

**What is shaping the practice of health professionals
and the understanding of the public in relation to
increasing intervention in childbirth?**

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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.

Signature

Date.....

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Abstract

The increasing rates of intervention in childbirth are an issue for women, their families, health professionals, and society across much of the Western World. This study is a response to these increasing rates of intervention, as reflected in the research question: ‘What is shaping the practice of health professionals and the understanding of the public in relation to increasing intervention in childbirth?’ The participants in the study were nine health professionals: midwives and obstetricians, who were interviewed individually, and thirty-three members of the public who took part in six focus groups. The research was carried out under the umbrella of critical hermeneutics, and the particular approach used was that of critical interpretation as formulated by Hans Kogler. This approach enabled a hermeneutical thematic analysis of that which is shaped (worldviews) and a critical structural analysis (discursive orders, social practices, relationships of power and structures of domination) of the shaping and shapers of practice and understanding.

The research process facilitated by critical interpretation in identifying and describing the shaping and shapers of practice and understanding adds an important dimension to the statistical picture of increasing intervention that is of concern, both to health professionals and the public. The research revealed that the everyday world and its associated processes of socialisation in the 21st century - in particular pain, choice, and technology - shape the practice of health professionals and the understanding of the public in relation to increasing intervention. The study’s findings were supported by the revelation that many of the social and cultural values, such as convenience, ease, and control, that underpin Western society in the 21st century, correlate with what intervention has to offer, which results in intervention being increasingly sought after and utilised. This milieu of intervention, which increasingly surrounds childbirth, is shown to be calling into question those things that have traditionally been at the heart of childbirth: the ability of the woman to birth and the clinical skills of the health professional. This research provides insight and awareness of those things that are shaping understanding and practice and birth itself and creating a milieu in which intervention is increasingly normalised.

Chapter One

Orientation to the study

By 2010 more than half of all women having babies will choose a caesarean section as a way to give birth (Johnston, 2001).

These words in the New Zealand Herald on March 16th 2001 illustrate, in part, the culture surrounding childbirth in Aotearoa-New Zealand (Appendix E) at the beginning of the 21st century, in which intervention is increasingly becoming the norm. Now, six years later, these words could almost be seen to have been prophetic. While the caesarean section (Appendix E) rate in 2007 is not yet 50%, the spontaneous vaginal delivery rate at National Women's Hospital (Appendix E) in Auckland in 2005 was 53.2% (National Women's Report, 2005). Caesarean sections in some quarters are increasingly being presented as safe, or even safer than vaginal birth, and in some countries celebrities have almost created a mythology that a caesarean is the best way to birth (Deverux, 2001; Warwick, 2001). It seems that everywhere in the public domain: in magazines, newspapers and on talkback radio, there are stories about women choosing interventions such as induction, caesarean sections, and epidurals (Wane, 2002). There are even extreme examples where reportedly one of the main drawbacks to having an elective caesarean section is the removal of all jewellery (Stirling, 1998). While this may not be typical, there is little doubt that at the beginning of the 21st century there is increasing normalisation and acceptance of interventions such as caesarean sections, epidurals and inductions (Appendix E) in childbirth, which is leading to a culture of intervention.

The research question, purpose and aims of the study.

The research question, 'What is shaping the practice of health professionals and the understanding of the public in relation to increasing intervention in childbirth?' is a response to the growing culture of intervention. The purpose of the research is to understand and explain this culture, by uncovering, analysing and bringing to awareness the taken-for-granted, invisible influences that are shaping practice and understanding in relation to increasing intervention.

The reasons for undertaking this study.

The radical change that increasing rates of intervention is bringing about in relation to childbirth and the definition of birth is the first reason for undertaking this study. Whereas ‘normal birth’ once meant birth without medical intervention (Page, 2000), birth at the beginning of the 21st century is spoken of as ‘normal’, even when it has been induced, augmented, or an epidural has been used (personal conversation, 2003). In some places there is even a reframing of caesarean section as caesarean *birth* (Kitzinger, 1997). If we accept that ‘normal’ is a word that has its meaning defined and given to us by the culture and times in which we live (Page, 2000), then it would appear that births involving intervention are increasingly being framed as normal. This change in the nature of birthing is demonstrated in the dramatic increase in the intervention rates and, in particular, induction of labour, caesarean sections, and epidurals, as illustrated by the following national statistics for Aotearoa-New Zealand:

Caesarean sections have increased from 5.2% in 1976 to 23.12% in 2003.

Induction rates have increased from 7.0% in 1988/89 to 19.7% in 2003.

Epidural rates have increased from 13 %. in 1995 to 24.2% in 2003.

(Ministry of Health 1999, 2006).

The potential of these rising rates of intervention to radically change the face of childbirth for women, their families, health professionals, and society in Aotearoa-New Zealand provided the first reason for undertaking this research.

The second reason for undertaking this study and adopting a particular philosophical stance in relation to the research question comes from the personal domain. Two people, a sixteen-year-old, and a middle-aged man who came to our house to put in a cat door, provided an important catalyst for the way I would approach the study. These two people gifted me with the insight that a culture was growing up around childbirth that was leading very different people to view intervention as an acceptable part of birth. The sixteen-year-old, in a general discussion, stated emphatically that when she had a baby it would be by caesarean section, because ‘that is the way you have babies’ (personal conversation, 2001). Similarly, when in conversation with the middle-aged tradesman, I said that I taught midwifery, he commented, ‘I hope you are teaching them that women must have caesarean sections’.

When asked why I would teach this, he looked at me aghast, and asked had I not seen the programme on TV ‘which showed what terrible damage normal deliveries did to women’s pelvic floors’? These two conversations served as a catalyst for the stance from which I approached the research, in that my primary interest was in discovering and articulating what it is that is shaping the prevailing understanding in relation to intervention in childbirth.

The third reason for undertaking this study is professional, and is connected with the Aotearoa-New Zealand Maternity Services, and in particular to midwifery. In 1990 the Nurses’ Amendment Act restored the autonomy of midwives, and made direct entry midwifery possible (Papps & Olssen, 1997). In this country, a pregnant woman chooses a Lead Maternity Carer (LMC), (Appendix E) who then becomes responsible for ensuring the provision of Maternity Services. This process is the ‘cornerstone’ of maternity care in Aotearoa-New Zealand (Ministry of Health, 2007). In 2003, 78.1% of women were registered with a midwife as their Lead Maternity Carer (Ministry of Health, 2006). In the seventeen years since midwives have gained their autonomy, intervention in childbirth has increased dramatically (Ministry of Health, 2006). Strid (2000) challenged midwives in Aotearoa-New Zealand at their sixth national conference in relation to rising intervention rates since the advent of independent midwifery. Strid (2000) reminded the midwifery profession and individual midwives that they needed to protect childbirth from medicalisation. While I am not suggesting cause and effect in terms of midwifery autonomy and rising rates of intervention, the situation is of real concern to me as a midwife, and to the profession of midwifery (McAra-Couper, 2006). The challenge of Judi Strid, who spoke as a consumer advocate at that 2000 conference, was in itself a catalyst for this study.

Justification for the study

This study, while focused on intervention and the culture of intervention, does not primarily explore interventions themselves. Rather, it explores the social and cultural context in which intervention is taking place, in order to illuminate that ‘*which is shaping*’ understanding and practice. Substantial, significant, and important work has already been carried out in relation to women, pregnancy, childbirth and the processes of socialisation that shape and influence women and their understanding.

However, the justification for this study lies in the fact that there is still limited research, worldwide or in Aotearoa-New Zealand (Arthur, 2003; Clements, 2005; Douche, 2001; Surtees, 2003), on the social, cultural and psychosocial influences that shape understanding and practice in relation to increasing intervention in childbirth in the 21st century. A number of recent research studies looking at increasing rates of intervention suggest that more qualitative research needs to be carried out on the subject, so that the social, cultural and psychosocial factors leading to rising rates of intervention can be understood in all their complexity (Kingdon, Baker & Lavender, 2006).

Therefore, this research seeks to present these social, cultural and psychosocial factors in relation to increasing intervention, with the purpose of gaining some understanding of the complex nature of the milieu of intervention that surrounds childbirth in the third millennium. The public and health professionals alike are, with some urgency, seeking to understand the phenomenon of increasing intervention, and the contribution of this research to that body of knowledge justifies and makes the study significant.

Study Context

All the participants in the study were from the greater Auckland area of Aotearoa-New Zealand. Nine health professionals (midwives and obstetricians) were interviewed, and 33 members of the public, in six focus groups, also took part in the study. The majority of the participants were women: only four of the health professionals and two of the public interviewees were men.

Philosophical underpinnings

The research question of this study: ‘What is shaping the understanding of the public and the practice of health professionals in relation to increasing intervention in childbirth?’ requires a methodology that facilitates both the uncovering and the analysis of that which is doing the shaping. To facilitate this, the study is underpinned and informed by critical hermeneutics, because this methodology focuses not only on the subject matter itself but also on the way in which its meaning is shaped and constructed. Hermeneutics unmask and brings forth that which is hidden. However, for the most part it ignores the question of power in relation to the historical and cultural contexts of that which is being uncovered (Kogler, 1999).

Critical hermeneutics, on the other hand, provides a stance from which it is possible to analyse the influence of power practices on understanding, a stance which is important for research that seeks to show that which is shaping understanding and practice (Kogler, 1999). Kogler (1999) suggests that to pursue a research question with a hermeneutic and critical lens enables not only the possibility of coming to an awareness of the thing in itself, but also enables one to recognize those by whom the thing in itself is shaped, and who it serves.

However, critical hermeneutics does not in itself necessarily constitute any one paradigm, and does not, of itself, provide a methodological basis for research (Chaw, 1995). For the purpose of this study it was important to have a methodological strategy that both met the specific objectives of the study and would allow the study to happen within the limitations and framework of a thesis. For these reasons, the study uses the method of critical hermeneutics called *critical interpretation*, as formulated by Hans Kogler. The philosophical underpinnings of *critical interpretation* come from insights formulated by Gadamer and Foucault (Kogler, 1999). The project of *critical interpretation* is to bring together the analytical tools of discourse analysis with an analysis of power practices and structures, along with the insights that hermeneutics offers (Kogler, 1999). The project, then, of this thesis is to bring the insights gained from the participants' understanding and practice together with an analysis of the discourses and power structures which inform and shape these understandings and practices. The linking of *critical interpretation* and the project of the thesis in this way provides a sound methodological framework for uncovering and analysing that which is shaping understanding and practice in relation to increasing intervention in childbirth.

Position of Researcher

The personal and professional position from which I approach this research is that of being a midwife, a midwifery lecturer, a feminist, a woman, and someone who has a healthy suspicion of what goes on around her. I undertook my midwifery training in 1989 for the express purpose of going to Bangladesh where I worked for many years. This meant that my early life as a midwife was full of complicated childbirth, with interventions. In Bangladesh we did more ventouse deliveries than normal ones as only the problems came to our clinic.

We often longed for the facilities and resources that are taken so much for granted in Aotearoa-New Zealand. When I first returned from Bangladesh I would talk about a ventouse delivery as a ‘normal’ delivery just because the baby had delivered vaginally.

With this background experience of complicated deliveries, I had to relearn about normal childbirth on my return to Aotearoa-New Zealand. Since then, I have lectured in midwifery, and worked in a tertiary setting (Appendix E) in a delivery unit caring mainly for high risk women. With this background of complexity and intervention I have been grateful to my colleagues at the Auckland University of Technology who have helped me to do some relearning around normal birth, and continue to encourage, challenge and constantly remind me that birth is a normal process. I have also had the privilege of attending two home births as second midwife in the last five years. While this is not many, and was over a period of time, the lessons of home birth in terms of the ownership of the birthing process are imprinted on my mind and heart. In addition, I have had the privilege of working alongside expert midwives in the tertiary setting whose commitment to normal birth is inspiring. These experiences have served to ground me, and remind me that birthing is a *normal* process, in spite of the possible complications that sometimes require intervention.

Addressing my presuppositions

I sought to identify and address the presuppositions that I brought to the study prior to the collection of data. I did this in a number of ways such as being interviewed by one of my supervisors about the understandings I brought to the research. This was very helpful as it revealed some presuppositions that I had not been aware of. As a result, I created a list of presuppositions, to which I added throughout the course of the research, and which I endeavoured to keep in mind at all stages of the process. Any position that I take is significantly shaped by the philosophical stance that whatever surrounds us in our personal, professional and public life is shaped and constructed. This shaping and construction reflects and disseminates the values and interests of those groups who, for one reason or another, are powerful and dominant in any given society. This position has led me to have a natural suspicion of things that surround us in our daily lives.

Alongside this position runs a strong belief in the possibility of uncovering and exposing such construction and bringing it to people's awareness – and, of course, changing the world! A background of theology (especially liberation theology), structural analysis, anti-racism work, Treaty of Waitangi workshops (Appendix E), feminist analysis, and other involvements in the social sciences have all equipped and led me to take up such a position. I therefore find myself drawn by inclination and interest to the worldview of the critical theorists.

One of the main reasons I believe I sit most comfortably under the critical umbrella are the early experiences I had of encountering difference. At 16 years of age I was on a ferry between Wellington and Christchurch when I met a young man who was a Hindu. This was a seminal event in my life because I realised that the 'good Catholic girl' from rural Aotearoa-New Zealand with a different background, parents, and education could have been Hindu. This moment of 'enlightenment' meant that I never quite saw the world in the same way again. Kogler (1999) would say that in these moments of difference we recognise our previously unnoticed prejudgements. It is in these moments that the voice of the 'other' calls forth and brings into the light the silent features of our own preunderstanding (Kogler, 1999). Kogler, in discussing Gadamer's notion of pre-understanding, states that while understanding is dependent on historically engendered preunderstanding, it may be able to work itself free from this dependence again and again. During the time of carrying out this research I have occasionally been able to work my understanding free of its historical constraints for brief moments in time. I have found myself in a place where I can see in the moment the construction of a particular notion outside of myself, whether it be woman's choice, or pain-free labour. It is an exciting and yet terrifying insight into the nature of understanding itself. However, this is usually only in the moment and for the moment. I have to admit that most of the time while I approach the work with some awareness, I am still bound by my own 'situated', pre-structured perspectives (Kogler, 1999). This life position from which I come stands me in good stead in that it enables me time and time again to come from a position of awareness (if only ever partial) of the pre-understandings and presuppositions that I bring to the research process.

The historical context of intervention

If we want to understand today, then we have to search yesterday (Buck, n.d). The understanding of intervention at the beginning of the 21st century has to be contextualised in 'yesterday', in order to gain a picture of those things that have previously shaped, and still shape, understanding and practice. To this end, a brief synopsis of the history of intervention follows. In the Western history of birth the age of intervention is said to have begun in the 17th century. It was during this time that forceps and surgery began to be widely used in childbirth (Wagner, 1994). It was the surgeons' possession of forceps that gave them the platform from which to directly challenge the midwives' traditional role as the attendants at birth (Arney, 1982). However, the advent of forceps only forms a small part of the complex picture of the medicalisation of childbirth that took place during the 17th century (Papps & Olssen, 1997). During this time a scientific revolution took place, and such things as circulation were discovered, the microscope was invented, and a whole range of new surgical procedures and techniques were developed, which ensured the dominance of the medical model (Papps & Olssen, 1997).

The changes in the 17th century meant that childbirth, and the way women birthed, was in the process of being reconceptualised. Midwifery during this time continued to be based on an understanding of birth as being natural and normal, and something to be attended or waited on - not hurried along or interfered with (Arney, 1982). However, the reconceptualisation of birth meant that the body was increasingly viewed as a machine and the physician as the one to keep the machine running, and even to make it run more efficiently. A machine, it was claimed, was not normal or abnormal, but rather effective or ineffective, so the new scientific model freed birth from nature and opened it up to improvement through the possibility of intervention (Arney, 1982). This rational approach to childbirth undermined the body of knowledge of traditional midwifery practice. Science gradually replaced traditional folklore and women's customs with new medical rites which claimed to be based on scientific principles and objective knowledge (Papps & Olssen, 1997). Medical dominance was also ensured by the control the medical professional had over drugs and medicine and especially chloroform. Chloroform was used as an anaesthetic for the first time in 1847 and more significantly, was used by Queen Victoria with her eighth child (Papps & Olssen, 1997).

Between 1750 and 1870 men-midwives and medical doctors eroded the public confidence in female midwives' abilities, and by 1800 the medical surgeons and apothecaries were routinely attending birth (Papps & Olssen, 1997). The decline of the midwife was further accelerated by such things as the so-called 'scientific midwifery' which had developed in France (Arney, 1982). The 17th century, not unlike the 21st century, was a time of intersecting interests and movements of growing scientific knowledge around pregnancy and birth along with developing technology and skills, which resulted in extensive use of intervention and technology in childbirth (Wagner, 1994). The new medical doctors (backed by the newly emerging scientific discourse) took over birth in the 18th century and saw themselves as bringing rational knowledge where previously there had only been ignorance and tradition (Papps & Olssen, 1997). The single most important occurrence through which the medical profession staked a claim in childbirth, and eroded the role of the midwife, was in regard to difficult birth. The role of medical practitioners had previously been to deal only with the difficult births when called by the midwife, but it now became a role of prevention and correction, often through intervention (Papps & Olssen, 1997). Medical doctors gradually extended their control from coping with difficult births to managing pregnancy generally as part of an enlarged role in the normal care of the patient (Papps & Olssen, 1997).

Two other things of significance in the late 1800's were the legitimisation of hospital births and the beginning of prenatal care. These ensured that medicine gained dominance over the practices surrounding pregnancy and birth (Wagner, 1994). The growth of hospital births redefined pregnancy and birth as medical problems rather than natural phenomena. The development of 'lying-in' hospitals was to change the face of childbirth. The first such hospitals appeared in and around London during 1739-1765 (Papps & Olssen, 1997). These lying-in hospitals in England provided the base that would ensure that childbirth was brought under medical management (Papps & Olssen, 1997). Alongside this, doctors who attended women of the upper classes in public hospitals gained a reputation whereby they attracted these women to their private practices, which resulted in the doctors emerging as a major player in the childbirth stakes (Papps & Olssen, 1997).

The medical model increasingly framed women's bodies as problematic, and as such required control and regulation, which led to increasing use of intervention in the process of birth (Mander & Fleming, 2002, Katz Rothman, 1989). The new scientific and technological knowledge, supported by a social alliance and an expanding role of doctors through education and control of key resources, saw a new model of birth come to the fore (Arney, 1982). It was a model in which technology and intervention played a part that they had not played traditionally. As knowledge of medicine gained ascendancy over the knowledge of midwifery, a further re-conceptualisation of birth took place. Birth became a 'thing' to be 'managed' and 'handled' and no longer a process to be waited on, or attended to – so the role of intervention in childbirth was cemented in place (Wagner, 1994). Katz Rothman (1991) claims that the development of technology by the industrial society coincided with the rise of the medical model supported by patriarchy. The synergy of these movements increasingly shaped understanding and practice by creating fear of what could happen if women birthed without the aid of pain relief, medicine and technology (Donley, 1998). Technology and intervention increasingly became synonymous with a safer and better outcome and a more positive experience of childbirth. This historical synopsis of intervention in childbirth is important, as it is this context that provides the starting point from which it is possible to gain insight into increasing intervention in the 21st century.

The thesis will be presented in the following manner:

Chapter Two: Literature Review

The review of literature explores the rising intervention rates in childbirth and what is shaping understanding and practice in relation to key interventions. The interventions of caesarean section, epidural and induction are explored alongside the reasons that these interventions have increased. Following the review of this literature the often cited 'cascade of intervention' is presented, followed by an exploration of maternal age, which is an important factor in the increasing rates of all interventions. The review then gives a list of social, cultural, and psychosocial factors that are identified in the literature as shaping understanding and practice, in relation to intervention in childbirth. The literature from this list that is the most significant in relation to the research question and its findings is then presented.

Chapter Three: Methodology

This chapter explores first of all the choosing of the methodology which best facilitates a research process centred around the question of what is shaping understanding and practice. The starting point for this journey - critical hermeneutics - is presented, followed by *critical interpretation* as formulated by Hans Kogler, which sits under the umbrella of critical hermeneutics. The philosophical underpinnings of *critical interpretation* are then explored. This involves a presentation of some Gadamerian, Heideggerian and Foucauldian concepts. Then follows an explication of the concepts that Kogler has developed, which underpin *critical interpretation* and inform the process of research undertaken in this study.

Chapter Four: Methods

This chapter presents the methods and frameworks that inform and guide the research undertaken for this study. The method outline includes the recruitment and involvement of participants, ethical considerations, the interview processes, the methods and frameworks used for analysis, and the rigour of this qualitative research study.

Chapters Five to Ten: Findings from the Data

Chapter Five is an introduction to the findings from the data.

Chapters Six to Nine have a Part One and a Part Two. Part One is the hermeneutical analysis of the data, and presents the worldviews of the participants. Part Two is the critical analysis, and presents the worldviews and the discursive symbolic orders, social practices, relationships of power and structures of domination that shape these worldviews.

Chapter Six presents the hermeneutical and critical analysis of the everyday world and its associated processes of socialisation. **Chapter Seven** presents the hermeneutical and critical analysis of the notion of choice. **Chapter Eight** explores the worldviews in relation to pain, and the critical analysis of these worldviews. **Chapter Nine** presents the worldviews in relation to technology and technification, and provides a critical analysis of these ‘shapers’ of understanding and practice.

Chapter Ten: is the culmination of the data chapters and explores the ‘how’ of birth, and the possibility that increasing intervention is bringing about a new default mode of childbirth.

Chapter Eleven: Concluding Chapter

The final chapter presents the research question alongside the findings of the study, and the significance of these findings. It also presents the place of these findings in relation to other literature, as well as the implications for practice and education suggested by this research. The question of further research is discussed, as are the limitations of the study.

Summary of Chapter One.

Chapter One has introduced the research study and placed it in context: public, personal and professional. It has also presented the reasons and justification for carrying out the research along with an outline of the thesis. The catalyst for this research - the ‘normalisation’ of intervention - has been presented. The research process of *critical interpretation* which facilitates insight into the shapers and shaping of practice and understanding has been introduced. In this way, Chapter One has given an indication of how a research question centred around the word ‘shaping’ is explored through a research process facilitated by *critical interpretation*, to reveal that which shapes.

Chapter Two

Literature Review

Introduction

The purpose of this literature review is to place the study in the context of what has been researched and written in relation to the research topic (Polit & Hungler, 1995). This context informs, in part, the questions asked in the interviews as well as providing background to the concerns and findings of the study. Clarification of the knowledge about the subject matter demonstrates the significance of the study by identifying the scope and gaps of what is known to be shaping understanding and practice in relation to increasing intervention in childbirth. A topic such as increasing intervention that involves the public and health professionals, and their understanding and practice, opens itself up to an almost infinite amount of research and literature. A multitude of studies were reviewed, but only those that were deemed to be the most significant in terms of situating and contextualising this study follow in this review.

The processes and underpinnings of *critical interpretation* claim that it is essential to not only recognise what is happening, but also to identify and describe those structures that are embedded in the political, social and cultural institutions of a society that are in effect bringing about what is happening (Kogler, 1999). To this end, the interventions that are increasingly being used in practice are identified in this literature review, along with an exploration of the social and cultural factors that shape and legitimate the use of these interventions. The catalyst for this study was the rising rates of intervention in childbirth, and so it is important that the most significant of these interventions are identified at the outset of this review. They are: caesarean sections, epidurals and inductions. Their significance lies in the dramatic increase in these procedures over the last 15 years in Aotearoa-New Zealand (Bulger, Howden-Chapman, & Stone, 1998; Ministry of Health, 2003; Ministry of Health, 2006). The intervention of caesarean section is particularly significant at this time, as recent research has highlighted increased morbidity and mortality from caesarean sections. This provides another compelling reason to be concerned about increasing rates of intervention (Deneux-Tharaux, Carmona, Bouvier-Colle & Breart, 2006).

The Caesarean Section Epidemic

Savage (2002) claims that at the turn of the 21st century there is a global caesarean section epidemic. The highest rates of caesarean section in the world are in South America, led by Chile, with a national caesarean section rate in 1994 of 37%, followed closely by Brazil who in 1996 had a caesarean section rate of 36.4% (Gomes, Silva, Bettiol & Barbieri, 1999; Murray & Pradenas, 1997). There is, in effect, an increase in caesarean sections in so-called developed and developing countries. However, this increase may be more than appropriate in some developing countries as they work towards better and more accessible maternity services (Stanton & Holtz, 2006). In the United States during the 1970's caesareans were performed at a rate of 5%, whereas in 2005 they have reached an all-time high of 30.2% (Department of Health and Human Services, 2006; Moon, 2002). In the United Kingdom in 1953 the caesarean section rate was 2%, in the 1970's it was 4%, and in the year 2000, when the National Sentinel Caesarean Audit was carried out, it had reached 23.1% (Royal College of Obstetricians and Gynaecologists, 2001). Caesarean section rates in Aotearoa-New Zealand have followed a similar trend, and in 2003 and 2005 some facilities reported rates of 30% (Ministry of Health 2006; National Women's Annual Clinical Report, 2005).

The World Health Organisation recommended in 1985 that the caesarean section rate not exceed 15% (World Health Organisation, 1985). This was based on the caesarean section and perinatal mortality rates in developing countries, which suggested that there was no benefit to women or babies if the rates were any higher (Belizan Althabe, Barros, & Alexander, 1999; World Health Organisation, 1985). This rate was revised in 1994 when the World Health Organisation published recommendations which stated that the caesarean section rate should range between 5-15% (Stanton & Holtz 2006; World Health Organisation, 1985). Chalmers, Enkin and Kierse (1989) examined the WHO recommendations in light of the research and evidence available, and concurred that there was no justification for a caesarean section rate higher than 15% (Chalmers, 1992). Stanton and Holtz (2006) compiled a database of caesarean section rates from the developing world for the year 2000, and they reported a caesarean section rate of 12% with variations between regions of 3-26%. The 5% caesarean rate as recommended by the World Health Organisation is seen by some as being too high for the developing world, as it may result in unnecessary caesarean sections (Ronsmans, Van Damme, Filippi, & Pittrof, 2002), while

the 15% caesarean section rate is perceived by some in the developed world as being too low, because such a rate may prove to be harmful to women and babies (Sachs, Kobelin, Castro, & Frigoletto, 1999). There remains much debate and little consensus about the optimal level for caesarean section, with some calling it a myth for which there is little evidence (Ministry of Health, 2006; Stanton & Holtz, 2006). Cyr (2006) believes that an ideal caesarean section rate cannot be decided outside of those things that frame individual values and beliefs. It does appear that the trend of increasing caesarean sections will be shaped by cultural and social factors as much as medical and clinical indicators (Cyr, 2006).

It has to be noted at this point that a number of recent studies have raised important questions around the perceived safety of caesarean sections. Deneux-Tharaux, Carmona, Bouvier-Colle and Breart, (2006) undertook a population-based control study which reviewed maternal deaths for a five-year period between 1996 and 2000 in France. After potential confounders were adjusted for, postpartum death was 3.6 times higher after caesarean than after vaginal delivery. MacDorman, Declercq, Menacker, and Malloy (2006) examined infant and neonatal mortality linked to caesarean section where the women had no indicated risk. They reviewed nationally linked databases for birth and infant death data for 1998-2001 in the United States. In this time there were 5,762,037 live births and 11,897 infant deaths and the findings of their study showed that neonatal mortality rates were higher among babies born by caesarean section (1.77 per 1,000 live births) than those delivered vaginally (0.62) (MacDorman, Declercq, Menacker, & Malloy, 2006). These two studies raise some very real concerns at a time when not only are the caesarean rates rising, but this procedure is increasingly perceived by some as safe and in some cases safer than vaginal birth. While there appears to be some degree of silence in relation to this material and its implications, groups such as the American College of Obstetricians and Gynecologists responded quickly to the findings. In a press release of August 2006, they stated that as a result of the study on maternal death, the mode of delivery may be a risk factor that can be modified, by choosing vaginal delivery over non-medical caesareans (American College of Obstetrics and Gynecology, 2006). These studies may, in years to come, impact profoundly on the shaping of understanding and practice in relation to caesarean sections.

Reasons Offered for Caesarean Section Epidemic

The reasons cited for the caesarean epidemic are as many and as varied as the women having caesarean sections. However, there are some clinical reasons that do appear more often than others in the literature.

Table. L1 The four most common clinical reasons given for caesarean sections				
	Dystocia	Previous caesarean section	Malpresentation (breech)	Fetal distress
United States (Chaffer & Royle, 2000).	30%	35%	10%	8%
A study in Scotland which looked at clinical indicators for caesarean sections over a 30-year period compared caesarean sections done in 1962 (6.2 %) with the caesarean sections done in 1992 (18.2 %).				
Scotland (Leitch & Walker, 1998)	42.2% - 1962 36.7% - 1992	4.5% -1962 15.2% -1992	10.8% - 1962 16.0% -1992	18.1% - 1962 18.9% - 1992
Auckland, New Zealand. (National Women's Report, 2005)	28%	18.5%	11.9%	16.9%

Clinical indicators for caesarean sections are accepted as standard, although the percentages may differ from place to place. The interesting things of note from the study carried out in Scotland as presented in Table L1, is that while the main indicators for caesareans (dystocia and fetal distress) remained constant, the two groups with the largest relative increases were malpresentation and previous caesarean section. The authors of this study suggest that while clinical indicators themselves had not changed, the threshold of practitioners' judgement about when intervention should take place had changed, and it was this that led to the increased rate of caesarean sections (Leitch & Walker, 1998). This is echoed in the National Women's report, which questions the commitment of practitioners to vaginal birth after a previous caesarean section, because the majority of caesarean sections were elective, and so were planned in advance and took place prior to the onset of labour (National Women's Annual Report, 2005).

This trend in relation to vaginal birth after caesarean sections (VBAC) appears to be worldwide, because repeat caesarean section is the most common obstetric indicator for caesareans in both the United Kingdom (28%) and in the United States (40%) (Dodd, Crowther, Huertas, Guise & Horey, 2004). It seems imperative that not only the rationale for the first caesarean section is examined closely, but that the reasoning that informs understanding and practice in relation to the decreasing number of VBACs is determined. This trend, if left unchecked, can only result in increasing numbers of caesarean sections. Ecker, and Frigoletto (2007) also argue that pregnant women in the 21st century are different in a number of significant ways from women of an earlier time. Women in the 21st century are older, have a higher Body Mass Index, have more multiple pregnancies and more premature, low weight birth infants, and a significant number have used reproductive technology - all factors which are associated with increased caesarean section rates (Ecker & Frigoletto, 2007) .

It appears that whether it is New Zealand or the United Kingdom there are a myriad of clinical factors, and a growing number of non-clinical factors, that may be responsible for increasing rates of caesarean section (Francome, Savage, Churchill, 2006; National Women's Report, 2000). This is illustrated by two research studies carried out in New Jersey and in Stockholm which undertook to account for the increased caesarean section rates. Both of these studies used a system of clinical classification developed by Michael Robson to research the trends in relation to the rising caesarean section rates in their respective facilities and regions (Florica, Stephansson & Nordstrom, 2006). The study carried out in New Jersey between 1999 and 2004 reported that the greatest increase in caesarean sections was where there had been no trial of labour and also involved cases where caesarean sections had previously been relatively rare such as full term singleton pregnancies with cephalic presentations. Nulliparous women's rate of no-trial of labour cesareans with no complications or medical indicators increased by 22.6% per year while the rate for multiparous women increased by 19.6% (Denk, Kruse, & Jain, 2006). Both of these studies concluded that medical indications did not by themselves provide an adequate explanation for the rapid increase in caesarean sections (Denk, Kruse, & Jain, 2006; Florica, Stephansson, & Nordstrom, 2006).

A shift in patient preferences, changes in patterns of practice and a lower threshold on the part of the health professionals for undertaking a caesarean section were identified as the most likely drivers of their increase (Denk, Kruse, & Jain, 2006; Florica, Stephansson, & Nordstrom, 2006).

Francome, Savage and Churchill (2006) undertook a comprehensive analysis of a survey of obstetricians' views which was carried out in Britain in 2005. They concluded from their analysis that factors such as fear of litigation, women's requests, and a shortage of skills in junior staff were some of the reasons which could help explain the increasing rate of caesarean sections. Lavender, Hofmeyr, Neilson, Kingdon and Gyte (2006) in their systematic review of caesarean sections for non-medical reasons at term cite factors such as the safety of the baby, pelvic floor trauma, avoidance of labour, avoidance of pain, and convenience, as reported benefits of an elective caesarean section. Ecker and Frigoletto (2007) argue that the level of risk that women once tolerated - that is, their threshold for risk - has changed. Therefore, the level of risk that used to be tolerated so that a caesarean section could be avoided is currently being reset, because any risk is too great a risk (Ecker & Frigoletto, 2007). Ecker and Frigoletto (2007) suggest that in the immediate future it is unlikely that any of these factors will change, and that caesarean sections will continue to increase.

It would appear that although clinical indicators in relation to caesarean section have increased worldwide, they do not of themselves explain the trend towards more caesarean sections. This is illustrated by a number of women in Aotearoa-New Zealand who are paying \$10,000 for private elective caesarean sections (Page, 2007). In New Zealand the Ministry of Health does not fund a caesarean section unless medically indicated. The reasons given for these women choosing to pay for private elective caesareans is the facilitation of choice, and women availing themselves of an experience of birth that is controlled and predictable (Page, 2007). A comprehensive picture of evidence and explanation in relation to rising caesarean sections rates is provided only when such non-clinical indicators are taken into account as these, above all else, are increasingly shaping understanding and practice.

The Epidural Epidemic

Richardson (2005) describes the use of epidurals (Appendix E) in Canada as an epidemic: nationally, 85% of women have epidurals for something which is supposedly a natural physiological event. Epidural rates, while not at the level of Canada, have increased steadily in Aotearoa-New Zealand in the last 15 years. In 2003 they are recorded as being 24.2% nationally, with regional variations from 3.7% to 40% (Ministry of Health, 2006). National Women's Hospital (Appendix E) reports a rise of epidural analgesia in spontaneous vaginal deliveries from 45% in 2000 to 50% in 2005, with 62.3% of all women using epidural analgesia or anaesthesia (National Women's Annual Report, 2005). These figures reflect a worldwide trend: in 2004, 25% of women in the United Kingdom and 66% in the United States had epidural analgesia during labour (McGrady & Litchfield 2004). It would appear that epidurals are increasingly becoming an accepted and expected part of childbirth everywhere.

Reasons Given for Rising Rates of Epidural Use

The clinical reasons for the epidural epidemic are more difficult to pinpoint than those for caesarean section, as there are fewer studies which give clear clinical reasons for the rising rates of epidurals. However, one of the reasons most often presented for the rising rates of epidurals is the pain of labour itself. It is argued by some groups that outside of childbirth it is not acceptable either for someone to be in such pain, or for the physicians not to intervene and to alleviate it (American College of Obstetricians and Gynaecologists, 2004). There is little doubt that in the Western World at the beginning of the 21st century pain is seen as something to be relieved, usually by safe and effective pharmacological means (Leap & Anderson, 2004). There are strong voices which oppose and challenge this stance, and claim that the pain of normal labour is manageable, is a rite of passage, an empowerment of women, and that removing the pain of labour is medicalising and pathologising a natural process (Crabtree, 2002; Davis-Floyd & Mather, 1992; Katz-Rothman, 1989). However, despite such voices, it seems that pain – both in everyday life and in childbirth – is coming to be regarded only as something to be relieved, and, more often than not, relieved pharmacologically.

The lack of clear-cut and easily identifiable reasons for the increase in epidurals is partly because pain is never just about physiology. In fact, pain exists at the intersection of culture, society, mind and body (Morris, 1993). Therefore, an exploration of the rising rates of epidurals involves sociological as well as physiological factors. This is reflected in literature that looks at which groups of women are more likely to use epidurals in childbirth. Glance, Wissler, Glantz, Osler, Mukamel and Dick (2007) reviewed the Perinatal Database of New York State to see if there was an association between ethnicity and epidural analgesia in labour.

This retrospective cohort study included 81,883 women who birthed between 1998 and 2003. They concluded from their study, after adjusting for demographics, insurance, provider differences and clinical issues, that Hispanic and Black women were less likely than white and non-Hispanic women to have epidural analgesia in childbirth (Glance, et al, 2007).

In Aotearoa-New Zealand the 2003 epidural rates for different ethnic groups were as follows:

Maori women 13.2%; Pacifica women 16.1%; Asian women 32 %;
European women 28.3% (Ministry of Health, 2006).

It would appear that ethnicity plays some part in shaping the understanding of women in relation to epidurals, and perhaps epidural analgesia is offered more readily to some ethnic groups. However, it could also be argued that this association between ethnicity and epidural use may be linked to socio-economic status as much as ethnicity. In Aotearoa-New Zealand, the socio-economic data provided is according to the New Zealand Deprivation (NZDep) scores (an index of neighbourhood socio-economic deprivation that is calculated by using data from the Census) which places women in categories ranging from the least to the most deprived (Ministry of Health, 2006).

To find meaningful data about socio-economic factors affecting intervention in Aotearoa-New Zealand it was a matter of sifting through various sets of data, as in the maternity reports the decile scores are linked to ethnicity rather than mode of birth.

A tertiary facility in one of the highest socio-economic areas, National Women's Hospital, has an epidural rate of 42.5%, while Middlemore Hospital, a facility with the greatest number of 'most deprived' women, has an epidural rate of 11.9% (Ministry of Health, 2003).

There are a number of variables, of course, which need to be taken into consideration when reviewing these figures. Issues such as the nulliparous- ratio and the ethnicity of the women who use these facilities need to be taken into account. National Women's annual report (2005) suggests that there is a complex interaction between a number of variables such as age, ethnicity, and choice of Lead Maternity Career which is associated with the rising rates of epidurals. There is a significant body of statistics, commentaries and research which supports this notion of complex interaction. Olayemi, Aimakhu and Akinyemi, (2006) explored the influence of Westernisation on the perception of pain among young pregnant women in Nigeria. This study illustrated the interaction between education and preferences with regard to pain relief. The researchers used a questionnaire to assess pain scores 48 hours after delivery. The pain scores were lowest among those with no formal education: those who were uneducated across all groups in the study had the lowest mean pain score (Olayemi, Aimakhu & Akinyemi, 2006). The researchers discussed the limitations of the study in terms of the adequacy of the research tool for measuring perception of pain. Another limitation was the confounders, which they did not measure for, such as the women's social situation, which may also have impacted on their perception of pain. However, while acknowledging these limitations, the study does present a case for Westernisation leading, through education, to increased perception of pain in childbirth. When all the indicators for pain relief itself were taken into consideration women who were educated were still more likely to need pain relief (Olayemi, Aimakhu & Akinyemi, 2006).

Stark (2003), in a demographic study carried out in Michigan, USA, explored antenatal preferences for epidural analgesia, and discovered that women with graduate degrees and with incomes over \$50,000 demonstrated a greater preference for epidurals during labour. Stark (2003) suggests that the reasons this group of women may prefer epidurals are that they are more comfortable with the technology, have the resources to pay for the service, and are more likely to have private insurance and be cared for by an obstetrician.

All these factors have been shown to be part of the complex network of influences that create preference for and use of epidurals. This is illustrated further by an Australian study which researched the difference in the rates for obstetric intervention between private and public patients in New South Wales during 1996 and 1997 (Roberts, Tracy & Peat, 2000). The findings of this research showed that low-risk primigravidaes who birthed vaginally in a private hospital were much more likely to get an epidural in labour (50.8%) than a similar woman in a public hospital (35.2%) (Roberts et al, 2000). While this study collected data on many factors such as age, parity, and medical conditions there were some factors, such as duration of labour which were not available.

However, the researchers argue that the reliability and size (171,157) of the database ensures that the differences reported are valid, if not generalisable to other populations with different systems or models of maternity care. This study adds important information to the growing picture of complexity in relation to increasing rates of epidural. In Aotearoa-New Zealand there are no similar private hospitals, and any such comparisons have to be made between private or public Lead Maternity Carers. However, these comparisons are difficult, as in the 2003 Maternity report, 25.2 % of women who had epidurals are classified as 'other' (they are not reported as being cared for by a midwife, GP, or obstetrician) which makes any real interpretation of the data difficult. National Women's, in its report for 2005, presents statistics for the epidural rates for nulliparous women in labour and distinguishes between public Leader Maternity Carer's: independent midwives (68%), domino midwives (58%), community midwives (64%) and private obstetricians (86%). However, it must be noted that, on average, the women who were cared for by private obstetricians were older and more often European - two demographic factors which by themselves are associated with higher rates of intervention (National Women's Report, 2005). The reasons for the rising rates of epidurals are obviously complex and, like increasing caesarean rates, appear to be related also to social, cultural and non-clinical indicators. This is the context that created the impetus to carry out this study, as it seemed that there was a growing need to look at these social and cultural factors which shape understanding and practice.

The Induction (query) Epidemic?

There is much written about induction, and the literature and research in relation to this topic is extensive. It examines, among other things, the risks associated with induction, the possible link of induction to increased caesarean sections, the rise of elective inductions, epidemiology of labour induction, maternal and neonatal outcomes of induction, women's satisfaction with induction, and the methods of induction (Coonrod, Bay, & Kishi, 2000; Duff & Sinclair, 2000; Homer & Davis, 1999; Maslow & Sweeny, 2000; Wong, Hui, Choi & Ho, 2002). It appears that inductions are definitely increasing, and are becoming a common, rather than exceptional procedure. Inductions in New Zealand have risen from 7.0% in 1988 to 19.7% in 2003 (Ministry of Health, 2003, 2006). Similarly, in the United States, inductions have more than doubled from 9.5% in 1990 to 20.6% in 2003 (Martin, Hamilton, Sutton, Ventura, Menacker, & Munson, 2005). At National Women's (while acknowledging a problem with collecting data, which may have resulted in the numbers of inductions being under-represented) it appears that the induction rate has remained relatively stable since 1997 at 26-27% (National Women's Annual Report, 2005). While there has been an increase in the number of inductions worldwide, some researchers and writers stop short of classifying this increase as an epidemic (Gulmezoglu, Crowther & Middleton, 2006). The reasons for the debate about this term are explored in the following section.

Reason for Increased Inductions

There are a number of clinical reasons that can be readily identified as indications for induction. Some of these are post-term (42 completed weeks), post-dates (40 weeks + 1 day to 41 completed weeks) diabetes, premature rupture of membranes, and maternal request (Davies, 2005; Gulmezoglu, Crowther & Middleton, 2006; Royal College of Obstetricians and Gynaecologists, 2001). National Women's Report (2005) presents the following indicators as reasons for induction: post-dates (26%), hypertension (15%), prolonged rupture of membranes at term (12%), and maternal request (8%). This report also notes that these indicators are influenced by factors such as age and ethnicity. Increasing maternal age is associated with higher rates of induction for post-term and maternal request (National Women's report, 2005). The data collected nationally for induction shows that women aged 40 years or over have the highest rates of induction (Ministry of Health, 2006).

There are a number of clinical factors and indicators, such as maternal age, diabetes and post-dates which, as a result of research carried out in the last 10 years or so, have changed practice with regard to induction (Boulvain, Stan, & Irion, 2004; Crowther, Hiller, Moss, McPhee, Jeffries, & Robinson 2005; Gulmezoglu, Crowther & Middleton, 2006; Hawthorne, Irgens, & Lie, 2000; Sanchez-Ramos, Oliver, Delke & Kaunitz, 2003). A systematic review carried out in 2006 which include 19 trails reporting on 7984 woman conclude that a policy of induction after 41 completed weeks (post-dates) compared to waiting for spontaneous labour was associated with fewer perinatal deaths (Gulmezoglu, Crowther, Middleton, 2006). The increase in rates of induction that are attributed to post-dates and diabetes appears to be an appropriate response to the evidence about these conditions in pregnancy, as induction, in this instance, does give better outcomes for certain groups of women and their babies (Boulvain, Stan, Irion, 2004; National women's report 2005). It is this research and evidence which suggests that while inductions have increased that this increase may be appropriate rather than epidemic.

Later in the review I will explore the research and literature around choice and maternal request, but it is sufficient to say at this point that maternal request is increasingly being identified as a significant indicator for induction. At National Women's Hospital (Auckland, New Zealand) in 2005, maternal request was the fifth most common reason for induction (8%). Glantz (2003), in researching labour induction rates in Upstate New York which has a 20.8% overall induction rate, found that 25% of these inductions had no apparent medical or obstetric indication (Glantz, 2003). The question of maternal request causing increased induction rates is a difficult one to assess, in that 'social inductions' may be under-reported because of the stigma and judgment that surrounds such requests. However, it appears that in some areas, maternal request may indeed be the factor that pushes the increasing induction rate from an appropriate response to 'epidemic' proportions.

‘Cascade of Intervention’

Historically, a ‘cascade of intervention’ was the term used to describe the interventions associated with induction, augmentation and third stage (Inch, 1985; Roberts, Tracy & Peat, 2000). More recently, a ‘cascade of fear’ has been talked about in relation to the anxiety women increasingly feel towards childbirth which is purported to cause “uterine inertia and fetal distress” (Foureur & Hunter, 2005, p.102). I would also claim that anecdotally there is a significant body of conversation which links induction, epidural and caesarean section together as a ‘cascade of intervention’. Each intervention is seen as impacting on the other, inevitably resulting in increasing rates of intervention. It is not uncommon to hear comments that epidurals lead to more caesareans, and more inductions lead to more epidurals and caesareans, and so on. It seems important in light of this anecdotal evidence to briefly present a synopsis of the research in relation to the links between induction, epidural and caesarean section, and to establish whether or not there is such a ‘cascade of intervention’.

The link between epidurals and other interventions, in particular caesarean section, can be seen in studies from the early 1990’s (Thorp, Hu, Albin, McNitt, Meyer, Cohen, & Yeast, 1993; Thorp, Parisi, Boylan, & Johnston, 1989). There were a number of significant limitations to these pieces of research, which prompted several randomised controlled trials to address what was becoming a very controversial area of practice.

These trials found that epidural analgesic provides safe and effective intrapartum pain control without any adverse labour outcomes (Clark, Carr, Lloyd, Cook, & Spinnato, 1998; Impey, MacQuillan, & Robson, 2000). A systematic review of all the randomised and observational studies appearing in peer review journals since 1980 concluded that there is sufficient evidence to show that epidurals are associated with a lower rate of spontaneous vaginal delivery and a higher rate of instrumental vaginal delivery (Lieberman & O’Donoghue, 2002). However, the review also points out that there is insufficient evidence to determine whether or not an epidural increases the risk of caesarean section. This review is critical of the existing randomised trials. It claims they are too small, and that a clear interpretation of the data is not possible because of problems with protocol and the lack of a homogeneous population (Lieberman & O’Donoghue, 2002).

However, it appears that the early indications of a link between epidural and increased caesarean section rates may be explained in part by the research itself. Women who were going to have difficult labours and experience dystocia were more likely in non-randomised or retrospective research to turn up disproportionately in the group having epidurals (Smiley, 2002).

A recent study carried out in Sweden investigated the association between epidurals for pain relief and the mode of delivery. This population-based cohort study included 94,217 primigravidaes at term who started labour spontaneously, or were induced (Eriksson, Olausson & Olofsson, 2006). This data, covering births between 1998 and 2000, was collected from the Swedish medical birth register, which covers 99% of the births in Sweden. The study concluded that there is no clear link between epidural use and caesarean section or instrumental delivery, and little evidence to suggest that epidural rates should be restricted to improve obstetric outcome (Eriksson, Olausson & Olofsson, 2006). There are a number of variables, such as the drugs used for epidurals, the advent of 'walking' epidurals in some places, and the changes in management of epidurals, which can account for the differences between the early studies which suggested a link between epidurals and mode of delivery, and later studies in which there is no clear link.

A link between induction and caesarean sections has been presented by some research (Dublin, Lydon-Rochelle, Kaplan, Watts & Critchlow, 2000). However, these findings have been challenged by other studies, and it would appear that there is no robust evidence to suggest that more inductions lead to increased caesarean section rates (Gulmezoglu, Crowther & Middleton, 2006). At National Women's in 2005 the rate of caesarean sections was higher among nulliparas following induction (35%), as opposed to those who laboured spontaneously (21%) (National Women's Report, 2005). However, the authors of the report note that this is contrary to recent literature, which suggests that women induced for post-dates are more likely to deliver vaginally than women who labour spontaneously (National Women's Report, 2005). It would appear that the anecdotal links that are made between one intervention and another are not readily supported by the evidence, even though there may be individual situations, such as that experienced at National Women's in 2005, where this appears to be the case.

It is important to acknowledge, however, that there are factors other than just one intervention influencing another, which may be instrumental in bringing about a 'cascade of intervention'. A study from the United States showed that government hospitals had a 13.7% induction rate, while private investor-owned facilities had a 30.5% induction rate (Coonrod, Bay, & Kishi, 2000). Roberts, Tracy and Peat (2000) also showed in their study that the induction rate varied between private patients in private hospitals (25.7%) and private patients in public hospitals (21.1%) and all public patients (15.7%). Murray (2000) carried out a research study in Chile that sought to explain the association between private health insurance cover and a high rate of caesarean sections. In the postnatal survey, women with private obstetricians showed consistently higher rates of caesarean section: 57-83%, than those cared for by midwives or doctors on duty in public or university hospitals: 27-28%. Furthermore, the rate of *elective* caesarean sections was 30-68% for women with private obstetricians, and 12-14% for women not attended by private obstetricians (Murray, 2000). This study concluded that the business ethos prevailed in these decisions, and that the doctors involved had no moral objection to non-medical caesarean sections and were happy to meet women's requests (Murray, 2000). In Aotearoa-New Zealand it is possible to draw some conclusions by comparing different groups of Lead Maternity Carers.

At National Women's Hospital in 2005, standard primipara women cared for by private obstetricians had a spontaneous vaginal delivery rate of 32%, compared to 58% of those cared for by independent midwives (National Women's, 2005). However, it must be noted again that private obstetricians cared for women whose actual demographic background is associated with higher rates of intervention (National Women's Report, 2005).

Belizan, Althabe, Barros, and Alexander (1999) researched the incidence of caesarean sections in Latin American countries, and correlated these with socio-economic, demographic, and healthcare variables. They discovered a significant correlation between rates of caesarean section and the gross national product per capita (the higher the gross national product, the higher the caesarean section rate), the proportion of urban population, and the number of doctors per 10,000 of the population (Belizan, Althabe, Barros, & Alexander, 1999). In Brazil, 55% of women from families earning more than \$1000 (£700) per month were having caesarean sections (Belizan, Althabe, Barros, & Alexander, 1999).

In 2002, Behague, Victora, and Barros researched the consumer demand for caesarean sections in Brazil and they found that caesarean sections were more common among wealthy and educated women, those with more antenatal attendance, and primiparous women. Overall, 83% of women who had had a caesarean section had repeat procedures, and those with the greatest need for caesarean sections were often the least likely to receive one (Behague, Victora, & Barros, 2002). The important psychosocial factor that was identified in this study was that the more social power a woman had, the more likely she was to experience intervention of one kind or another (Behague, Victora, & Barros, 2002).

In Aotearoa-New Zealand certain ethnic groups such as Maori and Pacifica women are more likely to birth normally, with minimal or no intervention, while European and Asian women are more likely to have caesarean sections and other interventions such as epidurals (Ministry of Health, 2006). While there are no sets of data directly dealing with the issue of socio-economics and mode of birth it is possible to compare data from District Health Boards (Appendix E) which are in different decile areas. I have already presented the data comparing different decile areas in relation to epidurals, but it is also possible to see the differences in relation to caesarean sections.

In 2003, Middlemore, the most deprived end of the decile scale, had a caesarean section rate of 16.1%, compared to National Women's, on the least deprived end of the decile scale, which had a caesarean section rate of 29.1% (Ministry of Health, 2006). In this limited way, it is possible to illustrate to some degree the links between socio-economic indicators and increasing intervention in childbirth in Aotearoa-New Zealand. There is little doubt, as stated previously, that European and Asian women, and women who are from higher decile areas are increasingly choosing intervention (Ministry of Health, 2006).

It appears from the literature that any link between interventions and any 'cascade of intervention' is influenced by a number of variables other than the intervention themselves, such as insurance, wealth, access to resources and private health care. Once again, the evidence suggests that the reasons for intervention are complex and multilayered, and that social, cultural and even economic factors have an important part to play in shaping understanding and practice, and possibly bringing about a 'cascade of intervention'.

Maternal Age

The one non-clinical factor that is constantly presented as key in relation to increasing rates of intervention is maternal age, the age at which women are giving birth, especially for the first time. It is interesting to note the amount of recent media interest in this topic. Titles and headlines such as ‘The Changing Face of Motherhood’, ‘Women Advised to Freeze Eggs Until Later’, ‘Woman to be Oldest Mum at 63’, ‘Britons Put Fun Before Babies’ reflect the interest in the public debate about maternal age and childbirth. Opinions range from maternal age being framed as just another criticism that is levelled at women (Kitzinger, 2006) to middle age pregnancy being described as a health hazard (Stuart, 2006). In Aotearoa-New Zealand, the age of women giving birth is also increasing. In 2005, at National Women’s Hospital the proportion of births to women below 30 continued to fall, while for women above 30 it continued to rise. This reflects the national trend, as in 2003 the median age of women giving birth passed 30 years for the first time (Ministry of Health, 2006). The reasons for increasing maternal age being linked to higher rates of intervention are complex. The most easily identified reason is that older women are more likely to have chronic or acute medical conditions which complicate their pregnancy and childbirth.

The National Women’s Report of 2005 claims that women over 35 years of age are more likely to develop gestational hypertension or have chronic hypertension than younger women, and they are more likely to develop gestational diabetes (38.2%) or have type 2 diabetes (38.5%) when compared with the rest of the delivery population (22.1%). As stated previously, older women over 40 years of age are more likely to be induced (40%) when compared to women under 20 years of age (21%). Older women are also more likely to have a caesarean section and epidurals. In fact 53% of women over 40 years of age have elective or emergency caesarean sections compared to 16.3% of women under 20 years of age (National Women’s report, 2005). It is not surprising then that anecdotally one of the understandings that the public have is that older women are more likely to have complications and have a higher chance of having a caesarean section. The statistics, along with the understanding of the public about maternal age, illustrate the importance of age in relation to increasing intervention, especially in light of the fact that the average age at which women birth is expected to increase.

There have been a number of research studies showing that maternal age is in fact an *independent* risk factor for complications of pregnancy and childbirth, including fetal death and stillbirth (Fretts, Schmittdiel, McLean, Usher, & Goldman, 1995; Reddy, Ko & Willinger, 2006). In a study carried out by Cleary-Goldman et al (2005) maternal age was shown to be statistically significant in its association with miscarriage, chromosomal and congenital abnormalities, gestational diabetes, placenta previa, and caesarean section. Women aged 40 years and older are also at increased risk for abruption, pre-term delivery, low birth weight and perinatal mortality (Cleary-Goldman et al, 2005; Newburn-Cook & Onyskiw, 2005; Odibo, Nelson, Stamillo, Sehdev & Macones, 2006). The size of these studies, unlike earlier smaller ones, has made it possible to identify with some certainty the increased risks associated with maternal age. Tracey, Robson and O’Herlihy (2006) undertook research to assess the impact of maternal age on a number of obstetric indices, such as uterine efficiency, to see if maternal age is associated with dystocia, and so with increasing intervention. The results of the research showed that all the indices: oxytocin augmentation, prolonged labour, instrument delivery, and intrapartum caesarean section increased significantly and progressively for older women (Tracey, Robson & O’Herlihy, 2006).

A number of the studies presented above (Cleary-Goldman et al, 2005; Fretts et al, 1995; Reddy et al, 2006) use large databases from which to draw conclusions about maternal age and fetal death, still-birth, and other obstetric complications. Rubins (1997) suggests that methods of analysis such as the logistic regression used in these studies may not always be the most appropriate method for dealing with material from large databases. However, it appears that for these research studies, which were primarily concerned with the probability of an outcome and sought to provide an understanding of the relationships between variables, that logistic regression was an appropriate tool of analysis. There is also much discussion about large databases in relation to the data and its reliability. The studies by Cleary-Goldman et al (2005) and Fretts et al (1999) both used databases which were created specifically for the research and were maintained and monitored by the researchers. Fretts et al (1999) described the database they used which had “450 computerised internal-consistency checks” for each birth entry (p.955). The Faster database was a prospective database created as a result of the multicenter investigation and the statistical analyses of this trial was reviewed by an independent group (Cleary-Goldman et al, 2005).

The database used by Reddy, Ko and Willinger (2006) was that of The National Center for Health Statistics and while such a large database could be seen to be problematic in relation to the data collected, the researchers selected particular states in America to be in the study. The states which met the criteria of 80% or more complete reporting for particular data entry fields which were important to the study were selected. This is one of the ways these researchers addressed some of the problems with using a National Health statistics database. All of the studies appear to be well aware of the problems that using large databases can pose and many put in stringent criteria and strategies to avoid, counter and manage such problems.

The significance of complications brought about by increasing maternal age appears to be complemented by psychosocial factors which impact on intervention rates. Berryman, Thorpe, and Windridge (1995) argue from research they carried out that older women actually feel more vulnerable during pregnancy, and have greater concerns around safety. Windridge and Berryman (1999) confirmed these findings in their research on the experience of women giving birth after 35 years of age (n=54), compared with younger women aged 20 to 29 (n=53). This study identified a number of significant factors in relation to age, one of which was that older women felt more vulnerable, and were more likely to believe that their baby's life could be potentially at risk during labour and delivery (Windridge & Berryman, 1999). The limitation of this study was in the number of women interviewed (n=107), which means that the results have to be interpreted with some caution (Windridge & Berryman, 1999). However, despite these limitations, the researchers raise some interesting questions about the psychological aspects of increasing maternal age that may impact on the valuing and use of intervention (Windridge & Berryman, 1999). Older women are at higher risk for more complications, still birth and intervention in labour. When these statistics are considered alongside the feelings of vulnerability and a heightened awareness of risk, then the psychological factors can be seen to be as important as the physiological ones.

The literature review has so far presented three interventions: caesarean section, epidural and induction, along with the reasons why these interventions are increasingly being utilized, and in some cases are being classed as an epidemic.

The review has also explored the interaction between these interventions and the claim that one intervention leads to another, creating a ‘cascade of intervention’. As well as this, the review has explored the non-clinical factor that is most identified with increasing intervention, that of maternal age.

There is a long list of other factors that are identified in the literature as shaping practice and understanding in relation to intervention in childbirth. **Pelvic floor issues (continence, and long term effects of childbirth)** (Farrell, Allen, & Baskett, 2001; Foldspang, Mommsen & Djurhuus, 1999; Nygaard, 2006; Ritcher, 2006; Sultan & Stanton, 1996). **Women’s informed choice and maternal request** (Gamble, Health, & Creedy, 2000; Marx, Wiener, & Davis. 2001; Moon, 2002; Nerum, Halvorsen, Sorlie & Oian, 2006; Showalter, 1999; Wickham, 2002, Young, 2006). **Demographics - place of birth** (Papps & Olssen, 1997; Roberts, Tracy, & Peat, 2000). **Fear, and fear of pain** (Alchagen, Wijma, & Wijma, 2001; Alehagen, Wijma & Wijma, 2006; Parson, 2002). **Psycho-social pressures** (Benzies, Tough, Tofflemire, Frick, Faber, & Newburn-Cook, 2006; Lemonick, 1999; Neggers, Goldenberg, Cliver, Hauth & 2006; Saisto, 2001; Warwick, 2001). **Expectations and the establishment of a culture of intervention** (Castro, 1999; Hopkins, 2000; Merkin, 2006; Walker, Turnbull & Wilkinson, 2002; Warwick, 2001). **Wealth and social power of women** (Behague, Victora, & Barros, 2002; Coonrod, Bay, & Kishi, 2000; Robinson, 2000). **Body image and sexuality** (Bastian, 1999; Chang, Chao & Kennedy 2006; Davies, 2006; Earl & Church 2003). **Fear of litigation** (Coulson & Cain, 1999; Dubay, Kaestner & Waidmann, 1999; Perkins, 2006; Stewart, 2001; Symon, 2006).

Many of the factors mentioned above to some extent shape practice and understanding. However, some of these, such as the issues in relation to pelvic floor (as identified above) and litigation I will not be reviewing. This is not because they are not important in and of themselves or that they did not show themselves in the research. The issue of the pelvic floor did show itself in the data from the health professionals, but did not really feature in data from the women, except as a source of amusement. The issue of litigation is a very important factor for health professionals in terms of shaping their practice, and it appears in the data chapters, but did not feature as significant for the public. The issues of pelvic floor and litigation, I would argue, are taking on more significance in Aotearoa-New Zealand, and in the next five to ten years may come to be perceived as major issues.

However, while acknowledging the importance of both these issues, I have chosen to present in this literature review other social and cultural influences that showed themselves more clearly in the data to be shaping understanding and practice.

There is much academic writing about the social and cultural practices surrounding pregnancy and childbirth. Crouch and Manderson (1993) claim that during the 1980's in particular there was a high degree of interest in childbirth. During this time, numerous works appeared, including critical sociological studies, ethnographies of birth, and feminist writing, some of which had such an impact that they have achieved almost iconic status. (Crouch & Manderson, 1993). Such works include *The Woman in the Body* (1987), by Emily Martin; *Recreating Motherhood* (1989) and *In Labour* (1991), by Barbara Katz Rothman; *Women Confined: Towards a Sociology of Childbirth*, (1980) and *The Captive Womb* (1986) by Ann Oakley. These, and many other writers, researched and wrote about the social significance, social context and the socialisation of women, pregnancy and childbirth, and in particular the medicalisation of birth. Such works began to articulate and make accessible the “fuzzy border between nature and culture, the biological and the social” (Crouch & Manderson, 1993, p.57). It is this ‘fuzzy border’ and the prevailing cultural and social context that shapes childbirth, and which will be explored in the following section of this literature review. I chose the particular research and literature that is presented because it best reflects the everyday world and the processes of socialisation that the participants in my study presented as shaping their understanding and practice.

Choice

One of the most important processes of socialisation that showed itself in the literature to be shaping practice and understanding is the notion of choice. The understanding surrounding choice as a concept and a right has changed dramatically in Aotearoa-New Zealand, and in the wider Western world, in the last 30 years. In relation to health, there has been a movement away from the paternalistic approach of the 20th century, where the doctor ‘knew best’, and made all the decisions, often with little or no explanation (Walsh, 2005). In the 1960's and 1970's, important social movements such as feminism demanded accountability with regard to childbirth, and women set out to reclaim their bodies back from intervention, technology and the medicalisation of childbirth (Papps & Olssen, 1997).

In Aotearoa-New Zealand, as elsewhere, women lost trust in the medical profession because of the medicalisation of birth, and they increasingly reacted against the use of sedation and the associated use of forceps, demanding more flexible and natural ways of birthing (Donley, 1998). These social movements brought about a change in the relationship between the health professional and the woman accessing the maternity services. The Cartwright Inquiry (Appendix E) undertaken during 1987 and 1988 in Aotearoa-New Zealand was a catalyst for the redefining of the relationship between the health professional and consumer in this country. Coney (1988) states that as a result of the Cartwright inquiry, doctors took more care about informing their patients about the choices available, and women themselves began to show a new assertiveness in relation to choice. These changes redefined the relationship between the health professional and the consumer, and reflected the changing place of women in society. In 1996 the Code of Health and Disability Consumers Rights became law and, among other things, enshrined choice and the right to choose in health care, thus establishing a culture of choice in Aotearoa-New Zealand. This legislation, along with changes to the health system in the 1990's (including the amendment to the Nurse's Act of 1977, which gave midwives their autonomy) established a framework in which choice became all-important. These changes meant that the pregnant woman was framed as a consumer who, through choice, could exert her rights and have control over and direct her experience (Davis, 2003). The changes were a response to the concerns of the time: concerns such as autonomy, control of one's own body, and self-determination, and this meant that the "language of patient rights, patient empowerment, and patient self-determination began to constitute the *lingua franca* of professional practice" (Cox White & Zimbelman, 1998, p.478).

In the 21st century a philosophy of care that is increasingly based first and foremost on the value of choice and the right to choose, is shaping practice and understanding across the Western world. Johanson, Newburn and MacFarlane (2002) claim that in the United Kingdom in the last decade the predominant and growing philosophy of health care, including childbirth, has been centred around 'value-free choice'. Choice and informed choice, fostered by a particular philosophical and social stance, has created a culture in which choice has become the individual's right (Wagner, 1994).

There is much research and literature not only around choice, but also around informed choice, and some of the material debates whether informed choice is a reality or a myth, a blessing or a curse, and asks who is informed, who is doing the informing, and whether it is possible to ever be fully informed (Amu, Rajendran & Bolaji, 1999; Davis, 2003; Young, 2006). Whatever the stance, there is little doubt that at the beginning of the 21st century informed choice is one of the cornerstones of practice and understanding in relation to childbirth. Much of the discussion about informed choice in relation to intervention appears to be centred around the right of women to choose an elective caesarean section. It is worth exploring this particular topic, as it presents in a unique way, the power given to choice and the right to choose.

The debate in relation to choice and the choosing of elective caesarean section covers a wide range of opinion. There are those who believe that performing a caesarean section simply in response to maternal request is not ethically justifiable (Wagner, 2000), and those who believe that the costs, benefits, and risks are so balanced between caesarean and vaginal birth that it should be a matter of choice (Moon, 2002). Paterson-Brown (1998) claims that elective caesarean sections must now be an accepted part of medical practice, and that health professionals can no longer hide behind clinical indicators and withhold prophylactic caesarean sections. Others, however, claim that maternal choice alone should never determine a method of delivery (Amu, Rajendran & Bolaji 1999; Young, 2006). Marx, Wiener and Davies (2001) claim that the right to choose an elective caesarean section is the result of people increasingly believing that caesarean is best, of women not being given full information, and of years of hospitalised, medicalised birth. In other words, the right to choose an elective caesarean section is a result of the *milieu* in which women find themselves: the choices that are available result from interests other than just the individual's right to choose a certain procedure.

This is illustrated in part by research and literature which looks at the shaping of women's understanding in relation to choice and caesarean sections. Gamble, Health and Creedy (2000) carried out a systematic review of literature in relation to elective caesarean sections and maternal request. This review, as well as later research showed that in fact few women request a caesarean section if they have not experienced current or previous obstetric complications (Gamble, Health & Creedy, 2000; Gamble, Health & Creedy, 2001).

While the most common indicator for elective caesarean sections may be seen to be maternal choice, it would appear that in some cases, reasons such as a previous negative birth experience underlay the request. Gamble, Health and Creedy (2001) suggest that the focus on women's request for caesarean sections actually diverts attention away from other vested interests. They argue that vested interests, such as those of the physicians, shape understanding and practice in relation to the increasing intervention rates of caesarean sections much more than women's choice. These findings have been supported by more recent studies such as the 'Listening to Mothers' survey carried out in the USA. Results from the survey refute the belief that women were requesting caesarean sections without medical reasons, and the authors of the survey claim that virtually no women surveyed (0.08%) chose an elective caesarean section (Childbirth Connection, 2006). The main factor identified as increasing the caesarean section rate was that women were not being offered vaginal delivery after a caesarean section (VBAC), and the responsibility for this lay with their caregiver, who was often unwilling to support a VBAC (Childbirth Connection, 2006). Kingdon, Baker and Lavender (2006) carried out a systematic review to determine whether a trial of planned caesarean section versus vaginal birth in healthy women with singleton cephalic pregnancies at term was a possibility. While they found little evidence to support such a trial, they also brought to the fore the lack of any real evidence about the numbers of women requesting elective caesarean sections (Kingdon, Baker & Lavender, 2006).

This lack of evidence is highlighted by Lavender, Hofmeyr, Neilson, Kingdon and Gyte (2006) in their systematic review on caesarean section for non-medical reasons at term. They argued, after reviewing the research, that the choosing of elective caesarean sections requires further qualitative and quantitative research, to gain a clear picture of women's views, in order that the influence of both psychosocial and obstetrics factors can be more fully understood (Lavender, Hofmeyr, Neilson, Kingdon & Gyte, 2006). The notion of informed choice assumes an objectivity and neutrality in relation to the informing of choice that is, in effect, an illusion (Beech, 2003). There is considerable evidence that comes from a number of disciplines, both within and outside of health, which shows that the informing of choice is influenced by a number of factors, not the least of which is the attitudes of health professionals, and the way evidence is presented to women (Johanson, Newburn & MacFarlane, 2000; Stewart, 2006).

The claim to objectivity that is understood to be part of the informing of choice can easily lead both health professionals and women to an erroneous place, where they believe that choice is not contextualised, and constructed.

A number of research studies illustrate the *shaped* nature of choice, whereby health professionals influence the choices people make by the language they use, the way they present options and frame the choices that are available (Johanson, Burr, Leighton, & Jones, 2000; Simpson, Johnstone, Goldberg, Gormley, & Hart, 1999; Stapleton, Kirkham, & Thomas & Curtis, 2002). A qualitative study examining the use of evidence-based leaflets with regard to informed choice in the maternity services showed that clinical pressures, time pressure and limited discussion meant that choice was often not readily facilitated for women (Stapleton, Kirkham & Thomas, 2002). In fact, what *was* presented was not informed choice, but a 'right' or 'wrong' choice, which came out of the litigious milieu in which health professionals practiced, leading them to present technological intervention in a positive light (Stapleton, Kirkham & Thomas, 2002). This research showed that women's trust in health professionals usually ensured their compliance with the professionals' preferred choice. 'Informed compliance', rather than 'informed choice' was seen as determining care (Stapleton, Kirkham, & Thomas, 2002). The above study and others like it were done in a fragmented care model, where women did not usually see the same midwife at different antenatal visits. This hinders the development of a relationship based on trust, which could have facilitated an exchange of information (Stapleton, Kirkham & Thomas, 2002; Stapleton, Kirkham, Thomas, & Curtis, 2002). This is another avenue for further research, as there appears to be little or no information about the facilitation of informed choice in the model of continuity of care, where such a relationship of trust is formed.

The question remains, of course, about how feasible, let alone possible, it is for health professionals - or anyone else for that matter - to give information that is unbiased. A randomised controlled trial regarding the use of evidence-based leaflets to promote informed choice in maternity care concluded that in everyday practice, evidence-based leaflets were actually ineffective in promoting informed choice in women using maternity services (O'Cathain, Walters, Nicholl, Thomas & Kirkham, 2002).

It would appear that in the everyday world of practice it may be very difficult to facilitate genuine informed choice, and that pamphlets and information given to the women to encourage informed choice may be much less influential than are the health professionals, family, friends, or the culture of birth in the institutions in which they give birth (Soltani & Dickinson, 2005). Choice, and informed choice, with the status and power that these concepts are given in health care at the beginning of the 21st century, means that often the context and construction of a particular issue remains invisible. Choice is, in effect, *shaped*, and in part limited and predetermined, which means that women are often – contrary to popular belief - left with only the illusion of real choice (Troutt, 2001).

Social, Cultural and Psychosocial Influences

Some of the other social, cultural and psychosocial influences are also important to present and discuss. There is a great wealth of material in the media, and in everyday conversation about psychosocial influences. The most relevant of these will be presented in the following so as to show something of the shaping of understanding and practice. Commentaries and conversations include remarks such as, ‘too posh to push’, ‘honeymoon freshness’, ‘Hollywood syndrome’ (where one can give birth with barely a stretch mark) and, of late, ‘yummy mummies’ or glamorous mothers (Daniel, 2006; Jones 2005). It is not surprising that in the Western world a number of these commentaries are centred around body image and sexuality. Moorhead (2006) in an article in the *Guardian*, draws attention to a website set up by a mother of two called ‘The shape of a mother’. This website ‘reveals’ what is called society’s greatest secret: the stretch marks, sags and scars of the post-pregnant body. It has been set up so that women can affirm that their bodies are acceptable just as they are, and that they do not have to judge themselves by the image of the ‘idealised pregnant woman’ created for them by the Pamela Andersons, Victoria Beckham and Gerri Halliwells of the world (Moorhead, 2006). The power of the media and celebrities in shaping understanding and practice in relation to intervention in childbirth appears to be widespread and significant.

There are some writers who claim that nobody has a right to demand that a woman gives birth vaginally, and that to speak of a ‘caesarean section epidemic’ is an outdated way of thinking about women and their reproductive needs (Showalter, 1999). Others raise questions about women who invest so much money, time and energy on their bodies by going to the gym and eating the right food, yet they do not seem to be able to trust these fit, healthy bodies to carry out the birthing process (Nicholas, 2002). Yet others call for an end to an age-old method of gestation and delivery that they see as being more suited to the Dark Ages than the Third Millennium (Bridgemen, 2001). Others claim that in a risk-free society, where vaginal delivery is increasingly framed as risky, and caesarean section as safe, then the latter fits more easily within this society that is obsessed with managing risk (Klein, 2004; Paterson-Brown, 1998).

It would appear that there may be a new paradigm emerging in relation to childbirth, as captured by this comment about an American celebrity who gave birth by an elective caesarean section. A health professional seriously suggested that such women are an “icon of a modern generation of women – strong, independent, articulate, informed, and rejoicing in the ability to have virtually pain-free childbirth” (Davis-Floyd, 2006, p.248). Davis-Floyd claims that those who work to promote natural and normal birth in the 21st century are, in effect, being defeated, not only by the dubious interpretation of certain evidence, but also by socio-cultural trends, fashions, and fads. These trends, fashions and fads are shaping understanding and practice in relation to intervention, and the results can be seen in those hospitals in the United States that have a 50% caesarean section rate (Davis-Floyd, 2006).

Historically, the issue of control has always been at the centre of childbirth, and it is not surprising that it is also at the heart of the psychosocial influences shaping understanding and practice in relation to increasing intervention. In the late 1980’s and early 1990’s two important works, that of Emily Martin’s *The Woman in the Body* (1987) and Davis-Floyd’s *The Technocratic Body: American Childbirth as Cultural Expression* (1994), showed that middle-class and professional women’s overriding concern was that of control. These women expected to have and exercise this same control during childbirth, aided and supported by technology (Davis-Floyd, 1994).

In Aotearoa-New Zealand, the choice of an elective caesarean section has recently been presented as something that enables women to stay in control while birthing (Page, 2007). This expectation of control in childbirth, for some groups of women, is also reinforced by the understanding that childbirth is a fearful experience, and therefore something to be controlled. Parson (2002) claims that the growing perception that middle-class women are choosing to have caesarean sections because they are 'control freaks' who want to plan and organise their lives around the date and time of giving birth is erroneous. She argues that women are choosing interventions such as caesarean section because they are terrified of childbirth, as they no longer know, and nor are they taught, how to cope with the demands of birth (Parson, 2002).

A number of research studies have looked at this phenomenon of fear of childbirth (tokophobia). These studies have shown a positive correlation between the expectations women have about birth being a fearful experience, the actual fear they experience during childbirth, and the total amount of pain relief received during labour (Alehagen, Wijma, & Wijma, 2001; Alehagen, Wijma & Wijma, 2006). Fisher, Hauck, and Fenwick (2006) conducted research on the influence of social context on women's fear of childbirth, and found that the social dimensions of fear were magnified by inherited 'horror stories', the fear of the unknown, and fear for the safety of the baby, while personal fears were centred around pain and losing control (Fisher, Hauck & Fenwick, 2006). The study also identified two factors which help women to be less fearful: support from other women, informal networks, and a positive relationship with midwives (Fisher, Hauck & Fenwick, 2006).

Waldenstrom, Hildingsson, and Ryding (2006) carried out research into the fear women had antenatally, and its association with their subsequent experience of birth and caesarean sections. The study showed that at least 10% of women feared childbirth, and that women who feared childbirth and had counselling had a three to six times higher elective caesarean section rate than women who had no counselling or did not fear childbirth. While there are a number of variables to be considered in this study, not the least of which is the availability of counselling, and the empowerment of women to ask for what they need, it appears that fear of childbirth is linked not only to the amount of pain relief women have, but also to the elective procedures they may choose (Waldenstrom, Hildingsson & Ryding, 2006).

The complexity of the psychosocial issues is illustrated by research in Finland, which looked at the characteristics of different personalities, as well as the relationships of pregnant women with their partners, and the influence these had on the women's attitude to their pregnancy and their forthcoming delivery (Salmela-Aro, Nurmi, & Halmesmaki, 2001). The more anxiety, vulnerability, depression, low self-esteem, dissatisfaction with the partnership, and lack of social support the women reported, the more pregnancy-related anxiety and fear of vaginal delivery they experienced (Saisto, Salmela-Aro, Nurmi, & Halmesmaki, 2001). While this is not surprising, it is interesting to note that lack of support and dissatisfaction with the partnership were the strongest predictors of severe fear of vaginal delivery (Saisto, Salmela-Aro, Nurmi, & Halmesmaki, 2001).

Psychosocial influences such as fear are complex, and yet it does seem that childbirth may be situated within a social milieu of fear in the Western world in the 21st century. Pincus (2006), claims that the system that surrounds childbirth in the United States "feeds on fear" (p.250). Women and their families are told, "Your baby's most dangerous trip is out through the birth canal" (Rooks, 2006, p.249). Pregnancy and childbirth is framed as being 'high-risk', and women and health professionals increasingly believe that childbirth is a frightening, unsafe process. The issue of fear is highlighted in this literature review because it is one of the most important psychosocial factors. A climate of fear means that those things that will avoid the 'danger' will increasingly become more attractive and sought after, resulting in further increases in intervention.

Technology

Much of the literature about the technology that contextualises this study is explored extensively in the chapters which present the findings from the data. However, this literature review would be incomplete without presenting some of the literature that does not appear in the data chapters. In the last twenty years or so there has been a proliferation of books about technology, and in particular technology and reproduction, books such as: *Are Mothers Really Necessary?* (Mullan, 1987); *The Baby Machine*, (Scutt, (Ed). 1988); *Birth by Design* (Devries, Beniot, Van Teijlingen & Wrede, 2001) and *Tomorrow's People* (Greenfield, 2003).

There has also been a proliferation of journal articles and research about technology and childbirth. A number of research studies have looked at the characteristics of technology and its effects on human beings, such as alienation and disembodiment (Akrick & Pasveer, 2004; Budgeon, 2003; Sandelowski, 2002). Other research has focused on the nature and place of technology in the birthing setting, the attitudes and satisfaction of women with technology in childbirth, as well as some studies which have contrasted the experiences and attitudes of women who chose home-birth as opposed to those who chose hospital birth (Davis-Floyd, 1994; Kornelsen, 2005). Kornelsen (2005) showed in her research that the number of interventions a woman experienced correlated in part with her attitude towards technology. In her research, there was no significant difference in the levels of satisfaction with the birth experience between groups of women who made either extensive or minimal use of technology. Kornelsen puts this down to the congruence between expectation and experience.

In other words, if a woman is expecting a high-tech environment, with epidural and ventouse, and she holds technology in high regard, then such an experience will be a positive one and she will report high levels of satisfaction (Davis-Floyd, 1994). Davis-Floyd (2006) argues that for women today, “the epidural means freedom from pain, the electronic fetal monitor means freedom from fear, (an illusion of course, but a powerful one), and the elective caesarean section means freedom from uncertainty (another even more powerful illusion)” (p.248). There is little doubt that the everyday world of technology is increasingly shaping women’s understanding and the practice of health professionals in relation to the place of technology, and is resulting in increasing intervention in childbirth.

Summary

The review of literature presented in this chapter has placed this research within the context that produced the question, and was the catalyst for carrying it out. The increasing rates of caesarean sections, epidurals, and inductions have been presented, and some reasons for these ‘epidemic’ increases have been explored. This exploration has facilitated an understanding of the context of increasing intervention, in which the non-clinical factors (social, cultural and psychosocial) have been shown to be as significant as the clinical ones in the shaping of understanding and practice.

The association between rising intervention rates and the social, cultural and psychosocial considerations not only places this study in context, but it also shows the significance of the study insofar as a number of researchers and reviewers have identified the need for qualitative studies which will explore this association. Central to the process of this research (*critical interpretation*) is the identification of those values, beliefs, interests and ideology that inform and support these non-clinical factors, as currently there appears to be limited awareness of them. There is an urgent need for this exploration, as it is imperative that the public and health professionals gain a full picture of what is leading women to choose procedures that are resulting in increasing intervention in childbirth.

Chapter Three

Methodology

The purpose of this study is to explain the culture of increasing intervention in childbirth by uncovering, analysing and bringing to awareness the shaping of understanding and practice. The methodological considerations of this study require a philosophical stance which first, explores how understanding and practice is shaped and secondly, facilitates an analysis of this shaping. Kogler, the philosopher whose work underpins this study explores in his book *The Power of Dialogue* ‘how’ one takes up a critical stance in relation to meaning and power while recognising the context and ‘situatedness’ of the interpreter (Hendrickson, 2004). Kogler (1999) claims that it is only through using a “methodologically undogmatic amalgam of interpretively gleaned insights and conclusions, phenomenological observations and analytically conceived results and arguments” that the “underlying premises of interpretive praxis” can be revealed and brought to consciousness (Kogler, 1999, p.11). The revealing and bringing to consciousness of underlying premises (the shaping of understanding and practice) is primarily realized in this study through the stories of the participants. These stories present a vivid, rich and in-depth picture of the participants’ worldview and so provide “interpretively gleaned insights and phenomenological observations” into the subject matter. This interpretive insight is further informed by critical analysis that brings to awareness the taken for granted and invisible influences that shape practice and understanding. This chapter establishes the relationship between the purpose of the study and the methodology chosen. It illustrates that the study is best informed by *critical interpretation* as formulated by Hans Kogler.

The choosing of a methodology in relation to the question Critical hermeneutics.

Critical hermeneutics provides the most appropriate umbrella for this research to come under. It has its origins in the philosophical traditions of hermeneutics and critical theory and in a debate between Gadamer and Habermas in the 1960s (Chaw, 1995; Madison, 2000). This debate centred on what constitutes knowledge and was in response to empirical and analytic knowledge being recognized at the time as the only valid form of knowledge (Bernstein, 1985).

A critical hermeneutic stance not only questions what constitutes knowledge and understanding but it also challenges the view that any given reality is ‘just the way things are’ and so it enables hidden assumptions and values that constitute knowledge and social practices to be made visible (Chaw, 1995). Moreover, a critical hermeneutic approach presupposes that shared meaning is created and that this in turn shapes and indeed constitutes the way things are (Thompson, 1981). In allowing the researcher to focus on the conditions that construct and shape meaning - our prejudices, history and our traditions - critical hermeneutics makes it possible for the researcher to recognise relationships between power, texts, and the shaping of social systems (Allen, 1995). Critical hermeneutics provides a methodology that allows for an analysis of the influences of power and power practices on preunderstanding and understanding (Kogler, 1999). The goal of such a research process is to understand and uncover how power structures and ideologies direct and limit interpretations (Lutz, Jones & Kendal, 1997). Therefore, critical hermeneutics, and its focus in the first instance on the conditions through which meaning is constructed and shaped, provides an approach which facilitates the intent of this study.

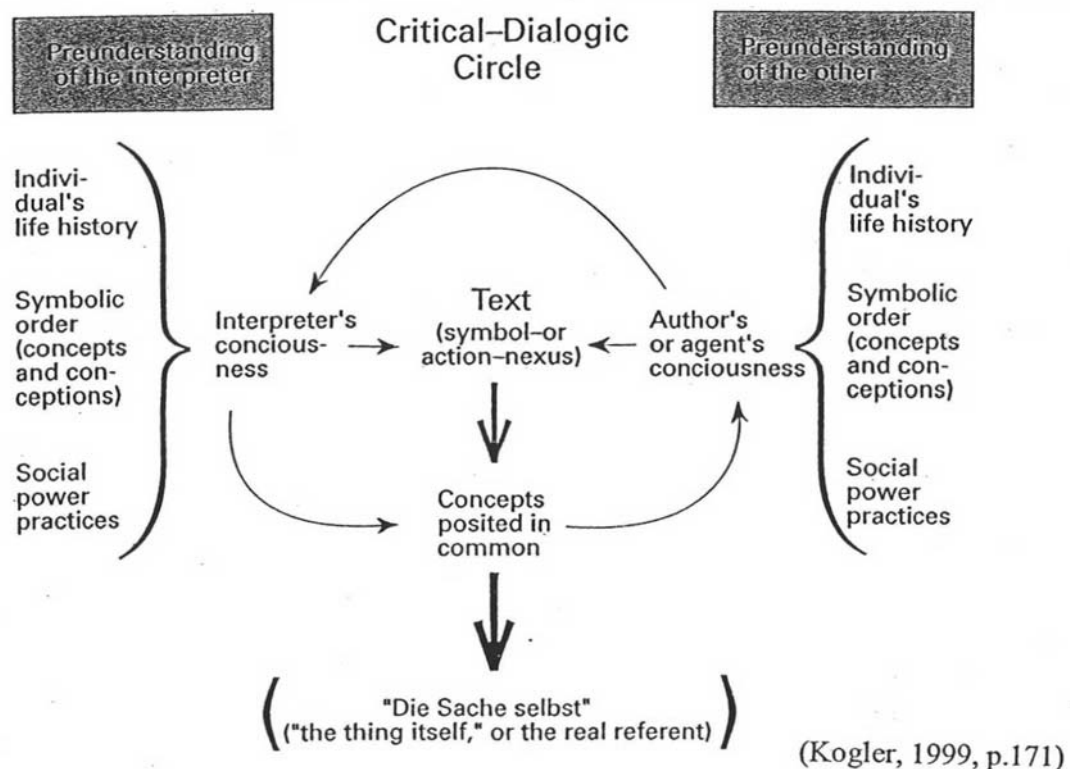
However, while the study comes under the umbrella of critical hermeneutics, the process of research was best served - as explained in the following - by employing a methodological strategy which comes from *critical interpretation* as formulated by Hans Kogler. A methodological approach, which is informed by *critical interpretation* underpinned by the philosophical insights of Gadamer and Foucault, has much to offer a research process which seeks to uncover that which shapes understanding and practice.

Towards critical interpretation

Kogler’s project of *critical interpretation* seeks to bring together the analytical tools of discourse analysis (analysis of power practices and structures) along with the insights of hermeneutics with respect to the “nature of preunderstanding and the dialogic nature of interpretation” (p.2). Kogler (1999) claims that philosophical hermeneutics, critical social theory, and, in particular, discourse analysis are not incompatible. Ricoeur (1991) supports such a stance in that he claims the moment hermeneutics and critique become radically separated they will “be no more than ideologies” (p.307).

To this end, Kogler (1999) argues that the question of power for hermeneutics becomes inevitable if hermeneutic reflection is taken far enough. Likewise, reflective social critique will inevitably have to acknowledge the 'situatedness' of critique, and Kogler goes as far as to talk about a hermeneutic grounding of discourse analysis. Hermeneutics is used here in the sense of a "consciousness that recognises that interpretive understanding must proceed from preunderstanding" (Kogler, 1999, p.1). Kogler (1999) claims that his hermeneutic grounding of discourse analysis does little more than clarify how analysis is linked to preunderstanding. In effect, Kogler (1999) seeks to make possible a hermeneutic approach that seeks both distance from and description of that which is understood. This study seeks to bring about such distance and description of understanding and practice in relation to intervention in childbirth through an analysis of the discourses and power structures which inform and shape the same. To this end, the model of critical dialogue, which Kogler captures in his critical-dialogic circle (figure, M1), illustrates the process that can lead to distance, description, "power critique and the formation of new, reflectively aware concepts" (Kogler, 1999, p.172).

Figure M1.



The philosophical underpinnings of critical interpretation

Kogler is essentially interested, as presented in Figure M1, in facilitating an analysis of power practices and how they shape and influence one's own as well as others' preunderstanding (Kogler, 1999). To this end, Kogler draws on a number of philosophers such as Gadamer [1900-2002], Heidegger [1889-1976], Foucault [1926-1984], Bourdieu [1930-2002], Saussure [1857-1913], Taylor [1931-], and Habermas [1929-] (Kogler, 1999). However, Kogler believes, as already indicated, that the most promising path to understand understanding and the interpretive act is in a "methodological mediation" between insights developed by Gadamer and Foucault (Kogler, 1999). I present the work of Gadamer, Heidegger and Foucault insofar as it underpins and informs the stance Kogler takes. Alongside this I also show how Kogler differs from these philosophers and how he develops their ideas to make possible the stance of *critical interpretation*.

The Gadamerian concepts of preunderstanding and dialogue

The Gadamerian concepts of preunderstanding and dialogue which are central to Gadamer's hermeneutic position are viewed by Kogler as enabling a productive analysis of the interpretative act. Preunderstanding and dialogue make possible such an analysis to the extent that the hermeneutic background of interpretation and the hermeneutic orientation of the interpreter is able to be "thematized" (Kogler, 1999). Dialogue and preunderstanding provide an important first step in the research process in that the voices of the participants are made present through dialogue. This in turn reveals their understandings and consequently preunderstandings (background and orientation) so that the notions, events and ideas that shape understanding and practice are able to be identified and eventually thematized. Gadamer claims that "every act of understanding discloses another's meaning against a shared historical background that binds text and interpreter together" (Kogler, 1999, p.25).

He states:

The real meaning of a text, as it speaks to the interpreter does not depend on the contingencies of the author and his original audience. It certainly is not identical with them, for it is always co-determined by the historical situation of the interpreter and hence by the totality of the objective course of history (Gadamer, 2002, p. 296).

Kogler (1999) claims that from a Gadamerian perspective, understanding is subject to an historical-cultural preunderstanding and insofar as preunderstanding makes possible understanding, “it is impossible to get behind preunderstanding” (p.88). This background on which every interpreter has to draw, and which is made known through linguistic disclosure is, according to Gadamer, always beyond the control of the interpreting subject (Kogler, 1999). Kogler claims that this stance leads to Gadamer’s strong thesis that interpretive understanding is beyond subjective control and is in effect a “trans-subjective event” of dialogue (Kogler, 1999). In other words, an individual’s understanding is not an event that is determined by that individual but rather it is something she is involved in and goes through (Kogler, 1999). To this end, Gadamer claims that “subjective reflection is always subordinate to tradition”, which in effect means that the interpreter is unable to “bring forth in a thematically open manner the basic assumptions that internally determine her” (Kogler, 1999, pp.34, 25).

In fact history does not belong to us; we belong to it. ...the self awareness of the individual is only a flickering in the closed circuits of historical life. *That is why the prejudices of the individual, far more than his judgments, constitute the historical reality of his being* (Gadamer, 2002, p.276-277).

Gadamer presents interpretive understanding as essentially a linguistic and linguistically determined process in which preunderstanding in turn is grounded and embedded in language (Kogler, 1999). Language and world are presented from a Gadamerian stance as being in union with one another. The subject is always within a linguistically disclosed world: “through a text or conversation this linguistic world disclosure establishes the framework with which subjects are mutually able to relate themselves to something” (Kogler, 1999, p.41).

Gadamer states:

The structure of the hermeneutic experience ...itself depends on the character of language as an event...what constitutes the hermeneutical event proper is not language as language...it consists in the coming into language of what has been said in the tradition ... it really is true to say that this event is not our action upon the thing, but the act of the thing itself (Gadamer, 2002, p. 463).

Language and understanding are linked to one another, in that language is seen to be the “basis of every hermeneutic theory”, insofar as being is “elementarily linguistic” and the being of language consists precisely in the “bringing into language of being” (linguistic ontology) (Kogler, 1999, p.37). In other words, language for Gadamer “ontologically encompasses reflective consciousness” and gives rise to the view that the nature of understanding is a “transsubjective event” (Kogler, 1999, p.37).

For Kogler, the difficulty with Gadamer's analysis is that the ‘how’ of understanding is expanded one-sidedly in the direction of an understanding that comprehends truth (Kogler, 1999). Unity and common truth (which is the basis of Gadamer's linguistic ontology) is placed at the centre of dialogic attitude (Kogler, 1999). In other words Gadamer, in his linguistic ontological grounding of understanding, presents understanding and the uncovering of meaning as always being directed toward the subject matter (truth) and an event in which reflective subjectivity and individuality has no place (Kogler, 1999). Gadamer's linguistic ontology, which conceives understanding as a dialogic event of truth, in the sense of an unfolding and deepening of a shared view oriented towards the subject matter, appears to Kogler to be constraining and limiting to an open understanding of meaning (Kogler, 1999).

This constraint and limitation is something that needs to be overcome methodologically, in order to facilitate the exploration and revelation of the shaping of understanding and practice. A methodological stance is required, in which meaning revealed by individuals, is linked to that which shapes and brings about meaning and is perceived as truth rather than a stance orientated to pre-existing truth. To this end, the Gadamerian idea of language as “productive dialogue in which substantially different views confront one another and ultimately are fused into a new and deeper insight” is viewed by Kogler as important in developing *critical interpretation* (Kogler, 1999, p. 68). Kogler believes the Gadamerian concept of dialogic understanding can be retained and conceived in a new way. According to Kogler, dialogic understanding cannot be seen to proceed from Gadamer's idea of “universal consensus or from the idea of a prior being-in-the-truth” (Kogler, 1999, p. 84).

Rather, Kogler's presentation of dialogic understanding has the more modest objective of making present one's own and the other's constraints and limits of understanding ensuring that understanding becomes "a reciprocal, critically challenging process with the other, but without the metaphysical guarantee of a comprehensive truth and without the further (albeit assured) goal of a final consensus" (Kogler, 1999 p.84).

For these reasons, Kogler suggests that Gadamer's thesis - that understanding is a trans-subjective event, and subjective reflection is necessarily subordinate to tradition - is too strong. He would rather see understanding as a reciprocal interplay between implicit assumptions of one's own interpretative premises and another's meaning (Kogler, 1999). Through this reciprocal interplay, the "symbolic experience of another's meaning can be set out and at the same time, the ontological potential for hermeneutically overcoming the constraints of one's own preunderstanding" that one brings into the dialogic situation of interpretation is made possible (Kogler, 1999, p.84). Therefore, instead of differing views being "dialogically synthesized into a unified truth", Kogler claims that he will show that preunderstanding is "a structural complex, differentiated through symbolic assumptions, social practices of power and individual meaning perspectives that are articulated through interpretative acts" (Kogler, 1999, p.68). Kogler accepts that Gadamer's philosophical hermeneutics is important insofar as it opens up the possibility of viewing dialogue methodologically, reciprocally and critically. To this end, Kogler (1999) retains the concept of dialogic understanding, preunderstanding and linguistically determined understanding as he seeks to unfold a theory of dialogic intersubjectivity, in which differing views enable a differentiation of and a "getting behind" preunderstanding. This differentiation of preunderstanding is essential, not only to show how power practices influence preunderstanding, but also to support Kogler's own differentiation of preunderstanding into symbolic orders, power practices and individual perspectives. The development of Gadamer's notions of dialogue and preunderstanding by Kogler in this way provide the groundwork from which a methodological framework for this study has been developed in order to show how understanding and practice is shaped.

Heidegger's three-faceted account of fore-structure

Kogler deals with Gadamer's position and his own need to differentiate the features of preunderstanding by taking into account Heidegger's three-faceted account of the ontological background of understanding (Kogler, 1999). This three-faceted account of fore-structure, Heidegger designates as fore-having (the social context), fore-sight (the interpreter's context) and fore-conception (determinate conceptual scheme) (Kogler, 1999).

Kogler's model of *critical interpretation* is framed by a similar differentiation in which he speaks of a practical sphere of acquired habits and practices, a symbolic sphere of assumptions and beliefs, and a subjective sphere that reflects biographical events (Kogler, 1999). For Heidegger, the three features of fore-having/sight/conception "constitute the formal framework of ontological preunderstanding – that is, of our projection of being that is always already brought into every thematic interpretation" (Kogler, 1999, p.89). Kogler (1999) claims that these features (fore-having/sight/conception) "constitute aspects of the being of Dasein (as understanding)" in that they provide a background that is impossible to avoid with regard to every explicit interpretation insofar as "they determine the explicit meaning to be grasped in interpretation precisely through the prior constitution of meaning" (Kogler, p.89).

In Heidegger's view:

The interpretation of something as something is essentially grounded in fore-having, fore-sight, and fore-conception (Heidegger, 1996, p. 141).

The knowing of something (in which something becomes intelligible as something) is always subject to the meaning having already been constituted and so in part remains always subject to "substantial and never fully recoverable preunderstanding" (Kogler, 1999, p.89).

But the significance itself with which Dasein is always already familiar contains the ontological condition of the possibility that Dasein, understanding and interpreting, can disclose something akin to "significations" which in turn found the possible being of words and language (Heidegger, 1996, p. 82).

Heidegger seeks to identify the phenomena of the world and to identify them as prior disclosure of being (Kogler, 1999). This position of Heidegger's presents a problem for Kogler because it means that the subject always finds herself in a prior context. This problem is centred around the concern that "from within the framework of the a priori of readiness to hand it is not possible to conceive a dialogically open relationship of the other that allows the other to exist in her alterity as co-subject while still enabling one to relate critically to oneself" (Kogler, 1999, p.90). In effect, the assumptions that underlie Heidegger's stance mean that it is not possible to unfold an adequate theory of dialogic inter-subjectivity (Kogler, 1999). In contrast to the "a priori of readiness to hand" nature of preunderstanding, Kogler wants to claim that "an approach that views language as the co-original mediating dimension of our preunderstanding opens up a dialogic experience of worldhood" (p.91).

Kogler, in contrast to Heidegger who could only contemplate the experience of the phenomenon of worldhood as an "implicit and precociousness process", asserts that through the "symbolic disclosure of other horizons of meanings, the phenomenon of worldhood becomes experientiable... a reflective distance to one's own worldhood is effected" (p.91). In other words, the participation and socialization into cultural practices is possible not only because someone is linguistically able, but because they understand at the same time the symbolic order and the discourses that exist within the practices of everyday events (Kogler, 1999).

Kogler (1999) points out that "religious practices are inconceivable without a horizon determined through theological concepts", as are the practices of measurement and statistical analysis without scientific research (p.91). Even everyday practices such as shopping, exercise, and what is eaten for breakfast also remain completely unintelligible without having "embedded linguistically explicable meaning" (Kogler, 1999, p.91). Therefore, inherent in cultural practices is an understanding that encompasses language, yet these practices cannot be reduced to language. The constitution of meaning cannot be given over to language as the most fundamental dimension of being (Kogler, 1999).

Rather, Kogler claims that the features of preunderstanding – a practical sphere of acquired habits and practices (fore-having), a symbolic sphere of assumptions and beliefs (fore-conception), a subjective sphere that reflects biographical events (fore-sight) - need to be viewed not as background of an implicit and preconscious process but as background of “linguistically mediated and linguistically achieved dialogue” (Kogler, 1999, p.91). While the background always has a perspective particular to any individual and her place within a particular society and culture the symbolic and the practical are to be reframed as “meaning-constituting and meaning-shaping dimensions of the interpretative act ... [they are] to be correlated intrinsically with the specifically situated and experienced self-understanding of the individual” (Kogler, 1999, p.6-7). In other words the acquired habits, practices, assumptions and beliefs which inform and give meaning to an individual are shaped and constituted and the practical and symbolic spheres can be seen to be bringing about this shaping and constituting.

Therefore Kogler claims that the fore-having and the fore-conception can be reconceptualised as meaning-constituting and meaning-shaping dimensions of the interpretative act rather than the “projection of being that is always already brought into every thematic interpretation” (Kogler, 1999, p.89). Kogler (1999), inspired by Heidegger’s fore-structure of understanding, seeks to formulate a model of preunderstanding that will integrate “symbolic assumptions (fore-conception), social practices (fore-having) and the individual’s perspective (fore-sight) and allow him to distinguish between different discursive orders, social practices and individual perspectives. Kogler (1999) in effect seeks to separate the analysis of the fore-structure from the hermeneutics of Dasein so that he can incorporate this analysis (the fore-structure) into a dialogic conception of understanding.

However, to carry out such a project Kogler needs to specify how the “operation of power on preunderstanding can be grasped conceptually and thematized critically” (Kogler, 1999, p. 93). Kogler (1999) proposes three steps in his efforts to show the “implicit structuring of our understanding and preunderstanding through power” (p.93). The first step in effect analyses how the “explicit linguistic understanding of something as something depends primarily on implicit background assumptions” (fore-conception) (Kogler, 1999, p.93).

The second step seeks to show to what degree this “symbolic predisclosure is permeated by social practices” (fore-having) (Kogler, 1999, p.94). The third step sets out to show the extent to which “the individual perspective of the interpreter is co-determined by these power practices” (fore-sight) (Kogler, 1999, p.94). These three steps make available a process by which the data in this study was initially approached. The steps provided a ‘way into’ uncovering the shaping of practice and understanding in relation to intervention in childbirth.

These three steps which inform the research process revolved around:

1. coming to an awareness of *that which is* the ‘thing in itself’ - that which is disclosed to thought as an object within conversation
2. recognizing the shaping of *that which is*
3. analysing the relationships of power and structures of domination and their role in constituting what is viewed by an individual as reality (*that which is*).

This process was underpinned by Heidegger’s fore-structure of fore-conception/having/sight which Kogler presents as the practical, symbolic and subjective spheres, which provided for the purposes of this study a methodological framework that further processed the information gained from using the three steps presented above. This process and framework were further refined for ease of use, which led to the data being approached and analyzed from four angles: the worldview of the individual, the world of social practices, the discursive layer (symbolic orders), and the relationships of power and structures of domination. The interaction of these layers during the process of analysis led to a description of that which is constituting the constituted, or in other words that which is shaping practice and understanding.

This research process and methodological framework are presented in depth in the methods chapter. However, for the moment it is important to note that the gaining of insight into what is shaping practice and understanding which is at the heart of this research process, requires a methodology that is capable of showing the shaping and the shapers: in other words, the operation of power on preunderstanding. Kogler seeks to develop such a methodological base through using and reinterpreting certain Foucauldian concepts.

Foucauldian concepts of episteme and discourse

Kogler (1999) reframed the notion of fore-conception with the Foucauldian terms ‘episteme’ and ‘discourse’. Episteme is that which is formed through an “inner structure...which is given in things as the inner law and hidden network (Kogler, 1999, p.95). Discourse is presented as that which “determines the horizon and background for the experience of objects, subjective speaker roles, the conceptual field and thematic options” (Kogler, 1999, p.96) and as that which ... “is defined as a group of statements that belong to a single system of formation; thus I shall be able to speak of a clinical discourse, economic discourse” ... (Foucault, 2003, p.121). Discursive practice is, described as a “body of anonymous historical rules, always determined in the time and space that have defined for a given social, economic, geographical or linguistic area the conditions of operation” (Foucault, 2003, p.131).

Kogler (1999) claims that the early Foucault “broke with the discourse-extrinsic conception of meaning” (the implicit-explicit) in a way that serves well a “hermeneutics that proceeds from the impossibility of going beyond language” (p.94). Foucauldian discourse analysis in effect recognises that “objects and subjects are relative to and constitutively dependent on discursive disclosure of meaning” which gives rise to the possibility of showing how “power practices are capable of operating within the symbolic order of discourses and dialogue” (Kogler, 1999, p.94).

The distinction that Foucault makes between the symbolic discursive and social power practices is central to the formulation of Kogler’s *critical interpretation*. Kogler (1999) claims that such a differentiation enables individuals to understand themselves as situated, and facilitates a critical stance from which it is possible to gain insight into how power structures that are embedded in social practices and institutions give a particular meaning to a particular event which is seen as reality. The pursuing of this distinction between the discursive level and that of social practices also provides a starting point and makes possible a process of research which sets out to show the shaping of understanding and practice in relation to increasing intervention in childbirth.

The Foucauldian concepts of “archaeology” of discursive formations (analysis that reveals symbolic structures) and the “genealogy of power practices” (techniques of normalization, control and exploitation) inform, give structure and detail to the project Kogler has undertaken (Kogler, 1999, p.175). Kogler (1999), in effect, wants to take the insights gleaned from archaeology and genealogy and integrate them into a “dialogic hermeneutics”, but in a way that will allow preunderstanding to be seen as “constitutive for interpretive understanding” (p.179). To this end, Kogler (1999) seeks to show how a critical discourse analysis that accepts that preunderstanding is constitutive for interpretive understanding is possible. In this way Kogler develops but differs from Foucauldian analysis.

Kogler’s “hermeneutic reconceptualisation of discourse analysis” in effect turns the hermeneutic insight that it is “impossible to transcend language” into the claim that interpreters are always subject to specific discursive orders (p. 96). Kogler (1999) believes the claims that language is an all-encompassing event has to be curtailed. In effect, dialogue makes it possible for an interpreter to get behind meaning and to critically review discursive limits – “thereby opening up a space for subjective-critical activity” (p.96). Kogler (1999) claims that by “introducing the concept of episteme at the ontological layer of the fore-conception of dialogic speakers, the abstract sublation of subjects within the event of language (Gadamer) as well as their concrete confinement within discursive orders (Foucault) are overcome” (p.97).

In effect, through the dialogic process an individual can gain a position to view that, which they are within. The hidden networks and inner laws which determine and constitute this position can, if only ever partially and in the moment, be known. The stance that Kogler takes in formulating *critical interpretation* requires him to account for the influence power has on social practices, the discursive symbolic layer of meaning and an individual’s worldview (Kogler, 1999). Likewise this study is required to develop a process whereby the relationships of power that shape understanding and practice in relation to increasing intervention in childbirth can be accounted for.

To this end, Kogler argues that:

Inasmuch as understanding involves individualizing rather than normalizing, interpreting rather than objectifying, pluralizing rather than encompassing - in short a radically dialogic process - we can free ourselves from our own potentially power determined preunderstanding through an understanding of the other disclosed in this dialogic way (Kogler, 1999, p.109-110).

In effect, Kogler claims that it is possible - by means of understanding self, related social practices, and the influence of power - to give back to agents “a space for reflection and action over against established interpretations and structures of domination” (p.239). It is this space that is required for the present research process which seeks to show the shaping of practice and understanding, and this space is readily provided by using frameworks based on Kogler’s formulation of *critical interpretation*. To account for these methodological requirements, the concepts that underpin and guide Kogler’s project of *critical interpretation* are presented in the following section of this chapter. The methodological processes, frameworks and method that were developed from these concepts for the purpose of carrying out the research and analysing the data are presented in the methods chapter.

The concepts that inform and underpin Kogler’s critical interpretation

Power, domination, freedom

Power

A key concept in any study which is aligned with a critical stance is the notion of power. Kogler (1999) readily acknowledges that structures of power exist and that the social world is made up of many diverse power relationships, but he does not in any way reduce the social world to power and power alone. Rather the world and society is seen as disclosing itself through a “multithreaded interpretive framework” into which power structures are tightly woven (Kogler, 1999, p. 232). To this end, Kogler aligns himself with the early Foucault, whom he claims did not subscribe to a “totalizing theory of power” in which power is seen to be an “exclusive ontological substrate of social relations” or the “metaphysical ground of every symbolic or social meaning, action or knowledge” (p.231-232).

Kogler (1999) views power as existing between individuals, groups or social institutions and as cutting across these groups, rather than being the right and property of a particular class or group of people. Kogler does not believe that a situation of power, in and of itself, is necessarily negative. However, Kogler (1999) also believes that it is methodologically impossible to “outstrip power” insofar as “understanding cannot be assured a preunderstanding that has always evaded the structures of domination” (p. 232). He highlights the need to explicate and make overt the effects of power on our own and others’ thought (Kogler, 1999). In effect, this process of explication and making overt makes possible analysis of the subject matter insofar as it facilitates an awareness of the relationships of power that give rise to certain understanding and practices.

Relationship of power

Kogler calls on Foucault in defining a relationship of power as “a mode of action which does not act directly and immediately on others; instead it acts upon their actions, an action upon action, on existing actions or on those which may arise in the present or the future” (Foucault, 1983, as cited in Kogler, 1999, p.233). From this stance Kogler (1999) presents power relationships as confrontations between individuals each seeking to advance their own interests. Power relationships are viewed as intersubjective and are potentially reversible insofar as they do not contain an “a priori fixed structure or causality” (Kogler, 1999, p.235). However, Kogler (1999) suggests that for an individual, reality often appears to be “ontologically fixed and causally irreversible” (p.235). Whereas, a particular way of being is none other than the product of “symbolic world disclosures that paradoxically attempt to do away with the dimension of reversibility...by establishing a firmly united world picture that joins together reality and social hierarchy” (Kogler, 1999, p.236).

It is important that a research process which seeks to explicate the shaping of understanding and practice can proceed from a position in which these things are not in themselves viewed as fixed or irreversible. In other words, there has to be a process by which the “united world picture” that power relationships present can be prised open to reveal that which shapes. To this end, *critical interpretation*, which proceeds from the tension between self-understanding and power structures, helps to “break the spell of power-laden forms of identity, thereby opening up possibilities for reflexive self-determination and self-empowerment” (Kogler, 1999, p.243).

This is the moment in the research process when the shaped (understanding and practice) and the shaping of the same are placed side by side so that the power relationships determining such understanding and practice can be recognized.

Domination, Freedom and Resistance

Kogler (1999) claims that the later Foucault made an important distinction between the notion of ‘power’ and ‘domination’. An analysis of power in the dialogic model of *critical interpretation* sees freedom and free individuals as a condition for power and sets out to determine to what degree there is a lack of freedom in any given power relationship (Kogler, 1999). The exercise of power can be seen to eliminate this potential freedom and to transform individuals into subjects of structures of domination (Kogler, 1999). A power relationship that can no longer be reversed or made fluid by an individual is in effect domination (Kogler, 1999). An analysis of power within this model of *critical interpretation* will therefore need to determine if there is a predisposition in a power relationship to negate freedom.

Kogler (1999) claims that for Foucault the recognition of the other as a free subject is “objectively built into” any power relationship, for within all such relationships, individuals set out to shape the wishes, goals, expectations and thoughts of others (p.234). However, an individual who has been shaped in a way that serves the interests of a particular group can be seen to be in a power relationship of domination, which negates her freedom. It is important to note that these structures of domination “are built into the symbolic order itself and they belong structurally though not consciously to the world view into which a subject qua socialization and culturalization is integrated” (Kogler, 1999, p.237). In effect, Kogler (1999) claims that social relations have inscribed within them the interests of structures of domination which mould individuals into subjects that reflect these interests. These structures of domination are seen to “reproduce themselves through social interactions inasmuch as they turn the individuals through socialization processes, into bearers and producers of these structures” (Kogler, 1999, p.238).

Kogler (1999) claims these structures of domination are fused “with an implicitly authorized understanding of reality which allows them to be seen as legitimate and to appear to correspond to the natural order” (p.237). This is illustrated by the fusion of concept and conception, insofar as a particular concept such as cultural experience of birth, pain, or even racial superiority is determined through conceptions based on deep-seated ontological premises, and is then confirmed and validated by the experiences of culture and the individual’s experience (Kogler, 1999). Therefore, it is feasible to see that when a concept is separated from its conception, and understanding from explanation, and that which is shaped is mistaken for reality, then a negation of freedom in terms of what is understood as possible is brought about.

However, Kogler (1999) argues that the “positing of shared concepts can lead to a disclosing of the corresponding conceptions and underlying assumptions and that concepts themselves help to form an interpretive bridge” (p.171). Paradoxically the very interaction of shaping, forming, informing and influencing which is at the heart of every power relationship of domination, also means that such relationships are reversible. This means that the socialization and domination of individuals to systems and structures is never absolute or complete (Kogler, 1999). To this end Kogler (1999) talks about resistance which begins with identifying and describing relations of domination because there is in effect no relationship of power which potentially cannot be changed or transformed. Kogler argues that the critical task is to provide opportunities for such resistance in that it needs to “lay bare and to unmask the process of normalization and habitualization which turn individuals into subjects preformed through specific dominations” (Kogler, 1999, p.238).

Critical interpretation informed by the Foucauldian distinction between power and domination and the notions of freedom and resistance create a space, according to Kogler, in which a “hermeneutic critique of power can situate itself” (p.236). It also provides a space in which the research process of this study through dialogic interaction can differentiate between that which is understood and practiced (perceived to be fixed and irreversible - domination) and that which is shaping understanding and practice (potentially reversible –power).

This is illustrated by Wolf (2001), who discovered when interviewing women for her book *Misconceptions* that practices such as episiotomies, caesarean section rates, and epidurals were not about biology, but rather about litigation, politics, vested interests, money, and beliefs about who holds the power in the delivery room. *Critical interpretation* sets out to unmask the shaping and shapers of such assumptions that have led to a ‘normalization’ and ‘habitualization’ of certain practices and understandings around childbirth. This study sets out to analyse the structures of power relations in such a way that the one-dimensional picture that presents understanding and practice and the structures of domination as one and the same can be prised open to reveal the multi-dimensional nature of the relationship.

Kogler (1999) believes that “power prevents human existence from corresponding to its own self understanding” (p.244). It is important to note at this point that the importance of analysing power relationships and structures of domination is primarily about the extent to which they impede or hinder an individual’s or a community’s ability to be self determining (Kogler, 1999). This is one of the reasons this study was undertaken in the first place, because discussion (anecdotally) more often than not put the explanation for the increasing rates of intervention at the door of women. It is not unusual to hear reasons for the rising rates of intervention such as: it is women’s choice, this is what women expect, this is what women want and so on, as if women decide in isolation what they choose, and what their expectations are. The impeding of self realisation by social structures is something that this study set out to understand, and the concepts of power, domination, freedom and resistance as presented by Kogler provided a sound starting place for such a process.

Social practices

Social practices in Kogler’s *critical interpretation* are the concrete expression of the fore-having (social context). They are, in effect, the patterns of actions that through “ritualized repetitive action inscribe and reproduce themselves in the individual’s mode of behaviour, gestures and movements” (Kogler, 1999, p.98). These practices form a network of “socially pre-given contexts of purposes and ends into which the individual is socialized through practical and often unconscious means” (Kogler, 1999, p.92).

They are related to power insofar as they draw a boundary between what is real and reasonable, nonsense or fiction, and regulate and decide in part what is truth and reality (Kogler, 1999). Power-laden social practices shape meaning and constitute the background of interpretive subjects and their focus is the practical constitution of meaning (Kogler, 1999). This understanding of social practices provides an important cornerstone in the research process of this study insofar as it presents a starting place for an analysis of what regulates and determines understanding and practice.

Symbolic orders

Kogler (1999) draws on Saussurian semiotics to show that cultural meaning and social practices can be analyzed according to an internal structure. Kogler believes that the analysis of the symbolic organization of cultural meaning and practices according to its internal structure enables a genuine symbolic sphere to be acknowledged: a sphere where meaning and understanding is organized. He claims that while this approach frees meaning from a pre-symbolic reality, the structuralist and poststructuralist must show how an implicit structured order relates to the explicit understanding and the experience of a person's world (Kogler, 1999).

Symbolic orders create meaning and understanding for individuals, insofar as meaning and understanding is structured and organized in such a way that these orders are 'implicit in every explicit' understanding (Kogler, 1999). In other words, this is the discursive layer at which meaning is given to certain things, and the internal rules of discourse are created so that there are certain ways to think, behave, practice. Kogler would claim that to understand a symbolic order it is necessary to "grasp the regulative function of basic ontological assumptions that gives statements, perceptions and actions their meaning within a particular context" (p.180). Symbolic orders are a system of ideas with a common form which discursively frames experience so that what is real and counts as legitimate is in effect specifically set out (Kogler, 1999).

To lay out and reconstruct the symbolic order that underlies the meaning of particular concepts within historical-cultural contexts requires that “the ontological premises that function within such an order as the rule engendering truth, relevant statements and experiences” be revealed (Kogler, p.181). Experiences such as pregnancy and birth can be shown to be constructed from and informed by such premises – a construction that for the most part remains concealed within the understanding, experience and practice related to childbirth. However, these premises do carry within them an authority that shows itself as the product of specific rule systems and specific beliefs about how things should be and as such give credence to one way of seeing the world over another.

Monto (1997) claims that while individuals are socialized into rule systems throughout their lives, there are times in life, like pregnancy and birth, when this socialization is intensified. Monto (1997) would go as far as to say that during this time there is an intensive and even aggressive communication of dominant cultural definitions and meanings of what it is to be pregnant and how one should birth. Such authority within ontological premises of how something should be, consequently reflect the interests of and give power to certain groups. It is these premises that confer authority and reflect certain interests that the research process of this study endeavours to uncover.

A methodological dilemma

The central concern of this research process is to show how practice and understanding are shaped. This presents the methodological dilemma of how the research process, and the researcher herself, can escape such shaping. Kogler (1999) claims that preunderstanding and the worldview of the interpreter is influenced by power which is mediated through symbolic orders and social practices which shape all background knowledge. If this is so, then understanding requires preunderstanding which depends “ontologically on historical and cultural meaning contexts” (Kogler, 1999, p.105). This in effect means that understanding is ‘power saturated’ and as such, traps one in a problematic circle from which it is difficult to envisage an escape. The interpreter cannot free herself from her own particular preunderstanding, (which is always to some degree dependent on and determined by power relations), because in order to understand, this is the very thing she needs to draw on (Kogler, 1999).

Therefore, how can a researcher, who seeks to reveal the shaping of understanding and practice, stand outside a shaped ‘power-saturated preunderstanding’? In effect, how is it possible to know if the understanding and analysis that is revealed in this study has itself escaped the influences of power and domination? The question becomes one of how to methodologically ‘outstrip power’, so that it is possible to carry out an analysis which does more than reflect the socialization of the research participant and researcher alike.

Kogler (1999) believes that a stance of critical dialogue is possible, insofar as the confrontation with “differing views, assumptions, and practices ...triggers a process of self distancing and a stance of reflexivity, whereby” one is able to recognise “the hidden aspects of the other’s and one’s own natural understanding” (p.7). Self distancing makes critical understanding possible, in that it enables one to “go beyond and get behind oneself and our own norms” (p.109). Reflexivity is based on a distinction between two forms of ‘subjective-identity’ (Kogler, 1999, p. 269). A person can see herself as having an identity with a certain biographical history, and she can also objectify this self-understanding and see her identity as a result of social and cultural practices and not just biographical details (Kogler, 1999). This objectifying and thematization of the biographical self is what enables the individual to distance herself from the socially situated self (Kogler, 1999).

Critical hermeneutics seeks to produce tension between the “reflexive-distanciated self” and the “situated-biographical self” (Kogler, 1999, p.270). It is the possibility of ‘distancing ourselves’ through the use of dialogic reason that gives one a place to stand, and so be able to critique and dispute the way that things are (Kogler, 1999). In other words, Kogler's hermeneutic analysis centres round the creation of a reflexive distance that enables an individual to examine her own thought and behaviour. Kogler claims that this “critical practice of self-distanciation brings about a heightened sense of self-understanding and insight into usually hidden linkages between symbolic relations and social networks of power” (Kogler, 1999, p.252). Kogler in bringing together hermeneutic and distancing reflexivity presents a “novel conception of reflexivity’ in that reflexivity is presented as “dialogic mediation” (Hendrickson, 2004, p.384).

This process of analysis which is based on unfamiliarity and uncovers contrasting beliefs, assumptions and practices can lead the interpreter and, in this instance, the researcher to review her own previously unquestioned background (Kogler, 1999). Points of difference and unfamiliar features can lead to a new self understanding as the constraints and limitations of another's and one's own worldview are recognised and explored (Kogler, 1999). This approach makes it possible to gain some freedom in relation to those things that may be shaping understanding and practice insofar as it enables the process of research to 'get behind' the meaning to see that which is shaping understanding and practice. This process of dialogue which facilitates encountering difference and the unfamiliar provides a space in which reflexive distancing can take place. Kogler (1999) uses historical and cultural examples when discussing reflexive distancing, which means that it is possible that a researcher can almost take up an 'outsider' position in relation to the subject matter. This raises the issue of how such reflexive distancing can take place in one's own culture and time let alone among one's own profession.

Some critics of Kogler claim that there is no difference between 'practical reflexivity' and the reflexivity of 'self distancing' that Kogler attributes to the interpreter which enables the recognition of those things that are constructing meaning (Hendrickson, 2004). Hendrickson (2004) argues that he, like Kogler, is inclined to see the first and third person stances as separate and that there has to be case for structural analysis that can gain distance from a society so to critique that society. Kogler puts a case forward for the movement away from the socially situated self to the reflexively critical self as providing a starting point in which the "spell of social circumstances" is broken, and space for freedom is opened up (Kogler, 1999, p.270). In the distancing of self and the subsequent revelation of the socio-cultural constructions of meaning and practice, individuals create a space for reflection (Kogler, 1999). I would argue that it is possible in using the processes described above to bring about a degree of self distancing between the researcher and her own 'situatedness', the researcher and the participant, the researcher and the data, the researcher and the literature within her own culture, time and profession. The degree to which this dialogic and collaborative process required that I continually critiqued and checked my own position and preunderstandings was unexpected.

Yet it was this very process that ensures the bringing forth of premises that underlay “interpretative praxis” and provides the space for *critical interpretation* and the showing of that which shapes. It is in this reflective space that analysis can take place, over and against established interpretations and influences, which shape practice and understanding.

It is important to note that for Kogler (1999), the process of reflexivity is not seen as leading to total “self objectification” or “alienation of self” but rather is process that develops “a critical and distinctive self” (p.268). The dialogic approach sets out to uncover the hidden aspects of an individual’s context so that they become co-interpreters in the task of uncovering the relationships of power and structures of domination that shape their reality (Kogler, 1999). In this way, both self understanding and social context are an indispensable “point of departure (and point of return)” for *critical interpretation* (Kogler, 1999). Kogler (1999) claims that the critical self he presents is modest in scope and dialogic in nature and while distanced is “still tied to its context, albeit reflectively” (p.273). This stance is important to this research process, in that the self understanding and the social context of the participants is the starting point, and the ‘way into’ recognizing that which is shaping understanding and practice in relation to intervention in childbirth.

While Kogler has shown how unfamiliarity enables the possibility of a critical self there is still the question of how this methodological stance facilitates the research process. Kogler (1999) claims that through a dialogic process, distancing and reflexivity makes it possible to thematically organize the symbolic order as it is reflected in the social and institutional practices from which individuals have gained their meaning. This dialogic process enables an individual to become aware of the processes of socialization and culturalisation that have permeated their self-understanding. This in turn leads to individuals gaining an awareness of a possible “realized existence” rather than a “stabilization and reproduction of dominant structures” and can lead to an understanding and analysis of the “ontological premises and social structures” which determine and constitute her context (Kogler, 1999, p.245).

Naomi Wolf (2001), as mentioned previously, provides insight into the context surrounding childbirth and she claims that the choices women make in this area are less about what an individual woman wants and more about the vested economic and institutional interests that surround childbirth. Kogler (1999) would claim that in this instance where self-realization around birth and choice is “functionally deflected by domination”, distanciation and reflexivity provide a stance from which it is possible to gain insight into those things that are shaped (p.246).

The process of self-distanciation and the stance of reflexivity provide an important spring-board for this study, insofar as they create a space in which to realize something of that which is shaping practice and understanding. Kogler claims that *critical interpretation* is primarily a process of “truly reciprocal elucidation” and that it is only through “co-operative dialogue” that things that invisibly shape meaning and behaviour can be thematized (Kogler, 1999, p. 263). This process of co-operative dialogue happened naturally in all the interviews and was an important feature of and guide for the analysis that followed. The process, in effect, enabled the researcher - and at times the participants - to recognise the hidden aspects of understanding, and in that moment to gain insight into their “situatedness” and the shaping of practice and understanding in relation to increasing intervention in childbirth.

Summary

This chapter has presented the philosophical underpinnings of *critical interpretation*, namely: hermeneutics and discourse analysis and specifically Gadamer’s preunderstanding and dialogue, Heidegger’s fore-structure of understanding, Foucault’s distinction between the symbolic discursive layer of reality and social practices, and the Foucauldian notions of episteme and discourse. It has also presented the methodological considerations of *critical interpretation* such as power, power relationships, freedom, domination, resistance, social practices, symbolic order, distanciation and reflexivity. Throughout this chapter there have been suggestions and glimpses of the translation of these philosophical underpinnings and methodological considerations into a method for carrying out the processes of interpretation and analysis required for this study. The following chapter illustrates how these underpinnings of philosophy and methodology are formulated into a method that facilitates the process of research in this study.

Chapter Four

Methods

The previous chapter presented the philosophical underpinnings and methodological requirements of *critical interpretation*. This chapter presents the method, the methodological processes and framework/s that guide the research process of this study. The method brings together the insights of hermeneutics and the analytic tools of discourse analysis, as presented in the previous chapter, in order to create a space that ensures distance from and description of those things that are shaping practice and understanding. The methodological and philosophical underpinnings that guide the research process of this study and inform the methods used to gather and analyse data are formulated into a template which reflect the individual perspective (worldview), the world of social practices, discursive symbolic orders and the relationships of power and structures of domination as presented in the methodology chapter. This template underpins and informs the process of research and provides the ‘method’ of research. What follows is an explication of the template, an explanation of the method, and an illustration of the methodological framework. This clarifies how the data was approached and analyzed, so that insights could be drawn, to show the shaping of practice and understanding.

Identifying the participants and obtaining their worldviews.

The capturing of the worldview is informed by hermeneutics and it is here that the voices of the participants are heard and the articulation of ‘that which is shaping understanding and practice’ takes place. In other words, this is the talking, listening, and initial writing phase of the method in which the subject matter through the dialogic process of interview shows itself to the researcher. This phase ensures that the participant is able to inform me of their worldview, and what has influenced and shaped their experience, practice, understanding, and preunderstandings. It involves the collecting, transcription and the reading of the data as well as the categorising of the data into themes. At this point in the research process, practice and understanding (that which is shaped) is identified. It is here that the Gadamerian ideas of preunderstanding and dialogue inform the method insofar as it is necessary to thematize the background and context of the participant in order to understand what is shaping practice and understanding.

The participants

Interviews of five midwives, four obstetricians, and six focus groups of the public involving 33 people took place during the research: i.e. a total of 42 people. All of these participants reside in the greater Auckland region in New Zealand. In the interviews with the health professionals six women and three men were interviewed, and all but two of the participants in the focus groups were women. The participants were chosen through purposive sampling because of the researcher's network and her knowledge of the population of doctors, midwives and consumers in Auckland. This knowledge indicated that for reasons of location, interest or practice some practitioners and public were more 'expert' on this topic than others. It was clear that some sectors of society – namely, women who were white and middle class - were increasingly choosing intervention (Ministry of Health, 2006) and so it was important that these women were interviewed. In this way, purposive sampling ensured that those who participated were more likely to have a worldview which would contribute to the emerging knowledge around intervention and the reasons for its increasing use in childbirth. For this reason Maori and Pacifica women who have the lowest rates of intervention were not actively recruited for the study. However a number of Pacifica women who had heard of the study indicated an interest in being interviewed. A focus group was carried out and proved to be an important part of the research. However, in the main the public who were interviewed came from those groups which have been identified statistically as more likely to choose intervention

The number of participants who took part in the research and the amount of data collected was driven by two principles. The first principle was that the purpose of the study was to generate theory and knowledge in relation to intervention rather than test a theory. This means that small samples are adequate to capture a full range of themes emerging in relation to the culture or phenomenon of interest (Polit & Hungler, 1991). The second principle is in relation to the point at which it was determined that no further data needed to be collected. This point was reached when it was clear that additional collection of data is no longer generating new insights (Krueger & Casey, 2000). These two principles in effect determined the number of participants who took part in the study and the amount of data collected.

Ethical considerations:

Protection of the participants: Confidentiality and informed consent.

The health professionals.

The health professionals were all contacted by letter to which the consent form and the letter of information about the research study were attached (Appendix C & D). Potential participants indicated their willingness to be part of the study by either returning the consent form signed, e-mailing or phoning the researcher. They were also given the opportunity to ask any questions or raise any concerns they may have had about being part of the study. If the potential participant did not reply, this was taken as an indication that they did not wish to participate in the study. There were four potential participants who did not reply. One potential participant was approached again as it was doubtful that the first letter had been received and this in fact turned out to be the case. In the other three cases the non-reply was taken as an indication that they did not wish to take part in the study. Once the potential participants had indicated their willingness to take part, a time and place of convenience (which would ensure the interview would remain confidential and the participant anonymous, even though the latter was not always indicated as necessary by the participants) was arranged and the interview took place.

The focus groups of the public

The potential participants were identified through purposive sampling using the researcher's social networks. An intermediary or the researcher, depending on what was appropriate, approached the potential contact participant by phone or email. The contact participant, who was provided with the letter of information explaining the research project and the consent form, spoke to the other members of her particular group (coffee, familial, friendship) to ascertain their willingness to take part in the research (Appendix A & B.). Those who were willing to take part were provided with their own letters of information and consent forms. In one instance I went to the group before the interview and met with them to give out the letters of information and consent forms and answer any of their questions. Ideally the potential participant needed to return the consent form or email to indicate they were willing to take part in the focus groups. This happened more often than not, but there were some occasions when the full informing and gaining of consent of some participants took place on the day of the interview.

However, these participants did know that the research was taking place on that day and turned up expecting to be part of it. There was always the option in this instance for the person not to participate or for their material not to be included but this was not an option taken by any of the participants. Once the consenting contact participant or the participants individually had indicated their willingness to participate, a venue, time and date was arranged for the convenience of the participants. In many of these focus groups children were present. No amount of reading about how focus groups should be conducted can prepare a researcher for the challenging interactions and participation of toddlers. The context of the group, and in particular the children, more often than not influenced the research process, and often dictated when it was time for the interview to end. This was a fascinating and enriching side of doing focus groups with mothers with young children.

The interviews for both groups - the health professionals and the public – were audio-taped, and there was one recorder-transcriber who came to each focus group. The interviews sometimes lasted up to 90 minutes, and on average were about 60 minutes. The role of the recorder-transcriber was to record during the focus group the first word or words of what each participant said. She gave each of the participants a pseudonym which was often related to a colour they were wearing. This process not only facilitated the transcription of the data but ensured accuracy of the transcription. Confidentiality of the participants was protected in that no real names or place names were used in the processing of the data or the final work. Pseudonyms were used at all times, and a confidentiality agreement was signed by the recorder-transcriber and the transcriber. One other transcriber was used for transcribing some of the tapes although I transcribed the bulk of the interviews. The data was kept in a secure computer programme and the floppy disks, tapes and hard copy in a locked filing cabinet, to which only I have access. At the completion of the study the tapes from the focus groups will be destroyed as will those of the health professionals if these participants have not requested that they be returned. The consent forms are kept in a locked cabinet at AUT under the care of the Principal Supervisor and the data will be destroyed after six years. This is in accordance with the requirements of Auckland University of Technology's Ethics Committee (AUTECH) (2001) and the Auckland Health Research Council Ethics Committee (2003), from whom ethical approval was obtained.

While as a researcher I took every precaution to protect and ensure the confidential nature of the interview and the anonymity of the participants (one individual from the other - health professionals and one group from another - the public), some health professionals identified themselves as having taken part in the study. This was something I was not prepared for and initially it took me by surprise. On a number of occasions in the clinical setting some of the participants (health professionals) publicly identified themselves as being part of the study. This led to very interesting discussions which further informed my thinking. On one occasion, purely by chance, three participants (health professionals) and I happened to be in the same place. One of them asked me about the study, and all three readily identified themselves as having taken part in it and proceeded to have a spontaneous focus group on the topic. On another occasion, near the end of the interview, the participant invited other midwives to join in the arranged interview. This also took me by surprise, and I quickly had to ensure that the others fully understood that this was a research study, and gain their consent so that their contribution could be used as part of the data. In this situation, all the participants were interviewed individually. While the researcher's responsibility to ensure the anonymity and confidentiality of the participant is paramount, this process taught me that both anonymity and confidentiality belong to the participant. The responsibility is the researcher's and the ownership is the participant's.

The interviews

Critical interpretation requires that the dialogic process of doing research focuses on the conditions through which meaning is constructed, so that those things that unconsciously shape the participants' understanding and practice (their worldview) are revealed or made visible (Kogler, 1999). This process presented a number of requirements which had to be taken into consideration with regard to the type of interview that would be carried out. It was clear from the outset that neither a conversational style nor a more interrogative structured interview would best facilitate the research process. Therefore, the interviews were semi-structured so that the participants could explore what was shaping their practice and understanding, and I could also direct this exploration as necessary. On reflection, what took place during the interviews - both with the individuals and in the focus groups - was a facilitated conversation.

As I have indicated, the health professionals were interviewed individually (even when the midwife invited other midwives to join the interview), while the public were interviewed in focus groups. Morgan (1997) argues that combining different research methods can strengthen a research project, and that individual interviews and focus groups can be seen as complementing one another. With regard to this research, the individual interviews were used for the health professionals so that an in-depth understanding of their practice and its shaping could be obtained. The quality and depth of insight that the data generated in relation to the practice of health professionals was important in order to gain an understanding of an individual's practice.

Focus groups were deemed to be appropriate for the public because I was seeking to uncover what it is that influences a more general understanding. A group discussion was seen as a more appropriate method for providing evidence of the similarities and differences in the participants' understandings, experiences and opinions (Morgan, 1997). Krueger & Casey (2000) also argue that focus groups are more likely to reveal factors that influence understanding, opinions and behaviour. Focus groups enable the researcher to learn about the participants' experiences and perspectives in a way that focuses not only on what a person thinks, but why they think the way they do and what shapes their thinking (Morgan, 1997). To this end, it seemed that the interaction of the focus group would explore the shaping of understanding in relation to intervention in childbirth in the most productive way to meet the requirements of the research question. Therefore, while the individual interviews provide in-depth insight and understanding of the midwives' and doctors' practice, the focus groups reveal aspects of experiences and perspectives that would not be accessed without the interaction of the group (Morgan, 1997).

Interviews with health professionals

The key areas to be explored in the semi-structured interviews were identified before the interviews took place but this did not preclude the participants from raising other issues. These areas were covered in a number of general, open-ended questions. This was done to ensure consistency across the interviews, and to conduct the interview in such a way that the shaping of understanding and practice was revealed.

The key areas explored were:

- 1) the participant's beliefs around childbirth and their understanding of the birth process
- 2) the participant's background, training, experience, influences, and formative encounters
- 3) the socially situated self of the practitioner
- 4) the participant's understandings of what is happening in relation to intervention
- 5) the participant's thinking around what is behind the changing patterns of intervention in childbirth in general, and in their place of work and practice
- 6) the participant's awareness of any opinions, beliefs, or values which differ from their own in relation to intervention in childbirth
- 7) the participant's understanding of what they see as the changes in the last five years that have impacted on intervention.

During the interview these areas were not covered in any order or using the words or phrases presented above: rather, the interview was led by the participant. However, during the process of the research I had these areas and their attached questions in a clear file in front of me so that I could ensure that all aspects were covered, or at least raised for comment during the interview.

Interviews with public

The intention was that the focus groups with the public would, after any necessary introductions, start with an icebreaker or a conversation starter. However, I found that I needed a different technique because most of the people in the groups knew one another, people arrived at different times, there were children present, and women naturally started talking about birth and their experience. In effect, I realized that I needed a technique which would make it clear that the formal part of the interview was starting, and I did this by asking each group (except for the first one) to brainstorm the words they associated with childbirth.

I did not do the brainstorming with the first group because I was trying hard to follow the process set out for focus groups. However, the groups soon taught me about the appropriateness or not of some of the processes such as ice breakers. The process and procedure for running the focus groups was informed primarily by the work of Krueger & Casey (2000) and Morgan (1999). The characteristic feature of a focus group is the use of the interaction of the group to produce data and insights (Morgan, 1997). This interaction of the group means that less structured interviews are conducted, often without a pre-constructed interview questionnaire or even guideline (Morgan, 1997). However, for the purposes of this research, some means of directing the participants towards the question of the study was required, and consistency across the groups also needed to be ensured. I therefore formulated an outline of what each group needed an opportunity to discuss. This approach has been coined the “funnel” approach and is seen as a compromise between structured and unstructured interviews (Morgan, 1997). It requires a less structured approach at the beginning and moves towards a more structured discussion of specific questions (Krueger & Casey, 2000; Morgan, 1997). This is, in effect, the method used in the focus groups during this research study.

The following is the guideline I used, as informed by the process outlined in the work of Krueger and Casey (2000).

Introductory Questions

The topic is introduced and the members of the group are asked to think about their own connection to the topic (Krueger & Casey, 2000). The participants are asked open-ended questions, and in this case they were encouraged to brainstorm the things they most readily associated with childbirth.

Transition questions

These questions move the conversation into the key questions of the study and they also make the link between the participant and the research topic (Krueger & Casey, 2000).

The issues raised by the brainstorming led naturally into a discussion of the words chosen. The participant was asked about her words, and the brainstorming was explored further with other members of the group commenting and adding to the exploration. This was a very useful technique, and more often than not raised most of the issues that were identified as key questions that needed to be covered in the interview.

Key questions.

These are the questions that are at the heart of the study. Its key driver is the uncovering of the shaping of understanding in relation to intervention in childbirth, and the key questions relate to this goal. For the purpose of illustration I will list some of the headings under which the key questions were formulated, and present samples of each.

Women's expectations:

- Do you think that the expectations women bring to childbirth have much influence on their experience of childbirth?
- What or who do you think has the most influence on the expectations women have about childbirth, where they birth and what type of birth they have?
- Do you think there is an expectation about the way woman should birth

Women's choice:

- Do you think women's choice and what a woman wants has an important role to play in how she gives birth and what happens to her?
- What do you understand about informed choice?
- Do you think there is such a thing as informed choice?

Technology:

- What words do you associate with medical technology, for example scans, epidurals, caesarean section?
- Do you think that technology makes birth safer?
- If technology and human clinical skills can give the same information what would you trust to give the best information – technology or the human clinical skills?

Changes in society:

- What things in society do you think are influencing women and the way they approach birth that is different from your mother's and grandmother's time?
- Do you think these changes in relation to birth are generated by society, by women, by midwives, by the medical profession - or they just are?
- What things in society do you see influencing women to choose intervention?
- Would you be concerned if birth becomes a process of intervention rather than a normal process?

Ending questions:

These questions bring the discussion to an end, and also enable the participants to reflect on what was said previously, and to add anything further if they wish (Krueger & Casey, 2000).

Three types of ending questions are proposed by Krueger & Casey:

- a) The “all things considered” question, which allows the participant to take up a final position (Krueger & Casey, 2000, p.45). “All things considered, what do you think is the key factor shaping your understanding of intervention in childbirth in 2006?”
- b) The summary question is asked after the interviewer has given a short summary of the discussion. The participants are asked to comment on the summary (Krueger & Casey, 2000).
- c) The insurance question, which is to ensure that all critical aspects of the issue have been covered, and leads to the final question: “Have we missed anything?” “Is there something that should have been part of the discussion that was not?” (Krueger & Casey, 2000).

I found that when it came to the ending questions, the approach I took differed from group to group. However, there was one thing that I ensured was always part of the ending, and that was the insurance type of question. I always gave the participants the opportunity to bring up anything the group, or a member of the group, had really wanted to discuss in relation to the research question, or anything that they thought we ought to have discussed that we had not. I saw this as a key moment in the research process as it not only indicated to me something I may have overlooked, but it also presented to me the concerns of an individual or group that I had not previously taken into consideration.

A copy of the questions and process outlined above were placed in a clear folder and taken to each interview to ensure that the key areas were covered. However, they were not covered in any order or even asked in the question format presented above. The groups directed the process, and more often than not the brainstorming meant that they jumped naturally into topics such as pain, choice, expectations and technology. On the whole, my role was to facilitate the discussion rather than to direct or lead it. At the end of the interview I would make a quick mental check of the key questions, and if there was an area which had not been touched on then I would ask these questions. Often the only two topics missing from the material I wanted to cover were the issues of pelvic floor and litigation. There was also the opportunity for questions that were not part of my original list of key areas to be incorporated into the interview, if they showed themselves as having particular significance. This happened with regard to the question about the importance of the way that women birth. This question came out of groups two and three, and began to show itself as a key question in the research. It was therefore added into the questions to be asked during the subsequent interviews.

I learnt many things from undertaking the interviews. From listening to the tape of the pilot interview I learnt how not to interview. I learnt that I needed to speak more clearly and slowly, to not talk over the other person, and to not assume that I knew what they were talking about. I learnt that I needed to let people finish their sentences, and to refrain from make encouraging sounds as they were speaking, because these made later transcription of some words difficult. The biggest thing I learnt from the pilot study was about the role of a researcher. I learnt that if I was to interview well and effectively, there was a role to play that was not about being a woman, midwife or health professional, and that this role required different skills and had its own boundaries. I also learnt that if the person I was interviewing was known to me then I often needed time to catch up before the interview began. This ensured that the first part of the interview was not about what had happened to the person in practice in the last month. I learnt to make the beginnings and endings much clearer, and as I became more familiar with the process and the material the interviews flowed more easily. This does not appear to have affected the interviews in any way, except that the last two interviews with the health professionals were a little shorter. The same material was covered in these interviews, and in the same depth, but more adeptly because I had become more skilled at interviewing.

The other interesting thing of note when I was interviewing midwives and doctors was the number of times we had to reschedule interviews. One participant finally got to be interviewed on the fifth attempt. All our other attempts had been thwarted for one reason or another - often because of women going into labour. This made the process interesting, varied, and at times frustrating. This experience of changing plans was also part of interviewing the public. However, by the time I was doing these interviews I was used to the fact that life happens, and the many delays and changes with times, dates and venues were duly accepted as being part of the life of a researcher.

The data from the interviews

The majority of the data was transcribed by the researcher. A small part of the data was transcribed by a typist who had signed a form of confidentiality. The interviews were transcribed word by word – this was to ensure that the interview was captured in its entirety. The transcripts were then offered back to all the participants for clarification. However, only a small number commented on the transcripts. All the participants are keen to see a summary of the analysis when the study is completed. The transcripts were then analysed using the methodological process and framework as informed by *critical interpretation*.

It was important for me as a researcher to use a method that would allow the interviewing, transcription and analysis to happen in a way that was respectful and careful of the participants. As a researcher who was taking as my point of reference each participant's context, beliefs, values, and conceptual framework, I attempted to ensure that the analysis of power and social practices remained as sensitive as possible. This means that while it is the individual's understanding that gives insight into the structures of power and domination, it is important that they themselves are seen as a vehicle for, rather than a victim of this understanding. Gathering and processing the data in this way ensured that I approached the participant's worldview in a respectful manner.

The analysis of the data using critical interpretation

The lens of *critical interpretation* is underpinned by the philosophy of Heidegger's fore-structure of understanding. It is also underpinned by the Foucauldian distinction between the symbolic discursive layer of reality and the layer of social practices, along with the Foucauldian notions of episteme and discourse which inform the analytical method used in this study (Kogler, 1999). This method of analysis uncovers not only the worldview of the participants but also that which supports and makes possible these worldviews so that the operation of power on understanding and practice may be revealed.

This process of analysis as informed by *critical interpretation* consists of three stages as illustrated in the following:

- **The first stage of analysis** involves a comprehensive reading of the transcripts, followed by a sorting and categorizing of the data. This stage focused on identifying the worldviews of the participants (meaning that is shaped).

At this stage of analysis the data from the interviews was put under headings. Every piece of data was placed in the context of a question or statement which I had formulated so to begin the process of critical reflection.

For example: What is the particular lens that intervention in childbirth is viewed from? What are the power words, the words that indicate power in this telling? What is normal for this person around intervention – what are the signifiers – and what is signified? Whose privilege is being maintained and whose set of values are being promulgated in this practice and by this understanding? Where is the participant situated in relation to those things that influence intervention in this piece of data? There were fifteen such statements or questions under which data could be placed and then analyzed. Rather than just provide a description of the data, it was important to do an initial analysis which showed something of the discursive framing.

Cheek (1996) claims that texts are embedded in discursive frameworks which have been shaped by particular discourses. The data was therefore questioned in a manner which would uncover the implicit unspoken and unstated assumptions which shaped the text in the first instance (Cheek 1996). This process required writing, rewriting and processing the material that the data and questions generated, only to start writing again. This approach facilitated my thinking about the data, and a clear articulation of the notions being explored. It also enabled the writing to move from the conversational mode engendered by the interviews to an academic style. In these ways the questions initially identified and described the worldviews of the people interviewed and gave a glimpse of the shaping of understanding and practice that this process of analysis sought to uncover.

- **The second stage of analysis** involved the utilization of a methodological process to reveal the shaping of meaning and the identified worldviews.

Once the participants' worldviews are described, those things which give meaning and shape these worldviews need to be explicated. To facilitate this process the data is unpacked using four layers of analysis: worldview, social practices, discursive symbolic order, and the relationships of power and structures of power and domination. The following is an abbreviated illustration of this framework, using the concept of "choice" as the example.

1st layer. The worldview of the participant

This layer was explored using a hermeneutical lens. An example of a worldview which showed itself in the data regarding choice is captured in such statements as:

- It is my choice...I have a right to choose what happens to my body
- I have a right to choose an elective caesarean section and the health professional will work to meet this need.

2nd layer. Social practices

This layer explored the worldviews using both a hermeneutical and critical lens. First of all there was an identification of that which was regarded as normal for the participant in relation to their understanding or practice with regard to intervention. Once this had been established, another question was then asked of the data, from the critical paradigm. This concerned issues of power, domination and vested interests in relation to what is normal and acceptable. Some examples of normal practice and understanding in relation to the world of social practices regarding choice were:

- A health system now allows for women's choice that involves technology and surgical procedures.
- A legal system backs up the individual to choose what is best for them: consent must be given for all procedures - even vaginal births in some places.

3rd layer. Discursive Symbolic level of reality

This involved critical analysis, and sought to bring to awareness that which underlies reality, and that which constitutes, shapes, and forms meaning itself. For example:

- Choice is a right.
- Choice just exists: it is neutral, not constructed.

4th layer. Relationships of power and structures of domination and power.

The symbolic discursive orders, social practices, and an individual's worldview are shown to reflect the interests and values of relationships of power and structures of domination. This layer is very complex, and for the purposes of illustrating this process I name some of the relationships and structures that were identified in the analysis of bringing about a culture of choice. Relationships and structures such as capitalism, technology, patriarchy, consumerism, and even postmodernism, appear to have some vested interest in promoting an understanding and practice that facilitates the right to choose.

This methodological process and analytical method further thematizes the material provided by the participants so that those things that shape and are the shapers of practice and understanding in relation to increasing intervention can be revealed

- **The third stage of analysis** involved a structuring and exploration of the data and associated literature which showed something of the shapers (relationships of power and structures of domination). This stage links the shapers, the shaping, and the shaped (worldviews).

To prepare for this stage of analysis, I read a wide range of current literature in such areas as sociology, anthropology, theology, philosophy, fiction, and popular non-fiction, from feminist, indigenous and other perspectives. Alongside this, magazines, newspapers, journals and television were also scrutinized. The purpose of this eclectic reading was to identify those groups or ideologies which discursively framed the notions presented. While the reading was extensive the analysis up to this point was comprehensive, lengthy, and generated files and files of material. This reading and material needed to be brought together, structured and channelled into a form which would make the description of the shaping and shapers of practice and understanding more workable. Kogler (1999) argues that the presentation of shared and contrasting understandings and concepts, and the assumptions that inform these, provides a space in which those things that shape can be glimpsed and described. I developed at this point a number of frameworks which would set out clearly the various positions, assumptions, and realities of the participants in a way that created a reflective space in which the operation of power on understanding and practice could be revealed.

The philosophical insights provided by Kogler with regard to power, power relationships, freedom, domination, resistance, social practices, symbolic order, distanciation, and reflexivity (as presented in the methodology chapter) give structure and form to this stage of data analysis and the frameworks formulated. The frameworks that were developed linked the philosophical and methodological underpinnings of *critical interpretation* with the data for the purpose of facilitating analysis.

The following two frameworks were used for data analysis. A refined version of the framework is used to present the analysis in the findings from the data chapters (chapters 5-10)

The departure point for critical reflection is the space which provides a conscious awareness of the underlying premises which inform worldviews.
What is the worldview (reality) for the participant?
What does this worldview pre-suppose in terms of what a culture/society/people value?
Where does the authority for this understanding/practice come from?
What specific rule systems delimit what can be stated and what is accepted?
What is not acceptable for the participants?
What has become acceptable for the participants?
What are the specific rule systems which give meaning to the participants' understanding?
What is shaped as a result of these rule systems?
What is shaping this reality?
The whole purpose of the analysis of the data in this way is to bring to light the underlying premises which inform worldviews and to uncover the power laden symbolic forms so as to open up a more self determined mode of life. The above analysis shows how understandings and preunderstandings are permeated by discursive orders, social practices, relationships of power and structures of domination which may prevent human existence from corresponding to its own self understanding and instead correspond to an understanding created for it.

Data was also collated at the end of each section in a number of ways. To ensure that I stayed consistently congruent with the philosophical underpinnings and methodological considerations put forward by Kogler the following framework was developed and used for the end of each section of data.

The shaping of understanding and practice in relation to intervention in childbirth		
Childbirth is... (descriptions of the shaped – the worldviews from the data of understanding and practice).		
The shaping of understanding/practice is... (description of the shaping – discursive orders and social practices).		
Beliefs/Values	Institutions	Daily living activities the norm and the usual
A platform for intervention is then formed (an identification of the shapers – relationships of power and structures of domination are described)		

While this method may seem at times complex, convoluted, and even cumbersome, this was because at the beginning I was unsure of how to best show the links between understanding, practice, and their shaping. As I refined and refined the process of analysis, I clarified how these links could best be shown. The process of the research increasingly facilitated the showing of these links so that eventually the analysis was simplified, congruent and user-friendly, and facilitated the process of research and the answering of the research question. The method of analysis facilitated by these frameworks in setting out worldviews, social practices and symbolic discursive meaning, provides a space for critical reflection over and against established interpretations and ways of understanding and practice. This space for reflection ensures a description of the shaped, the shaping and the shapers of understanding and practice in relation to increasing intervention in childbirth.

Rigour

Trustworthiness

There is a great deal of literature relating to qualitative research and rigour: Annells (1999), Davis & Dodd (2002), Guba & Lincoln (1989), Hammersley (1992), Koch (1999), Sandelowski (1993), Whittemore, Chase & Mandle (2001), - to name just a few. While the differences between qualitative and quantitative paradigms are readily acknowledged, the approaches to evaluating the processes and findings of qualitative research still vary widely.

Some of these variations are evident in the following: Guba and Lincoln's (1989) presentation of the criteria of credibility, transferability, dependability and confirmability. Hammersley's (1992) contention that the criteria for evaluation of qualitative works is based on the purpose and goal of the research, Koch's (1996) claim that rigour (trustworthiness) can be established through providing a trail of methodological, philosophical and theoretical decisions, and Sandelowski's (1993) assertion that "artfulness" has a place in rigorous qualitative studies. These writers capture something of the complexity of the discussion about rigour and qualitative research. Davis and Dodd (2002), Koch (1996) and Sandelowski (1993) present some particularly important challenges to qualitative researchers in relation to rigour: attentiveness to the research process and the audit trail, congruence, and being faithful to the spirit of qualitative research. I show how these principles have been strictly adhered to, demonstrating the rigorous nature of the research methods used in carrying out this study.

The audit trail.

The audit trail for this study is found primarily in the concepts of *critical interpretation* such as dialogue, distanciation, and reflexivity, and in the journaling of the events, actions and influences that took place during the time of the research. One way for a study to appear credible is for the researcher to keep a 'reflexive' journal, in which the processes of the research and the interactions between researcher and participants are recorded (Koch, 1996). A journal was kept, not only to record processes and interactions, but also to record the development of my thinking, the insights gained, and the dialogue generated from such insights. Dialogue is a key concept in *critical interpretation*, and Kogler (1999) says that this dialogue should be co-operative, reciprocal and participative. It is the dialogue that is established between the researcher and the participants, the researcher and the data, the researcher and the literature, the researcher and those to whom the research is presented, the researcher and the events that surround the research process that primarily establishes an audit trail. In the last two years this dialogue has increasingly been caught on tape or scribbled in notebooks which I have learnt to carry with me to capture the thinking and conversation that takes place when I am walking, driving, having coffee and even teaching. It was often at these times - which are outside the 'formal thinking time' - that some of the most important processing of information has happened.

A number of writers claim that recording the processes and decisions a researcher makes in a journal and then writing these up in sufficient detail so that they are made available, means that the reader is more able to evaluate the interpretation and its trustworthiness (Koch, 1999; Pyett, 2003). An extensive journal was kept during the time of conducting this research. All stages of the research were reflected on, from gaining ethics approval, to coming up with the research question, finding participants, contacting participants, processing the data, presenting the research at conferences, and having discussions about the topic. The journal, in effect, was a recording of the dialogue, as well as of all the events, actions and influences that affected the research process and also me, as the researcher during this time. This material is woven into the study, and is found in various places, but it is most readily seen in informing much of what is written in the previous part of this Methods Chapter. The dialogue captured in the journal, on tape and in notebooks was augmented by the field notes made within ten minutes of leaving the place of the interview. At the end of each interview with a health professional I first of all wrote down my impressions from the interview, then I wrote down anything that stood out, that was different, that was a surprise, or was just something that I needed to remember. Usually these things were to do with the data, but sometimes they were related to the interview and the way in which I had carried it out. The capturing of each of the interviews in this way meant that when I looked back I had a summary of the interview, and notes which could give me direction and provide clarification in terms of its context.

Audit trail: Transcription of data.

At the end of each interview with the focus groups the recorder-transcriber and I would go through a similar process as soon as we had left the venue. We dialogued about our impression of the group and the things that really stood out - things that were different from or similar to other groups - and did a general summarising of the experience of that particular group. This was very helpful, as it clarified a number of points. It ensured that there was a similar understanding between the recorder-transcriber and myself about what had taken place in the focus group. Any discrepancies were then able to be clarified by returning to the data, and to the participants if necessary. I also sought feedback from the recorder-transcriber about the interviewing and the consistency of the questions asked from one group to another.

This ensured that while the groups led the process, the necessary material was covered in each interview, and there were no glaring omissions or differences on my part with regard to subject matter and process. This process was part of ensuring that the audit trail was imbued with a “continuous reflexivity and self-scrutiny” that is part of a sound qualitative research project (Pyett, 2003, p.1171). This conscious understanding of the research process also guided the way the interviews were transcribed. Most of them were transcribed by me, as the researcher, and all of them were transcribed as soon as possible after the interview took place. The interviews were transcribed word for word to ensure verbal accuracy. Once the material had been transcribed I listened to the tapes again, while following the written material, and made notes of clarification or expansion when inflection, tone, or other indicators added to the meaning. The early transcription of the interviews ensured that the transcription or the first reading of the interview took place while it could still be ‘heard’ by the researcher. This ensured that the tone, texture, context, inflection, body language, and total interaction could be captured in the transcription of the data. The transcripts were then sent back to the participants to give them the opportunity to confirm, delete or amplify. The purpose of this was to provide additional clarification and to ensure that further scrutiny of the material took place by those from whom it had come.

Audit trail: Presentation of research.

Another important part of the audit trail, which ensures that the nature of the dialogue is reciprocal, is the presentation of the research methodology, method and preliminary findings while the study is still underway. This involves not only the presentation of the research but an engagement with the material by those to whom it is presented, so that they evaluate and comment on its relevance and meaning. The acceptance of the research by a third party must “ultimately entail a degree of trust in the diligence and integrity of the researcher” (Wainwright, 1997, p.16). Over the last three years I have presented aspects of this research on six different occasions at midwifery conferences. The most recent of these presentations was in September 2006 at the 9th Biennial New Zealand College of Midwives Conference where I was a keynote speaker. The material has been met with much interest, agreement and ‘ahness’ because it is both relevant, and representative of midwives’ and consumers’ experience. Midwives and consumers have asked me to publish, speak and share the findings, as they were often experiencing a similar situation or they could see the importance of the research because of the changing nature of their practice.

I have also presented at two research conferences the latest of which was the 7th International Interdisciplinary Conference Advances in Qualitative Methods in 2006. One of most significant moments in relation to presenting the work of this thesis was at this conference. A PhD student and her supervisor who were not at the conference drove a number of hours to hear my presentation since I was using Han's Kogler's work. This was an invaluable meeting as the PhD student was also using Kogler's work and this meant we could talk, discuss and clarify our understandings of Kogler, our research methods and our reasons for using such methods. Guba & Lincoln (1985) speak of transferability which is, in effect, the identification by the reader or audience of the degree to which the findings of the research are applicable in their own setting. This requires that the researcher provides data, process and findings in sufficient 'thickness'. Such 'thickness' of description enables the readers or listeners to recognise similarities between the two settings, that of the research and their own experience. Pyett (2003) claims that we need to provide detail and context for the reader or hearer so that they can assess our interpretation and so make a judgment about the trustworthiness of the research. The presentation at these conferences of an in-depth slice of the data enabled the midwives and consumers present to not only assess the relevance and trustworthiness of the study, but also to share their perceptions with me. The meeting in Australia of someone using the philosophical approach of Kogler who could comment, critique and discuss in-depth my methodology and methods also adds to the trustworthiness of my interpretation. To this end my limited but significant email conversations with Hans Kogler in relation to *critical interpretation* and his direction regarding his work and critique of his work ensured that I engaged deeply with the material furthering the trustworthiness of the research process.

Reflection and Reflexivity.

While the journaling, recording, detailing and presentation of the research material in part presents an audit trail which advances the credibility of the study, it is also important that I account for my own preunderstandings and 'situatedness'. In Chapter One, I have situated myself in relation to the research, and presented my pre-understandings as far as possible. While it is difficult to make a claim for 'value-free research', for research can never be free of researcher bias, it is possible to carry it out in a way that provides reliable accounts about a particular subject (Davis & Dodd, 2002).

Davis and Dodd (2002) argue that the rethinking that is taking place with regard to qualitative research means that rigour requires on the part of the researcher a “sense of responsibility, accountability, partiality, and subjectivity within the research” (p.285). They argue that rigour is a matter of being attentive to the research process and making visible the process of research undertaken through “reflection and reflexivity” (Davis & Dodd, 2002, p.285). I would argue that in this study, the processes of reflection and reflexivity are interwoven into the very fabric of the research process informed by *critical interpretation*. *Critical interpretation* itself ensures that I not only have an awareness of my own position in relation to the process of research but that as far as possible I make visible my bias. Davis and Dodd (2002) claim that “interviewing is a social interaction”, and to some degree there is an engagement of the researcher’s values, especially when the subject matter – such as childbirth - is deeply personal (p.283).

Self distancing and reflexivity.

There are some techniques that are advocated to enhance rigour with regard to this engagement, such as bracketing or delaying the literature review until the data is obtained, so that it can first of all be seen in its own light rather than be informed by the literature (Koch, 1995). There is much debate around techniques such as bracketing, and even about the possibility of being able to carry out such an action (Annells, 1999; Koch, 1996). However, I did find that there was a need at times, when engaging with the subject matter of childbirth, to be able to distance myself in some way from my own stance and profession. By using *critical interpretation*’s process of ‘self distancing’ and a stance of reflexivity, I ensured that as the researcher I was able to recognise something of the hidden and shaped aspects of my own understanding. The process of self distancing made it possible for me to get behind some of my own personal and professional preunderstandings and to critique these. The stance of reflexivity enabled me to objectify my particular biographical background and gain insight into the social and cultural practices that shape me. To facilitate a stance of reflexive distance I used the contemporary idea of parking. The image of parking, was effective in making me, as researcher, aware of my own bias, and making visible - as far as is ever possible - those things that may influence my hearing, interpreting and analysing of the data. I often became aware during the interviews, transcriptions, or analysis, of ideas, impressions and judgments that needed to be parked.

These were written down and reflected on and then checked against the interview, transcription or analysis. This process was about being attentive, and making my own position visible in the process. For me, this was one of the most intriguing parts of the research process insofar as I had to unpack my own preunderstandings, judgments and positions, and at times park them to let the voice of the participant and the research process be heard. It was this constant engagement with the data on multiple levels that gave the data its richness and depth and resulted in the insights into what is shaping practice and understanding in relation to childbirth. Koch (1996) argues that the position and preunderstandings of the researchers does not get in the way of research but makes it more meaningful. I would agree that this was certainly my experience in this study.

Congruence.

Annells (1999) argues that the credibility and validity of research rests on the congruence between the philosophical approach, the way the nature of reality is perceived, and the relationship of the researcher to that reality. Koch (1999) also argues that there should be congruence between the ontology, epistemology and methodology. She claims that the researcher's ontological position should inform the way knowledge is approached, which in turn leads to the most appropriate methodology. I have addressed this issue in the previous Methodology Chapter, and also in this present chapter. I have made as visible as possible the processes of research which guided the philosophical underpinnings, the generation of knowledge, the process of analysis, and the coming to the research findings. Koch (1996) claims that the exact way data is generated is underreported, or reported in such a way that it is difficult to gain a picture of what really took place. In order to illustrate the process of analysis and further establish the credibility of this study I have included in this chapter the tables that were developed and utilized for analysing the data, in order to give a sense of the congruence between philosophy (ontology and epistemology) and the research method. This is to ensure that the processes may be described fully enough for the reader to adequately understand and judge the validity and usefulness of the process.

Artfulness.

Sandelowski (1993) argues that qualitative researchers need to ensure that the harshness and rigidity implicit in the understanding of rigour does not detract from the “artfulness, versatility and sensitivity” which are hallmarks of sound qualitative research (p.1). This does not mean that the place of rigour is to be denied, as the problem is less with rigour itself, and more with the way it has been categorized and understood (Pyett, 2003). The research carried out for this study is carried out within the structure of a PhD, and so requires that a certain level of theoretical, philosophical and methodological knowledge is presented in an academic manner, which could perhaps hamper the artfulness and versatility of qualitative research. However, while this may sometimes be the case, it is also possible to ensure that the presentation of the research is done in such a way as to ensure that it is accessible, dialogic and relevant. To this end, I have taken great care to present the research and its findings in ways that have meant the ‘artfulness’ of the presentation has enhanced the credibility of the study, and the methodology, the findings, and the research processes have been made accessible to everyone. The first time I presented the methodology at a midwifery conference I made a model out of a box to explain the methodology. While the explanation was inherently complex, the box enabled and facilitated understanding to the extent that three midwives (who had never undertaken research) asked for copies of the box because for the first time they understood how a research process could lead to findings that may be relevant to practice. This was important confirmation of the methodology in relation to its links to the research question and findings, and was a result of the ‘artfulness’ of the methodological presentation.

Summary

This chapter has presented the methods by which the process of research was undertaken to show what is shaping understanding and practice in relation to increasing intervention in childbirth. The methods chapter has explained the methods used and linked these with the methodological and philosophical underpinnings of *critical interpretation* which inform the processes of this research. In the chapter there has also been an explication and a showing of the processes used to contact participants, protect their anonymity, ensure confidentiality, facilitate informed consent and enable safe participation in the research. There has also been a showing of how the data was gathered both in the individual interviews and the focus groups.

There has been a comprehensive presenting of the way the data was analysed and the frameworks that were utilized in the analysis of the data. Finally the chapter has addressed the question of rigour and has linked this question to the methodological requirements of *critical interpretation*. The methods and processes are set out in the chapter in some detail as it is recognised that Kogler's work is not widely used. In light of this it seemed important that enough detail was given so that the methods of the research could be seen to facilitate not only a safe and appropriate process but also a process that is methodologically sound.

Chapter Five

Introduction to the Findings from the Data

In this chapter and the following data chapters I present the themes and findings that emerged in response to the research question. The following data chapters fulfil the purpose of this study which is to uncover, reveal, analyse and to bring to awareness the taken-for-granted and invisible influences that shape practice and understanding in relation to increasing intervention in childbirth.

The research question which informed the study focused on the practice of health professionals and the understanding of the public. This is not to suggest that the practice of health professionals is not influenced by understanding or that the understanding of the public is not influenced by and influencing of practice. Rather the intention of the study is to utilize that which is most readily at hand for the health professional (practice) and for the public (understanding) in order to thematize the hermeneutic background and orientation so as to unravel the “underlying premises of interpretive praxis” (Kogler, 1999, p.11).

These premises showed themselves as points of ‘energy’ and ‘engagement’ in the interview process. During the initial transcription and analysis of the data these points were grouped together as points of commonality and were initially framed under multiple headings such as choice, expectations, socialization, horror stories, influence of practitioner, deskilling of practitioner, informing of women, authority/expert, control, predictability, blame, pain, pain relief, safety, technology, wealth, education, caesarean section culture - to name just a few. Kogler (1999) claims that it is important “to consider with regard to power-laden world-disclosure the specific object itself”, and the way it is thematized (p.106). Further cross-referencing and systematic classification of these points of ‘energy’ and ‘engagement’ enabled this consideration of the object itself and led to the formation of four general categories under which these premises could be placed so that those things that were shaping practice and understanding could be identified and “thematized” (Kogler, 1999).

The thematization of the premises led to four categories: choice, pain, technology and socio-cultural influences. The socio-cultural influences (the everyday world and its associated processes of intervention) became an umbrella under which the other three themes were explored. Kogler (1999) states that the way an object is thematized, the concepts which enable one to get hold of it, and the “thematized focal points” all have to be comprehensively analysed in relation to social, individual and discursive power. The three broad areas of pain, choice and technology that showed themselves as “thematized focal points” in effect capture the nature of birth, the journey of birthing, and the challenges to birth and birthing. All intervention involves technology, and while pain, for the majority of women, is the one certain thing about childbirth and is inherent to the nature of birth, it is choice that provides a bridge between pain and technology. It is identifying interplays such as this which enables the process of research in this study to “uncover undetected power complexes” (Kogler, 1999, p.106) and so show what is shaping practice and understanding in relation to increasing intervention in childbirth.

The research process of uncovering, analysing and bringing to awareness the shaping of understanding and practice not only brought forth the findings of the study but also gave birth to the argument which comes from these findings. The findings from the data chapters present this argument: that the everyday world and its associated processes of socialization shape understanding and practice in ways that are leading to increasing intervention in childbirth. The findings and the argument are presented in a way which reflects the methodological processes of *critical interpretation*. To this end, the everyday world and associated processes of socialization are presented through the worldviews of the participants. For the purposes of this study the everyday world is what the participants speak of to the researcher, and this is classified methodologically as worldview. Kogler (1999) claims that these worldviews are brought about through socialization and cultural context (everyday world) and that any attempt to bring them to conscious awareness is best informed by “interpretively gleaned insights and conclusions, phenomenological observations and analytically conceived results and arguments” (p. 11).

The data from the everyday world of the participants is explored firstly through a hermeneutical lens so that the opinions, understanding, thinking and viewpoints of the participants are presented. The capturing of the everyday worlds (worldviews) in this way ensures that the *shaped* nature of understanding and practice in relation to increasing intervention in childbirth is identified.

These worldviews (*the shaped*) are presented in **Part One** of each of the chapters dealing with the findings from the data. The social practices and discursive orders (*shaping*) that underpin these worldviews are then explored in **Part Two** of these chapters, revealing the relationships of power and structures of domination (*shapers*). In **Part Two** of these chapters the worldviews, discursive orders and social practices are presented in a table which is then followed by an exploration and elucidation of the relationships of power and structures of domination. This exploration and elucidation makes visible the *shaping* and *shapers* of practice and understanding, creating a space for reflection. In this space, the link between an individual's worldview and the relationships of power and structures of domination that shape this worldview and lead to increasing intervention, are described and made overt.

The image of a river helps portray the research process, the argument which is developed from this process, and the way the findings are presented in the following chapters. The water, which is the river itself, and is most readily identified as such, represents the worldviews – ‘the shaped’ – presented in Part One of each chapter dealing with the findings from the data. The river bed and the river banks represent the discursive symbolic orders, and social practices respectively. These both provide ‘the shaping’. The source and force of this river are provided by the relationships of power and structures of domination, which are ‘the shapers’. Both the ‘shaping’ and the ‘shapers’ are presented in Part Two of each chapter which presents the findings from the data. The reason this image best captures the research process and the way the findings are presented is that while the water is the river, the river bed in fact supports and determines the flow of the river, the river banks contain and direct the river, while the source and the force actually control and, in part, constitute the river itself.

The river, the worldview
(**the shaped**).



The source and the force, the
relationships of power and
structures of domination (**the
shapers**).



The river bed, the
discursive orders
(**the shaping**).



The river bank, the
social practices (**the
shaping**).



However, the water itself has a life and energy of its own, and while the river naturally flows in one direction, water itself does many things such as splashing, spraying, seeping and pooling. The water may go off into tributaries, become rapids, or be dammed - all of which in turn affect the bed, banks, source, and force of the river. There is an interdependent relationship between the river, its bed, its banks, and its source and force. In the same way, an interdependent relationship exists between the worldviews, the discursive symbolic order, social practices and relationships of power and structures of domination. This relationship is one of constant interplay and tension between the shaped, shaping and shapers. The exploration of this connection, interplay, and tension is what enables the revelation of *that which* shapes practice and understanding and is presented in the following chapters.

It is important to note at the outset of these findings from the data chapters that the shaping of understanding and practice is not primarily brought about by any of the readily identified findings such as pain, choice or technology. Rather, issues such as pain, choice, and technology are themselves shaped in ways which result in the increasing acceptance and use of intervention currently occurring in Aotearoa-New Zealand.

A participant in this study, an obstetrician, captures this acceptance and use of intervention:

I find it hard to believe that a higher proportion of women need intervention or need major intervention...There is no evidence to support these rates of intervention and the outcomes are not better by having more intervention - and yet there is more and more.

The findings from the data chapters that follow describe the milieu in which a higher proportion of women than ever before are the recipients of major intervention. It is important to acknowledge at the outset, and to keep in mind during the reading of these findings, that there are a number of worldviews that present themselves in the study in relation to natural childbirth. For the purposes of this study the worldviews that do not primarily shape practice and understanding in relation to increasing intervention in childbirth, are simply presented, but not explored in any depth.

Chapter Six: Part One

Hermeneutic analysis of the everyday world and processes of socialization

The everyday world and its associated processes of socialization (worldviews) are presented in the first sections of these chapters which reveal the findings from the data so that the understanding of the public, and the practice of health professionals in relation to increasing intervention can be described. In most instances the data presented under these worldviews is a just a small sample of the extensive material available to me from the participants. I have chosen the data that best represents the range and variety in relation to a particular worldview so that all the voices of the participants are heard. The everyday world (worldviews) and processes of socialisation in relation to the gendering of women, body image, body fluids, along with social values such as control, organization, convenience and ease are presented in the following.

Worldview: ‘There is a right and wrong way to birth.’

Many women in the focus groups spoke of how beliefs about a right and wrong way to birth shape their understanding. Pain and pain relief was a focus that revealed these understandings, as illustrated in the following excerpts from six participants.

I really felt that if I asked for pain relief, I was being weak and not able to cope. That was what drove me. It wasn't so much about the baby; it was about me.

I actually had a really good birth in retrospect but I was too scared to ask for pain relief because I thought I was weak because I wasn't having a homebirth.

You were meant to be a strong woman and succeed, and part of that idea of success was not having pain relief.

You were a better woman if you birthed naturally and had no pain relief.

It was about having the right sort of birth and being a strong woman and succeeding and all that stuff.

It was embarrassing to ask for pain relief as that meant that you didn't and couldn't birth properly. You couldn't do it properly.

The shaping of understanding in this instance suggests that the right way to birth means that women cope with pain. The coping with pain is equated with strength, power, success, admiration and approval. The 'wrong' way to birth is where a woman does not cope with the pain and rigours of childbirth, and requires intervention of one kind or another. This is associated with weakness, being ineffectual and unsuccessful. For some women, the ideology of natural birth still strongly shapes their understanding of childbirth and their attitudes towards intervention.

The worldview that informs women about the 'right' way to birth is captured very powerfully by the next woman:

I had to have counselling before I gave birth to my second baby so I could ask for pain relief. I wanted to be able to ask, but it took heaps to break through that whole 'I will succeed' thing and also that whole belief that 'this is the way to birth' thing. So when I was having my second baby I did say, 'I would like to have some gas now,' but that took so much courage and I think we had a code word which I would use if I could not say the sentence and couldn't ask for it.

This piece of data illustrates how powerful the worldview of the 'right way to birth' is for some women. While the struggle to step outside the 'right way to birth' could be seen as something particular to this woman, there is evidence to suggest that it is part of a much more complex picture. Martin (2003) argues that because of socialisation women have internalized a notion of how they should birth. In this instance, the notion of the 'right way to birth' so powerfully shapes understanding in relation to intervention that the woman requires counselling so that she can have the courage to ask for pain relief.

A number of women presented a worldview that further developed the notion that there was a right and wrong way to birth. This worldview that real women birth naturally is presented by the following participants.

It is like you're a real woman if you birth naturally...and cope with the pain.

Yes birthing naturally: this is what they say makes you a [real] woman.

To have a natural birth and to do it without pain relief...this is what you are built for.

If you do take the pain relief - well what sort of woman are you?...I mean, you hear the story about dropping one in the fields and then just keeping going on.

However, this notion of the ‘real woman’ in relation to natural birth and pain was very much tongue-in-cheek from these participants. While they may have once understood birth and themselves in this way, they did not, in reality, equate anything about being a ‘real woman’ at the beginning of the 21st century with birthing naturally.

A number of women in the focus groups explored the connection between being a ‘real’ woman and childbirth by reflecting on a time when womanhood was linked to childbirth:

I felt when I was having [name] especially that I was meant to ‘do it’ in a certain way and as natural as possible was the trend at the time. I don’t know whether it was a trend or it was movement; it started a long time before I had babies and whether women are still feeling that, I don’t know.

Once upon a time to be a really good woman you birthed babies and lots of them and enjoyed it and were fulfilled in that, but that has changed now.

I think for us, when we were growing up there was that generation that was taking back childbirth and part of that was assuming all power and knowledge of it. So we see it as a personal failure when we don’t birth naturally because we were rejecting doctors and the medical profession. There is that whole: we are strong, we will influence, take that job, women can do it, we don’t need men, all that sort of stuff.

These participants believe that the worldview of birth as natural and pain as something to be entered into and dealt with had a lot to do with the time in which they grew up. These participants grew up in the 1970s, in an age where birth was loudly proclaimed as natural, and the cry of Helen Reddy, ‘I am woman, hear me roar!’, echoed loudly in their ears. This significantly shaped their understanding of how birth should be. In this focus group the women who had grown up in the 1960-70s had very different experiences and expectations from a younger woman in the group who was a child of the 80’s.

The older women in the group felt that if they did not birth naturally and without pain relief they had failed and not done the job properly, while the younger woman in the group felt rather differently about childbirth and intervention:

I didn't feel like that at all [to birth naturally is the only way]...I just think even though I had an epidural and forceps delivery I felt that I did my best and I still had this beautiful baby at the end of it. I felt really good about that.

This woman did not identify with the older women in the group regarding their feeling of failure if they did not birth naturally. There were no moments of anguish for her about not doing the job properly, or being less than a 'real' woman because she had to have intervention to birth her baby. This woman's understanding in relation to intervention was shaped by the attitude of whatever happened was 'okay' and there was little or no connection between the way she birthed and how she saw herself as a woman.

The following women also capture something of this movement away from equating birthing naturally with being a 'real woman' or letting the side down:

There is a tendency to perhaps judge women who prefer to have a caesar, like they are not real women.

If I had had a caesarean I would not feel less a woman. Why would I?

You do not need to have a natural birth to be a real woman sort of thing.

I think it is also important about how someone feels about the birthing and in how they are treated when they make the decision. If you say you are going to have a caesarean section it is important you are not ridiculed and made to feel like you are not a good mother. It is also important that you are not made to feel like you could not possibly have any idea of what it feels like to have a baby because you have not had the experience. Whereas if you are made to feel that you have made the right decisions and you are part of that decision then you should feel just as proud to have the baby that way or any way.

These participants believe that accolades and praise conferred on a woman because of the way she births are misplaced. They believe that what is important is that however a woman chooses to have a baby - vaginally, abdominally, naturally, normally, physiologically or pharmacologically - that she is made to feel good about it.

It appears that at the beginning of the 21st century the notion of the 'right' way to birth has significance only in as far as it facilitates an acceptance and appreciation of the way an individual woman births. This change in understanding opens up possibilities in relation to intervention and the acceptance of intervention in childbirth.

A number of health professionals also discussed the changing nature of childbirth. A midwife suggests that while childbirth is shaped by certain physiological and biological realities, it is also equally shaped by the social context within which women birth:

There are a lot of cultural things wrapped up in the feelings of what it is to be a woman and having a vaginal delivery. Less and less being a woman is about birth maybe.

An obstetrician supports the stance that society and culture frame childbirth for women so that they birth in certain ways:

I think it is all tied up with family and social pressures and expectations. While some groups of women are more inclined to vaginal births because of their society, others like the 'too posh to push'...well again it is social expectations making the women like this.

Another obstetrician explores the changing nature of being a woman and their changing expectations:

Women are changing. They want different things and see different things as being important when it comes to being a woman and having a baby.

This obstetrician also captures something of the changing expectations women have in relation to childbirth:

It was like with incontinence and I would ask women why they put up with it. They would say, 'Oh well I spoke to my sister or my mother and they said this is what happens. This is your lot so put up with it.' Women, however, are not going to put up with that any more or accept that this is the way things have to be when it comes to childbirth.

These health professionals suggest that the understanding women have with regard to childbirth, and in particular vaginal birth, is tied up with the social and cultural definitions of womanhood. At the beginning of the 21st century it would appear that childbirth and the way a woman births may no longer be paramount, or even a factor in the defining of women and their role. The severing of the connection between the 'right' way to birth (birthing naturally) and being a 'real' woman impacts profoundly on the understanding of the public and the practice of health professionals in relation to intervention. In effect, these changing social and cultural expectations facilitate the possibility and ready acceptance of intervention as part of childbirth.

Worldview: 'There is a certain way to behave, to dress, and even to look when birthing.'

The processes of socialization which appear to inform a woman about the 'right' way to birth also impact on how women behave when birthing. One woman recounts the behaviour she expected of herself when giving birth:

I was worried about my appearance. With my first baby it wasn't important what I wore and 'what I wore to the hospital' became the family joke for years afterwards. So with my second baby I was obsessed that I had to look like the catalogue women and of course it didn't happen. I put a ribbon in my hair for God's sake. I don't know what fantasy I was occupying. It was really strange, like I'm not going to be the grunting, pooing, foul woman giving birth. I was going to be nice, and bought matching pyjamas for the occasion with slippers that matched. It was like the total fantasy.

This participant presents two contrasting images of a birthing woman: the 'nice' woman that she really wants to be when giving birth, and the grunting, pooing, foul woman which she was informed she was like by her first birthing experience. She suggests that women's understanding is shaped in such a way that they 'know' there is a certain way to behave even when giving birth.

These women identified some of the behaviours that they believed were acceptable or not when birthing:

It is the pain but it's also that out-of-control thing. You feel so disgusting and gross and you feel sick as - well you know. I spewed up and all I could think was, 'I've vomited over this clean bed'. It is just so undignified...it's not pretty, it's dirty and messy and embarrassing. It is not nice at all.

I was more than happy to have a normal delivery – but I was not going to be out of control with pain so I opted for an epidural. I wanted my birthing experience to be really easy, nice, and happy – I wanted to be really relaxed. Like the contractions – the most painful thing for me and then after the epidural I was able to give birth without feeling any pain and it was all happy - it is so much nicer.

I sort of think if I had a long labour and a lot of pain, and I was really beside myself with pain - then I might behave badly but I never raised my voice in any of my labours.

I really wanted to swear but I didn't. I did not even raise my voice.

Birth is primarily an event socialized by the everyday worlds from which women come. If the everyday world informs women that birth is to be happy, controlled, and a 'nice' event in which women behave well, then those tools of intervention which can facilitate such a birth will be increasingly valued and sought after.

The image of birth as a controlled and happy event during which one could behave well is captured by the next participant:

I have had an amazing experience recently. I was there when [name] birthed. We were there up until the delivery – my husband and I were there when the epidural line went in and then after the epidural set in she was feeling so comfortable. We were watching the chart and saying, 'Oh wow, you are having a contraction' and we were looking at her and looking at the chart and she was sitting there comfortable and cool as a cucumber drinking a cup of tea. We are going, 'Wow look at that, look at that contraction - wow!' and had a hand on her stomach and going, 'Wow, that is amazing!' and she was like so comfortable and I said, "Why didn't I birth like that? That looks like so much fun," because when I birth I am like 'Wwhhhhagggggggggghh!' I am like monster-woman...like a bear.

This participant speaks of the epidural with amazement, incredulity and wonder in relation to the type of birth an epidural facilitates, as it is credited with enabling a labouring woman to be cool as a cucumber rather than like a monster-woman. The epidural in this instance is not just a procedure that is chosen to relieve pain; rather it is part of a complex sociological and cultural understanding that women have of themselves and how they should or would like to behave during childbirth. Understanding shaped by regarding birth as a 'nice', controlled and dignified event will increasingly determine that women choose those things which make the 'nice', the controlled and the dignified possible. The increasing use and acceptability of intervention is, in effect, a by-product of the internalised understandings that women have of how they should behave when giving birth.

The everyday world and its associated processes of socialisation in relation to 'nice' dovetails neatly with the socialisation of women with regard to their bodies. The attractive, well controlled body has always played a central role in the socialisation of women, and in the 21st century it would appear to be instrumental in shaping women's understanding in relation to their choices about intervention in childbirth.

This woman presents her experience of her body during childbirth:

My fear was more around feeling my body was taking me over, and that I had to give my brain away. Actually the first time I had a baby my mum was with me and she said, 'Just let your body do its work, just let go.' That was the best advice really because then it was fine after that. But actually doing that takes so much courage. I wanted to be in control and control it. But it is so powerful and primitive I suppose. I've always lived from my neck up. That's how I felt. I didn't really get too involved from the neck down.

The fear spoken of in this data is to do with the 'bodiness' of the birthing process, and the feeling that the body is in control during childbirth. The body is viewed as a powerful and primitive force, a force which somehow seems to be separate from the woman, not a part of her and yet a part of her. The shaping of this woman's understanding that the body and mind are separate and that the mind is in control of the body means that birth as a 'body' process needs to be regulated and controlled. This socialization provides fertile ground for the acceptance and choosing of intervention which will control the 'bodiness' of birth.

This socialisation is further illustrated by the avoidance of the ‘bodiness’ of noise during labour and birth:

You can walk into delivery suite where there are ten rooms and I can tell you exactly which women belong to midwives and which women do not by the screams. Our women do not want that [screaming]. They find it undignified, they find it out of control, and the epidural service is safe and good.

If the bodily expressions of birth, such as noise, are framed as loss of control and dignity then those things that avoid the making of such noise will increasingly be sought after. The technology of birth and its associated interventions can be seen to offer women the tools to bring about an experience which is controlled, quiet, dignified and above all else ‘nice’. The shaping of understanding and practice in relation to what is acceptable behaviour in childbirth means that some women will increasingly choose intervention, as it facilitates control and dignity.

There was extensive discussion about the socialisation of women in relation to body and body image and the general dissatisfaction women have with their bodies, and how this could lead to something such as surgery being framed as a user-friendly procedure.

These participants explore the issue of body image:

Body image is huge in everything not just in relation to birth.

They’re really into their body image and how they look. Body image is huge in Brazil and so it is not surprising women would choose things such as operations to preserve their body image.

Body image - well it would be a reputation thing as well though, because it is what everyone else is doing - like having a caesarean section - and it is safe. It will interfere less with my work life and I will still look good.

This midwife also explores the issue of body image:

I think the rise in intervention is a number of things but is associated in part with people who have a strong body image as they think it is going to maintain their body the way it is ‘meant’ to be.

These participants do not find it surprising that women, whose lives are framed by looking and presenting their bodies in a particular way, would choose intervention and, in particular, a caesarean section to preserve and sustain their body image. This worldview is informed by an everyday world in which tummy tucks, extreme makeovers, and other cosmetic surgery are resulting in a ready and growing acceptance of surgical procedures.

A number of women discussed, albeit jokingly, the possibilities that cosmetic surgery presents:

Participant 1: I was giggling before because I was thinking about extreme makeovers and you do hear of the stories overseas where when they do a caesarean section they routinely do a tummy tuck as well.

Participant 2: Yes that is true, they routinely overseas do a tummy tuck along with the caesarean section and they get rid of all the excess skin.

Participant 3: Oh it costs 10 and a half thousand dollars to have a tummy tuck here.

Participant 2: Oh while you are doing my caesarean, I would like to have had a tummy tuck as well.

Participant 4: I remember asking at the time when I was having my caesarean, if they wanted to do a tummy tuck as well. I think he must hear the request all the time because he just laughed it off.

This discussion was almost an aside and a light-hearted moment as the group considered such things as tummy tucks and extreme makeovers. Procedures such as liposuction, botox and cosmetic surgery appear to have become increasingly normalized. The resulting milieu means that surgery is increasingly framed as something which is body and user friendly, and a tummy tuck during a caesarean section may not be as far fetched as it sounds. It is only a small sideward step between the techniques and procedures related to the preservation of body-image, and the framing of a caesarean section as yet another body-preserving procedure.

This is illustrated by the following obstetrician's reflection on an article in a magazine:

I think you only have to read the magazines. Look at that recent article [where women discussed why they would want to birth normally when they do little else that is normal as they wear make up and dye their hair] and so you have a four-page spread saying why women should have a caesarean section.

The way women understand intervention such as surgery is changing, as described by one woman:

Over the next few generations surgery will become more acceptable, more commonplace. Like extreme makeover is becoming really popular and so it is not the big deal that it once was to Jo Public, even though there are still massive risks associated with surgery. Jo Public still sees it as a quick fix and something they are relaxed about; something that is more acceptable. I am sure that surgery will become more acceptable in our generation.

Surgery is increasingly being perceived as another quick fix, and just one more thing on the market which can be purchased. This shaping of understanding regarding surgery and surgical procedures will inevitably normalise such procedures, and result in increasing intervention.

Worldview: 'The everyday world is "clear, clean lines", and the messiness of birth is something that is increasingly incongruent with this world.'

Alongside the 'bodiness' and noise of birth, a number of women presented the 'messiness' of birth as significantly shaping their understanding in relation to birth, the place of birth and interventions that may accompany birth.

[With reference to homebirth] the thought of cleaning up the mess! My midwife said there would be no mess cos she takes it away...but even so!

I considered delivering at home - but all that mess! Just let the facility clean it up as they are set up for it; they deal with that kind of mess.

I like the clinical cleanness. They just know what is right. [Having a home birth] would be like having heart surgery in your basement or something.

For these women, messiness is something to be avoided and dealt with in hospital. The birthing unit or hospital is seen by the participants as set up for birth, as it promised ease, convenience, cleanliness and disposal by someone else of all the mess. The meaning given to messiness and the rightful place for messiness appears to shape the public's understanding and inform the choices they make with regard to the most appropriate place for the 'mess' of childbirth.

Alongside the conviction that birth was a messy process, best taken care of in a hospital or birthing centre, were vivid and graphic descriptions of the 'messy' bodily functions and fluids of birth:

I spewed up...I thought, 'I am going to vomit!' I leant over and plaaaagghh...I vomited all over my husband and thought, 'Oh my God!'...just so undignified!

I feel like I know about birth [now], but having said that, in the moment of [giving birth] it was all so disgusting.

Well, if I had been told it was going to feel like a giant crap then I would have known. Of course the midwife goes, 'Oh well, we have been waiting for that.' I'm going, 'Well why didn't you tell me?' It is so gross it has to be like this. Why does this have to happen when you are about to birth?

I didn't know that it would feel like you were pooing a bowling ball, and when it came it was like, 'This is wrong; it is coming out the wrong hole! I am pooing, not having a baby! What a gross thing!'

In the telling of these experiences of the 'messiness' of birth there is almost an expectation, or at least a wish, that birth was not like this, that birth could be different, and that it did not have to involve these very basic elements of one's being. As the women talked about the messiness of birth it was almost as if there was a break or a fault line between the ways they live in the everyday world, and the experience of birth.

One woman described this break or fault line in relation to her everyday world:

[Our world] is clear, clean lines and surfaces - you know... [but contrast this to] losing control and pooing when giving birth!

This woman suggests that the everyday world that shapes women's understanding means that the 'messiness' of birth is less and less acceptable.

There is little doubt that the everyday worldview of these women in relation to bodily functions, bodily fluids, and modesty is challenged during childbirth. This challenge is shaping understanding and practice, as some women will seek out those things that remove and protect them from the messiness of birth, and so will increasingly choose the tools and procedures of intervention.

This midwife also explores the congruence between the everyday world and a 'clean cut':

I just think of this woman who lives in the inner city, eats out, runs a business, has the palm pilot, the company car and so has a certain mindset, as do the people she is mixing with and who have influence in her life, telling her she does not have to go through all the stuff of birth. Just have a clean cut.

This example further illustrates the shaping of understanding by society, its values, and the processes of socialization. The worldviews of both the public and the health professionals suggest that the shaping of understanding by 'clear, clean lines', the desire to avoid messiness, and the attractiveness of the image of the 'clean cut' are leading some women to increasingly choose intervention.

Worldview: 'The social values of convenience, ease and "fit-it-in-ness" inform the everyday world.'

Participants looked for metaphors from their everyday lives to capture how they saw birth mirroring society:

Having babies will be like ordering fast food...fast food babies!

It seems inevitable to this participant that babies, like other everyday things in the 21st century, will eventually be procured in ways that are fast, convenient and ready to go - the 'fast food' baby. The commonplace nature of fast food, and the ease and convenience associated with it, means that this worldview is an important shaper of understanding.

An obstetrician explores further the notion of convenience:

I think a lot of intervention happens because women are older and they don't want to be inconvenienced. They are only going to have one child and so why bother with natural birth. Some ethnic groups are very clear on it. They are only having one, so they have elective caesarean.

A notion of 'fit-it-in-ness' emerged from a number of participants. A midwife offers her explanation:

You have also got an aging clientele having their first baby and they want to fit it in with other things in life and, unfortunately, some of the obstetricians actually accommodate them so that it is a 9 to 5, Monday to Friday induction of labour. It suits some midwives too. I think a lot of it is because the women are older and they don't want to be inconvenienced.

Another midwife also explores the consequences of 'fit-it-in-ness':

It is more clean-cut and they don't have to wait hours. They book in, they know the date that they are having their baby and they don't have to give up any golf lessons and the like. They believe this baby is going to fit into their lifestyle whereas the reality, probably, is that they are going to head themselves up for post-natal depression because their expectations are totally unrealistic.

An obstetrician further explores what has to fit in with what:

Women are professional, and this is world-wide, and having a baby is part of a process of growing up. It is not a biological process and it kind of fits into their lifestyle - while their lifestyle does not fit into the baby.

A midwife considers the 'fit-it-in plan' of professional women:

So having a baby for professional women is often about getting pregnant, getting induced at 38 weeks because you are getting uncomfortable, or asking for an elective caesarean; having it then done under epidural without removing your make-up, and six weeks later the baby goes to the nanny and back to work. We see lots of this.

A woman confirms that for some women childbirth needs to fit around work:

I think it is as much the understanding that you gain before you have the caesarean section. I mean you know when you can have it and if you are on a big project you know, 'Okay, I have to have my project finished by this date and I can fit it in.'

The following women see how other women fit their baby into a busy schedule:

I think it is very easy to say that people shouldn't be able to choose to have a caesarean section but I heard of a woman who had a nanny lined up after she had had her elective caesarean section. The nanny was coming in five hours a day until she went back to work at three months, and then the nanny was going to be full-time after that. I just thought, 'Oh, so this baby is just a blip in your schedule!'

Yes, exactly, it is very much for some people like, 'This is on my schedule now. I have to have this baby now.' It is like for some women that they have to have this experience in their life, go through this but they really do not want to participate so they are going to fit it in and then get back to their real life as soon as possible.

These women suggest that convenience is a consideration:

Choosing intervention - well it is convenience. That is the thing you do now: here is your little checklist of what is going to happen next - and see it all fits like this.

I think in Auckland it is more like people with careers choosing caesarean sections because of convenience for getting on with work and less disruption.

The everyday world of women, in which they juggle their busy family lives and careers, is marked by 'fit-it-in-ness' and convenience. It is only natural that these values inform the choices women make in relation to childbirth and intervention. In this data, the participants present what is almost becoming an urban myth the woman who fits the baby into her busy schedule, has the nanny lined up and chooses the elective procedure for the convenience and ease of fitting the birth into her busy life. Pregnancy and childbirth, like the other facets of life, become something to be scheduled, arranged, orchestrated, planned, and even paid for if necessary. The shaping of understanding in this way means that those things that best facilitate convenience and 'fit-it-in-ness' will be increasingly valued and sought after, which will inevitably result in increasing intervention.

A number of women suggested that values such as convenience and ‘fit-it-in-ness’ are shaping women’s understanding because of the pressures that women find themselves under at the beginning of the 21st century.

One woman places the ‘fitting-in’ of childbirth in the context of women’s lives:

Fitting childbirth into life really asks that other things are looked at. Women are having to sort of shuffle childbirth and having babies in amongst such a busy full life. I mean I’m not advocating that woman can’t do both but it’s bloody hard and yeah I think a lot of it is about the pressures put on women.

Another woman asks a question regarding the pressures women are under:

What is putting women in that position that they’ve got to book a caesarean and fit it all in?

Another woman suggests we need to reflect on the pressures on women:

The poor woman, if she can’t even take two weeks out to just have the baby and have a rest - bloody hell, that’s scary!

Many women shared their own personal experience of pressure they were under to fit it all in. This woman shares her experience:

There are a lot of pressures aren’t there: modern day pressures, lots of debt; we have to send [child’s name] to day care full-time - so 11 hours a day. You come home from your own day and you shout at them and yell at them and you think, ‘That was a great day with my kids.’ Someone else has the benefit of seeing them crawl for the first time; their teeth come through. I was back at work after two weeks. It was only part-time one day a week but it was an 11-hour day for that time, and it is hard to fit it all in.

These women articulate the very real pressures a lot of women are under that inform their choices and shape their understanding in relation to childbirth and intervention. They believe that the pressure of modern life to fit everything in is shaping women’s understanding. Childbirth itself becomes something to be ‘fitted in’ and intervention makes the fitting in possible.

These worldviews raise the possibility that it may not be the intervention itself that the woman is opting for, but rather what the intervention offers, such as convenience and ‘fit-it-in-ness’. A way of birth which involves intervention, its tools and procedures, may be chosen not because of a commitment to a certain way of birth, but because a certain way of birth suits and facilitates a way of life and the pressures and demands of that life.

Worldview: ‘Fashion, fads and the media shape understanding and practice.’

A number of women identified the cultural and social phenomena of fads, fashion, trends, and the media as shaping understanding in relation to intervention in childbirth.

A participant shares the influence of fashion, fads, the media and celebrities on shaping her understanding in relation to intervention in childbirth:

Well I remember when I got pregnant none of my friends had had babies and I was 26 and I remember saying to my midwife I would like to book in for a caesarean and she said, ‘Well you can’t just do that.’...I wanted to have a caesarean section because it seemed like the easy option. I am not sure where I got that from. It must have been from television or celebrities. The only thing I could think of was that lots of stars were having elective caesarean sections around the time I had my first child. I think the media and the celebrities having caesarean sections got me thinking like that.

A midwife also explores the influence of fashion and fad:

I think intervention and influences to allow intervention come from society. I think we get a lot of influence from America. Women want to have a good sex life, and they think that if they have a caesarean then they are not going to have their bits misshapen. Maybe it is male dominated, I don’t know. I think men are under pressure today, as women are and I think the media influences a lot worldwide. The world is getting smaller in terms of communication, because we have got internet, satellite television - so I think film-stars can influence the outcome by what they have so, it is a trendy thing and what is in fashion. It’s fashionable to have an epidural. It’s fashionable, and you hear people saying, ‘When I had my epi...’

A number of other women also presented fashion and fad as shaping understanding and the choices women make:

These women chose intervention because the person next door is choosing it.

Maybe there is society pressure to choose intervention. Like if you are rich then this is the way you give birth. If you do not have a caesarean then it's like you are not hip or something.

I think choosing caesarean sections in places like Brazil – it's like a fashion statement there. It has got so much poverty and extremes. It is like to show, 'Well, I am rich!'

These sentiments were echoed by a number of health professionals, and are best expressed by an obstetrician:

I think we are on an upward spiral [in regard to intervention] but I am not convinced that there is a really good reason for it. I guess it is a philosophical thing or a trend as much as anything. I mean should it be necessary all of a sudden for the population to be delivered by caesarean section? But if they are driven by the patient coming through the door saying they want that, it will inevitably go up unless the fashion changes, and suddenly everyone wants vaginal births again.

This participant, working in a public system with a mandate to provide safe, cost- effective maternity care, believes that fashion is informing choice and shaping understanding and practice in such a way that increasingly intervention is chosen and supported as a choice.

Worldview: 'The social values of "control" and "being organised" shape understanding and practice.'

Health professionals and the public spoke at length about an everyday world in which childbirth is viewed as something to control rather than be controlled by.

An obstetrician explores the reasons for control:

Women are now having babies at a later age and many of them are not having more than two children. The expectations of having a labour that they are going to be able to have control of, and that it is going to be pain-free, are really great, and so those interventions carry on because that is the expectation now: to have control.

There appears to be a worldview centred on the 'out of control' nature of birth which is primarily linked to the pain of childbirth.

The expectation that women will be in control during the process of birth appears to be shaping understanding in such a way that pain and birth will increasingly be controlled and regulated. This regulation and control of pain will inevitably result in increasing intervention.

One woman explores the notion of control:

So people think, especially business people that are used to being planned and organised, 'Okay, let's just have intervention'... like you can see how it becomes attractive. Like waiting for my baby to arrive that week he was overdue, that was hell. It was like, 'Whenever am I ever going to go into labour?' and that waiting actually is very debilitating. Being a very organized person I was not used to it and like it was like, 'Well, I am ready to have my baby now and I want to have it NOW!' I suppose having a caesarean section, you have that control.

An obstetrician echoes these sentiments and presents the importance of control for some women:

I think there are certain women, professional women, who are in control of a lot of things, for whom control is important and so they will choose an epidural. They are well read, have been on the internet and know they do not have to go through the pain. You try getting someone who is a lawyer or an accountant to go through two days of labour. She wants to be in labour for two minutes - well you know what I mean!

The everyday world in which women know what is going on, what is happening, and in which they are in control, appears to be contested by the process of birth. This need to be in control leads some women to choose those things that will give control - which inevitably are tools or procedures of intervention. In this way the shaping of understanding by the need to control and the presentation of those things which can offer control leads to increasing intervention in childbirth.

Health professionals also presented the notion of predictability alongside that of control as shaping understanding and practice in relation to intervention.

One obstetrician suggests that predictability is an important part of control:

It is the unpredictability of vaginal birth that is the problem. If we could guarantee someone that they could have a fairly straightforward delivery then that would be fine. We cannot say everything will go well because what happens when your perineum is in tatters. So why not have a caesarean section?

Surgical procedures are being imbued with the qualities of control, predictability and order, while vaginal birth is seen by some to be chaotic, unpredictable and random. The valuing of these qualities is just one further reason for intervention in childbirth to be increasingly in demand.

This worldview is explored further by another obstetrician:

Yes, I think if I had said 15 years ago, 'I am not having a normal delivery because I do not want my bottom ripped up,' people would have looked at you as if to say, 'Why are you thinking about you for? It is all about the baby; you are really selfish.' Whereas now, I think it is probably a culture change for women in that they are not prepared to have so much left to chance. It is a control thing too. They do not want things happening to them that they cannot control and cannot predict. So therefore they choose a caesarean section.

This participant claims that women now want to control how things happen and when they happen and will no longer put up with things just happening to them.

A Pacifica woman presents the changes in her generation in relation to control and childbirth: (cf Chapter 4, p. 4 re inclusion of Pacifica women)

I was more than happy to have a normal delivery but it is painful and so I opted for an epidural. My midwife said, 'Pacifica women are stoic and do not show pain.' But it is like in our culture you just cope with pain - but I would take pain relief every time.

This woman challenges the assumption that all Pacifica women share the same stoical attitudes about pain, which mean that they are in less need of pain relief. Another Pacifica woman interviewed linked the “just coping with the pain” to a traditional worldview in which a particular understanding of nature and God led to an acceptance of the way things are. She contrasted this worldview with her own, in which she believed that it is not only possible, but necessary, to control things such as pain.

Being in control is underpinned by a sense that everything must be planned and organised, as this midwife describes:

In this part of the city the women are very articulate and it is very society influenced. And it is what you tell your friends. You have this group who don't want to feel any pain. They can have everything that's going for them and they are happy with their outcome. They are even happy if they have a caesarean. They have sort of become soft. I suppose it goes right back to knowing the sex of the baby on a scan, doesn't it, where the planning of the family becomes important. We will plan when we have it; we want to know what sex it is, so we can plan what clothes to buy, what colour to paint the room, and then the next step is we will plan when we will have it so we will be induced and then we plan the labour.

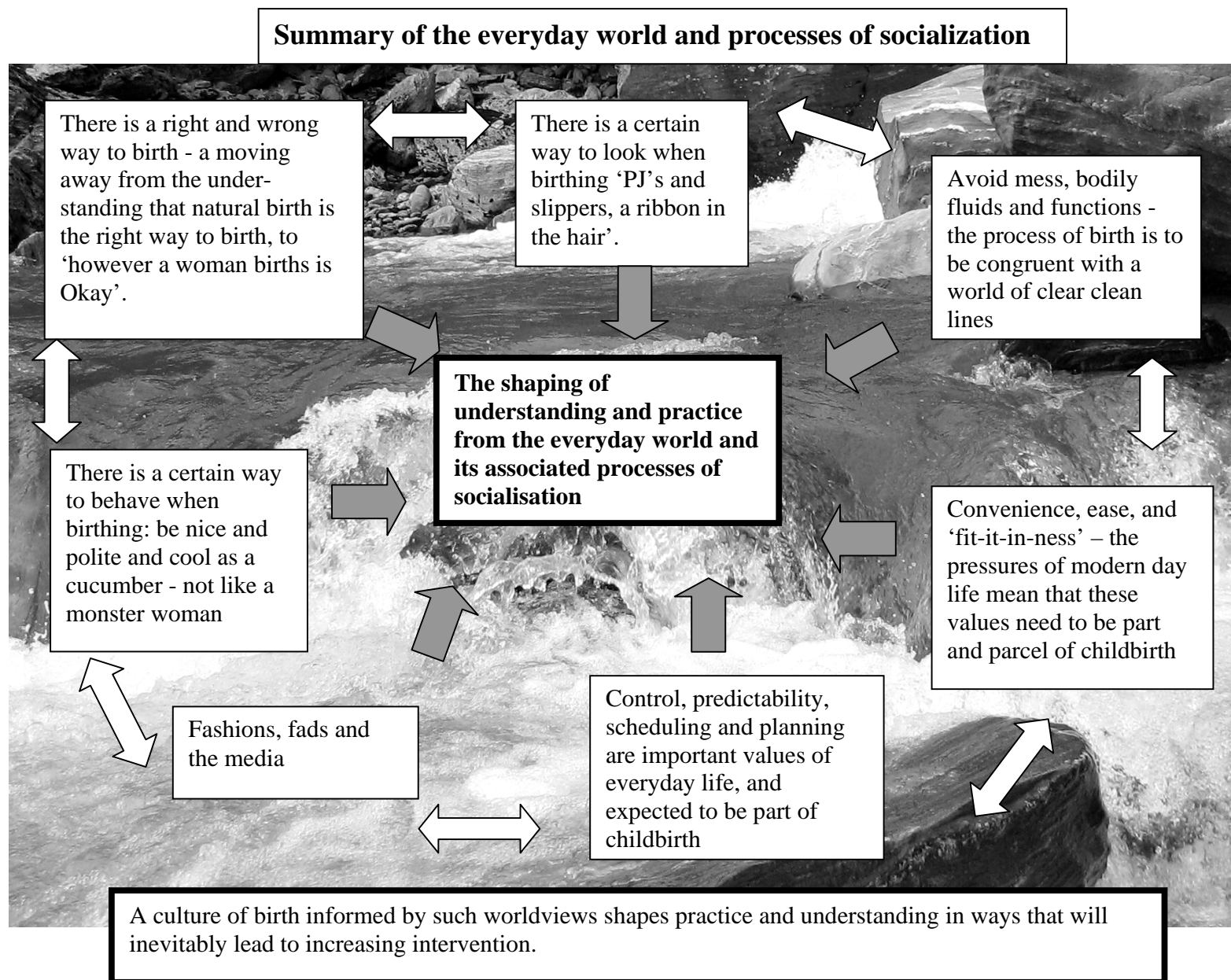
The sense of control that being able to plan for the date and time of birth is explored by the next woman using the example of an elective caesarean section:

With my second child when I had the elective caesarean section it was like turning up to a dinner date. You go in there and you go up to the room that you are going to come back to after the baby. They put the needle in and then you go on down and you meet everyone and you get into theatre and have the epidural. Then you have the baby and you get sewn up and back to your room.

The participant likens her elective caesarean section to ‘turning up to a dinner date’ where you have been invited to come to a particular place at a particular time. As at a dinner party, you are introduced to people you do not know, you are orientated to and even shown around the house, and you are invited to sit and have a drink, and the proceedings are directed by the hostess or host. Women’s experience of knowing the date, time and place of their caesarean appears to offer in itself some sense of control. These women offer an important insight into the shaping of their understanding by their everyday world in which events are planned, organized and controlled.

Their everyday world calls into question the value and place of ‘waiting’ and ‘not knowing’, since these things are not valued, encouraged, or even readily experienced in everyday life. Those things that facilitate control and knowing will be increasingly valued and sought after, and in a number of cases will result in increasing intervention.

This exploration of the worldviews of control, predictability, organization and planning further illustrates the shaping of understanding and practice in relation to intervention. These worldviews do not necessarily lead to a particular intervention or even intervention itself, but they do suggest that a particular procedure may be preferred because of what it has to offer. Control, predictability, organisation and planning do not readily equate with the often chaotic, unpredictable, irrational and inconvenient nature of birth. In this instance, the shaping of understanding and practice appears to be less about the intervention itself, and more about those things intervention offers: control and predictability. Intervention will inevitably increase and become the norm if what it has to offer increasingly reflects and correlates to the everyday world and the values that make up and are important in that world.



Chapter Six: Part Two

Critical analysis of the everyday world and processes of socialization

The everyday world and processes of socialization (worldviews) that are presented in the Part One of this chapter provide the starting point for critical reflection. These worldviews facilitate an exploration of discursive symbolic orders, social practices, relationships of power and structures of domination that inform this everyday world and shape understanding and practice. To facilitate the presentation of the material and the process of analysis tables are used to capture the interplay between the worldviews and the shaping of these by social practices, discursive symbolic orders. This is followed by an exploration and elucidation of the shapers of the worldviews (the relationships of power and structures of domination). The worldviews that are explored first are in relation to the gendering of women, body image, body fluids, and other social values such as control, organization, convenience and ease.

The shaping of two contrasting worldviews in relation to the ‘right way to birth’.

Table. C1. THE SHAPING OF PRACTICE AND UNDERSTANDING		
Worldview (the shaped)	There is a ‘right way’ to birth, and coping with the rigours of childbirth is an important part of being a woman, as a ‘real’ woman endures and copes with the pain of childbirth.	There is no right way to birth. Birth is just one of many events in women’s lives, and has little to do with informing a woman about what it means to be a woman.
Social Practices (natural order) (the shaping)	A social system in which birth and the processes of birth are linked to the status of being a ‘real’ woman, and in which women are strong and birth naturally.	A social system in which birth and the processes of birth are not linked to any status around being a woman.
Discursive Symbolic Orders (the shaping)	Being strong, coping with the pain of birth means you are a real woman. The unacceptable That a woman seeks help with the pain of labour	The way a woman births is just that. There is little or no connection to being a woman, and whichever way a woman births should be accepted and supported. The unacceptable That the birth and the birth experience defines who a woman is

Alongside the worldview that there is a right and wrong way to birth, the participants present the worldview that there is a correct way that women should behave when giving birth.

The shaping of the worldview that there is a correct way to behave is presented in the following.

Table C.2 THE SHAPING OF PRACTICE AND UNDERSTANDING	
Worldview (the shaped)	Women's understanding is shaped by processes of socialization which result in women behaving, or wanting to behave in certain ways during childbirth. The social and cultural norms which define good behaviour as being in control, 'nice', polite and quiet during childbirth mean that those things that enable such behaviour will be increasingly sought after and valued.
Social Practices (natural order) (the shaping)	A social and cultural context legitimates certain ways in which women are expected to behave, including how to behave when birthing.
Discursive Symbolic Orders (the shaping)	<ul style="list-style-type: none"> • The image of the 'ideal woman' is the image against which all women measure themselves. • Being 'nice', polite, and in control is 'good' behaviour, as opposed to being loud, noisy and out of control which is 'bad' behaviour. <p>The unacceptable That women are not given the opportunity to birth in ways that correlate with their everyday world in which they are in control, 'nice', and polite.</p>

The relationships of power and structures of domination whose discursive orders and social practices support the processes of socialization (presented above in tables C1 and C2) describing the way that women 'should' behave when birthing have been explored by a number of writers. Women are gendered in any given society, and in the West this gendering has traditionally been framed by Patriarchy and the Judeo-Christian tradition. The relationships of power and structures of domination that are associated with these traditions led women to a certain understanding about how they should act, behave and dress (Andrews, 2003; Blum & Stracuzzi, 2004; Rubin, Nemeroff & Russo, 2004). In the Patriarchal and Judeo-Christian traditions of the West, women have also been led to associate goodness with altruism, and are socialized to feel selfish if they put their own needs before those of others (Fournier, 2002; Gilligan, 1982).

While it is impossible to deny institutional control over women's birth experiences and, in particular, the control exerted by hospitals, the medical model, and medical technology, it is the social controls over women's birth experiences that is of interest here. Martin (2003) claims that a woman's birth experience is regulated by social mechanisms, namely internalized technologies of gender, which compel women to act in certain ways. Martin (2003) argues that women bring to birth a sense of how they should behave, and that some white, middle-class women "often worry about being nice, polite, kind and selfless in their interactions during labour and childbirth" (p.54). Martin (2003) explores Gilligan's idea that white, heterosexual, middle-class women are relational, caring, polite, and are subjected to the tyranny of being 'nice' and kind. These findings are important in that they suggest there is an internalized sense of how a woman should behave during birth, which disciplines her and her body, even in relation to an event such as birth (Martin, 2003). This unquestioned sense of how a woman should behave is the internalization of the values, interests and beliefs of those relationships of power and structures of domination which would have women behave in the ways described in tables C1 and C2. These kinds of behaviour and birthing at the beginning of the 21st century appear to shape understanding and practice in ways that result in an increasing utilization and acceptance of intervention in childbirth.

There is evidence to suggest that women's appearance as well as their behaviour is regulated when it comes to pregnancy and even birth. In 1991, when Demi Moore, eight months pregnant, posed nude on the cover of *Vanity Fair* she is credited with making pregnancy sexy (www.usatoday.com.life). This sexy image of pregnancy, which the media touted, increasingly turned pregnancy into a glamorous, sexy and even a 'body- beautiful' experience (Daniel, 2006; Upton & Han, 2003). Johnson, Barrows, and Williamson (2004) carried out research on the meaning of bodily changes for first-time mothers. The study highlighted the key role "hegemonic feminine beauty" plays in women's perception of themselves even when they are pregnant (p.371).

While it is impossible to claim that there is any *one* way that women are socialized, it is possible that there may be a discursive framing supported by social practices which impacts unconsciously on the choices women make in relation to pregnancy and childbirth, which implies how they ‘should’ behave and present themselves. Birth is primarily a social event, and the way women birth appears to be related as much to the understanding a woman gains about herself from her everyday world as to any medical institution or any movement to make birth more natural (Martin, 2003). Therefore, while Demi Moore and other celebrity mothers have made overt the idealised body and the idealized pregnant body, individual women carry these ideals within themselves (cf Table C2) with the result that the ideals *shape* their understanding about the way they should look when pregnant, and behave when birthing.

At the beginning of the 21st century, the gendering of women continues to socialize them into certain kinds of behaviour and appearance. When the everyday world of women values the ‘nice’, the calm, and the controlled, this world increasingly expects the controlling of the body by an epidural, and rejects the valuing and celebrating of the body as ‘monster woman’ and ‘big bear’. When this everyday world also values science and technology and all that it has to offer, then there is fertile ground in which the practices of intervention can take hold. These processes of socialization reflect the interests of the structures of domination which, through discursive orders and social practices, give meaning to and support women in acting, behaving and even dressing in certain ways, even in the throes of childbirth. In this way, meaning is authorised and legitimated so that such behaviour is seen as ‘the way things are’ and even as reality itself. Therefore, certain relationships of power and structures of domination such as the bio-medical model, patriarchy, consumerism, feminism, celebrity culture, and science and technology discursively inform and support, through social practices, the processes of socialization, which ensure that the interests, beliefs and values of these structures increasingly *shape* understanding and practice in ways that lead to increasing intervention in childbirth.

The shaping of worldviews in relation to the body and bodily fluids, and the influence this has on the choices women make.

Table. C3. THE SHAPING OF PRACTICE AND UNDERSTANDING	
Worldview (the shaped)	The everyday world is clear, with ‘clean lines’...the body is powerful and primitive and needs to be controlled, and messy bodily functions and fluids need to be avoided or at least contained. Pharmacology and surgery are acceptable solutions and procedures when it comes to childbirth.
Social Practices (natural order) (the shaping)	A social network promulgates through its systems the practices of <ul style="list-style-type: none"> • Control of self • ‘Clear and clean’ • Control of the primitive and powerful body and messy body fluids • Surgery and pharmacology as normal, acceptable and commonplace
Discursive Symbolic Orders (the shaping)	<ul style="list-style-type: none"> • The world is clear and clean, and those things which are not, are to be controlled and, in particular, the body and its functions and fluids; its primitive and powerful nature is to be controlled. Surgical and pharmacological solutions are commonplace and so readily accepted. <p>The unacceptable That the functions, fluids, power and primitiveness of the body be uncontrolled, and that surgery and pharmacological solutions not be available.</p>

Attitudes towards the body have always been a key component in the socialisation of women, and in the 21st century they appear to be no less instrumental in shaping understanding and practice, and aiding the establishment of a culture of intervention. Warren and Brewis (2004) claim that in the West there is a commonly held belief that the mind is in control of the body, and the body, therefore, can be moulded, shaped, and made to obey our wishes and commands. This discursive framing of the body is supported by social practices such as the emphasis on mastery over the body through diet and exercise, and the use of bio-medical technologies which can remake and remodel the body (Walters, 2006). This is illustrated only too clearly in the cult of the makeover. Makeovers started out as television programmes ‘making over’ gardens and houses, and then they moved on to ‘making over’ people.

Such programmes frame surgery and pharmacology as just another tool to bring a person the desired body and life they have always longed for. It is very difficult to get any meaningful statistics on the rates of such surgery in Aotearoa-New Zealand, but in the USA in 2004 more than \$15 billion was spent on cosmetic surgery (Walters, 2006). Walters (2006) claims that breast implants have risen by 147% in the last seven years, and tummy tucks by 144% in the same time period. It is not surprising then to read in an article entitled, “Why mothers should be offered caesareans” that some women equate cosmetic surgery with the choice to have an elective caesarean section (Lavender & Kingdom, 2006). While the numbers may not be large, there does appear to be an increasingly casual approach to surgery, which means that it is increasingly seen as being acceptable and readily available (Shute, 2004). In other words, the discursive orders which give meaning to surgery and pharmacology and the social practices which support and encourage this meaning (cf Table C3), are shaping understanding and practice, and determining the choices women make when it comes to intervention.

Warren and Brewis (2004) claim that pregnancy and childbirth challenge the dominant worldview that the body is something to be controlled and remodelled, as they serve as a reminder that humans have limited control over the body. This reminder results in embodied events such as pregnancy and childbirth increasingly being viewed as something that is out of control, not to be trusted, and in need of being regulated (Warren & Brewis, 2004). An example of the challenge that childbirth offers to the notion of control is the noise and messiness that are part of childbirth. In a society where noise, such as screaming during labour, is discursively framed as a loss of control and dignity, those procedures which provide an option where this can be avoided, will be increasingly sought after. In 2003, one in four women in Aotearoa-New Zealand had epidurals, and in 2005 at National Women’s Hospital in Auckland, 62% of women had epidurals (Ministry of Health, 2006; National Women’s Report, 2005). In the 21st century the West is increasingly informed by relationships of power and structures of domination such as the bio-medical model, capitalism, consumerism, and secularization whose values lead to cognition being valued over embodiment, with the belief that humans have, and should always exercise, the capacity to control and regulate their lives and bodies (Warren & Brewis, 2004).

It seems inevitable that the discursive framing and social practices which inform and support such structures will increasingly shape understanding and practice in relation to childbirth in ways that result in the body being increasingly regulated and controlled. This is the socialization captured in Table C3 that provides fertile ground for the acceptance of a culture of intervention.

Such discursive framing of the body means that basic bodily functions and body fluids are increasingly framed as disgusting and unacceptable. This discursive framing is supported by social practices which increasingly normalize avoidance of bodily functions and fluids, and the so-called ‘messiness’ of birth. Isaksen (2002) claims that disgust at the lack of continence, which is an integral part of birth, is a result of an enculturated and socialized view of how a person views and values themselves, rather than just a feeling of disgust at the sight and smell of faeces. In Western societies, where bodily functions and body fluids are increasingly sanitized and removed from the immediacy of an individual’s world, any experience of these functions and fluids in an uncontrolled way, such as during birth, will be viewed with disgust and distaste. Isaksen (2002) argues that the social norms and cultural meanings that surround such ‘messiness’ of the intimate functions of the body and losing bodily control, can put an individual’s identity and human dignity at risk. This appears to be particularly true in Western culture, where individualism is embodied in such a way that the identity and dignity of an individual is expressed by maintaining control over the body (Isaksen, 2002).

It appears that the discursive framing of messiness is also supported by social practices which indicate where it is appropriate for such messiness to take place. A *Sunday Star Times* article on women shunning homebirth reported an interview with a woman who rejected the idea of a homebirth because she claimed that her home was a sanctuary, and that she did not want that kind of experience (blood on the floor) in her home (Laugesen, 2004). Hospital and birthing units are increasingly seen as the most appropriate spaces for birth as these facilities are set up to cope with such things and promise ease, convenience, cleanliness, and disposal of the mess by somebody else. This framing of bodily functions and fluids and the place where such things belong is illustrated only too clearly by the choices women make regarding the place of birth. In 2003, 84% of woman gave birth in secondary or tertiary hospitals (Ministry of Health, 2006).

While the reasons for this are complex, such things as the meaning given to messiness and the definition of the rightful place for messiness, as presented in table C3, can only lead to the further normalization of hospital as the place to birth.

Throughout the interviews there was almost a longing by the participants for birth not to involve the very basic elements of one's being. They were deeply reluctant to experience the body and its functions in such an uncontrolled way. When the women talked, it was almost as if there was a break or a 'fault line' between their everyday world and their experience of birth. The process of birth itself appears to take some women to a place where rules, expectations, and parameters are profoundly different from anything they have experienced up to that point. The participants in one of the focus groups claimed that nothing prepares women for this experience, and that if they could have avoided it in the moment they would have. This does give rise to the question of how much of a part this plays in the valuing of a caesarean section over a vaginal birth (Ministry of Health, 2006). During a caesarean section the bodily fluids, on the whole, are contained within tubes, catheters, redivacs and containers. In an operation, body fluids are framed as part of a procedure that is sterile, controlled, clean and tidy. This means that there is minimal, or no contact with the messiness of birth, and this may make it very attractive for some women. Although this was not a choice of the women in the focus groups, they still referred to these fluids and functions as dirty, messy, embarrassing, and something to be avoided. The discursive framing of bodily functions, bodily fluids and bodily containment as presented in Table C3 are, in the moment of birth, challenged - and challenged in such a way that in the 21st century the "messiness" of birth appears to be growing less and less acceptable.

While it could be argued that some women have always been challenged in relation to the bodily functions and fluids of childbirth, I would argue that never before have there been so many options, choices and possibilities which allow women to seek out those things that remove and protect them from what the women in the study called 'the messiness of birth'. It appears that the 'messiness' of birth is not only incongruent with a world of clear and clean lines (cf Table C3) but it also calls into question those very things that are central to an individual's embodied understanding of themselves, which they gain from their everyday world.

Therefore, certain relationships of power and structures of domination such as science, technology, the surgical and pharmacological (whose values are promulgated through control and regulation of the body), ensure that the body, its functions and fluids and the so called “messiness” of birth are controlled. The discursive framing and social practices that support these structures, as presented in Table C3, increasingly shape understanding and practice, so that the choices made about birth, the place of birth, and the control, regulation and messiness of birth facilitates increasing intervention in childbirth.

The shaping of the worldviews of convenience, ease and ‘fit-it-in-ness’ are presented in the following table.

Table C4. THE SHAPING OF PRACTICE AND UNDERSTANDING	
Worldview (the shaped)	<p>The everyday life of the public is increasingly shaped by expectations that:</p> <ul style="list-style-type: none"> • life will be as easy and convenient as possible • things will happen as quickly as possible • the tools of science and technology will facilitate these expectations.
Social Practices (natural order) (the shaping)	<p>A social network which promulgates through its systems the practices of</p> <ul style="list-style-type: none"> • ease, convenience and ‘fit-it-in-ness’ • certain fashions and fads which determine choice by making available and acceptable that which can be chosen.
Discursive Symbolic Orders (the shaping)	<ul style="list-style-type: none"> • Ease and convenience are seen as important; even essential. • Fashion and fad give meaning to what is chosen • Technology and its attributes are associated with those things that are important and highly valued. <p>• The unacceptable That things not be easy and convenient, and that fashion and fads be ignored and technology not be a part of the everyday world.</p>

The everyday world in a society such as Aotearoa-New Zealand is set up to facilitate convenience and ease in carrying out the daily tasks of living. For example, people can bank and shop online 24 hours a day, 7 days a week. Such services shape understanding and fuel the expectation that things should be hassle-free, straightforward, and always suit the needs and wishes of the customer.

To this end, services are constantly marketed on their ability to deliver their product or service in a way which will involve a minimum of discomfort or inconvenience for the client. As a result of such a worldview, those relationships of power and structures of domination, whose interests are served in making life easier and more convenient can be seen to influence many aspects of life in the West. In 2001, Americans spent more money on fast food than on higher education, computers, software or new cars (Schlosser, 2002). In the West those things that make everyday life easier and more convenient such as the computer, mobile phone, microwave, weed whacker, rice cooker, remote control, garage door opener come primarily from science and technology (Catherall, 2005). It follows that if those things that make life more convenient, hassle-free and easier are technological, then society will increasingly value and place importance on things technological. Therefore, the shaping of understanding that women bring to childbirth means that, increasingly, the values of ease and convenience will give meaning to events such as birth. In other words, the biological and physiological nature of birth will increasingly be determined, directed and managed primarily by the tools of technology and the parameters of science.

The discursive framing of childbirth by the tools of technology is discussed by Lavender and Kingdon (2006) who claim that in Britain, birth without intervention is seen as old-fashioned. There is less and less value placed on the ability of the woman to birth naturally and more and more on utilizing the tools of technology to birth which is seen as 'progressive' (Lavender & Kingdon, 2006). Klein (2004) links the 'quick-fix culture' of the 21st century with caesarean sections on demand, insofar as they are increasingly seen by some women as an easy and convenient way of giving birth. The discursive framing and social practices of the network and systems of technology shape understanding and practice in relation to that technology and its attributes. This shaping of understanding results in values such as progress, ease, convenience, and 'fit-it-in-ness' as set out in table C4, being increasingly associated with technology, which inevitably leads to increasing intervention in childbirth.

The shaping of the worldviews in relation to control and predictability.

Table C5. THE SHAPING OF PRACTICE AND UNDERSTANDING	
Worldview (the shaped)	Childbirth is a process that is inherently unpredictable. It is important to be in control, to have mastery over the body, to predict, to manage time, organize and plan when things will happen.
Social Practices (natural order) (the shaping)	<p>A social network promulgates through its systems the practices of</p> <ul style="list-style-type: none"> • Assuming and retaining control over life events. • Mastery over the body • Accurately predicting outcomes. • Services centred around the saving of time, being on time, creating time, managing time, and creating space for 'quality' time, and above all ensuring that things go to plan in the time provided. • Planning and organising for everything, so that dates and times are known and outcomes are predictable
Discursive Symbolic Orders (the shaping)	<ul style="list-style-type: none"> • Individuals have the capacity to control their bodies. The body can be made to obey the wishes and commands of an individual, thanks to science. • Time is planned, organized, controlled, and even manipulated, and things are made to follow a plan, with a real focus on productivity and efficiency. • Nature, the body, and birth, which is primarily linked to nature, is increasingly framed as something to be harnessed, and its unpredictability controlled. • Science, pharmacology and technology, which provide the means with which to control the environment, the body, and daily living activities are increasingly valued. <p>The unacceptable</p> <p>To be unable to plan and predict, to wait upon an uncertain time and date, to not be in control and have mastery over.</p>

Naisbitt, Naisbitt and Philips (2001) claim that in the 21st century people have become focused on productivity and efficiency, and that they need to control, plan and make things happen. This everyday world as displayed in Table C5, will inevitably ensure that those procedures which are seen to give control and facilitate planning and predictability are increasingly valued and sought after.

This is clear in some of the data from the participants for whom technology and its tools offered order, predictability and a controlled environment, while biology and nature were increasingly seen as being disorderly, unpredictable and uncontrolled. The shaping of practice and understanding in relation to this desire to control, plan and make predictable as presented in Table C5, is explored in the following, using examples presented by the participants.

The first example is in relation to pain and pain relief. Illich (1997) argues that the “art of suffering” and the meaning given to suffering has been abolished, resulting in pain becoming something that is to be controlled and regulated. The implications of this discursive framing of pain are that those things that will control and regulate pain are made readily available and become increasingly acceptable. The advertising world feeds on and encourages this discursive framing: an advertisement in the *Herald on Sunday* (10th Dec, 2006) read: ‘I don’t have time for headaches’, and pictured a box of “Panadol Rapid” as the solution. Relationships of power and structures of domination such as science, pharmacology and technology increasingly authorize the control and regulation of pain in the everyday world. This discursive framing of pain supported by social practices which make pain relief available and accessible significantly shapes understanding and practice in relation to the inevitable increase in intervention that will control and regulate pain.

Another example from the participants to be explored in relation to control, organization and planning is the notion of time. Naisbitt, Naisbitt & Philips (2001) claim that people in the West live in ‘high-tech’ time, and that there is an obsession to save time and to see how much can be achieved in a certain time frame. This obsession has led to a discursive framing of time as something which needs to be controlled, managed and planned so that things are as efficient as possible (Naisbitt et al, 2001). This means that social practices will increasingly facilitate efficiency, planning, scheduling, and the certainty of knowing when and where events will happen (cf Table C5). Birth may well be in the process of being reinvented as a scheduled life event such as a wedding or a birthday, rather than an unscheduled biological event or process (Zarembo, 2001).

Katz Rothman (1989) claims that in a technological society the criterion that is applied to machines is also applied to people, so that whatever facilitates speed and efficiency becomes more highly valued and utilised. The relationships of power and structures of domination and their discursive orders and social practices (cf Table C5) inform and support the stance that everything is to be managed, controlled and made increasingly efficient. This stance profoundly shapes understanding and practice in relation to increasing intervention.

Another example from the participants is in relation to control itself, and the desire to control the body and not to be controlled by the body. Control, predictability, efficiency and rationality discursively inform the everyday world that it is possible to free the body from nature, improve it and increasingly control its unpredictability (Arney, 1982; Katz Rothman, 1989). Budgeon (2003) suggests that in the 21st century relationships of power and structures of domination in Western society increasingly frame the body as an object to be controlled and regulated. This is seen in the monitoring and surveillance of pregnancy carried out by highly sophisticated obstetric and reproductive technology, which regulates and controls the body and pregnancy in ways that are unprecedented (Arney, 1982). This need to control and regulate may be linked to the fact that nature, whether it be a tsunami, earthquake, or even bad weather, serves to remind humans that they only ever have partial governance over their environment (Warren & Brewis, 2004). Therefore birth, which is linked primarily to nature, reminds people of the limited governance humans have over their body, and is therefore likely to be increasingly framed as something that needs to be controlled and regulated (Warren & Brewis, 2004).

The extreme example of this is the suggestion that procedures such as an elective caesarean section are only a reflection of the control women now have over all other aspects of their lives and such choices are just another way of controlling and planning what happens (Parson, 2002). The relationships of power and structures of domination, whose values and interests are served in pregnancy and childbirth being increasingly regulated, controlled organized and planned for, as presented in Table C5, can be seen to be increasingly shaping understanding and practice in relation to childbirth. This shaping of understanding and practice provides fertile ground for the establishment and acceptance of a culture of intervention.

The discursive framing and social practices that are part of the socialization processes of women in relation to childbirth, whether they be about the way women appear and behave or the messiness of birth, present important issues for consideration with regard to intervention. I would argue that those things that shape understanding and practice are, in effect, one step removed from the intervention itself. In other words, it appears that for many of the public, and for some health professionals, it is not the epidural or the caesarean section that is chosen; rather, it is a choice for whatever the epidural or caesarean section facilitates. It is this correlation between what the intervention has to offer and the everyday world of the public and the health professionals which primarily shapes understanding and practice, rather than the intervention itself.

The everyday world and associated processes of socialization – a summary of that which is shaping understanding and practice in relation to intervention in childbirth.

THE SHAPERS: Relationships of power and structures of domination (the source and force of the river - that which in part controls and constitutes the river)

- Patriarchy and Judeo-Christian tradition
- Celebrity culture and western hegemonic feminine beauty
- Bio-medical model, surgical, pharmacological and technological interests
- Consumerism, feminism, capitalism and the ideas of the new age movement

THE SHAPING: The discursive symbolic orders and social practices shaping the worldviews (the river bed and river bank which contain, direct and support the river)

- Internalised notions of how to behave: controlled and dignified – tyranny of nice, kind and polite
- Mind in control of body, mastery over body, cognition over embodiment, containment of mess, regulation and control of body
- Sexy, glamorous, ‘yummy mummies’, body beautiful, cosmetic surgery, makeovers, shopping 24/7, quick-fix-culture, fast food, productivity and efficiency



THE SHAPED: Worldviews that are currently shaping understanding and practice. (The water - that which is seen to be the river)

- The right way to birth is whatever works for the woman
- Look and behave in a certain way when in labour
- Go for clear and clean lines; avoid mess
- Value convenience, ease, ‘fit-it-in-ness’, control
- Follow fashion, fads and media



The correlation between the everyday world with its associated processes of socialisation and particular practices and procedures (intervention) will not only ensure the normalisation of intervention but will also result in increasing intervention in childbirth.

Chapter Seven: Part One

Hermeneutic analysis of choice

The notion of choice presented itself in the data as powerfully shaping understanding and practice in relation to increasing intervention in childbirth. The meaning of choice and the importance given to it is first explored, and then those things shaping, informing and even determining what can be chosen are identified.

Worldview: ‘An individual has a right to choose what is best for them. Informed choice is to be supported and respected by health professionals.’

Across the focus groups one of the clearest messages given by the public was that women should have the right to choose whatever they wanted with regard to intervention in childbirth.

These women stated:

I would support women having the right to choose whatever is best for them, even if that means epidurals without really being in labour, or elective caesarean sections.

Choice is always good, and women should have the right to choose whatever is right for them.

I think women should have a choice and should be supported in that choice by the health professional.

Health professionals should be saying, ‘How do you feel about that’? I mean, I do think it is a woman’s choice and she should be able to choose. Our society has changed so much that a woman does have the right to choose now.

I think women should have a choice and if they want to have an elective caesarean section then they should be able to have one, as what is important is the baby, not the way you have it. So the woman’s choice matters and should be respected.

The data from the public suggests that the meaning and importance given to choice, along with conviction about the right to choose, is shaping understanding and practice in relation to childbirth and intervention.

There is an expectation that the right of choice is to be respected and supported by health professionals. However, while most of the public in the focus groups agreed with this worldview of choice, they did so with some conditions attached:

Absolutely I think a woman should have choice and be able to choose what she wants - but maybe the pros and cons should be pointed out.

I do not have a problem with women choosing whatever they want as long as it is informed.

Yeah, I think women should choose what they want as long as people know the implications of their choices.

I think if we want to have an elective caesarean section we should be able to, as it is a woman's individual choice as long as we are informed about our choices.

The worldview of the right to make a choice is reframed as the right to make an informed choice. Informed choice appeared across the focus groups as significantly shaping the public's understandings about childbirth and intervention.

One woman further explores the meaning of choice, and what makes a choice a right choice:

I think each to their own. I mean I did not want an epidural, but if the person next to me wanted one then who is say that they shouldn't have one, as long as there is no harm to or effect on the baby. I think in the end having pain or not having pain ...it does not matter. What matters is that I am happy or they are happy with the experience and result. If it is not doing anyone any harm then why not...I think it is what works for you what makes you happy.

Choice is seen as an almost absolute right of the woman and is intrinsically linked to the notion of happiness. These beliefs significantly shape understanding about intervention in childbirth.

Worldview: ‘If choice is informed it is therefore a right choice and something to be respected and supported by health professionals’.

Informed choice and the right to choose was also identified by the health professionals as shaping practice.

One obstetrician shares his experience and stance in relation to choice:

A pregnant woman who comes in to see you as an obstetrician, is a grown woman, not a child, and they are not to be patronised. If they come to you and say they want a caesarean section because of a, b, c, and d and they understand the risks and have read widely,...how can you deny them that choice? What right have we got to say, ‘No I am not going to do it’? We used to be able to say ‘No’ like that, but we cannot do it now - and who wants to do it? It is wrong not to support their choice.

This participant presents a stance taken by most of the health professionals in the study: if a woman is fully informed and aware of all the risks, and chooses a certain procedure or a particular way to birth then it would be wrong not to support that choice. This data captures a shift in the relationship between health professionals and the public, a shift which has resulted in a significant change in practice. Health professionals can no longer refuse to comply with women’s requests. Rather, it appears that health professionals are required to listen and, more often than not, support the choices women are making. So choice and the power of choice are shaping not only the understanding of the public, but also the practice of health professionals in relation to childbirth and intervention.

An obstetrician recalls a recent experience in relation to choice:

I think women usually get what they want in the end. I have had very few women who have had a caesarean section for no real indication. I have got a couple coming through at the moment who are adamant that they want a caesarean section and they are well informed and know the risks. They are both over 40 and having first babies, and I will agree in the end. I usually encourage them to make a decision late so that if you do, by chance, happen to find them at term with an effaced cervix and the head well down, they might well be persuaded to labour. Otherwise they do get what they want.

A midwife explores the power of choice:

If it were a woman's choice to be induced at thirty-six weeks, would we do it? Some women could decide that she's had enough and heaps do decide that they have had enough at 36 weeks. If someone actually came along and said that she wanted to be induced and it's my choice, should we do it? It is the same question when a woman says she wants a caesarean section with no clinical indications whatsoever. Should we do it? Would we do it? Well maybe we would.

Both these health professionals are clear that they would probably end up supporting a woman who was adamant about having a caesarean section or being induced, despite their beliefs about vaginal birth and going to full term. The right to choose can be seen to be shaping practice, in that there exists a milieu in which health professionals may, or eventually will acquiesce to the woman's request. The women in the focus groups also presented a number of situations where their choice had been influenced by health professionals. Many of these situations involve pain relief or the use of particular technology such as a scan or Doppler, and are presented in the sections on pain and technology.

Another obstetrician presents a situation where choice increasingly leads women to intervention, and results in a culture of intervention:

Yes I must admit in the place I worked before women's choice played a much bigger part in the care they received than it does here at the moment and so there was much more intervention. But you see it was a different population mix and if I was practicing in another place it may be different in relation to intervention, as it seems it is different depending on different social strata and the amount of choice involved.

This obstetrician suggests that the actual importance placed on choice and the right to choose depends on the women's social and cultural backgrounds. It appears that choice is shaped differently in different populations. At the present time, in the sectors of society where choice and the right to choose are primarily shaping understanding there are increasing rates of intervention.

The association of a culture of choice with increasing intervention means that it is important to identify those things that shape choice. The shaping of choice by particular values and interests provides the context out of which understanding and practice is shaped. This shaping of choice is now considered.

Worldview: ‘Choice is shaped and informed by social and cultural beliefs, values and interests’.

The following woman captures the *shaped* nature of choice by presenting two very different experiences of choice in relation to childbirth:

The biggest difference between my first and second birth was that I did not have a say with my first. I was young, he was early, they took over. They tried to stop the labour and that did not work. They just wheeled me in and put me up in stirrups which now is like a really unnatural way to have a child and like I did not have any say. The second time around antenatal classes made a world of difference as they were saying you do have choices. At the antenatal classes the one message I got was, ‘It is your choice.’ They told you what was on offer and said that you take whatever it is you want to take. I remember thinking, ‘Wow it is my choice!’ and it was all about our choice and our choosing. This time in the 1990’s, this was the time when choice was the thing. What I most clearly remember is the midwife who took the class told us about choice and that it was our choice.

This piece of data illustrates the changing nature of choice and how it shapes understanding and practice. This participant presents a range of experience, from having had no choice to having all the decision making power. She captures a change in attitude towards choice that took place in Aotearoa-New Zealand in the space of 10 to 15 years. In this country in the late 1980’s significant changes in the delivery of health services took place. These changes were a result of wider social movements such as feminism and consumerism, and in Aotearoa-New Zealand they were driven in particular by the recommendations of the Cartwright Inquiry (Appendix E). This inquiry sought to make visible the power exerted by health professionals over women, as described in this participant’s first birthing experience. The results of this Inquiry challenged and changed the nature of choice and consent, which in turn fitted into the milieu created by feminism and consumerism whereby in the 1990’s ‘choice was the thing’. In sharing her experience of the changing nature of choice, this participant captures the social and cultural influences on choice and the subsequent shaping of understanding and practice.

The *shaped* nature of choice which is presented above is also explored in relation to inter-generational differences. The next woman captures this *shaped* nature of choice in presenting the differences between her generation and her mother's.

When it comes to what you can do and have, they [mothers] say, 'Trust the doctor and do what the doctor says as the doctor knows best and it is not up to you. It's not your choice or what you want'. I don't trust the doctor to know what is best for me. I am much more likely to trust myself and question what the health professional says.

This participant's mother sees authority residing in the doctor while the participant sees it as residing in herself.

The following Pacifica women explore further the *shaped* nature of understanding in relation to choice:

I think in past generations birth was seen as a natural thing and so I don't think they knew there was a choice or were open to another option to it being another way. I don't know if it is religious or cultural or both but traditionally with our values we don't choose as part of birth. Natural birthing...it was just birth. I have a lot of (name of religion) friends and they would never have an elective caesarean section because it is against their religion, like there is no option because God made you this way to have babies. Why would you go against the way you were made?

For women of Pacifica culture, well it is like they are just having babies so there isn't any choice 'cause this is what you do...give birth naturally. You wouldn't even consider anything else as that is how it is. You are having a baby and choice does not come into it.

I think education is key in terms of people knowing about choice...and making a choice. If they were more informed like, 'Hey do you know an elective caesarean section is an option?' (if it was) rather than a normal birth, then I think they would have one if they wanted to. I think education is key in having choices and I think if women knew there was a choice then you may see more taking that choice. But at this stage, cultural-wise, it is not an option for many women as we do not have our babies that way. We have our babies naturally. I think as women become more educated and more aware of their choices they may choose [intervention].

This data offers two important insights. First, it suggests that particular worldviews shape women's understanding in relation to the choices they make, whether that be a natural birth or an elective caesarean section. Secondly, it describes these worldviews and shows how understanding and choice is shaped by family, culture, belief systems, education and religion. The participants suggest that education in particular shapes women's understanding in relation to the choosing of intervention as it enables women to know that they have a choice, as well as what choices are available. It would appear that the more aware women are of their choices, the greater is the likelihood of their choosing intervention.

This obstetrician explores further the role of education in shaping choice and the choices women make in relation to intervention:

I think the education is key in relation to choosing intervention. I mean a lot of women [in a particular area of Auckland] would not even think about having a caesarean section. When you are planning to have a family of five or six or even eight or nine it is not appropriate. They are not going to consider the implications for their pelvic floor, incontinence, sexual dysfunction, and all the other things that the 'too posh to pushers' use for not having a vaginal birth and having an elective caesarean section. Their world is different and there are many reasons for the differences between women, but partly it is about education and social expectations and the choices they have.

Choices around birth are influenced by values that a woman's education as well as her social, cultural and economic group place on children, birth, the body and its functions.

Another obstetrician speaks of the social changes in women's lives which inform and shape the choices they make:

I think women choosing intervention is all those things [wealth, ethnicity and education]. It is about all those things...and about being well informed. Having gone through and being a mother and having those choices as a mother I think people are very poorly informed by antenatal classes. They are often not told the truth and there is this huge myth about, 'You just wait and see, you just wait and see what happens'. It is like there is this big secret. I think the secret is out now. I think women are thinking, 'Do I want to have incontinence like my mother or my friend?' I think a lot of women are saying, 'Look I eat healthy, I look after my body, I go to the gym then maybe I do not want to take that risk.'

This participant presents a myriad of influences on the choices women make such as education, fitness, and zero tolerance for putting up with what their mothers endured. She suggests that women, especially those who are educated, wealthy and of certain ethnic groups, are not only less likely to put up with things such as incontinence but are also more likely to want to manage any risk that childbirth may present to their fit and healthy bodies. This stance in relation to the body and risk means that these groups of women are more likely to choose intervention, as they see this as a way of minimising the risk.

Other participants agree that attitudes towards childbirth and the body, and what women will choose in relation to both is changing:

Yes maybe my mother's generation was closer to nature but, as I said to you, for them it is God's way and you do not interfere with it. She said to me that is why I had pre-eclampsia because I interfered with nature and so all this because you are not letting it happen naturally and maybe there is something in that.

Yes, but you see if I told my parents our attitudes towards fixing what is wrong they would go, 'But you are crazy - that is normal. After all it is normal for women to leak, as this is what happens when you have babies'. Older women we know will put it off and if it is personal they will not tell, whereas our generation, well, we would go to any length to get ourselves right.

The two generations worldviews can be summed up as follows:

Table H1. Worldview (past)	Worldview (present)
You have babies, you will leak, that is normal	You have babies; you do not need to leak as that is not normal
You put up with it	You do not need to put up with it
It is personal, so put off doing anything about it	We would go to any lengths to get ourselves right
The premises that shape understanding	
Nature reigns	Intervention reigns - interfere with nature and make it better

A worldview which informs women that they no longer have to accept what is, but rather that the problem can be fixed, reconstructed, or the risk avoided in the first place, suggests a willingness to control and change nature to a degree not thought of in the past. This change in attitude from one generation to another gives an important insight into the informing of choice and the shaping of understanding.

The latter approach, while to be applauded, provides fertile ground for accepting and even embracing intervention as something that can control and enhance the body and nature.

The informing of choice by ‘horror stories’.

Horror stories of one sort or another appeared in all the focus groups, and were shown to be a particularly powerful shaper of understanding with regard to the choices women make around intervention in childbirth.

These women claim that passing on the horror of birth through story appears to be a fairly common way of informing women about birth and the choices they have:

With my first one it was scary and your close friends share their birthing experience and you get a lot from them. You get horror stories and you get quite scared.

The birth was okay. It was not as bad as I thought it would be. I suppose there is always the first time it is unknown and everyone tells you all the horror stories so you expect it to be bad.

The first time I have not spontaneously gone into labour, I have not had the experience of your waters breaking in the supermarket, all those horror stories.

I felt like I could drive [post caesarean section] but I thought ‘No’. I had heard the horror stories of being in the accident, jamming on your brakes, stitches popping and all that.

No one tells you anything useful. They tell you horror stories but nothing that is really useful like what it is like having no sleep and babies that do not settle; you know, all that sort of stuff.

The telling by other women, friends, family and the media about how birth will be, what it involves, and what women will most likely experience, does appear to predominately revolve around the ‘horror’ of birth. The shaping of these women’s understanding by such stories left them feeling fearful, anxious, horrified, determined to avoid pain, requesting a caesarean section, and then being relieved when the experience of birth was not as bad as it had been made out to be.

The worldview that the horror stories evoke for women appear to shape their understanding so that there is an expectation that birth will involve fear and horror:

I think for me when I had (name) and I had her in four hours, well the other women who had 24hr and 36hr labour and even 3 days of labour, well I actually felt ripped off. I did...I felt like, 'what the frig did I do wrong?'...I really did ... I did not talk about my birth with them because my birth was so easy and these women had been to hell and back. I felt bad and I thought, 'if I tell people about my birth they will think that I was showing off'...and I did, I felt ripped off I did...I remember [name] saying to me, 'Oh we are going to start pushing now'. And so I did. I did this almighty AUGGGGGGGGGGGh like this and like that was like my biggest noise and she goes, 'Ah what was that for'. I said wasn't that a push and she said it is not from up there it is from down here. Honestly with my second child three sets of pushes and she was out and it was simply because I had done the big WHAAAAAGH like on TV, but it was not meant to be a whaggggggggh at all. Rather it was meant to be done down there, and then of course she was out like that. I mean I felt I had been ripped off because you heard so many horror stories and no I did not want horror but I didn't want to be so normal. Being normal was being like those other women where they cried and were traumatized for the rest of their life. I wanted to be normal!

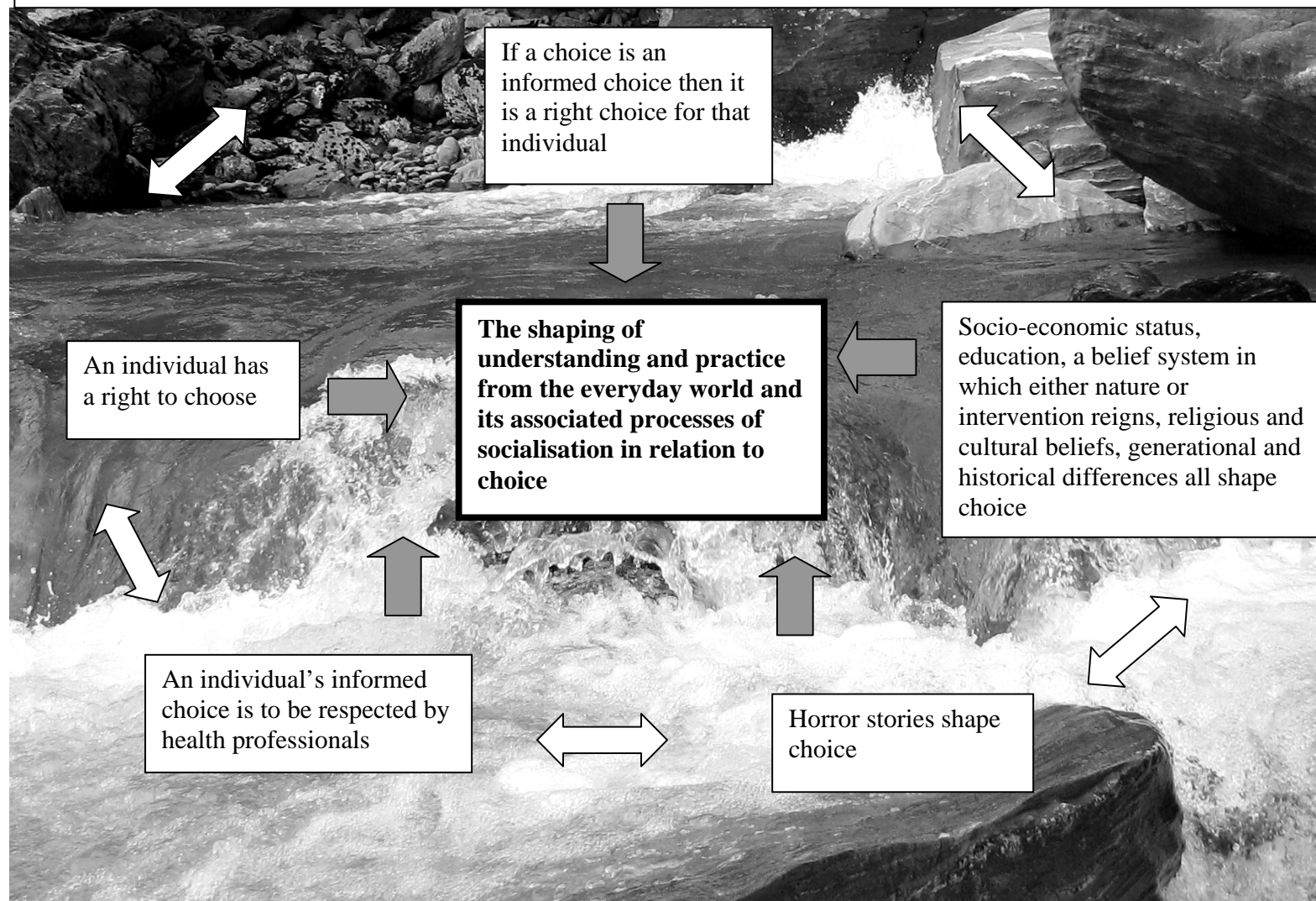
This story captures the power of a worldview which presents birth as full of horror. The woman presents very vividly the understandings she had of the way birth would be: long, drawn out, going to hell and back, full of horror, swearing, raising your voice, crying and being traumatized for the rest of your life. Her experience of birth which involved none of these aspects led her to believe that she had done something wrong and she felt cheated and would not talk about her birth with other women. The participant's understanding was shaped in such a way that she thought it was only through suffering the horror of birth and gaining a certain kudos for enduring such a horror that one had a birth story worth telling.

Another woman had a similar experience:

Yes I agree I wanted a little bit of drama...I had no drama either, and yet everyone else seems to have a bit of drama. I had a bit of stitching and bleeding; that was all the drama I had. I remember the midwife telling me that I had to go for a pee and when I had done that she said, 'You can go home now'. I was like, 'Oh that's it, like can't I stay here a little bit longer. Like, hey, I have had no drama. Really I have had nothing happen'.

This woman also felt cheated and disappointed without the drama. Stories about birth, and in particular horror and negative stories, have been identified as significant in creating fear for women in relation to birth (Melender, 2002). Choice and what can be chosen is determined over and above all else by the birthing culture. A culture of birth that is set around horror, fear, and anxiety will increasingly ensure that those procedures that control, tame, and even avoid the experience of horror, and that reduce the fears that women bring to birth will be increasingly understood as helpful, useful, and even essential for birthing.

The summary of the everyday world and the processes of socialization in relation to choice



A culture of birth is increasingly established in which choice is a 'right', and informed choice determines practice, and where women are increasingly choosing intervention.

Chapter Seven: Part Two

Critical analysis of choice

This section of the chapter presents the worldviews of choice and the discursive symbolic orders, social practices, relationships of power and structures of domination which give shape and constitute that which is choice.

The shaping of the worldview of the right to choose and to have this choice respected by health professionals.

Table C6. THE SHAPING OF PRACTICE AND UNDERSTANDING	
Worldview (the shaped)	An individual has a right to choose what is best for them. Knowledge and information informs choice, and when a woman makes an informed choice, as is her right, it is the 'right' choice for her and needs to be supported by health professionals.
Social Practices (natural order) (the shaping)	<p>A society in which legal, health and educational systems ensure that:</p> <ul style="list-style-type: none"> • Choice is a right. • The individual has the right to choose what is right for them. • Information facilitates choice. • The right and ability to choose determines in part how 'right' or 'wrong' a decision is for an individual. • Health professionals accept and respect an individual's choice (within acceptable boundaries). • Resources which make choice possible are readily available (e.g. epidural facilities).
Discursive Orders (the shaping)	<ul style="list-style-type: none"> • An individual's choice should be upheld by health professionals • Informed choice ensures that the individual's choice is always best. • An individual's autonomy (individualism) is highly valued and the right to choose is paramount. <p>The unacceptable</p> <ul style="list-style-type: none"> • That an individual is denied the right to choose or to make an informed choice. • That an individual's informed choice is not supported by the health professional.

The prevailing wisdom says choice, and the right to choose belongs to the woman and the woman alone, as it is only the woman who can choose what is 'right' for her (Uhrich, 1996). Such a stance is often associated with neo-liberalism, which advocates for a social order based on individual choice (Holmes, 2004; Leap & Anderson, 2004; Surtees, 2003). Such social order is more likely to be found in affluent countries, as these are marked by individualism rather than traditional family and kinship values (Holmes, 2004). The valuing of the individual and individualism (cf Table C6), is inherent in a neo-liberal social order, and gives rise to a belief system which enshrines an individual's right to make a choice. This is illustrated, by a study in which 1,530 obstetricians were asked how they would respond to a woman who requested an elective caesarean section because it was her chosen method of birth (Habiba, et al, 2006). Compliance with this request ranged from 15% -79% and there was little or no evidence to suggest that the differences in the obstetricians had anything to do with medical evidence. Rather, their responses which were found to be the highest in the United Kingdom (79%), were determined by social and cultural factors (Habiba et al, 2006). Here we see that discursive orders and social practices in relation to choice create a milieu where it is possible for an individual to request an elective caesarean section. Such a milieu readily shapes practice.

The discursive orders and social practices which inform and support choice impact on midwives as much as on obstetricians. Gallop (2006) claims that a logical consequence of the autonomy that is fostered in Aotearoa-New Zealand by the midwifery model, means that women should be able to choose whatever type of childbirth they desire, even when this is a caesarean section. This culture around choice is further illustrated by an expert panel convened by the National Institute of Health. This panel, while not actively encouraging mothers to have a caesarean section, claimed that they could find no real reason to discourage women from the increasingly popular procedure (Stein, 2006). The report from this panel was seen as vindicating those who advocate women's choice in birthing, as it removes the stigma that surrounds choices such as caesarean section (Stein, 2006).

The discursive framing of choice and the social practices which increasingly support choice as presented in Table C6, mean that the *right to choose*, rather than that which is chosen, determines to some extent the rightness of the choice. Beech (2003) would claim that such framing creates an illusion of choice rather than real choice, in that choice is seen as good even when it results in higher rates of intervention with poorer outcomes. The illusion is, in effect, choice itself, insofar as the right to choose, and what is chosen, is determined by the milieu in which a person finds themselves, rather than what any individual may actually wish to choose.

The discursive framing and social practices as shown in Table C6, which inform and support the notion of choice as a right and consequence of autonomy is underpinned by the premise that an 'informed choice' is worthy of dictating practice. This 'informed choice' appears to make any given choice a good choice, and one which is to be respected by health professionals. Such a stance however presupposes that the informing of any given choice is neutral, and informed by nothing other than reasoned argument and debate. Edwards (2003) argues that this is far from being the case and the autonomy of women and their access to information does not neutralise the shaping of the information they receive or the options they are given. Edwards (2003) asserts that the choices women make are in fact limited, insofar as they are determined by the information, birth practices and models of care that are provided for them to choose from. She highlights the fact that certain types of research are funded while others are ignored; this not only informs, but also determines many of the choices women make. This is illustrated by those sectors of society where choice is highly valued and those things that are increasingly chosen come from limited and predetermined frameworks of intervention. Choice itself (cf Table C6) is discursively framed and supported by social practices which reflect the interests of certain relationships of power and structures of domination, such as individualism and neo-liberalism. When these interests intersect with other interests such as science and technology they readily shape understanding and practice, and lead to increasing intervention in childbirth.

In the preceding section ‘choice as a right’ was explored along with the milieu that such a worldview creates. This association of choice with increasing intervention means that it is important to explore those things that *shape* choice. Therefore in the following I illustrate how understanding and practice in relation to choice is shaped and the way that this relates to increasing intervention.

The shaping of worldviews in relation to choice at different times.

Table. C7. THE SHAPING OF PRACTICE AND UNDERSTANDING		
Worldview (the shaped)	You do not have any choice. Decision-making is vested in those with the most expert knowledge, and the expert knows best so their opinions will be followed.	Everything is about choice, and whatever happens only happens because women choose it. Decision-making rests primarily with the person to whom the event is happening, as an individual knows what is best for them, and it is their right to make their own choice.
Social Practices (natural order) (the shaping)	A social network promulgates through its systems the practices of: <ul style="list-style-type: none"> • Those in authority and with the professional knowledge primarily making the decisions. • Valuing and following the authority of the expert. 	A social network promulgates through its systems the practices of: <ul style="list-style-type: none"> • The individual who is pregnant or birthing primarily making the decisions. • The expert representing one opinion among many, and the authority of the expert giving way in part to the authority of individual opinion or wishes. • The authoritative opinion of the expert being questioned, challenged, and even rejected.
Discursive Symbolic Orders (the shaping)	The authority and power is vested in individuals and groups who have expert knowledge, and they primarily make the decisions. The unacceptable That the person to whom the event is happening is the primary decision maker.	The authority and power is vested in the individual to whom the process is happening, and they are the primary decision-makers. The unacceptable That people with expert knowledge are the primary decision makers.

These two contrasting worldviews that determine differently where authority resides illustrates the shaped nature of choice. The first worldview is shaped and supported by the discursive orders and social practices in which the authority over knowledge and decision making is vested in the expert. The relationships of power and structures of domination (shapers) such as patriarchy, modernity and certain religious groups influenced and constituted such a worldview. In contrast current relationships of power and structures of domination such as postmodernism, consumerism and feminism, along with seminal events such as the Cartwright Inquiry in Aotearoa-New Zealand (Appendix E) can be seen to be constituting a worldview in which the person who is experiencing the process is the primary decision-maker (Coney, 1988). Anderson (2006) argues that the identifying of women as consumers in the 1990's meant that a woman giving birth had, in effect the rights of a consumer, and so could choose whatever she wanted: woman as a consumer meant that "choice is king" (Anderson, 2006, p.51). Anderson (2006) argues that consumer rights need to be reframed as citizens' rights, and that individual choice should not be the 'gold standard' of care. Rather, the best care in relation to what determines practice should be based on the best evidence (Anderson, 2006). The importance of the data presented in Table C7 is that it illustrates the *shaped* nature of choice. Choice does not exist in and of itself, but rather facilitates the interests of those who are best served by the promotion of choice as an individual's right.

The shaping of worldviews by culture, society, religion and education in relation to choice.

Table C8. THE SHAPING OF PRACTICE AND UNDERSTANDING		
Worldview (the shaped)	You birth naturally and with as little intervention as possible because that is what religious, cultural and family beliefs say about birth.	Formal education gives you knowledge and social power, and so gives you choices. You birth in the way that feels most comfortable and works best for you because of the education and information you have been given. Making a choice is your right.
Social Practices (natural order) (the shaping)	A society in which social, cultural, educational and religious systems support giving birth naturally, because God made women to birth in this way. It is not a matter of choice.	A society in which social, cultural and educational systems support a woman in deciding which is the best way for her to have her baby. This is important, as the choice is hers and nobody else's.
Discursive Symbolic Orders (the shaping)	<p>God, nature, family, and culture all decree that women give birth as God and nature designed them to, and as family and culture expect them to.</p> <p>The unacceptable</p> <p>That a woman chooses anything outside the system designed by God, nature, culture and family.</p>	<p>Women give birth in the way they choose to give birth, and that works best for them, as they have learnt about through education and information.</p> <p>The unacceptable</p> <p>That a woman is made to give birth in a way that she does not choose, and which does not work best for her.</p>

The two contrasting worldviews presented here are both framed by discursive orders and supported by particular social practices. The individual's right to choice *may* be seen as a better and more progressive stance than one where religion, family or culture determine what happens, but in effect, *both* stances reflect the interests of particular relationships of power and structures of domination. Underlying the notion of choice is the question of who has the power to decide what happens. When this power is vested in a central figure such as the priest, father or God, this figure determines what happens, and as shown in Table C8, the discursive orders and social practices support the authority of these figures. However, when there is a decentering of authority - as in postmodernism - and a movement away from centralized authority, a different social order evolves (Jordan, 2005).

The discursive orders and social practices of this social order no longer inform and support the authority vested in the 'bonds of blood, soil and religion' and the privileged status of a *few* but rather they inform and support the authority of the *many* in a pluralistic, diverse way (Jordan, 2005, p.150).

The degree to which women's understanding differs across generations (cf Table C8) illustrates the power of social and cultural movements and structures to shape the way people understand themselves, and how they then become the 'the bearers and producers' of such notions as the right to choice (Kogler, 1999). The right of an individual to choose, to make a decision, and to have control over what happens to them is underpinned by the liberal stance of freedom and equality, which seeks to universalize the freedom of individual choice (Fournier, 2002). Choice and the right to choose, is a particular philosophy which currently *shapes* practice and understanding. The relationships of power and structures of domination of postmodernism, individualism, consumerism, and capitalism (shapers) have their interests served and their beliefs promulgated by this philosophy of choice. (Leap, & Anderson, 2004; Sakala, 2006). It appears that in the 21st century in a country like Aotearoa-New Zealand that there is milieu which not only *shapes* choice as a right, but also prescribes which particular items of choice are available as normative and neutral. This milieu masks the interests of those relationships of power and structures of domination which are best served in promoting and establishing a culture of choice.

The shaping of the worldview that birth is full of horror and fear.

Table C9. THE SHAPING OF PRACTICE AND UNDERSTANDING	
Worldview (the shaped)	<ul style="list-style-type: none"> • Birth is a process full of anxiety, fear, and sometimes horror. It therefore needs to be controlled, tamed, and perhaps even avoided, and anything that enables such birthing is increasingly seen as helpful, useful and even essential for birth. • Women are informed about birth through ‘horror stories’, to the extent that these stories are valued and lauded over the ordinary stories of birth so that women who birth normally think they have not birthed properly. • Birth is seen as something that increasingly requires tools and a high-tech environment, as portrayed on TV in medical dramas.
Social Practices (natural order) (the shaping)	<p>A social context in which:</p> <ul style="list-style-type: none"> • Birth is scary, anxious, fear-filled and even at times full of horror. • The ‘reality’ of birth is presented on TV programmes such as <u>ER</u> or <u>Bodies</u>. • Birth is storied about, and information is passed on through horror stories.
Discursive Symbolic Orders (the shaping)	<p>Birth is full of horror, and corresponds to the images portrayed on TV in medical dramas. Anything that can reduce this horror is to be valued and made available.</p> <p>The unacceptable That birth be a fear-filled, horrifying experience, and that there be no way to alleviate that fear and horror.</p>

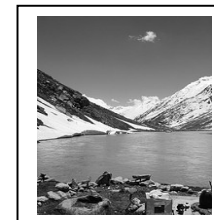
The structures of domination and the discursive informing of women that birth is full of horror means that those tools that control and tame the perceived horror and fear of birth increasingly shape understanding and practice. Choice, in this instance, is made not in relation to birth itself, but rather in relation to the shaping of understanding by stories of horror. These stories, appear to be significant for a number of women in terms of the fear they associate with giving birth. Melender (2002) carried out a study about the experiences of fear associated with pregnancy and childbirth which, among other things, sought to identify factors associated with the fears women brought to childbirth. Negative stories or horror stories were one of the significant factors identified in the study as a cause for fearing birth (Melender, 2002).

Understanding is shaped in this instance not necessarily by the experience of birth itself. Rather, understanding is shaped by relationships of power and structures of domination supported by their discursive framing and supporting social practices. These present birth as being not only full of horror, fear, anxiety but also make available and acceptable the means with which to deal with these emotions. It is this shaping of understanding - and inevitably practice - that results in increasing intervention in childbirth.

Choice – a summary of that which is shaping understanding and practice in relation to intervention in childbirth.

THE SHAPERS: Relationships of power and structures of domination (the source and force of the river-that which in part controls and constitutes the river)

- Neo-liberalism, individualism and capitalism
- Research, science, technology and others with vested interests in the informing of choice
- Consumerism
- Patriarchy, religious groups, cultural norms and beliefs
- Formal education, postmodernism, consumerism, feminism



THE SHAPING: The discursive symbolic orders and social practices shaping the worldviews (the river bed and river bank which contain, direct and support the river)

- Social order based on autonomy and the rights of the individual and individual choice
- Choice is seen as a right and neutral (not constructed in any way) and the act of choosing makes what is chosen the right thing
- The framing of women as consumers in the 1990's meant that a woman in effect had the rights of a consumer and so can choose what she wants
- The investing of authority in whom – the centralisation of authority (experts and important people) or a decentering of authority (the individual)
- Socio-economic status, education, religious, cultural beliefs, generational and historical differences and horror stories give meaning to and shape choice



THE SHAPED: Worldview (the water, that which is readily most seen to be the river)

- Choice is a right
- If a choice is an informed choice then it is a right choice for that individual
- Informed choice is to be respected by health professionals
- The doctor is the expert
- The individual is the expert in relation to their needs
- Birth is full of fear, horror and anxiety



Choice in and of itself cannot be directly related to increasing intervention, and yet the statistical evidence is clear that intervention of one sort or another is increasingly being chosen. Choice, and the milieu it creates when coupled with experiences of the everyday world and processes of socialisation (cf chapter 5) shape understanding and practice in ways that lead to increasing intervention.

Chapter Eight: Part One

Hermeneutic analysis of pain

The issues of pain and pain relief make up approximately 40% of the data gathered for this study, and pain is also interwoven with other factors in approximately another 30% of the data. This amount of data on pain suggests that it profoundly shapes understanding and practice in relation to increasing intervention in childbirth. In this section, pain is explored first of all in relation to birth being a painful experience, and secondly in relation to the meaning that is given to pain and pain relief, which appears to shape, inform, and even determine understanding and practice.

Worldview: ‘Childbirth is painful, and pain is something to be alleviated or avoided.

The understanding that childbirth is painful is described vividly and is overwhelmingly present in the following data:

Giving birth is like holding a cigarette lighter up your bum.

People say birth is positive pain. I saw it as nothing like that. What was positive about it? Actually I hated it, I could not stand it.

I was saying during the labour, ‘Get the knife out.’ I just wanted a healthy baby and to survive this experience, and I thought ‘What is wrong with me?’. I had no idea it would hurt so much; it would be so painful. I was saying, ‘Freeze, freeze my spine, freeze my spine!’ I was saying, ‘It is no joke.’ I wanted them to freeze my spine NOW.

I would also choose to have an epidural if I was going to have a baby because everyone knows birth is really painful.

The belief that childbirth is painful comes as no surprise and it may appear to be of little significance because it is ‘common knowledge’. However, any understanding of pain is shaped and given a particular meaning. Many of the participants regarded their beliefs and experience of pain in childbirth as being the key factor in choosing intervention:

The pain of childbirth was excruciating, terrible and overwhelming, and the epidural was relief, blissful and enabled me to feel like myself again.

Childbirth is really painful and so have an epidural and take the pain away.

It hurts and it is painful is childbirth, and I do not want to feel that pain again, so I will have an epidural and no pain.

Delivery is painful so I will have an epidural. I want it to be painless.

You are told and informed that childbirth is incredibly painful, so give me something. I do not want to feel the pain - anything but that.

The shaping of understanding in relation to intervention in this instance is linked to the contrast between the experience of pain and the relief of that pain. The powerful contrast of language: *excruciating/relief, terrible/blissful, overwhelming/enabled-me-to-feel-like-myself-again*, vividly presents the experience of pain as opposed to the experience of pain relief. In this instance, a worldview that sees little or no value in experiencing pain shapes understanding in such a way that pain is viewed as something to be taken away, relieved, or avoided and this will inevitably lead to increasing intervention.

This worldview in relation to pain is summed up by one woman:

My philosophy on the pain thing is that if I was going in to have a wisdom tooth pulled out or an appendix out, I would not intentionally choose to have pain. If I had pain...I would have pain relief.

This participant equates the pain of labour with pain in other situations, where no one would ever intentionally choose to have pain when it could be avoided. The example of tooth-pulling was frequently cited in the interviews to illustrate that pain is pain, and whether it is childbirth or tooth-pulling, pain is something to be avoided, and pain relief is to be embraced. The shaping of understanding by such a worldview leads to a ready acceptance and use of intervention to relieve the pain of childbirth.

The worldview that pain is seen as something to be avoided and taken away was also present in the data collected from the health professionals, as the following illustrates:

After all, we are living in a modern society where we don't have to, and nor are we expected to, cope with pain the way we used to. Our ancestors were exposed to pain a lot more frequently and therefore got used to coping with pain. Like if we have a bit of a headache we pop a few Panadol. If we have a bellyache we get something from the chemist; we have anaesthetics for teeth and everything else, whereas before we used to put a piece of cotton around it and slam the door! I think we have been conditioned not to expect to suffer from pain... I think coping with pain could be cultural...maybe it is the society that we live in. Our expectations are changing in regard to how we deal with pain and pain relief, and so therefore pain in childbirth.

I think some women believe it is their God-given right to have intervention. They think, 'Why should I suffer?' because they don't want to suffer in life anyway, so why suffer in childbirth.

No, [the value of pain] does not exist...certainly the professional career woman will nearly always choose an epidural.

These health professionals present a worldview in which people have been conditioned not to cope with pain, where pain is seen to be bad, is to be avoided, and where there is an increasing expectation that pain will be taken away. This worldview is presented as one of the side effects of scientific and technological advances and the professional age in which we are living. One participant raises the important question about why the pain of childbirth should be treated differently from any other pain. Worldviews in which little or no value is placed on pain and 'pain is seen as something to be avoided' shape understanding and practice in such a way that interventions which result in pain-free childbirth are increasingly valued and sought after:

In our practice, I would say 95% of the primigravidaes have an epidural at least. There are very few who do not have one.

The women here do not want to feel any pain and are happy to have a caesarean section if it means that they will not feel pain.

I think to a huge degree society's idea about pain and the medical profession's idea and anaesthetists' availability is that women don't have to have pain in labour and I actually think that we are teaching young midwives not to cope with the pain of labour. They know about being in partnership with the woman and the first thing they do is say, 'The woman wants an epidural.' And a lot of the time it is because they themselves can't cope with the woman's pain, not that the woman can't cope with her pain. So we somehow need to teach the young midwives how to cope with women in pain, because they have actually been brought up with epidurals on-tap and really do not know how to cope with pain.

It is not just information from the practitioner or the midwife; it is information from the family, their culture and society itself. So they have that whole image of, if I have an epidural I am going to have a totally pain-free labour. They do not really understand that there could be other issues associated with that, so they come in and say they want an epidural because they do not want pain.

These health professionals present the worldview that women do not want to experience pain and seek to avoid it. Not only do the birthing women hold this view, but health professionals themselves also contribute to the avoidance of pain by their own inability to cope with pain. This worldview of pain avoidance is informed by media, friends, family, and a society which supports a pain-free everything, leading to the expectation that childbirth should also be pain free. For both the public and the health professionals the worldview that pain is something to be taken away and avoided is shaping understanding and practice in relation to the acceptance of the increasing use of intervention.

Worldview: Coping with pain is not for ordinary women, but is 'heroic' or 'superwoman-like'.

The worldview that the pain of childbirth is not something ordinary women cope with was presented as shaping the understanding of some of the women:

I had a friend who for her first baby had an 'okay' time, and then for her second birth she just said, 'Epidural please. I am no hero.'

Normal delivery is painful and so I opted for an epidural. I did not want to be superwoman.

There was no way I was going to be a hero. It just did not appeal to me at all. Just give me the drugs.

This worldview suggests that putting up with the pain of childbirth is heroic and superwoman-like, and not something to be undertaken by ordinary women. For these participants, the relief of the pain of childbirth is much more important than any kudos or superwoman status derived from putting up with and coping with the pain. This worldview gives further insight into the cultural and social milieu that shapes understanding in relation to intervention. A milieu in which pain is not something ordinary women should have to cope with will increasingly facilitate an acceptance and choice of interventions that can alleviate and take pain away.

In the study there were worldviews that stood in stark contrast to the above, where although childbirth was seen as painful, the pain was something to be actually coped with, because women did not want to be seen to be 'a wuss'. This material, while it does not add anything directly to the argument in terms of increasing intervention, is included in this section of worldviews, as it provides the contrast with those presented above.

Worldview: 'I will cope with the pain and deal with it, because I do not want to be seen to be a wuss'.

These women present a worldview in which they talk about coping with the pain of childbirth:

The pain was really awful with the syntocinon and I thought that I was a real 'wuss' because at 10a.m. the pains really started, and at 2p.m. I got my epidural and I thought I was a real 'wuss' because I could not go longer without the epidural. I felt I was really bad only lasting four hours, and that I should have been able to go a lot longer.

At the time of starting syntocinon my midwife said, 'You will need an epidural.' I said I did not want to be wuss, and so would not have one straight away.

*I mean my mother - she is 63-64 years old and she always thought she was a 'wuss' because she was induced with two out of three. She always thought she had not done a very good job because she was induced, and she found it very painful and, in fact, found it **incredibly** painful!*

The worldview that ‘you should not be a wuss’, or do not want ‘to be thought of as a wuss’ seems to exist across generations. This worldview results in the shaping of understanding that intervention for pain is ‘only for wusses’: the weak and ineffectual, while the strong and powerful will endure the pain, even the pain augmented by syntocinon. The shaping of understanding by the worldviews of either not wanting to be ‘a wuss’, or not wanting to be a hero or ‘superwoman’, leads on the one hand to the rejection of intervention, and on the other to its ready acceptance, and even the clear expectation of its availability. Kogler (1999) claims that the worldview of the ‘other’ provides a departure point for critical reflection, and makes it possible to see how these different worldviews - in this case with regard to pain - shape the understanding of the public in relation to intervention in childbirth.

Contrasting Worldviews in relation to pain and pain relief	
Childbirth is painful, but pain is something to be put up with, dealt with, coped with	Childbirth is painful, and pain is something to be alleviated or avoided.
<i>Pain is a natural thing and a woman's body is meant to have a baby.</i>	<i>Have an epidural to take the pain away. Who wants to feel pain?</i>
<i>The pain wasn't that bad, and your body adjusts to cope with it. Your body is pretty amazing</i>	<i>I did not want to feel this pain. Delivery is painful, so I will have an epidural</i>
<i>The pain is labour - the pain is part of birth and it is not that bad.</i>	<i>I will have an epidural for the pain; pain is bad.</i>
<i>But if you do not have the pain you can't feel when to push. You know pain - it is part of it.</i>	<i>Give me something. I do not want to feel the pain.</i>
<i>I thought, 'Yeah that hurt, yes it was painful.' But it wasn't that bad actually. I wasn't scared. I was excited.</i>	<i>I would have pain relief. I would not have pain if I did not have to.</i>
<i>Yeah it did hurt a bit. I wasn't afraid of the pain because I knew, thought I knew, what was happening to my body so I just went with it.</i>	<i>Don't put up with the pain if you do not have to.</i>
<i>I opted not to have any drugs and that is why I did not want to have one. I have a friend who is very fit and she spat out her baby. I thought I would/could do that too.</i>	<i>Give me something – why should I put up with pain? I got an epidural eventually.</i>

These worldviews represent the age-old divide of: ‘Put up with the pain,’ or ‘Get rid of the pain’. The different worldviews presented in this way give an opportunity to gain insight into what is shaping understanding and practice in relation to intervention. It is particular worldviews that provide specific meaning, and create a milieu which – in this case - either stigmatize or normalize intervention for the relief of pain. This, in turn, results in either the decreased or the increased acceptance and use of intervention for pain relief.

There was a significant amount of data about epidurals. This data for the most part focused on the worldviews that informed and shaped women’s understanding of epidurals and their experience of them. Some women in the focus groups had attended antenatal classes which were seen to be instrumental in forming and informing their understandings of epidurals and pain relief.

Worldview: ‘Epidurals are bad, to be avoided, and could damage your babies.’

These women present the worldview that they were given at antenatal classes six to eight years ago:

You knew that doing without pain relief was a better thing. There was the whole earth-mother thing that drugs are bad. We got a whole lot of information from antenatal class about how the drugs cross the placenta and into the system, and the potential brain damage or whatever to your baby.

Yes, you knew that if you had pain relief your baby would sleep for days and the thought of doping your baby before it was born was a terrible image, whereas nowadays it does not seem as bad.

These participants illustrate the ‘earth-mother’ approach to intervention resulting in their negative view of epidurals, which supports the option not to have pain relief.

Some of the women interviewed had had their babies in the last year or so, and were pregnant again at the time of the interview. They also shared about the influence of antenatal classes on their understanding of pain relief and, in particular, of epidurals:

You got the idea that it is best to have your baby naturally and that it was best to go through the pain of labour. At our antenatal classes they were negative about things that were not about birthing the natural way.

Antenatal classes are definitely pro doing things naturally...not having pain relief and the like.

Yes I got the impression from antenatal classes that epidurals were no good and you were better to avoid it and that they were bad for you and the baby.

That was the one thing that really annoyed me at antenatal classes: they were so negative about such things as epidurals and there are often situations where you need intervention and epidurals and drugs. I just felt that, while the ideal is to have it as fabulous and natural without anything, the reality is that all of us had some type of intervention.

These women received similar negative messages about intervention in their recent antenatal classes, confirming a continuing trend over several years. Epidurals, rather than being presented as an option or a choice, are framed as a procedure to which meaning, value, and even judgment is attached. These participants use the phrases ‘fears created’, ‘ideas given’, ‘facts told’, ‘impression given’, ‘negativity about’, ‘understanding you should have’, to describe the shaping of their understanding. These phrases suggest an active process of shaping so that the understanding these women develop reflects a certain worldview. In this instance it is a worldview that sees the women’s interests being best served through the processes of natural birth and the avoidance of epidurals.

Worldview: ‘Epidurals are not bad, are not to be avoided and do not damage your baby.’

An interesting point in the data is that the women’s experiences or their friends’ experiences of having an epidural shaped their understanding about epidurals in stark contrast to what they had learnt at antenatal classes:

Everyone had been so anti-drugs and anti-epidurals at antenatal, but as we were booking in to be induced we saw (name) and they had just had their baby. He said, ‘Epidural is the way to go.’ I still remember thinking at that stage ‘Oh ‘okay’, well maybe after all these guys have been through it, so maybe there is something in it’.

I got the impression from antenatal that epidurals were not good and you were better to avoid it and that it was bad, but after I had an epidural at 9 o’clock I just cruised from then on. I think they made the epidural out to be worse than it was. In fact it was good. I could get up and walk and all. The anaesthetist came back once and topped me up and when I wanted to push I could, and I could feel it, so it was great.

The contractions were the most painful thing for me and then after the epidural I was able to give birth without feeling any pain and was great. The midwife was the key person for me. She encouraged me to go for what I wanted: drugs, epidural...whatever I wanted.

My big thing, well, I was terrified of the birth, but I was not so worried about that as having 24/7 a baby to take care of. I know I am hopeless when I am tired. I thought if I go through two days of hell and then this child screaming at me 2 hrly through the night I am going to be a wreck. I am not going to be able to cope. So I was far more concerned with getting through whatever the birth held in a way that made me capable of looking after the baby, and if that meant an epidural, so be it.

The understanding of these women was shaped antenatally by the view that epidurals were something to avoid. However they, along with a good number of others in the focus groups re-framed their viewpoint of the epidural as a procedure which enabled them to cope and deal with childbirth, rather than something to be avoided. The understanding of some women appears to be increasingly shaped by their experience of epidurals, leading to a worldview in which the epidural is regarded as having a positive role to play in childbirth.

Worldview: ‘Health professionals influence women’s understanding and choices when it comes to pain and pain relief.’

The women in the focus groups spoke at length about the influence of the health professionals in shaping their understanding of intervention and, in particular, pain relief. This material is significant because so often there is an impression given that pain relief is something primarily decided and determined by the woman:

Your baby, well, ‘You are meant to do it naturally’ is the message I got and, I felt hugely pressured to do it naturally. I really respected my Lead Maternity Caregiver, but I waited until she left the room because I was too scared to ask for pain relief, an epidural, when she was there.

This woman felt pressured into birthing naturally. She is clear in another part of the data that her Lead Maternity Carer (LMC) was in fact trying to empower her, and that she really respected and trusted the LMC and knew she had her best interests at heart. The participant’s understanding of childbirth and intervention was so greatly influenced by the LMC’s beliefs that she could make a choice for intervention only in the absence of the LMC.

A woman shares the understanding she gained from health professionals about pain and pain relief:

When I told my anaesthetist it was like, 'YOU LASTED FOUR HOURS with syntocinon!' Like, 'How did you do that?' Whereas I had felt I was really bad only lasting four hours...that I should have been able to go a lot longer.

This woman was given the impression by the anaesthetist that lasting four hours when labour is being augmented by syntocinon was something remarkable and amazing. Her own understanding was that she should have been able to last a lot longer because she was giving birth, and this was something her body was designed to do. In this instance the anaesthetist's response shaped the woman's understanding from disappointment at her 'failure' to amazement at her 'success'.

One woman describes the role two health professionals played during the birth of her first and second children with regard to pain and pain relief. She describes her first experience:

My first midwife and LMC had been like, 'Are you alright dear? Do you want drugs now?' and like I was doing the huffy puffy thing and I was out of control. I had no control whatsoever and I had no idea and I was given no idea.

As a result of this distressful experience this woman sought out an LMC for her second pregnancy whom she thought would enable her to birth without drugs, and she describes this experience:

I think I was in transition at that point, not pretty. Then the midwife arrived and she completely calmed me down with just getting me to breathe which I had not had with the first one. The midwife calmed me right down, and in doing so she halved the pain and I was fine.

While acknowledging the variables that may have impacted on these approaches for the management of this woman's pain, it does appear that health professionals significantly shape the experience and understanding of women in relation to pain: the coping with pain, and the acceptance and use of intervention to deal with the pain of childbirth.

Events and interactions that may seem relatively unimportant to the health professional may impact powerfully on a woman's understanding in relation to pain and pain relief as illustrated in the following:

The first one was so different. I was 2cms dilated and I said to the midwives, 'How about I go for a walk?' You know and they said, 'It is the middle of the night, it is dark, where are you going to walk?' -that was their response. I could not believe it. I said I might go up and down the stairs and they laughed the two of them and they said come back when you are ready for the drugs. I went up and down a few times and my husband just said (sighs) as you can imagine. So then I went back in and said, 'Oh 'okay', fine do your business.' But there was no positiveness towards me doing the walking.

The response of the midwives to this woman's suggestion of activity so much discouraged her that she acquiesced to their suggestion of drugs.

The same woman tells of a very different experience of being induced with her second child:

So the second time I arrived and had the pessary put in again. It was late at night and I went to the staff on the ward and said, "Do you think I could go for a walk?" and they said, 'Yes, it is a beautiful evening - off you go.' What a difference. Initially I went, 'Oh my God!' It was so different getting the kind of response of doing all you can to make it come on. Again at 7am when I said, 'We are going for another walk' it was like, 'Yes, off you go, good on you. Do whatever you need to do.' The whole atmosphere I just felt like the stars were aligned, and things were going my way and it was just a completely different feeling.

The staff's encouragement evoked a completely different feeling from her first experience. While both these experiences involved induction, the attitudes of the health professionals about what is possible in relation to the induction and coping with the pain make all the difference.

The health professionals interviewed also talked about other health professionals and the institutions in which women birth as influencing women's understanding and choices about pain and pain relief. This is best summed up by the following midwife:

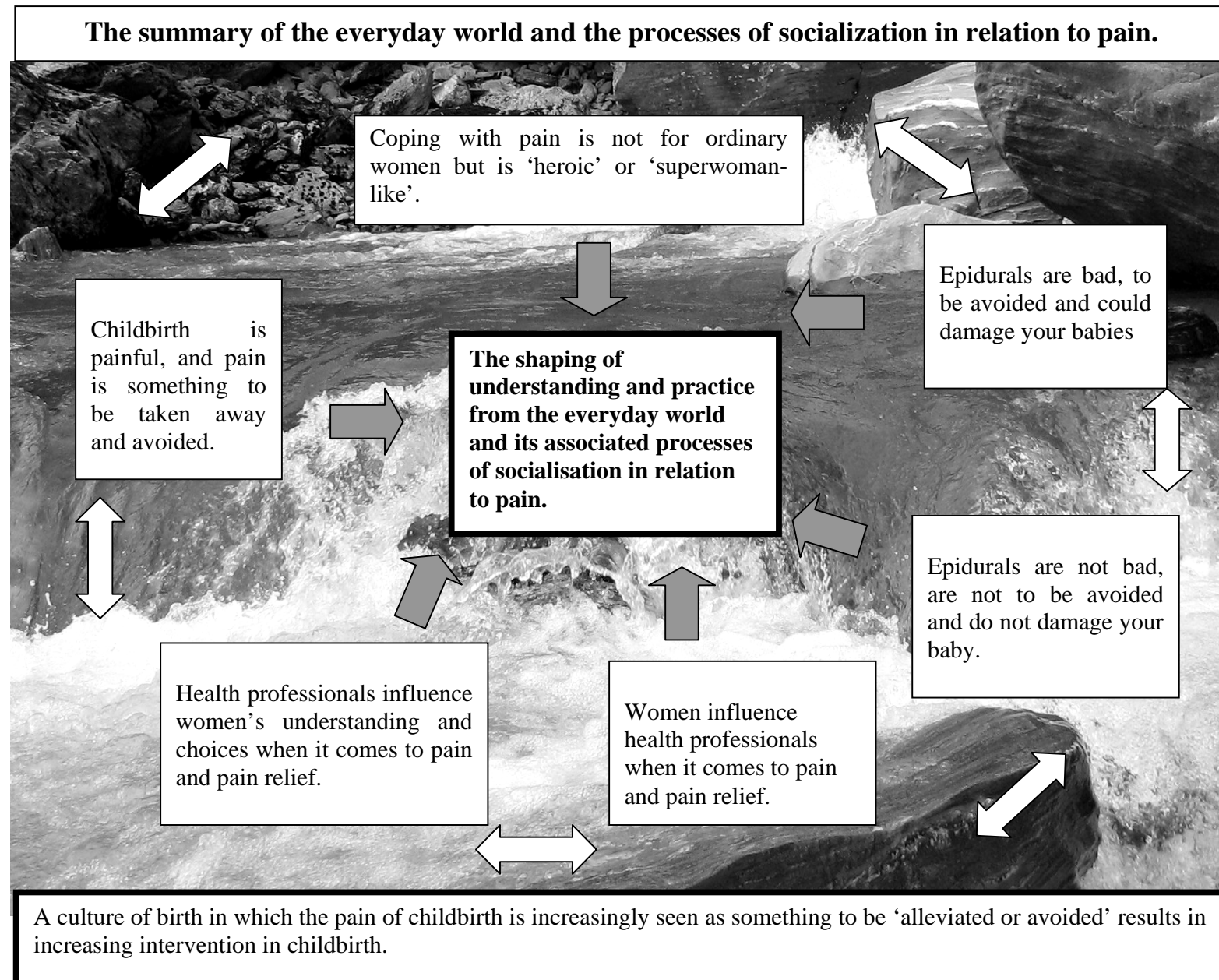
In the delivery unit I worked in we actually felt that the epidural rate was really higher because we had anaesthetists on the round and every time they saw a woman they talked about epidurals. We actually took a stance that anaesthetists or obstetricians could not do rounds which included low-risk women. To facilitate this we actually changed the way we put the names on the board so blue being low-risk and red being high-risk, and so it was only the red that they could go to on the round. We actually noted that the epidural rate and intervention rate dropped significantly. There was no other pressure being put on, and the midwife took sole charge of the low-risk women and would invite people in if she felt a consult was required.

This participant is clear that it is simply the anaesthetist's mentioning the possibility of an epidural during labour that resulted in low-risk women requesting and receiving epidurals. It would appear that just the words exchanged on the medical round, which would have been an introduction to the anaesthetist and the service he offered, were enough to make some women decide to make use of the service. However, when the words were not spoken and the option was not presented as a matter of course, fewer women chose to have an epidural. It would appear that the words that are spoken, the information that is given, and the options that are presented during labour by health professionals do shape the way that women cope with the pain of labour and their use of pain relief. This can determine in part the decreasing or increasing use of intervention in childbirth.

Worldview: 'Women influence health professionals when it comes to pain and pain relief.'

She has had an epidural each time with the last three babies. I thought, 'We will get her through without an epidural this time.' However, during labour she sat up in the bed and said, 'I am not having this baby until I have the epidural' and I thought 'Phew you won't be able to not have this baby, this baby will come.' Her husband took me to one side and he said, 'She will not have that baby until she has the epidural, I am telling you.' Do you know, she did not have any more contractions! Here is a Gravida 5 at 5cms, and through sheer power of her mind she stopped her contractions. She got the epidural in and she laboured and had a perfectly normal delivery.

The vivid image presented by this midwife illustrates the control the woman is able to exercise – not only over her body, but also over the practice of the health professional. In this instance it is the woman's determination to have an epidural that shapes the practice of the health professional in relation to intervention in childbirth. For a number of health professionals in the study, a woman's request for an epidural is significantly shaping their practice in relation to increasing intervention in childbirth.



Chapter Eight: Part Two

Critical analysis of pain

This chapter presents the critical analysis of pain as presented in Part One of Chapter Eight. This chapter explores the social practices, discursive symbolic orders, relationships of power and structures of domination, and so present the shaping and shapers of understanding and practice in relation to pain.

The shaping of the worldviews that pain is something to be coped with and pain is something to avoid.

Table C10. THE SHAPING OF PRACTICE AND UNDERSTANDING		
Worldview (the shaped)	Childbirth is painful, but women are able to experience and cope with the pain of childbirth which can be empowering. The object of the exercise is to enter into those things that are natural, and for women to be supported through them.	Childbirth is painful and pain is something to be avoided and relieved; epidurals are an acceptable and safe way to cope with the pain of labour. The object of the exercise is to avoid experiencing those things that are natural and painful.
Social Practices (natural order) (the shaping)	A society in which social systems ensure that: <ul style="list-style-type: none"> • Women cope with pain. Epidurals are avoided. • Women appear to be strong. They can bear the pain, and do not want to be seen as being weak. • Health professionals support women to birth naturally. 	A society in which social systems ensure that <ul style="list-style-type: none"> • Pain is taken away, controlled, or avoided. Epidurals are readily available. • Women do not have to be put up with pain. • Health professionals support women to have pain-free labour. • Resources are spent to make pain relief available.
Discursive Symbolic Orders (the shaping)	<ul style="list-style-type: none"> • Women are not weak or 'wusses'. • Pain is to be coped with, and while childbirth is painful the experience can be empowering. • The health system and health professionals believe that the pain of labour is something to be coped with. <p>The unacceptable That the pain of labour be taken away for reasons not clinically indicated.</p>	<ul style="list-style-type: none"> • Women do not have to be heroes or superwomen. • Pain is to be taken away. • An epidural is an appropriate tool for pain relief in labour. • The health system and health professionals believe that the pain of labour is not something that has to be coped with. <p>The unacceptable That the option of pain-free labour not be available for a woman.</p>

The shaping of practice and understanding in relation to pain gives every appearance of a complex tapestry into which is woven threads of experience, knowledge and socialization. The only thing that can be claimed emphatically is that a myriad of influences such as age, family, ethnicity, personality, experience, education, inclinations, society, and culture all impact consciously and unconsciously on understanding and practice. However, the correlations between discursive orders, social practices and the worldviews presented in table C10 provide some insight into those structures of domination that are constituting the different approaches to pain and pain relief. In effect, the structures of domination ensure that discursive framing of pain, and the belief systems engendered from such framing, are supported by social practices which make possible and acceptable the procedures and resources required to either put up with pain or avoid it. The discursive framing of pain as something to be dealt with and coped with is shaped by such factors as naturalism, theism, feminism, midwifery and a number of others (Donley, 1998; van Teijlingen, Lowis, McCaffery & Porter, 2004). The discursive framing of pain as something to be avoided and eliminated is also shaped by a myriads of meaning and social practices. These range from utilitarianism, in which happiness is equated with the absence of pain, to technology and consumerism, which promise that a solution to all discomfort is possible and purchasable (Naisbitt, Naisbitt & Philips, 2001).

The avoidance of pain is also supported, in part, by certain structures of domination that discursively frame nature as something to be dominated, manipulated and controlled by science and technology (Sawicki, 1991). This discursive framing of nature, and hence of pain, is supported by social practices (cf Table C10) which ensure the ready acceptance and availability of things such as epidurals which, in effect, control nature by taking away pain. In 2005, 62.3% of all women birthing at National Women's Hospital had epidural analgesia or anaesthesia (National Women's, 2005). Marmor and Krol (2002) argue that the choice to take away pain with something like an epidural is, to some extent, limited and decided for women by the cultural inclination to avoid pain, the interests and training of health professionals, economics, and a raft of other factors. Wolf (2001) argues that, while there may be a politicizing of pain and pain relief by midwifery, medicine, feminism, religion and other interested parties, women will still choose pain relief not because of a political stance but because childbirth is painful.

Surtees (2003) claims that some women found the experience of the epidural blissful and empowering, and welcomed intervention that relieved pain. While it is hard to argue against the claim that childbirth is painful and that an epidural in this situation may be empowering, it is important to note that the meaning given to pain, or in this case the meaninglessness of pain, is a product of a specific historical place and time (Morris, 1993). While it may be very difficult to imagine any other stance, it has to be noted that it is, in fact, the discursive orders and social practices of certain structures of domination within a society that inform and support a particular stance in relation to pain and pain relief, rather than pain itself (Morris, 1993). The discursive orders which frame pain as something to be denied and avoided are supported by social practices which make pain relief readily accessible. This shapes the practice of the health professionals and the understanding of the public in ways which inevitably result in increasing intervention.

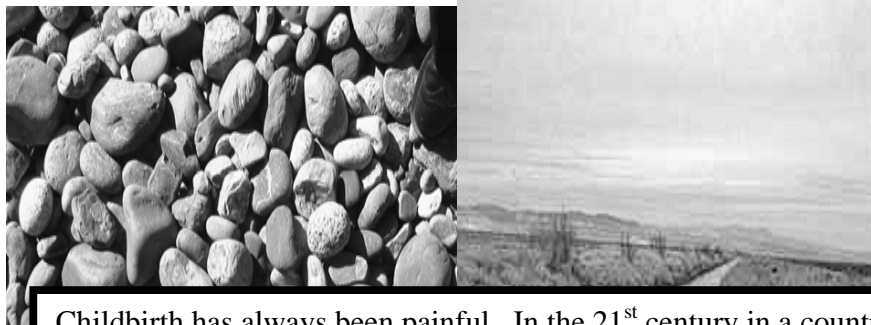
Pain – a summary of ‘that which’ is shaping understanding and practice in relation to intervention in childbirth.

THE SHAPERS: Relationships of power and structures of domination (the source and force of the river-that which in part controls and constitutes the river)

- Utilitarianism, technological network, consumerism and feminism, midwifery, religion, patriarchy, naturalism.

THE SHAPING: The discursive symbolic orders and social practices shaping the worldviews (the river bed and river bank which contain, direct and support the river)

- Happiness equates to absence of pain, nature is able to be dominated, manipulated and controlled; a solution can be found to pain. There is no value in putting up with pain. We have the technology to deal with pain.
- Birth is a natural process and pain is part of that process. It is to be dealt with, as the experience empowers women. What is natural and the way God made it should not be interfered with.



THE SHAPED: Worldview (the water, that which is readily most seen to be the river)

- Pain is to be taken away and avoided as one is not a hero.
- Epidurals are to be embraced.
- Pain is to be coped with as one does not want to be seen as a ‘wuss’.
- Epidurals are to be avoided.



Childbirth has always been painful. In the 21st century in a country like Aotearoa-New Zealand where a culture of birth in which science and technology ensures unprecedented access to effective pain relief, and social and cultural values present pain as something to be avoided, increasing intervention can only ensue.

Chapter Nine: Part One

Hermeneutic analysis of technology and technification

The everyday world and its associated processes of socialization (worldview) with regard to technology presents itself readily in the data. The participants discussed, storied and explored at length how the values, attributes and meaning of the everyday technological world shapes understanding and practice in relation to increasing intervention in childbirth. The data about technology is presented first of all in the context of technology itself. It is then presented in relation to those things that can be identified as informing and supporting the place of technology that enables increasing intervention in childbirth.

Worldview: ‘The ‘everydayness’ of technology itself, along with its values and attributes, shape understanding and practice.’

These women present the everyday, usual, commonplace events and procedures that take place during pregnancy and childbirth, as being what shapes their understanding:

Are you saying having a scan is a choice? Are you sure about that?

Having a scan is not presented as a choice. It is just something you have. I suppose you do choose to go and have it.

One of my friends, her midwife talked her out of one because she didn’t believe in scans and she didn’t have one and was fine.

You mean to say you don’t actually have to have a scan? Are you sure about that?

Although these participants were well informed, they did not readily understand that they had a choice about having a scan. While on one level they realized that no one could actually make them have it, they did not see having a scan as a choice because it was part of the normal rite of passage of early pregnancy. A scan was just something everyone did, so you went and had one too. The participants seem to be surprised by the possibility of a woman *not* having a scan.

This worldview increasingly frames the scan as a usual and commonplace event of pregnancy rather than something you have to make a choice about, thus ensuring that understanding and practice are shaped in such a way that scans are an accepted and expected part of pregnancy. Once again, increasing intervention becomes inevitable.

These men and women explore the place of technology and technological processes and the inevitability of the technification of birth:

Look, in a hundred years we will probably sit at home and take a pill with a machine and just do it yourself and out will come the baby...technology is only going to increase and things are going to become less natural as technology gets better.

It is inevitable [that birth becomes more of a technological event]. Inevitable, because you are never going to stop the scientists. They will always do what they do, which is finding new ways of doing things.

Many people have tried to predict what technology will do and very few get it right. I think it is sad...I guess but we are going down the road of more drugs and technology. It is all technology.

I think there is a movement to take birth further and further out of the body; that is the way science works. Like people will be just growing somewhere in a little tank and then, like, popping them out at a certain point. I think there will be more movement towards that. Mind you, it is a pretty complicated mechanism and to simulate a womb perfectly would be incredibly difficult.

The participants in this focus group present a future in which technology will become even more important than it is now, and where it will enable humans to do things as yet not thought of. Scientific discoveries and technological advances are seen as taking physical processes such as birth further and further out of the body and away from bodily functions. These participants suggest that the 'everydayness' of technology will increasingly shape understanding and practice in such ways that the technological rather than the natural will become the norm, and this will inevitably lead to increasing intervention in childbirth.

A number of health professionals also explored the normalization and ‘everydayness’ of technology:

Young people rely more and more on 21st century technology, so it is not natural or normal to be without technology.

Technology is increasingly all around us and there is always something new. ...You can see why people expect it to be used during birth.

These participants suggest that the increasing use and place of technology in the everyday world will increasingly give rise to the expectation that childbirth includes technology, its processes and its tools of intervention.

This woman explores a similar theme:

Can't you now choose the timing of things so, like, there are no surprises? You can say, 'I have had enough' and I will have the baby at 6 o'clock on this day so then I will have two weeks off, the nanny will be in and it will be fine... I do not know if it is possible to choose [the day and the time] but if it is, I think that is disgusting...It is sad, it is like knowing the sex of the baby before it is born. It takes away all the surprise, all the magic. It is just like cooking eggs.

The possibility of birth processes that reflect the attributes of technology such as control and functionality, is offensive to this woman. She laments the diminishment of the experience of birth itself such as not knowing, surprise and magic, which will be valued less and less.

Many participants, both health professionals and the public, explored the attributes of technology such as technological showing, disclosing and knowing. The most common example of this in the data was in relation to scans, as seen in the following example:

We found out the sex this time so that was good. It really was. It is good to know.

This optional extra of finding out the sex of the baby can be seen as little more than utilizing what technology has to offer. However, it also denotes a milieu in which technological showing, disclosing and knowing is increasingly valued as opposed to things being hidden, not known and shrouded in mystery. This milieu in which the technological is increasingly valued shapes understanding and practice in ways that facilitate increasing intervention.

One woman places technology and the knowledge it offers within a social context that increasingly normalizes certain practices in relation to intervention:

I think we will increasingly be able to choose our babies. I think anyone would choose to have a healthy baby rather than an unhealthy one. So you start culling out the unhealthy babies. I mean we will be choosing certain things about our babies like them being blonde. I guess it is easy to justify things like babies who are going to have diseases, as no one wants them to suffer.

This woman describes an everyday world facilitated and made possible by technology, in which babies will be increasingly chosen for such things as health and bloneness. A society which only wants healthy babies suggests that suffering and disease is regarded as something bad, negative and to be eradicated. While it may be difficult to understand and accept that suffering and disease can be understood in any other way, it has to be acknowledged that different societies and cultures give different meaning to such things. Technology exists within a social and cultural context that enables a technological tool to be used in a particular way - not primarily because the tool is capable of such use, but rather because the context in which the tool is used permits such use. Understanding and practice in this instance is shaped not so much by technology itself but by the social and cultural context which allows and facilitates the availability and accessibility of technology for certain purposes.

A number of women spoke of technology as separating and distancing them from the experience and so from the reality and, in doing so, changing the meaning of experience.

A woman comments on this aspect of technology:

If pain is taken away by an epidural it then makes for a very unreal world. It means that you are no longer really experiencing things as they happen and how they should happen.

Two other women also explored the notion that technology shapes women's understanding by removing them from the experience and in doing so, gives the experience a different meaning.

There is more meaning in things that don't have as much technology. I don't know what I mean by the word 'meaning' but there is more meaning for a woman to have the baby naturally. Then the woman will have more connection with the emotions around the birth than just experiencing the birth process through technology.

Yes I think technology removes you from the reality of what is happening. It is like the scan shows you the baby, rather than you feel the baby.

These women present a worldview in which one engages with the real by experiencing the experience. Taking away the pain of childbirth is seen to make the experience of labour unreal because pain is seen to be an important part of the experience. These participants present an important insight in that to intervene is defined as 'coming in as something extraneous' or 'to come between' (Fowler & Fowler, 1961). In this case, pain is the experience and the epidural is the extraneous thing coming in between pain and the experience of the woman. This is not to say that having an epidural is not an experience of the pain of labour, but it is an experience which is facilitated by something, that has come in between the woman and the pain. For these participants, the pain of labour, when experienced through an epidural, loses something of its meaning, as does the ultrasound image of the baby as opposed to feeling the baby kicking and moving.

The meaning is transformed from an experience of the 'thing itself' (in this case 'the pain' or 'the actual baby') to a representation of the thing and a distancing from the thing itself. Technology is presented by these participants as shaping women's understanding by separating them and distancing them from the experience of the 'real' and changing the meaning of their experience.

However, other women saw technology as enhancing their experience and making it more real and, in fact, increasingly performing the social function of introduction:

This time it was amazing because at 32 weeks they thought I might have placenta previa (which I did not thank God). They did a real close-up on the face, and he was swallowing and you could actually see his whole face and whole lips and watch him swallowing and we saw the amniotic fluid in his tummy afterwards, but it was a full picture of him: his face and his lips and him swallowing. We came away just feeling like we had seen him. We knew he was there and he was doing everything he should be. It was really cool, much better than the last time when it was a big blur.

This woman and her partner felt that a late scan gave them a greater knowing and fuller picture of their baby. In this instance the scan becomes more than a clinical tool, in that it becomes a medium through which the parents are introduced to their child. Once the clinical information has determined the baby is alright the scan then takes on a role which, while being incidental to the health professional, is in fact of the utmost importance for the woman and her partner. It appears that understanding and practice may increasingly be shaped by technology which, for some women, enhances rather than removes them from the experience, and which has as much a social as a clinical function. The normalisation and acceptance of technology in relation to childbirth, whether it be a scan or an epidural, appears to ensure the inevitable increase of intervention in childbirth.

The 'everydayness' of technology, with its values and attributes, was also explored by the health professionals. They saw this 'everydayness' of technology as deskilling them, in relation to clinical and traditional midwifery and obstetric practice.

Worldview: ‘The ‘everydayness’ of technology, with its values and attributes, leads to the deskilling of health professionals.’

The health professionals presented a significant amount of material in which technology is seen to provide more accurate information, and so is regarded as being safer than traditional clinical skills. This valuing of technology appears to be leading to a devaluing of, and to some extent, a redundancy of some clinical skills. The Royal College of Midwives in the United Kingdom claims that the trend towards caesarean births and epidurals had led to a deskilling of the profession of midwifery, as non-interventionist methods of care were becoming less and less common (Akbar, 2002). The data collected in this study from the midwives and obstetricians suggests that this deskilling of health professionals in traditional and clinical skills is actually shaping understanding and practice in relation to increasing intervention in childbirth.

Worldview: ‘Deskilling results in the transference of skill from doctor/midwife to technology.’

This midwife explores how the changing nature of listening to the fetal heart is, in effect, deskilling health professionals:

The classic example of intervention because it happens, I find, is having a Doppler to listen to the fetal heart because that is the done thing now. Why use a pinnards? However, there may be a woman who doesn’t want you to use the Doppler and I am not sure how many midwives would say, ‘Oh okay I will listen with a pinnards.’ Some midwives do not feel confident any more using a pinnards.

This obstetrician also presents the deskilling of health professionals in relation to listening to the fetal heart.

There is a lot of deskilling because of machines like CTGs. The other day there was a woman who was decelerating and one thing and another, and I went and sat next to her and the student midwife was in there. I sat there for 10 mins or so with my hand on the abdomen and I could see the student midwife looking at me as if to say, ‘Why is a doctor doing this?’ There is too much reliance on technology. You ask for a pinnards in a delivery unit. ‘Why do you want it, the woman is on the CTG’ and you say, ‘No, I want to hear it’ and invariably someone says, ‘Why do want to hear it?’ and ‘What do you want to hear?’ Why can they not understand you do not hear the baby. You hear the machine.

These health professionals present two examples where technology does not necessarily give the best or the most accurate information. The use of Doppler or of CTG as the preferred way of listening to the fetal heart or recording contractions, in effect, deskills the health professional. It does this by moving them one step away from the heartbeat or the contraction itself, which results in a transference of skill from the health professional to a machine. For these participants, technology is shaping practice because health professionals are increasingly only hearing and seeing a representation of the fetal heart or the contraction, and that representation is increasingly viewed as providing more accurate and trustworthy information than clinical skills. Technology in this way ensures that intervention will increasingly be used in childbirth.

Worldview: ‘Technology is increasingly seen as giving the best and most accurate information and so is increasingly valued and trusted over clinical skills.’

A number of participants, both the public and health professionals, suggest that the information that comes from technology is given more authority than information from other sources, such as the woman or the health professional. Understanding and practice is shaped by the status, power and place given to technology in the everyday world which increasingly results in a transfer of authority from the knowledge of the woman and health professional to technology.

This midwife presents an example of the trust placed in technology:

One of my women had gone to see her doctor with one of her children and he had said, ‘Hop up and I will do an antenatal.’ He rang me and told me he thought the baby was very big and that I should do a scan. I asked him if doing a scan would make the baby smaller. A scan isn’t going to tell you anything you don’t know. It might tell you baby is big but so what. If the baby is big do you think I would not know that?

This participant is clear about the limits of technological knowledge compared to clinical knowledge. She knows how big this baby is from her clinical skills and judgment, and cannot see how a scan will add to her management or knowledge.

One obstetrician also questioned the reliance on technology by health professionals, which leads them to trust their clinical skills less and less:

I think scanning sometimes leads to more intervention than there needs to be. People become over-dependent on it and they treat the scan and not the woman. The abruption is the classical one. If someone comes in with an abruption clinically then you treat them as an abruption. If someone comes in with a little bit of bleeding and you are not sure what it is, you don't scan them and find out that they might have had an abruption and treat them as such because there are many false positives. But people think, 'Oh scan for an abruption.' 'NO NO NO,' I say. What is clinically defined is what gives you your clinical picture.

Practice that is increasingly shaped by technology and interventionist practices is seen by some practitioners as enhancing, validating and even replacing clinical judgment.

This midwife also explores the trust put in technology rather than in clinical skills:

If I am at home and the mother says the baby has not moved and it is this and it is that, I sit with her for a while and I poke and prod the baby and listen to the fetal heart for a couple of minutes. I watch to see if I can see fetal movements and if I have a good acceleration and a few kicks that says to me, 'Bugger off and leave me alone' then you can be pretty certain your baby is alright. Why do you need expensive technology? Why do you need to go in there and have them scanned by someone who does not have a third of your experience to be told this woman needs to be induced? Common sense goes out the window. Even with induction of PGs, if you have a woman with a cervix that is fully effaced and really thin then why the hell does she need PGs? She needs a good stir up and maybe an ARM the next day. She will go into labour and really, why are you that desperate to get them induced in they are unfavourable. I just think we could avoid so much if we listened to ourselves and trust our skills.

This participant presents a number of areas in which she believes health professionals are losing trust in their own skills and she challenges the primary role of technology in practice. However, in a technological age it may be unrealistic to suppose that the art of hands, ears and eyes will continue to be valued as a valid way of practicing. For some practitioners, this midwife's claim that she is '...pretty certain the baby is alright' is not good enough, as they would assert that you need to be absolutely certain that the baby is alright. For an increasing number of midwives the Cardiotocograph or the Biophysical Profile promise certainty, whereas traditional midwifery skills do not (personal conversation, 2006).

It would be difficult to justify the claim that technology makes such a promise, but technology does seem to hold within itself the promise of things being 'alright' in a more certain and definite way than do the traditional skills of midwifery.

In this instance it appears that for some midwives the tools of technology are more trustworthy than the 'knowing' that comes from a prod, a poke, acceleration or a kick. Practice appears to be increasingly shaped by the fact that technology is seen to offer accuracy, certainty and precision in comparison to the perceived guesstimate skills of the human senses.

Worldview: 'Being with women with technology results in deskilling and redundancy of health professionals' skills.'

One midwife explores the role of technology in deskilling midwives' traditional midwifery skills:

Partly, epidurals have done it and it is easy to put an epidural in and epidurals have taken away the midwife's skills. Machines have done it. Cardiotocographs have done it and even putting Syntocinon through pumps to a degree has taken away the need to be totally there because you know it is not going to run through. I mean when you were counting drops you had to be there. So mechanising labour has done it. It has taken away skills from the midwife.

It appears that technology not only has the potential to deskill but it may also result in less involvement of the health professional with the woman thus changing the relationship between the two of them. Functions such as feeling for contractions, listening to the sounds of labour, and supporting the woman through the passage of labour, become skills that are in some instances appropriated by or given over to machines and technology. Midwives, it appears, are learning less about what it is to be with women and more about what it is to be with women with technology. It is possible that the midwifery body of knowledge, along with other bodies of knowledge, are being reframed to accommodate and facilitate the technological age of the 21st century and the increasing intervention in childbirth.

Another midwife explores further the issue of the deskilling of midwives:

The technology has deskilled us. It is the loss of using our hands and our ears and our eyes. Look that woman is curling up her toes. They look at me so. Well, I say she is going to deliver very soon. They ask me how do you know that. It is the huge amount of epidurals we're having. They don't know the knowing. I mean the other day I knew this woman was about to deliver and it was only because the breathing and her noises had changed, and I don't think the younger midwives are getting enough of that now. The higher the epidurals go, the more you have taken away the woman's change in her breathing and the change in her whole persona and noise and that sort of thing that told you this woman was fully without doing a VE. Now we have to do a VE to say that she is fully I have been the devil's advocate. They'll say, 'Can I do a VE to see if she is fully?' and I will ask them why and tell them, 'Why don't you go for other signs?' They don't see enough of the other side; they do not hear the change in breathing, they don't put their hand on the abdomen to feel it pushing and then they don't have the confidence.

This participant believes that through technology the art of midwifery is being lost. The use of the senses to notice the change in breathing, the curling of the toes, the feel of an expulsive uterus, the change in the persona, the noises and smells of labour is no longer regarded as being the most appropriate way of receiving and processing information from which decisions are made. The participant suggests that the use of technology is shaping practice in such a way that midwives will have less and less confidence in traditional ways of knowing and understanding labour.

One obstetrician speaks about a similar deskilling in relation to the medical profession:

I think we will end up doing far more sections and we are losing the skills to avoid people having caesarean sections. We still have the skills here to stop primigravida ending up with caesarean section but you know those skills are going and people are going to end up with a higher caesarean section rate. ...We see this deskilling in relation to breeches also. Most of my registrars would not know how to do a breech extraction. Most would not know how to do a breech delivery. I was brought up with breech delivery and all the manoeuvres. The registrars today cannot do rotational forceps; they cannot do breech extraction, breech delivery. We are deskilling our whole population of future obstetricians.

It would appear that in both medicine and midwifery there is a deskilling of health professionals, as technology and its tools and procedures increasingly replace the skills and knowing of the clinician. This deskilling is resulting in increasing intervention in childbirth.

Worldview: ‘Technology in a litigious milieu provides health professionals with evidence that they did something.’

The majority of health professionals in the study linked technological ‘knowing’ and the trusting of technology over clinical skills to one of the most significant shapers of their practice, litigation.

Litigation is, to me, the single most important influence that has changed my practice, and I have seen this change in New Zealand in the last ten years and I have been through the whole thing. I think one of the biggest influences is this name and blame culture that we live in.

We know if you have a difficult situation and you do a caesarean section that is the end of that situation. No one is going to blame you for doing one caesarean but if you stuff up with the baby you will be blamed forever. Those are the things that influence us when it comes to intervention. When was someone last taken to court for doing something like monitoring a woman, putting in a luer, or doing an ARM?

My belief is, Why intervene unless it is necessary? rather than, ‘Let’s intervene just in case’, which I often see happen. Practitioners intervene just in case this happens, just in case she bleeds. It is defensive.

I don’t actually think much of CTGs. I am a bit dubious about them, and look at the research about them. But what about the baby recently antenatally with the severe decelerations. I think interventions like CTG’s are really tricky but with the Health and Disabilities breathing down your neck you are going to use them. You are going to go for and use the interventions and be on the safe side because that is how it will be judged.

The fear of litigation is identified by the health professionals as significantly shaping their practice. Safety becomes synonymous with action. Defensive practice and doing something ‘just in case’ becomes a very real response in a milieu which rewards and defends action and places suspicion and judgment on ‘inaction’. Therefore, practice is increasingly shaped by an understanding which equates safety with action or intervention, which, more often than not, involves technology, its processes and tools. In this way, litigation reinforces the move towards increasing intervention in childbirth.

Technology and intervention are different sides of the same coin, as technology makes intervention possible and there is not one intervention which does not use a technological tool of some kind. The shaping of understanding and practice by the tools of technology was significantly present in the data.

Worldview: “Technology equals ‘safer’ as it can detect if something is wrong and it tells you if the baby is ‘okay’ ”.

One midwife captures the increasing place and role of technology in pregnancy:

I think women and society have changed their expectations in relation to birth and the need for intervention. There is pressure from various people and groups that you need to go down the track of intervention when you are pregnant because that is what happens and it is what is best. Women now ask for scanning and some of them come with videos and say it would be good to see the baby because it helps with the bonding. It is expected that you would have an 18-week anatomy scan. It is almost as if midwives and family want you to have a scan so that you will know that everything is ‘okay’, that the baby is ‘okay’. Do you really know everything is ‘okay’? And yet that is the expectation that you will know everything is ‘okay’ by having a scan.

Here we see bonding and ‘okayness’, functions once ascribed to the woman, increasingly being mediated through technology. This participant suggests that understanding and practice are increasingly shaped by technological tools such as the scan in that the tool itself is seen to facilitate bonding, and reassures parents that their baby will be ‘okay’.

Many of the women in the focus groups felt that technology not only told you that your baby was ‘okay’, but that it also made birth safer:

Yeah, technology has made birth safer because fetal distress is one thing. I had a long labour and at one point my baby did get quite distressed and just by changing my position in the bed it actually eased off. So it was the way I was lying and various other things but it was technology that told us.

I guess technology means that you feel like you know at the earliest, so maybe you have the chance of doing something maybe. Yeah it feels safer.

The humans are and could be wrong. The humans can make mistakes and on the whole technology is more trustworthy....Humans make mistakes.

I felt very secure with the people who were in charge. It wasn't anything to do with the technology but I think the technology enables you to be part of it as well. I don't feel it's a trust thing and thinking that the midwife or doctor wasn't any good at what they were doing. I have trust in the people but I think technology enabled you to share in the birth more.

Birth is safer than it was isn't it? Look at 20 years ago, the mortality and the morbidity, so technology must make birth safer.

I do not care how much technology there is as long as the baby is okay and if it keeps the baby okay. ... [if it does this] then I am all for technology.

For these participants technology appears to make birth feel safer. Technology facilitated the hearing, seeing and knowing of what was happening and enabled the women to be more informed about their birthing process and to experience more of what was happening. If the public's perception is primarily informed by the accuracy and factual knowledge that technology has to offer, then the technological will be increasingly valued, trusted and utilized.

Across the focus groups there was a strong coupling of technology with safety. In one sense, the association of safety with technology leaves little room to question its role, appropriateness and the number of times it is used, as such a stance would suggest that the safety of the baby was something that could be compromised. When the wellbeing of a baby is held up against a concern about the possible over-use and reliance on technology, most women would trade off such concerns for the increasing assurance that their baby will be safe.

The ability of technology to give reliable and accurate information was presented by some participants as ensuring the safety of a baby:

I know about three or four people that have gone for scans and because of those scans they have been told something is wrong and they have had to have a caesarean section immediately. If they had not got that right then and there, then the baby may not have been okay or lived out that day. In fact I am totally for it. When my sister-in-law at 34 weeks refused to have a scan to see how her baby was growing we thought she was crazy.

This woman explores the assurance of safety that many of the women in the focus groups associated with technology. From such data it is possible to see how scans and caesarean sections are readily accepted as in this instance they ensure not only the safety but also the survival of the baby.

A number of health professionals reflected on this perception of technology and medical procedures guaranteeing a safer birth:

Often people say that caesarean sections are safer or that this intervention is safer and that it is safer to have an intervention than not to have it. In reality we still don't know how safe is safe. Especially when you compare that there is still a two-fold increase in maternal mortality for women who actually do have surgery and things like that. However, we don't often say that because things are safer than they used to be years ago.

This stance is supported by an obstetrician:

There is increasing evidence to support the belief that some women have, that caesarean sections are safer for the baby. Though having said that, it is much more dangerous for the woman, and there has not been an RCT looking at this. There is a lot of retrospective data only. How would you do an RCT anyway, and it would be a foolish thing to embark on.

Both of these health professionals are clear that despite the prevailing belief about the safety of caesarean sections, they are, in fact, not safer for the woman. Even so, it does appear that practice is shaped by the fact that the word 'safe' has been developed in some instances to mean 'safer' and even 'safer than' in relation to technology and some medical procedures.

Another obstetrician comments on this:

It is a safety thing and there really is no doubt that anaesthetics and epidurals are safer, as are transfusions and antibiotics. The risks are not great, so it is not as if you are taking a huge risk with your life.

The understanding of 'safe' in relation to medical procedures comes about because many procedures are *safer than they used to be*. This equating of 'safe' with 'safety' facilitates the acceptance of technology and medical procedures thus further shaping understanding and practice.

While there may be a growing belief around the safety of medical procedures and technological tools, a midwife and an obstetrician sound a note of caution:

We do not know what the long-term effects are going to be, and if we do know about certain things, we often don't mention them because we don't think that that needs to be mentioned at that time. For example, how many women at the present time are told that post-natal depression or post-traumatic distress disorder could be a potential risk for a woman who has a caesarean? I do not think we give full information all the time. Often we give what we feel the woman may want to hear or sometimes we just haven't had that information to give.

Health professionals do not know the long-term effects of any interventions at the present time.

These health professionals suggest that women and health professionals often act in the giving and receiving of information as if procedures such as caesarean sections and epidurals are always acceptable and safe. There appears to be an implicit agreement that the procedure comes with a guarantee of safety and a good outcome. Possible consequences - either short term such as postnatal depression, or long term such as possible infertility – are ignored. These participants, along with other health professionals, raise the question of 'How safe is safe?' and acknowledge the incompleteness of information that may be known or given about a particular procedure.

However, it would seem that increasingly there is an expectation that technology will keep women and their pregnancy safe, that nothing will go wrong and everything will be perfect or at least 'okay'. In a number of instances this expectation appears to have translated itself from an idea of things being 'okay' to an expectation of perfection when it comes to the baby and the birth process.

One midwife captures this expectation:

It is almost as if society has the expectation in regard to pregnancy and birth that nothing should and will ever go wrong.

An obstetrician supports this:

The expectation is that every woman goes into pregnancy expecting to have a normal baby and a normal outcome for herself, and anything less than that is always someone's fault.

These two participants present a worldview that everything will progress “normally” and will be “okay”. While this worldview seems reasonable, it is important to note that those things that are increasingly responsible for things being ‘okay’ in relation to pregnancy and childbirth are technological.

There was a large amount of data from women which suggest that technology is responsible for keeping babies safe and that it actually guarantees that everything will be alright.

Yeah if the scan said there was nothing wrong with the baby, then I would think the baby was alright.

They check the heart and they measure all the organs and stuff but at least you know it's got all its organs and that is really reassuring that the baby is okay.

Up till then you do not really know. The scan is when you first know that the baby is alright. They do measurement of all the limbs and you know the baby has five fingers and toes and it is alright.

I think it is quite good because if your baby had a club foot or a heart defect or something it is quite reassuring to know that the baby is alright. It is like a safety thing for the baby as well. Like if it does have a heart defect that would not necessarily be picked up at birth. Whereas with a scan, they can see the actual heart functioning and they can act on those things. I don't think it is something you feel you have to do. I think it is something most people want to do.

If you have an amniocentesis and have the results before the scan then the scan is not such a big deal because I had all that information before the scan then the scan was almost nothing, as I already knew things were okay.

Before I went I was so worried there was going to be a hand sticking out here, or something wrong and there was nothing wrong. She was alright.

The two words that the participants associated most readily with scans were 'reassuring' and 'exciting'. The scan almost appears to have become more than a technology tool which gives information. Rather, it is infused with qualities of reassurance, excitement and promise. Before the advent of scans women were primarily informed by their bodies and their babies about how well the pregnancy was progressing. The advent of scans and amniocentesis has shaped understanding so that technology is seen as 'the way' in which women are best informed about the wellbeing of their baby. This information given by technology is perceived to be more reliable than information from other sources, as it provides 'real' reassurance and information. The attributes of reassurance and making the pregnancy real which are increasingly associated with the scan shape understanding in ways that is leading to increasing intervention in pregnancy.

While the scan was seen as reassuring it was also initially viewed by some women as nerve-racking:

It is also nerve-racking having a scan because you are going to see if the baby is alright. What say they tell you something is wrong? What would you do?

Other women spoke of the relief they felt after the scan showed that the baby was alright. Both the nervousness and the relief suggest that understanding is shaped in such a way that the scan is viewed as being the most reliable informer about the health of her baby. Understanding is shaped by the promise that if nothing is detected by the scan or amniocentesis, then you will have a healthy child.

I know a child that is disabled. She had an amniocentesis and everything was fine but baby got stressed during birth. She had meconium in her waters when they broke and so that gives you an indication something is wrong. They kept saying 'No, No everything is fine' and they kept carrying on. It wasn't until the heart rate went virtually to nil that they decided to do anything about this and now she is in and out of specialists all the time. She cannot drink properly, she cannot eat properly and she has to have surgery and all of that because they did not intervene earlier. She had had an amnio and she was a 'perfectly normal' child.

While acknowledging the tragedy that led to this child becoming disabled, I want to focus on the promise that the participant believes amniocentesis gave the woman and her family. Amniocentesis as a test only gives information about chromosomal or genetic conditions. Amniocentesis has an accuracy rate between 99.4 and 100% in diagnosing chromosomal abnormalities. However, no one test can guarantee the birth of a healthy baby, as not all conditions can be known and excluded before the child is born. Amniocentesis does not tell a parent about brain function or the capabilities or capacity of an unborn child. Yet in this story there is an implication that the test did give the parents the information that they were going to have a perfectly healthy child. It seems as if the test holds the promise that the child will be perfectly normal, whereas all that can be said in reality is that the child will be chromosomally and genetically normal. It appears that tests like amniocentesis are increasingly shaping understanding in that the test results are seen to hold the 'promise' of a normal and healthy baby.

This trust in technology and medical procedures to guarantee perfection is illustrated by an obstetrician:

Age certainly influences intervention and your level of intervention. You know if someone is 40 and they have had IVF... you are almost pleading with them to have a caesarean section because you know if they have a caesarean section they will have a good baby. At 38 and a half weeks with an elective caesarean section we will give them an absolutely perfect baby.

I would hesitate to subscribe this belief, of an absolutely perfect baby, to this obstetrician but suggest that by delivering this baby by caesarean section at 38 weeks, he believes the likelihood of any unnecessary risk to the baby is reduced. If understanding and practice is shaped by a worldview in which technology and its tools are increasingly seen to hold the *promise* of a 'healthy baby' then it seems reasonable that technology will be increasingly used and sought after.

Furthermore, the public data suggests that technology such as scans do not always provide correct and accurate information:

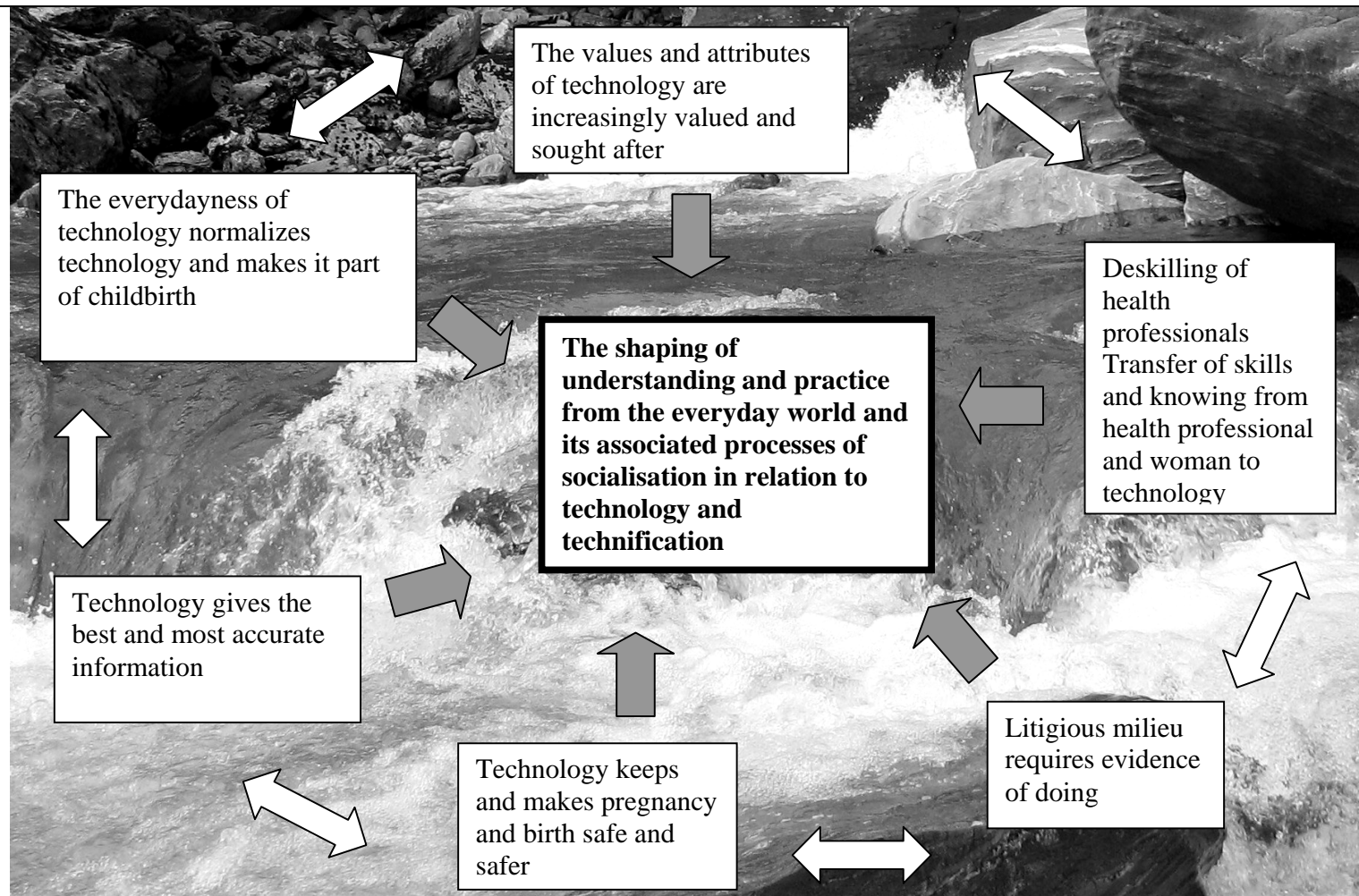
We got to the 20 week scan just to check the baby out, as you do, and they said there was a cyst on his bowel and it was very little at that stage, and they were going to do another scan and talk to the paediatricians. They did all that and more scans and so we were all set up for surgery two days after birth. Some days before birth the sonographer, who was not the top woman, did the scan and could not find the cyst and so thought 'Oh well must be the position the baby is in.' Two weeks later after the baby was born they still could not find it and the surgeon was saying, 'Well perhaps we should do exploratory surgery'. They gave us all our options, all sorts of things, rather a scary position to be in, and in fact we had a very happy healthy little boy and all was okay. The surgeons were like, 'Oh well it could have gone.'

And in contrast:

Well she is spina bifida and she has had a lot of surgery done and they did not know before she was born, even though she had scan, scan, scan and scan. There are three types of spina bifida and hers did not show up, and no scan still shows it up even though there is a gaping great hole in her back.

There was a certain incredulity in the women's voices and in the other women's reactions to the sharing of these stories. They were shocked at the inability of the scan to pick up such a condition. The idea of a scan seems to hold within it the guarantee of correct and accurate information and the assurance that if the baby has been pronounced to be 'okay' then it will be 'okay'. In spite of these kinds of examples which bring the accuracy of the scan into question there is still an increasing belief that the scan is an intrinsic part of pregnancy, and that it plays an important role in telling women that their baby is 'okay' and safe. This belief will ensure that such intervention continues to increase. Technology and the associated technification of society are legitimating, and so normalising, its use in childbirth. This growing trust in technology is shaping practice and understanding in ways that lead to increasing intervention.

The summary of the everyday world and the processes of socialization in relation to technology and technification



The technification of society and everyday experience of technology is shaping understanding and practice in unprecedented ways and ensuring the valuing and utilization of technology which results in increasing intervention in childbirth.

Chapter Nine: Part Two

Critical analysis of technology and technification

The worldviews presented in the first part of this chapter are now explored in relation to the discursive symbolic orders, social practices, relationships of power and structures of domination that shape understanding and practice in relation to technology.

The shaping of the worldviews in relation to the 'everydayness' of technology, the attributes and value given to technology and the subsequent deskilling of health professionals.

Table C11. THE SHAPING OF PRACTICE AND UNDERSTANDING		
Worldview (the shaped)	The everyday world is increasingly shaped by the attributes and values associated with technology, but clinical skills and other knowledge and values are also important. Birth is an experience which should be facilitated by nothing other than birthing itself and women must be empowered to birth unaided. The tools of technology are used when birth becomes complicated.	The everyday world is increasingly shaped by the attributes and values associated with technology and those things that are valued, sought after and trusted are increasingly technological. Birth is becoming increasingly complex, and is a process in which women are supported and aided to birth. Technology and its tools are the most trustworthy in ensuring the safety of women and their babies.
Social Practices (natural order) (the shaping)	Social and technological systems create a context in which: <ul style="list-style-type: none"> • Trust, relationships and faith are as important as facts and knowledge. • Clinical skills and knowing are valued as much as technology in terms of making birth safe. • Nature is credited with the power to sustain the pregnancy and bring about the event of birth. 	Social and technological systems create a context in which: <ul style="list-style-type: none"> • Knowledge and information provided by technology is trusted over clinical skills. • Technology gives best and most accurate information and makes pregnancy and birth safe. • Technology is available and accessible. • Technology increasingly determines, directs, and manages nature and all things biological.
Discursive Symbolic Orders (the shaping)	The embodied is valued as well as cognitive knowledge. There is a place for mystery, magic and wonder, and for not knowing when, where, and how. Birth is a natural process and technology aids, but does not replace clinical skills. The unacceptable That the tools and values of technology are the primary means of defining the experience of birth.	Technology, science, research and the tools and values associated with these things increasingly define what is available, acceptable and sought after, as technology makes birth safe. The unacceptable Lack of access and availability of technological tools, procedures and processes.

Some writers claim that Western society, at the beginning of the third millennium, is undergoing a fundamental transformation from an industrial society to an information society. The technology revolution is transforming all domains of social and economic life, and even reshaping the foundations of society (Castells, 2000; Golding 2000). Such a transformation will affect the expectations of women, their families, and health professionals in relation to pregnancy and childbirth, which will increasingly reflect the promises and possibilities of scientific and technological advancements.

The worldview that technology increasingly defines what is important and valued in society raises the question about whether the discursive orders and social practices of society shape technology, or those of technology shape society. In other words, are the understandings and practices of intervention in childbirth shaped by the interventions themselves, or by a society which designs, requests and expects such interventions to be part of the experience of childbirth? Over time, this question about technology has been approached in a number of different ways. One approach, labelled 'technological determinism', claims that technology determines human history (Roe, Smith & Marx, 2001). Critics of technological determinism argue that technology and society mutually shape and constitute one another (MacKenzie & Wajcman, 1999). Roe, Smith and Marx (2001) argue that the 'before and after' pictures of the introduction of a particular piece of technology often give the illusion that technology is in and of itself an autonomous change agent. Whereas, even something as well known as the pill, would never have been linked to a sexual revolution if society's attitudes to women, children, and sex had not allowed for the separation of the sexual act from procreation (MacKenzie & Wajcman, 1999). The development of technology appears to be as much a product of society and, in particular, a product of certain groups (relationships of power and structures of domination) whose interests are served in and through the technological (Williams, 2001).

While technology may not in and of itself cause social change, it does, however, change human experience and interaction (Strum & Latour, 1999, Wajcman, 2002). Actor-network theory presents technology and society as 'mutually constitutive' networks (Faulkner, 2001; Hughes, 1986).

Herein lies one of the difficulties of showing the constituting of the worldviews presented in Table C11, in that the ‘constituted’ (worldview) and the ‘constituting’ (relationships of power and structures of domination) appear more often than not as a ‘seamless web’ (Faulkner, 2001; Hughes, 1986). To show something of the structures of domination which, through discursive orders and social practices, constitute the worldviews presented in Table C11, there needs to be a pulling of a few threads of this seamless web. The pulling of these threads will facilitate the identification of some of the patterns, designs and arrangements that ‘constitute’. It is possible to pull threads such as gender, ethnicity, and consumerism to illustrate not only the mutual constituting and shaping of technology and society, but also those structures of domination which underpin this mutual constituting and shaping. What follows is a pulling of these threads to illustrate how certain structures of domination, through discursive orders and social practices, shape technology, which shapes society, which in turn shapes technology, and so on.

The ‘gendering’ of technology, by which women’s knowledge and ‘tools’ (such as the baby’s bottle) are not regarded as technology, suggests that technology, and the place of technology in a given society, is shaped to reflect the values and interests of a particular group - and in this instance, a particular gender (Cowan, 1999; Faulkner, 2001; Winner, 1999). An example of structures of domination informing and supporting the development of technology from an ethnic perspective is in the field of film and photography. Photography and film were developed using the white face as the norm, which resulted in an understanding that white people photographed and filmed better than black people (Dyer, 2001). The constituting of the ‘knowledge’ in the photo and film world that whites filmed and photographed better was a privileging of whiteness, not due to the technology of film and photo itself, but because the equipment was made in a particular way to ensure this privileging (Dyer, 2001). The result of this development was the ethnicizing of technology because it was shaped to reflect the interests and values of a particular race (Dyer, 2001). The pulling of these threads of gender and ethnicity illustrates how the values of a society are embedded in the discursive orders and social practices that surround the development of and use of technology and, in effect, serve the interests of particular groups. While technology may not in and of itself determine society, it can be said to impose on a society a “determinate pattern of social relations” (Heilbroner, 2001).

Consumerism is another thread that, if pulled, will also show something of the structures of domination which constitute the relationship between technology and society. Dugdale (1999) claims that consumerism and the pursuit of pleasure and goods have, since World War II, become the new social order. Consumerism, in effect, fosters a system that values the production of a social order based on control through choice by fostering individual needs and desires, and promoting consumption of the goods of production (Dugdale, 1999). This new social order in which people are encouraged to pursue individual freedom and happiness is exemplified in contraception and the new reproductive technologies. These new technologies provide opportunities in which the body and its desires, as well as the baby, can literally be controlled or designed, and that what is chosen is in fact regulated and constrained (Dugdale, 1999; MacKenzie & Wajcman, 1999). Those things that are chosen are, in reality, selected from a restricted array of technological interests which reflect, in this instance, particular economic and political interests (MacKenzie & Wajcman, 1999).

Technology is essentially political in so far as it is constrained politically, and will always serve the interests of one group over another (Mackenzie & Wajcman, 1999; Roe, Smith & Marx, 2001; Winner, 1999). Winner (1999) believes that focusing on the infrastructures that are created for technology makes it possible to realize that technology is designed to support certain social options over others, and consequently serves and promulgates the values of particular groups (structures of domination) (McKenzie & Wajcman, 1999).

For mankind is not free to choose...things economic and social move by their own momentum and the ensuing situations compel individuals and groups to behave in certain ways whatever they may wish to do - not indeed by destroying their freedom of choice but by *shaping the choosing mentalities* [italics mine] and by narrowing the list of possibilities from which to choose (Schumpeter, 1950, p.129-130)

Williams (2001) claims that the range of choice in relation to technology is not only severely limited at any given time, but that choice is itself hegemonic. The minds and desires of those who choose are, in effect, shaped in any given situation by hegemonic discursive orders and social practices.

The pulling of the threads of 'gendering', 'ethnicizing' and 'consumerism' presents some of the ways in which discursive orders and social practices inform and support an everyday world where technology is increasingly normalised and valued. A particular piece of technology may be developed and used, not because of the science and research that supports it, but because of those whose interests are furthered by the development and use of that technology (McKenzie & Wajcman, 1999).

Roe, Smith and Marx (2001) claim that technologies, science, new inventions and discoveries are increasingly viewed by society as being responsible for all that is progressive. 'Reality' in the modern era can be seen to be determined by technological progress, the force of its progression, and the compulsion to create ever new needs (Heidegger, 1997). Heidegger suggests that such a compulsion leads to the desire for everything to be new, and for the new to be replaced by the newer. Contemporary existence is informed and supported by discursive orders and social practices which have resulted in a culture of 'replaceability' in which every entity can be replaced by something the same, if not better (McNeil, 1999). Naisbitt, Naisbitt and Philips (2001) present this contemporary technological society as a self-perpetuating engine sustained by upgrades, add-ons and refills. Language is changing to accommodate technology - so fires are 'turned on', food 'zapped', information 'downloaded', people 'plugged in', 'on line', and 'surfing the net' (McNeill, 1999; Naisbitt, Naisbitt & Philips 2001). This discursive framing of technology and the social practices that support such framing mean that a belief in the technological becomes embedded in the everyday world and technology is seen as offering solutions to all social, economic and personal problems (Roe-Smith & Marx, 2001).

Technology also increasingly determines social relationships, and the ways that individuals relate to one another (Strum & Latour, 1999). While it is unlikely that technology will ever completely determine human relationships independent of nature, it has to be recognized that nature, while still being a force, in a technological age is no longer an independent force (Williams, 2001). MacKenzie and Wajcman (1999) argue that looking back to a time when the body was in a 'natural' state, unaided by technology is, in fact, misguided.

They suggest that in a world where nearly everything about a person can be changed, it makes little sense to speak of the natural and that technology which enables such changes should be engaged with so that it is used for the good of everyone (MacKenzie & Wajcman, 1999). In fact, humankind is already well on the journey of embracing technology to enhance and augment nature:

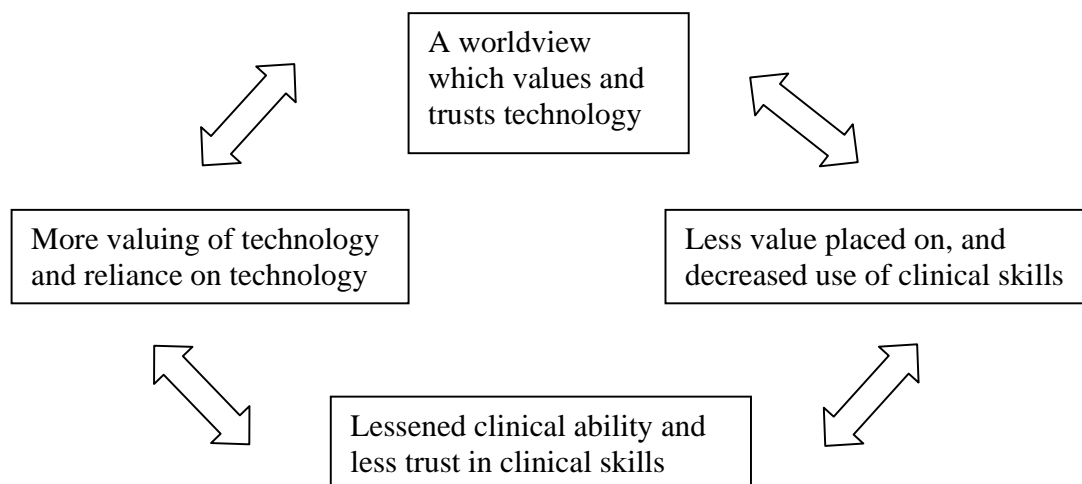
Given a choice, people will prefer to keep bones from crumbling, their skin supple, their life systems strong and vital. Improving our lives through neural implants on the mental level, and nanotechnology...on the physical level will be popular and compelling. It is another of those slippery slopes - there is no obvious place to stop this progression until the human race has largely replaced the brains and bodies that evolution first provided (Kurzweil, (1999), as cited in Greenwood, 2004, p 4).

There is an implied inevitability that the future of humankind will involve “merging intimately with technology”, and that technology will involve a reworking of human reproduction and biology (Greenwood, 2004, p.5). Such an approach suggests that the goalposts have shifted, and continue to shift in relation to nature and experience, and that the technological (cf Table C11) is increasingly defining life and living.

To gain an understanding of the technological and the way it shapes understanding and practice, it is important to consider Heidegger’s claim that the essence of technology does not exist in the technological, or in the machine itself, but rather, it is in the ‘standing reserve’ which serves the needs of the technological system. This notion of ‘standing reserve’, as presented by Heidegger, offers valuable insight into the discursive orders and social practices that support and inform a technological society and the processes of technification. Heidegger claims that technology, in effect, transforms humanity into ‘standing reserve’, so that ‘human resources’ are regarded as just another resource – similar to power and money (University of Hawaii, n.d.). However, ‘standing reserve’ does not refer simply to supply but rather, refers to the ‘presencing’ of things, insofar as everything is increasingly affected by technological revealing (McNeill, 1999). McNeill (1999) claims that in the modern era all things are being swept into a vast, tight network, in which their meaning lies in their being available to serve some end that sits under the umbrella of technification.

Naisbitt, Naisbitt and Philips (2001) present contemporary society as a network of technology which promises to make people better, smarter, happier, and higher performers, as well as provide them with security, stability, privacy and control, while giving them peace of mind. This all-pervasive network of technology promises to be the basis of the new world economy, which leads people to believe that any solution is only a purchase away (Naisbitt, et al, 2001). It corresponds to a transformation in the very way that 'presencing' itself is understood. McNeill (1999) claims that there is no longer a desire to stand 'in the presence of things themselves', and that a network and system of replaceability and 'substitutability' orders things into 'standing reserve' to serve the technological operation. This operation entails a displacement from the immediate field of presencing or actuality to *representation* and objectification (McNeill, 1999). This, Heidegger (1977) claims, is the essential problem with technology: not technology itself but that technology denies the possibility of entering into a more original revealing of 'what is'.

In relation to birth, technology hinders, and even prevents, the revealing of what was once the primary 'knowing' about birth - that which came by way of the senses and through clinical skills. It is this original revealing that is often no longer seen and is denied by the technification of birth. This is nowhere more apparent than in the deskilling of health professionals, as their clinical skills become increasingly devalued. This deskilling of health professionals can be presented in a circular movement which leads from a worldview of valuing technology, to decreased use of clinical skills, to lessened clinical ability, to more valuing of technology.



Understanding and practice in relation to increasing intervention is being more and more shaped by discursive orders and social practices which present technology as more accurate and trustworthy than non-technological skills. Traditionally, the midwifery model of care has been underpinned by the world of *presencing* through the senses, while the medical model of care has been underpinned by the world of *representation* through tools and technology (Wagner, 1994).

However, social practices such as listening to the fetal heart with the Doppler suggest that even midwives no longer readily claim a place for the senses over technology. The processes of technification result in the 'thing that is to be known' - in this instance the fetal heart - being objectified. This objectification leads from away 'presencing' to 'representation' (McNeill, 1999). When things are no longer experienced in and of themselves, it is inevitable that experience will increasingly be facilitated through technology and its associated processes. It is also inevitable that those powers associated with presencing, such as the senses of seeing, touching, smelling and hearing, which have long been the main tools of health professionals - and of midwives in particular - will be increasingly devalued. This means that health professionals will become less involved and engaged in the process of labour itself and, in effect, will learn more about what it is to be with women through technology, than learn about what it is to be with women in the experience of labour itself. Already, the cardiotocograph monitor is used when the woman is in labour, because 'that is the way you monitor the labour'; the epidural is used, because 'that is how you manage pain'; the scan is used, because 'that is how you tell an abruption, and whether the baby is all right'. The original revealing of labour, of the progress of labour, of abruption, of the fetal heart, of the 'all rightness' of the baby seems to be no more, but rather, a representation of these things is mediated and presented through technology.

This mediation and presentation through technology is demonstrated in the recent advertising of 4D colour scanning in Auckland for pregnant women. This scan is performed at the end of the medical part of the scan, solely for the purpose of gaining a clear, live-action image of the fetus. This process means that scanning is increasingly imbued with a social as much as a clinical function.

The scan itself has become a 'rite of passage' in the journey of pregnancy, and women see themselves as 'just having a scan', with little thought given to a practice whereby a woman can now be first introduced to her baby through technology. Such technology gives new meaning to the events of pregnancy and birth, as these primal experiences become increasingly mediated through technological means.

Katz Rothman (1989) claims that this era of technology will result in our knowing what we know about birth, not because of anything to do with birth, but rather because of the way birth is managed. In other words, birth is no longer known about as birth itself, but what we know about birth is the *representation* of birth that has been learnt about through managing birth. In this way, the original '*presencing*' is masked and concealed. What is known, in this instance, is not that which comes into appearance of itself but that which is determined through technology and the process of technification to be the 'important', 'valuable' and 'necessary' information in relation to birth. Labour, the abruption, the progress of labour are no longer seen or the fetal heart is no longer heard. Rather, they are seen and heard in ways that are determined, mediated and constituted by the process of technification. There is no longer value placed on the actual experience itself, the presencing of the "thing in itself". Rather, that which is mediated through technology is increasingly valued as the most important and even seen as reality and actuality. This change in practice has led to the ascendancy of technology over the skill of the health professional and the knowing of the woman and has in effect transferred the skill of the doctor and midwife and the knowing of the woman to the machine.

Technology is also seen to hold within itself the promise that safety in pregnancy and childbirth increasingly resides in the domain of the technological and the scientific. The 'all rightness' of the baby is primarily made known to the woman and the practitioner through the use of technology. The association of safety with technology even leads to a belief among some that a caesarean section is a safe - and even 'safer' way to birth, and that intervention is always preferable to non-intervention (Wane, 2002).

In this instance, 'safe' is linked primarily to the development of anaesthetics - and while anaesthetics and surgical operations are safer than they have ever been there is still concern as to the perceived 'safety' of anaesthesia (Lagasse, 2002). At what point does the knowledge that a particular procedure is safer *than it used to be* make it the normal, preferred or most appropriate way of carrying out certain functions? (Wane, 2002).

The discursive framing of technology and its tools of intervention as 'safe' and 'safer' (cf Table C11) is increasingly supported by social practices which translate the statistical success of surgical procedures and anaesthesia into an availability and acceptability of 'operations' per se. Such an association of safety with technology, and in particular with surgical procedures, is disputed by some women and health professionals, and yet the rising intervention rates would suggest that there may be a case to answer in regard to the association of safety with things technological. It does appear that practice and understanding is increasingly shaped by a belief that safety resides primarily in the technological, and this will inevitably lead to increasing intervention.

In this technological age, that which is natural, of nature, and 'of itself' is increasingly hidden, and in some cases it becomes difficult to differentiate the 'real' from the 'unreal'. In the 21st century, technology can transform nature as never before, and it is little wonder that the catch cry of this time is "Is that real?" or "Is that fake?" (Naisbitt, et al, 2001). Never before has the real been obscured by technology in such a way (Naisbitt, et al, 2001). McNeill (1999) argues that technological 'presencing' results in the *actual* presencing of something else, and that even actuality itself is not being allowed to encroach too closely. He suggests that the process of technification, which concerns itself primarily with what can serve it and secure it, appears to withdraw people from the actuality and experience of things themselves (McNeill, 1999).

Naisbitt et al (2001) claim that the two biggest markets in the \$8 trillion-a-year economy of the United States are: consumer technology, and escape from consumer technology! This two-sided technological operation with its huge economic base and its processes of technification has produced a system which replaces reality and actuality with representation, and has transformed the real into being primarily 'standing reserve', for the service of the technological system itself.

Technological presencing means that reality is that which secures the technological operation itself, rather than the presencing of something in and of itself. Wolf (2001) claims that in the United States women are encouraged to wait until the amniocentesis results are in before they start attaching to their baby - even though this may be a month after quickening, when they can first feel the baby move. This modern era is concerned primarily and pragmatically with the sustainability of the technological system, and that which is valued and seen as 'real' by this system. The shaping of understanding and practice by the technification of childbirth results in *representation*, rather than the *presencing* of things in and of themselves.

The discursive orders and social practices that inform and support the technological network are reinforced by the litigious age in which health professionals practice. This culture of litigation further ensures that the representation of birth is mediated through technology; therefore action (intervention) is increasingly valued and sought after. Thus the deskilling of health professionals in their traditional skills is further ensured, and this profoundly shapes understanding and practice in relation to increasing intervention in childbirth. Increasingly, processes and skills that are outside the umbrella of technology are likely to be seen as quaint and old-fashioned, and as such, become more and more devalued.

The everyday world is increasingly shaped by the attributes and values associated with technology. Relationships of power and structures of domination, such as the technological network and system, the free-market economy and science, along with their supporting discursive symbolic orders and social practices, ensure that technology is increasingly valued and sought after and that reality itself is increasingly centred around the technological. These relationships of power and structures of domination are further supported by social movements such as consumerism which also - albeit unintentionally - support and aid the technification of birth. A culture of birth in which technology is increasingly the norm, can only result in increasing intervention in childbirth, as it calls into question those things which have traditionally been at the heart of childbirth: the ability of the woman to birth, and the clinical skills of the health professional.

Technology and technification – a summary of that which is shaping understanding and practice in relation to intervention in childbirth.

THE SHAPERS: Relationships of power and structures of domination (the source and force of the river - that which controls and in part constitutes the river)

- Technological revolution
- Technological networks supported by other structures of domination such as consumerism, patriarchy, white privilege, and political and economic interests

THE SHAPING: The discursive symbolic orders and social practices shaping the worldviews (the river bed and river bank which contain, direct and support the river)

- Technology offers solutions to life and determines social relations and human experience ('representation' replaces 'presencing'). Technology is progress and is the new world economy. There is surveillance, regulation and a devaluing of things not of the technological network. Childbirth is technified and objectified
- Consumerism fuels desire for technology, for whatever is new, and promotes a culture of replaceability
- There is control and regulation of nature and the body by technology and its tools and procedures which keeps pregnancy and childbirth safe



THE SHAPED: Worldview (the water - that which is most readily seen to be the river)

- The process of technification and the everydayness of technology normalizes technology
- The values and attributes of technology are increasingly valued and sought after
- Technology gives the best and most accurate information and makes pregnancy and birth 'safe' and 'safer than'
- Technology and technification result in deskilling of health professionals and transfers skills and knowledge to machines
- Technification facilitates the technological mode of birth



A culture of birth in which technology is increasingly the norm can only result in increasing intervention in childbirth as it calls into question those things which have traditionally been at the heart of childbirth: the ability of the woman to birth, and the clinical skills of the health professional.

Chapter Ten:

The hermeneutical and critical analysis of the default mode of birth

This chapter is the conclusion of the chapters which present the findings from the data, and is the culmination of this study's presentation of the shaping of practice and understanding in relation to increasing intervention. The conclusion focuses on the worldview that assesses the importance given to particular ways of birthing. The first two focus groups with the public called into question the importance of women birthing in any specified way. This question then became part of subsequent focus groups, and established itself as a key finding in the research. The line of questioning about the 'how' of birth starts with the assumption that this 'how' is, or has been, important, and that the default mode of the 'how' is 'natural' or 'normal' vaginal birth.

The following responses are representative of the initial responses from the public when they were asked the question about the importance of the way that women give birth:

It is important because I think it will be sad if woman do not birth naturally.

It is important. I am sure it is, but why exactly I am not sure.

It does matter how women birth and I do think that it would be sad if women no longer gave birth naturally - but I cannot think why.

It would just be another lost art and it would be sad if woman could not birth naturally, but well...

Of course it is important how women give birth. But yes - why is it important? That is a very good question.

As the focus groups explored this question it was often a struggle for the participants to come up with reasons for the importance of the 'how' of birth.

Rather, there was almost a belief, albeit tinged by sadness, that birth was becoming increasingly interventionist, and that it was inevitable that the 'how' of birth would become less natural and that natural birth may not always be an option. This sense of inevitability regarding the 'how' of birth was also felt by this midwife:

I guess the sort of changes we are seeing where women are choosing more intervention is hard to roll back, as evidenced in most countries of the world where caesarean section rates are high. I think it is probably a question of time. I think it is sad but maybe there will be a time when women will not attempt to have a vaginal birth.

There was some data which suggested that natural birth does matter, because it empowers women and makes them feel amazing and strong:

...the more positive birth experience the better. I felt really clever when I did it. I felt so so clever. I felt I could reach out and push the walls of National Women's down! If I could do that I could do anything. It was amazing. I wouldn't actually be without that experience.

Yet for a significant number of women in the focus groups the 'how' of birth was not, in and of itself, important:

It is not really a concern to me if birth will become less and less natural and technology has more of a place.

It is not a concern to me either if birth involves more technology.

If I was told I could choose an elective caesarean section I would. I would choose to have another baby by caesarean section. I mean, my niece says to me, 'My mum has this big cut where my baby brother came from'. You see, they know. I would like to have one more but I do not know if I could go through a normal birth or experience like that again.

[I said] 'I would like a caesarean section to have this baby out, and as soon as possible', and they gave me all the reasons why it was not a good idea. In the end we compromised. They brought me on and then my baby was born a day before his due date. They gave me all this philosophy on why it should all be natural but it all fell on deaf ears as I was not happy about it.

These participants are not concerned that birth may become less of a natural process and more of a technological one. If the 'how' of birth is given less importance than it has had previously, and if natural birth is not necessarily seen as the default mode, it is inevitable that intervention will increase in childbirth.

Worldview: 'What matters most of all is not 'how' you give birth, but a live and healthy baby and mother.'

This view was expressed by a number of women in the focus groups:

However, if at the end of the day I had had to have a caesarean section it would not have worried me as the object of the exercise is to have a live baby.

Now that I have her and I am never going to experience natural birth well - so what really. I mean, once they are here and alive it does not matter. What do those 24 hours matter?

Initially I felt angry about having a caesarean section because I did not want to have one but she was breech and my mother had had a stillbirth. My specialist said there were too many risks just for the sake of experiencing childbirth. I remember him saying to me that you go through pregnancy carrying your baby to have a live baby. You forget about how you deliver and making sure you and the baby are safe and healthy - that is the important thing. If you have to have a caesarean - well really, get over it.

It is always first and foremost, 'healthy mum and health baby'. That is still absolutely top priority. Mum lost her first baby during childbirth so both my babies were born in hospital with everything around me. Once when I went to my GP and I said something along the hippie line she said, 'You do realize that you could die from doing this don't you? You do want to keep your uterus don't you?' As this was my first baby, you can imagine my reaction!

I think women should have a choice; like even with having my own baby or if they want to have an elective caesarean section then they should be able to have one. What is important is the baby. It does not matter to me how you have the baby.

When I went and spoke to my GP about it I said to her, 'Oh well I am one of the ones increasing the elective caesarean rate'. She said, 'Today you may get one woman a year die, and it is often because of other complications rather than directly birth-related, and the death of babies is very very low, whereas 20 years ago the morbidity rates of babies and women dying were really high'.

These women capture a worldview that was present in all the focus groups in response to the question, ‘Does it really matter how you give birth?’ Their primary concern was to ensure a live and healthy baby and mother. There can be little argument against the desirability of these outcomes, and yet it is almost as if the experience of birthing itself is purely incidental to the outcome, and its sole significance is in relation to the live and healthy baby. This is illustrated by the very pragmatic view that if a woman has a caesarean section, she needs to ‘get over it’ because the ‘how’ of birth is not primarily important. While such framing of a clinically indicated caesarean section is understandable, it raises a number of issues about the shaping of women’s understanding in relation to the ‘how’ of birth, outside of such clinical requirements. It seems that increasingly, women’s understanding is shaped by the belief that the safety and wellbeing of a woman and her baby is an issue for every woman, in every pregnancy and birth. In this way, the outcome of birth, even when the outcome is not an issue, is defaulted to, and the way a women births is increasingly framed as being of secondary importance.

The shaping of the worldview in relation to the importance or otherwise of the 'how' of birth.

Table C12 THE SHAPING OF PRACTICE AND UNDERSTANDING		
Worldview (the shaped)	<p>The 'how' of birth does matter. The default mode is natural birth, which assumes 'live and healthy', and that natural birth is the best way to ensure this.</p> <p>The object of the exercise is a live and healthy mother and baby, using all the women's resources to bring this about.</p>	<p>The 'how' of birth does not matter. The default mode is a live and healthy baby, and whatever way that happens is fine.</p> <p>The object of the exercise is a live and healthy mother and baby, using all the tools of technology and science to ensure this.</p>
Social Practices (natural order) (the shaping)	<p>A context in which educational, cultural, religious and social systems ensure the practice that:</p> <ul style="list-style-type: none"> • Women give birth naturally. • Vaginal birth is the safest way of ensuring a live and healthy baby. 	<p>A context in which educational, cultural and social systems ensure that:</p> <ul style="list-style-type: none"> • The outcome, not the experience of the birth matters; experience is secondary to a healthy mother and baby. • Intervention means that fewer women and babies die, and technology and its tools are the way of the future.
Discursive Symbolic Orders (the shaping)	<ul style="list-style-type: none"> • The experience of natural birth is seen as something important in itself, as this is part of what makes the birth safe for the mother and the baby. • The way a woman delivers is not forgotten, but is part of the experience, and is an important and defining life event. <p>The unacceptable That women rely primarily and in the first instance on technology to ensure that their baby is alive and healthy.</p>	<ul style="list-style-type: none"> • The way of giving birth is secondary to the outcome, and is increasingly separated from the outcome. • The purpose of birth is to have a live and healthy baby, not an experience of birthing. • The safety and wellbeing of baby is an issue for every woman in every pregnancy. • Birthing in the 21st century needs to be determined by things other than primitive bodily functions. <p>The unacceptable That women do not have the options to choose all that technology and science have to offer, and so guarantee that their baby will be alive and healthy.</p>

The constituting of the worldview in which the ‘how’ of birth is not of primary importance is based on the beliefs that the outcome is more important than the process (even when the outcome is not an issue) and that natural processes will be increasingly facilitated by technology. The worldview is also affected by the everyday world of women in which status and value is no longer associated with birth. These worldviews and their underlying beliefs and assumptions increasingly call into question natural birth as the default mode of childbirth. The new default mode appears to be centred primarily around the outcome of a live and healthy baby and whatever way that happens is acceptable. This new mode of birth will mean that those things that are associated with facilitating best outcomes will increasingly be utilized and sought after. This change in the default mode as presented in table C12 means that the understanding of the public is increasingly shaped in such a way that intervention is framed as the safest way to ensure a live and healthy baby.

Davis-Floyd (1994) contrasts the position of women in America in the early 1980’s with women in the 1990’s, in relation to childbirth. She claims that the early 1980’s women wanted natural childbirth and resisted intervention, while women in the 1990’s felt comfortable and empowered by technological intervention, and had little interest in resistance. This change is fundamental to the shaping of understanding and practice in relation to increasing intervention in childbirth. It showed itself in the data of this study in beliefs about the importance of ‘how’ women birth. The everyday world and the associated processes of socialisation as described in this study are bringing about a new default mode in relation to the ‘how’ of birth. Women not only have fewer children, but most women no longer gain their value and status from childbirth. Vaginal birth has been categorised as last century’s definition of womanhood (Bridgeman, 2001; Showalter, 1999). In societies where natural birth is no longer linked to womanhood, and technology has become the facilitator of birth through surveillance and scheduling, then the ‘how’ of birth is declining in importance (Harvey 1997; Hunt, 1996). This new default mode of birth will mean that women will increasingly feel comfortable with, and empowered by, technological birth which will result in increasing intervention.

This challenge to the way that women birth confronts one of society's most closely held beliefs. It provides an opportunity to stand back and look at the beliefs that characterize a society at any given time. Kogler (1999) claims that only in situating oneself against cultural certainties is the researcher able to unmask the power relationships and structures of domination that have vested interests in the way women birth. These data chapters have in fact provided the space to stand back and look at the shaping of understanding and practice. This exploration of worldviews: from the socialisation of women in relation to their appearance and behaviour, to the avoidance of pain and the embracing of epidurals, to the culture of choice and the technification of society, make clear that while birth may be a biological event there is never a time when birth is not shaped by society (Arney, 1982; Wolf, 2001). These worldviews are being shaped by relationships of power and structures of domination, which are increasingly challenging and calling into question the age-old acceptance of natural birth. The challenge of increasing intervention is impacting profoundly on childbirth, as the process of birth itself is being called into question.

The everyday world and its associated processes of socialisation, in particular choice, pain and technology - a summary of that which is shaping understanding and practice in relation to intervention in childbirth.



THE SHAPERS: Relationships of power and structures of domination (the source and force of the river - that which controls and in part constitutes the river)

- Technological revolution; Technological networks supported by other structures of domination such as consumerism, patriarchy, white privilege, and political and economic interests
- Patriarchy and Judeo-Christian tradition
- Celebrity culture and western hegemonic feminine beauty
- Bio-medical model, surgical, pharmacological, research and science,
- Consumerism, feminism, capitalism and the ideas of the new age movement
- Neo-liberalism, individualism, cultural norms, values and beliefs
- Formal education, postmodernism, consumerism, feminism
- Utilitarianism, midwifery and medicine

THE SHAPING: The discursive symbolic orders and social practices shaping the worldviews (the river bed and river bank which contain, direct and support the river)

- The everyday world and associated processes of socialisation increasingly correlate with what intervention has to offer.
- Pain is something to be avoided and science and technology ensure unprecedented access to good pain relief.
- The establishment of a culture of choice where women are increasingly choosing intervention.
- Technology is increasingly the norm, valued and utilized over and above other skills and experiences
- The how of birth is no longer of prime importance: rather the guarantee of a live and healthy baby and those things which can guarantee such an outcome (science and technology) are what matter.

THE SHAPED: Worldview (the water - that which is most readily seen to be the river)

- The 'how' of birth is increasingly of little importance and this is bringing about a new default mode of birth which will further increase intervention in childbirth.



The everyday world and its associated processes of socialisation, in particular choice, pain and technology, are shaping understanding and practice in ways that are changing the 'how' of birth – the nature of birth itself, the ability of women to birth and the clinical skills of health professionals.

Chapter Eleven

Concluding Chapter

The findings of the research

Understanding and practice is *shaped*. This research makes the shaping overt in relation to increasing intervention in childbirth. The findings of the research coalesce to form the argument that the everyday world and its associated processes of socialisation in the 21st century, regarding pain, choice, and technology, shape the practice of health professionals and the understanding of the public in relation to increasing intervention. Social and cultural values such as control, predictability, ‘fit-it-in-ness’ and regulation are not just products of the 21st century, but rather have been shaping understanding and practice for some time. In effect, this shaping can be traced back to the 18th century and the Enlightenment when science was embodied in technology, which led to the technification of society (Polkinghorne, 2004). This technification ensures that not only is nature increasingly manipulated and contained, but the lives of humans are increasingly regulated so that the human sphere becomes more “controllable and predictable” (Polkinghorne, 2004, p.35). It is this constant interplay between the everyday world and relationships of power and structures of domination that has, over a long period of time, created a milieu which, in the 21st century, is resulting in increasing intervention in childbirth. This milieu of increasing intervention is profoundly shaping, determining and maybe irreversibly changing midwifery and obstetric practice and the understanding of the public in relation to childbirth.

The argument of this research, as presented in the chapters which reveal the findings of the data, is captured by the image of the river. As the river is in part shaped and constituted by the river bed, the banks and the source and force of the river, so too is practice and understanding shaped and constituted by the discursive symbolic orders, social practices and relationships of power and structures of domination. However, as with the river, this shaping is never absolute, and there is a constant interplay and tension between the shaped, the shaping and the shapers. Describing, identifying and bringing to awareness this interplay and tension reveals in the findings of the research *that which* is shaping practice and understanding.

That which is primarily shaping understanding and practice are the underlying economic, ideological, social and cultural values and beliefs such as consumerism, patriarchy, the Judeo-Christian tradition, postmodernism, neo-liberalism, capitalism and a raft of other interests. The interests of these relationships of power and structures of domination are reflected in the *shaped* nature of reality. Postmodernism and neo-liberalism shape a reality which values autonomy and in which choice and authority is invested in the individual and their wishes. The technological network and capitalism are *shapers* of a reality in which the technological is increasingly valued, utilised and sought after. Utilitarianism and consumerism shape a reality in which pain is something to be avoided and managed. Patriarchy, the Judeo-Christian tradition, and western hegemonic gendering of women continue to shape reality, and seek to regulate and control the behaviour and appearance of women.

These relationships of power and structures of domination do not exist or operate in isolation, but rather they shape, influence and impact on one another. The merging of these relationships and structures, one with the other, is in effect *that which* shapes understanding and practice. It is unlikely that the wish to avoid pain (utilitarianism) would result in increasing intervention without the support of consumerism, the technological network and even postmodernism. Similarly, it is highly unlikely that women would increasingly choose intervention (neo-liberalism) without the support of consumerism, and even particular hegemonic gendering. I would argue that no one relationship of power or structure of domination is shaping practice and understanding, but rather a convergence of those things which underpin society at the turn of the century is resulting in increasing intervention. This is clearly illustrated in the findings of this research. The everyday world increasingly correlates with what intervention has to offer, the avoidance of pain readily correlates with unprecedented access to good pain relief, the technification of society correlates with the normalisation of technology in childbirth, and a culture of choice correlates with women increasingly choosing intervention. This research reveals not only the convergence of these interests and values, but also the complexity and the hiddenness of *that which* shapes which is more often than not lost amidst the superficial, and apparent reasons given for the rising rates of intervention.

The significance of the description and identification of the shaping and shapers is found in the space created by the process of this research, in which recognition and awareness of *that which* shapes is made possible. The significance of such a space and hence this research, lies in the finding that at this time the shaping and shapers are increasingly calling into question those things that have traditionally been at the heart of childbirth: the ability of women to birth and the clinical skills of the health professionals. The space created by this research gives a moment to pause, reflect and engage in discussion and debate about the impact of such change. It is imperative that this discussion takes place at this time, as not only are the skills of the health professionals and the ability of women to birth naturally under threat, but soon there may not be a space in which it is deemed possible, important or necessary to have such a discussion. It seems likely that some of the skills of health professionals will soon become obsolete, and that a limited legacy will be passed onto ensuing generations.

Relating Findings to Other Studies

In the literature review a comprehensive presentation of material referring to increasing rates of intervention, and the reason for these increasing rates, situates and contextualises this study. The findings of this research study are also confirmed and complemented by a number of other studies. With regard to choice and the right to choose, the findings were echoed by a number of researchers and writers who question the culture of choice, the ability to be fully informed, and the 'rights' that choice give (Amu, Rajendran & Bolaji 1999; Anderson, 2006; Beech, 2003; Davis, 2003; Stapleton, Kirkham & Thomas, 2002; Young, 2006). Other writers and researchers confirmed the shaping and contextualising of choice (Childbirth Connection, 2006; Declercq, Sakala, Corry & Appelbourn, 2006; Gamble, Health & Creedy, 2001; Marx, 2001). In relation to pain there was much writing and research which confirmed and complemented the findings that pain in a society like Aotearoa-New Zealand is increasingly something to avoid, while pharmacological pain relief is something to be embraced (Leap & Anderson, 2004; Glance, Wissler, Glantz, Osler, Mukamel & Dick, 2007; Morris, 1991; Surtees, 2003; Wolf, 2001).

There was also research which confirmed the findings that pain was related in some cases to certain social indices such as ethnicity, economic and even education (Olayemi, Aimakhu & Akinyemi, 2006; Roberts, Tracy & Peat, 2000). In relation to technology there was a deluge of research and literature which confirmed and complemented the findings with regard to the normalisation of technology and the technification of society (Castells, 2000; Golding 2000; Naisbitt, Naisbitt & Philips, 1999; Roe Smith & Marx, 2001; Wajcman, 2002; Winner, 1999). The amount of material about the processes of socialisation of women that confirmed and complemented the findings of the study was vast (Andrews, 2003; Blum & Stracuzzi, 2004; Fournier, 2002; Gilligan, 1982; Rubin, Nemeroff & Russo, 2004).

One of the most significant pieces of research which confirms and complements the findings of this study in relation to the everyday world and its processes of socialisation is presented in an article entitled *The Technocratic Body: American Childbirth as Cultural Expression*, by Robbie Davis-Floyd, published in 1994. The tenets that support the technocratic model, such as life is to be controlled; technology is to be trusted more than nature; mind should control body; mind is more important than body; pain is bad and not to be felt all confirm and support the findings of the study (Davis-Floyd, 1994). However, while the findings of this present study are in some ways similar to those presented in *The Technocratic Body*, they also expand on the tenets of this model of birth. The present study adds aspects such as 'fit-it-in-ness', convenience, ease, and avoidance of mess. This similarity yet difference leads me to believe that the findings of the present study suggest that the technocratic model described by Davis-Floyd in 1993, as the template for the future, is in fact the actual template for now.

In situating this research in relation to increasing intervention in childbirth, it is important that I acknowledge two studies carried out in Aotearoa-New Zealand which confirm some of the findings of this research in relation to the shaping of understanding and practice. Clements (2005) and Arthur (2003) researched respectively the experience of nulliparous women choosing an elective caesarean section, and elective caesarean section and maternal request. Arthur & Payne (2005) while acknowledging the small size of their study, present a tentative finding that women's request for an elective caesarean section is shaped by their understanding that vaginal birth is a risky process.

Clement (2005) in her study found that women had an overriding “concern and worry” for themselves and their babies and having an elective caesarean section was a way in which they could protect themselves (p.97). These studies confirm and add to *that which* shapes women’s understanding in relation to caesarean section.

While there is much material which supports, confirms and even adds to the findings of this study there is little or no material which directly contradicts the findings. This may be to do with the limited amount of research in relation to this particular topic. The limited knowledge and even real confusion over the reasons why women choose intervention, and the myriad of interests that are served in increasing rates of intervention, provide both the context and significance of this study. In reports such as the New Zealand Maternity Report and the annual National Women’s Report which present a statistical picture of the rising intervention rates, the authors make occasional comments about interactions between a number of variables in an attempt to give insight into the rising rates of intervention. Variables such as ethnicity and socio-economic indices are commented on and the reports do more than hint at the complexity and the influence of psychosocial influences on the rising rates of intervention. However, there is little research to provide reasons for the way these psycho-social influences may be impacting on intervention rates, or even what these psycho-social influences actually are. This is the space that this research fills, in that the qualitative findings of this study complement, explain, and give meaning to the statistical evidence of increasing rates of intervention in childbirth. Lavender, Hofmeyr, Neilson and Kingdon (2006), after reviewing the research in relation to the intervention of elective caesarean sections, argued that until further qualitative research explored those things that are influencing women’s views in relation to intervention it would not be possible to gain a full picture of what is leading to increasing rates of intervention.

Ecker and Frigoletto (2007) reiterated the complex nature and reasons for increasing intervention in childbirth, and in particular caesarean sections, and they called for more clinical trials in areas in which there is still uncertainty in regard to increasing intervention rates. They argue that these trials are needed so that health professionals may best educate women about their choices, risks, and the trade-offs they may have to make when choosing intervention.

I would argue that while further clinical trials may be necessary, without research which presents *that which* is shaping understanding and practice, and normalising and making intervention acceptable, then it would be difficult to gain a full picture of the rising intervention rates. The complexity of the rising intervention rates cannot be underestimated or attributed only to the intervention themselves, and the call by reviewers, researchers and clinicians for further research (qualitative and clinical trials) to address this complexity attests to the significance of this study. In the United States 6% of the women due to deliver in January 2007 were induced in late December, so that tax breaks worth \$4000 per child, could be obtained (Samways, 2007). It is only when such things are explored that practice and understanding can be seen to be shaped by much more than the interventions themselves. Young (2006) claims that the ready acceptance and normalisation of intervention in childbirth is creating a culture of intervention that will not be easily reversed. The urgent need to research those things that are informing women and health professionals and normalising intervention is the space to which this study brings understanding. This reflective space provides an opportunity to be aware of the real and complex reasons for increasing intervention, as it is only in this kind of space that there exists the potential to understand and reverse such a culture. The findings of this study means that the complex nature of rising rates of intervention and the culture of intervention that surrounds childbirth in the third millennium may increasingly be understood. It is this contribution to a body of knowledge which is urgently seeking answers to the questions about what is shaping practice and understanding, which situates this study and gives it significance.

Implications for Practice

The implications for practice to emerge from this study are numerous and complex. They are numerous in that the study brings to awareness many things which are shaping practice and understanding and leading to increasing intervention. The implications are complex in that the shaping: of pain as something to avoid, choice as a right to be respected by health professionals, technology as an accepted and expected part of childbirth along with the everyday world and processes of socialisation of the 21st century, are all creating a milieu in which intervention is increasingly normalised, sought after and utilized.

The complexity of these sociological and cultural factors means that understanding and addressing the increasing rates of intervention in childbirth in any meaningful way is not going to be easy. In fact, it may be extremely difficult to prise apart the increasing rates of intervention from the cultural and social influences, and in particular the level of technification of society in the 21st century which are shaping and informing practice.

The complex nature of the findings of this research present another implication for practice in regards to the reasons that are readily given for rising rates of intervention. The findings of the study suggest that it is not appropriate for the rising intervention rates to be laid just at the door of women because 'it is women's choice' or at the door of obstetricians because 'it is more medicalisation of birth' or at the door of midwives because 'seventeen years of independent midwifery and seventeen years of unprecedented intervention'. The blame game around the rising rates of intervention needs to stop, as do the simplistic answers which imply that women wake up one day and decide to have their baby by elective caesarean section. Trite and simplistic answers to describe what is in fact a very complex interaction of a number of factors does everyone - the public and health professionals alike- a disservice, and does not explain or provide solutions for practice. Finding practice answers and solutions to the rising rates of intervention requires courage and rigour so that the complexity of what is shaping practice can be explored. This study provides insight into and analysis of the complexities involved. This insight and analysis enables health professionals and the public alike to recognise that while there are no simple answers, the trends need to be carefully and thoughtfully appraised rather than accepted as 'the way things are'.

It could be argued that the implications for midwifery practice are of particular significance. A milieu in which intervention is increasingly the norm stands in sharp contrast to the body of knowledge that is midwifery. Midwifery comes from the perspective that birth is a normal physiological process and that the majority of women need little or no intervention. The implications for midwifery of increasing intervention are captured powerfully in the data section on the deskilling of health professionals. A participant in this section spoke of new midwives no longer having the opportunity to smell, hear, feel, touch and know birth itself, and that midwives in the 21st century are no longer with women but with women with technology.

There is a clear challenge to health professionals, and to midwives in particular, regarding clinical skills. Unless a stand is made to defend, in the case of midwifery, a body of knowledge, and in the case of all health professionals their clinical skills, then these things will be increasingly devalued and lost. However, to meet this challenge and to ensure that clinical skills are not lost, the rising rates of intervention must be understood in all their complexity. Understanding and practice is fundamentally shaped by a social and cultural milieu, and it is this milieu which is primarily deskilling health professionals.

One of the most important implications of this research for practice, both for the public and health professionals lies in the bringing to awareness of that which is shaping understanding and practice. Kogler (1999) claims that an exploration of any given matter needs to enable people to know that their choices and their understandings are theirs and not shaped and determined by other interests and values. In short, what Kogler seeks and what has been my aim through this research process, is to facilitate a more self-determined way of life. To this end, the findings of the study seek to provide a “space for reflection and action over against established interpretations and structures of domination” so that the public and health professionals may have a fuller understanding of *that which* shapes and leads to increasing intervention (Kogler, 1999, p.239). However, the shaping of understanding and practice raises the question about to what degree an individual can be self-determining. In fact, how many people have the time, energy, inclination or interest to gain distance from, create space around, engage with a process of difference so to understand that which is accepted and known as reality? When a woman gets pregnant she finds herself caught up in the reality that is ‘being pregnant’. For the majority of women this reality, ‘just is’ and to talk at this point about self-determination and coming to an understanding of the reality that surrounds pregnancy and childbirth is almost impossible. When one looks at the journey Naomi Wolf took in her own pregnancy as recorded in the book *Misconceptions*, one could be forgiven for thinking self-determination in relation to pregnancy and childbirth is actually impossible. Wolf (2001) carried out extensive research and interviews, had numerous discussions and debates, and visited facilities that offered many different versions of maternity care.

She discovered that the practices and understandings in relation to childbirth had little to do with the physiological reality of pregnancy, but everything to do with the shaping of practice and understanding by certain relationships of power and structures of domination. It is interesting to note that even with all the knowledge and insight Wolf gained around the interests that shape childbirth she still knew that she did not have “the courage or the faith to give birth with no access to drugs” (Wolf, 2001, p.163). She presents the shaping of her understanding which ensured that her choices were not primarily determined by herself but rather by those things which took away her courage and faith.

Therefore while an important implication of this research for practice is self-determination, such determination is only ever partial. Even when reality is glimpsed and known there still remains the tension between the shaped, the shaping and the shapers which means that an individual may still not act or choose in a way that is self-determining. However, the tensions and paradox of self-determination do not make this implication for practice any less important. While intervention may still be chosen for lack of courage or faith, it is imperative that a space is created, in which the public and health professionals will increasingly recognise in the choosing, those things that shape their understanding and practice and will (if only ever partially) be more able to determine for themselves their choices and their practice. It is only when such a space exists, and there is at least the potential for self-determination that there is any possibility that change can be brought about so that the public and health professionals can ensure that their understanding and practice reflects their values and beliefs.

Implications for Education

The findings of this research are important for education in that they show the complexities surrounding the rising intervention rates in childbirth. I would argue that the research has much to contribute to the education of student midwives, medical students, midwives, obstetricians and, of course, the public. The research is important for student midwives and medical students insofar as they need to understand the context of practice and the many influences that shape their own practice, the institutions in which they practice and the public to whom they will be providing a service.

In many undergraduate programmes the context of practice is already taught and explored and this research will add to the understanding of that context, and in particular will provide in-depth knowledge in relation to rising rates of intervention. Health professionals and students alike, in order to understand the rising rates of intervention, rely on statistics reported by service providers such as National Women's. The findings of this study add flesh to the bones of the statistics and facilitate education about intervention, in that they provide in-depth and meaningful explanation of a number of the variables in these reports. The findings inform and provide insight into what could primarily be viewed as a clinical phenomenon. The research in this way serves to remind student and practitioner alike that any clinical picture such as rising rates of intervention is complex, and shaped by more than just clinical indicators or the interventions themselves.

The findings of this research suggest that it is imperative that educational sessions and staff development processes encourage health professionals to explore, debate and come to a greater understanding of those things that are shaping their practice in a milieu of increasing intervention. Such an educational opportunity which facilitates a description and identification of the shaping and the shapers means that health professionals can explore ways that their practice could be shaped *differently* in relation to intervention. This provides an opportunity to work through specific issues and challenges, such as those to the body of knowledge that is midwifery, so that solutions can be found to the deskilling that appears to be part of a milieu of increasing intervention. The keeping alive of midwifery clinical skills through education requires that at the undergraduate and professional level the art, the wisdom, and the knowing of normal, natural birth continues to be taught and valued. At the recertification workshops that the Midwifery Council requires midwives to attend, where experienced and senior midwives are present, the art, the wisdom and the knowing of midwifery sometimes fills the room. As a lecturer who teaches in these workshops I often feel humbled and privileged to be the recipient of such practice wisdom. It is this that must be captured, and through education shared, and passed on in volume, especially to student midwives. It seems imperative that in this age of increasing intervention, that educational opportunities and processes are provided for the passing on of such practice wisdom, as it is this that will ensure that clinical skills are kept alive.

There are a number of profound implications for education of the public as a result of the findings of this research. It is possible, through education, to provide a space in which the public have the opportunity to identify and describe that which is shaping their understanding. The awareness such education brings will not necessarily result in less intervention, but as mentioned previously it will at least give an opportunity for the public to be aware of the values and interests that are informing their choices, and at best enable a more 'self-determined way of life'. During this research the public spoke at length about the way things such as epidurals were framed at antenatal classes, which profoundly shaped their understanding. Surely, if there is time for giving such information at antenatal classes there is time for awareness-raising about the context and interests which shape and constitute the choices the public are making.

Implications for Research

This research set out to show the shaping of practice and understanding, and to that end it identified the *shaped*, the *shaping* and the *shapers* in relation to increasing intervention. Throughout the study, as a result of the interaction with the participants and the process of research itself, a number of studies which could confirm, support and add even more depth to the *shaped* nature of understanding and practice suggested themselves. One such study is in relation to midwives gaining further insight into the shaping of practice. Research which would examine the extent to which midwives and midwifery had been changed, reframed and deskilled by increasing rates of intervention would further elucidate the shaping and shapers of practice. Such a study could focus on the ways that midwives accommodated or resisted a culture of intervention. It would provide invaluable insight and information into how midwives protect the tenets of midwifery in their practice. Such a study would also capture something of the *shaped* nature of practice, which would possibly confirm the *shaping* and *shapers* identified and described in this study. It could also be argued that a study which interviewed midwives and obstetricians in a focus group could also illustrate the shaping and shapers of practice. I would argue that it is possible to readily identify the differences between the different bodies of knowledge that are midwifery and obstetrics, and that little is gained by carrying out research which just confirms these stances.

I think it is important that the complexity of the shaping and shapers of the beliefs of the individual midwife or obstetrician in relation to increasing intervention, is given an opportunity to present itself as it has in this study, for example the obstetrician who stuns the student midwife by asking for a pinnard so that he can really listen to the fetal heart.

The findings in this study in relation to the *shaped* nature of understanding could be complemented by intergenerational research looking at childbirth, and in particular interventions in childbirth. Such research could interview women in the same family and capture their understandings of childbirth and intervention. I believe such research would significantly and powerfully illustrate the *shaped* nature of understanding and readily identify the *shaping* and *shapers*. At one point I considered including groups of women who came from very different stances, and comparing these stances, for example home birth women with women who choose intervention. However, there have been a number of studies which have compared these groups of women and I am not convinced that a replication of these studies would necessarily have added to the knowledge gained in this study. Another piece of research which could add to the findings of this study and could possibly provide another piece of the jigsaw in relation to rising rates of intervention would be to carry out focus groups with men. This is addressed to some extent in the next section under limitations, but it is something to be considered for further research on the shaping of understanding in relation to intervention in childbirth.

Limitations

There are some limitations in a qualitative critical hermeneutical study which are inherent to the method itself, as each philosophical stance brings particular, and so limited, understandings to the research process (Geanellos, 1998). The findings of this study are of course not able to be generalised and there is no expectation that the study would produce the same findings if replicated, or that rules or guidelines about how practice and understanding is shaped could be formulated. Koch (2006) argues that no matter what research approach one uses, reflexive writing, which was at the heart of this study, is a sound process for facilitating analysis and critique that leads to new knowledge in a given subject.

In this instance, the qualitative approach of *critical interpretation* provided not only insight and understanding into the context in which the participants practiced and lived, but also into the shaping and shapers of the increasing rates of intervention. Therefore while this research is not able to be generalised it does provide some explanation, insight and elucidation that gives health professionals and members of the public a viewing platform from which to gain a greater understanding of the increasing rates of intervention. The other limitations of this research are to do with the scope of the study. The participants come only from the greater Auckland region. They were purposively chosen and were representative of those groups who are most likely to choose intervention, as it was hoped they would provide the best insight into the shaping of understanding and practice. This meant that purposive sampling of the public led to the inclusion in the study of mainly white, middle class women, while Maori women in particular were not interviewed as a group. The reason for this was that Maori women as a group are less likely of all the ethnic groups to be represented in statistics related to rising rates of intervention. This therefore meant that comparisons could not be made between groups who were more likely or less likely to choose intervention. However, as explained above, this was not something that I sought to do in this particular piece of research.

The voice of men is not really heard in the data from the public, and this is possibly a limitation of the study. This was initially not intentional, as the first focus group did include men but the other groups presented and self-selected in such ways that they were made up of women. In two of the groups partners and husbands did come in at the beginning or the end and made the comment that this was women's business, and they certainly were not venturing an opinion about such matters. Much of this discussion involved joking, and was tongue in cheek, and the men were often surprised when I suggested that it might be good to interview a group of men. My supervisors and I did discuss at various times throughout the study the possibility of interviewing a group of men, but as time went on and it did not happen naturally, it seemed that this could be another piece of research for the future. Another limitation may be the time between the interviews of the health professionals and finishing of the interviews with the public - a time span of 18 months. It may have been good to return to the health professionals after the public had been interviewed to see if anything had changed in their practice over the time of the study.

Closing thoughts.

The journey of this research started from the intuition that the rising rates of intervention were not a direct result of the choices women were making or the changing practice of health professionals. This initial intuition regarding the rising rates of intervention led to the formulation of the research question that centred on the uncovering of *that which* is shaping the understanding of the public and the practice of health professionals in relation to increasing intervention in childbirth. This question supported by the research process sought to show that the choices the public are making and the practice of health professionals does not exist in a vacuum, but within a social and cultural context that shapes and constitutes understanding and practice in a particular way. The research process, through the insights of the participants and the analysis of the researcher, revealed complex, multilayered and interwoven values and interests that are shaping practice and understanding. This connection between the worldviews of the participants, and the social practices, symbolic discursive orders, relationships of power and structures of domination, confirmed the initial intuition of the study that something other than the choices of women and practice of health professionals was leading to increasing intervention. Understanding and practice in relation to intervention in childbirth is shaped and this shaping is leading at the beginning of the 21st century to increasing intervention in childbirth. However, the insights that this research presents are not only about the shaped or the *shaping*, but also about the play ‘in between’ and the possibilities this presents. The water in the river, is always in play: splashing, pooling, seeping, crashing into rapids and wandering off into tributaries. In the play it reveals the river bed (discursive symbolic orders), it erodes and changes the shapes of the bank (social practices) and even influences the source and force of the river itself (relationships of power–structures of domination). The public and the health professionals, like the water, are also in play, and while understanding and practice is *shaped*, this research offers in the description and recognition of *that which shapes*, the opportunity of eroding, changing and influencing the milieu of increasing intervention.

Appendix A:

Letter of Information for Public participants Letter of information regarding research project to be undertaken by Judith McAra-Couper at AUT for her Doctoral Thesis.

Information sheet for potential participants

You are invited to take part in a research study the title of the study is “In the public arena what is shaping perceptions of intervention in childbirth?”

Who am I?

My name is Judith McAra-Couper. I am a Midwife teacher currently teaching at AUT and also working as a midwife in Middlemore delivery unit. I am also doing my PhD (part time) at Auckland University of Technology.

The aim of the study.

The study will explore what is shaping perceptions of intervention in childbirth from the public perspective.

Who can be participants in the study?

Members of the public who have an interest in childbirth and are willing to share their experiences and understandings of childbirth can be in the study.

Who will select the participants?

Participants will be selected through the social networks of the researcher and through advertisements. Therefore, the participants will self select or be selected by someone who knows of their interest, experience or involvement in childbirth.

How many participants will be involved?

There will be approximately 5-8 focus groups each with approximately 4-6 people in them. You will be part of one of these focus groups.

If I decide to participate what will it involve?

It will involve one or two focus group interviews lasting approximately 60-90 minutes. The interview/s will be conducted at a place that is private, convenient and agreed upon by the group. There will be an agreement in the group of confidentiality. This means that the material that is discussed and shared within the group cannot be discussed outside of the group.

In the interview we will explore the question of what is shaping your perceptions in relation to intervention in childbirth. You will be asked to tell me about your experiences, understandings and perspectives on childbirth. Questions will also be asked about what you think is shaping childbirth in relation to interventions such as women choosing elective caesarean sections and epidurals. There may be an opportunity for a second interview for you to contribute to the insights arising from the 1st interview. I would send you a copy of these insights prior to the second interview.

The interview will be audio taped and later transcribed. These tapes and transcripts remain confidential to my typist, my research supervisors and myself. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity.

Following the interviews you will be given a copy of the transcripts and invited to add further comments and delete any parts of the interview you do not want included in the study. You may also withdraw yourself or the information you have provided at any stage prior to the completion of the data analysis. At the end of the study the audiotape will be destroyed.

What will be the risks and benefits to me of participating in this study?

I do not anticipate any risks to you from this study. However, occasionally such interviews in which you share your thoughts, ideas and knowing can make a person feel unsafe. You do not have to answer all the questions and you may stop the interview at any time. If you feel on reflection after the interview that you have said too much or exposed things that you wish you had not, you may delete any material you do not want to be included in the final work. You may have friend, family or whanau support you to understand the risks and/or benefits of this study and any other explanation you may require. Alongside this, the issues surrounding the subject of the interview may lead you to want further information and explanation of the matter discussed. If this is the case, you would be given the appropriate phone numbers and places to access this information and support.

In the unlikely event that you were harmed in any way while taking part in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation and Compensation Act. Should you have any questions about ACC contact your nearest ACC office (freephone 0800 735 566) the ACC website (www.acc.co.nz/claimscare/making-a-claim/medicalmisadventure/index.html) or the investigator. As a person it is unlikely that there will be any direct benefits to you from participating. However, most people involved in such studies do find it helpful to have their opinion heard and their knowing added to a body of knowledge around such an important issue as intervention in childbirth.

Your participation in the study is entirely voluntary (your choice). You do not have to take part in the study. If you do agree to take part you are free to withdraw from the study, including withdrawal of any information provided, up until the time when data analysis is complete. After that time it may be impossible to separate data from individuals. If you choose to withdraw you do not have to give a reason.

What will happen to the results of this study?

The final research will be published as a PhD thesis, which will be available in the Auckland University of Technology library and other libraries. Short articles relating to the study will be published in relevant professional journals and presented at conferences and seminars. Your identity will not be revealed in any of these contexts.

Where can I get more information about the study?

You can get more information by contacting Dr Marion Jones or the researcher Judith McAra-Couper. The contact details are at the end of this information sheet.

This study has received ethical approval from the Auckland Ethics Committee. Any concerns regarding the nature of this project should be made in the first instance to the Project Supervisor Marion Jones.

If at any time you have queries or concerns regarding your rights as a participant in this study you may wish to contact the Health and Disability Advocate 0800 555 050 (Northland to Franklin).

Thank you for taking the time to read this information. If you have any further questions about the study or would like to participate please feel free to contact me.

Researcher

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Version 1:11/4/03 Approved by Auckland Regional Committee (Health Research Council) on 20/5/2003: Reference number AKX/03/04/113

Appendix B.

Consent form for Public Participants Consent to Participation in Research

Project Supervisor:
Dr Marion Jones

Researcher:
Judith McAra-Couper

- I have read and understood the information sheet for volunteers taking part in the study researching “ in the public arena what is shaping perceptions of intervention in childbirth?”
- I have had an opportunity to discuss this study. I am satisfied with the answers I have been given.
- I have had the opportunity to use whanau support or ask a friend to help me ask questions and understand the study.
- I understand that taking part in this study is voluntary (my choice). I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.
- I have had time to consider whether to take part.
- I consent to the interview being audiotaped and transcribed.

Request for Interpreter

English	I wish to have an interpreter	Yes	No
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero.	Ae	Kao
Samoan	Ou te mana'o ia i ai se fa'amatala upu.	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea.	Io	Ikai
Cook Island	Ka inangaro au i tetai tangata uri reo.	Ae	Kare
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu	E	Nakai

I _____ (full name) hereby consent to take part in this study.

Date: _____

Signature _____

Contact Details

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Version 2. 20/5/03 Version 2. 20/5/03. Approved by Auckland Regional Committee (Health Research Council) on 20/5/2003 Reference number AKX/03/04/113

Appendix C: (please note this study started out as a Masters Thesis)

Letter of Information for Health professional participants

Judith McAra-Couper at AUT for her Masters Thesis.

Information sheet for potential practitioner participants

Title of Study: What is shaping midwifery and obstetric practice in relation to intervention in childbirth.

You are invited to take part in a study looking at what midwives and doctors believe is shaping practice in relation to intervention in childbirth.

Who am I?

My name is Judith McAra-Couper. I am a Midwife teacher currently teaching at AUT and also working as a resource midwife in Middlemore delivery unit. I am also doing part time masters study at Auckland University of Technology.

The aim of the study.

The study will uncover that which is shaping midwifery and obstetric practice in relation to intervention in childbirth.

Who can be participants in the study?

The study is looking at midwifery and obstetric practice so therefore the participants will be midwives and doctors. There will be 4-6 midwives and 4-6 doctors.

If I decide to participate what will it involve?

It will involve one/two interviews lasting approximately one hour. The interview/s will be conducted at a place that is private, convenient and agreed upon by the two of us.

In the first interview we will explore the question of what is shaping midwifery and obstetric practice in relation to intervention in childbirth. You will be asked to tell me about your experiences as a practitioner in relation to intervention in childbirth. You will be asked to explore the things that impact on your practice in relation to intervention. Questions will also be asked about what you as a practitioner think are the things that are shaping practice in relation to intervention in childbirth.

There will be the opportunity for a second interview for you to contribute to the analysis I would have shared with you in written form.

The interview will be audio taped and later transcribed. These tapes and transcripts remain confidential to my typist, my research supervisors and myself. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity.

Following the interviews you will be given a copy of the transcripts and invited to add further comments and delete any parts of the interview you do not want included in the study. At the end of the study your audiotape will be offered back to you or destroyed, which ever you prefer.

What will be the risks and benefits to me of participating in this study?

I do not anticipate any risks to you from this study. However, occasionally such interviews in which you share your thoughts, ideas and knowing can make a person feel unsafe. You do not have to answer all the questions and you may stop the interview at any time. If you feel on reflection after the interview that you have said too much or exposed things that you wish you had not, you may delete any material you do not want to be included in the final work. As a practitioner it is unlikely that there will be any direct benefits to you from participating. However most people involved in such studies do find it helpful to have their opinion heard and their knowing added to a body of knowledge around such an important issue as intervention in childbirth.

What will happen to the results of this study?

The final research will be published as a Masters thesis, which will be available in the Auckland University of Technology library. Short articles relating to the study will be published in relevant professional journals and presented at conferences and seminars. Your identity will not be revealed in any of these contexts.

Your participation in the study is entirely voluntary (your choice). You do not have to take part in the study. If you do agree to take part you are free to withdraw from the study, including withdrawal of any information provided, until data analysis is complete. After that time it may be impossible to separate data from individuals. If you chose to withdraw you do not have to give a reason.

This study has received ethical approval from the Auckland University of Technology's ethics committee. Any concerns regarding the nature of this project should be made in the first instance to the Project Supervisor Marion Jones. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz 917 9999 ext 8044.

Thank you for taking the time to read this information. If you have any further questions about the study or would like to participate please feel free to contact me.

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Approved by the Auckland University of Technology Ethics Committee on 31st May 2001 AUTEK Reference number 01/32

Appendix D:

Consent to Participation in Research

Title of Project: What is shaping midwifery and obstetric practice in relation to intervention in childbirth?

Project Supervisor: Marion Jones

Researcher: Judith McAra-Couper

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed
- I agree to take part in this research.

Participant signature:

Participant name:

Date:

Project Supervisor Contact Details:

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**Approved by the Auckland University of Technology Ethics Committee on 31st May
2001 AUTEK Reference number 01/32**

Appendix E: Glossary of Key Terms

Aotearoa: The most widely used and accepted name for New Zealand which has its origins in the Maori Language. It is used in this thesis in combination with New Zealand to acknowledge the tangata whenua (people of the land – indigenous people) and the bicultural nature of Aotearoa-New Zealand.

Cartwright Inquiry: (1987-1988) A government inquiry (presided over by Judge Cartwright) into the treatment of cervical cancer at National Women's Hospital in Auckland. This inquiry came about through an article entitled 'The Unfortunate Experiment' which was published in a popular magazine in June 1987. The article exposed research into cervical cancer which was at best unethical, and at worst life threatening for women who were used for this research, about which they had no knowledge and had given no consent. The recommendations from the Cartwright report established patient's rights and informed consent, and provided for patient advocacy. It was a turning point, especially with regard to the health professional- patient relationships, and is seen as a seminal event in the history and development of health and maternity services in Aotearoa-New Zealand (Coney, 1988; Papps & Olssen, 1997) .

Caesarean Section: an operation through the abdominal wall for the purpose of operative delivery of the baby (Ministry of Health, 2006).

Caesarean Section Emergency – acute; performed urgently once labour has started, because of clinical reasons (Ministry of Health, 2006).

Caesarean Section Elective: a planned procedure performed usually before the onset of labour (Ministry of Health, 2006).

District Health Board (DHB): an organisation which runs the public health facilities in a particular area establish by the New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2006)

Epidural: a procedure used during labour for analgesia or anaesthesia, which involves an injection of an analgesic drug into the epidural space (Stables & Rankin, 2005).

Induction of labour: an intervention, usually by pharmacological means, which brings about the onset of labour (M.O.H., 2006).

Lead Maternity Carer (LMC). an authorised practitioner such as a midwife, obstetric specialist, hospital team or general practitioner (GP) that has been chosen by the woman to provide her maternity care, including labour and birth.

National Women's Hospital. National Women's Hospital is a large tertiary hospital located at Auckland City Hospital. National Women's is the largest Women's Health Provider in New Zealand (National Women's Report, 2004). National Women's Hospital releases a clinic report each year which they present at a day of robust discussion, critique and comment. These reports have greatly informed this study.

Tertiary facility: In Aotearoa-New Zealand there are six tertiary facilities, two of which are within the Auckland Region. They are major referral centres for difficult obstetric and neonatal cases. These centres, also known as L3 units, have intensive care facilities, and provide secondary care (complicated childbirth, epidural analgesia, caesarean sections and specialist obstetric and paediatric care) for women.

Treaty of Waitangi Workshops: These are workshops run in New Zealand to explore the historical context of the signing of the Treaty of Waitangi in 1840. The workshops also explore the ongoing consequences and implications in the areas of economics, social development, education and health arising out of 170 years of colonisation of the indigenous peoples of Aotearoa New Zealand.

- Akbar, A. (2002, August 19). Rise in Caesareans is harming midwifery. *The Independent*. Retrieved June 11, 2003, from http://news.independent.co.uk/uk/health_medical/article173881.ece
- Alehagen, S., Wijma, K., & Wijma, B. (2001). Fear during labour [Electronic version]. *Acta Obstetrica et Gynecologica Scandinavica*, 80(4), 315-320.
- Alehagen, S., Wijma, B., & Wijma, K. (2006). Fear of childbirth before, during and after childbirth [Electronic version]. *Acta Obstetrica et Gynecologica Scandinavica*, 85(1), 55-62.
- Allen, D. (1995). Hermeneutics: Philosophical Traditions and Nursing Practice Research. *Nursing Science Quarterly*, 8(4), 174-182.
- American College Obstetricians and Gynaecologists. (2004). American College Obstetric and Gynaecologists committee opinion no.295: Pain Relief During Labour. *Obstetrics and Gynecology*, 104(1), 213-215. Retrieved December 13, 2007, from <http://www.greenjournal.org/content/vol104/issue1/>
- American College Obstetricians and Gynaecologists. (2006, August 31). American College Obstetricians and Gynaecologists News Release. Cesarean Delivery Associated with increased risk of Maternal Death from Blood Clots, Infection, Anesthesia. Retrieved October 12, 2006, from http://www.acog.org/from_home/publications/press_releases/nr08-31-06-2.cfm
- Amu, O., Rajendran, S., & Bolaji, I. (1998). Maternal Choice alone should not determine method of delivery. *British Medical Journal*, 317(7156), 1397-1402. Retrieved January 16, 2007, from <http://www.bmj.com.ezproxy.aut.ac.nz/cgi/content/full/317/7156/462#resp2>
- Anderson, T. (2006). No more consumers, please. *The Practising Midwife*, 9(7), 51.
- Andrews, M. (2003). Calendar Ladies: Popular Culture, Sexuality and the Middle Class, Middle-Aged Domestic Woman [Electronic Version]. *Sexualities*, 6(3-4), 385-403.
- Annells, M. (1999). Evaluating phenomenology: Usefulness, quality and philosophical foundations. *Nurse Researcher*, 6(3), 5-19.
- Arney, W. (1982). *Power and the Profession of Obstetrics*. Chicago: The University of Chicago Press.
- Arthur, D. (2003). *Maternal Request for an Elective Caesarean Section*. Unpublished thesis presented in partial fulfilment of the requirements for the degree of Masters of Health Science (Midwifery), Auckland University of Technology, Auckland.
- Arthur, D., & Payne, D. (2005). Maternal Request for an elective caesarean section. *New Zealand College of Midwives Journal*, 33, 15-18.

- Bastian, H. (1999). Commentary: "health has become secondary to a sexually attractive body". *British Medical Journal*, 319(7222), 1403. Retrieved January 15, 2007, from <http://www.bmj.com.ezproxy.aut.ac.nz/cgi/content/full/319/7222/1397>
- Beech, B. (2003). Challenging the illusion of choice. *AIMS Journal*, 15(3). Retrieved November 2, 2006, from <http://www.aims.org.uk/>
- Beech, B. (2005). Choice - an abused concept that is past its sell-by date. *AIMS Journal*, 17(4). Retrieved November 6, 2006, from <http://www.aims.org.uk/>
- Behague, P. B., Victora, C. G., & Barros, F. C. (2002). Consumer demand for caesarean sections in Brazil: informed decision making, patient choice, or social inequality? A population based birth cohort study linking ethnographic and epidemiological methods. *British Medical Journal*, 324(7343), 924-925. Retrieved December 14, 2006, from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=102326>
- Belizan, J., Althabe, F., Barros, F. C., & Alexander, S. (1999). Rates and implications of caesarean sections in Latin America: ecological study. *British Medical Journal*, 319(7222), 1397-1402. Retrieved January 15, 2007, from <http://www.bmj.com.ezproxy.aut.ac.nz/cgi/content/full/319/7222/1397>
- Benzies, K., Tough, S., Tofflemire, K., Frick, C., Faber, A., & Newburn-Cook, C. (2006). Factors Influencing Women's Decisions about Timing of Motherhood [Electronic Version]. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 35(5), 625-633.
- Bernstein, R. J. (Ed.). (1985). *Habermas and Modernity*. Worcester: Polity Press.
- Berryman, J., Thorpe, K., & Windridge, K. (1995). *Older Mothers, Conception, Pregnancy and Birth after 35*. London: Pandora.
- Bianco, A., Stone, J., Lynch, L., Lapinski, R., Berkowitz, G., & Berkowitz, R. L. (1996). Pregnancy outcome at age 40 and older. *Obstetrics and Gynecology*, 87(6), 917-922. Retrieved December 11, 2006, from <http://www.greenjournal.org/cgi/content/abstract/87/6/917>
- Blum, L. M., & Stracuzzi, N. F. (2004). Gender in the Prozac Nation. Popular Discourse and Productive Femininity [Electronic Version]. *Gender and Society*, 18(3), 269-286.
- Boulvain, M., Stan, C., & Irion, O. (2004). Elective delivery in diabetic pregnant women. Cochrane Review. In the Cochrane Database of Systematic Reviews, Issue 1. Retrieved November 11, 2006, from <http://www.mrw.interscience.wiley.com.ezproxy.aut.ac.nz/cochrane/clsysrev/articles/CD001997/frame.html>
- Bridgeman, S. (2001, March 22). Away with this old-style method of having babies. *The New Zealand Herald*, p. A13.

- Broadhead, B., & James, D. (1999). Worldwide Utilization of Cesarean section. In B. Flamm, & E. Quilligan (Eds.), *Cesarean Section: Guidelines for Appropriate Utilization*. New York: Springer Varlog.
- Buck, P. (n.d). If you want to understand today, you have to search yesterday. Retrieved January 20, 2007, from www.quote garden.com/history.html.
- Budgeon, S. (2003). Identity as an Embodied Event [Electronic Version]. *Body & Society*, 9(1), 35-55.
- Bulger, T., Howden-Chapman, P., & Stone, P. (1998). A cut above: the rising Caesarean section rate in New Zealand. *New Zealand Medical Journal*, 11(1059), 30-33.
- Castells, M. (2000). *The Rise of the Network Society* (2nd ed.). Oxford: Blackwell.
- Castro, A. (1999). A Commentary: increase in caesarean sections may reflect medical control not women's choice. *British Medical Journal*, 319(7222), 1401-1402. Retrieved January 7, 2007, from <http://www.bmj.com/cgi/content/full/319/7222/1397#resp2>.
- Catherall, S. (2005, February 27). The secrets of the womb. *Herald on Sunday*, p. 26.
- Chaffer, D., & Royle, L. (2000). The use of audit to explain the rise in caesarean section. *British Journal of Midwifery*, 8(11), 677-684.
- Chalmers, I., Enkin, M. W., & Kierse, M. J. N. C. (Eds.). (1989). *Effective Care during Pregnancy and Birth*. Oxford: Oxford University Press.
- Chalmers, B. (1992). WHO appropriate technology for birth revisited. *British Journal of Obstetrics and Gynaecology*, 99(9), 709-710.
- Chang, S-R., Chao, Y-M., Kenney, N. J. (2006). I am a woman and I'm pregnant: body image of women in Taiwan during the third trimester of pregnancy [Electronic version]. *Birth*, 33(2), 147-153.
- Chaw, S. W. (1995). *Towards a "critical hermeneutical " conception of social research*. Paper presented at the Asia-Pacific Human Science Research Conference, Monash University, Australia.
- Cheek, J. (1996). Taking a View: Qualitative Research as Representation [Electronic version]. *Qualitative Health Research*, 6(4), 492-505.
- Childbirth Connection (2006). *New National Survey Results from Mothers Refute Belief That Women Are Requesting Cesarean Sections Without Medical Reason*. Retrieved August 16, 2006, from <http://www.childbirthconnection.org/pdfs/LTMIIpressrelease.pdf>

- Clark, A., Carr, D., Loyd, G., Cook, V., & Spinnato, J. (1998). The influence of epidural analgesia on cesarean delivery rates: a randomised prospective clinical trial [Electronic version]. *American Journal of Obstetrics and Gynaecology*, 179(6), 1527-1533.
- Cleary-Goldman, J., Malone, F. D., Vidaver, J., Ball, R. H., Nyberg, D. A., Comstock, C. H., Saade, G. R., Eddleman, K. A., Klugman, S., Dugoff, L., Timor-Tritsch, I. E., Craigo, S. D., Carr, S. R., Wolfe, H. M., Bianchi, D. W., & D'Alton, M. (2005). Impact of Maternal age on obstetric outcome. *Obstetrics and Gynaecology*, 105(5), 983-990. Retrieved January 16, 2007, from <http://www.greenjournal.org/cgi/content/full/105/5/983>
- Clement, F. (2005). *Concern and Worry: The experience of nulliparous women choosing an elective caesarean section*. Unpublished thesis presented in partial fulfilment of the requirements for the degree of Masters of Health Science (Midwifery), Auckland University of Technology, Auckland.
- Cnattingius, S., Forman, M. R., Berendes, H. W., & Isotalo, L. (1992). Delayed childbearing and risk of adverse perinatal outcome. A population based study. *Journal of the American Medical Association*, 268(7), 886-890.
- Coney, S. (1988). *The Unfortunate experiment*. Auckland: Penguin Books.
- Coonrod, D., Bay, R. C., & Kishi, G. Y. (2000). The epidemiology of labour induction: Arizona, 1997 [Electronic Version]. *American Journal of Obstetrics and Gynaecology*, 182(6), 1355-1362.
- Coulson, C. C., & Cain, J. M. (1999). Medical/legal/ethical aspects of Cesarean section [Electronic Version]. *Current Obstetrics and Gynaecology*, 9(1), 53-54.
- Cowan, R. S. (1999). The industrial revolution in the home. In D. MacKenzie, & J. Wajcman (Eds.), *The Social Shaping of Technology*. Philadelphia: Open University Press.
- Cox White, B., & Zimbelman, J. (1998). Abandoning Informed Consent: An Idea Whose Time Has Not Yet Come [Electronic Version]. *Journal of Medicine and Philosophy*, 23(5), 477-499.
- Crabtree, S. M. (2002). *Lead maternity carer midwives' construction of normal birth*. Unpublished thesis presented in partial fulfilment of the requirements for the degree of Master of Arts, Massey University, Palmerston North.
- Crouch, M., & Manderson, L. (1993). Parturition as Social Metaphor. *Australian and New Zealand Journal of Sociology*, 29(1), 55-72.

- Crowther, C. A., Hiller, J. E., Moss, J. R., McPhee, A. J., Jeffries, W. S., & Robinson, J. S. (2005). Effect of Treatment of Gestational Diabetes Mellitus on Pregnancy Outcomes [Electronic version]. *The New England Journal of Medicine*, 352(24), 2477-2486.
- Cyr, R. M. (2006). Myth of the ideal cesarean section rate: Commentary and historic perspective [Electronic version]. *American Journal of Obstetrics and Gynaecology*, 194 (4), 932-936.
- Daniel, L. (2006). Yummy Mummies: Hijacking motherhood and undermining women? *British Journal of Midwifery*, 14(4), 198.
- Davies, D., & Dodd, J. (2002). Pearls, Pith and Provocation. Qualitative Research and the Question of Rigor [Electronic version]. *Qualitative Health Research*, 12(2), 279-289.
- Davies, L. (2006). A body of Knowledge - body image in pregnancy and the role of the midwife. In S. Wickham (Ed.), *Midwifery: best practice* (Vol. 4, pp. 89-93). Edinburgh: Elsevier.
- Davis, D. (2003). Spoilt for choice: consuming maternity care. *British Journal of Midwifery*, 11(9), 574-578.
- Davis-Floyd, R. E. (1994). The Technocratic Body: American Childbirth as cultural expression [Electronic version]. *Social Science and Medicine*, 38(8), 1125-1140.
- Davis-Floyd, R., & Mather, F. S. (2002). The technocratic, humanistic and holistic paradigms of childbirth. *MIDIRS: Midwifery Digest*, 12(4), 500-506.
- Davis-Floyd, R. (2006). Roundtable discussion: Part 2. Why do Women go along with this stuff? "Pain and Gain" [Electronic version]. *Birth*, 33(3), 248-249.
- Davis, R. (2005). "I'm ready for you, baby, why wont you come?" Further discussion around the issue of post dates pregnancy and the intervention of induction of labour. *New Zealand College of Midwives Journal*, 33, 9-11.
- Declercq, E. R., Sakala, C., Corry, M. P., Appelboum, S. (2006). *Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences. Executive Summary*. Retrieved December 20, 2006, from http://www.childbirthconnection.org/pdf.asp?PDFDownload=LTMII_ExecSum
- Denke, C. E., Kruse, L. K., & Jain, N. J. (2006). Surveillance of cesarean section Deliveries, New Jersey, 1999-2004 [Electronic version]. *Birth*, 33(3), 203-209.
- Deneux-Tharaux, C., Carmona, E., & Bouvier-Colle, M. H., & Breart, G. (2006). Postpartum Maternal Mortality and Cesarean Delivery [Electronic version]. *Obstetrics and Gynecology*, 108(3), 541-548.

- Department of Health and Human Services. (2006). *New Report Shows Teen Births Drop To Lowest Level Ever*. Retrieved February 11, 2007, from <http://www.cdc.gov/nchs/pressroom/06facts/births05.html>
- Devereux, M. (2001, March 24-25). Big upsurge in caesarean births. *Weekend Herald*, p. A20-21.
- Devries, R., Beniot, C., van Teijlingen, E. R., & Wrede, S. (2001). *Birth by Design. Pregnancy, Maternity Care and Midwifery in North America and Europe*. New York: Routledge.
- Dodd, J. M., Crowther, C. A., Huertas, E., Guise, J. M., & Horey, D. (2004). *Cochrane Database of Systematic Reviews: Planned elective repeat caesarean section versus planned vaginal birth for women with a previous caesarean birth*. Cochrane Library. Retrieved December 10, 2006, from <http://www.mrw.interscience.wiley.com.ezproxy.aut.ac.nz/cochrane/clsysrev/articles/CD004224/frame.html>
- Donley, J. (1986). *Save the Midwife*. Auckland: New Zealand New Women's Press.
- Donley, J. (1998). *Birthrites: Natural vs Unnatural childbirth in New Zealand*. Auckland: The Full Court Press.
- Douche, J. (2001). *Caesarean section in the absence of clinical indications: Implications for midwifery practice*. Paper presented at the Midwifery Research: Gaining Ground and Influencing Practice Conference, Wellington, New Zealand.
- Dubay, L., Kaestner, R., & Waidmann, T. (1999). The impact of malpractice fears on cesarean section rates [Electronic version]. *Journal of Health Economics*, 18(4), 491-522.
- Dublin, S., Lydon-Rochelle, M., Kaplan, R. C., Watts, D. H., & Critchlow, C. W. (2000). Are there adverse maternal and neonatal outcomes associated with induction of labour when there is no well accepted indication [Electronic version]. *American Journal of Obstetrics and Gynecology*, 183(4), 986-994.
- Duff, C., & Sinclair, M. (2000). Exploring the risks associated with induction of labour: a retrospective study using the NIMATS database [Electronic version]. *Journal of Advanced Nursing*, 31(2), 410-417.
- Dugdale, A. (1999). Inserting Grafenberg's IUD into the sex reform movement. In D. MacKenzie, & J. Wajcman (Eds.), *The social shaping of Technology* (2nd ed.). Philadelphia: Open University Press.
- Dyer, R. (1999). Making 'white' people white. In D. MacKenzie, & J. Wajcman, (Eds.), *The Social Shaping of Technology* (2nd ed.). Philadelphia: Open University Press.

- Earle, S. (2003). "Bumps and Boobs": Fatness and Women's experience of Pregnancy [Electronic version]. *Women's Studies International Forum*, 26(3), 245-252.
- Ecker, J. L., & Frigoletto, F. D. (2007). Cesarean Delivery and the Risk-Benefit Calculus. *New England Journal of Medicine*, 356(9), 885-888. Retrieved March 25, 2007, from <http://content.nejm.org/cgi/content/full/356/9/885>
- Edwards, N. (2003). The choice is yours - or is it? *AIMS Journal*, 15(3), Retrieved November 16, 2006, from <http://www.aims.org.uk/>
- Eriksson, S. L., Olausson, P. O., & Olofsson, C. (2006). Use of epidural analgesia and its relation to caesarean and instrumental deliveries - a population based study of 94,217 primiparae [Electronic version]. *European Journal of Obstetrics and Gynecology and Reproductive Biology*, 128, 270-275.
- Farrell, S. A., Allen, V. M., & Baskett, T. F. (2001). Parturition and urinary incontinence in primiparas. *Obstetrics and Gynecology*, 97(3), 350-356.
- Faulkner, W. (2001). The Technology question in feminism: a view from feminist technology studies [Electronic version]. *Women's Studies International Forum*, 24(1), 79-95.
- Fisher, C., Hauck, Y., & Fenwick, J. (2006). How social context impacts on women's fears of childbirth: a Western Australian example [Electronic version]. *Social Science and Medicine*, 63(1), 64-75.
- Florica, M., Stephansson, O., & Nordstrom, L. (2006). Indications associated with increased cesarean section rates in a Swedish hospital [Electronic version]. *International Journal of Gynaecology and Obstetrics*, 92, 181-185.
- Foldspang, A., Mommsen, S., & Djurhuus, J. C. (1999). Prevalent urinary incontinence as a correlate of pregnancy, vaginal childbirth and obstetric techniques [Electronic version]. *American Journal of Public Health*, 89(2), 209-212.
- Foucault, M. (2003). *The Archaeology of Knowledge* (A. M. Sheridan - Smith, Trans.). London: Routledge.
- Foureur, M., & Hunter, M. (2005). The place of birth. In S. Pairman., J. Pincombe., C. Thorogood., & S. Tracy (Eds.). *Midwifery Preparation for Practice*. Sydney: Elsevier.
- Fournier, V. (2002). Fleshing out Gender: Crafting Gender Identity of Women's Bodies [Electronic version]. *Body & Society*, 8(2), 55-77.
- Fowler, H. W., & Fowler, F. G. (1961). *The concise Oxford Dictionary of Current English* (4th ed.). London: Oxford University Press.
- Francome, C., Savage, W., & Churchill, H. (2006). *Caesarean birth in Britain*. London: Middlesex University Press.

- Fretts, R. C., Schmittiel, J., McLean, F. H., Usher, R. H., & Goldman, M. B. (1995). Increased Maternal Age and the risks of Fetal Death [Electronic version]. *The New England Journal of Medicine*, 333(15), 953-957.
- Gadamer, H-G. (2002). *Truth and Method* (J. Weinsheimer, & D. G. Marshall, Trans. 2nd revised ed.). New York: Continuum.
- Gallop, C. (2006, November 2). Women's right to choose Caesarean. *The New Zealand Herald*, p. 17.
- Gamble, J. A., Health, M. & Creedy, D. K. (2000). Women's request for a cesarean section: a critique of literature [Electronic version]. *Birth*, 27(4), 256-263.
- Gamble, J. A., Health, M., & Creedy, D. K. (2001). Women's Preference for a cesarean section: Incidence and associated factors [Electronic version]. *Birth*, 28(2), 101-110.
- Geanellos, R. (1998). Hermeneutic philosophy. Part 1. Implications of its use as methodology in interpretive nursing research [Electronic version]. *Nursing Inquiry*, 5, 154-163.
- Gilligan, C. (1982). *In a different voice*. Cambridge, MA: Harvard University Press.
- Glance, L. G., Wissler, R., Glantz, C., Osler, T., Mukamel, D. B., & Dick, A. W. (2007). Racial Differences in the Use of Epidural Analgesia in Labour. *Anesthesiology*, 106(1), 19-25. Retrieved February 5, 2007, from <http://gateway.ut.ovid.com.ezproxy.aut.ac.nz/gw2/ovidweb.cgi>
- Glantz, J. C. (2003). Labour induction rate variation in upstate New York. What is the difference [Electronic version]. *Birth*, 30(3), 168-174.
- Gnomes, U, A., Silva, A, A., Bettiol, H., & Barbieri, M. A. (1999). Risk factors for the increasing caesarean section rate in Southeast Brazil: a comparison of two birth cohorts, 1978-1979 and 1994 [Electronic version]. *International Journal of Epidemiology*, 28(4), 687-694.
- Goldberg, L.(2001). Rethinking the birthing body: Cartesian dualism and perinatal nursing [Electronic version]. *Advanced Nursing*, 37(5), 446-451.
- Greenfield, S. (2003). *Tomorrow's People. How 21st century technology is changing the way we think and feel*. London: Penguin Books.
- Guba, E., & Lincoln, Y. (1989). *Fourth Generation Evaluation*. Newbury Park California: Sage.
- Gulmezoglu, A. M., Crowther, C. A., & Middleton, P. (2006). *Induction of Labour for improving birth outcomes for women at or beyond term. Cochrane Systematic Review*. Retrieved December 6, 2006, from <http://www.mrw.interscience.wiley.com.ezproxy.aut.ac.nz/cochrane/clsysrev/article/CD004945/frame.html>

- Habiba, M., Kaminski, M., Da Frè, M., Marsal, K., Bleker, O., Librero, J., Grandjean, H., Gratia, P., Guaschino, S., Heyl, W., Taylor, D., & Cuttinik, M. (2006). Caesarean section on request: a comparison of obstetrician's attitudes in eight European countries [Electronic version]. *British Journal of Obstetrics and Gynaecology*, 113(6), 647-656.
- Hammersley, M. (1992). *What's wrong with ethnography? Methodological exploration*. London: Routledge.
- Harvey, J. (1997). The Technological Regulation of Death: With Reference to the Technological Regulation of Birth [Electronic version]. *Sociology*, 31(4), 719-735.
- Hawthorne, G., Irgens, L. M., & Lie, R. T. (2000). Outcome of pregnancy in diabetic women in northeast England and in Norway, 1994-7. *British Medical Journal*, 321(7263), 730-731. Retrieved October 17, 2005, from <http://www.bmj.com/cgi/content/full/321/7263/730?ijkey=2cf2c3ec11e667f6ef38c9978766bb5acf64543e>
- Heath, C., Luff, P., & Svensson, M. S. (2003). Technology and medical practice [Electronic Version]. *Sociology of Health & Illness*, 25, (3) 75-96.
- Heidegger, M. (1977). *The Question concerning Technology and other Essays*. (W. Lovitt, Trans.). New York: Harper Torchbooks.
- Heilbroner, R. L. (2001). Do Machines Make History? In M. Roe-Smith, & L. Marx (Eds.), *Does Technology Drive History? The Dilemma of Technological Determinism*. London: MIT Press.
- Hendrickson, P. (2004). Review essay: Reflexivity as dialogue and distancing: Kogler's project of a critical hermeneutics. *Philosophy and Social Criticism*, 30(3), 383-388.
- Holmes, M. (2004). The Precariousness of Choice in the New Sentimental Order: A response to Bawin-Legros [Electronic Version]. *Current Sociology*, 52(2), 251-257.
- Homer, C. S. E., & Davis, G. K. (1999). Can elective labour induction be woman-centered? *British Journal of Midwifery*, 7(11), 686-689.
- Hopkins, K. (2000). Are Brazilian women really choosing to deliver by cesarean? [Electronic version]. *Social Science and Medicine*, 51(5), 725-740.
- Hughes, T. P. (1986). The seamless web: Technology, science, etcetera, etcetera [Electronic Version]. *Social Studies of Science*, 16(2), 281-292.
- Hunt, L. (1996). Come back, Mommy dearest. Feminists turn their backs on childbirth. *New Statesman*, 127(4391), pp.32-34. Retrieved September 18, 2000, from http://web4.i.../purl=rcl_EIM_0_A2097847&dyn=31!xrn_24_0_A20978747?sw_aep=au

- Illich, I. (1977). *Limits to medicine: medical nemesis; the expropriation of health*. New York: Penguin.
- Impey, L. MacQuillan, K., & Robson, M. (2000). Epidural analgesia need not increase operative delivery rates [Electronic version]. *American Journal of Obstetrics and Gynaecology*, 182(2), 358-363.
- Inch, S. (1985). Management of the third stage of labour – another cascade of intervention. *Midwifery*, 1(2), 114.
- Isaksen, L. W. (2002). Toward a Sociology of (Gendered Disgust). Images of Bodily Decay and the Social Organization of Care Work [Electronic version]. *Journal of Family Issues*, 23(7), 791-811.
- Johanson, R., Burr, R., Leighton, N., & Jones, P. (2000). Informed choice? Evidence of the persuasive power of professionals [Electronic version]. *Journal of Public Health Medicine*, 22(3), 439-440.
- Johanson, R., Newburn, M., & MacFarlane, A. (2002). Has the medicalisation of childbirth gone too far? [Electronic version]. *British Medical Journal*, 324 (7342), 892-895.
- Johnson, S., Burrows, A., & Williamson, I. (2004). Does My Bump Look Big in This? The Meaning of Bodily Changes for First-time Mothers-to-be [Electronic version]. *Journal of Health Psychology*, 9(3), 361-374.
- Johnston, M. (2001, March 16). Caesareans normal by 2010: Specialist. *New Zealand Herald*, p. 2.
- Jones, H. (2005, December). Too posh to push? Netdoctor.co.uk. Retrieved June 10, 2006, from http://community.netdoktor.com/ccs/uk/pregnancy/coping/beyond/article.jsp?articleIdent=uk.pregnancy.coping.beyond.uk_pregnancy_article_2711
- Jordan, B. (2005). Social Theory and Social Policy, Choice, Order and Human Well-being [Electronic version]. *European Journal of Social Theory*, 8(2), 149-170.
- Katz-Rothman, B. (1989). *Recreating Motherhood. Ideology and Technology in a Patriarchal Society*. New York: W.W. Norton & Company.
- Katz-Rothman, B. (1991). *In Labour. Women and Power in the Birthplace*. New York: W.W. Norton & Company.
- Kingdon, C., Baker, L., Lavender, T. (2006). Systematic Review of Nulliparous Women's Views of Planned Cesarean Birth: The Missing Component in the Debate about a Term Cephalic Trial [Electronic version]. *Birth*, 33(3), 229-237.
- Kitzinger, S. (1997, March 22). A battle for women's bodies. *The Independent (London)*, Retrieved June 10, 2006, from http://www.findarticles.com/p/articles/mi_qn4158/is_19970322/ai_n14095010

- Kitzinger, S. (2006). Shelia Kitzinger's Letter from Europe: What makes a good mother? Is that the only Question? [Electronic version]. *Birth*, 33(3), 254-255.
- Klein, M. C. (2004). Quick Fix Culture: The Cesarean - Section - on - Demand Debate [Electronic version]. *Birth*, 31(3), 161-164.
- Klein, M. C., Sakala, C., Simkin, P., Davis-Floyd, R., Rooks, J. P., & Pincus, J. (2006). Roundtable discussion: Part 2. Why do Women go along with this stuff? [Electronic version]. *Birth*, 33(3), 245-250.
- Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation. *Journal of Advanced Nursing*, 24, 174-184.
- Koch, T. (1999). An interpretive research process: Revisiting phenomenological and hermeneutical approaches. *Nurse Researcher*, 6(3), 20-34.
- Koch, T. (2006). 30th anniversary commentary on Koch T. (1994). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing* 19, 976-986 [Electronic version]. *Journal of Advanced Nursing*, 53(1), 101-102
- Kogler, H. H. (1999). *The Power of Dialogue. Critical hermeneutics after Gadamer and Foucault* (P. Hendrickson, Trans.). Cambridge: MIT Press.
- Kornelsen, J. (2005). Essences and imperatives: An investigation of technology in childbirth [Electronic version]. *Social Science and Medicine* 61(7), 1495-1504.
- Krueger, R. A., & Casey, M. (2000). *Focus Groups. A practical Guide for applied research* (3rd ed.). London: Sage Publications.
- Lagasse, R. (2002). Anaesthesia Safety: Model or Myth? A review of the Published Literature and Analysis of Current Original Data. *Anesthesiology*, 97(6), 1609-1617. Retrieved October 18, 2005, from <http://gateway.ut.ovid.com.ezproxy.aut.ac.nz/gw1/ovidweb.cgi>
- Laugesen, R. (2004, July 4). You are having it where? Investigates the declining interest in home births among NZ mothers. *Sunday Star Times*, p. C1-2.
- Lavender, T., Hofmeyr, G. J., Neilson, J. P., Kingdon, C., & Gyte, G. M. L. (2006). Caesarean section for non-medical reasons at term. *In the Cochrane Systematic Reviews, Issue 4*. Retrieved December 14, 2006, from http://www.mrw.interscience.wiley.com.ezproxy.aut.ac.nz/cochrane/clsysrev/articles/CD004660/pdf_fs.html
- Lavender, T., & Kingdon, C. (2006). Caesarean delivery at maternal request: why should we promote normal birth. *British Journal of Midwifery*, 14(5), 302-303.

- Leap, N., & Anderson, T. (2004). The role of pain in normal birth and the empowerment of women. In S. Downe (Ed.), *Normal Childbirth evidence and debate*. London: Churchill Livingstone.
- Leitch, C. R., Walker, J. J. (1998). The rise in caesarean section rate: the same indications but a lower threshold [Electronic version]. *British Journal of Obstetrics and Gynaecology*, 105(6), 621-626.
- Lemonick, M. (1999, January). Designer Babies. *Time*, 153, 64.
- Lutz, K., Jones, K. D., & Kendall, J. (1997). Expanding the praxis debate, contributions of clinical inquiry. *Advances in Nursing Science*, 20(2), 23-31. Retrieved November 12, 2006, from <http://gateway.ut.ovid.com.ezproxy.aut.ac.nz/gw2/ovidweb.cgi>
- McAra-Couper, J. (2006). *Women and midwives conscious guardians – but of what?* Key note address given at the 9th Biennial National Midwifery Conference, Christchurch, New Zealand.
- MacDorman, M. F., Declercq, E., Menacker, F., & Malloy, M. H. (2006). Infant and Neonatal Mortality for Primary Cesarean and Vaginal Births to Women with "No Indicated Risk" United States, 1998-2001 Birth Cohorts [Electronic version]. *Birth*, 33(3), 175-182.
- McGrady, E., & Litchfield, K. (2004). Epidural analgesia in labour [Electronic version]. *Continuing Education in Anaesthesia, Critical Care & Pain*, 4(4), 114-117.
- MacKenzie, D., & Wajcman, J. (Eds.). (1999). *The Social Shaping of Technology* (2nd ed.). Philadelphia: Open University Press.
- McNeill, W. (1999). *The Glance of the Eye, Heidegger, Aristotle, and the Ends of Theory*. New York: State University of New York Press.
- Madison, G. B. (2000). Critical theory and Hermeneutics: Some outstanding issues in the debate. In L. E. Hahn, (Ed.), *Perspectives on Habermas* (pp. 323-338). Chicago: Open Court.
- Mander, R., & Fleming, M. (2002). *Failure to progress. The contraction of the Midwifery Profession*. London: Routledge.
- Marmor, T. R., & Krol, D. M. (2002). Labor pain management in the United States: Understanding patterns and the issue of choice [Electronic version]. *American Journal of Obstetrics and Gynecology*, 186(5), Supplement 1, S173-S180.
- Martin, E. (1987). *The Woman in the Body*. Milton Keynes: Open University Press.
- Martin, J. A., Hamilton, B. E., Sutton, P. D., Ventura, S. J., Menacker, F, & Munson, M. L. (2005). *National Vital Statistics Reports. Births: Final Data for 2003*, 54(2). Retrieved December 20, 2006, from http://www.cdc.gov/NCHS/data/nvsr/nvsr54/nvsr54_02.pdf

- Martin, K. A. (2003). Giving Birth Like a Girl [Electronic version]. *Gender and Society*, 17(1), 54-72.
- Marx, H., Wiener, J., & Davis, N. (2001). A survey of the influence of parent's choice on the increase in the caesarean section rate [Electronic version]. *Journal of Obstetrics and Gynaecology*, 21(2), 124-127.
- Maslow, A. S., & Sweeny, A. L. (2000). Elective Induction of Labour as a risk factor for cesarean delivery among low-risk women at term [Electronic version]. *Obstetrics and Gynecology*, 95(6), 917-922.
- Melender, H. L. (2002). Fears and coping strategies associated with pregnancy and childbirth in Finland [Electronic version]. *Journal of Midwifery and Women's Health*, 47(4), 256-263.
- Merkin, D. (2006, January 1st). Our Vaginas, ourselves. *The New York Times Magazine*. Retrieved March 8, 2006, from http://www.nytimes.com/2006/01/01/magazine/01wwln_lead.html?ex=1293771600&en=e8c7da5423c90b46&ei=5088&partner=rssnyt&emc=rss
- Ministry of Health. (1999). *Obstetric Procedures*. Wellington, Author.
- Ministry of Health. (2001). *Report on Maternity 1999*. Wellington, Author.
- Ministry of Health. (2003). *Report on Maternity 2000 & 2001*. Wellington, Author.
- Ministry of Health. (2004). *Report on Maternity Maternal and Newborn Information 2002*. Wellington, Author.
- Ministry of Health. (2006). *Report on Maternity. Maternal and Newborn Information 2003*. Wellington, Author. Retrieved December 14, 2006, from <http://www.nzhis.govt.nz/publications/maternityreport03.pdf>
- Ministry of Health (2007). Section 88 Maternity Notice 2007. Retrieved March 15, 2007, from <http://www.moh.govt.nz/moh.nsf/indexmh/section88-maternity-notice-2007-feb07?Open>
- Monto, M. A. (1997). The lingering presence of medical definitions among women committed to natural childbirth [Electronic version]. *Journal of Contemporary Ethnography*, 26(3), 293-361.
- Moon, S. (2002). C-section rebirth; Procedure making strong comeback after a decade. (Caesarean-section births on the rise). *Modern healthcare*, 32(27). Retrieved December 12, 2006, from <http://proquest.umi.com.ezproxy.aut.ac.nz/pqdweb?index=9&did=133813201&SrchMode=3&sid=2&Fmt=3&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1176328485&clientId=7961&aid=1>

- Moorhead, J. (2006, August 4). One of Societies Greatest secrets. *The Guardian*. Retrieved December 15, 2006, from <http://www.guardian.co.uk/g2/story/0,,1836931,00.html>
- Morgan, D. L. (1997). *Focus Groups As Qualitative Research* (2nd ed.). London: Sage Publications.
- Morris, D. B. (1993). *The Culture of Pain*. Berkeley: University of California Press
- Mullan, B. (1987). *Are Mothers really necessary?* London: Boxtree.
- Murray, S. F., & Pradenas, F. S. (1997). Cesarean birth trends in Chile 1986 to 1994 [Electronic version]. *Birth*, 24(4), 258-263.
- Murray, S. F. (2000). Relation between private health insurance and high rates of caesarean section in Chile: qualitative and quantitative study [Electronic version]. *British Medical Journal*, 321(7275), 1501-1505.
- Naisbitt, J., Naisbitt, N., & Philips, D. (2001). *High Tech, High Touch. Technology and our Accelerated Search for Meaning*. London: Nicholas Brealey Publishing.
- National Women's Hospital (2000). *Annual Clinical Report 2000*. Auckland: Author.
- National Women's Hospital (2004). *National Women's Annual Clinical Report 2004*. Auckland: Author.
- National Women's Hospital (2005). *National Women's Annual Clinical Report 2005*. Auckland: Author.
- Neggers, Y., Goldenberg, R., Cliver, S., & Hauth, J. (2006). The relationship between psychosocial profile, health practices and pregnancy outcomes [Electronic version]. *Acta Obstetrica et Gynecologica Scandinavica*, 85(3), 277-285.
- Nerum, H., Halvorsen, L., Sorlie, T., & Oian, P. (2006). Maternal request for Cesarean Section due to Fear of Birth: Can It Be Changed Through Crisis -Orientated Counseling? [Electronic version]. *Birth*, 33(3), 221-228.
- Newburn Cook, C. V., & Onyskiw, J. E. (2005). Is older maternal age a risk factor for Preterm Birth and Fetal Growth Restriction? A systematic review [Electronic version]. *Health care for Women International*, 26, 852-875.
- Nicholas, D. (2002, July 8). Fear of Pregnancy. *The Dominion Post*, p. B4.
- Nygaard, I. (2006). Urinary Incontinence: is cesarean delivery protective [Electronic version]. *Seminars in Perinatology*, 30(5), 267-271.
- Oakley, A. (1980). *Women confined: Towards a Sociology of Childbirth*. London: Martin Robertson.
- Oakley, A. (1986). *The Captive Womb*. New York: Basil Blackwell.

- O'Cathain, A., Walters, S. J., Nicholl, J. P., Thomas, K. J., & Kirkham, M. (2002). Use of evidence based leaflets to promote informed choice in maternity care: a randomised controlled trial in everyday practice [Electronic version]. *British Medical Journal*, 324(7338), 643-645.
- Odibo, A. O., Nelson, D., Stamillo, D. M., Sehdev, H. M., & Macones, G. A. (2006). Advanced maternal age is an independent risk factor for intrauterine growth restriction [Electronic version]. *American Journal of Perinatology*, 23(5), 325-328.
- Olayemi, O., Adeniji, R. A., Udoh, E. S., Akinyemi, O. A., Aimakhu, C. O., & Shoretire, K. A. (2005). Determinants of pain perception in labour among parturients at the University College Hospital, Ibadan [Electronic version]. *Journal of Obstetrics and Gynaecology*, 25(2), 128-130.
- Olayemi, O., Aimakhu, C. O., & Akinyemi, O. A. (2006). The influence on westernisation of pain perception in labour among parturients at the university college hospital Ibadan [Electronic Version]. *Journal of Obstetrics and Gynaecology*, 26(4), 329-331.
- Page, E. (2007, February, 11). Caesareans on sale for \$10,000. *Sunday Star Times*, p 5.
- Page, L. A. (2000). *The New Midwifery. Science and sensitivity in practice*. Toronto: Churchill Livingstone.
- Papps, E., & Olssen, M. (1997). *Doctoring Childbirth and Regulating Midwifery in New Zealand. A Foucauldian Perspective*. Palmerston North: Dunmore.
- Parson, S. (2002, July 8). When push comes to shove. *The Dominion Post*, p. 8.
- Paterson-Brown, S., & Fisk, N. M. (1997). Caesarean section: every woman's right to choose? *Current Opinion in Obstetrics and Gynaecology*, 9(6), 351-355.
- Paterson-Brown, S. (1998). Should doctors perform an elective caesarean section on request? Yes, as long as the woman is fully informed. *British Medical Journal*, 317(7156), 462-465. Retrieved January 14, 2007, from <http://www.bmj.com.ezproxy.aut.ac.nz/cgi/content/full/317/7156/462#resp1>
- Perkins, B. (2006). Midwifery and malpractice. *Midwifery Today*, (79), 22-23.
- Pincus, J. (2006). Roundtable discussion: Part 2. Why do Women go along with this stuff? "We must continue to press forward" [Electronic version]. *Birth*, 33(3), 249-250.
- Polit, D. F., & Hungler, B. P. (1995). *Essentials of Nursing Research: Methods, Appraisal and Utilization* (5th ed.). Philadelphia: Lippincott, Williams & Wilkins.
- Polkinghorne, D. E. (2002). *Practice and the Human Sciences. The case for a Judgment-Based Practice of Care*. Albany, USA: State University of New York Press.

- Pyett, P. M. (2003). Validation of Qualitative Research in the "Real World" [Electronic version]. *Qualitative Health Research*, 13(8), 1170-1179.
- Reddy, U. M., Ko, C-W., & Willinger, M. (2006). Maternal age and the risk of stillbirth throughout pregnancy in the United States [Electronic version]. *American Journal of Obstetrics and Gynaecology*, 195(3), 764-770.
- Richardson, H. (2005). Epidurals: Why the Epidemic? Childbirth.org. Retrieved March 8, 2006, from <http://www.childbirth.org/articles/labor/epiepidemic.html>
- Richter, H. E. (2006). Cesarean delivery on maternal request versus planned vaginal delivery: Impact on development of pelvic organ prolapse [Electronic version]. *Seminars in Perinatology*, 30(5), 272-275.
- Ricoeur, P. (1991). *From Text to Action Essays in Hermeneutics II* (K. Blamey, & J. B. Thompson, Trans.). Illinois: Northwestern University Press.
- Roberts, C. L., Tracy, S., & Peat, B. (2000). Rates for obstetric intervention among private and public patients in Australia: population based descriptive study [Electronic version]. *British Medical Journal*, 321(7254), 125-126.
- Robinson, J. (2000). Richer women, worse care. *British Journal of Midwifery*, 8(5), 280.
- Roe-Smith, M., & Marx, L. (Eds.). (2001). *Does Technology Drive History*. Cambridge: Massachusetts Institute of Technology.
- Ronsman, C., Van Damme, W., Fillippi, V., Pittrof, R. (2002, March). [Correspondence] [Electronic version]. *The Lancet*, 359, 974.
- Rooks, J. P. (2006). Roundtable discussion: Part 2. Why do Women go along with this stuff? "Your baby's most dangerous trip..." [Electronic version]. *Birth*, 33(3), 249.
- Royal College of Obstetricians and Gynaecologists (2001, October). *The National Sentinel Caesarean Section Audit Report*. Retrieved November 18, 2006, from http://www.rcog.org.uk/resources/public/pdf/nscs_audit.pdf
- Rubin, D. B. (1997). Estimating Causal Effects from Large Data Sets Using Propensity Scores. *Annals of Internal Medicine* 127(8 pt 2), 757-763. Retrieved June 10, 2006, from http://annals.org/cgi/content/full/127/8_Part_2/757
- Rubin, L. R., Nemeroff, C. J., & Russo, N. F. (2004). Exploring Feminist Women's body consciousness [Electronic version]. *Psychology of Women Quarterly*, 28(1), 27-37.
- Sachs, B. P., Kobelin, C., Castro, M. A., & Frigoletto, F. (1999). The risks of lowering the cesarean delivery rate. *The New England Journal of Medicine*, 340(1), 54-57. Retrieved December 8, 2006, from <http://content.nejm.org.ezproxy.aut.ac.nz/cgi/content/full/340/1/54>

- Saisto, T., Salmela-Aro, K., Nurmi, J-E., & Halmesmaki, E. (2001). Psychosocial characteristics of women and their partners fearing vaginal childbirth [Electronic version]. *British Journal of Obstetrics and Gynaecology*, 108(5), 492-498.
- Sakala, C. (2006). Carol Sakala's Letter from North America: An Uncontrolled Experiment: Elective Delivery Predominates in the United States [Electronic version]. *Birth*, 33(4), 332-335.
- Samways, A. (2007, March 13). Side Swipe. *The New Zealand Herald*, p. A14.
- Sanchez-Ramos, L., Olivier, F., Delke, I., & Kaunitz, A. M. (2003). Labour induction versus expectant management for postterm pregnancies: a systematic review with meta analysis. *Obstetrics and Gynecology*, 101, 1312-1318. Retrieved March 10, 2006, from <http://www.greenjournal.org/cgi/content/abstract/101/6/1312>
- Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1-8.
- Sandelowski, M. (2002). Visible Humans, Vanishing Bodies, and Virtual Nursing: Complications of Life, Presence, Place and Identity. *Advances in Nursing Science*, 24(3), 58-70. Retrieved November 12, 2006, from <http://gateway.ut.ovid.com.ezproxy.aut.ac.nz/gw2/ovidweb.cgi>
- Savage, W. (2000). The caesarean section epidemic [Electronic version]. *Journal of Obstetrics and Gynaecology*, 20(3), 223-225.
- Savage, W. (2002). *The Caesarean Section Epidemic*. Paper presented at the New Zealand College of Midwives 7th Biennial Nation Conference, Dunedin, New Zealand.
- Sawicki, J. (1991). *Disciplining Foucault: Feminism, Power and the Body*. London: Routledge.
- Schlosser, E. (2002). *Fast Food Nation*. London: Penguin.
- Schumpeter, J. A. (1950). *Capitalism, Socialism and Democracy* (3rd ed.). New York: Harper Perennial.
- Scutt, J. (Ed.). (1988). *The Baby Machine. Commercialisation of motherhood*. Carlton: McCulloch Publishing.
- Showalter, E. (1999). Commentary: all women should have choice. *British Journal of Obstetrics and Gynaecology*, 319(7222). Retrieved January 15, 2007, from <http://www.bmj.com.ezproxy.aut.ac.nz/cgi/content/full/319/7222/1397>

- Shute, N. (2004, May 31). Makeover Nation; Americans are opting for cosmetic surgery in record numbers. But do they know the Risk. *U.S. News & World Report*, 136(19), 52-56. Retrieved December 12, 2004, from <http://proquest.umi.com.ezproxy.aut.ac.nz/pqdweb?did=640903021&sid=1&Fmt=3&clientId=7961&RQT=309&VName=PQD>
- Simpson, W. M., Johnstone, F. D., Goldberg, D. J., Gormley, S. M., & Hart, G. J. (1999). Antenatal HIV testing: assessment of a routine voluntary approach. *British Medical Journal*, 318(7199), 1660-1661. Retrieved January 6, 2007, from <http://www.pubmedcentral.nih.gov.ezproxy.aut.ac.nz/articlerender.fcgi?artid=28144>
- Smiley, R. (2002). Epidural analgesia, 2002 update: an expert in obstetrical anaesthesiology reviews the advantages of local anaesthetics, spinal and combined spinal/epidural techniques, "walking epidurals" and "patient controlled analgesia". *Contemporary Obstetrics and Gynaecology*, 47(6), 32-49. Retrieved January 2, 2007, from <http://mediwire.sma.org/main/Default.aspx?P=Content&ArticleID=138898>
- Soltani, H., & Dickinson, F. M. (2005). Exploring women's views on information provided during pregnancy. *British Journal of Midwifery*, 13(10), 633-636.
- Stanton, C. K., & Holtz, S. A. (2006). Levels and trends in cesarean birth in the developing world [Electronic version]. *Studies in Family Planning*, 37(1), 41-48.
- Stapleton, H., Kirkham, M., & Thomas, G. (2002). Qualitative study of evidence based leaflets in maternity. *British Medical Journal*, 324(7338), 639- 643. Retrieved January 6, 2007, from <http://www.pubmedcentral.nih.gov.ezproxy.aut.ac.nz/picrender.fcgi?artid=84395&blobtype=pdf>
- Stapleton, H., Kirkham, M., & Thomas, G., & Curtis, P. (2002). Language use in antenatal consultations. *British Journal of Midwifery*, 10(5), 272-277.
- Stark, M. A. (2003). Exploring Women's Preferences for Labor Epidural Analgesia [Electronic version]. *The Journal of Perinatal Education*, 12(2), 16-21.
- Stein, R. (2006, March 30). NIH Panel Finds No Extra Risk in Caesarean Section. *Washington Post*, p. A01. Retrieved June 12, 2006, from <http://www.washingtonpost.com/wpdyn/content/article/2006/03/29/AR2006032901619.html>
- Stewart, S. (2001). Midwifery in New Zealand - a cause for celebration. *Midwifery Digest*, 11(3), 319-324.
- Stewart, S. (2006). Informed choice: The challenges for Midwives in New Zealand. *British Journal of Midwifery*, 14(10), 574.
- Stirling, P. (1998, May 16). Birth of a Trend. *The Listener*, 28-31.

- Strid, J. (2000). *Revitalising Partnership*. Paper presented at the 6th National Conference of the New Zealand College of Midwives, Cambridge, Waikato, New Zealand.
- Strum, S., & Latour, B. (1999). Redefining the social link: from baboons to humans. In D. MacKenzie, & J. Wajcman, (Eds.), *The Social Shaping of Technology* (2nd ed.). Philadelphia: Open University Press.
- Stuart, J. (2006, December 2). The changing face of motherhood. *The Independent*. Retrieved January 4, 2007, from http://news.independent.co.uk/uk/this_britain/article2027398.ece
- Sultan, A. H., & Stanton, S. L. (1996). Preserving the pelvic floor and perineum during childbirth - elective caesarean section? [Electronic version]. *British Journal of Obstetrics and Gynaecology*, 103(8), 731-734.
- Surtees, R. (2003). *Midwifery as Feminist Praxis in Aotearoa/New Zealand*. A thesis submitted in fulfilment of the requirements for the Degree Doctor of Philosophy in Education, University of Canterbury, Christchurch, New Zealand.
- Symon, A. (2006). Are we facing a complaints and litigation crisis in the health service. *British Journal of Midwifery*, 14(3), 164-165.
- Thompson, J. B. (1981). *Critical Hermeneutics. A study in the thought of Paul Ricoeur and Jurgen Habermas*. Cambridge: Cambridge University Press.
- Thorp, J. A., Hu, D. H., Albin, R. M., McNitt, B. A., Cohen, G. R., & Yeast, J. D. (1993). The effect of intrapartum epidural analgesia on nulliparous labour: a randomized, controlled, prospective trial. *American Journal of Obstetrics and Gynaecology*, 169, 851-858.
- Thorp, J. A., Parisi, V. M., Boylan, P. C., & Johnston, D. A. (1989). The effect of continuous epidural analgesia on cesarean section for dystocia in nulliparous women. *American Journal of Obstetrics and Gynaecology*, 161(3), 670-675.
- Treacy, A., Robson, M., & O'Herlihy, C. (2006). Dystocia increases with advancing maternal age [Electronic version]. *American Journal of Obstetrics and Gynaecology*, 195(3), 760-763.
- Troutt, B. (2001). The myth of informed choice. *Royal College of Midwives Journal*, 4(10), 342.
- Uhrich, L. (1996). The right to choice in childbearing. *International Journal of Childbirth education*, 11(3), 4-7. Retrieved June 5, 2006, from <http://proquest.umi.com.ezproxy.aut.ac.nz/pqdweb?index=17&did=592417291&SrcMode=3&sid=1&Fmt=3&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1176348997&clientId=7961&aid=1>

- University of Hawaii (n.d.). The question concerning technology. University of Hawaii, Critical link. Retrieved November 28, 2006, from <http://www.english.hawaii.edu/criticallink/heidegger/index.html>
- Upton, R. L., & Han, S. S. (2003). Maternity and its Discontents "Getting the body back" after pregnancy [Electronic Version]. *Journal of Contemporary Ethnography*, 32(6), 670-692.
- Van Teijlingen, E., Lowis, G., McCaffery, P., & Porter, M. (Eds.). (2004). *Midwifery and the Medicalization of childbirth: Comparative perspectives*. New York: Nova Science Publishers Inc.
- Wagner, M. (1994). *Pursuing the Birth Machine*. Camperdown NSW: ACE Graphics.
- Wagner, M. (2000). Choosing caesarean section. *The Lancet*, 356(9242), 1677-1680.
- Wajcman, J. (2002). Addressing Technological Change: The Challenge to Social Theory [Electronic version]. *Current Sociology*, 50(3), 347-363.
- Waldenstrom, U., Hildingsson, I., Ryding, E. (2006). Antenatal fear of childbirth and its association with subsequent caesarean section and experience of childbirth [Electronic version]. *An International Journal of Obstetrics and Gynaecology*, 113, 638-646.
- Walker, R. B., Turnbull, D. A., & Wilkinson, C. (2002). Exploring the notion that a "culture" of caesarean section exists in Australia. *Midwifery News*, 25, 28.
- Walsh, D. (2005). Professional power and maternity care: The many faces of paternalism. *British Journal of Midwifery*, 13(3), 708.
- Walters, J. (2006, October, 31.). Beauty a beast of a habit to kick. *The New Zealand Herald*, p.B3.
- Wainwright, D. (1997). Can sociological research be qualitative, critical and valid? *The Qualitative Report* [On-line serial], 3(2). Retrieved March 15, 2002, from <http://www.nova.edu/ssss/QR/QR3-2/wain.html>
- Wane, J. (2002). Delivered to Order. *Little treasures*, 91, 37-40.
- Warren, S., & Brewis, J. (2004). Matter over Mind? Examining the Experience of Pregnancy [Electronic version]. *Sociology*, 38(2), 219-236.
- Warwick, C. (2001). A midwifery perception of the rising caesarean rate. *Midirs, Midwifery Digest*, 11(2), 152-156.
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in Qualitative Research [Electronic version]. *Qualitative Health Research*, 11(4), 522-537.

- Wickham, S. (2002). A few choice thoughts. *Midirs, Midwifery Digest*, 12(1), 20-22.
- Williams, R. (2001). The Political and Feminist Dimensions of Technological Determinism. In M. Roe-Smith, & L. Marx (Eds.), *Does Technology Drive History? The Dilemma of Technological Determinism*. London: MIT Press.
- Windridge, K. C., & Berryman, J. C. (1999). Women's experiences of giving birth after 35 [Electronic version]. *Birth*, 26(1), 16-23.
- Winner, L. (1999). Do artifacts have politics? In D. MacKenzie, & J. Wajcman (Eds.), *The Social Shaping of Technology*. Philadelphia: Open University Press.
- Wolf, N. (2001). *Misconceptions*. London: Chatto & Windus.
- World Health Organisation. (1985). Appropriate Technology for Birth. *Lancet*, 326(8,452), 436-437.
- World Health Organisation. (1985). Joint *Interregional Conference on Appropriate Technology for Birth*. Retrieved January 31, 2007, from <http://www.weikert.de/alexandra/who1.html>
- Wong, S. F., Hui, S. K., Choi, H., & Ho, L. C. (2002). Does sweeping of membranes beyond 40 weeks reduce the need for formal induction of labour [Electronic version]. *British Journal of Obstetrics and Gynaecology*, 109(6), 632-636.
- Young, D. (2006). "Cesarean Delivery on Maternal Request": Was the NIH Conference Based on a Faulty Premise? [Electronic version]. *Birth*, 33(3), 171-174.
- Zarembo, A. (2001, March 24-25). Increase in caesarean births. Deliveries booked like a visit to the hairdresser. *Weekend Herald*, pp. 20-21.