of care and management in labour and one which falls within the Midwife's sphere of practice.' (UKCC, 1992). The debate between the professions, namely midwifery versus obstetrics and paediatrics, centres mainly on the concern about potential risks and the benefits associated with the use of water.

In the United Kingdom in 1993 Baroness Cumberledge commissioned a review of maternity care. This investigation produced the document *Changing Childbirth* (1993), which set out to change the emphasis and quality of maternity care in the United Kingdom by giving more choice to mothers. The resultant initiatives from this document led to the commissioning of further research into the effectiveness and safety of a variety of childbirth options including water birth.

Tolerance of waterbirth by the British medical profession was accelerated by the study by Gilbert and Tookey (1999); this study is discussed in Chapter Three. This study buoyed waterbirth's reputation until 2002 when Nguyen et al. published the results of their New Zealand study that had investigated the near-drowning experiences of four neonates born into water. This article is detailed later in Chapter Four.

In 1995 the first International Waterbirth Conference was held in London. All leading international waterbirth practitioners attended, some of whom had experience of more than one thousand waterbirths (Balaskas, 2004). The proceedings from this conference were published as *Water Birth Unplugged*, edited by Beverley Lawrence-Beech (1996). At this conference speakers from a variety of disciplines shared their knowledge and experience of 19,000 waterbirths (Balaskas, 2004, p. 20). One of the keynote speakers at this conference was Dr. Paul Johnson, neonatal physiologist at the John Radcliffe Hospital, Oxford. His research on the mechanisms that trigger breathing in the newborn provided scientific confirmation on the viability of birth underwater for babies who are not at risk. This response is known as the dive reflex (see further in this chapter). This confirmation provided a confidence boost for all practitioners involved with waterbirth. Paul Johnson's findings formed the basis of safety guidelines for birth in water (Balaskas, 2004). The waterbirth protocols from Auckland's main maternity units and hospitals in the appendices of this thesis reflect and give examples of adherence to Johnson's findings (see appendix1).

The literature I have read on waterbirth reveals seven main safety issues that have been regularly examined and discussed since waterbirth first appeared as a topic for discussion in midwifery and medical literature in 1992. These are: water temperature, perinatal outcomes, fetal hypoxia, water inhalation, placental delivery, cord snapping, and the

potential for midwives to suffer back injury. Researchers have identified that water temperature should be maintained at 37 degrees Celsius for the time of birth to prevent the possibility of water inhalation, temperatures lower than this may stimulate the baby to gasp or inhale after delivery of the head. Adverse Perinatal outcomes following waterbirth have been identified as; water inhalation contributing to hyponatremia, decreased oxygenation, respiratory distress and lung infections.

Fetal hypoxia was identified as a risk associated with waterbirth when the birth attendant fails to recognize chronic or prolonged fetal distress by way of fetal heart auscultation and then attempts to resuscitate an already asphyxiated baby. A baby asphyxiated in utero then born submerged in water has the potential to be born gasping and may then inhale water. A theoretical risk was identified proposing that delivery of the placenta should not take place underwater. The placenta should be delivered out of the pool to prevent the risk of water embolism through the placental bed/site, thus exposing the mother to the risk of embolism. There is anecdotal evidence to suggest that cord snapping is more prevalent following a waterbirth due to the increased elasticity and suppleness of the cord due to exposure to warm water for a period of time. It was identified that some midwives report suffering back injuries after attending waterbirths due to the nature of leaning into and across the pools when caring for women at waterbirths. Both the natural birth discourse and the scientific medical discourses have examined these seven safety issues. Water temperature has been examined by Zimmerman (1993); Deans and Steer (1995); Beech (1997); Odent (1997); Charles (1998); Kitzinger (2000); Geissbuehler, Eberhard, and Lebrecht (2002); and NZCOM (2002). Perineal outcomes following waterbirth have been studied by Zimmerman (1993); Kitzinger (1995); McCandlish (1993); Haddad (1996); Gordon (1996); Garland and Jones (1999); Garland (2000); Pellantova et al. (2003); Chapman (2004); and Fenton (2004). Fetal hypoxia and water inhalation surrounding waterbirth has been examined by Beech (1997); Gilbert and Tookey (1999); Geissbuehler and Eberhard (2000); and Nguyen et al. (2002).

Delivery of the placenta and cord snapping was studied by Odent (1984 1998); Forde et al. (1999); Fenton (2004); Gilbert and Tookey (2000); Garland (2000); and Cro and Preston (2002). Protecting midwives' backs during waterbirth was identified as a safety issue and

was investigated by Alderdice et al. (1995); Gordon (1996); and Garland (2000). Shoulder dystocia at waterbirth was studied by Cluett, Pickering, and Brooking (2001).

Infection in neonates and mothers following waterbirth was studied by Lenstrup, Schantz, Berget, Feder, Roseno, and Hertel (1978); Waldenstrom and Nilsson (1992); Kingsley, Hutter, Green, and Speirs (1993); McCandlish and Renfrew (1993); Rawal, Shah, Stirk, and Mehtar (1994); Cammu, Clasen, Van Vettere, and Derde (1994); Alderdice and Renfrew (1995); Eriksson et al. (1996); Gordon (1996); Forde et al. (1999); Garland (2000); Kitzinger (2000); Colombo, Pei, and Jost (2000); Richmond (2003b); Geissbuehler and Eberhard (2000); Nguyen et al. (2002).

3.7 The Scientific Medical Discourse

For the purposes of this thesis I have identified and named the scientific medical discourse in accordance with Payne (2002). This discourse, and its speakers, is underpinned by scientific medical knowledge; namely that of medicine, and in the context of this study, obstetrics and paediatrics. It should be noted some midwives would position themselves in this discourse on waterbirth also. My analysis shows that the scientific medical discourse contests the validity of the practice of waterbirth, or the use of water as a place in which to give birth. Its contestation is based entirely on the issue of safety of waterbirth. The predominant speakers deploying, drawing on and using the scientific medical discourse are named in the New Zealand media as obstetricians, paediatricians and neonatologists.

The emergence of waterbirth as an object of the scientific medical discourse within the medical and midwifery literature was made possible by the existence of several factors, which I now discuss. These are the historical context and evolvement of obstetrics within the medical profession, the common practice of birth occurring in hospital and not at home, and the dominance of science as the basis for what is deemed credible and ‘truth’ within the medical literature on the subject of waterbirth.

Speakers of the scientific medical discourse constitute waterbirth as unsafe and risky, therefore their gaze has always focused on safety issues and concepts of risk (Cammu et al., 1994; Colombo et al., 2000; Cro & Preston, 2002; Deans & Steer, 1995; Eriksson et al., 1996; Kingsley et al., 1993; Lenstrup et al., 1978; Nguyen et al., 2002; Pellantova et al., 2003; Waldenstrom & Nilsson, 1992; Zimmerman, 1993). It should be noted that the term 'waterbirth' sometimes gets used incorrectly in the literature. As I have mentioned previously, a waterbirth is when the baby is born under the water. Waterbirth literature from the scientific medical discourse has featured in British medical journals since 1992.

Waterbirth attracted media attention and publicity when in 1993 *The Lancet* published a letter which reported that in a Bristol maternity hospital one baby had died and another suffered possible brain damage resulting from their mothers using pools during labour (Odent, 1997). Although both mothers had used pools for labour, neither baby was born underwater. The president of the Royal College of Obstetricians and Gynaecologists was seen on television stating that waterbirth was 'unnatural' and babies who were born underwater might drown (Beech, 1997). Furthermore, in the United Kingdom, two midwives were suspended and disciplined at a Welwyn city hospital following their attendance at a homebirth where the woman had refused to get out of the pool and subsequently delivered in it. It was not that hospital's policy to 'do' waterbirths (Balaskas, 2004). Over this period the construction of waterbirth by the British media was that of it being a dangerous and unsafe birthing practice – it insinuated possible death of a baby by drowning.

The obstetric model or scientific medical discourse's construction of birth was prevalent in western society until the 1970s. According to Balaskas (2004) it emerged in Europe with the intervention of obstetric forceps in 1588. Around this time also, male physicians were relegated to attend Royal births. This heralded the appropriation of childbirth by male surgeons (Balaskas, 2004). Previously, birth had been the domain of women and their women attendants. In the seventeenth and eighteenth centuries, opinions about how to deliver began to diverge from the spontaneous vertical positions that had always been used. The new supine position meant that the birth process was ergonomically orchestrated to suit doctors; this way, the woman does not give birth – the doctor delivers her or her child and

her pain. He is seen as the 'lifesaver' and so his authoritative stance is maintained (Tew, 1998).

The beginning of the nineteenth century saw improved health conditions for women and the development of medical science. Doctors' successes in implementing new medical techniques increased overall faith in medical intervention and augmented the authority of obstetricians and their medical staffs (Donley, 1998).

The resultant takeover of birth by physicians had led to the denigration of much of the wisdom of traditional midwifery (Papps & Olssen, 1997). 'With the development of modern obstetrics, generations of women were encouraged to believe that their instinct and intuition about their own bodily processes had no role in childbirth and the only safe labour and birth was a technologically managed one.' (Balaskas, 2004, p. 4).

In the process of the medicalisation of childbirth men, by virtue of their location in the public sphere and their control over science at that time, came to colonise the birth room. 'Just as only men had "theoria" prior to the Enlightenment, only men had the knowledge which the "new" science yielded and hence, only men, it was decided, could correct the errors of nature in the instances that things went wrong. Men dominated life in the public sphere.' (Papps & Olssen, p. 4).

Therefore, whenever serious complications in labour called for instrumental or operative intervention, the place of delivery *had* to be the specialist obstetric hospital. From 1950 onwards (Papps & Olssen, 1997), the array of intervention was prolific and required the use of expensive technological equipment. 'As Obstetricians gained confidence in these interventions, they increasingly abandoned the philosophy of restraint.' (Papps & Olssen, 1997, p. 9). American statistics in Barbara Harper's book *Gentle Birth Choices* (1994) support this: 'The trend to medicalise birth into hospitals in 20th century America can be seen in that in 1900 95% of births took place at home compared with 50% in 1939 and 5% in the 1990s' (Harper, 1994, p. 9).

The shift from home as the place of birth to hospital had been the result of effective propaganda by the medical doctors and their supporting institutions of that era in

propagating the belief that birth was dangerous and that only with obstetric presence could the risk of danger be reduced. Tew (1998) argues that the effect was that while this propaganda inspired confidence in the public, it destroyed the confidence of mothers in their own reproductive capabilities. It also destroyed the confidence of alternative birth attendants, midwives and general practitioners 'who believed in restraint and practiced accordingly' (Tew, 1998, p. 11).

While British literature such as Alderdice et al. (1995), Gilbert and Tookey (1999, 2000), and McCandlish (1993) appear to have the most publications critiquing waterbirth; they are followed by Scandinavia (Cammu et al., 1994; Eriksson et al., 1996) in terms of volume of literature, with Switzerland being the next largest contributor (Geissbuehler & Eberhard, 2000, 2002). There are two main defining journal articles, which I will explain to show their relevance to the emergence of this discourse. These papers polarised the opinion of the safety of waterbirth within the scientific medical discourse. They are the most recent and largest of all scientific medical research on waterbirth to date.

The first article of importance was published in 1995. Alderdice (survey researcher), Renfrew (professor of midwifery), Marchant (research midwife), Ashurst (co-ordinator), Hughes (project administrator), Berridge (computer programmer) and Garcia published in the *British Medical Journal* an article entitled 'Labour and birth in water in England and Wales' (1995). This piece of research was undertaken at the Institute of Epidemiology and Health Services Research at the University of Leeds.

The second article of importance is by Gilbert and Tookey (1999), published in the *British Medical Journal*, entitled 'Perinatal mortality and morbidity among babies delivered in water: Surveillance study and postal survey'. Gilbert is a senior lecturer in clinical epidemiology at the Department of Epidemiology and Public Health, Institute of Child Health, London. Tookey is a senior research fellow employed at the same institute.

The Alderdice et al. (1995) study was the result of the British House of Commons Health Committee report on maternity services in 1992. The report recommended that all hospitals should provide women with 'the option of a birthing pool where it is practicable'. (House of Commons, 1992, p. 5). The lack of relevant research on labour and birth in water

prompted the Department of Health to fund this survey. Two hundred and nineteen maternity service providers throughout the United Kingdom and Wales were surveyed. Sources yielded a total of 8255 women who had laboured in water but got out of it for delivery, and 4494 women who had given birth in water (n=12,749). Irrespective of whether or not water was thought to have contributed to outcome, 12 babies who died after their mothers gave birth in water or both, between 1992 and 1993, were reported. None of these cases were reported to be directly related to labour or birth in water. There were 51 reports of morbidity in babies, including respiratory problems and infections. The study concluded 'there is no evidence from this survey to suggest that labour and birth in water should not continue to be offered as an option to women in England and Wales'. (p. 838). Questions remained, however, about the possible benefits and hazards, the conditions of clinical practice, and resource use. The survey suggested that 'a randomised controlled trial could address some of these issues' (p. 837).

The tolerance of waterbirth by the British medical profession, in particular, was tempered by the study by Gilbert and Tookey (1999). This surveillance and postal survey study looked at all waterbirths (0.6% of all deliveries) in the British Isles between March 1994 and March 1996 (n=4032). It was conducted to compare the perinatal morbidity and mortality rates for babies delivered in water and for babies delivered conventionally (not in water). Over 25 months, 1500 consultant paediatricians in the British Isles were asked to report monthly whether or not they knew of any births that met the case definition of 'perinatal death or admission for special care within 48 hours of birth following labour or delivery in water' (p. 484).

There were five perinatal deaths among the 4030 live births in water (1.2 per 1000 live births). Two of these babies were stillborn and one was a concealed pregnancy delivered unattended at home. One was diagnosed before immersion. The remaining three postpartum deaths were associated with abnormal pathological findings. Therefore no deaths were directly attributable to delivery in water. There were two admissions to special care for water aspiration. Interestingly, this is the main concern of waterbirth's critics but the issue was not explored in depth by Gilbert and Tookey (1999). The article detailed that the two admissions for water aspiration may have been attributable to delivery in water. Similar cases have been reported in the literature, wherein lamb's inhibitory mechanisms that

prevent breathing until contact with cool air can be overridden by sustained hypoxia (Johnson,1996). In theory, therefore, some babies with unrecognised chronic hypoxia may gasp underwater. The report also noted that it had no comparative data available for the risk of lower respiratory tract problems in babies of low-risk women who delivered conventionally.

In total, 35 babies in the British Isles, of whom 32 survived and three later died, were admitted for special care within 48 hours of delivery in water. (One baby was born in Scotland, leaving 34 babies out of 4030 delivered alive in water in England and Wales being admitted for special care). Thus, there was an overall risk of 8.4 per 1000 live births. Of the 32 survivors, 13 required respiratory support and 15 had lower respiratory tract problems, variously labeled as: pneumonia, transient tachypnoea of the newborn or 'wet lung' (9), suspected aspiration (3), meconium aspiration (1), water aspiration (1), and 'freshwater drowning' (1).

Gilbert's and Tookey's (1999) study concluded that

> 'the similarity in perinatal mortality and morbidity in low risk women suggests that delivery in water does not substantially increase adverse perinatal outcomes. Overall rates may, however, mask specific benefits and harms, such as water aspiration or snapped umbilical cord. We could not determine whether the low mortality and morbidity in babies delivered in water could be further reduced by conventional delivery'. (p. 488).

The word 'substantially' is used in an ambiguous manner here, creating an uncertainty regarding the safety of waterbirth. The conclusion of the study as stated leaves readers to decide for themselves where they position themselves on the subject of safety in waterbirth.

Since these two studies, a burgeoning interest in the use of water in labour in the United Kingdom has seen the development of a unique concentration of knowledge and expertise within the mainstream maternity system. 'Positive encouragement towards water in labour and childbirth has come from the Royal College of Midwives, which recommends that midwives should develop the knowledge and skills to assist women at a waterbirth' (Balaskas, 2004, p.13).

Until the early 1990s all research on waterbirth had consisted of only anecdotal evidence and women's positive accounts of their waterbirths. The increasing numbers of waterbirths from here onwards necessitated more formal assessment. By this time, waterbirth was brought into the gaze of obstetricians, hence the emergence soon after of their discourse on waterbirth. Because of differences in methodologies used, the results of waterbirth research had not always been regarded as valid. Fitzgerald (2003) explains this:

> The medical profession favors research by large multi-centered randomized control trials. This has ethical dimensions, being in the control group could deny the woman the use of water and therefore not be appropriate for all evaluation. Research is equally vital to midwives to support the woman's choice in waterbirth; however audits of practice and reflections are the mode which midwives commonly use for evaluation, and this is not often recognized by the medical profession. (p. 13).

The scientific medical discourse considers the 'gold standard' type of study – that is, the most respected as being free of bias of any type – to be the 'double-blind' randomised control trial (RCT). However, a double blind trial is not suitable for a study of waterbirth in which subjects cannot help but be aware of which group they are in, that is, whether or not they are receiving treatment. Additionally, such trials may not be considered ethical:

> The problem has been that other types of studies have been used to assess the benefits and possible risks of waterbirth. The study groups may be tailored to match as closely as possible for other variables such as age or socio-economic grouping, but they are essentially self-selecting in their choice as to whether they have the treatment being studied, and they are aware of receiving it.
> (Balaskas, 2002, p. 20).

Maude (2003) in her Masters Thesis 'It's Beyond Water' details the traditional hierarchy of evidence that exists and rules research study worldwide. It rates systematic reviews and meta-analyses as priority, then randomised controlled trials, followed by cohort studies, case-control studies, cross-sectional surveys and, lastly, case reports (p. 39). Interestingly, qualitative research study, which looks at 'how can we understand the factors that impact on people?' and 'how do individuals feel and behave the way they do?' (Maude, 2003), is

excluded. This demonstrates that qualitative research is considered unimportant by some and as being of a low status on the scientific hierarchy of what is deemed ‘evidence’.

Medical science has contributed enormously to society, but, as it has been developed in western societies, it has become intrinsically linked to status and power hierarchies which govern the social and institutional structures of those western societies. Science has traditionally been seen as a masculine way of representing the world (Papps & Olssen, 1997). Consequently, male knowledge has come to represent the authority of what is deemed truth, factual or real.

Waterbirth is an example of a marginalised form of birthing knowledge because of the scientific power that speaks about it in the press and in medical literature. The scientific medical discourse that generally speaking admonishes or cautions the public on the issue of waterbirth operates in particular from institutions that are hospitals or the physical sites of obstetric practice. Cheek, Shoebridge, Willis, and Zadoroznyj (1998) discuss how institutions then enforce such knowledge: ‘hospitals operate a social relational system where a form of “social order” reigns; this order legitimizes which may or may not be appropriate and worthy of adherence.’ (p. 93).

3.8 The Dive Reflex Discourse – To Believe Or Not To Believe?

This section describes the discourse I have termed ‘the dive reflex discourse’ (also known as the diving reflex). Here I aim to show the basis for the argument that exists between the scientific medical discourse and the natural birth discourse over whether or not this reflex safeguards babies being born into water. The dive reflex is a physiological process that has been observed in fetal lambs and it is asserted that, on the basis of this, human newborns have the same reflex. This discourse draws on the notion that the human body has reflexes, which are instinctive responses that are meant to act as inherited safety mechanisms. The natural birth discourse supports the existence of this reflex with its overall view that the human body has inherent natural capabilities. I now discuss the characteristics of a

suppression of breathing mechanism, termed the ‘dive reflex’, and its implications and meaning for babies born underwater.

Consultant clinical physiologist Paul Johnson of John Radcliffe Hospital, Oxford, United Kingdom, published results (1996) of his experiments with fetal lambs born underwater in the *British Journal of Obstetrics and Gynaecology* (March 1996, vol. 103, pp. 202–208). His findings are the formation of his theory known collectively as ‘the dive reflex.’ The following is a summary of how this reflex works and the physiology behind it.

Physiology and mechanisms that inhibit breathing under water in babies

Babies practice breathing movements in utero early in pregnancy. Practiced breathing movement influences lung development. Movement of the diaphragm and chest stimulate lung and alveolar development.

The fetus does not aspirate amniotic fluid when breathing in utero because the lungs are already filled with lung fluid. Final reabsorption of lung fluid is completed within six hours after birth. The reabsorption is initated by the commencement of breathing. After birth, the lung fluid is used in the vascular system.

A prostaglandin (prostaglandin E2) produced by the placenta has a strong inhibitory role in some brain functions including breathing. This also contributes to the cessation of breathing movements 48 hours before the start of labour.

When a baby is born into water, the dive reflex works completely. While the umbilical cord pulsates (i.e. the placenta is still attached to the uterine wall) no reflex bradycardia commences.

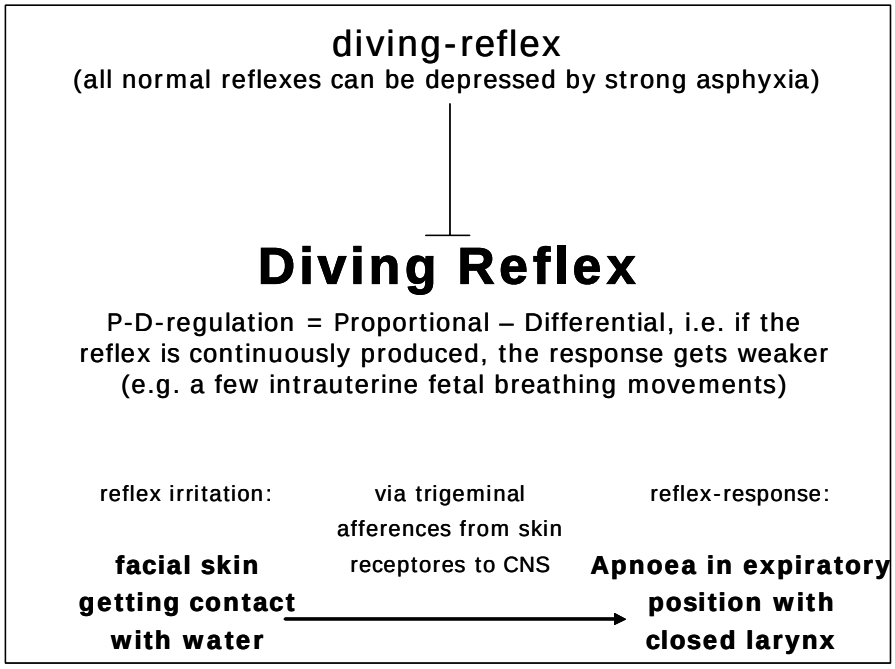
Apnoea (cessation of breathing) occurs in the expiratory position with closure of the larynx. It is triggered by the receptors of the facial skin and is transmitted via the trigeminus nerve. If this reflex continues to work, a reflex bradycardia commences, including a change of heart minute volume in favour of blood distribution to essential organs.

The dive reflex is similar to the larynx reflex in babies when they regurgitate food – the larynx closes.

Reflexes submit to a control; in this case a proportional-differential control. This control reacts to a stimulus by rapidly and erratically commencing counter regulation behaviour at first. Then it reaches a different, constant, final result. This means that if an adequate stimulus is continuously present during very long phases, there will be an adaptation of the reflex reaction. If the reflex is continuously produced the response gets weaker. Therefore babies born underwater should not be submerged for long periods of time.

(This process is shown in diagrammatic form in Figure 1).

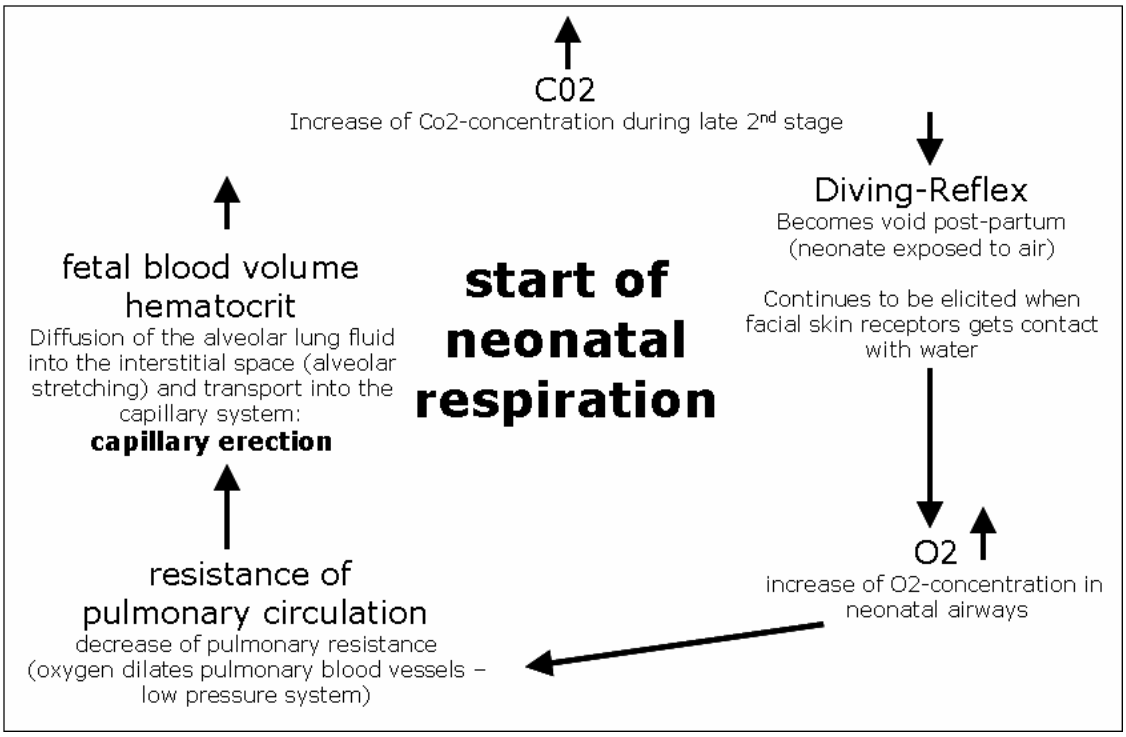
Figure 1: The Dive Reflex (Johnson, 1996).



Kitzinger (1995) states:

> It is often said that the baby has spent its fetal life in water. This is wrong. It has been in amniotic fluid. The fetus senses what is in the fluid in which it is immersed. The entrance to the larynx has more taste buds than the whole of the tongue. It is bristling with chemoreceptors and is the key to determining whether we breathe or swallow. If the baby's larynx senses water, breathing is inhibited and swallowing may occur. Water in the larynx causes the diving response – apnoea, swallowing, arousal, bradycardia and hypertension, and blood flow is distributed to the brain, heart and adrenal glands. Once the baby is brought to the surface of the water, the dive reflex becomes void and spontaneous breathing occurs. With exposure to oxygen the following process takes place. (p. 203)

Figure 2: Start of Nenonatal Respiration (Johnson, 1996).



However, with birth asphyxia in utero the dive reflex is overridden. Johnson (1996) says:

> Unlike air breathing after birth, acute hypoxia in utero inhibits breathing unless it is severe and prolonged when gasping will occur – at which point some inhalation of amniotic fluid, or water if the fetus is so immersed, could occur. (p. 203).

Danger exists when the birth attendant does not identify birth asphyxia while the woman is labouring, or fetal distress in utero. During the second stage of labour it is customary for the midwife to auscultate the fetal heart after every contraction to ensure that the baby has coped with that contraction. If a baby was born submerged, already suffering from asphyxia, there is the potential for the baby to be born gasping, thus the risk of water inhalation. Johnson (1996) also highlights the risk that the birth attendant will not be able to differentiate and accurately diagnose the condition of such a baby at birth and may resuscitate incorrectly:

> Water inhalation is likely to trigger bradycardia and thus be confused with hypoxic bradycardia by the birth attendant. Bradycardia is a normal response to the peripheral carotid chemoreceptors sensing hypoxia, whereas in non-apnoeic asphyxia the hyperapnoeic response to hypoxia overrides the bradycardia to cause tachycardia. When hypoxia becomes very severe, bradycardia and hypertension occurs in both apnoeic and non-apnoeic asphyxia. The major differences in these

> mechanisms contribute to the difficulties of assessing fetal condition during birth based on gross heart changes (pp. 205–206).

Kitzinger (2000) echoes this: ‘babies can drown when submerged but only when they are already severely compromised and literally at their “last gasp” or if they are kept underwater at birth’ (p. 215).

In their more recent controversial article, Bowden, Kessler, Pinnette, and Wilson (2003) refute the existence of the dive reflex.

> Proponents of the practice (waterbirth) have claimed that infants will not breathe or swallow during an underwater birth. We could find no conclusive evidence that an infant would not inhale or swallow the tub water during the birth as they swallow and inhale amniotic fluid in utero. We are particularly intrigued to find a photograph in a book on waterbirth showing an infant’s face with the mouth wide open. This photo lends support to our theory that hyponatremia can be caused by swallowing tub water during birth. (p. 973).

Therefore Bowden et al. (2003) disagree with the existence of the dive reflex. Such fluid-swallowing theories appear regularly in the literature. It is my experience that babies born underwater often grimace, move their heads vigorously from side to side and open and close their mouths once the head is born, as they also do in conventional birth.

Johnson (1996) points out:

> ...there is as yet little reported evidence of drowning or serious aspiration having occurred in the recent history of water births… it is worth pointing out that water inhalation is likely to trigger bradycardia and thus be confused with hypoxic bradycardia by the birth attendant. (p. 205).

To alleviate the concern about waterbirth babies being born ‘bluer’ than those born at conventional births, Johnson (1996) discusses such causes:

> …of course a baby delivered in this fashion does not receive the multiple stimuli to breathe simultaneously as would occur in most conventional births. [Cool air, light, sound, gravity.] It is therefore likely that the onset of air breathing will commence quietly without crying and thus effective gas exchange may be slower to be established. It might be anticipated that infants may be more often blue or cyanotic for longer periods after birth under water. (p. 207).

To summarise, it is basically the fluid-swallowing theory versus the chemoreceptor initiation of breathing mechanism that forms the discourse of the dive reflex, and which one people choose to believe. People's choice of theory generally determines their subjectivity on waterbirth and whether or not they deem it to be a safe or unsafe practice (Beech, 1997).

Critics of the dive reflex theory, mainly, though not exclusively, from the scientific medical discourse (Geissbuehler & Eberhard, 2000; Bowden et al., 2003; Nguyen et al., 2002), claim that the theory is overtly staking nature and the human body as being superior and trustworthy. Such criticism suggests that nature is not foolproof and should not be totally trusted.

While all three discourses take subject positions within their discourses, the authors on waterbirth choose platforms that are usually based on measuring a variety of variables and birth outcomes. There is an overwhelming precedence to *compare* waterbirth outcomes to conventional birth outcomes.

The following chapter illustrates how these three discourses I have identified from the literature, are deployed in the media in accordance with Foucault's notions of discourse, power and the subject.

CHAPTER FOUR: HOW WATERBIRTH IS CONSTRUCTED BY THE NEW ZEALAND MEDIA

4.1 Introduction

This chapter analyses the discourses pertaining to waterbirth in the newspaper articles collected over a five-year period (2000–2005) for this study. I have applied Foucault's and Fairclough's notions to the data to extract information that shows these notions in operation. Firstly, I show how the media calls to, and represents, a person's subjectivity in relation to waterbirth. Secondly, I show how Foucault's notion of discipline and power is evident in the expected adherence of midwives in particular to waterbirth protocols in New Zealand's main maternity institutions, and how the media depicts this discipline. Thirdly, I examine Foucault's notion of the panopticon, using excerpts to give examples of the scientific medical discourse being used to survey and discipline the practice of waterbirth. Fourthly, I show how the media uses exclusion in discourse to promote and prevail their discourse of choice. Finally, I show how circulation of discourse is executed within the media.

4.2 Subjectivity in Text

I use Weedon's (1987) view of 'subjectivity and common sense' to highlight the power relations in our society that are used to offer women subject positions in relation to waterbirth. 'Common sense has an important constitutive role to play in maintaining the centrality of "difference" as a focus of power in society' (p. 75) and is achieved through language. By following what is defined as 'socially normal' people will then accept dominant definitions as true and necessary and the meaning of difference (Weedon, 1987). The assumptions that inform common sense notions of, for example, waterbirth, relate to particular definitions of what is natural, appropriate, moral, safe or good (Weedon, p. 77). In the context of this study they rely particularly on the definition of safety. Common sense entails multiple social meanings and specific ways of understanding the world that guarantee or validate these meanings.

> Common sense knowledge is not a monolithic, fixed body of knowledge. It is often contradictory and subject to change. However its power comes from its claim to be natural, obvious and therefore true (Weedon, 1987, p. 77) .

In this study I show that the dominant discourse, the scientific medical discourse, uses certain language in its description of waterbirth to appeal to the common sense of women and the public in general. It portrays women who may opt to have a waterbirth as unsafe or exposing themselves to unnecessary risk. In doing so it creates the binary opposition of reasonable woman/unreasonable woman. The *Collins* dictionary (1987) states that 'reasonable' infers 'Faculty of thinking; sanity; sensible or logical thought or view; not excessive; suitable; thinking logically in forming conclusions.' (*Collins*, 1987, p. 438).

Some examples of the language used to offer women the subject position of 'reasonable woman' from the New Zealand newspaper articles are:

> **For some women, cases of problems arising from waterbirths, including those reported from National Women's, would be enough to persuade them to have a non-waterbirth, Ms Gilbert said.**
>
> **'Others are prepared to trade off a small risk of a very serious outcome against the perceived benefits of the experience. There may also be hope of physical benefits for the infant and mother but there is no clear research evidence that immersion in water during labour reduces duration of labour, perineal tears, or use of analgesia.'**
>
> **'My own personal opinion is if it doesn't benefit the mother and places the baby at risk, then what's the point?' Dr Kushel said.**
>
> **(9 August, 2002, *The New Zealand Herald*)**

Note the words used in relation to waterbirth: 'problems'; 'trade off'; 'serious outcome'; 'small risk'; 'places the baby at risk' all appeal to the question of the safety of waterbirth, whilst the words 'perceived benefits'; 'hope of physical benefits'; 'no clear research' all question the validity of waterbirth as a practice. This excerpt insinuates that a woman who chooses waterbirth is being indulgent; that while the possibility of something going wrong is small, it is life threatening, particularly for the baby. Furthermore, the woman is not

guaranteed that a waterbirth will benefit her. Therefore, this is not a reasonable choice that a reasonable woman who is concerned about the wellbeing of her baby would make.

I would suggest that being safe in birth is used to dominate a woman's subjectivity and play on her emotions as a good and caring prospective mother, as shown in these examples from the newspaper articles (NZPA is the New Zealand Press Association.)

> **Waterbirths continue to be popular with Canterbury women as doctors call for more research to confirm this method is safe.**
> **(A. Moffat, 26 March, 2002, *The Press*, Ed. 2, p. 4)**

Here the reader is aware that waterbirths are a practice that is popular but doctors are not convinced that they are a practice that is safe.

> **In each case, when doctors x-rayed the babies chests they found damage consistent with a near drowning. While all the babies got better, they were sick for several days.**
> **(NZPA, 25 March, 2002, *The Evening Post*, Ed. 1, p. 5)**

Here the image is of a young baby having nearly drowned as a consequence of having been born in water, and their wellbeing threatened.

> **Waikato Women's Hospital strives to provide high quality and women-centered maternity care. It also offers choices in birthing such as water-birth facilities, with the security of specialist obstetric and neonatal input when necessary.**
> **(12 February, 2002, *Waikato Times*, Ed. 2, p. 8)**

Here the reader is informed that high quality care is on offer including waterbirth facilities. This is immediately followed by the reassurance of specialist obstetric and neonatal care. One reading that could be made of this juxtapositioning of waterbirth facilities and medical care is that waterbirth/birthing can become complicated. Birthing can be both safe and unsafe.

One article that clearly uses a selection of powerful and emotive words to gain authority by appealing to common sense is the article entitled:

Newborn 'fell on floor' at birth pool
(M. Dearnaley, 15 September, 2003, *The New Zealand Herald*)

This article details the unfortunate incident of a baby spontaneously delivering as its mother abducted her leg to exit a birthing pool. The mother was moving from the pool to a bed. The baby delivered unpredictably and quickly, falling onto the floor and hitting its head. However, the words 'birth pool' bring the readers' attention to the incident happening in a birth pool. The article then goes on to further implicate the use of a waterbirth pool:

> **The parents of a disabled baby are complaining of a cover up over claims that their daughter fell on her head during a spontaneous delivery at an Auckland waterbirth pool.**

Readers unfamiliar with the process of a waterbirth may find the situation of events confusing and may assume the waterbirth pool had contributed to this event. The use of the word 'disabled' may induce fear and mistrust, presenting the birth pool as a potentially dangerous place to birth.

The competing position of safe versus unsafe is evident in the following two excerpts:

> **Women in labour at a new Auckland birth unit will be able to gaze up at a miniature Southern Cross while lying back in a warm pool…**

Four paragraphs later in this article…

> **He [maternity services manager] acknowledged the controversy over the safety of waterbirths, which he said were only for low-risk deliveries and where the lead health worker had experience.**
> **(23 May, 2002, *The New Zealand Herald*)**

> **They arrived by the dozen, each cradling a swollen belly, each keen to check out the latest in East Coast maternity care… Most were impressed with the soothing pink décor, homely feel and discreet facilities, but most were intrigued by the spacious bath…**

Then three paragraphs later

> **Gay Hayes said the bath or 'pool' would give pain relief during labour. It was unlikely to be used for waterbirths.**
> **(30 June, 2000, *The New Zealand Herald*)**

Women reading these articles may initially imagine themselves labouring in a warm pool gazing up at a miniature Southern Cross, only to be warned later of the argument surrounding such an occurrence should they choose to labour in water. The reader is made aware that the practice of waterbirth is contested and not part of routine practice: that while pools are there they are not necessarily used to give birth in. The media's role here has been to appeal to a woman's subconscious and her common desire for security and safety in labour. The initial use of words that appeal to this subconsciousness are followed by words that appeal to common sense. The beginning sections of both these articles use quite sensual terms, which may convey relaxation, comfort and informality. However, they quite clearly identify the limits to the use of water during labour and birth.

Women who give birth in water are often ecstatic and sometimes even evangelise about the experience.

> **After having a baby by Caesarean, ventouse, forceps and now a waterbirth, Jacki says 'give me a waterbirth any day.'**
>
> **(6 October, 2004, *Waikato Times*)**

> **But the water really helped. It was fantastic because when you are in labour the sensations are so intense you can't stay still. The water makes it so much easier to move around. The warmth also helped with pain relief… the pushing stage was fantastic. Although it still hurt like crazy, I got to actively do something rather than just bear it like before… Afterwards I thought, wow, I gave birth as naturally as possible…**
>
> **(21 December, 2002, *Evening Standard)***

> **Wellington woman Tanya Taylor had a waterbirth at home six months ago. Her son Beck is her third child, but the first to be born in water. 'I have nothing but wonderful things to say about it. It is just the most amazing way to give birth,' she said. The water was so relaxing Beck arrived without complications in 45 minutes. She decided on a waterbirth after labouring in the bath in her previous two pregnancies, and then getting out before birth. A recent review in the British Medical Journal said there was no difference in mortality between babies delivered in or out of water she said.**
>
> **(N. Maling, 24 March, 2002, *Sunday Star-Times)***

Women's enthusiasm about particular birthing practices inspires other women to consider the same kind of experience for themselves (Fitzgerald, 2003; Richmond, 2003a). The above excerpts show how women's experience and anecdotal evidence of waterbirth may influence the subjectivity of other women, and their ideas regarding waterbirth.

In a quantitative study (Bramadat & Driedger, 1993) that looked at satisfaction with childbirth and theories and methods of measurement, 91 postpartum women related their satisfaction with labour, delivery, and overall care. It noted that women's perception of personal control may be predictive of a less painful labour. This could be true of Jacki (6 October, 2004, *Waikato Times*), who would not have had personal control in her previous birth experiences of caesarean section, forceps and ventouse. The study also highlighted that women's perception of being in control during childbirth emerged as the best single predictor of childbirth satisfaction (p. 25).

There is evidence in the media of constructing women who voice the opinion or desire to birth normally/vaginally/naturally as 'alternative', 'earth mothers' or 'hippies.' It could also be stated that waterbirth is sometimes constructed subjectively as being 'old fashioned' as opposed to a modern way in which to birth, despite the relatively recent emergence of waterbirth. Collectively, these strategies are marginalising waterbirth. Articles that demonstrate this are:

> **Some of her friends were startled to learn she'd had a waterbirth. 'There's been quite a bit of surprise,' Says Mrs. Somerville, who doesn't consider herself alternative.**
>
> **(A. Patterson, 2 February, 2005, *Central Leader*, p. 13)**

It is interesting that Mrs. Somerville feels the need to clarify with the media that she does not consider herself to be alternative and she would rather that people did not assume she was. She herself perhaps regards 'alternative' people as different from herself. According to Balaskas (2004) waterbirth is said to appeal to more educated women from wealthier backgrounds who are at lower risk from health problems of all kinds. However, if waterbirth becomes more widely available, Balaskas suggests that this bias will be less critical for future studies (Balaskas, 2004, p. 20). In the following excerpt, Burgham, a

columnist, highlights the tendency to construct waterbirth as being not 'the modern' way to give birth;

> **Childbirth is always going to be hard work – that's why it's called labour – but that doesn't stop us modern mums trying to control the situation. If baby is looking too big we can be induced or even have him cut out. And these days there is no need to suffer pain. While women over millenniums have simply screamed, squeezed someone's hand, or bitten on a cloth, we prefer to go for the heavy-duty epidural anaesthetic so we can read magazines during the contractions.**
>
> **Even those who go for the old-fashioned home birth option need accessories; plenty of candles and massage oils, a support cast of thousands, a digi-cam, a birthing pool and possibly dolphins if they are available.**
>
> **(S. Burgham, 8 October, 2000, *The New Zealand Herald)***

Here waterbirth is categorised as 'old fashioned' and somewhat whacky as opposed to a modern way to experience birth. Language use here is effective in marginalising waterbirth as a way in which to birth. Modern birth uses intervention and has 'easy' and 'clean' connotations; and is contrasted with 'old fashioned' which has cluttered and tiresome connotations. Links are made between dolphins and waterbirth in New Zealand, a remnant of Estelle Myers' time (see Chapter Three).

> **People think if you give birth at home you're crazy and choose a warm fuzzy experience as opposed to a safe baby, but that's not the case, mothers who supported active births were wrongly stereotyped as tree-hugging hippies she said…**
>
> **(Client of Taranaki Base Hospital, 15 September, 2004, *The Daily News*)**

Waterbirth is considered an active way to birth, therefore the reader might assume here that waterbirthing is something attributed to 'tree-hugging hippies' too. The image of 'tree-hugging' conjures up images that defy common sense in some people. The use of these words could also portray a sense of ridicule to the notion of birthing actively for some people. The words 'as opposed to a safe baby' also imply here that active birthing may threaten the safety of the baby. The opposite to this would be to deliver one's baby

passively on a bed in a hospital; these are criteria for ‘safe birth’ and are strongly attributed to the scientific medical discourse.

For a pregnant woman reading these articles her views on waterbirth would most likely be one of wariness, due to the dominant discourse holding a larger quantity of articles on the subject. There is a juxtapositioning of the speakers from both discourses and their subject positions evident in most of the articles I have examined. This presents a personal dilemma for the woman choosing whether or not to have a waterbirth. It would remain up to the individual to decide for themselves their position on waterbirth. The identities that emerged from the articles were that of the reasonable woman who would not put her baby at risk, and the unreasonable woman, albeit alternative woman, who rejects convention and may be encouraged by the perceived benefits of labouring in water to choose to birth this way. Underlying these identities is the construction by the scientific medical discourse that birth is a risky life event that is potentially hazardous to all women.

I will now examine the articles for Foucault’s techniques of power (1997).

4.3 Discipline in Text

Foucault (1997) said that discipline is a political anatomy of detail (p. 138). Discipline was the result of a multiplicity of often minor processes, of different origin and scattered location, which overlap, repeat, or imitate each other. Collectively these often minute, meticulous techniques gradually converge and produce the blueprint of a general method – a discipline (p. 139).

The appendix to this thesis shows the waterbirth protocols I have collected from North Shore Hospital, Waitakere Hospital, Birthcare Auckland, and Counties Manukau (Middlemore) Hospital. Of note and concern, Auckland’s National Women’s/ City Hospital, New Zealand’s largest maternity care provider, does not have a waterbirth protocol (www.adhb.govt.nz/newborn/guidelines.htm). Also included in the appendix is the New Zealand College of Midwives consensus statement on the use of water in labour and birth. Analysis of the documents shows that they are repetitive in nature and all draw on the same safety issues – low-risk criteria of the pregnant woman, temperature of the water,

maternal and fetal observations to be maintained, delivery of the baby underwater, procedure for shoulder dystopia and episiotomy, delivery of the placenta and emergency situations. (see appendix 1).

By stipulating that only low-risk women may access birth pools on the basis of maintaining optimal safety of the mother and baby, it can be seen that waterbirth becomes disciplined. Only certain women can have waterbirths and others cannot. Those with identified risk factors such as hypertension are excluded. This effectively constructs the boundaries whereby low-risk women are 'allowed' and high-risk women are not. What the criteria say to women considering a waterbirth is high-risk women have to be kept 'extra safe'. If a woman is to be considered low risk, she does not require intensive monitoring and intervention. It can also be seen that the establishment of these protocols assists in normalising the practice of waterbirth too, by way of clear boundaries to enhance safe practice. These boundaries are clearly a multiplicity of processes and techniques drawn from the same body of knowledge resulting in a documented protocol for waterbirth.

Chapman (2004) in her audit of five North Island (NZ) hospitals' waterbirth protocols found that 'appropriate waterbirth knowledge and training of practitioners is promoted by all hospitals' (p. 21). However, she did find that the criterion of women having to be 'low risk' was sometimes enforced too rigidily; 'there are marked inconsistencies between hospitals on exclusion criteria for use of the pool in labour, resulting in some women being prohibited from using the pool in some institutions and not in others' (p. 22).

In the newspaper articles used in this study, Foucault's notion of discipline is seen in operation when applied to midwives who practice waterbirth. Midwives who are contracted to maternity institutions in New Zealand, either as independent midwives with access agreements, or those employed as staff members, must adhere to and obey the waterbirth protocols of that institution as they are stipulated in relation to waterbirth. The following four excerpts demonstrate discipline by way of waterbirth protocols.

> **Massey University midwifery lecturer Robyn Maude, who has researched waterbirths, said… 'There are certainly some conditions such as water temperature that need to be observed.' She had attended about 20 waterbirths since 1997 and used sonic**

> **equipment to monitor a baby's heart rate for signs of stress. Babies that gasped and got water into their lungs were those who got stressed, but trained midwives knew how to avoid that.**
>
> **(25 March, 2002, *The Dominion Post*)**

This excerpt indicates that midwives are expected to know waterbirth policy and that it is considered part of being a competent practitioner to do so. It implies that following waterbirth policy can help ensure midwives are able to avoid stressing the baby. Readers are then reasurred that if midwives are following certain conditions then safety is maximised.

> **Many New Zealand institutions where waterbirth is an option do have policies in place to ensure its safety and midwives are guided by standards for practice, which holds the safety of the mother and baby uppermost.**
>
> **(31 March, 2002, *Sunday Star-Times*, p. 8).**

> **Palmerston North hospital has five spa baths in delivery rooms, as well as a larger spa bath that can be used for waterbirths. Clinical Midwife co-coordinator Susan Taylor said there was a written policy and guidelines on waterbirths for all staff members. 'The baths are used frequently, mainly for comfort and pain relief during labour, but also for births.' There had been no problems with waterbirths at the hospital**
>
> **(25 March, 2002, *The Evening Standard*)**

The third excerpt firstly identifies the use of water as an analgesic first and foremost. Saying 'But also for births' indicates that waterbirth may be an unusual occurrence at Palmerston North Hospital. The safety of waterbirth is being emphasised and made explicit here by telling the reader that this hospital is watchful of waterbirth by way of ensuring 'all staff' comply with 'written policy and guidelines'. This excerpt portrays a meticulous observance of the practitioner of waterbirth.

> **…In the Health and Disability Commissioner's report, the midwife is quoted as saying she was unaware of guidelines regarding temperature of birthing pools. Patterson criticized the midwife for failing to acknowledge her shortcomings, and forwarded her case to the director of proceedings to consider further disciplinary action.**
>
> **(G. Meylan, 6 November, 2005, *Sunday Star-Times*)**

Criteria for the safe limits of pool water temperature during labour and waterbirth are well documented in the literature. Guidelines for acceptable temperatures have been amassed from scientific medical knowledge such as Zimmerman et al.'s (1993) study that concluded that if water temperate is higher than the woman's body temperature the resultant fluid loss increases blood viscosity, culminating in poor placental perfusion (p. 1789). Deans and Steer (1995) warranted a water temperature no higher than 36–37º C as 'even a modest fever in a woman can lead to fetal temperatures approaching 40 ºC' (p. 390). A large literature review conducted by Charles (1998) examining fetal hyperthermia from warm water immersion suggested that an increase in maternal temperature 'to around one degree centigrade above baseline was unlikely to compromise a healthy fetus. However at levels higher than this the maternal-fetal temperature gradient is reversed and the fetus increases its metabolic rate and oxygen demands.' (p. 156). The review concluded by recommending close, hourly monitoring of pool temperatures. Gordon (1996) reasoned that the fetus is entirely dependent on the mother for temperature control. His policy is to maintain pool temperatures at 35º C and below during the first stage of labour, and below 37º C during second stage, whereas maternal temperature is maintained at or below 37º C for the duration. The New Zealand College of Midwives (2002) consensus statement on waterbirth (appendix) echoes Gordon's recommendations. Therefore, the issue of water temperature has been in the literature for a considerable length of time.

Foucault (1977a) spoke of the creation of power whereby one person could be made to do what another person wished. He called this discipline the production of 'docile bodies'. Auckland's National Women's/City Hospital does not have a waterbirth policy (www.adhb.govt.nz/newborn/guidelines.htm). Hospital-employed midwives there are banned from assisting women to have waterbirths (Patterson, February 2, 2005, *Central Leader*). However, if a woman were to deliver 'accidentally' in one of the hospital's water pools the midwife in attendance would be disciplined by way of peer review and a meeting with the charge midwife or unit manager to discuss her management of that labour. An 'incident form' – a mandatory document to be completed in cases of adverse events – would most likely be completed by the midwife and her manager, which would then be sent to the Occupational Health and Safety division of the hospital for filing and future reference should further action against the hospital occur. In this way midwives are made docile bodies.

Excerpts from the media articles that demonstrate this particular protocol and the production of practitioners as docile bodies are:

> **Concern about the safety of waterbirths has meant hospital staff are banned from delivering babies in water, but the hot-tub births are being assisted by independent midwives, who are not covered by the ban.**
>
> **National Women's clinical leader David Knight says there is no policy for waterbirths – except that staff do not perform them.**
>
> **'They [the pools] were specifically installed for labouring, not for delivery' says Dr Knight.**
>
> **(A. Patterson, February 2, 2005, *Central Leader*, p. 13)**

Hospital-employed staff are made to be docile bodies as waterbirth is a marginalised practice at this hospital and outside the norms for its birthing practices. Use of the word 'banned' explicitly conveys an exercising of power. The *Collins* dictionary (1987) meaning of 'banned' is: 'prohibit, forbid, outlaw' (p. 41). While hospital midwives are banned from allowing women to birth in water, independent midwives are not. This highlights the latter as autonomous practitioners. This excerpt clearly puts the message across that National Women's Hospital regards waterbirth as something highly dangerous; so much so that a ban is in place. Waterbirth's potential to cause harm is too great.

Just as midwives are made docile bodies, so too are women. While pools have been installed so that women can labour in them, they are unable to deliver in them:

> **Pregnant women from all over the Bay of Plenty flocked to Whakatane hospital this week for a sneak look at the new Ko Matariki maternity unit…Gay Hayes said the bath or 'pool' would give pain relief during labour. It was unlikely to be used for water births.**
>
> **(S. MacLeod, 30 June, 2000, *The New Zealand Herald*)**
>
> **Midwifery director Ann Yates says the changes to birthing units and rooms reflect the consultation with midwives and women and the trends in birthing practices globally. At least half of the rooms will have pools for relief of pain in labour, each room will have its own en suite, and most postnatal rooms will be single.**

(17 May, 2001, *The New Zealand Herald*)

> **The group was putting a strategy together for the Taranaki District Health Board to get permission to build a birthing pool in one of the hospital's birthing rooms. The hospital had two spa pools, but they were not suitable for women to give birth in.**
> **(K. Woodham, 15 September, 2004, *Taranaki Daily News*)**

Therefore, should a woman be comfortable in the pool and want to remain there for delivery, she also is a subject of discipline, as when in the care of hospital staff she will be asked to get out for the second stage of labour.

These three excerpts make it clear to the reader that water is not the place to birth – it is only the place to labour in. Clear boundaries are dictated in relation to birthing spaces.

Foucault (1977a) thought that the easiest way to discipline people was to observe them. The following concept of the panopticon discusses this.

4.4 Panopticon in Text

Foucault (1977a) stated that 'constant surveillance as a form of discipline could induce a feeling or state of conscious and permanent visibility that assures the automatic functioning of power' (p. 201) and that 'People under surveillance will respond to the constraints of that power by complying and obeying' (p. 205).

Those speakers of the scientific medical discourse will construct and judge waterbirth. Because waterbirth deviates from the practices and norms established from the scientific medical discourse in the realm of birth, it is considered a 'deviant' practice. McHoul and Grace (1998) simplify this: 'One person has the capacity to judge someone else on the basis of knowledge that only the former possesses' (p. 71). Therefore from the perspective of the scientific medical discourse waterbirth is seen as an unscientific and potentially dangerous practice.

Foucault (1977a) examined other humble procedures that resulted from the discipline of observation. These too, are evident in our maternity systems in relation to the practice of

waterbirth. Examples are spatial structure – only one or two rooms in each delivery suite in the hospital contain baths or pools in which to have a waterbirth; and unified operations – each maternity provider has a policy and procedures manual with a specific waterbirth protocol. A documentary process is an essential component of the maintenance of power (Dreyfus & Rabinow, 1983, p. 158). This is evident in the birth registers where a waterbirth is recorded; this gives the authorities an ability to fix a web of objective codification. Other procedures such as a woman's name and documented details on the whiteboard in the staff area of a delivery suite provide information to passers by. Computer screens in common staff access areas show information on a woman's labour and birth, and the common routine of having to keep the charge midwife of the delivery suite 'up to date' on a woman's progress are all observatory in nature. 'More knowledge leads to more specification and creates a possible measurement of the overall phenomenon that is [waterbirth], its description, characterisation, collective facts, and calculation of gaps between individuals and their distribution in a given population' (Dreyfus & Rabinow, 1983).

Another way of surveilling the phenomena of waterbirth and its practitioners is to quantify it (Foucault, 1977a, p. 142). Excerpts from the newspaper articles that demonstrate the panoptic gaze in New Zealand's maternity care institutions over waterbirth are as follows.

> **At Pukekohe, about a quarter of the 408 births last year took place in its two small spa-like pools, and up to three-quarters of mothers-to-be used them for pain relief at some point in their labour.**
>
> **(M. Dearnaley, 22 August, 2003, *The New Zealand Herald*)**

> **At least five babies have been hospitalized for near drowning in the past 18 months following waterbirths. Doctors are calling for more research into waterbirths; amid anecdotal evidence the practice is becoming more popular. But midwives argue there is no evidence water birthing harms children. The problem is no one knows how many waterbirths are occurring or how many complications there are.**
>
> **A study has been conducted at National Women's Hospital in Auckland and is expected to be published shortly. It details the**

> **hospitalization of four babies in 10 months following waterbirths. A fifth case has occurred since the study was completed…**
>
> **Doctors had no idea how many waterbirths were occurring, or who was doing them, Kuschel said. 'If we had five cases [of hospitalization] but there had been 5000 cases of delivery under water then that would be pretty uncommon really. But if there have been only 50 then that is pretty common. We don't actually know what the denominator is.'**
>
> **(N. Maling, 24 March, 2002, *Sunday Star-Times*)**

Within New Zealand's maternity care institutions, the body of knowledge/power exercising the panoptic gaze over waterbirth is the scientific medical discourse. This is clearly stated in the second excerpt above. In this excerpt, in order to maintain their authorative stance on waterbirth as being an unsafe birthing practice, the speakers of the scientific medical discourse seek to quantify *how many* waterbirths are taking place and *by whom*. This way they have concrete evidence and data with which to cite quantifiable risks and adverse events, should their evidence support it. They are then able to apportion blame onto individual practitioners of waterbirth when mothers or babies are harmed as a consequence of waterbirth. There is someone to be made accountable for practicing in this unsafe manner. Collectively the scientific medical discourse produces knowledge from these observations then establishes from them the criteria for what constitutes the truth on waterbirth.

Maling's (2002) article also portrays the distinction between midwives' and doctors' competing views of the use of water during birth. This article portrays doctors as questioning the practice of waterbirth and midwives as arguing its safety. The media in this instance are perpetuating this professional division of views on whether or not waterbirth is a safe practice.

> **Mrs. Guilliland said while she had no exact numbers of waterbirths in the province, about 30 per cent of women were using water during labour nationally. 'Women have been using water for pain relief for as long as women have been having births. I think that's not well understood by medicine.'**
>
> **(A. Moffat, 26 March, 2002, *The Press*)**

Here Mrs. Guilliland distinguishes between women's knowledge and birthing practices and how labouring in water is steeped in history. The historical claim of tradition normalises the use of water as an analgesic. This knowledge is in a way separate from medical knowledge. So a distinction is shown between women's knowledge of birthing and medical knowledge.

Therefore, maternity practitioners, particularly midwives, who practice waterbirth are constantly under surveillance and are being docile bodies when they record 'waterbirth' in the birth register or when they submit their annual statistics for their yearly or three-yearly competency reviews. Surveillance of all waterbirth practitioners originates from the New Zealand government's Ministry of Health division by way of surveillance of members of the New Zealand Midwifery Council, College of Midwives and the register of registered medical practitioners. This reflects Foucault's work in *Discipline and Punish* (1977) and his theses on governmentality, through which disciplinary institutions 'thus require ever-alert attention to "government" of all composite parts to ensure the implementation of disciplines' (Shumway, 1989, p. 70). Foucault's link between knowledge/power is also intertwined with his notion of governmentality.

Through the media, the scientific medical discourse calls for 'more research' and a database on which to record lists of practitioners who 'do' waterbirths (Maling, 2002). Ultimately these forms of data collection equate to surveillance, hence the conscious state of permanent visibility for waterbirth and power for the scientific medical discourse to prevail.

The negativity and portrayal of waterbirth as unsafe in the media is perpetuated by the wariness of the speakers of the scientific medical discourse when quoted in newspapers and other forms of media. Such is their power that their word is often hearsay or the circulated 'norm' by which waterbirth is compared to. This is discussed in detail in the following analysis using Foucault's notion of exclusions in discourse.

4.5 Exclusions in Discourse in Text

As explained in Chapter Two, exclusions in discourse is the process by which discourses limit what can be said and what can be counted as knowledge.

In my experience I have observed in the hospital setting (though not exclusively) that practitioners who favour waterbirth often find it hard to talk openly and freely about waterbirth for fear of being marginalised by their more senior colleagues and excluded, ridiculed or lowered in hierarchical rank within their institutions. I have also observed that midwives in particular, who choose to incorporate waterbirth in their realm of practice in this country, are often considered 'alternative' practitioners, and not within the norm.

A discourse becomes habitual within particular cultures in certain periods. Once something is tabooed, that status begins to feel obvious (Mills, 2004, p. 59). An example of a discourse becoming habitual at a certain period in time was the scientific medical discourse that followed the publication of a New Zealand case study (Nguyen, 2002). The case study detailed the hospitalisation of four babies in a 10-month period following waterbirths. The case study alone was the stimulus for the majority of the media articles I have collected for this study. Therefore, this particular construction of waterbirth was dominant in the media for a substantial length of time afterwards. Headlines for the articles of those in support of the scientific medical discourse on the alleged unsafeness of waterbirth included:

Waterbirth study call after near-drownings
(25 March, 2002, *The Evening Post*, Ed. 1, p. 5)

No waterbirths benefits – study
(9 August, 2002, *The Dominion Post*, Ed. 2, p. 9)

Research call after waterbirth babies injured
(25 March, 2002, *The Press*, Ed. 2, p.7)

Doubts over water births

(9 August, 2002, *The New Zealand Herald*)

Call for research into waterbirths
(25 March, 2002, *Otago Daily Times*)

Here Nguyen et al. (2002), the speakers of the scientific medical discourse, are depicted as stating and warning the public that babies have been injured or have nearly drowned following waterbirths. There is a tone of finality and definitiveness of their findings

reflected in these headlines.They cast doubt over the benefits and plausibility of birthing in water and request further research into the practice and knowledge of waterbirth. This concern for further 'academic study' supports Foucault's (1981) notion of the 'will to truth' in that the speakers of this discourse believe research will produce 'the truth'. Overall, there is a generalised questioning of the safety of such a practice. The underlying manoeuvres of the 'will to truth' are described by Foucault (1981): 'Whilst we often experience this will-to-truth as richness, fecundity, a gentle and insidiously universal force… we are unaware of the… prodigious machinery designed to exclude' (p. 56).

In contrast, headlines of articles published at the time that resisted the case study from the natural birth discourse included:

Few waterbirth problems in city
(L. Carson, 25 March, 2002, *The Evening Standard*)

Midwife defends waterbirths
(L. Haines & NZPA, 25 March, 2002, *The Dominion Post*)

Waterbirths popular
(A. Moffat, 26 March, 2002, *The Press*, Ed. 2, p. 4)

Waterbirth report scaremongering
(31 March, 2002, *Sunday Star-Times*, Ed. A, p. 8)

No problem with Capital waterbirths
(A. Paltridge, 3 April, 2002, *The Evening Post*, Ed. 3, p. 9)

Here the speakers of the natural birth discourse, who were exclusively midwives, contest the Nguyen et al. (2002) findings by presenting waterbirth as a popular practice that in their views has encountered few or no problems in its history. Midwives defend the continuation of the practice and state the case study to be scaremongering and deliberately constructing waterbirth as a dangerous practice. The construction here is one of defence and an assertion that the scientific medical discourse speakers are exaggerating their claims through the case study findings. Foucault's (1981) notion of 'will to truth' is evident here also, in that there is a clear division between knowledge that is perceived to be true and that perceived to be false.

Foucault (1981) describes the use of exclusion in discourse in the way that doctors, prestigious events, or people held in high esteem by society are often introduced by the recitation of their credentials, giving that speaker credibility and the right to speak, the right to be considered worth listening to, and the right to have all other voices silenced (Mills, 2004, p. 57). Evidence of exclusion among speakers utilising the scientific medical discourse in the media in this way can be seen in the following excerpts from the newspaper articles:

> **Medical Association chairman John Adams said it was 'sensible' to research what risks, if any, were involved in waterbirths.**
> **(L. Haines, & NZPA, 25 March, 2002, *The Dominion Post*)**

> **Waterbirths have no proven clinical benefits, a New Zealand study published this week in the journal of American Academy of Paediatrics says.**
> **(9 August, 2002, *The Dominion Post,* Ed. 2, p. 9)**

> **Mr. Kuschel, National Women's clinical director of newborn services, said 'Unfortunately there aren't very good studies that have looked at the safety of water birthing or the benefits of it either.'**
> **(25 March, 2002, *The Press*, Ed. 2, p. 7)**

> **In an editorial in Paediatrics, Ruth Gilbert, a senior lecturer at the Centre for Paediatric Epidemiology and Biostatistics in London, said adverse events, including death, had been caused by waterbirths.**
> **(9 August, 2002, *The New Zealand Herald*)**

What Foucault (1981) also describes here regarding exclusion is that even when the entry into discourse is ritualised by credentials being made explicit, the fact that the underlying discourse is evading attempts to regulate it cannot quite be hidden (Mills, 2004, p. 57). It is an attempt to exhibit exclusiveness, thereby excluding other available discourses. When Foucault (1981) spoke about 'order of discourse' and 'will to truth' he claimed that a range of institutions throughout academia: educational establishments, publishing houses and legal institutions have led us to the point that it is almost impossible to question what the truth is and what is factual.

Excerpts from the speakers utilising the natural birth discourse that also cite credentials in the introduction of the speaker help to illustrate this point. Suffice to say, however, that their credentials may be seen by some readers as not carrying as much weight as the medical discourse speakers:

> **New Zealand College of Midwives director Karen Guilliland said the study did not provide any evidence that waterbirths were dangerous, and international research had found no safety issues.**
> **(A. Moffat, 26 March, 2002, *The Press*, Ed. 2, p. 4)**

> **Leading international researcher Sheila Kitzinger was working on an international database, which Ms Maude said she wanted to coordinate in New Zealand. It would collect statistics about labours and births in water and their outcomes.**
> **(L. Haines & NZPA, 25 March, 2002, *The Dominion Post*)**

The media's selection of the words 'director' and 'leading international researcher' as opposed to the previous use of 'senior lecturer', 'clinical director' and 'medical chairman' illustrate this.

The overall validity of knowledge can be strengthened by how a discourse is circulated. I now discuss how circulation of discourses occurs in our society, and how the media contributes to this.

4.6 Circulation of Discourses in Text

Foucault (1981) suggests that discourses which are repeatedly commented on over a period of time are the ones most likely to be considered valid and worthy of recognition. They are also the discourses that remain in circulation as legitimate knowledge for great lengths of time, for example, the Bible (Mills, 2004).

Waterbirth has coded contents and qualified speakers. Speaking about waterbirth induces educators, doctors, administrators and parents to speak of it and speak to others about it, thus enclosing others in a web of discourses, which sometimes addresses them, or imposes knowledge of waterbirth on them, 'or uses them as the basis for constructing a science that is beyond their grasp – all of this together enables us to link an intensification of the interventions of power to a multiplication of discourses.' (Foucault,1987, p. 32).

Lasting commentary can often silently articulate what was said 'beyond' the text. An example of this, as discussed previously, can be seen in the Nguyen et al. (2002) case-study. It was the continued and repetitive commentary of their 'facts' that kept waterbirth a controversial topic among women, midwives, doctors and the general public that year. The group of authors published their case study in the American Academy of Pediatrics Journal. This peer-reviewed publication is held in high esteem and considered to contain sound and truthful comment on the paediatric issues it examines. The website (http://pediatrics.aapublications.org) states: 'Pediatrics is an official peer-reviewed journal of the American Academy of Pediatrics. It is the most cited journal in the field of pediatrics (2005).' It is published in three languages (Italian, Spanish and Polish) with a monthly circulation to a readership of 78,000 worldwide. '[The journal] has the highest impact factor among all journals in the field of pediatrics' states the website.

In contrast, when women comment on the benefits they enjoyed with their own waterbirths, such commentary is more likely to be found in the *Little Treasures* parenting magazine, or weekly women's magazines – publications deemed less legitimate and valid in truth and fact by academics and speakers of the scientific medical discourse. *Little Treasures* has a readership of 227,000 and a circulation of 40,190 (R. Barraclough, personal correspondence, February 8, 2007).

The example I have chosen to extract from the newspaper articles to demonstrate Foucault's (1981) notion of circulation of discourses is the argument that exists between the scientific medical and natural birth discourses on the criteria for truth of, or existence of, the dive reflex in babies. The complexities of this reflex were discussed in Chapter Three.

Based on his experiments with fetal lambs born underwater, Johnson (1996) deemed there to be good evidence that fetal breathing has several active inhibitory components. These findings, when attributed to human babies, suggest that babies born underwater are prevented from aspirating water because of these inhibitory components, which when combined, are termed the dive reflex.

While the scientific medical knowledge doubts the existence or trustworthiness of such a reflex to sustain a baby being born underwater, speakers of the natural birth discourse believe that it is the dive reflex that prevents the baby from inhaling water during the waterbirth process. That is, the dive reflex prevents the neonate from drowning. While the natural birth discourse has a tendency to construct nature and the human body as superior and trustworthy, the scientific medical discourse by contrast suggests nature is not foolproof and should not be totally trusted. Excerpts to demonstrate this construction and circulation by the scientific medical discourse are as follows:

> **We know that babies make breathing movements… as a reflex action… even just as the head is delivered. How that translates into whether there's a significant risk in waterbirth, we need to find out, Dr Adams told NZPA.**
>
> **(L. Haines & NZPA, 25 March, 2002, *The Dominion Post*)**

Here the doctor is acknowledging the existence of 'breathing movements' and 'reflex action' but questions the imposition of risk to babies born underwater. The term 'reflex' is inferred here as being a behaviour that is inherent and unconscious and therefore uncontrollable. By using the word reflex, the doctor is challenging the validity and reliability of the dive reflex theory. 'We need to find out' is again calling for academic research to provide the scientific medical discourse with its 'truth'. Waterbirth is portrayed as an uncertain and therefore questionable practice, not to be carried out until it is proven to be safe.

> **The study… details the hospitalization of four babies in 10 months following waterbirths. In each case, when doctors x-rayed the babies' chests they found damage consistent with a near drowning. 'Their x-rays were typical of what you would see if your two year old was unsupervised and fell in a fresh water pool,' National Women's clinical director of newborn services Carl Kushel said.**
>
> **(N. Maling, 24 March, 2002, *Sunday Star-Times*)**

This excerpt also questions the infallibility of the dive reflex. Here empirical evidence is used to show that instead of breathing being inhibited as per the dive reflex, the newborns have inhaled water as they delivered. This has resulted in the quantification of the physical damage inflicted on the lungs of the newborn as being like that of a two-year-old near-drowning victim. The mental image is effective in that it is frightening for the reader.

The natural birth discourse constructs the presence of fluid in neonates' lungs from a different perspective, mainly that of the clinical incidence of transient tachypnoea of the newborn (TTN). Here a midwife contributes to the circulation of the TTN discourse:

> **A baby's lungs are filled with fluid before birth. Most is usually pushed out during the birth process and as the first breaths are taken. Changing from fluid-filled lungs to air-filled lungs is a normal physiological process…. Before and since the advent of waterbirths, hundreds of babies have been diagnosed with TTN. I wonder if the doctors who stated the five waterbirth babies were near-drownings would say the same if they saw the chest x-rays of those babies and observed that they had fluid in their lungs?**
>
> **(1 April, 2002, *The Evening Post*, Ed. 3, p. 12)**

> **Ms Maude said babies did not breathe when they were first born under water because sensory stimulators and reflexes set off when the baby experienced cool air and light in a non waterbirth were not triggered… 'There is no doubt these babies were unwell…but actually what they are trying to suggest is that it was related to their being born into water, and actually there is no international research that supports that.'**
>
> **Asked whether there could be other reasons for the babies' injuries, Ms Maude said she would be keen to know if doctors had found water or amniotic fluid in the babies' lungs.**
>
> **(L. Haines & NZPA, 25 March, 2002, *The Dominion Post*)**

Here the accusation that being born underwater has been the causative factor of the babies' condition is challenged. The two speakers above argue that it is not uncommon for neonates to have fluid in their lungs and that babies not born in water may also develop the same condition.

> **Midwifery advisor Norma Campbell said the National Women's study was scaremongering. 'These babies presented two to 12 hours after their birth, having been fine initially. Those patchy changes on the lung can also occur with babies born into air,' she said.**
>
> **(25 March, 2002, *Otago Daily Times*)**

The argument used in the above excerpts is that TTN occurs often, and babies born with it following waterbirth are automatically assumed by the scientific medical discourse to have suffered from the effects of being born in water, when in fact their clinical picture is

probably just that of TTN. This is a good example of how the same phenomenon is constructed differently by each discourse.

The second aspect that Foucault (1981) thought determined the circulation of a discourse was that of academic discipline. Academic discipline involves grand-scale grouping, which determines what can be regarded as factual or true within a given domain (Mills, 2004). Foucault deemed that disciplines determine what methods are used, how data is classified, what constitutes an argument and the formation of distinct methodologies for analysis – all within certain discursive limits: 'Disciplines allow people to speak "in the true", that is within the realm of what is considered true within that discipline, but they also exclude from consideration other knowledges which might have been possible' (Mills, 2004, p. 62).

The scientific medical and natural birth discourses are most commonly associated with 'medical' and 'midwifery' disciplines respectively although, as I continue to state, not exclusively. Traditionally the medical disciplines have been to do with disease, pathology, treatment and cures, observation and intervention, while midwifery (as discussed in Chapter Three) is traditionally based on the belief that birth is a natural, physiological event and the trustworthiness of the female human body to birth a baby. As discussed in Chapter Three each discipline favours certain knowledges to determine its 'truth'. From my analysis I have found that the speakers of the natural birth discourse prefer a mix of methodologies and knowledge, including experiential, scientific and anecdotal evidence, while the scientific medical discourse predominantly favours structured, traditional scientific research design, thereby excluding most other forms of knowledge. Examples of excerpts that reveal discourses drawing on varied methodologies and the importance placed on the academic discipline for each discourse are as follows:

> **Your story on waterbirth 'drownings' is nothing but poor reporting and sensationalist in the extreme. As midwives we prefer to base our practice on sound evidence rather than anecdotal evidence from four cases. A study published in the British Medical Journal (1999) of more than 4000 waterbirths in England and Wales showed no adverse effects from waterbirths for mothers or babies. Many other studies have shown increased benefits.**
>
> **(D. Holland, 31 March, 2002, *Sunday Star-Times*, Ed. A, p. 8)**

Although this speaker reveals herself to be a midwife, and hence more likely to be associated with the natural birth discourse, she draws on the scientific medical discourse of the *British Medical Journal* and critiques its findings of a waterbirth study. This speaker deems the study in question to be in her view 'anecdotal evidence', something she doesn't regard as contributing to the 'truth' on waterbirth.

> **I am a midwife who has attended more than 100 women who have chosen to use water for birth. I have never ceased to be amazed at the wonderful relaxation and unrestricted movement which the warm water provides for the mother and the gentle birth for the baby. My experience is borne out by studies (one of more than 4000 waterbirths) which showed no adverse effects for mothers, or for babies who have delivered into a birth pool and from all the families who I have worked with who rave about the wonderful effect of birthing in water.**
>
> **(A. Gilkison, 31 March, 2002, *Sunday Star-Times,* Ed. A, p. 8)**

Again, this speaker is more likely to be associated with the natural birth discourse yet draws on the scientific medical discourse of the *British Medical Journal* study of 4000 waterbirths. This drawing on the same body knowledge demonstrates circulation of discourse well. Yet this speaker also places importance on her own experience and anecdotal evidence of waterbirth, 'the wonderful effect' as contributory to her 'truth' on waterbirth.

> **A Capital Coast District Health Board spokeswoman said the hospital's two birthing pools had been used by midwives 'for as long as anyone can remember, and nobody can remember ever having a problem or there being a difficulty.'**
>
> **(A. Paltridge, 3 April, 2002, *The Evening Post,* Ed. 3, p. 9)**

Here the speaker's identity and professional discipline are missing but anecdotal evidence is drawn on to support the practice and safety of waterbirth.

> **New Zealand College of Midwives director Karen Guilliland said the study did not provide any evidence that waterbirths were dangerous, and international research had found no safety issues.**
>
> **(A. Moffat, 26 March, 2002, *The Press*, Ed. 2, p. 4)**

This speaker is strongly associated with the natural birth discourse yet draws exclusively on the scientific medical discourse's academia to speak her 'truth' on waterbirth. She refutes

the study (Nguyen et al., 2002) in question as providing any 'truth' towards the safety of waterbirth.

It can be seen that the speakers of the natural birth discourse prefer to state experience over prolonged periods of time as well as the findings of large international studies as their constitution of 'truth' regarding the safety of waterbirth. Thus dominant speakers of the natural birth discourse draw on multiple sources or bodies of knowledge to support the practice.

Alternatively, the scientific medical discourse is more exclusive and indicates that its academic discipline and version of 'truth' on waterbirth would be derived from 'reliable scientific evidence', 'good studies', and 'population based studies'. Two excerpts that echo this are:

> **The Medical Association is supporting a call for more research into waterbirths after five babies born that way have been admitted to hospital for near drowning in the past 18 months… 'Unfortunately there aren't very good studies that have looked at the safety of waterbirthing or the benefits of it either,' he said.**
>
> **(25 March, 2002, *Otago Daily Times*)**

> **'Despite the increased popularity in waterbirths during the past decade, there is a paucity of reliable scientific evidence about the benefits and hazards associated with this form of birthing,' they said. [Nguyen et al., 2002]**

> **In an editorial in Paediatrics, Ruth Gilbert, a senior lecturer at the Centre for Paediatric Epidemiology and Biostatistics in London, said adverse events, including death, had been caused by waterbirths. Population based studies could not exclude a clinically important or increased or decreased risk in mortality or illness.**
>
> **(NZPA, 9 August, 2002, *The Dominion Post*, Ed. 2, p. 9)**

Here the speakers of the scientific medical discourse fail to mention Gilbert and Tookey's (1999) study of 0.6% of all deliveries in the British Isles between March 1994 and March 1996 – i.e. 4032 waterbirths in total (Gilbert & Tookey, 1999). Three possibilities exist as to why this study has been kept invisible: firstly, there may be ignorance of its existence; secondly, excluding reference may have been deliberate; and thirdly, the reporter may have

omitted the speaker's reference to the study. There is also the possibility that the study's findings were not acceptable to these speakers and did not contribute to their version of 'truth' on waterbirth. The study's crucial finding was 'The similarity in Perinatal mortality and morbidity in low risk women suggests that delivery in water does not substantially increase adverse Perinatal outcomes.'(Gilbert & Tookey, 1999, p. 488). This is perhaps not a discourse on waterbirth that these speakers wish to circulate.

In the third excerpt the media have chosen to accentuate the line 'adverse events, including death, had been caused by waterbirths.' Interestingly, the speaker is quoting the very author of the most extensive population-based (hence scientific) study on waterbirth to date. Gilbert and Tookey's (1999) study mixed into this circulation is probably an oversight by the media, who are obviously unaware of its findings. The findings of Mrs. Gilbert's study do not exclusively support the discursive practice of waterbirth. What is interesting to note is that Gilbert's and Tookey's (1999) study findings in relation to the five babies who died showed that 'Five Perinatal deaths occurred among the 4030 live births in water in England and Wales. Two babies were stillborn; one after unattended delivery at home and the other was diagnosed before immersion. All three postpartum deaths were associated with abnormal pathological findings; neonatal herpes, intracranial haemorrhage following precipitate delivery, and hypoplastic lungs confirmed on postmortem. Therefore all five deaths cannot be directly attributed to birth underwater.'(Gilbert & Tookey, 1999, p. 485).

The final aspect of circulation of discourses that Foucault (1981) examined was that of rarefaction. Rarefaction refers to the fact that humans find themselves speaking on subjects in a repetitive and fairly predictable way within certain socially agreed boundaries and restrictive parameters (Mills, 2004, p. 63). Foucault (1981) stated that discursive limitations such as these are sanctioned by an institution of some kind (Mills, 2004, p. 63). Therefore, within the maternity care institutions and within the discourses on waterbirth themselves, the language and flow of information is generally the same about waterbirth worldwide. The rituals of discourse bind rules about who can utter certain types of phrases. Examples as presented in the media show that midwives are sanctioned to discuss normal birth and obstetricians are sanctioned to discuss obstetric interventions. I now give excerpts from the newspaper articles to show the utterances of each discourse in relation to waterbirth, as

sanctioned by the institutions that govern them, beginning with the commonly read utterances of scientific medical discourse:

> **Waterbirths had no proven clinical benefits.**
> **(9 August, 2002, *The Dominion Post,* Ed. 2, p. 9)**

> **The researchers, from the University of Southampton, said this alternative method of giving birth could be used to help in managing slow labours. Some doctors and midwives have shunned birthing pools, claiming that in some situations they put the health of mother and baby at risk.**
> **(27 January, 2004, *The New Zealand Herald*)**

.

In contrast, the natural birth discourse is commonly heard to utter the discursive limitations of waterbirth as follows:

> **Ms Maude said doctors, who come from a background of treating illness, were used to 'managing' labour but pregnancy was a natural process and 80 percent of women would give birth without any need for intervention.**
> **(A. Paltridge, 3 April, 2002, *The Evening Post,* Ed. 3, p. 9)**

> **During a waterbirth, the midwife will catch the baby and bring it out of the water before it gasps for breath. Ms Brandt believes waterbirths are safe if the baby is healthy and not in distress. 'I've done lots of waterbirths and never had a problem. There's an element of risk in every birth, whether it's on land or water.'**
> **(A. Patterson, 2 February, 2005, *Central Leader,* p. 13)**

To summarise these excerpts into an utterance of the natural birth discourse, it could be said that pregnancy and birth are natural processes, waterbirth is safe when the woman and her baby are low risk and healthy, and that every birth has its risks.

Following the deconstruction of the media articles according to the notions of Foucault – subjectivity, discipline, panopticon, exclusions in discourse and circulation of discourse – it can be seen how speakers of each discourse contest the overall safety of waterbirth in New Zealand.

I now examine the same media articles with Fairclough's (1995b) notions of order of discourse, intertextuality and linguistic representation.

CHAPTER FIVE: FAIRCLOUGH'S ANALYSIS OF MEDIA DISCOURSE

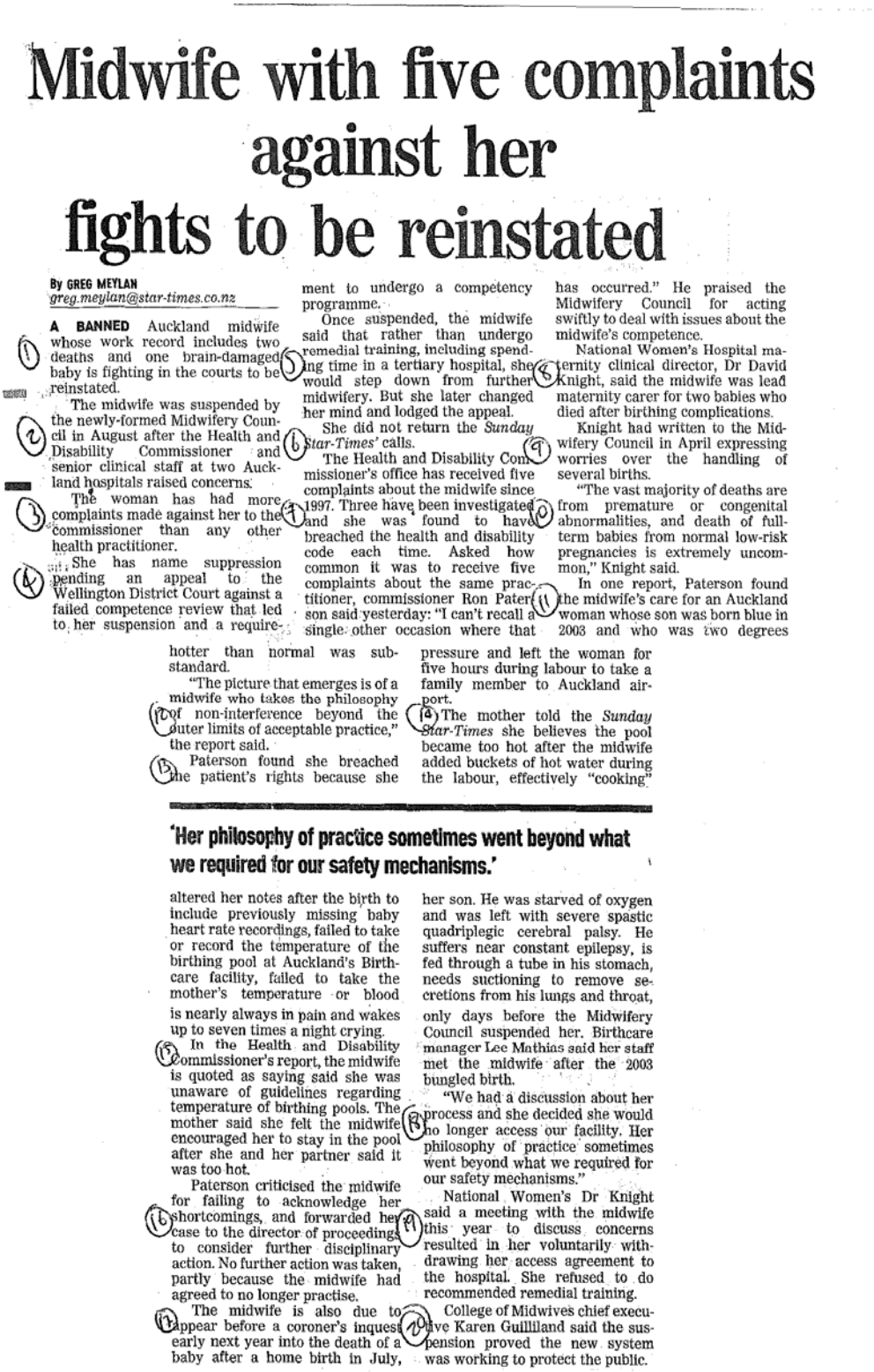
5.1 Introduction

In the previous chapter I utilised Foucault's discourse analytic concepts to examine how the natural birth discourse and scientific medical discourse are drawn upon in the media. By applying Fairclough's analytical concepts of media discourse I am able to demonstrate the active role the media has in utilising and disseminating discourses for public consumption in newspapers.

The following section of analysis in this findings chapter details Fairclough's (1995b) three notions of critical analysis of media discourse: order of discourse, intertextuality and linguistic representations in text.

Order of discourse and intertextuality are shown in extracts from the newspaper article 'Midwife with five complaints against her fights to be reinstated' (G. Meylan, 6 November, 2005, *Sunday Star-Times*, p. 1). I chose this article because it is rich in multiple discourses and multiple genres that showcase how the process of order of discourse is achieved. The article is shown below in Figure 3.

Figure 3: Midwife With Five Complaints Against Her Fights to be Reinstated



Midwife with five complaints against her fights to be reinstated

By GREG MEYLAN
greg.meylan@star-times.co.nz

A BANNED Auckland midwife whose work record includes two deaths and one brain-damaged baby is fighting in the courts to be reinstated.

The midwife was suspended by the newly-formed Midwifery Council in August after the Health and Disability Commissioner and senior clinical staff at two Auckland hospitals raised concerns.

The woman has had more complaints made against her to the commissioner than any other health practitioner.

She has name suppression pending an appeal to the Wellington District Court against a failed competence review that led to her suspension and a requirement to undergo a competency programme.

Once suspended, the midwife said that rather than undergo remedial training, including spending time in a tertiary hospital, she would step down from further midwifery. But she later changed her mind and lodged the appeal.

She did not return the *Sunday Star-Times'* calls.

The Health and Disability Commissioner's office has received five complaints about the midwife since 1997. Three have been investigated and she was found to have breached the health and disability code each time. Asked how common it was to receive five complaints about the same practitioner, commissioner Ron Paterson said yesterday: "I can't recall a single other occasion where that has occurred." He praised the Midwifery Council for acting swiftly to deal with issues about the midwife's competence.

National Women's Hospital maternity clinical director, Dr David Knight, said the midwife was lead maternity carer for two babies who died after birthing complications.

Knight had written to the Midwifery Council in April expressing worries over the handling of several births.

"The vast majority of deaths are from premature or congenital abnormalities, and death of full-term babies from normal low-risk pregnancies is extremely uncommon," Knight said.

In one report, Paterson found the midwife's care for an Auckland woman whose son was born blue in 2003 and who was two degrees hotter than normal was substandard.

"The picture that emerges is of a midwife who takes the philosophy of non-interference beyond the outer limits of acceptable practice," the report said.

Paterson found she breached the patient's rights because she pressure and left the woman for five hours during labour to take a family member to Auckland airport.

The mother told the *Sunday Star-Times* she believes the pool became too hot after the midwife added buckets of hot water during the labour, effectively "cooking"

'Her philosophy of practice sometimes went beyond what we required for our safety mechanisms.'

altered her notes after the birth to include previously missing baby heart rate recordings, failed to take or record the temperature of the birthing pool at Auckland's Birthcare facility, failed to take the mother's temperature or blood is nearly always in pain and wakes up to seven times a night crying.

In the Health and Disability Commissioner's report, the midwife is quoted as saying said she was unaware of guidelines regarding temperature of birthing pools. The mother said she felt the midwife encouraged her to stay in the pool after she and her partner said it was too hot.

Paterson criticised the midwife for failing to acknowledge her shortcomings, and forwarded her case to the director of proceedings to consider further disciplinary action. No further action was taken, partly because the midwife had agreed to no longer practise.

The midwife is also due to appear before a coroner's inquest early next year into the death of a baby after a home birth in July, her son. He was starved of oxygen and was left with severe spastic quadriplegic cerebral palsy. He suffers near constant epilepsy, is fed through a tube in his stomach, needs suctioning to remove secretions from his lungs and throat, only days before the Midwifery Council suspended her. Birthcare manager Lee Mathias said her staff met the midwife after the 2003 bungled birth.

"We had a discussion about her process and she decided she would no longer access our facility. Her philosophy of practice sometimes went beyond what we required for our safety mechanisms."

National Women's Dr Knight said a meeting with the midwife this year to discuss concerns resulted in her voluntarily withdrawing her access agreement to the hospital. She refused to do recommended remedial training.

College of Midwives chief executive Karen Guilliland said the suspension proved the new system was working to protect the public.

This article details the court proceedings and disciplinary recommendations made against a midwife who failed to provide appropriate care and intervention at two births; one a mis-managed waterbirth, possibly attributing to permanent brain injury to the baby, and the other a death of a baby born at home.

The third notion, linguistic representation is demonstrated in two articles written by Dearnaley (2003a, 2003b): 'Newborn "fell on floor" at birth pool' (M. Dearnaley, 15 September, 2003, *The New Zealand Herald*), and 'Baby's fall "not linked" to birth pool closure' (M. Dearnaley, 16 September, 2003, *The New Zealand Herald*). I chose these articles to demonstrate linguistic representation as I felt they showcased well how linguistics are used by the media to call on people's subjectivity by way of sensationalisation and shock value when the exact context and content of the story is backgrounded. This allows the reader to see how the media strategically presents information. The articles are shown in full now:

Article 2003a

Newborn 'fell on floor' at birth pool

Monday September 15, 2003

By MATHEW DEARNALEY

The parents of a disabled baby are complaining of a cover-up over claims that their daughter fell on her head during a spontaneous delivery at an Auckland water-birth pool.

But they believe a complaint they lodged against a midwife after their child's birth last October was behind a mysterious, if belated, decision by the Counties–Manukau District Health Board last month to close the pools at its three maternity units.

These are due to reopen today with the addition of handrails and other access improvements ordered by a Labour Department inspector.

But the parents want the Botany Downs pool where their baby was born to stay shut while their case is fully investigated.

Officials did not disclose any complaints by patients when the pools were shut, referring only to an alleged back injury suffered by a midwife about two years ago.

But they were closed less than two weeks after the same inspector, Margaret Stevens, responded to a complaint by the baby's parents that she had no jurisdiction to investigate it.

She noted that it was already under investigation by Health and Disability Commissioner Ron Paterson, the appropriate authority for such complaints.

The midwife claimed in case notes that she caught the baby as it fell from the birth canal while its mother was moving from the pool to a bed.

This followed what the family says was a potentially dangerous drop in the pool's water temperature.

But the baby's parents, her maternal grandmother and an aunt have provided witness statements to Mr Paterson saying it was left to the father to pick the infant off the hard floor outside the pool after she bounced off a step.

The grandmother said the midwife had her back turned as the baby slid from the mother and fell head-first to the ground while the father and aunt tried desperately to catch it.

'Before we could do anything, the baby slid out head first, hit the top step and outer edge of the bath, slid down the outside step, hit the floor, bounced back up toward [the mother] still connected to the umbilical cord and fell back on to the floor.'

She was not breathing spontaneously so was given cardiac massage and taken to Middlemore Hospital. Her parents, who have asked not to be named, say she was given the anticonvulsant drug phenobarbitone and suffered daily fits for eight months while a diagnosis of cerebral palsy emerged.

This means she is not expected to walk or talk properly, but they say it was not until seven months after they lodged a complaint about the midwife that the health board began an internal inquiry.

Mr Paterson has just this month decided to investigate claims by the parents that the midwife mismanaged the delivery and gave inaccurate information to hospital staff.

The child's father said he had to lift one of his partner's legs out of the pool in the absence of a handrail and fears this may have triggered her sudden delivery. He estimated the baby fell about 800mm.

Although the midwife's notes said she had cut the umbilical cord, she acknowledged in June to the board's medical misadventure unit that she asked the father to do this.

'I felt it was important for him to do it as I was not sure the baby would survive.'

Admission notes taken at Middlemore by a doctor who has since left the country noted the pregnancy was normal and the baby was rescuscitated after it 'dropped on floor'. Spokeswoman Lauren Young said the health board had carried out all Occupational Safety and Health improvement requirements but she could not describe these in detail.

The board's sudden closure of all its small spa-like pools shocked midwives and expectant mothers, particularly as Ms Stevens was at pains to say this was not a requirement of her improvement notice.

Ms Stevens said then that she issued the notice after noticing the lack of handrails and other features during a routine visit.

The OSH inspector could not be reached for clarification but her regional manager, John Forrest, acknowledged a link between concerns raised by the parents and the agency's interest in the birth pool.

But he said its primary focus was the safety of employees and its jurisdiction did not extend to allegations of medical misadventure.

Article 2003b:

Baby's fall 'not linked' to birth pool closure

Tuesday September 16, 2003

By MATHEW DEARNALEY

South Auckland health chiefs deny any direct link between their closure of birth pools and allegations that a baby fell on its head during delivery.

The Counties–Manukau District Health Board reopened three of its four birth pools yesterday after completing most of a set of improvements prescribed by the Labour Department's Occupational Safety and Health service (OSH).

New steps, wooden seats and a wider lip have been added to pools at Botany Downs, Papakura and Pukekohe, but handrails are not expected to be installed until later this week.

Midwives have been asked in the meantime to take particular care with women climbing in and out of the pools.

The larger of two pools at Pukekohe remains closed until a small foot-step is completed, but one pool that opened yesterday is at the centre of an investigation into a complaint against a midwife by parents of a baby suffering suspected cerebral palsy.

Health and Disability Commissioner Ron Paterson has agreed to investigate their allegation that the midwife mismanaged their baby's delivery at the Botany Downs birth pool in October and tried to cover this up with false information to Middlemore Hospital staff.

The midwife denies the allegations, and has told the Accident Compensation Corporation's medical misadventure unit she caught the baby with both hands as it "delivered spontaneously".

But the parents, the baby's maternal grandmother and an aunt have given witness accounts of allegedly seeing the baby fall out of the birth canal and bounce on its head down a step on to the floor as its mother climbed out of the pool.

The midwife refused yesterday to say anything about the case, asking the Herald not to try to talk to her.

But she told ACC she feared the baby was stillborn because it felt lifeless and was not breathing before resuscitation began "well within" one minute of delivery.

Board chief executive Stephen McKernan strongly rejected the cover-up allegation.

And he said although the board did not consider it appropriate to comment on clinical matters under investigation by external agencies, the pool closures were "not directly linked" to the family's complaint.

Mr McKernan acknowledged that an OSH improvement notice issued last month for Botany Downs focused on safety aspects of its use 'and in particular women getting in and out of the pool' as well as the avoidance of back injuries to midwives.

But although the notice did not require the board to close any pools, he said a management decision was taken to do so to allow time to discuss and make necessary improvements.

Midwives were shocked at the suddenness of last month's decision, saying they were not consulted and describing it as 'complete overkill'.

> *But a College of Midwives spokeswoman said yesterday she was unaware of the complaint at Botany Downs, and was saddened for both the family and midwife concerned.*
>
> *Asked at the time about any history of accidents prompting the move, health board spokeswoman Lauren Young mentioned only a complaint about two years ago of an alleged back injury to a midwife.*
>
> *A Nurses Organisation lawyer representing the midwife involved in the latest case, who remains a board employee and has had no internal action taken against her, could not be reached.*
>
> *Ms Young said late yesterday in response to questions which the Herald put to the board on Friday that there was no delay in investigating the baby's birth, but no formal complaint was received from the family until April.*
>
> *She said a skull x-ray and head ultrasound performed on the baby on the day it was born were normal and showed no evidence of trauma.*
>
> *But the parents, who do not want to be named, cite a scan in November in which a radiologist suggested that damage to a part of the brain which controls muscle movement was consistent with "moderate to severe" oxygen loss.*
>
> *The father said last night that he complained about the midwife to a paediatrician four days after the birth, after learning of her denial that the baby hit the ground.*
>
> *He denied a board suggestion that the family turned down the offer of a meeting with health staff a week after the birth, saying he and his partner met the paediatrician then, although other relatives and clinicians pulled out of the appointment.*
>
> ** A question-mark was omitted in yesterday's Herald in a Middlemore Hospital doctor's admission note that said the baby had a healthy pregnancy but was "delivered while moving to bed, dropped on floor?"*

It is timely to discuss how Fairfax and the key source of these articles as the country's main media outlet operates. Fairfax pays a yearly fee to the NZPA that enables it to choose from the pool of NZPA stories that are released each day. Fairfax papers share stories among themselves in order to get good regional cover (television interview on *Breakfast Today*, TV2, June 2005, Simon Dallow, TVNZ, and Bryce Johns, editor of the *Waikato Times*).

The economics of mass media and the role of economics in media institutions play an important part in determining media practices and their texts. This role is noteworthy and of importance to this analysis as it underpins the choices made in choosing discourses for public consumption. In an intensely competitive commercial environment, the media and commercial broadcasting are profit-making organisations. Profit is made by selling audiences to advertisers: 'This is achieved by acquiring the highest possible readerships or listener/viewer ratings for the lowest possible financial outlay' (Fairclough, 1995b, p. 42). The downfall of being influenced by such commercial pressures is that typically there is

more emphasis placed on making programmes or media text that is **entertaining** than informative or educative (Fairclough, 1995b). This affects factual content and communication style. 'What makes "good newspapers" is usually a vamped up dramatic construction, of casual style, with emphasis on personalities rather than fact' (Fairclough, 1995b, p. 36).

I now begin with Fairclough's first concept of the order of discourse.

5.2 Order of Discourse

Order of discourse is the umbrella term used in linguistics to effectively summarise how an article has been constructed according to the discourses available for selection. In a sense I work backwards here to describe the order of discourse used in the article in bold below, while going on to describe the intertextuality and linguistic representations used to show order of discourse.

The newspaper articles in this study were examined to see which discourse was given priority and the most positioning and volume within the individual text. Which discourse was made to 'stand out' the most and drive the overall communication about waterbirth in the text? I asked of each article 'What is the dominant discourse saying here about waterbirth in society at the time this article was published?'

Extracts from the article Figure 3 are used to show the order of discourse in operation. The newspaper is mediating source events in the public domain to a readership in a private (domestic) domain under competitive economic conditions.

Communicative event:

Midwife with five complaints against her fights to be reinstated

(G. Meylan, 6 November, 2005, *Sunday Star-Times*, p. 1)

A full view of this article can be seen in Figure 3. (see page 100). Within this article selections have been made among available discourses, and selection of particular ways of articulating them together; both are likely to be ideologically significant choices. According to Fairclough (1995b) dominant discourses will underpin how an article 'rationalises' what is being said about a topic – in this case waterbirth. In this way, Fairclough's works draw on Foucault's notion of knowledge/power and domination through language .The decisions made by the media on how to construct the relations between this midwife, her practice of waterbirth and the disciplinary personnel she encounters is rationalised by the media's articulation of the discourses available. Order of discourse can, although not exclusively, highlight the ideological assumptions and effects, as shown in the consequence of the selection of discourses used. Potential ideological effects are exposed in this way.

The media mediated between the public event of the midwife's wrong doings and the private consumption of this information by gathering information from the various discourses associated with public sources such as the court room, maternity hospital, birthing unit, Health and Disability Commissioner's office, and Midwifery Council offices.

Enabling private consumption of the communicative event involves reporting 'reported speech'. An example from the article is '**the midwife is quoted as saying she was unaware of guidelines....'** (Para 15). The media will choose which discourses they feel best portray their media outlets' preferred ideological stance, and in this way convey the ethos and overall image of the media outlet. The reputation of the media outlet is at stake if it repeatedly reports from a biased or left-wing slant. The media outlet wants to be seen as reporting the feelings and ideology of the majority of the population, of being fair and rational. Fairclough (1995b) suggests that collectively such attributes will contribute to ensured readership and newspaper sales.

The public colloquial language of waterbirth as revealed by the analysis of this article speaks predominantly from the scientific medical discourse; the scientific medical discourse is supported by the order of discourse in that it argues the use of hot water to have caused damage to the baby:

> **The mother told the *Sunday Star-Times* she believes the pool became too hot after the midwife added buckets of hot water during the labour, effectively 'cooking' her son. (Para 14)**

The media has allowed no 'comeback' from the natural birth discourse as the media has chosen not to order the discourses in this way. The media could have chosen to add that perhaps the midwife thought the pool was too cool and in fact hot water was needed to bring the pool up to the correct temperature for labouring in (see Chapter Three). The follow-on sentence from this draws on the scientific medical discourse, which, as it is positioned, leaves the reader assuming that labouring in hot water has caused or attributed the injuries to the baby:

> **… He was starved of oxygen and was left with severe spastic quadraplegic cerebral palsy. He suffers near constant epilepsy, is fed through a tube…. (Para 14).**

The other socially available discourse to the media here could have given the reader some further insight into time frames of labour, length of time in the pool and, most importantly, whether or not this baby actually delivered in water or not; there is no information to state this was the case. This is an example of how the media chooses order of discourse through discourse practice to push the ideological stance it wants the article to communicate.

To summarise, I would state that the order of discourse in this article has been to prioritise the communicative event from an order of official discourses, mainly from a selection of legal and disciplinary-type discourses. The colloquial language used on waterbirth is recognisable. The traditional demarcation between dominant and alternative discourses on waterbirth remains. Multiple genres have been used to articulate the dominant discourse. The media has chosen to avoid using the genre of the midwife's voice itself. Reported speech of the midwife is used rather than her speaking.

I now show how intertextuality contributes to the order of discourse.

5.3 Intertextuality

Intertextuality is an analysis of texts from the perspective of discourse practice or, more specifically, discourse processes. 'It looks at the ways in which genres and discourses available within the repertoires of orders of discourse are drawn upon and combined in producing and consuming texts, and the ways in which texts transform and embed other texts which are in chain relationships with them' (Fairclough, 1995b, p. 75). Intertextuality is the umbrella term for the twin perspectives of discourse practice and discourse types that appear in texts simultaneously and complement each other. I examine these perspectives now.

5.3a Discourse practice

Discourse practice involves the transformation of source texts. In the article discussed here (6 November, 2005, *Sunday Star-Times* – please refer to the complete article in Figure 3 earlier in this chapter) the source text is the press conference at Wellington District Court, as alluded to in the fourth paragraph. The discourse practice is complex. Here it articulates together features of the source discourse (the court hearing's recommendations and findings) to the target discourse (general public, families, midwives, other health professionals). Discourse practice straddles the division between society and culture, and discourse language and text (Fairclough, 1995b).

The article uses a creative mix of genres and discourses. These are a press conference at Wellington District Court; findings from the Health and Disability Commissioner's Report; an interview with the disabled baby's mother with the *Sunday Star-Times;* details of the Midwifery Council suspension notice; previous interview material of two senior clinical staff at two Auckland hospitals; an interview with the Health and Disability Commissioner Mr. Ron Patterson; reporting from a court hearing at Wellington District Court; details of the midwife's failed competency view; an interview with National Women's Hospital's maternity clinical director Dr. David Knight; details of one report on the midwife from the Health and Disability Commissioner; details of the up-coming coroner's inquest meeting; an interview with *Birthcare* manager Lee Mathias; and an interview with New Zealand College of Midwives Chief Executive Karen Guilliland.

Genres are styles, modes and voices and are ways of using language associated with particular relationships between the producer of the text and the audience (reader) (Fairclough, 1995b, p. 77). The notion of genre in this analysis is not to be confused with that of Foucault's 'subject position', though they are indeed similar. As stated in Chapter Two there are multiple genres within one article. This article uses the following genres: press conference genre, court hearing genre, report findings genre, interview genre, aggrieved person genre, concerned doctor genre, midwifery manager genre and accused midwife genre. Additionally, the article uses the following discourse types: law and order discourse, discourse of the Health and Disability Commission of New Zealand, discourse of the New Zealand Midwifery Council, Coroner's inquest discourse, scientific medical discourse, and sick/disabled child discourse. Examples of traces of genres and discourses from the articles are shown below:

Report findings genre:

> **In one report, Paterson found the midwife's care for an Auckland woman whose son was born blue in 2003 and who was two degrees hotter than normal to be sub-standard.**
>
> **(Para 11)**

Interview genre:

> **'We had a discussion about her process and she decided she would no longer access our facility.'**
>
> **(Para 18)**

Disabled/sick baby discourse:

> **He was starved of oxygen and was left with severe spastic quadriplegic cerebral palsy. He suffers near constant epilepsy, is fed through a tube in his stomach, needs suctioning to remove secretions from his lungs and throat, is nearly always in pain and wakes up to seven times a night crying.**
>
> **(Para 14)**

New Zealand Health and Disability Commission discourse:

> **The Health and Disability Commissioner's office has received five complaints about the midwife since 1997. Three have been**

> **investigated and she was found to have breached the health and disability code each time.**
>
> **(Para 7)**

In summary, this article has articulated eight genres and seven different discourses from those socially available within orders of discourse. By mixing discourses creatively, the communicative event draws upon the order of discourse by reproducing the already known boundaries that exist between the scientific medical discourse and the natural birth discourse.

Fairclough (1995b, p. 59) thought that discourse practice mediated between the textual and the social and cultural. He states:

> Media texts are sensitive barometers of cultural change which manifest in their heterogeneity and contradictoriness the often tentative, unfinished and messy nature of change. Textual heterogeneity can be seen as a materialization of social and cultural contradictions and as important evidence for investigating these contradictions and their evolution. (p. 60)

This statement reinforces the social nature of birth and people's understanding of it from their cultural perspective as either one of two contradictions: it is a normal physiological event that carries risk for a minority of women; or that it is a potentially hazardous life event that requires surveillance and intervention at all times. By examining discourse practice I am exposing the tension that exists between the scientific medical discourse and natural birth discourse in relation to birth. I feel the discourse practice evident in this text articulates the genres and discourses in a way that has promoted the scientific medical ideology and determines what constitutes safe practice, and its need to discipline those who do not follow suit. Fairclough (1995b) says that any text makes its own small contribution to shaping aspects of society and culture.

5.3b Discourse type

The discourse type of this media story is called a 'hard news' story from the popular New Zealand press. As a hard news story it is different in genre from other types of articles,

which are in a choice relation within the order of discourse – soft news stories, comments and features. It has the typical generic structure of a hard news story: a 'nucleus' consisting of a headline (in fact both a major and a minor centrally located, bold one) and a lead paragraph, which gives the gist of the story; a series of 'satellite' paragraphs, which elaborate the story in various directions; and a final 'wrap-up' paragraph, which gives a sense of resolution to the story.

The source text is transformed into and embedded in the article. Ambivalence of voice exists. The article occasionally gives direct quotes from the Health and Disability Commissioner's report: '**The picture that emerges is of a midwife who takes the philosophy of non-interference beyond the outer limits of acceptable practice.'** Additionally, the newspaper sometimes (radically) transforms and reformulates the quotes: **'Patterson criticized the midwife for failing to acknowledge her shortcomings…'.** There is mixing of genre here – the combination of the informative hard-news genre with elements of the discipline/persuasive genre. Also, the *Sunday Star-Times* article is putting across that this midwife is campaigning to be reinstated despite a work record that includes two deaths and one brain-damaged baby. Only two of these cases are detailed. A feature here is the chain relations in the way the article is intertextually linked into another chain (see para 17), which consists of previous coverage of one of the baby's deaths in the popular media. This sort of chaining is a quite general feature of media texts.

In this discourse type within the order of discourse of the *Sunday Star-Times*, this genre is standardly articulated with the combination of official and colloquial discourses. A by-product of the bridge between public (the midwife before the courtroom) and private domains (people reading about the courtroom appearance in newspapers) has been a communication style and ethos which adjusts towards the priorities, values and practices of private life. The use of highly emotive language helps achieve this – the description of the condition of the baby (para 17) is an example of this communication style. As a result the media has developed its own 'public colloquial language', a public language for use in certain ways on certain topics (Fairclough, 1995b, p. 38). The public colloquial language of waterbirth as revealed by the analysis of this article speaks predominantly from the scientific medical discourse. Examples of this are:

> **‘Her philosophy of practice sometimes went beyond what we required for our safety mechanisms.’**
>
> **(Para 18)**

> **‘The picture that emerges is of a midwife who takes the philosophy of non-interference beyond the outer limits of acceptable practice.’**
>
> **(Para 12)**

Use of the words ‘our safety mechanisms’ suggest ownership of knowledge on the safety of waterbirth by these speakers of the scientific medical discourse (both speakers are doctors). A division between knowledges and hierarchy is insinuated by use of the words ‘her’ and ‘we’. The scientific medical discourse speakers are contesting here the philosophy of non-interence (strongly attributed to the natural birth discourse) against ‘acceptable practice’, as the analysis in Chapter Four shows; scientific medical discourse knowledge has been used to underpin accepted waterbirth practice.

It can be said then that the official discourses used in this article are prioritised in order to portray the discursive practice of waterbirth as being something beyond the usual practice of safe childbirth. Waterbirth is implicated, though not proven, to have caused severe brain injury to the baby in question. The official discourses used to do this have been the discourse of law and order; the discourse of competency reviews; the discourse of New Zealand’s Health and Disability Commission; the discourse of maternity hospital clinical director doctors; the discourse of a grieving mother; and the discourse of a newly formed disciplinary council of midwives.

What these official discourses have in common is that they are all deemed to be expert in their field, they are considered what Foucault (1994) would deem ‘legitimate knowledge’ or truth on their topics. The *Sunday Star–Times* believes it has put forward the official word and truth on these incidents.

5.4 Linguistic Representation in Text

Here I use Fairclough’s (1995b) analysis of linguistics in text. The focus of this analysis is on how events, situations, relationships and people are represented in texts. A common

assumption is that media texts do not merely ‘mirror realities’, as is sometimes naively assumed; they constitute versions of reality in ways that depend on the social positions, interests and objectives of those who produce them (Fairclough, 1995b, p. 104). This is achieved by the media by way of choice during the process of producing a text. Therefore linguistic representation in text is essentially an account of what choices have been made – what is included and what is excluded; what is made explicit or left implicit; what is foregrounded and what is backgrounded.

The social motivations for particular choices and ideology and relations of domination are exposed throughout this analysis. I have used the following two articles to show linguistic representation in text.

Newborn ‘fell on floor’ at birth pool

(M. Dearnaley, 15 September, 2003, *The New Zealand Herald*)

Baby’s fall ‘not linked’ to birth pool closure

(M. Dearnaley, 16 September, 2003, *The New Zealand Herald*)

See pp.101-105 for these articles in full format.

These articles are two in a series of three which detail the complaint made by parents of a baby who spontaneously delivered and fell on her head as the mother abducted her leg to exit a birthing pool. The parents claimed that the midwife was negligent in not catching the baby and for having her back turned as the mother exited the pool. The baby girl was acutely ill after the fall and transferred to a hospital where she received anti-convulsant drugs due to seizures that occurred following the fall. Eight months after the birth, a diagnosis of cerebral palsy was made. Eleven months after the birth, the parents went public with the details of the birth incident, having lodged a complaint with the Health and Disability Commissioner and the Accident Compensation Corporation’s Medical Misadventure Unit. Following the public announcement, the District Health Board closed all birthing pools in South Auckland, although it did not disclose reasons for doing so. The third article (16 September, 2003) states that the district health ‘chiefs’ denied a link

between the closure of the pools and the incident. The two articles used in this analysis quote the midwife's defense in her own words.

5.4a Presuppositions: presences and absences in text

A text's presuppositions are important in that they position the reader (Fairclough, 1995b, p. 107). Presuppositions help establish represented realities as convincing. For example, the opening paragraphs of these two articles help convince the reader of an authentic situation:

> **The parents of a disabled baby are complaining of a cover-up over claims that their daughter fell on her head during a spontaneous delivery at an Auckland water-birth pool.**
>
> **(2003a, 15 September, 2003)**

> **South Auckland health chiefs deny any direct link between their closure of birth pools and allegations that a baby fell on its head during delivery.**
>
> **(2003b, 16 September, 2003)**

These opening paragraphs 'anchor the unknown in the known' (Fairclough, 1995b, p. 107). They assume there are other texts**.** These other texts are common ground for oneself and the reader, in which what is now presupposed is explicitly present; already part of the 'said' – for example, **'complaining of a cover-up over claims that…)'.**

Authenticity is also achieved by positioning the reader through presupposition as being someone who is already familiar with what is meant by a disabled baby, the meaning of spontaneous delivery and what a birth pool might be. These things are taken as given knowledge for the audience. If something is presupposed, it is in a sense present in the text, but as part of its implicit meaning. From these opening headings examples are shown that demonstrate what is present and absent – presupposed or taken for granted. It is made explicit, therefore made present, that the baby is disabled; she fell on her head at an Auckland birth pool; birth pools have been closed; and that allegations have been made of a baby falling on its head.

It is taken for granted, therefore made absent, that there might not have been a cover-up at all; South Auckland 'health chiefs' have organised the closure of birth pools; falling on her head has caused the baby girl to be disabled; and that the location of the birth pool itself contributed somehow to the baby falling on its head.

I suggest that the implicit meaning of these texts so far (in the opening paragraphs) give an overall meaning of 'Oh, a baby fell on its head at a birthing pool – how shocking!' Fairclough spoke of 'scale of presence' (p. 106). Presence can flow from 'absent' to 'foregrounded'; absent – presupposed – backgrounded – foregrounded. Generally speaking there are differentiating degrees of presence (foregrounding and backgrounding are discussed later in this analysis).

The following excerpt from article two is rich in what is absent from the text:

> **But the parents want the Botany Downs pool where their baby was born to stay shut while their case is fully investigated.**
>
> **(M. Dearnaley, 15 September, 2003, *The New Zealand Herald*)**

The parents do not want the pool used by anyone until the (probably lengthy) investigation of the circumstances surrounding their baby's unfortunate birth is completed. The reader then presupposes that indeed it was the location of the birthing pool that has contributed to this incident. Why else would the pool need to be closed? There is no information given in either articles as to why the woman was exiting the pool, or if the pool was full or emptying. Questions also need to be asked such as 'If delivery was so imminent why was she getting out?' 'What circumstances prevailed at the time that meant she should exit the pool?' 'Was this her choice or was the midwife following guidelines?' Neither article details the woman's parity. In my experience spontaneous, rapid delivery of this type following abduction of a leg, hence acutely increasing the pelvic outlet diameter, is not uncommon among women who have had two babies or more. Women having their third or more babies will sometimes deliver like this as they sit down on a toilet and splay their legs, swing one leg to get off a bed or out of a car. This is common anecdotal knowledge among midwives whom I have spoken to.

A more general absence that Fairclough (1995b) notes is that of the absence of historical context in most news stories (p. 106). It is noted here that this article is dated September the following year (2003) of the October (2002) birth. Therefore this article, and the parents' request for the pool to be shut, comes 11 months after the incident. One might assume that if birthing pools were culpable in this way, why had they not been shut immediately afterwards? Lack of historical context enhances the dominant scientific medical discourse (birth pools can cause babies to fall) and assists it to dominate people's common-sense judgment. Also no other information is given about the past use of the birthing pools and any other incidents or lack of incidents.

Another example of presupposition in text is:

> **The Grandmother said the midwife had her back turned as the baby slid from the mother and fell head-first to the ground while the father and aunt tried desperately to catch it.**
>
> **(2003a, 15 September, 2003)**

It is made explicit here, therefore present, that the midwife was obviously a distance from the woman with her back turned, not within visual sight of the woman. The midwife is unaware that the woman is delivering her baby, for if she had been aware surely she would have tried to catch the baby seeing what a precarious position the mother was in? This statement has an ideological function – to position the reader into thinking that this midwife is negligent. This statement 'fudges the boundary between the generality of the population and its government or other powerful agents' (Fairclough, 1995b, p. 108). 'Powerful agents' in this case refer to the Health and Disability Commissioner, health 'chiefs' and the Accident Compensation Corporation investigating, thus ruling on the legitimised 'truth' of what actually happened.

To summarise, the ideology that is embedded within the implicit meaning of these articles is that women who are located in or around birthing pools run the risk of having their baby fall on the floor, and there is the possibility that cerebral palsy might ensue from such a fall.

I now examine the linguistic representation method of categorisation to showcase the choices made by the media when selecting grammar in texts.

5.4b Categorisation

'[The] Media make categorisations both explicit in vocabulary and those that are implicit in how people or things figure in process types' (Fairclough, 1995b, p. 112). Categorisation reveals that there are always alternative ways of wording any aspect of a social practice. This alternative wording may correspond to different categorisations and, as a result different discourses are realised. Fairclough (1995b) states that it is grammar and its associated process types and participant types that makes us choose the language we use to represent something. We either represent something as an action or event. We will choose single clauses or single words with systematic patterning and tendencies to describe things. An example of categorisation from the article 2003a is:

> **The Grandmother said the midwife had her back turned as the baby slid from the mother and fell head-first to the ground while the father and the aunt tried desperately to catch it.**
>
> **'Before we could do anything, the baby slid out head first, hit the top step and outer edge of the bath, slid down the outside step, hit the floor, bounced back up toward (the mother) still connected to the umbilical cord and fell back on to the floor.'**
>
> **(2003a, 15 September, 2003)**

Here the event is described in slow motion, giving the impression that there might have been time to prevent the baby from falling. Choice of the words 'slid', 'head first' and 'tried desperately' convey a sense of desperation over the potential prevention of the event if the midwife had not had her back turned. Choice of the words 'hit the top step', 'outer edge of the bath', 'hit the floor', 'bounced back up still connected' and 'fell back on the floor' describe the main categorisation of a baby that hit hard surfaces on several occasions; there were a series of hard knocks before eventually falling on the floor.

Fairclough (1995b) proposes that one way of promoting significant ideological effects is for newspapers to systematically contrast discourses, e.g. good people versus bad people. This is achieved when discourses are foregrounded; for example, the baby who is the casualty at

the centre of these articles represents a disaster. Evidence of ‘good people’ and ‘bad people’ categorised by these articles are shown below.

Here the parents are categorised as ‘good people’:

> **But they believe a complaint they lodged against a midwife after their child’s birth last October was behind a mysterious, if belated, decision by the Counties Manukau District Health Board last month to close the pools at its three maternity units.**
>
> **(2003a, 15 September, 2003)**

Here the midwife is categorised as a ‘bad’ person and, again, the parents are categorised as ‘good’:

> **Mr. Paterson (Health and Disability Commissioner) has just this month decided to investigate claims by the parents that the midwife mismanaged the delivery and gave inaccurate information to hospital staff.**
>
> **(2003a, 15 September, 2003)**

> **But one pool that opened yesterday is at the centre of an investigation into a complaint against a midwife by parents of a baby suffering from suspected cerebral palsy.**
>
> **(2003b, 16 September, 2003)**

The midwife is portrayed through categorisation, positioning and choice of words as a passive rather than active participant in this event. One must ask ‘Is this how she [the midwife] would have viewed the event? Is this how she sees herself? I would suggest that the reader is swayed to categorise waterbirth as a practice associated with midwives; the negative categorisation of the midwife then troubles the representation of waterbirth in this text also.

5.5 Foregrounding and Backgrounding in Text

The processes of foregrounding and backgrounding in text are aimed at the relative positioning of different topics within the generic structure of a text. Topics that are foregrounded are those which appear informationally prominent in headlines, or in the lead

paragraph. Foregrounding involves using main sentences to foreground the information, whereas subordinate clauses usually background it. The element at the beginning of a clause is termed its 'theme'. An example of foregrounding from article 2003a is:

> ***(2003a) Headline*: Newborn 'fell on floor' at birth pool**
>
> ***Lead paragraph*: The parents of a disabled baby are complaining of a cover-up over claims that their daughter fell on her head during a spontaneous delivery at an Auckland water-birth pool.**

The information that is foregrounded and made immediately obvious to draw the reader in here, I would suggest, is that the parents are demanding the truth to be revealed on how their daughter fell on her head at the birth pool. They are seeking accountability. The element at the beginning of a clause is called its 'theme', so theme is put in a prominent position. The theme of article 2003a is that of a baby disabled as a consequence of malpractice.

The final position in a clause, or what is sometimes called the 'information focus' position, is also prominent, especially if it comes at the end of a sentence. In spoken language this will be recognised by the increased pitch of intonation in the speaker's voice. In text, when one reads the sentence out loud, the nucleus most naturally falls on the final word (Fairclough, 1995b, p. 121). Examples from article 2003a showing final words of paragraphs being positioned as informationally prominent, (Table 4a) thus foregrounded, are:

Table 4a: Foregrounding in Text

Paragraph	**Final words**
Paragraph 1	waterbirth pool
Paragraph 4	fully investigated
Paragraph 10	bounced off a step
Paragraph 11	desperately to catch it
Paragraph 12	to the floor

Paragraph 13	cerebral palsy
Paragraph 14	internal inquiry
Paragraph 16	fell about 800mm
Paragraph 18	survive
Paragraph 22	birth pool
Paragraph 23	medical misadventure

So if the first and final words are used to foreground information, I now examine the first and final words of some of the paragraphs to show how the theme is discernable in only a few words (Table 4b), (article 2003a, 15 September, 2003):

Table 4b: Foregrounding in Text

Paragraph	**First words**	**Final words**
1	The parents of a disabled baby	water-birth pool
2	The midwife claimed	from the pool
10	But the baby's parents	bounced off a step
11	The Grandmother said	desperately to catch
12	Before we could do anything	fell back on the floor
13	She was not breathing	cerebal palsy
14	Not expected to walk	internal inquiry
20	The boards sudden closure	improvement notice
22	OSH inspector	interest in birth pool

The frequency in which different topics appear or are positioned also contributes to foregrounding. Fairclough (1995b, p. 120) calls this 'frequency of formulations'. In article

2003b (16 September, 2003), there are a total of ten paragraphs to the article's structure. The first five paragraphs exclusively convey information about the health chief's closure of the pools. The incident regaling the baby's fall is first introduced in Para 7. The midwife is allocated four clauses in the final two paragraphs. In the first clause she declines to comment and the second clause is abstract and informationally foregrounded by its content: **'But she told ACC she feared the baby was stillborn because it felt lifeless and was not breathing before resuscitation.'** This is the final sentence in this article. It is the only quotation of the midwife's reported speech. By positioning the topic and the voice of the midwife in this way, she is effectively foregrounded to the reader, despite the fact that her views and voice have been backgrounded until now. This final sentence highlights her and her association with the social practice of waterbirth. As the final sentence according to Fairclough (1995b) acts as an information nucleus, the use of grammar also demonstrates his notion of categorisation; grammar chosen for the 'midwife-at-the-water-pool category' is 'stillborn', 'lifeless', 'not breathing', 'resuscitation'.

The final aspect of foregrounding and backgrounding that Fairclough (1995b) urges analysts to uncover is 'the local coherence relations between sentences. This coherence also contributes to the relative salience of propositions' (p. 120). '*But'* is often used in a reassuring way, linking some risk or threat with the means of avoiding it. An example of this in article 2003a is:

> **But they believe a complaint they lodged against a midwife after their child's birth last October was behind a mysterious, if belated, decision by the Counties–Manukau District Health Board last month to close the pools at its three maternity units.**
> **(15 September, 2003, *New Zealand Herald*)**

By working backwards to the previous paragraph, in this case the lead paragraph, the last sentence of the previous paragraph has no linking word but there is nevertheless a coherent meaning relation between that sentence and those preceding it. The preceding sentence was **'spontaneous delivery at an Auckland waterbirth pool.'** This sentence characteristically imposes a closure, a conclusion, in a form that defuses the follow-on paragraph (the one shown above). Therefore linking words, such as 'but' are often used to introduce the rebuttal, attack, reaction or alternative point. Fairclough (1995b) points out that these linking words subtly differentiate the preceding paragraphs from the next by differentiating

into antagonist and protagonist respectively. The protagonist position according to Fairclough (1995b) is usually given more weight. I feel this concept is shown exactly in this article, as throughout the remainder of this article the discourse of the aggrieved parents is given priority and is strongly informationally foregrounded.

The notion of foregrounding and backgrounding enhances reader awareness not only of what is represented in text but what relative weight importance is attached to different elements within a representation.

To summarise this chapter, it can be seen that the order of discourse prioritised waterbirth from a selection of mainly official-type discourses (legal and disciplinary). There was little inclusion of the natural birth discourse or that of the midwifery perspective. Intertextuality articulated discourse practice to overtly promote the scientific medical ideology. Discourse type was most commonly law and order discourses to underpin the ideology being presented – that waterbirth is beyond the usual practice of safe childbirth.

Linguistic representation highlighted lack of historical context. The implicit meaning through presupposition, absences and presence was that birth pools are potentially dangerous places for babies. Categorisation saw waterbirth linked to midwives and the negative categorisation of midwives reflected on waterbirth. Foregrounding and backgrounding showed how simple clauses and grammar use alone are strategically used to draw our attention to the ‘theme’ or overall ideology being asserted in a text. The theme attributed to waterbirth in these texts was that of injured babies.

This concludes my analysis of Fairclough’s (1995b) linguistic analysis of the newspaper articles.

CHAPTER SIX: SUMMARY AND DISCUSSION OF ANALYSIS

6.1 Summary of Foucault's and Fairclough's Notions as Demonstrated Throughout This Study

The aim of this thesis was to identify and analyse the discourses evident in the media in relation to waterbirth. The perspective of subjectivity (Weedon, 1987) was used to show how subjectivity in relation to waterbirth is offered to women and the public alike. It was shown that the scientific medical discourse chooses certain language in its description of waterbirth to appeal to the common sense of people reading about it. The scientific medical discourse classifies women as irrational or deliberately exposing themselves to risk if they choose to have a waterbirth. The safety of waterbirth is contrasted against the perceived benefits of labouring in water for the mother.

Being safe in birth is used as an agent to dominate a woman's subjectivity, and her emotional want to be a good and caring prospective mother. Jostling of safe/unsafe subject positions is clearly evident in the articles. The construction of waterbirth by the media has a tendency to construct women who want waterbirths as being old-fashioned, and somewhat alternative. This labeling assists in the legitimation of the common-sense approach to birth. Labelled women/people, as within any social practice, are therefore marginalised in particular spectrums of social life. There is an element of 'why choose a waterbirth when in today's modern birth culture there is a pain-free, choose-your-date-and-time option you can pay for? Collectively, these aspects create an overall sense of wariness towards waterbirth for women.

In essence, the subjectivity of waterbirth I have revealed is that women are more likely to be influenced into a subject position offered by the scientific medical discourse with its back-up reassurance to women that what they are saying and doing makes them good, safe, rational women.

Foucault's (1977) notion of discipline was shown with excerpts for the newspaper articles citing the scientific medical discourse's criticism of midwives who fail to adhere to the

waterbirth protocols in place in maternity care institutions. Foucault's notion of docile bodies resulting from discipline was shown in the articles whereby certain maternity care institutions will not allow midwives to conduct waterbirths despite having plumbed-in, specifically installed pools in which to do so. Pools are to be used for pain-relief in labour only. As the scientific medical discourse generally regards waterbirth as an unsafe birthing practice, certain institutions follow through on this by banning midwives from conducting them. Water is promoted as an acceptable place to labour in, but not to birth in.

Foucault's (1977) notion of the panopticon was shown with excerpts from the newspaper articles showing how the scientific medical discourse has over the past five years called repeatedly for quantification of how many waterbirths are occurring and who is conducting them. These are efforts to surveil the practice of waterbirth thereby keeping it visible within the public arena. Continued visibility creates an ongoing platform on which to voice commentary that derides waterbirth as being unsafe. As their commentary and observation fixes waterbirth as 'the object of information – never a subject in communication' (Foucault, 1977, p. 200), the automatic functioning of power is assured.

The panoptic gaze is exercised in our maternity health systems. Waterbirth is surveilled in the hospital systems by means of documentation in the birth register and patients' notes. There are lists of practitioners who 'do' waterbirths. Because waterbirth practice is not exposed and somewhat hidden in New Zealand, it remains noteworthy and of interest to practitioners and hospital personnel alike. The discourse most applicable to constituting a 'norm' for waterbirth in New Zealand is the scientific medical discourse, which identifies the use of water as a form of analgesia – not as a place of birth. The technique of subjection that induces a state of permanent visibility for waterbirth is the publication of the newspaper articles themselves, used in this thesis. By speaking about waterbirth in a nationally distributed newspaper system, it can be surveilled by the readers who are New Zealand citizens. It is the language and wording used in these articles that establishes and circulates norms around conventional-type birthing practices against which waterbirth is assessed.

Foucault's (1981) discussion on how people attempt to define what we can say and what we can consider as legitimate knowledge is bound in his notion of 'exclusions in discourse'. Midwifery practitioners of waterbirth are often labeled as 'alternative' birthing practitioners as waterbirth is not within the realm of skills and experience of all midwives. There is also the existence of an underlying 'taboo' on waterbirth in New Zealand. The scientific medical discourse seeks to exclude waterbirth from the milieu of birthing practices, trends and overall birth culture in today's society by the continuation of commentary that voices wariness and distrust of waterbirth. The citing of 'near drownings' may generate alarm, shock and cause most people to visualise a baby drowning as it is born, in order to draw the public's attention to what the media have to say about it.

My findings examined an article published by a group of New Zealand paediatricians in 2002 (Nguyen et. al, 2002). This article informed the public of adverse outcomes with babies born in water. The dominant discourse on waterbirth that followed this article was highly effective in excluding waterbirth as a rational and safe way to birth for some people. Exclusion of waterbirth was enhanced by the media's inclusion and focus on the qualifications of the doctors involved in publishing the article, and the place of publication (an academic journal). These were emphasised to promote the status and kudos of the speakers from the scientific medical discourse, thus making it a more trustworthy discourse.

Persistent commentary on a discourse over a prolonged period of time according to Foucault (1981) ensures that the discourse is maintained as legitimate knowledge in print. Powerful discourses such as the scientific medical discourse will be used and spoken of for years; the information in them is used as a precursor to any follow-on discourses that replace them. The contents of an article published by a group of New Zealand paediatricians in 2002 examined in this study contributed to the basis of the overall discourse of waterbirth in New Zealand today, 2007. The place of publication and the authority and status of the publication house helps to ensure circulation of the discourse, as it will be read by people who deem such publications to be 'truthful' or legitimate knowledge on their subjects.

The academic disciplines associated with each of the discourses show that the scientific medical discourse prefers reliable scientific evidence, preferably randomised controlled

trials, population-based studies and literature reviews as the means by which to speak the 'truth' on waterbirth. The natural birth discourse indicates that experience and conducting waterbirths over many years, and the findings of large international studies published in midwifery journals, constitutes legitimate knowledge on waterbirth for this discourse, although there is dual preference in methodology selection evident for the natural birth discourse.

Rarefaction, as defined by each of the discourse's institutional influences over what delimits what each discourse typically says of waterbirth saw the scientific medical discourse typically uttering that waterbirth is clinically unproven, it is an alternative, unnatural method of giving birth, it is risky, and confirmation by way of research is needed to ascertain if it is safe or not. By contrast, the natural birth discourse is typically heard to utter that pregnancy and labour are natural processes, 80% of women can give birth without intervention, waterbirths are safe for low-risk healthy women, there are elements of risk with every birth whether it be on land or in water, and finally that water is a good form of pain relief.

Fairclough's (1995b) linguistic analysis looks firstly at the order of discourse revealed that the media chooses as being the ideologically significant or preferred discourses to underpin or 'rationalise' an article with. The order of discourse generated from the articles examined saw the media choosing official-type discourses such as legal and disciplinary by which to construct waterbirth. The use of these discourses ensured that the boundaries between the dominant scientific medical discourse and the natural birth discourse remained in place. Although there was creative use of mixing of genres and discourse within the one text, the overall articulation supported the dominant discourses' view of legitimate knowledge on waterbirth.

Intertextuality from the perspectives of discourse practice and discourse type saw the articulation of eight genres and ten discourses in the one text used for analysis. Both genres and discourses were predominantly discourses in close association with the scientific medical discourse. Alternative discourses were seldom drawn on.

Presuppositions mean that what is present and what is absent in a text help to convey authenticity and to position readers by their common-sense assumptions. Presuppositions are part of the text's implicit meaning. What was made implicit in the two articles examined (2003a and 2003b) was that a baby was allegedly brain-injured after falling on its head as it delivered when its mother climbed out of a birth pool. What was made absent was that this event does not constitute a waterbirth, yet the words 'water' and 'pool' and 'birth' are used simultaneously and frequently to imply a waterbirth scenario was involved. It was undoubtedly an unfortunate and freakish combination of timing and circumstance that the woman ended up delivering her baby in this way. Waterbirth and its associated discourse should not have featured as a presupposition in this text in the way the media constructed it so.

The media characteristically uses vocabulary and grammar to categorise social practices. In doing so, different discourses are revealed. Fairclough (1995b) proposes that we use our words to represent actions or events. Positioning and choice of words within a sentence or paragraph is a tool to contrasting good and bad people, situations or ideologies. In doing so, categories are created.

In the analysis of the newspaper articles it was made clear that the media had created a particular category in order to appropriate blame on a midwife and her association with a birthing pool and an adverse birth outcome. This categorised her as negligent. The contrasting category was that of angry, grieving parents and their brain-injured child. Overall categorisation is a powerful tool used by the media to advance one dominant social discourse over another.

The media chooses which topics it wishes to make most prominent and the most influential in an article. This helps towards positioning the reader into the mindset of how the media outlet wants to convey a particular social practice. By putting the main theme of an article in the foreground, other topics are then considered subordinate and are backgrounded into position. Beginning and final words of paragraphs are seen to draw the reader's attention to their supposed importance; from these words, the overall theme of waterbirth as an unsafe birthing practice can be gleaned.

The articles examined for foregrounding and backgrounding technique showed that differentiation occurs, casting one discourse as the antagonist (in this case the midwife and the birth pool) and the other as the protagonist (in this case the parents of the brain-injured child). The weight of importance is attached to the parents and their situation while the midwife and birth pools are considered antagonistic to this whole ordeal.

6.2 Discussion

Women who have a waterbirth are more satisfied with the experience than women who give birth on land according to Gordon (1996, p. 135). In a study that examined women's perception of pain in the first stage of labour related to the use of analgesia Haddad (1996, p. 104) found that where women used only water as pain relief, 'surprisingly multips experienced more pain in the pool than primips.' The women who found pain relief from water the most beneficial were more likely to stay in the pool for delivery, and much less likely to have a forceps delivery or caesarean section (p. 104). Also, women who found pain relief from the water most beneficial were more likely to have a favourable outcome as far as the perineum was concerned.

A waterbirth, albeit a natural birth, is to some women an undesirable option when there is modern technology and conveniences available to them today, such as elective caesarean section and epidural analgesia. It should be noted that not all women share the same understandings of labour and birth. While sharing birth stories can be empowering for some women, negative stories can have the opposite effect and leave women feeling afraid of natural birth (Arthur & Payne, 2005, p. 18). Voicing negative attitudes and beliefs about normal/natural birth may influence a woman's subjectivity and has the potential to hinder her from birthing naturally (Arthur & Payne, p. 20).

The extent to which the media will influence a woman's decision-making on how to position herself among these discourses is known only to her. It is clear from this analysis that some women could be more strongly influenced to position themselves within the scientific medical discourse as it is determined by the speakers in these newspaper articles. There is a clear message in the overall construction of waterbirth, seen in two binary oppositions: safe/unsafe and modern/old-fashioned.

The dive reflex discourse is commonly referred to in the medical and midwifery journal articles on waterbirth I have read for this study. As it is maintained in print, it is used as a rationale in the questioning of whether or not waterbirth is something we should attribute as 'natural' for human beings to do. The circulation of the dive reflex discourse is more commonly found in literature from the speakers of the natural birth discourse. It is used as an arsenal in the debate of right or wrong.

6.3 Implications and Recommendations for Midwifery Practice

Here I reflect on the implications of waterbirth and its construction in the New Zealand media, and consider how my findings might impinge on midwifery practice.

The collection and analysis of the newspaper articles show midwives that a strong influence from the scientific medical discourse exists in New Zealand on the representation of waterbirth in the media. In some areas, this influence is strong enough to curtail and regulate the practice of waterbirth. I believe that waterbirth is only practiced by a minority of midwives in New Zealand.

Maternity practitioners require knowledge of the discourses I have highlighted and the influences these discourses have on their practice. This knowledge has the potential to create a better understanding and more informed decision-making as a practitioner. In this way, discourse analysis reveals to practitioners a way of seeing waterbirth through different discourses and how these discourses interrelate, exclude, dominate, subject, discipline, and remain in circulation.

The analysis reveals that maternity practitioners are disciplined and that waterbirth is surveilled by the scientific medical discourse. Midwives need to be mindful of this when considering the incorporation of the practice of waterbirth into their realm of childbirth practices.

The media too surveils maternity practice and readily informs the public of what constitutes 'safe' or 'standard' practice and if practices are blurred or crossed. Because of the overall

negative image the media gives waterbirth, the implication of this representation for midwives, as imparters of knowledge and advocates of informed choice for women, is that they should sensitively convey how our New Zealand society reads about waterbirth. A woman considering a waterbirth should be made aware of labels commonly given by the media to women who choose to waterbirth, such as 'tree-hugging hippie', 'alternative', 'irrational'. Midwives may be required to have discussions with women about the nature of subjectivity and how it may affect the woman's decision to aim for a natural, non-interventionalist birth. For some women this information will be new to them. Women will be vulnerable to criticism and need to be informed with recent research on waterbirth, and of the issues discussed in this study. Being informed allows them to defend their own decisions should they choose a waterbirth. Informed decision making enables women to show that they may not be jeopardizing their baby's safety and that they are rational decision makers.

Midwives, too, need to reflect on and explore their own position in relation to waterbirth. They need to decide whether or not it is something they can wholeheartedly offer to women in their care and support them with.

For midwives who have practiced waterbirth for many years without encountering any problems, the overt marginalisation by the media of waterbirth, by way of concern voiced over its safety, will make them feel their voices are silent. These midwives who feel confident with waterbirth for themselves as practitioners and for the women they care for should continue to question waterbirth's place within their realm of midwifery practice. Amongst increasing obstetric intervention and birthing technologies, these midwives should continue to ask questions such as 'Who will benefit from waterbirth here?' 'Who should I exclude?' 'Whose interests are being silenced or excluded here?' What is the power that puts upon me as a midwifery practitioner when I am involved with a waterbirth?

Currently maternity practitioners practice in a highly litigious climate, where women's rights and choices are sometimes foremost, over the judgment and wishes of the maternity practitioner caring for her (Redwood, 1998). Because waterbirth is the domain of midwives and within the scope of their normal practice (NZCOM, 2002), it is midwives who find themselves victims of a deeply entrenched culture within maternity to 'point the finger' at

individual practitioners whenever anything, for whatever reason or cause, goes wrong. It is this ever-present platform for blame that sees some midwives choose not to incorporate waterbirth into their repertoire of birth skills. It is also why some hospital-based midwives will not conduct waterbirths in the pools in their facilities – because no one will support them if something goes wrong. Health boards operate under the premise that they will not legally support or provide indemnity to midwives who conduct waterbirths where there are adverse outcomes.

Safety in childbirth has become highly contestable since the 1990s. This illustrates a paradox within childbirth; the distinction between illness and health. Smythe (1998) speaks of this paradox: 'Birth is described as a normal life event, yet they ask, what other perfectly normal event puts the lives of a woman and her infant at risk?' (p. 10). She also points out that due to the 1960s movement away from the implied supremacy of scientific knowledge and a return to the notion of 'natural' childbirth, which encompasses the belief that the woman herself is an active participant in all that happens, 'today's modern women have an expectation upon them that they will be able to proudly declare they had a "good birth" ' (p. 10). What midwives can take from this is to question for themselves 'Is waterbirth appropriate here?' 'Are we trying too hard to achieve a natural birth here so this woman can declare it so?' 'Is it important to me or this woman that she delivers naturally?' Or, alternatively, 'Why aren't we trying for a waterbirth here?' 'Could using water here assist this woman to birth naturally?' The trick is to negotiate the tight-rope we are all so familiar with, with our hearts in our mouths.

Most obviously, and of most importance, is the dire need for New Zealand-based research on waterbirth. To date, as a profession, midwives have no way of knowing how many women choose water as pain relief in labour; how many waterbirths actually occur; and what, if any, adverse outcomes are encountered following waterbirths.

6.4 Limitations of the Study and Suggestions for Future Research

One limitation of this study was that despite being aware of their existence I chose not to collect articles from New Zealand women's and parenting magazines. Doing so may have greatly increased and enhanced the voice of the speakers from the natural birth discourse

but, as stated in the method chapter, I wanted to examine the articles that ordinary New Zealanders read in their usual newspapers. I wanted to capture the overall representation of waterbirth in New Zealand. By collecting more data from those publications, the writing on women's subjectivity may have been enhanced and generally have extended the natural birth discourse somewhat. I also felt that accessing these publications may have created a bias toward those who promote waterbirth.

While my experience as a midwife in the United Kingdom saw waterbirth as a normal, accepted midwifery skill, my experience of waterbirth in New Zealand is that few midwives practice it. Therefore the context of me speaking about waterbirth as a hospital-based midwife in this country is limited and relegated to me speaking 'in the past' about my own experiences of caring for women having waterbirths. I do not bring a strong New Zealand midwife's perspective to this study.

Qualitative research on waterbirth in the future might be inclined to explore women's accounts of things that were said to them after they announced they'd had a waterbirth. Data collection could involve recording comments made to women by the medical profession/family/friends/colleagues and general public during and after the waterbirth. Findings from such a study would reveal if the issues I have uncovered in this study, e.g. the proposition that waterbirth is unsafe, the labels given to women who choose it, and the influences of the discourses over her decision, would provide credibility for the findings of this study.

6.5 Conclusion

This study has identified three discourses in relation to the discursive practice of waterbirth. The discourses are the scientific medical, natural birth and dive reflex discourses. These discourses originate and are derived from the discourses of obstetrics, midwifery and human physiology. These discourses position waterbirth as being either unsafe, unnatural and irrational; or safe, natural and rational. In the practice domain, it is doctors who are predominantly asserted as the speakers of truth and knowledge on waterbirth; the midwife is marginalised and frequently disciplined.

Having other health professionals read this study will raise the awareness of the tension and taboo that exists for waterbirth in New Zealand. This study will educate them on how the dominant discourses currently curtail and regulate its practice. Most obviously, there is a large window of opportunity for midwives in New Zealand to conduct further research into New Zealand waterbirths.

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APPENDICES

Appendix 1

New Zealand College of Midwives consensus statement: The use of water in labour and birth, July, 2002.

Waitemata District Health Board, Water for labour and birth at North Shore & Waitakere Hospitals, 2004.

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