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# BIRTH IN NEW ZEALAND

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# BIRTH IN NEW ZEALAND:
# What choice is there?

## CONTENTS

# CHAPTER ONE

## INTRODUCTION

### MATERNITY CARE IN NEW ZEALAND

According to international opinion New Zealand women are amongst the luckiest in the world when it comes to giving birth and New Zealand is admired for its progressive maternity system. Maternity care is complex, however, needing to accommodate the myriad changes that pregnancy brings and extending over a lengthy period of time. Additionally, because pregnancy is a healthy state not an illness, a woman may expect to plan her maternity care according to her own preferences. This is possible to only a limited extent, of course, because there are many aspects of the maternity system (hospital policies or fiscal decisions for example) that are beyond her control. She can influence the type of care she receives in areas where there is direct interface with the system though, for example choosing where she plans to birth and who will care for her, and here the choices she makes can be critical to her experience of pregnancy and birth. Three areas of the maternity care system which have direct impact on women and also set New Zealand apart from other countries are the Lead Maternity Carer (LMC) system, the eligibility of midwives to practise autonomously and the importance given to the concept of Informed Consent which enables women to be well informed before making decisions about their care. Each of these areas is relevant in the context of this project about choices for birth in New Zealand and is described in more detail in the following sections.

## THE LEAD MATERNITY CARER (LMC) SYSTEM

Under this system a woman is entitled to choose one health professional to coordinate and take responsibility for her care from conception, throughout pregnancy, labour and the postnatal period until approximately four to six weeks after her baby is born. The chosen LMC can be an obstetrician, a General Practitioner (GP) or a midwife, each having the same authority and scope of practice in managing care for women having normal, healthy pregnancies. All LMCs are able to make referrals to a specialist or for services such as ultrasound scans or laboratory tests as required and all LMCs, including midwives, are able to prescribe medications for maternity-related conditions. The LMC option is designed to ensure continuity of care during pregnancy and birth. It avoids care becoming fragmented amongst several health professionals who may each think the other is providing services. It also enables the LMC and pregnant woman to develop a relationship, the intention being to enhance communication and understanding during the stressful time of labour. The LMC system allows women to choose the carer they prefer knowing that all will provide the same components of care. The number of postnatal visits, screening tests, or schedule of check-ups whilst pregnant remains standard regardless of who the LMC is.

## MIDWIFERY AUTONOMY

Being able to choose a midwife as an LMC would not be possible without midwifery autonomy which is a very distinctive aspect of the New Zealand maternity model. Since 1990 midwives in New Zealand have been legally eligible

to work as autonomous health practitioners without requiring a doctor or obstetrician to oversee their practice. This model is often referred to as "independent midwifery" or "independent practice" and has resulted in midwives establishing themselves in businesses, individually or in partnerships with other midwives, throughout the country.

Women and midwives together worked and lobbied for many years to attain this status for midwifery. The cornerstone of their campaign was the premise that birth is a normal life event and therefore midwives, whose area of expertise is normal birth, should be eligible to provide complete care for women unless medical conditions dictate otherwise. Midwives within the LMC system work in partnership with the women they look after, a relationship designed to encourage women to become actively involved in their maternity care rather than being passive patients. According to the New Zealand College of Midwives (2008) more than 75% of New Zealand women now choose a midwife as their LMC.

## INFORMED CONSENT

The concept of women being well informed to make choices about maternity care is integral to the New Zealand maternity system. In 1988 the landscape of consumer participation in health care changed radically after the very public Cartwright Inquiry was conducted into the long-term and undisclosed use of cervical cancer screening and treatment for research purposes at National Women's Hospital in Auckland (Coney 1988). The results of the inquiry laid the foundations for greater sharing of information from health professionals to

consumers and the introduction of Informed Consent requirements for all medical procedures. Five years later the passing of the Health & Disabilities Services Act entrenched these rights in legislation, providing the framework for women to receive comprehensive information from which to make appropriate decisions about their care.

Paradoxically, despite the implementation of components such as those discussed above as well as support for normal birth by the two most influential organisations in the maternity arena in New Zealand (the Ministry of Health and the New Zealand College of Midwives), the rate of medical interventions[1] used in labour is steadily rising. The continuity of care the LMC system provides offers the opportunity for supportive relationships between women and LMCs where potential problems can be seen early and their consequences minimised. As noted earlier, midwifery autonomy enables midwives, the experts in normal birth, to provide all of a woman's care without recourse to other health professionals unless medically indicated and informed consent supports women to be well informed and in charge of their maternity care. Still, these measures have not stopped the increasing use of medical intervention during birth.

The continuing trend of rising intervention rates seems inexplicable alongside the emphasis on offering care designed to have the opposite effect. Considering

[1] Medical Intervention - for example, caesarean section, induction, forceps and other medical procedures which interrupt the physiological process of labour. (See footnote p.6)

caesarean section[2] alone, the most medical of interventions, we find that in New Zealand, and in countries with similar maternity care systems, there is almost a one in four chance of a woman requiring this operation. In 1985 the World Health Organisation declared that a caesarean section rate of more than 15% was unlikely to improve birth outcomes however in New Zealand rates have doubled from 11.7% in 1988 to 23.7% in 2004 (Ministry of Health, 2007:33). To have a baby in a New Zealand hospital, a woman risks becoming one of 20.4% whose labour is induced[3], 28% who use epidural anaesthesia[4], 13% who have an episiotomy[5] (Ministry of Health, 2007:36); 9.6% whose baby will arrive assisted by forceps or ventouse[6], (Ministry of Health, 2007:28); or 23.7% who have a caesarean section (Ministry of Health, 2007:33).

## POSITIONING MYSELF

I have struggled to understand this paradox during more than a decade of working in the field of pregnancy and birth care and this research project was an ideal opportunity to investigate it further. I wanted to define an area of inquiry which would be sufficiently unknown to me that it did not pre-empt my research and that would provide me with new understanding. I needed a fresh perspective to help me see beyond the many assumptions I had formed as a result of events witnessed and experienced. It was difficult finding my way into this research because of the opinions and information that I held already. Initially it was also

[2] Caesarean section - Baby is born via an incision in the abdomen.
[3] Induction – setting labour in motion by artificial means.
[4] Epidural anaesthesia – a local anaesthetic into the epidural space around the spinal nerves.
[5] Episiotomy – a surgical cut used to enlarge the vaginal opening.
[6] Ventouse – a suction device is attached to the baby's scalp by to help birth the baby.

difficult to let go of my desire to find an 'answer' to the paradox and let myself simply be the researcher, looking at the information without preconceived agenda.

My knowledge comes from twelve years experience as a childbirth educator and from working in a community agency funded by government to provide information and education to pregnant women and their families. The funding has been administered in different ways over that time: directly from the Ministry of Health, from a Regional Health Authority, and latterly by the local District Health Board. Working with different statutory organisations across a range of levels and functions has enabled me to observe and participate in the bureaucracy of the maternity system. These connections have given me the opportunity to see firsthand how complex and powerful the institution of maternity care is.

As a childbirth educator, teaching antenatal classes, I have worked with hundreds of expectant parents preparing for labour and birth. Through that work I have been invited to many births; as an emotional support, an advocate, an extra pair of hands, a camera/video person, a few times as an aunt, several times as a friend, and once or twice for no specific purpose. I have birthed two children of my own and I have also attended many births during two years of training to be a midwife – a career which I did not, in the end, pursue but which gave me valuable insights into the maternity system from the perspective of a health practitioner. Many of those births happened before I became interested in anthropology and all of them before the writing of this research project. They are all, however, etched into my

memory and have both informed my stance on birth practice in New Zealand and provided the focus for this research project.

## DEFINING MY RESEARCH TOPIC

Through the varied roles I have occupied in relation to the maternity system and hundreds of conversations I have had with women about their maternity care, it is apparent to me that many begin labour in a state of ambivalence between their hope to give birth naturally and their expectation they will need medical help during labour. The ambivalence reflects the reality that there are two paradigms of care operating in the New Zealand system. One defines birth as a natural, normal part of life happening with minimal medical intervention; the other portrays birth as a dangerous, risk-laden time during which medical expertise should be readily available.

Each paradigm lobbies for followers as though what happens in labour is simply a matter of making an informed choice or as if there is an absolute truth to be found and applied to all women giving birth. The ideology of birth as a normal social event is proclaimed loudly whilst the reality of a culture where birth is seen as a potential emergency is hushed and rationalised away, making it difficult to grapple with the contradiction between the two paradigms. The maternity system appears to suggest that birth is part of a normal healthy lifestyle. The implication is that expectant parents, with the support of their LMC, have control over how birth will be managed but in practice this is only true within specified parameters. The LMC role is constrained by the terms of contracts with both the Ministry of

Health for payment and with the hospitals that grant or rescind access to maternity facilities. The role of expectant parents is limited also, by how ably they can navigate the complexities of the maternity system.

The double message is further inscribed in the language we use. Phrases such as "succeed in giving birth naturally" or "lucky not to have any interventions" and descriptions of birth without pain relief as "being brave" imply that a natural birth is a positive outcome to aim for, and yet one that happens only in special circumstances or for exceptional people. Opposing this suggestion that natural birth is something to be prized and celebrated as "successful", "lucky" or "brave", some women describe feeling constrained from telling of their natural, drug- and intervention-free, births lest they become stigmatised as having radical or extremist tendencies or they make someone whose birth was different feel uncomfortable. It seems that although women are told a natural birth is normal and to be expected they should consider themselves lucky if it does happen and should not celebrate it too openly.

Another example of this double-bind is that, although theory supports natural childbirth as being safer for women and babies (Goer, 1995; Tew, 1990; Wagner, 1994), and despite it being a cost-effective option for governments and Health Boards, investment in drugs and technology continues to be the primary way to manage the pain and perceived risk of normal childbirth. Rather than researching methods of avoiding intervention the search is to improve technology and drug therapies. At the same time, as we develop more technology, we seem

simultaneously to develop greater trepidation and fear of situations that we cannot control. The unspoken assumptions are that science and technology can improve on nature, that interventions are normal, and that their use is always positive.

What this double-think and lobbying overlooks is the reality that how birth happens is an expression of the hegemony of the dominant medical paradigm within our culture (Davis-Floyd 2003). The way labour progresses is not simply a matter of the preparation that a woman makes and the actions she takes. It is influenced by hospital policies, staff attitudes, the people involved in her care, societal messages and other subtle pressures. The relationship between natural birth and medical birth is complex and investigation into how these opposing philosophies act on and alongside each other would prove useful in revealing the invisible structures that influence attitudes and mediate choices for birth.

As a first step into such an investigation this research project will review the models of birth currently used in New Zealand. It is prompted by my curiosity regarding the overt portrayal of birth as natural contrasted with the underlying message that it is inherently risky and unsafe. Whilst these two attitudes prevail in New Zealand society generally it is the effect on pregnant women and their preparation for labour and birth that is particularly interesting and relevant to me. Articulation of this dichotomy has proved troublesome and elusive and so this research project is a preliminary investigation to map the ground as it were. Hence the scope of this project is limited to defining and describing the birth practices that are currently available, to provide suggestions for future areas of

research, and to act as a foundation from which further research can be conducted.

# CHAPTER TWO

## METHODOLOGY AND THEORETICAL PERSPECTIVES

### INTRODUCTION

As outlined in the previous chapter, the intention for this research is to provide a review of current birth practice in New Zealand. To this end I describe and discuss three differing models[7] that have been identified from my experiences. The dominant style of birth is the "Medical Model" which treats pregnancy as potentially pathological and therefore requiring regular monitoring and testing. Less common but nevertheless well represented is the choice to birth without drugs and technological interventions, identified throughout this research as the "Natural Model" of birth. The third way, the "Maori Model", incorporates aspects of traditional Maori customs into current practice. The intention is to examine how each of these systems developed by constructing an historical view of birth in New Zealand. Within the review of each model a fictionalised birth story is included to illustrate relevant themes which are then discussed briefly. The remainder of this chapter provides more detail on how I have constructed this inquiry, the methods used and the theoretical framework in which it sits.

[7] These models are similar to Davis-Floyd's (2003:160) categorization of different styles of birth though they arose from my own experiences of working with women during pregnancy and birth.

It is very clear to me, through observations and listening to women, that the two dominant models of birth in New Zealand at this time are the Medical Model and the Natural Model. The former considers that birth is unsafe until proven to be otherwise, therefore requiring medical skills, equipment and technology to be available and thus it is conducted within a hospital setting. The Natural Model situates birth within a social and family context and ascribes no greater risk to it than to other areas of ordinary life therefore either hospital or a home setting would be considered appropriate.

Additionally, I have met families who have planned their birth experience by drawing on Maori customs and traditions, incorporating these wherever possible and simultaneously including elements of either or both the other models. This approach, which I refer to as the Maori Model, I have only experienced myself in the context of birth out of a hospital.

## RESEARCH METHODS

Having identified these three models I set out to investigate them further. I was able to construct a clear description of each model from my own working knowledge which provided a picture of birth in the present time. What interested me was how these three models had developed divergently and to understand this I searched the literature documenting the history of birth in New Zealand in order to construct a picture of the development of maternity care in this country. There is little written about maternity care in general historical literature and most of my information came from accounts by women who have been involved in this field;

managers, midwives or doctors in the main. To a lesser extent I also investigated the history of British maternity care since the New Zealand systems of public health were established whilst strongly under the influence of British jurisdiction. Most of this history of New Zealand's maternity care has been included in the literature review contained in Chapter Three and is used to inform the discussions that occur in Chapters Four, Five and Six on each of the three models.

## INCLUDING MYSELF

Initially my intention was to use only existing literature as data for this research however, as I worked through this process, my own experiences and thoughts rose up repeatedly to influence the focus and direction of my research. I realised that I had a comprehensive repository of knowledge within myself from my experiences, from stories that have been shared with me, from discussions with colleagues and from the reflections I have made over the years in countless notebooks, scraps of paper and academic assignments. This proved too compelling to ignore and, importantly, is what enabled me to describe each of the models in the form of fictionalised birth stories and in the discussion of each model. My direct experiences with birthing women and their families have informed my understanding of birth as it happens currently in New Zealand. Recurring themes have emerged, for example: of intuitive knowledge being devalued, of submission to medical authority, of the normal being made abnormal, and issues of safety and risk, to name just a few. What this research provided for me was the chance to reflect on those experiences, to step outside myself and, as

'the researcher', take a fresh look at the meaning I had ascribed to those experiences.

## MANAGING THE LITERATURE

Initially I had strings of information, lists and dates, seeming almost unconnected to each other until I reordered them according to a thematic analysis (Aronson 1994). After identifying a number of themes that emerged through reading the history I "coded" the data. To do this I literally cut up a copy of my draft and sorted the paragraphs and sentences into themes which had been identified as significant aspects of the history. The information in each pile was then reorganised so that it provided a meaningful description of a particular aspect of the evolution of New Zealand's birth culture.

When I attempted a chronological telling of history it offered me no contextual explanation for the development of the systems we use today and so, to find relevance in the material, I sorted it into themes which fitted a world view that made sense to me. I found myself drawing on feminist analyses, Marxist feminism, with its attention focussed on capitalism (inherent in the efforts of doctors to monopolise the financial gains of the birth "industry"), radical feminism for its analysis of the patriarchal power of obstetrics and government to control childbirth, and socialist feminism for its efforts to explain the relationship between capitalism and patriarchy and their effects on childbirth practice (Tong, 1989). It is pertinent here to note that although the doctor who is cited most prominently in seeing obstetrics placed at the top of the maternity care hierarchy is

a woman, the methods she uses to amass influence for herself and for obstetrics are masculinist[8] in character. At times I have questioned this analysis, worried that I may have relied too heavily on particular sources of information and allowed them to bias my interpretation. In the end I did not change my thoughts on the validity of the feminist perspective as a way of analysing the data collected for this historical overview and consider it is a valid approach from which to conduct an analysis of current childbirth practice.

## WRITING THE STORIES

In the chapter for each model of birth I have included a narrative illustrating key characteristics of that model. Originally these stories were not intended as a primary source of information but as I developed and refined them they changed the structure of the project. What began as an historical treatise developed, through use of the stories, into a portrait of the effects of history on the models of birth we have today. Ellis (2004) discusses the use of narrative to make one's writing more evocative, she encourages more description, use of details and scene setting so that the stories "show" rather than merely "tell". Also, I share Infanti's (2007:36) aim, to produce research that is practically useful, and to that end the stories are intended to make my work more widely "accessible and engaging in contrast to traditional scientific research-writing" (Infanti, 2007:37). The stories offer a snapshot of ways that birth happens to be reflected upon alongside the discussion.

[8]Usually attributed to use by men for reinforcing and maintaining patriarchal power structures.

Each story is grounded in the many experiences I have been privy to over more than a decade of work in this field and the actions, thoughts and comments employed are chosen for their commonality to the experiences of a large number of women. They have been crafted from my observations and experiences as well as stories I have heard or read and are reinterpreted, re-presented through my eyes and my words. As such, these narratives are 'fiction' according to Clifford's (1986:6) description, "in the sense of 'something made or fashioned'," but, they are certainly not 'fictional' according to Naryan's (1999:136) definition "in the sense of being entirely imagined fabrications". They are symbols of the interactions between myself and women I worked with and also they are symbols of their interactions with the medical system and the health professionals they met there (Crotty 1998:72).

Each story reflects different characteristics of the model it demonstrates and so do the different 'voices' that are used. The 'matter-of-fact, no-fuss' story of a medical birth is common to many women. As Davis-Floyd (2003) points out, modern birth practice is a rite of passage for women and using the voice of the mother, 'Libby,' allowed this story to express both the events entailed in this ritual and women's feelings about it. The culture of natural birth is not so broadly documented or well defined and for women is often an introspective and instinctive experience. Conversely, I have often observed that the extraordinary naturalness of birth, when it happens that way, has a profound impact on men and so it seemed natural to use a male voice to provide commentary for this story. Maori birth, as a model suffers from a degree of invisibility and the detail of this

story is drawn from textual sources, practical experiences and my own identity as a Maori woman and thus my knowledge of Maori culture. This is the only story written in the third person, symbolising its cultural distance from both the other models and the temporal distance from the traditional, time-honoured methods that are used.

## ORGANISATION OF THE PROJECT

Chapter Three presents a review of current literature which is relevant to the topics discussed in this research and Chapters Four, Five and Six present the three models of birth current in New Zealand, showing how they are expressed today and providing some discussion on significant themes. Chapter Four discusses the Medical Model and in tracing the history of birth practices in New Zealand shows that this model is not accidental, nor is it necessarily the best. Chapter Five looks at the Natural model of birth and why women might choose this option. In Chapter Six I examine a model of Maori birth practice, a third model we can draw on in New Zealand. The Natural Birth model appears most closely aligned with Maori birth customs but both of these models exist as minority choices at the present time. The Medical Model, on the other hand, is firmly entrenched in our hospitals and in the psyches of expectant parents throughout New Zealand. Chapter Seven synthesises this information, draws conclusions and highlights areas where further research would be helpful.

## THEORETICAL FRAMEWORK

In identifying a framework I was initially confused by what I saw to be an impossible opposition of the positivist, biomedical approach to childbirth which is predominant at the present time versus the constructionist viewpoint which sees the way we birth as developing from social and historical factors. What I realised, in the end, was that I needed to find the theoretical standpoint that enabled me to make sense of my data rather than be concerned with the perspective of different aspects of the data.

## CONSTRUCTIONISM

In order to find this place I retraced the path I had taken through my research. I had chosen an investigation of literature on the history of maternity care in this country believing this would reveal social, economic and cultural forces which had shaped today's birth environment. At the same time, I was aware that the process I saw and described was my view and not the only way to interpret those events. The meaning that I have made from this historical enquiry is my constructionist interpretation of the interactions between people and events within their specific social context in New Zealand (Crotty 1998:42).

## PHENOMENOLOGY

The stories, written from and of my own experience, began as simple sketches informed by recourse to literature and turned into the narrative descriptions of each model. They are a way of showing how the different models operate. According to Jackson (1996), narrative plays a central role in phenomenological

description showing the link between discourse and practice and is "a form of Being as much as a way of Saying" (1996:39). The stories do present my perception of birth, though, and through them I engage deeply with the object of the research, the New Zealand birth culture. This is indicative of the concept of intentionality held to be a core feature of phenomenology (Crotty 1998, Jackson 1996). In the doing of this research the interpretations that I ascribe to the way birth occurs arise from my own cultural consciousness and must be understood in the context of my relationship to that culture.

> This is to say, what is possible for a person, is always preconditioned by the world into which he or she is born and raised, but a person's life does more than conserve and perpetuate these pre-existing circumstances: it interprets them, negotiates and nuances them, re-imagines them .... (Jackson 1996:30)

In the context of this research, what Jackson describes is the way in which my initial response to the experiences I have had of birth were governed by the values, standards and norms of my world as it was then. However, my experiences and the understanding I drew from them have altered me and my response. In other words, as humans we have the facility to influence events we experience and simultaneously those events influence and change who we are.

A phenomenological approach offers the opportunity to reflect on an experience without prior understandings or judgements being imposed, to look as if seeing it for the first time in order to see new meanings (or possibly reaffirm old meanings)

whilst remembering that the particular meaning we find at any one time has limits and biases and comes from a particular context (Crotty 1998:81). A phenomenological approach to this research project is cognisant of the notion that the data presented has been interpreted through the filter of my life situation and requires that filter to be put aside so that the material can be responded to as if experienced for the first time and re-viewed from a new perspective.

In re-viewing the models of birth that will be described my hope is to clarify and articulate the cultural values and beliefs that operate in regard to birth and which are expressed through the treatment accorded to the childbearing body in each model. Csordas (1994:4) tells us that the body is the "existential ground of culture and self" and that our cultural values and beliefs are played out upon the ground of our bodies. In childbirth the messages thus transmitted are embodied by women and integrated into their newly emerging identity as a mother. Understanding the values and beliefs behind different styles of maternity care is critical to the ability to retain a sense of agency and self-identity while negotiating a path through them. It is in this regard that the ability of phenomenology to provoke new ways of seeing the world is particularly useful. With this theoretical framework in mind, the following chapter discusses the literature used in order to provide a background to the research.

# CHAPTER THREE

## LITERATURE REVIEW

Having outlined the project and theoretical framework in the previous chapter, this literature review will set the context for the research undertaken. The literature is broadly divided into two categories, the first regarding the discourse on the medicalisation of childbirth and the second covering the historical construction of birth in New Zealand. Medicalisation can be defined as the process by which aspects of life once considered normal and healthy, such as pregnancy and birth, become seen as pathological and needing medical care and monitoring. What is relevant here is the impact this has on women experiencing healthy, unproblematic pregnancies who, nonetheless, are subjected to frequent monitoring and testing which bespeaks perpetual concern that "something might go wrong". The literature shows medical knowledge to be authoritative in our society despite the abundance of material opposing the medical stance for pregnancy and birth (Wagner 1994, Donley 1998, Banks 2000, Davis-Floyd 2003, Edwards 2005). The historical construction of birth in New Zealand, developed in this chapter, documents the rise of obstetric medicine and concomitant medicalisation of birth that mirrored development of the British maternity system (Edwards 2005).

## THE MEDICAL DISCOURSE

Davis-Floyd (2003) has written comprehensively about the medicalisation of the American birth culture. She describes the ritualistic nature of American obstetrics, both in its indoctrination of obstetric health professionals and its treatment of women during pregnancy and birth. She suggests that birth, in its own right, is a ritual passage that transforms women into mothers and that medicalised birth usurps the natural process in order to socialise mother and baby into the core values of society (2003:153). Davis-Floyd also coined the term Technocratic Birth to describe a style of birth care that attempts to impose order and control on the unpredictable process of birth through the use of obstetric technologies which are considered superior to nature. The Technocratic model uses the machine as a metaphor for the body and so technocratic birth care is akin to mechanical repair of a dysfunctional machine. The Technocratic model has similarities to the Medical model of this research.

The comparison of body and machine was raised by Emily Martin (1987) as she compared women's descriptions of their reproductive processes with medical texts. Martin (1987:57) proposed that medical science has moved from a position of seeing the body as a machine to one where the reproductive processes are based on metaphors of production, where menstruation and menopause are "failed production" and a baby is the "product" of childbirth. In moving from machine to product Martin's analogy introduces the complexity of the hierarchies of power which are present in obstetrics where relations between patient-doctor can be likened to those between worker-foreman.

These representations of childbirth are a short step away from the commodification described by Rothman (1986) where all the elements of human reproduction have been separated out and are available to be bought, sold and traded. We have sperm donors, egg donors, surrogate pregnancies, babies conceived in laboratories and abortion available as an economic decision. Undoubtedly the ability to control fertility and reproduction has impacted positively on many lives; equally certainly it has made it possible to view a foetus as separate from the woman in whose body it grows. This ability to reduce childbearing into components that can be considered individually poses ethical dilemmas and potential conflicts of interest between mother and unborn baby. It also bestows on scientists and doctors a greater degree of control over pregnancy, labour and birth than most women feel they have themselves. It is not surprising that women and their families will often defer to the "expert" and delegate responsibility for most decisions to their maternity health professional.

The majority of literature on birth practices and labour and birth interventions comes from those who advocate keeping birth natural and minimising overuse of technology (Kitzinger 1992, Donley 1998, Banks 2000, Odent 2002, Davis-Floyd 2003, Kitzinger 2006). There is also a large body of writing which has challenged the model of medical birth by researching and promoting ways of working with the physiological resources that are naturally available in a woman's body (Odent 1984, Balaskas 1991, Wagner 1994, Buckley 2005). Indeed, two documentary films released this year (which I had the opportunity to see whilst conducting this

research) are examples of these two approaches to promoting natural birth. The first, "Business of Being Born" (Lake 2008) documents the negative aspects of unnecessary medicalisation and describes the birth "industry" whereas the second movie, "Orgasmic Birth" (Pascali-Bonaro 2008), promotes the positive aspects of birthing naturally.

Medicalisation can be identified by specific characteristics such as technology, specialised knowledge, social hierarchies and behaviours. The authority of medical knowledge is one of the most powerful ways used to overwhelm, persuade and sometimes pressure others into compliance. Jordan (1997) describes authoritative knowledge as that which "gains ascendancy and legitimacy" and may lead to the "devaluing" and "dismissal" of other knowledge. She suggests an important aspect of the dominance of authoritative knowledge is that it comes to be seen "not as socially constructed, relative, and often coercive but as natural legitimate, and in the best interest of all parties" (1997:56). Authority is bestowed according to social values but is not necessarily correct and nor is it the only possibility for knowing. Jordan, who has researched birth in several cultures, discusses shared knowledge (where all those involved in an activity or event take part in decisions) and intuitive knowledge as being equally valuable and useful tools. These different forms of knowing will be discussed in the following chapters relating to the three birth models described.

Institutionalised maternity care takes place in an environment where the majority of power lies in the hands of those (generally men) who make the policies and

decisions. Even when women take these roles they are still obliged to perform in ways dictated by positivist paradigms that value scientific models of behaviour. By following the passage of obstetric history it becomes clear that the way we birth in New Zealand is a reflection of western culture[9] and its patriarchal, capitalist ethos. Medicalised birth is the model which holds sway in contemporary New Zealand culture where drugs and technology have become diametrically opposed to birthing naturally which, in a bizarre oxymoron-like twist, is now considered the alternative way to give birth. My experience corresponds with Davis-Floyd's (2003:5) realisation that the majority of women, though appearing to agree that natural birth is best, seem willing to follow the path of medicalised birth.

## BIRTH IN NEW ZEALAND – CONSTRUCTING THE HISTORY

Women in New Zealand were mostly attended by lay midwives until the early twentieth century when those who could afford doctors' fees began to birth in hospital. The opening of the state-run St Helen's[10] maternity hospitals was the beginning of a divergence between the government and medical interests in New Zealand. At first the new hospitals were welcome additions to the maternity workforce, then they were seen by doctors as competition, and eventually they were accepted as they relieved doctors of a large part of their non-fee-paying client load. Over the next fifty years obstetric medicine established itself as the authoritative voice in the field of pregnancy and birth care.

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[9] This refers to cultural characteristics derived from Western Europe with values which prioritise reason, scientific knowledge, individualism and economic progress.

[10] Seven St Helen's hospitals opened in 1905 providing home and hospital birth services for a nominal fee, run by midwives with a female medical officer, and providing midwifery training for nurses and non-nurses (direct-entry midwives) (Donley 1998:33).

**The Rise of Obstetric Medicine**

An early disagreement between the government and the medical profession began soon after the St Helen's hospitals were established. In Dunedin there was conflict between the Otago Medical School and the St Helen's hospital over access to the latter for training purposes. Women who would previously have used the public hospital and been available for doctors in training were now going to the St Helen's hospital thus depleting clinical training numbers for the medical school. This was serious enough that both the British Medical Association and Otago Medical School petitioned the government to turn control of the St Helen's hospital over to them. It took some years but by 1929 training opportunities at the Dunedin St Helen's hospital were made available for doctors only, leaving midwives to go elsewhere for their training (Donley 1998:38). Availability of clinical experience is still an issue in the present day and often midwives who work in hospital settings find that although they are the caregivers during labour they are frequently required to step aside for trainee doctors when it comes to the birth itself.

In 1921 the government challenged medical interests by undertaking a national tour to discourage the public from using sedation because it increased the likelihood of forceps use.[11] A potential consequence of forceps use was an increased risk of puerperal sepsis[12]. Both sedation and forceps were used more

[11] A pair of metal "handles" used to grip either side of the head and help extract the baby during the final stages of birth.

[12] Puerperal sepsis, also called childbed fever, was a severe form of septicaemia caused by a bacterial infection in the genital tract. With knowledge of sterile techniques it was able to be controlled and since the introduction of antibiotics it can be treated (Pullon 1991:13).

frequently in hospitals under medical management than in the midwifery managed St Helen's hospitals (Donley 1998:42) and the advice was opposed by the New Zealand branch of the British Medical Association. According to Dr. Doris Gordon, a GP from Taranaki, the government advice was unscientific, misinformed women and attempted to persuade them away from using technology and doctors. Gordon (1955) felt that because of its non-scientific delivery it failed in its mission and thereby "paved the way for the triumph of ultimate truth" (1955:161) in the form of obstetric knowledge and practice.

This attempt by government to control the practice of doctors was one factor which led to the eventual establishment, in 1927, of the New Zealand Obstetrical Society. This was largely at the initiative of Gordon, a keen advocate of Twilight Sleep[13] sedation. She wanted to limit government control over medical interests, in this instance so that "doctors had freedom to give what pain relief they saw fit" (Gordon 1955:149). As an obstetrically trained GP Gordon was passionately committed to hospital birth under medical supervision (Banks 2000:68). Ten years after the formation of the Obstetrical Society New Zealand was a world leader in the use of Twilight Sleep.

By 1951, 95% of all births happened in hospital. In 1969 the last of the midwife-run St Helen's hospitals were transferred to the control of Hospital Boards and thus maternity care came under the control of the medical profession not the

[13] A combination of analgesic and amnesia-inducing drugs once used to manage pain in labour.

government. Throughout the 1970s small maternity hospitals were closed down and in 1978 a member of the Auckland Postgraduate School of Obstetrics and Gynaecology was reported in the Auckland Star newspaper as saying that "Childbearing is not the normal physiological event with few problems many people assume ... all babies should be born in hospitals which had caesarean section facilities ...". (Donley, 1992:4). As women were steered into large, obstetrically run hospitals both GPs and midwives had less of a part in maternity care and having a baby became a medical event.

**Medicalisation**

As a colony, New Zealand followed Britain's medicalised approach to birth by institutionalising maternity care (Edwards 2005:70). As birth moved from the domain of home and family into the control of government and legislation, care was transformed from a personal concern to a medical responsibility bestowing increasing authority on the government and the profession of medicine. Whilst obstetric medicine in New Zealand was on the rise its roots were still firmly fixed in the institutions of Britain. Gordon (1955), one of the key figures in maternity care in New Zealand during this time, often refers, in her autobiography, to the relationship between medical institutions in New Zealand and those of Britain. Obstetric examinations and training were still conducted in England not New Zealand and the British Medical Association was swift to support its New Zealand branch in disputes with the government. The link is apparent in incidents such as that cited earlier when the Otago Medical School was negotiating with the New Zealand government over clinical training access at the St Helen's hospital in

Dunedin and called on the British Medical Association to add strength to their case.

Undoubtedly one of the greatest incentives encouraging women into hospital for childbirth was the promise of relief from pain and in this regard Twilight Sleep played a significant role in hospitalisation and the medicalisation of childbirth. The combination of morphine and scopolamine used in Twilight Sleep could produce extreme reactions in women and caring for them became nursing care, not midwifery. There are reports of women being slapped, gagged and strapped down whilst under the influence of Twilight Sleep (Davis-Floyd and Sargent 1997:10) and the role of midwives changed from being "with women" into supporting the administration of pharmaceutical pain relief and obstetric technology. Twilight Sleep further promoted medicalisation by emphasising the divide between midwives and doctors. In 1924 Gordon wrote a thesis promoting the use of twilight sleep because "a national recognition of the advantages of pain relief would place [...] obstetrics on a higher plane" in reference to the fact that only doctors could give this medication. In her book Gordon (1955:158) is frank about her intention to use her thesis for political purposes to advance her ideas for medicalised maternity care. With the availability of sedation women were attracted to hospitals in increasing numbers, a change that was promoted enthusiastically as being a superior option to staying at home with a midwife.

The transformation of birth from a social and family event into a medical procedure was fully realised when fears of puerperal sepsis saw women being

turned into aseptic, sterile fields during birth in the cause of avoiding infection. In the final stages of labour they were transferred to a sterile 'theatre', draped with sterile cloths, shaved of pubic hair, swabbed with antiseptic solution, then 'delivered' of their baby by a sterile, scrubbed, gloved, gowned and masked attendant. The baby was cleaned and dressed in sterile linens immediately after birth, before being given to the mother to hold. Mothers were not allowed up to use a toilet for several days after giving birth, instead being bed panned and swabbed under strict aseptic conditions every four hours to prevent uterine infection. These techniques were introduced formally in 1925 and continued with only occasional challenge through to the 1950s (Donley, 1998:44).

**Economics**

As hospitalisation for birth became established there was a three-tiered system of maternity hospitals in operation. Private hospitals for fee-paying clients were owned and managed by doctors; public hospitals providing free services were owned and administered by the government but run by Hospital Board committees composed primarily of doctors. The St Helen's hospitals, also offering free services to the public, were owned and administered by the government and managed by midwives. As the number of doctors increased so too did the number of small public maternity hospitals managed by Hospital Boards. Obstetric doctors (obstetricians) were employed by the public hospitals on an annual salary with additional fees payable for certain services, for example, performing a caesarean section. The level of remuneration was set by the Hospital Board. As well as their employment by public hospitals, obstetricians could take

on patients referred from private hospitals where they were free to negotiate their fee directly with their patient without this affecting their salary from the public hospital.

Obstetric medicine, as an emerging profession in New Zealand, needed to establish dominance over a specific territory and ensure an adequate income for its members (Starr 1982). The simplest route to this end, once medicalisation had brought women into hospitals to birth their babies, was to control the way fees were set and paid. These steps had seen the successful establishment of the medical profession in Britain and with the support of the British Medical Association they were replicated in New Zealand. Lock (cited in Beasley 1996:14) claims "Medicalisation has traditionally been depicted in the literature as a process in which the medical community attempts to create a 'market' for its services by redefining certain events, behaviours and problems as diseases". By 1951, 95% of women were going to hospital for the once-considered-normal event of giving birth, hospital management and medical fees were largely in the control of the medical profession, and thus, the maternity system had become fully medicalised. Lock (cited in Beasley 1996:14) also reminds us, however, that medical systems both reflect and uphold current social orders.

**Politics**

Medical systems are also driven by politics and even though the beginnings of medical birth lie in the move from home to hospital, that move resulted from pressure of political interests as much as considerations of safety for women and

babies. In 1904 falling birth rates amongst British New Zealanders and Australians were a concern for the successful establishment of these two new colonies. A Royal Commission of Enquiry recommended improvements in maternity facilities and registration of all births in order to increase population numbers (Donley 1998:33). The Prime Minister of the time, Richard Seddon, described as a "savage racist"[14] (O'Connor 2001:286), considered this population increase a necessity and his colonising sentiment was later echoed by Gordon. In 1924 she advocated twilight sleep to encourage women into increasing the size of their families because, amongst other reasons, "in the womb of British womanhood lies the Empire's progress and her strength" (Gordon 1955:158). Gordon was an astute politician and used the voice of national women's organisations to persuade their members to lobby government ministers for the changes she wanted to make. She described the technique as "petticoat government at its best and ... a system seldom known to have failed" (Gordon 1955:170). Gordon's passion to medicalise maternity care was a driving force in the New Zealand context.

As hospitalisation, medicalisation and economic forces steered the New Zealand maternity system into the second half of the twentieth century, and with increasing promotion of drugs and technology, the role of midwives became devalued as doctors and then obstetricians became the professional birth specialists and medicalised birth became the norm. In 1951 there was a move by birth

[14]O'Connor suggests this was aimed at increasing Asian immigration, not Maori whose numbers had fallen to approximately 10% by the end of the nineteenth century (King, 2003:258).

consumers to encourage women to adopt the new psychoprophylactic measures for managing the pain of labour and the Parents Centre organisation began to provide antenatal education to prepare for birth. Then, towards the end of the 1970s, the Home Birth consumer movement was established with branches throughout the country and a mutually supportive Domiciliary Midwives Society was formed. Eventually, after strong demands from women for changes to the way birth was practised, a College of Midwives (separate from nurses' organisations) was established in 1989. This was a major move away from the domination of medicalisation but was only the beginning of a long journey to come out from under the umbrella of medicine and nursing and establish midwifery as the domain of normal birth. In 1990, with the passing of the Amendment to the Nurses' Act, midwives won the right to practise autonomously, no longer requiring the supervision of a doctor. The long negotiations to reach that point owed their success to the powerful combination of midwives working alongside consumers of their services. Over the next decade GPs moved out of maternity care in large numbers as midwives established independent practices and the fees for services decreased. Now more than 75% of women choose a midwife as their LMC (NZ College of Midwives, 2008).

**A Maori Context**

Developments in New Zealand's maternity care undoubtedly affected Maori but the impact of colonisation was also rapidly changing traditional practices and social structures. Before the influx of Europeans in large numbers Maori birth was considered to have low rates of mortality and morbidity, as reported by

missionaries and historians of the time (Donley 1998:126). With the loss of land undermining Maori economic, spiritual and social structures and the introduction of smoking, alcohol, sexually transmitted and other infections as an inevitable part of the colonisation process this situation worsened (Banks 2000:54). Early in the twentieth century there were health initiatives undertaken for Maori by Maori, for example, Te Puea Herangi, Sir Peter Buck and Maui Pomare were three who, separately, attempted to combine medical and traditional Maori ways of healing. By the 1930s, however, government changes to health policies ended their work and left Maori without culturally relevant services. In 1936 Maori maternal mortality was twice that of European women and the infant death rate nearly four times as high as European infants (Lambie 1956:91, Durie 1998:46). The establishment of the Maori Women's Welfare League in 1937 restored a 'by Maori for Maori' health initiative and this time it was run by women with an emphasis on providing care for women and children (Durie 1998:46). The availability of free maternity care in 1938 encouraged more Maori to birth in hospitals which, up until 1932, had not been legally obliged to provide maternity services for them (Banks 2000:63). It seemed that these measures would see improvements in Maori health standards, however, this was not to be the case.

Urbanisation of Maori, moving away from tribal land and the supportive structures of family and traditional customs into the cities in search of work, began as a trickle during the Second World War, increasing in the 1950s. Being separated from support and expertise in traditional ways of birth contributed to the drift into hospitals and by the 1960s most Maori births (95%) were in

hospitals (Donley 1998:128). Despite this, the maternal mortality rate during the 1960s was still approximately three times higher than for non-Maori (Donley 1998:128). In 1975 Whina Cooper led a march from Northland to Parliament to petition the government to stop alienation of Maori land which received unprecedented support from Maori and non-Maori. In the same year the Treaty of Waitangi Act was passed which would provide a means to enforce legal implementation of the terms of the Treaty originally signed between Maori and the British Queen Victoria in 1840. Urban Maori began to return to family land, learning the Maori language, and the protocols and skills of traditional customs, for example oratory, traditional art forms and marae protocol as well as reactivating community support for events such as birth.

## CONCLUSION

The change from birth as natural to the current medical model was shaped by many external forces; colonisation, medicalisation, economics, advances in pharmaceutical drugs and technological solutions to difficult situations. Safe and painless childbirth is proclaimed as the goal of the obstetrically inclined who engineered the movement of birth into a medical and then technological event. The belief that nature can be improved upon underlies that goal and has led to the development of machines and tools which initiate, monitor, augment and control labour and birth. The female body has been viewed as a collection of parts and systems to be streamlined and controlled (Martin 1987). With increasingly sophisticated and invasive procedures it is now possible to conceive in a laboratory, have pain-free labour due to epidural anaesthesia, a labour-free birth

via caesarean section and feed babies with a substitute milk. Technology has fuelled an enormous change in the way babies are born, from New Zealand's first successful caesarean section operation in 1889 (Donley 1998:54) through to 2008 when almost a quarter of all babies are born this way (Ministry of Health 2007), but has technology brought the improvements it promised? Against the backdrop of birthing history provided in this chapter, three contemporary models of birth practice will be examined in the following chapters.

# CHAPTER FOUR

## THE MEDICAL MODEL OF BIRTH

### A BIRTH STORY – Libby and Jeff

There we were, forty-one weeks pregnant and still no baby. Two earlier scans during pregnancy said everything was okay but 'they' suggested we check how baby was and think about being induced[15] because I was past the due date originally calculated by me and the one they had measured by ultrasound scan. The baby was a normal size, not too small, not too big, moving a lot and in a good position as far as we knew. I felt fine and Jeff (hubby) was not worried, we were sure she would come when she was ready. However, just to keep everyone happy, we wandered (well, I waddled!) up to the outpatient day clinic at the hospital. The assessment was done by hooking me up to a machine that prints out a reading of baby's heart rate; it records any contractions at the same time and I pressed a button every time baby kicked so that was recorded on the same print out. They also took my blood pressure and did another ultrasound scan to measure the amount of fluid around the baby.

[15] Induction of labour begins with the insertion of a hormone in gel form which is applied to the cervix; if this does not initiate labour the next step is to rupture the bag of membranes containing the baby and this can be followed by the use of an intravenous drip containing synthetic hormone to stimulate contractions of the uterus. All, or just one, of these procedures may be used to begin labour and can be used to augment it if progress is "not fast enough".

I guess that was the end of my laid back pregnancy really because suddenly, it seemed sudden to me anyway, things started to speed up. Baby was alright but they thought she was getting quite big and that we shouldn't wait too much longer. It was Thursday then so they booked me in for an induction the following Tuesday if I didn't start labour by myself in the meantime. When my midwife visited the next day we talked about self help things to try (basically the "hot curries, hot baths and hot sex" routine) or complementary therapies like acupuncture and homoeopathy. She said she would visit me again on Monday morning when she would do "a sweep"[16]. In the end she had to do the sweep but luckily for me my labour started later that night so I missed the induction – I've heard they can be a bit awful sometimes so I was pleased about that.

Labour wasn't too bad actually. We stayed at home for quite a while but by about five o'clock in the morning I couldn't wait any longer so we called the midwife and she told us to come up to the hospital then. When we got there I wanted to just keep walking around but she said she had to monitor baby's heart rate and that she would like a print out of it so I had to have the two belts round my middle and stay attached to the machine. At least I could sit on a swiss ball and didn't have to lie on the bed which was really uncomfortable to do. After that the midwife just checked baby's heart beat every now and again with the sonic aid, the one they use during

[16] During an internal (vaginal) examination a finger is passed around the cervix, stretching it and releasing the hormone prostaglandin which can help to trigger the start of labour. This is sometimes called stripping the membranes as it separates them slightly from the cervix. (Bennett & Brown1999:494).

antenatal visits. It was a bit of a nuisance sometimes, changing my position or having to stand still during a contraction, but apparently the rules say they have to do it at certain times. Later on they used that one that goes inside you, the one they attach to the baby's scalp, because she kept moving and they couldn't get a good print out. But that was after I had the epidural. Oh, yes and I had a few of those internal exams too, again apparently they have to do them according to their contract. They were really painful because I had to lie on my back and I hated it when a strange doctor came in once and did one - before I got the epidural I think or maybe later, I can't quite remember.

The good thing up there was the gas[17]. It helped through the internals as well and I could take the portable one into the bath with me. That was great, in the bath, nice and peaceful, just me and Jeff and nobody else came in. I wanted to stay in there all the time, I would have had the baby in there if I could but it didn't work out that way in the end. When I got in it just took all the pain away for a while and gave me a break which was just great.

In the end though I had to get out of the bath because things slowed down and even though they made me walk around and try different positions they said things

[17] The gas is Entonox, a mix of nitrous oxide and oxygen which is inhaled through a mask or sucked in through a mouthpiece. Other chemical forms of pain relief include pethidine or fentanyl, opioid analgesics which have a muscle relaxant effect; and epidural anaesthesia, where a local anaesthetic is injected into the dural space around the spine to numb the nerves. Fentanyl is often used now rather than pethidine which has a depressant effect on the baby's respiratory system.

just weren't going fast enough so they suggested breaking my waters. I wish someone had said how much it would hurt after that. I know the contractions got stronger but it still wasn't good enough so then they gave me that IV drip of hormone[18] to speed things up. Well, that really did the trick and we were all on after that, I got Jeff to call my Mum then as well because we were pretty shattered by then. We'd been up half the night and, quite frankly, I was feeling fed-up about how it was all going. I think I was getting a bit down and when they said the drip would make things even stronger and would I like an epidural I just said yes. I was scared of the needle in my spine and I'd always said I wouldn't have that, but there didn't seem to be much choice by then and I didn't know how much longer it was going to take or how much harder it might get. I was just exhausted and everything feels scarier then, I think. Anyway, the anaesthetist was lovely and told me all the side effects (not so lovely!) and seemed to be pretty good at his job. I have to say it was nice when the pain stopped. It did take a little while for the epidural to get going and at first I was a bit worried when I couldn't feel my legs (that was weird!) but I actually managed to have a bit of a sleep which was good. What I hadn't realised was that after the epidural I needed to be hooked up to so many things – an automatic blood pressure machine on my arm kept blowing up by itself, the epidural stuff was being fed in through a tube like an IV, only into my back. They were also giving me that syntocinon and IV fluids and (worst of all!!!) I had to have a catheter because I couldn't get up to go to the toilet. At least they put that in

[18] Syntocinon - a synthetic form of the naturally produced hormone oxytocin, which is given intravenously as a continuous infusion with the rate able to be adjusted as needed.

after the epidural so I didn't feel it! (I was a bit worried about how it would be when they took it out though.)

I had wanted to be upright as much as possible during my labour and thought I would kneel when the baby came out. All that went out the window though at the same time the epidural came in. When I was ready to push they whipped these stirrup things out that had been folded away, out of sight under the bed, for my legs to rest on. So there I was in all my glory, on my back, legs in the air and then they asked if I wanted a mirror so I could see what was happening!! It's true what they say though, you're over it by then, just want to get on with it and hold your baby. And the good thing was that the epidural wore off a bit so I had some feeling and I could push when I had contractions. That was hard though, lying on my back like that, it was really hard work. It wasn't the lovely image I had in my head beforehand either but it was quite exciting at the end. Thank goodness I managed to do it by myself, they were getting worried and had just called for one of the doctors. I think that must have given me a hurry-up, I didn't want some stranger poking around down there and I didn't want any of those cuts[19] or any of that forceps or ventouse[20] stuff to pull my baby out either. I just concentrated really hard and pushed and pushed and she came out by herself. I did tear a bit though and had to have stitches.

[19] Episiotomy – a cut to enlarge the vaginal opening.
[20] Ventouse – a cup which is attached to the foetal scalp by suction.

It was a bit hard to cuddle my baby straight away because I couldn't move very easily and still had those little needles into my veins even though they took out the drips and things. She was pretty sleepy and not too interested in feeding or anything for a while, but she was lovely - and still is. I hardly even noticed the placenta coming out. They said they gave me an injection to help it come quickly and I remember they cut the cord as soon as she was out; Jeff didn't want to do it so my Mum had to. I do remember them giving me an all over wash before I went up to the postnatal ward though. That was funny, having someone wash all your private bits and it didn't really feel clean, not like having a shower. I couldn't walk though from the epidural so it was the next day before I got to have one. Still, I've got my baby now and that's just what you have to do to get a baby. I'm alright...

## DISCUSSION

Medicalised birth is well documented generally and much of the discussion relating to the development of this model has been covered already in Chapter Three of this research. Therefore this analysis will focus on four specific aspects (authoritative knowledge, pathologising the normal, language, and loss of self) which reinforce the medical paradigm. Arguments for and against medicalised birth practices and an analysis of the development of New Zealand's maternity system are, likewise, well covered in the Literature Review in Chapter Three.

## AUTHORITATIVE KNOWLEDGE

In this birth story we hear the authoritative voice of scientific medicine. It is, in the scheme of things, a low-tech birth but what stands out is the extent to which

Libby's role as decision-maker is overridden by the assumptions of the dominant medical/technological perspective. Libby's bodily and intuitive knowledge that everything is alright is invalidated by the mechanistic argument that she is past the due date that the system considers normal. Later, although her labour is progressing and she is happy to continue in the bath, again the system decrees she is not labouring fast enough and intervenes to speed things up. In the end, Libby puts aside her hopes for the birth she wants and passively submits to the power of the medical hierarchy. It is salient to remember, as Brigitte Jordan tells us, that "The power of authoritative knowledge is not that it is correct but that it counts" (1997:58).

## PATHOLOGISING THE NORMAL

From the moment a woman learns she is pregnant she is inundated with information on how to care for herself, special precautions she must take and what to expect as her pregnancy progresses. A favourite tool for pregnancy is one of the many websites that email a weekly update of what pregnancy signs and symptoms to expect next. There is a proliferation of written information available, from the packs of free samples and discount vouchers given at confirmation of pregnancy to the health warnings on labels of products as innocuous as fruit teas. It is generally aligned with government health edicts and is, therefore, effectively a public health campaign socialising women into compliance with the medicalisation of their pregnancies and their bodies. As women learn to validate themselves in terms of the information they acquire from external sources rather than prioritising embodied and intuitive information, the

authoritative knowledge of pregnancy and birth gains ascendancy and becomes increasingly difficult to challenge. As Libby's story illustrates, even though she felt well or did not want to comply with treatments such as monitoring when past her due date or the type of monitoring expected when she first arrived in the hospital, women are fully socialised into accepting the abnormal as normal by the time they reach the point of giving birth.

## LANGUAGE

The language of obstetrics works to create a hierarchical division between the obstetric expert and the mother. Libby's story was told in the first person and using women's language, however, in obstetric jargon she may have found that her labour was being "augmented" rather than speeded up with IV hormones or that she experienced "ARM" (artificial rupture of membranes) instead of having her waters broken. Some of this jargon has become commonplace in lay-language these days, words such as "induction", "sonic aid", :epidural" and even "forceps" and "ventouse" are understood by most mothers. Familiarity creates the illusion that the procedures these words describe have also become part of women's lives. It is one thing to understand the term, quite another to understand the full ramifications of its use in practice.

## LOSS OF SELF

One effect of the process described so far is that expertise and authority become vested in external sources so that a woman may lose confidence in her own knowledge. She is told, or taught, how she will feel, should feel, and what she

should and should not do according to rules and guidelines constructed by health officials, maternity carers, magazines, television, websites and the media. In an environment where it becomes normal to defer to expert opinion a woman may be criticised and considered unreasonable if she chooses to follow her own judgements. If she has not retained a strong sense of her own agency throughout pregnancy but, instead, has learned to depend on the expertise of others, it can be difficult to cope with the multiplicity of decisions that are required during birth and afterwards when caring for a baby. By contrast, the story of Natural Birth in the next chapter describes a process which adds to the confidence and strength of new parents.

# CHAPTER FIVE

## THE NATURAL MODEL OF BIRTH

### A NATURAL BIRTH STORY – Suzy and Dan

*Before "Labour" Day:*

When Suzy first said she wanted to have this baby at home, I have to admit I was quite alarmed. I thought it was just pregnancy hormones actually, thought she'd get over it but – no. She did lots of investigation, found a home birth midwife and answered all my objections so in the end I had to agree. We kept it quiet from both our parents though, till quite late on too – we didn't want them badgering us and trying to change our minds. In the end they were very good, just said they weren't comfortable but it was our choice.

I was worried about safety but the midwives (two of them come out) carry all sorts of emergency equipment and when they explained how long it can take to get a specialist or an anaesthetist sometimes even if you're already in hospital it didn't seem such an issue. After all we're only ten or fifteen minutes away from the hospital ourselves. I didn't like to admit it at first, but I was also a bit concerned about the mess, wasn't there likely to be blood and stuff around? Suz had requested a birth pool and I imagined water leaking onto the carpet but she had the answer to those worries too, the midwives supply a bag of waterproof covers and sheets and

towels that they take away with them afterwards. We went to the local Home Birth Association information evening and found out all about using the pool and met up with others who were planning home births and water births as well which was quite amazing actually. That made me feel more settled and I realised that we were quite normal after all.

*"Labour" Day, 9am:*

Anyway, it's THE DAY now and I'd better stop fiddling with the pool and see how Suz is doing. Things are just going along steadily, contractions have been coming since about three o'clock this morning. We were both so excited that we couldn't go back to sleep so we had some breakfast and took the dog for a walk down by the river just as the sun was coming up. Suzy's sister Melanie is here now which is a good idea, it's freed me up to put the pool together and get all that working. My instructions are not to fill it yet though. The fridge and pantry are well stocked, good old Suz, she made sure there was plenty of nibbles for today and even stashed some extra meals in the freezer for the next couple of weeks. She has a box full of "Things To Be Used During Labour" in the pool room (massage oil, hot water bottle, wheat packs, rescue remedy and so on) so we're all organised.

*"Labour" Day, 12.30pm:*

Well, it's getting a bit intense now and Suzy's not as chatty as she was. She's been doing a lot of walking around inside and in the garden. Melanie and I are taking turns to wander around with her, trailing water bottle and snacks and trying to keep

an eye on timing contractions as well. It's surprisingly busy and the time is flying by, already its lunchtime. Suzy seems to find it comfortable in the kitchen, leaning over the bench when she has a contraction, I think it's the cool surfaces. I'm doing alright at back rubs too, no complaints so far anyway. I've been sent out to make lunch, probably just for me and Melanie I should think, and I might just get the pool started and partially fill it. It looks to me as though Suz might want to use it soon because those contractions are starting to get very strong now. Wonder when the midwife is coming? She rang a couple of hours ago and said she'd call in after lunch. Uh-oh, sounds like that was a painful one, better go and check up on Suzy, see if she's alright.

*"Labour" Day, 1.30pm:*

Well, it's all stepped up now, we won't get that lunch I don't think. When I came in to check on Suz she wouldn't let me go again so Melanie has taken over all the running around. I'm happy to stay with Suz because it's definitely hard work now. I feel pretty useless though but she doesn't want anything, just to hold my hand. The midwife arrived just before. She came to see how Suz was doing. She just watched her for a while, had a little chat in between contractions and said how well she was doing then went off to set out all her equipment - medical supplies, foetal heart monitor, blood pressure monitor, intravenous equipment, syringes and needles, suturing materials, special instruments, a portable oxygen supply, drugs for emergency situations – it all looks very business-like and reassuring to me.

It feels really nice now the midwife has arrived, she seems somewhere between a visitor and the builder, not like she's come to take over or be in charge. I mean, it gives me the feeling that the team is complete so we can get on with the job and at the same time it feels like a friend has arrived. Just before she came I was wondering how people manage to get to the hospital and how they know when it's the right time to go but once she arrived I just relaxed. She suggested that it was time to use the pool so we all moved to that room and now things have got serious, the atmosphere is calm and quiet, focussed I suppose you would say. Mel is fetching and carrying drinks, ice, nibbles and anything else we need; she put a note on the front door in case anyone called and turned the phone off. The midwife just listens to the baby's heart every now and again, tells Suz how well she's doing, watches and waits and writes notes in her book. I mostly hold Suzy's hand, offer her drinks, wipe her face with icy cold flannels and admire her stamina and patience. Suzy moans a bit during contractions and we both do lots of deep breathing together, then she seems to almost doze off in between. It's like we've stepped out of the world and are in a little private bubble.

*"Labour" Day, 4.30pm:*

I didn't even notice that the second midwife had been called but she's just appeared now at the same time as Suzy is starting to feel the baby coming down. Gosh, suddenly everything is getting energetic and exciting. I'm not sure about this bit, it's taking an awfully long time but the midwives look like everything's okay. Oh, the baby's coming, oh my gosh, there he is, it's a boy! Wow, Suzy's looking

stunned, the baby's crying and so am I. Oh, so is Mel and she's trying to take some photos at the same time. I bet they'll be all blurry!

*"Labour" Day, 8pm:*

Well, the midwives have just left and it's time for me to catch my breath, get to grips with what has happened. The last few hours flashed by, the midwives were keeping an eye on the baby and on Suzy. They sorted out the placenta and put it in the container we had ready, helped our little Samuel have his first breastfeed, checked that Suzy was okay and, when she was ready to get out of the pool, they helped her get changed and showered while I held my wee son. By the time they left we'd all had a celebratory glass of bubbly and something to eat, Suzy and Samuel were tucked up in bed, all the used towels and sheets were in the midwife's car to go back to the hospital laundry and the house was spic and span. I almost can't believe what has happened here today, Suzy said she feels like she can take on anything now and I'm just blown away. It seems like the most miraculous and at the same time the most ordinary thing in the world has just happened here.

## INTUITIVE AND EMBODIED KNOWLEDGE

"Suzy" and "Dan's" story, although it describes a home birth, raises issues which are common to any parents who plan to avoid medical interventions and drugs in labour and which propel them to engage with the dichotomy of the medical and the natural paradigms of birth care. The supremacy of current authoritative knowledge about birth is challenged when parents educate themselves and

research alternative ways to give birth (Davis-Floyd, 1996:127). My observation is that parents who choose to birth naturally develop, validate and trust their own intuitive knowledge (Davis-Floyd 1996:146), and see bodily changes as part of an integrated confirmation of the positive changes taking place as their baby grows. Browner and Press (1997:113) describe this embodied knowledge as "subjective knowledge derived from a woman's perceptions of her body and its natural processes...".

## SAFETY

The dominant ideology of birth in our society is that it is inherently risky. Against this climate of risk, intervention and technology, parents who choose to birth naturally present a challenge to authoritative knowledge. For them, the method of ensuring safety is to avoid technology and keep birth normal by keeping control of the birth process in their own hands as much as possible. When birth is seen as a medical event the consequent emphasis on potential problems can lead to an exaggerated concern about complications and an assumption that if a problem arises the only solution is to use medical technology (Henley-Einion, 2003:175).

The debate over safety is slanted towards positivist ways of thinking, using a perspective that separates women's bodies from the rest of their life and even sees a woman as being separate from her unborn baby (Davis-Floyd 1996:147). This thinking denies the strength of the woman-baby dyad, and undermines the validity of messages women receive from their bodies and their intuition (Davis-Floyd, 1996:146). In my experience, when a woman thus loses confidence in her "inner

knowing" (Davis-Floyd, 1996:154) she has little recourse but to accept medicalised help. Another possible consequence, if mother and baby are viewed as separate entities, is that decisions may be made only in terms of their meaning for the maintenance of the pregnancy whereas the baby's long-term safety is dependent on the viability of the whole family unit.

## SELF EFFICACY AND CONFIDENCE

The paternalism of the present maternity system, where the LMC or specialist is the expert and parents' knowledge is undervalued is not conducive to building the confidence in their own abilities that is such an important trait for new parents. If this, in itself, is not sufficient reason to challenge the system it is often the case that those parents who truly make their own decisions are more relaxed and confident about the birth process and the transition to parenting. This seems particularly so with parents planning to birth at home and it seems likely that the process of questioning and researching options for oneself creates a sense of greater self-efficacy. An associated and positive effect of parents being more self-reliant and holding more responsibility for what happens in labour is that they are less likely to blame others if the outcome is not as they expected.

## HOME BIRTH

At home is where birth is most likely to remain natural, especially in New Zealand where home birth midwives do not carry any drugs for pain relief. There are many different reasons for choosing to birth at home ranging from religious and philosophical principles through to phobias or dislike for hospitals, needles, or

other aspects of medicalised care. For some it is chosen because being in one's own home immediately shifts the balance of power to a more equal partnership between LMC and birthing family where responsibility is more likely to be shared.

As women sought to reclaim knowledge and power about birth that had been held by medical experts, some chose to forgo hospitals altogether and by the late 1970s the home birth movement was establishing itself throughout the country with local associations forming in the Manawatu, Nelson, Christchurch and Auckland and characterised by strong partnerships between women and midwives (Donley, 1992). By a happy accident domiciliary midwives (those who practised home birth) had remained under the auspices of the government so that their wages and conditions of contract were with the Ministry of Health and not under the jurisdiction of local Hospital Boards (Donley, 1989). This meant their mode of practice was not controlled by the medicalised Hospital Boards.

## CONCLUSION

A maternity service that respects and values input from its users and supports women to be involved and take responsibility for their birth experience makes sense in terms of personal health, public health and economic considerations. The first two principles of the Health Promotion Forum of New Zealand (2008) are that "health promotion works with people not on them" and that it "starts and ends with the local community". The structures are there in the New Zealand maternity system to enable women to opt for natural birth but it is often another matter entirely for women to know that and to find those structures.

# CHAPTER SIX

## A MAORI MODEL OF BIRTH

### A MAORI BIRTH STORY - Kara

Kara waits for her baby to be born. The contractions, which have been coming and going since the previous evening, will not let her lie still or sleep, instead they drive her to get up for some relief. Her partner, Willie, hardly stirs as she leaves the room and wanders through the sleeping house to the kitchen. The door of the spare bedroom is ajar and as she passes she looks in on her mother, still sleeping soundly. Her mother has been here for a couple of weeks, helping out with the older children, giving Kara a break and making sure everything is prepared for the new arrival; she does this for all her children. This morning Kara's father and two sisters will arrive and Willie's family, who live just five minutes away, will be around when needed. It is comforting to have their support but for the moment she is pleased to have time alone. As she potters about, tidying and straightening here and there, she remembers her first birth, five years ago, with her grandmother as the unofficial midwife. Nanny Rose had been helping women to give birth all her life and knew lots of tips and tricks to help babies out. She was pretty good with the rongoa (plant medicines) and mirimiri (massage) too but nanny was no longer with them, she had died not long after that birth and before the next one. Kara

knew she was lucky for the things Nanny had taught her at that time and looked forward to sharing them with her little sisters when their turn came.

Outside now, pacing the length of the garden she feels the solidness of the ground beneath her feet and thinks of the generations of women who have done this before her. She draws strength from the thought of her ancestors, especially her Nanny Rose, feeling their love and support rise up through her feet and legs from the land that her people revere as the original ancestral mother to them all – their beloved Papatuanuku. She gathers her dressing gown closer around her for comfort as a contraction bites sharply and she walks determinedly, concentrating on the rising wave of sensation from inside her, breathing deeply so she will not be overwhelmed. Glancing across to the house she sees that her mother is standing at the back door and is watching her intently. She knows that her mother is assessing her behaviour, looking for signs to reassure her that this labour is progressing normally or alert her to any potential problems. Nanny Rose helped her mother birth six children and taught her a lot too. It seems her mother is satisfied because she makes no movement, remaining calmly on the deck. Kara sees her lips are moving and knows she is saying karakia, calling their ancestors and gods to be near them for guidance and support. The thought strengthens her as another contraction begins. She knows that her peaceful time is over and that now she must get on with the work ahead.

As the household comes awake the atmosphere changes, her labour becomes more intense and Kara retreats to the sleepout where everything is set up for this day. She needs a quiet space where she can immerse herself in the internal rhythms of her body and focus on her labour. The midwife has been and given her approval of the way things are going, she will come back in two hours or they can phone if they need her before then. In the distance she can hear the children and the rest of her family in the house but she is happy with just her mother, Willie and her sisters helping her as she rocks and sways through the contractions. Sometimes they gently sing or chant and the soft cadence lulls her into a trance-like state that quietens any panic and reassures her that all is well. She leans on her husband or is supported on each side by one of her helpers when the fierce cramping happens in her belly; at other times she drops to her knees, taking advantage of the labour hormones that help her rest in between contractions and leaning over the cushions which are piled up for this purpose.

Sometime after the midwife returns (Kara has lost track of time by now) she feels the urge to bear down. Her mother shows one of Kara's sisters how to sit in front of her on the floor with legs drawn up, knees to her chin – like the old people used to do. Kara kneels in front of her and, as the urge comes, she presses the top of her abdomen against her sister's knees to add to the downward pressure as her baby is brought through the birth canal ready to be born. As if far away in the background she hears the soft karakia (chanting-praying) of Willie and the others as finally, after what seems a long time, her child is born and passed to her, red and wrinkled,

another son. The umbilical cord is tied with a muka string[21] after it stops pulsing and then cut with a mussel shell specially sharpened for the task, then the baby is wrapped and Willie takes him to the rest of the family who are waiting impatiently to meet him. As the women wait for the placenta to come, Kara's mother massages her daughter's abdomen vigorously setting off a new wave of contractions and when Kara squats over her birthing mat again she feels the placenta slide out easily. With a sigh of relief she leans back and relaxes. The placenta is placed into the specially made clay pot and put away safely till they can return it to their family land, more karakia are being said over the new baby, the sleepout is tidied and Kara helped to wash and freshen up. More of the family have arrived to share the good news and it is time for mother and baby to be nurtured and celebrated as they all move inside where a special birthday meal is waiting for them.

## SHARED KNOWLEDGE

This third birth story describes a different approach to birth that integrates family and traditional customs with the benefits of modern medical resources. Kara is willing to combine the knowledge of her grandmother, her mother, her midwife and her family with her own intuitive and embodied knowledge, and she puts all these together to use in birthing her baby. Even though this model is available in New Zealand it is not commonly encountered

[21] Muka, the inner fibre of the flax plant used for weaving and as string.

## INTERCONNECTEDNESS OR HOLISM

In the preceding story we see birth as an everyday event within the context of family life. Implicit to the sense of normalcy is the assumption that giving birth is a social act and not a medical event. In the past it would have been usual for a traditional healer to be available and such a person would also have been a member of the extended family, someone from within the same community. Durie (1998:69) conceived the model of the "whare tapa wha"[22] to describe the Maori model of health, a state in which spirituality, physicality, thoughts and feelings, and extended family each exist separately and in relationship with each other. To be healthy all four aspects need to be present in a person, to be functioning well and to be in balance with each other.

This birth story features all of the elements from the whare tapa wha model and shows how traditional Maori ways of birthing can be interwoven with current medical practice. In this story it is the birth family's culture which predominates and the extent of medicalisation is constrained and simultaneously contained by the presence of family members providing a protective barrier against intrusion. In this model birth occurs in the centre of the family, spirituality is integral and everything is underscored by a belief in the value of balance through all aspects of life. Constructing birth in this way provides a model for humanising and reconstituting it as a part of normal life.

[22] Whare Tapa Wha – literally "house of four sides"

## GENEALOGY AND THE EXTENDED FAMILY

Traditionally, being able to trace one's descent was key to a strong sense of identity and all Maori learned to recite their *whakapapa* (genealogy) at least as far back as those ancestors, or *tupuna*, who were among the first to arrive in New Zealand. Maori believed that after death people travelled to the world of spirit, continuing, as *tupuna*, to have a connection to the living through the medium of *karakia* or sometimes visions and dreams received by special people. The term *matakite* refers to someone who is clairvoyant or clairaudient or in other ways has an ability to communicate with those who have died. For Maori there is a symbolic thread stretching from *tupuna*, through the present and on into the future. This thread is realised physically in the birth of each new child who will continue family lines so that the strength and spirit of past generations will continue to exist. Genealogy interlaces with spirituality in the belief that at the moment of birth the spirit of a *tupuna* enters the body of the child and this is another way in which the ancestral line is continued.

The extent to which birth is central to family relations and social life is exemplified by terminology used in relation to pregnancy and birth. *Hapu*, meaning pregnant, is also the word for the smallest family unit, the sub-tribe, an extended family of aunts, uncles, parents, cousins and siblings. It is not too large a leap to interpret this usage as meaning that a pregnant woman is the extended family and in fact, this is axiomatic because without women and pregnancy the *hapu* does not continue. Similarly, a woman's pelvic region or reproductive anatomy is referred to as the *whare tangata*, literally "the house of the people". Growing new life is so

important that the term *whare tangata* is applied to pregnant women generally (Wepa & Te Huia 2006; Rimene, Hassan and Broughton 1998). In another example, the verb for "to birth" is *whakawhanau*, where *whaka* can be interpreted as "to make" and *whanau* is another word for extended family. These dual usages of words for family and for pregnancy indicate the interconnectedness and the significance that is ascribed to birth in the maintenance of the physical and spiritual life of Maori society.

The term *whare tangata* denoted a respect for the ability to carry and birth a child manifested in the requirement that a woman be nurtured and treated with care throughout pregnancy. Traditionally pregnant woman were fed whatever they requested and were protected from frightening or stressful situations in order to protect the baby. At the time of giving birth a woman was attended by family unless she was "of high rank" or there were exceptional circumstances. In such cases a *tohunga*, a healer skilled in *karakia* and the use of medicines, would be present as well (Makereti 1986:112). Everything possible was done to ensure the health and vitality of the child.

## SPIRITUALITY

It is common for Maori to be characterised as spiritual and cultural and for Pakeha[23] to be seen as having no unifying cultural or spiritual traditions. The perception of Pakeha culture as being non-spiritual is expressed in medicalised birth environments where spiritual concerns are easily overlooked or ranked as

[23] Pakeha –New Zealander of European descent .

having a lesser value than medically construed needs. For example chants or prayers, do not occur within the biomedical range of birth practices and, though they may be accommodated whilst birth is going well, if complications arise they will be considered as "optional extras". This imposition of the dominant Pakeha value system at a critical time ignores the fundamental role played by other traditions of healing such as rongoa[24] or karakia[25] for example.

In common with many indigenous peoples Maori consider their relationship with the land they live on to be a spiritual one. In the creation myths *Papatuanuku* was the first mother, from whom all living beings issued. She and *Ranginui*, the father of her children, were thrust apart by their children who felt the need for light and space. *Papatuanuku* became the earth and the earth mother, nurturing and providing a home for her children. Ancestral or tribal land creates and maintains kinship links through involvement in what happens to the land, whether that is working it for subsistence or producing goods to sell, providing a home for some members of the *hapu*, or simply being involved in decision-making. More importantly, the land provides a tribal identity and a sense of belonging to a family group which was, traditionally, at the core of Maori values (Durie 1998:35). In terms of birth, just as the land connects a person to the earth mother *papatuanuku* who nourishes them with food and a place to call home, so too does a placenta have the role of connecting an unborn baby to its mother so that her body can provide nutrition. Both processes enable a person to grow into independent life

[24] Rongoa is traditional Maori medicine often made from native plants.
[25] Karakia are chants, prayers, communications with the spiritual or divine.

and are reflected in the dual use of the word *whenua,* for both land and placenta. The placenta is returned to the land after birth as part of the stewardship role that Maori have towards land where the concept of permanent ownership does not traditionally exist.

An important role within traditional communities which has been all but lost to modern Maori society is that of the traditional healer, the *tohunga.* During birth the *tohunga* knew which *karakia* to use, knew the ancestry and history of all those involved and was aware of any possible complications from past grievances, misconduct or family upsets and so forth. As healers they had vast knowledge of traditional plant medicines and other cures. The passing of the Tohunga suppression Act in 1907 contravenes Article 4 of the Treaty of Waitangi, signed between Britain and Maori, which guaranteed Maori the freedom to practise their religion. The consequent outlawing of experts in traditional healing practices contributed to a loss of much specialised knowledge and a decline in health standards amongst Maori. This decline, stemming from a loss of spiritual and cultural values and identity, illustrates how fundamentally health care is connected to social life.

## RECIPROCITY AND BALANCE

The importance to Maori of maintaining the health of the whole community is expressed in the value placed on collective wellbeing, which is elevated in importance above that of the individual. The interdependence between Maori and their environment required reciprocal protection for both and a natural system of

values evolved that provided restrictions and became a form of public health care. Primarily it was the philosophical concepts of *tapu* and *noa* that ensured a safe balance was kept by providing rules for protecting both the people and the environment under specific circumstances. A wide range of meaning has been ascribed to the state of *tapu*, from sacred to spiritual, privileged, religious or superstitious, however, at its simplest it describes a situation, place or thing which is out of bounds for the wellbeing of all concerned either temporarily or permanently. There was usually ritualistic behaviour around the setting or lifting of a *tapu* and breaking of the prohibition was deemed to result in undesirable consequences (Durie 1998:7&8). The coupling of the concepts of *tapu* and *noa* suggests their equal and co-existent nature rather than a hierarchical relationship where one is valued over the other. Together they contributed to safeguarding Maori communities in a balance that shifted from one to the other as circumstances required.

In a context where every new life strengthened the community and was vital for its continuance, birth processes were closely protected against danger or harm for mother and baby. Near the end of pregnancy a temporary shelter was constructed and a woman and her attendants would remain there, in a *tapu* state until several days after the birth. Not all women had shelter, for some it was simply a move to a space outside their usual living place, but it was always a place separated from the daily life of the rest of the *hapu*. None of the people involved in the birth would return to their homes or be involved in preparation and cooking of food during this time. Food is used to remove the *tapu* state and so it was prepared by others

and left at an intermediate place where one of the attendants would collect it and bring it to the expectant mother and her helpers (Best 1929, Heuer 1972, Makereti 1986).

The creation myths of Maori society portray a structure where interdependence between female and male figures was instrumental to the development and survival of the people. There is a strong theme of a feminine life-giving and life-nurturing force balanced against the active, masculine elements in a relationship where one complements the other and power is shared (Mikaere 1995, Royal 2008). The complementary relationship that existed between men and women where roles were defined differently but the value of each was respected and equal (Hinewirangi & Hibbs 2006, Mikaere 1995) was vital for survival and brought an ethos of cooperation to the endeavour of birth. Although birth was mainly the work of women it was also common for the baby's father to be present and sometimes, in second and subsequent births, he would be the primary, or only, attendant.

At the present time, Maori women continue to be over-represented in the highest deprivation scales according to the criteria of the 2001 census. Maori mothers are younger and Maori birth rates are higher per capita than the national average (Ministry of Health 2007:13). Being over-represented in the NZ Index of Deprivation, Maori women are more likely to present with health challenges such as diabetes, obesity or poor nutrition and social issues such as poor housing, poverty or unemployment. These situations may lead to them being designated as

high-risk which increases their chance of technological interventions during their labours. However, contradicting this expectation, Maori mothers have fewer medical technologies used during labour; have the lowest rate of interventions in labour; and have fewer inductions of labour than any other ethnic group (Ministry of Health 2007). It would seem that investigation into this anomalous situation could provide important clues to slowing the increasing use of technology in labour and birth.

## CONCLUSION

The striking difference between today's birth culture and that of traditional Maori custom is captured in the degree of social connectedness that does or does not occur. In the past it was there throughout life, giving meaning and purpose to everyday events. In the context of the collective nature of Maori society and the importance of reproduction to ongoing survival of the *hapu* birth was protected and nurtured and endowed with value and ritual. The contrasting disconnection of the present day birth culture shows in the lack of relationship between women and their caregivers; the narrow focus of the medical environment where the spiritual and emotional significance of giving birth is seen as subordinate to the physiological act; and the devaluing of a woman's personal support networks evidenced by the almost universal lack of facilities for extended family or friends to be on hand in hospitals. To avoid these issues some Maori are returning to the use of traditional customs and weaving together a mixture of the new and the old. This can be easier to do if birthing at home where support by extended family and

friends can be easily arranged and where exposure to unknown medical staff is unlikely to happen.

# CHAPTER SEVEN

## DISCUSSION AND CONCLUSION

### DISCUSSION

At the centre of this research is the juxtaposition of the two dominant paradigms of birth in New Zealand society and their impact on women during pregnancy and birth. I have observed an uncertainty in women approaching birth, caught between wanting to believe birth is a normal event within their capability and seeing it as a dangerous, risk-laden event. It is my opinion that this uncertainty undermines a woman's confidence, creates dependence on external authority and devalues her own knowledge and intuition.

The literature referred to earlier in this research on the development of obstetrics and maternity care in New Zealand documented the construction of a maternity system that replicated British obstetrics (Edwards 2005) and imported the capitalist and patriarchal structures that existed in Europe at the time. As the numbers of doctors in New Zealand increased the medical profession needed to provide work and an income for its members. In maternity care the availability of pharmaceutical pain relief and antibiotics to control puerperal fever encouraged women to birth in hospitals with doctors rather than staying home with midwives. Then, as hospitals came under medical control and away from government, the medical profession had a virtual monopoly on supply of services and was in a position to negotiate the financial arrangements it required. Although this

description painted a somewhat callous picture, it must be remembered that it describes the maternity care system that is in place, not the people who work within the system.

At the outset of this research one of my aims was to understand how the medical and natural models coexisted and, as a preliminary step in this research I have described current birth practices and the rise of obstetric medicine to its current position of dominance in New Zealand maternity care. In that process what stands out clearly is the extent to which the way we give birth expresses the beliefs and values of our culture. Jordan (1993) writes of her struggles, more than three decades ago, to talk about "how childbirth could be understood as a culturally grounded, biosocially mediated, and interactionally achieved event" (1993:xi). While this notion appears obvious and self-evident in the context of this research, giving birth is still regarded primarily as a physiological event and not as an expression of cultural beliefs and values. Attempts to critique the current system often approach from a biomedical or sociological perspective, for example the works of Banks and Donley cited in this research, and challenges to the system are generally debated at a physiological or medical level. Jordan (1993) also describes birth as "consensually shaped and socially patterned .... consist[ing] of a set of internally consistent and mutually dependent practices that make sense from the inside out, though not necessarily from the outside in" (1993:xii). These ideas are discussed further in the following paragraphs in relation to each of the three models used in this research.

The narrative of the Medical Model describes a style of birth that is grounded culturally in the values of New Zealand society. It is structured hierarchically and women such as Libby are at the bottom. The hierarchy is preserved through the valuing of objective, scientific (medical) knowledge as being authoritative so that women's sense of how their pregnancy or labour is going can simply be ignored. This is again illustrated later in the story when, during the labour, we see that Libby is overruled when her medical caregivers encourage her to get out of the pool because they consider her labour is progressing too slowly. We see that she finally submits to the external authority, gives up her plans for the birth she wanted and accepts the status quo. This is a fine example of the biosocial mediation that Jordan (1993) describes, and which is referred to earlier in this chapter. The events of labour and birth are biologically universal but addressed in ways which are specifically socially determined. In this context, where deeply entrenched cultural messages are activated, for example to submit to medical expertise, it is almost inevitable that expectant parents will submit to the dominant biomedical authority and in so doing, simultaneously uphold and maintain its hegemony.

In the story of the Natural Model, on the other hand, we see that Suzy and Dan take more control over their birth. Choosing to forego the apparatus of medicalisation, such as technology and pharmaceutical drugs, shifts the balance of power. This is evidenced by the way the midwife takes a very low-key role in Dan and Suzy's story, watching and recording but largely keeping in the background until needed. In this model Suzy's intuitive knowledge and signals from her body

are supported and valued. Birth according to the Natural model is shaped and patterned according to beliefs and values held by those who choose it just as much as the Medical model is. For instance, Suzy chooses a birth pool as her main form of pain relief. From her position inside the social milieu of home-birthing families this choice is appropriate and unremarkable. From a medical perspective, however, it could be seen as inexplicable and bizarre. In the way that the Natural model of birth eschews the 'advantages' of technology and drugs it is a direct challenge to the biomedical control of birth which has created the hospital as the appropriate territory for birth.

The Maori Model is akin to Davis-Floyd's (2003:157) Wholistic Model in some respects. Most importantly they share a belief in the family being the significant social unit during birth although for Maori it is the extended and not the nuclear family. Both models treat the mother-baby dyad as one inseparable unit and also share the belief that health is dependent on balance between body, mind and spirit. The Maori Model operates on the basis of shared knowledge arising from a variety of sources (intuitive, embodied, traditional, medical, to name a few) and all are accorded equal status and used when appropriate. Here we see a model of birth grounded in a very different set of cultural beliefs and values. Although some aspects may not make sense from the outside, for example the importance ascribed to karakia and connection with ancestors, Maori birth traditions are internally consist and maintain integrity in relation to cultural beliefs.

Using Jordan's (1993) work on a crosscultural investigation of childbirth as inspiration, it is interesting to speculate on the possibility within New Zealand of effecting changes to our system of birth which would draw on the best of all these models. Currently, the dominance of medical authority is a major obstacle to this possibility as the choices on offer are restricted to those which fit with its values and beliefs, an example being the choice to birth without medical support – often called 'unassisted birth'. Although there are women doing this currently in New Zealand it is not an option that is recorded officially, or treated as acceptable in any way. Until recently anyone who attended such a birth was liable to prosecution. In other cultures it could be the usual way of birth, as Shostak (1981:161) describes for !Kung women of the Kalahari Desert. The power of the biomedical approach to birth also decrees what options are open to a woman dependent on her state of health, which state is also measured by biomedical standards. The majority of women are compliant with the pronouncements of biomedicine and it is rare for this view to be challenged to an extreme. There have been challenges made in other countries resulting in caesarean sections ordered by the Courts (Edwards 2005:90). Understanding these forces that are always acting in the background is vital to being able to make a real choice.

## WAYS OF KNOWING

A key ingredient in being able to make choices, then, is to understand the perspective from which information is constructed. It is necessary to take account of the values and beliefs that current authoritative knowledge is based on when assessing its validity. It is equally important to understand that there are other

ways of knowing which are valid according to different cultural parameters, the embodied or intuitive knowledge described in the Natural Model or the shared knowledge of the Maori Model are two such examples. If we understand that the knowledge we use to make decisions is only one perspective and not the absolute truth then it is possible to consider other paradigms of knowledge and include a broader range of information on which to base decisions. I suggest that more research regarding the ways in which authoritative knowledge is used, deliberately or unwittingly, would be beneficial for childbirth educators and midwives when working with expectant parents making decisions for birth and parenting.

## FUTURE DIRECTIONS

Authoritative knowledge is highly influential in decision-making but is not highly visible. If beliefs and choices about birth are socially and culturally constructed then it is important to make that process apparent so that a woman is able to make a true choice. For example, when a woman is diagnosed as having a baby lying in a breech position she will be offered (and advised) to consult with an obstetrician for advice on the best method of birth. It is most likely the obstetrician will advise that she elect to have a caesarean section before her due date. She will not be informed, however, of the beliefs and values that lie behind that advice, (for example, one possibility is that the obstetrician believes birth is inherently dangerous, that nature is flawed and technology is superior). On the other hand, if the woman goes instead to see an experienced midwife who has extensive experience at birthing breech babies naturally she is likely to be informed of the process for natural breech birth and encouraged to make her own decision. Firstly

she is likely to be given different information because the midwife has a different belief system regarding birth. Secondly she is less likely to be "advised" by the midwife and more likely to be "informed", because midwifery knowledge is not authoritative in our society. Although midwives have expertise in normal birth, normal is not the domain of authoritative biomedical knowledge and therefore, once a condition has been diagnosed as a "risk" or "abnormal" it is not safe for a midwife to "advise" as she may then be likely to face legal proceedings if the outcome is not good.

Earlier in this research the relationship between natural and biomedical paradigms was discussed as another area worthy of further investigation. In Chapter Three it was observed that the majority of material discussing the biomedical approach to childbirth is from the work of those who oppose this paradigm. It would be useful to know whether this continuous defining, critiquing, analysing and bringing to attention of the medical approach towards birth is helping to change the way birth happens or whether it is fuelling biomedicine's hegemony. Davis-Floyd (1996:126) talks of the movement toward natural childbirth as being the radical opposite of the biomedical approach and how the energy from the natural movement has been channelled into humanising the dominant paradigm. An analysis of the relationship between these two paradigms would therefore be an interesting investigation.

## REFLECTING ON THE PROCESS

It is difficult to avoid the metaphor of birth in thinking about the processes involved in completing this project. The greatest surprise was how long and tortuous it was, definitely a first birth and not at all as I had planned it to be. Two weeks before finishing my final draft I began referring to it as "my book" and suddenly the proportions fell into a new perspective. Which model did it follow? I think it was natural, it certainly benefited from the sensitive midwife-ing of my two supervisors and apart from my laptop, always at my control and no one else's, there was very little technology involved.

The analogy with a birth continues with the sense I had of not being in charge of the process, I continually found myself reorganising and restructuring my work. How the chapters fitted together, what was required from me chapter by chapter, and deciding where to place different sections was confusing. I like to see the big picture, to work to an overall plan, however this research took shape, and changed shape, with regular need for reappraisal. As I wrote a section it would change the perspective of parts already written. As in Sartre's "progressive-regressive method" (cited in Jackson 1996), what I made of the data and information I studied changed the way in which I understood what I had previously studied and written. It has been a phenomenological experience!

A significant learning has been the realisation of the responsibility that comes with doing "one's own" research. From the choice of topic or research question this project is entirely my construction. How I framed it, the methodology and

theoretical perspective, my analysis of the data, these are all expressions of who I am and will be used to measure my ability to produce an intelligent and coherent whole. This completed work is not what I expected it to be, and yet, it is what I had initially wanted to find out. Although I decided to confine myself to a simple review of birth methods in New Zealand the process of this research project has given me the understanding I sought of the contradictions inherent in the choices women make during pregnancy and birth. It has enabled me to clarify and articulate my view of the system of birth in New Zealand. The research shows that the dominant New Zealand birth culture is constructed from social and cultural values which prioritise positivist and reductionist attitudes to life and to women. The system we use is constructed hierarchically and purposely favours institutionalised power which is held primarily in the control of men historically and currently. Equally clearly it shows that this is only one way, that other ways exist and are valid, and that different cultural beliefs and values will give rise to different birth practices.

## CONCLUSION

In the previous chapters this research has explored issues of choice when planning to birth in New Zealand. My initial opinion was that there is a dichotomous message received by women approaching birth, reflected in ambivalence between the desire for a natural birth and an expectation of needing intervention. To begin investigating this opinion the research has explored three current models of birth to construct a picture of how birth occurs at the present time. It was also intended to provide a foundation for future, empirically grounded, research,

particularly research investigating the relationship between the biomedical and natural approaches to birth.

Through the historical data it was possible to construct a framework showing how medicalised birth developed in New Zealand in a way that was reflective of the social circumstances at the time. In particular it was shaped politically by relations with Britain as a colonising power. In the development of New Zealand as an outpost of the British Empire it was necessary for British New Zealanders to reproduce in sufficient numbers to maintain their numerical superiority within the population. Economically, factors acting on the medical profession drove it to become established as the controlling body in the area of childbirth in order to generate a field of work and a form of income for its members. The narrative accounts of different models of birth demonstrated the variety of ways that birth occurs in New Zealand at the present time. Discussion on each model highlighted significant and distinguishing factors of each, showing differences in values and approaches to birth.

What has been revealed is a system of maternity care that reflects the values of New Zealand society and is constructed to meet the requirements of those who work within it. How well this system serves those who are birthing in it is not the main purpose of this research however it is a serious concern and the description of a medical birth clearly shows that the birthing woman is not the focus of the system. This research does show, however, that there are structures in place which enable women to choose an alternative to the strictly biomedical model of

birth care as described in the narratives on the natural and the Maori models. That there is a choice in planning one's birth is of vital importance because, in the words of Rosemary Tong (1989:72) "To the degree that a person is deprived of power over his or her own body, that person is deprived of his or her humanity".

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