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**THE ELDERLY PRIMIGRAVIDA: CONTEST AND  
COMPLEXITY**

**A FOUCAULDIAN ANALYSIS OF MATERNAL AGE IN  
RELATION TO PREGNANCY AND BIRTH**

A thesis presented in fulfilment of the requirements for the degree of

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Ethical approval for the study was gained from the Massey University Human Subjects Ethics Committee and also from the Northern Regional Health Authority's Ethics Committee.

## Abstract

This study identifies and analyses the discourses deployed by women recalling their experiences of pregnancy and birth at the age of 35 or over, and by maternity service practitioners describing their practice in relation to women pregnant or giving birth for the first time aged 35 and over. The philosophical approach underpinning the study was derived from the works of Michel Foucault, particularly his concept of discourse and its inextricable relationship with power and subjectivity.

The data for the study included texts of published medical, midwifery and women's health literature and relevant government policies. The primary source of data was the transcripts from 32 interviews with women, midwives, general practitioners and obstetricians. The analysis reveals the diversity, contest and complexity that exists amongst women and the practitioners in their ways of thinking about prenatal genetic diagnosis, birth, and maternal age in relation to pregnancy and birth.

Textual analysis identified two contesting discourses regarding pregnancy and birth: the scientific medical discourse and the natural birth discourse. The scientific medical discourse demarcates the age of 35 as the time when pregnancy and birth become problematic for such women and assigns to them the label of "elderly" primigravida/primipara to signify their different status. Thus defined, "elderly primigravida/primipara" are recommended to be under the care of an obstetrician and to give birth in an obstetric hospital. The natural birth discourse opposes the construction of maternal age as an independent risk factor. Instead speakers reproducing this discourse argue that other factors are the cause of complications experienced by "elderly" primigravida/primipara, in particular the beliefs and fears perpetuated regarding these women and the interventions that occur as a consequence. Each discourse offers competing subject positions for the first time pregnant woman aged 35 or over. She is positioned in the scientific medical discourse as potentially pathological and incapable of giving birth without intervention. In contrast, the natural birth discourse positions her as not different from younger women and capable of giving birth naturally.

Maternal age has the potential to further complicate pregnancy in that women aged 35 and over are compelled to consider the possibility of being mothers of a child with chromosomal abnormalities, particularly Down syndrome. Analysis of the texts

showed that the participants brought numerous discursive identities into being in relation to prenatal genetic diagnosis. While most of the women and practitioners identified themselves as subjects of the medical genetic discourse, the discursive identities brought into play by the women were quite different to those deployed by the practitioners. Although the choice to undergo prenatal genetic diagnosis is a binary yes/no, the women revealed fragmentary and complex subjectivities. The study found that women assessed their capabilities to mother a disabled child drawing on multiple and contradictory discursive meanings of risk, motherhood and disability. In comparison, the practitioners positioned themselves as enforcers of informed choice, information experts and as vulnerable to discipline. I suggest that the legal discourse's subject position of vulnerable practitioner may complicate the practitioners' positioning and interests in informing women. Women's right to informed choice may compete in priority with the practitioners' desire to avoid being disciplined for the wrongful birth of a child.

A further finding of the study is the strategies deployed by women, midwives and general practitioners to resist power techniques such as surveillance. Women's tactic of elusion avoids the normalising gaze of prenatal genetic diagnosis. Similarly, a strategy of opposition is used by midwives and some general practitioners to create an opportunity for "older" primigravida/primipara to keep open the possibility of giving birth without intervention.

## ERRATA

P.14. The last two sentences have been emended so that the text reads: "... non-discursive factors were closely interrelated, discourse preceded the non-discursive factors."

P.22. The last line of the fourth paragraph: "... individual. The label..." should be emended to read: "... individual of a particular kind. Hence, the label distinguishes her..."

P.23. The reference to Cheek (2000) should include its page i.e. 30.

Pp.25 & 177. The authors' order of placement is incorrect and should be Papps & Olssen, 1997.

P.31. First paragraph, the first three lines should read: "... (Weedon, 1997, p. 199), which is a consequence of the connections that ..."

P.31. In the second line of the indented quotation from Taylor, the word "against" should be italicised.

P.31. The words "can not" in the last line of the fourth paragraph, should be "cannot".

P.32. The first line of the page should include the author's full reference, which is (Hekman, 1990, p. 152).

P. 33. Last paragraph, second sentence should read: "I explain the procedures used to identify and contact the participants, the ethical issues that arose and, the process undertaken to produce the data."

P.64. In the ninth line of the second paragraph, Small for Gestational Weight should read Small for Gestational Age.

P.65. In the fourth line from the top the spelling of "primigravidas" is incorrect.

P.72. The term "primipara" should be emended to "primiparous" in the first line of the third paragraph.

P.75. The word "placental praevia" in the eighth line of the last paragraph should be emended to "placenta praevia".

P.83. The first line of the last paragraph should be emended to read, "Speakers of the natural birth discourse challenge ...".

P.95. Third paragraph. The reference to Thom & Jennings (1996) should include the page number i.e. p. 230.

P.98. The end of the first sentence in the middle paragraph should be emended to read "... the knowledge that the extra chromosome 21 can come from either the father or the mother".

P.100. The quote from Ewald in the middle of the page should be emended to include the page number i.e. p. 199.

P.115. The spelling of “probability” in the second line of the second paragraph is incorrect.

P.146. The word “as” in the first line of the quote from Philip should be “at”.

P.175. Third paragraph, line 5 should read “... had a post-graduate diploma in obstetrics and gynaecology.”

P.189. First paragraph, first line should read “Timothy positioned women as subjects desiring intervention.”

P.193. Last paragraph, first line should read “The metaphor of a clock implies the existence of a biological mechanism...”

P.207. Section 10.3 heading, The word “process” is incorrectly spelt.

Pp. 224 & 229, the spelling of Griffin is incorrect.

P.239. Last paragraph, twelfth line should read “... knowledge that diabetes, although it presently cannot be cured, ...”

The following are to be added to the list of references:

Allen, A. (1996). Foucault on power: A theory for feminists. In S. Hekman (Ed), *Feminist interpretations of Michel Foucault*. (pp. 265 – 282). University Park, Pennsylvania.

Morse, J. (1991). *Qualitative nursing research: A contemporary dialogue*. Newbury Park: Sage

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## Chapter 1: INTRODUCTION

Eventalization means rediscovering the connections, encounters, supports, blockages, plays of forces, strategies, and so on, that at a given moment establish what subsequently counts as being self-evident, universal, and necessary. In this sense, one is indeed effecting a sort of multiplication or pluralization of causes.

Foucault, 1991, p. 76

Foucault's ideas on analyzing events such as pregnancy and birth for first time pregnant women aged 35 or over offer the potential to both disrupt this event and to expose the complexity of factors that impinge on it. During the twentieth century women who are aged 35 years or over and pregnant for the first time have been given several names by the medical profession, ranging from "mature age" gravida and "elderly" primigravida to "geriatric" primigravida. Indeed, one article about "elderly" primigravidas in the 1930s was published in the *Journal of Gerontology*. The criterion of 35 years of age was decided on at an international meeting of obstetricians and gynaecologists in 1955. Nonetheless, anecdotal information shows that even primigravida aged 25 or 27 years have been called "elderly" as recently as the late 1980s and early nineties<sup>1</sup>. Furthermore, medical literature has argued that first-time mothers over the age of 35 are at more risk from a variety of problems during pregnancy, labour and the postpartum periods, for example: pre-existing maternal hypertension, antepartum haemorrhage, preterm delivery and breech presentation. As a consequence, "elderly" primigravidas both in New Zealand and overseas are more likely to either seek care or to be encouraged to be in the care of obstetricians and to give birth in an obstetric hospital. For example, Cunningham et al (1996) recommended that because complications, such as placenta praevia and placental abruption, were more likely to occur in primiparas aged 35 and over, such women should give birth in a hospital and be under the care of specialist obstetricians.

The phenomenon of women delaying childbirth is not a recent one. However, the numbers of women choosing to delay the birth of their first child have been increasing since the 1970s. The trend has continued to the present so that in New Zealand the most common ages for childbearing are between 30 and 34 years (Statistics

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<sup>1</sup> The Society for Research on Women (1991) identified 27 years as the age for a first time pregnant or labouring woman to be called "elderly".

New Zealand, 1999). There are many reasons for women postponing childbirth and include an unparalleled increase of women in the workforce, a desire to further their career or education before embarking on parenthood, and a wish to gain financial security (Mansfield, 1986a).

The topic of this study was stimulated by my friends' and own experience of being pregnant for the first time at the age of 36. I was left with a curiosity about the different meanings that were associated with maternal age in relation to pregnancy and birth. My own experience was that as soon as I recognised I was pregnant, I went to see a local GP. My main reason for the visit was to discuss the issue of prenatal diagnosis with her. The issue of testing for chromosomal "abnormalities" had been brought to my attention by several of my friends who had chosen to have amniocentesis. At that time I was quite certain that I would prefer to have chorionic villus sampling [CVS], which was carried out early in the first trimester and thus allowed for an earlier and easier abortion if the results came back indicating that the baby had chromosomal abnormalities. To access such tests referral had to come from a medical practitioner.

I had been deterred from having an amniocentesis by one of my friend's experiences. She had disliked waiting the four weeks for the results. During this time she had begun to feel her baby's movements. These sensations had made the baby seem more human to her and had made her resolve to terminate the pregnancy should she receive a result that indicated that her baby had chromosomal abnormalities, even more painful.

I also knew from friends that the decision regarding genetic testing had a degree of public interest. One had been challenged on her decision to have the test. She was asked how she could consider ending another human being's life. I was pregnant with my second daughter when an acquaintance questioned my decision not to have an amniocentesis. Reflecting on this experience and that of my friend I felt a sense of "damned if you do and damned if you don't".

At that time I discovered that the age at which the New Zealand government subsidised the genetic tests was 37 years. If I wanted to have the test I would have to go to a private clinic, which performed both CVS and amniocentesis and would have to pay. When making further inquiries with the private clinic I recall that I was told that in early 1989 there was just under a 50 per cent chance that they might not be able to obtain the placental tissue necessary to successfully examine for chromosomes. I began to lose confidence in CVS as a method of determining the presence of chromosomal

abnormalities. Following further discussions with the GP and my husband and on the basis of the statistical probability I decided against having any genetic tests. However, I did revisit my decision throughout both my first and following pregnancy.

At that time I worked at a tertiary educational institution and was involved teaching registered nurses who had enrolled in a one year postgraduate course called the Advanced Diploma in Nursing [ADN]. Up until 1989 nurses who wished to train as midwives were required to complete the ADN while gaining registration as midwives. Consequently some of my colleagues and students were either registered midwives or midwifery students. I was also involved with a woman's health group, members of which were active lobbyists on birthing issues. I was very aware then of the contested nature of birth and the campaign for midwifery autonomy.

I decided that I wanted to give birth to my baby at home. I had no perceptions of myself as being different from any other pregnant woman because of my age. I felt that I had the same capabilities and therefore the same options. I believed that pregnancy and birth were normal physiological processes and that I would not necessarily have any problems regarding my baby's or my own wellbeing.

At that first antenatal visit, the GP and I also discussed my antenatal and birthing care options. When I asked her if she would provide my antenatal care she replied, "Oh, no. I cannot care for you. You're an at risk elderly primigravida. You will need to be in the care of an obstetrician." She then discussed how I could access the care of an obstetrician either through the public hospital or privately. I recall being quite taken aback by the way she labelled me. At the age of 36, I did not consider myself to be "at risk" and I certainly did not consider myself to be "elderly". I cannot recall whether she explained why I fell into this category or what it meant. However, I do remember that when I told her that I was considering having a home birth, she appeared to be momentarily thrown off balance. She told me that there was only one GP in the Auckland region who would support a woman of my age having a home birth. She gave me his name and warned me that as he was very popular, he might be heavily booked and I might have difficulty enlisting his care. As it transpired I became one of his clients. For him, my age was not a problem. He was confident that I would be able to give birth without necessarily needing intervention.

My interaction with the first GP had unnerved me. I no longer had the same certainty about birth. Perhaps my age did make birth more risky. Perhaps a home birth was too risky at my age. I started thinking about the hospital in which I would give birth

to my baby. I wanted to avoid the two level three obstetric hospitals<sup>2</sup> in my city as I wanted to avoid unnecessary medical intervention. A second reason was that I did not want to be subjected to medical students and the layers of doctors that one encounters in teaching hospitals. My choice then was to go to a local maternity hospital, which provided level one care. My midwifery colleagues told me that the midwives who worked there at the time were very experienced and supportive practitioners.

Throughout my pregnancy my choice of birthplace fluctuated between a hospital and a home birth. Finally, urged by the GP to make a decision so that he could make booking arrangements with the hospital, and supported by a domiciliary midwife I decided on having a home birth.

My experience left me with questions such as: why did the two GPs construct me so differently? Why did one see me as being “at risk” and needing to be under specialist care while the other agreed to be my primary carer and to support my choice to home birth? What knowledge did they bring into play when making their recommendations to me? What knowledge led to the government’s practice of providing free genetic testing to only certain women? My own experience had also highlighted for me the unstable and contradictory nature of one’s subjectivity.

## **1.1 THE PHILOSOPHICAL APPROACH AND AIMS OF THE STUDY**

✱ My epistemological position for this thesis then needed to account for the diverse ways of thinking about maternal age and the subjectivities that each produced. Gilmour (2001) notes that “the research inquiry is shaped by the intersection of the epistemological concerns directing the questions asked, the methods used for data collection, the analytic approach and the relationship between the researcher and the researched” (p. 4). I wanted to use a philosophical perspective that recognised the continual contest between interest groups and how the deployment of knowledge might be used to assert power and produce certain subject positions. In my analysis of the

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<sup>2</sup> In New Zealand there are three levels of maternity units. Level one refers to units, birthing centers or small hospitals which deal primarily with uncomplicated pregnancies and labours. Complicated cases are referred on to level two or three hospitals for assessment. Women may remain in their care or be referred back to the level one unit. Level two refers to hospitals which deal with both uncomplicated and most types of complicated labours and certain neonatal illnesses. More problematic cases are referred on to the level three hospitals. The level three hospitals are equipped and staffed to deal with all types of complicated labours and provide intensive care for neonates.

literature and other data I wanted to make knowledge problematic rather than accept it uncritically as the truth.

Parker (1992) notes that pieces of discourses can be found at work in texts. He defines texts as “delimited tissues of meaning reproduced in *any* form that can be given an interpretive gloss” (p. 6). Consequently, my data consisted of the texts gathered from medical, midwifery, women’s health and government publications and parenting magazines and the texts generated from the interviews with women, midwives, general practitioners [GPs] and obstetricians.

My initial search of the literature on maternal age revealed that the dominant body of literature comprised quantitative research drawn from hospital records and written by medical practitioners. While there was a small amount of research into “older women’s” perspectives, the perspectives of the midwives, GPs and obstetricians themselves were silent. By including maternity practitioners’ perspectives as well as those of women, I intended to end this silence and to reveal any diversity that was evident in the interview texts.

To identify the multiplicity of discourses was not my only reason for drawing on Foucault’s works. A further reason was that his notion of “subjugated knowledges” which refers to the kinds of knowledge that have been disqualified because they lack elaboration or sufficient scientificity. One outcome of Foucauldian discourse analysis is that it brings such subjugated knowledges and the history of their struggle to the foreground (Foucault, 1980).

The overall aim of this study was to identify and analyse the discursive field of maternal age in relation to pregnancy and birth. Weedon (1997) explains that the discursive field consists of multiple discourses that compete with one another. Each discourse has its own meaning of the phenomenon and way of structuring social institutions and systems. The discourses identified in the thesis would be those identified in the texts of women who had been “elderly primiparas” and maternity practitioners such as midwives, GPs and obstetricians. A second aim was to examine the historical development of the use of the term “elderly primigravida/primipara” in medical, midwifery and other relevant literature.

My purpose has not been to construct a “grand theory” of maternal age in relation to pregnancy and childbirth. I wish to make it clear from the beginning that my findings are limited by the texts that have been the material for my analysis, the historical and social context of the study and the partial nature of my interpretation.

## **1.2 TERMS EMPLOYED IN THE THESIS**

Throughout the process of this thesis, in particular when reading and writing, I have felt locked into the language of binary differences. Whatever term I use to discuss women aged 35 or over I am always constrained by the language of differentiation and the practice of signifying them as “Others”. The topic of prenatal testing also perpetuates the binary of normal/abnormal. Just as the older woman is differentiated in a way that constructs her negatively, so too is the fetus with extra chromosomes. Rapp (2000), encountered the same issues and with an awareness gained from the disabled rights movement of how terms like “defect” and “abnormal” project biases towards the disabled made the decision to place terms like these in quotation marks to indicate their problematic nature. I have adopted this practice of placing quotation marks around terms such as “abnormal”, “elderly” and “older”.

A further consideration was the naming of the unborn child. The medical profession employs the term “fetus”, while the women, and I spoke of “baby”. As a consequence I have used both terms as determined by the context. Throughout the thesis I have referred to the first time pregnant or birthing woman as primigravida/primipara. My juxtapositioning of these terms reflects the ambiguity present in the medical literature when authors have referred to this group of women. Both of the terms primigravida and primipara (as well as nullipara) are deployed in the published research reports which analyse the pregnancy outcomes of these women.

## **1.3 STUDY OUTLINE**

Overall, the study foregrounds the contested and complex nature of discourses brought into being in relation to pregnancy and birth for primigravida/primipara aged 35 and over.

Chapter Two of the thesis describes the philosophy of Michel Foucault, which underpins this study. The main concept derived from Foucault’s work and which shapes the steps of data collection and analysis in this study is discourse. The concept of discourse will be defined and discussed in relation to the study, as will its links with power, knowledge and subjectivity. Other concepts that have been derived from Foucault and used in the study to analyse power relations are resistance and technologies of power. Biopower, that is, power over life, is a further aspect of Foucault’s ideas on power and power relations, ~~biopower~~ that has an important significance to this study. Foucault posits that over time governments have become

increasingly interested and involved in the populations, the bodies of people that they govern. Childbirth is one area that comes under the realm of biopower and hence the relevance of biopower to this study. The final section of the chapter identifies aspects of Foucault's concepts that have been criticised, in particular his ideas on truth and power.

Chapter Three provides a description of the actual steps involved in undertaking the study. I explicate the processes used to ensure the adherence to ethical principles throughout the research process. The techniques used to determine and access the 32 participants, to conduct and transcribe the interviews and to analyse the texts are then described and discussed. Foucault's depictions of power being inextricably connected with knowledge and of power as contestable, foreground the power relations between the researcher and the interviewee. Consequently, I identify and explore the various positions of power that the participants and I took up during the interview process. The application of a postmodernist approach raised certain considerations for this study. A particular implication arose from postmodernism's rejection of universal truth, subjectivity, and the modernist assumption that language accurately reflects reality. In this way the criteria for and claims to validity and reliability are suspended. These implications are discussed in relation to this study.

Chapter Four is an archaeological and genealogical analysis of the literature in relation to pregnancy and birth for older women. In this chapter I show that the construct of maternal age is contested both from within and without the scientific medical discourse. The analysis explores the historical, social and political context within which the scientific medical discourse and its construction of the first-time pregnant woman at the age of 35 year as being problematic is articulated. The meanings of "elderly" primigravida/primipara are discussed. Rather than searching for a continuous development of the medical discourse I look for contradictions and ruptures. These assist in identifying the rules and boundaries of the discourse. Within the scientific medical discourse the theory that the problems experienced by "elderly" primigravida/primipara are caused by aging are opposed by some medical researchers. They propose that instead infertility is the reason for the complications in labour. Furthermore, evident in the midwifery and women's health literature from the late 1970s onwards is the emergence of the natural birth discourse which contests the scientific medical discourse. An alternative subject position is offered to the "elderly" primigravida/primipara that does not differentiate her from younger women on the basis of her age. The natural birth discourse argues that the "older" primigravida/primipara is

a historical and social construction and the high intervention rate and other complications are a result of medical practices.

The focus of the analysis of the literature shifts in chapter Five to the practices of prenatal genetic diagnosis specifically related to maternal age: amniocentesis and chorionic villus sampling. The same analytic tools of archaeology and genealogy are used to reveal the multiple overlapping and contesting discourses that comprise the discursive field of prenatal genetic diagnosis as produced in the medical, midwifery and women's health literature. I explore the changing representations of disability over time and how the legalisation of abortion in New Zealand was linked with the development of amniocentesis. In particular, I argue that the discourses of disability, neo-liberalism, risk and economics together operate to ensure that all women aged 35 and over are offered prenatal genetic diagnosis.

The first issue that had to be dealt with by the women was the decision whether or not to undergo genetic testing. Chapter Six explores and analyses the women's texts regarding genetic testing, the multiple discourses that they articulated and the subject positions taken. My analysis highlights that while the women's decision was binary in terms of either accepting or refusing to undergo prenatal genetic diagnosis there was diversity and difference in the discourses they deployed. The representations of motherhood and disability produced by the women who chose to undergo prenatal genetic diagnosis were in opposition to those produced by the women who decided against the tests. Difference was also evident in the meanings that the women gave to the information provided by the tests. I focus on how the women made sense of the information and its significance in relation to their own views on disability and motherhood.

In the analysis of the practitioners' and women's texts regarding genetic testing it emerged that the discourses articulated by the practitioners were different to those articulated by the women, hence the decision to separate the women's texts from the practitioners'. Chapter Seven explores the various subject positions brought into being by the practitioners. I propose that the intersection of the medical genetic discourse with the discourses of neo-liberalism and law combine to discipline the practitioners to enforce the practice of informing women of their risks and the availability of the prenatal genetic testing.

Chapters Eight and Nine identify and analyse the scientific medical discourse in relation to maternal age, pregnancy and birth. Chapter Eight focuses on the women's

texts. I describe how the women willingly were made subjects of the scientific medical discourse accepting their identification as subjects who were likely to encounter problems especially while giving birth. Constructing oneself and being constructed as potentially problematic legitimated the women's requirement for having specialist care and giving birth in the hospital setting.

Chapter Nine explores the obstetrician's and hospital midwives' texts and how they represented themselves and "elderly" primigravida/primipara. In portraying birth as a potentially dangerous event, especially for "older" first time mothers, the place of the obstetrician as the appropriate maternity carer for such women is legitimated. The position of the obstetrician as the expert practitioner is further sanctioned by hospital and Regional Health Authority referral guidelines that require midwives and GPs to consult with obstetricians when caring for primigravida/primipara aged 35 and over. The unstable and contestable nature of power relations between women and obstetricians, and midwives, GPs and obstetricians are identified and explored. A strategy of resistance evident in some of the practitioners' texts was that of evasion. This tactic created a space for "elderly" primigravida/primipara to remain in the care of a midwife or GP.

Analysis of women's and midwives' texts revealed the articulation of the natural birth discourse, which contests the scientific medical discourse's meanings of birth and "elderly" primigravida/primipara. Chapter Ten explores the alternative subject and power positions that are offered to women and midwives and GPs by the natural birth discourse. It is argued in this chapter, that this discourse is one that offers women the possibility for a normal birth. The strategy of choosing to give birth at home is discussed as an oppositional discursive practice. Emerging from the texts of the women and practitioners who deployed the natural birth discourse was the dual construction of birth as being unpredictably problematic. The intersection of the natural birth discourse with the medical discourse, I propose is a strategy by which women and independent midwives keep the possibility of natural birth open.

In the final chapter, chapter Eleven, I review the findings of the study and their implications for midwifery practice and education. I pursue the main theme of my thesis that the age of 35 and over have the potential to make more complex the already contested domain of pregnancy and childbirth for women and practitioners.

In the following chapter I locate Foucault within postmodernism and identify and describe his concepts that have been employed in this thesis.

## **Chapter 2: PHILOSOPHICAL UNDERPINNINGS**

Discourse ... appears as an asset – finite, limited, desirable, useful – that has its own rules of appearance, but also its own conditions of appropriation and operation; an asset that consequently, from the moment of its existence (and not only in its ‘practical application’), poses the question of power; an asset that is, by nature, the object of a struggle, a political struggle.

Foucault, 1972, p. 120

### **2.1 INTRODUCTION**

My work draws from the French historian and philosopher Michel Foucault (1926-1984), whose ideas have been increasingly used by nursing and health researchers (Cheek & Porter, 1997). His concepts have the potential to trouble the accepted ways of thinking about maternal age, to expose the complex nature of subjectivity and relationships between women and maternity practitioners. In this chapter, I locate Foucault within postmodernism and explore his ideas that reflect postmodernist theory. I then explicate the concepts I have employed from Foucault’s writing and that have shaped my research process. Foucault was a prolific writer whose views changed over time . Foucault is called a “philosophical nomad” by Heikkinen, Silvonen and Simola (1999), “always on the move, shifting between at least three areas: knowledge, subjectivity and power” (p. 141). Couzens Hoy (1986) points out that Foucault’s interest shifted from one topic to another accompanied by changes in his method and purpose. Consequently, I have limited my discussion to those concepts that have been employed in the present study.

### **2.2 POSTMODERNISM**

There is some debate about whether Foucault’s writings can be categorised as belonging to postmodernism or poststructuralism. In an interview with Gerard Raulet, Foucault (1994a) did not want to identify himself as a poststructuralist or postmodernist. Agger (1991, p.112) makes a distinction between postmodernism and poststructuralism by identifying postmodernism’s broader theorisation about society, culture and history. In comparison, Agger proposes that poststructuralism is more concerned with theories about knowledge and language. Poststructuralism is seen as a subset of, or part of the matrix of, postmodernism. Sarup (1993) describes poststructuralism as critiquing Enlightenment’s notions of the human subject, historicism, meaning and philosophy, critiques which are reiterated by postmodernism. Foucault when asked to place himself

within either of the above categories resisted the assignation of any label to his writing (Best & Kellner, 1991). I propose not to enter into the categorisation debate however, I have followed authors such as Agger (1991), Best and Kellner (1991), and Cheek and Porter (1997) and placed Foucault under the umbrella of postmodernism.

The two dominant philosophies in France until the rise of postmodernism were Marxism and phenomenology (Fahy, 2000). The term “postmodern” had been used prior to the 1970s (Ward, 1997), but in the 1980s it experienced a “boom time” and at this time emerged in philosophy texts (Rolfe, 2000). To actually find a consensus definition of postmodernism is difficult (Anderson, 1996). Cheek (1999) argues clearly that postmodernism does not have one theoretical approach. It consists of a “constellation” of theoretical perspectives. One identifying characteristic of postmodernism is its questioning and rejection of the foundations of modernist rationalism.

In many of its manifestations postmodernism is seen as a response to the ‘crisis’ of the Enlightenment Project, a project with its roots in the writings of the pre-enlightenment philosopher Descartes. The Enlightenment had advanced rationalism, universalism and transcendental forms of thinking.

Graham, Doherty, and Malek, 1992, p. 3

Postmodernism rejects the notion that one theory, coined a metanarrative or a grand theory, can explain all human behaviour and societies throughout the world and across time (Agger, 1991; Seidman, 1994). Some examples of grand theories are Marxism, Existentialism and Capitalism (Natoli, 1997). Postmodernists argue that such explanations draw on knowledges that are historically and culturally located. Groupings such as age, race, gender and sexuality each produce unique perspectives that need to be accounted for. Explanations are therefore always partial and limited.

Crotty (1998) states that what the spirit of postmodernism “...has brought into play is primarily an overpowering loss of totalising distinctions and a consequent sense of fragmentation” (p. 212). This postmodernist pluralism has something to offer to the subject of maternal age. The notions of heterogeneity and multiple truths appeal to me because of the experiences that I have described in Chapter One. The aim of my thesis is to show the heterogeneity and multiplicity of discourses, the subject positions available within these discourses and their various strategies of power.

Consequent to the critique of universal metanarratives is postmodernism’s assertion that there are multiple realities, multiple truths. Postmodernists see knowledge

as a social and historical construct. Knowledge that is claimed to be a truth is seen as an ideal that does not exist independently of human thought. For postmodernism, the criteria for establishing truth are not fixed and are determined by social relations of power (Rolfe, 2000).

Postmodernism also rejects modernism's ideal of rationality, the conscious subject, and the process of reasoning as a source of knowledge, of ascertaining what is truth. Subjectivity, as viewed by postmodernism, is fragmented, plural (Lister, 1997) and decentralised: "The self no longer uses language to express itself; rather the language speaks through the person" (Kvale, 1996, p. 22).

Modernism's belief in progress towards full knowledge, enlightenment and freedom is put into suspension by postmodernism. Instead, postmodernism views such ideals with mistrust. Johnson (1995) states that a postmodernist attitude produces "a crisis of faith" (p.122) in universal goals because postmodernists are aware of the oppression that may result as a consequence of such values. The assumption that words relate directly to their objects in the world is also suspended by postmodernism. Rather it declares that the words used to describe the world are historically and socially located.

Agger (1991) identifies Foucault as a significant postmodern theorist. Foucault's concept of discourse and its relations to power, knowledge and subjectivity exemplify postmodernism's disruption of modernism's ideals such as rationality and truth. Having outlined the main thoughts associated with postmodernism, I turn now to elaborate Foucault's theories that are relevant to this thesis.

### **2.3 DISCOURSE**

The term "discourse" has several meanings and Foucault's idea of a discourse is itself unique. Fairclough (1992) makes the point that there are multiple definitions of discourse. Some definitions overlap and others contradict depending on their disciplinary and theoretical perspective. Disciplines such as linguistics and social psychology employ the term discourse but in quite a different sense to Foucault. For example, mainstream linguistics' interest in discourse is in relation to spoken language and its organisation and occurrence (Mills, 1997). Fairclough (1992) identifies Foucault's use of discourse to refer to "different ways of structuring areas of knowledge and social practice" (p. 3). Discourse, however, was central to Foucault's work (Wuthnow, Davison Hunter, Bergesen & Kurzweil, 1984).

Foucault did not provide an exact definition of discourse. However, in *Archaeology of Knowledge*, Foucault writes that discourses should be regarded as “practices which systematically form the objects of which they speak” (1972, p.49). Significant in this quotation is its conveyance that discourses are performances, activities or events (McNay, 1994). Discourses are made apparent through people’s activities, their ways of doing things, their arrangements of certain times and spaces. An example of these are ideas of where pregnant women should labour and give birth or ideas of how a birth should proceed.

A second feature of Foucault’s statement above is that a discourse engenders a regular effect, for example, a systematized way of thinking about some thing (Mills, 1997). A discourse constructs an object, interpreting an event or a phenomenon in a particular way. The connection between words and objects is dynamic with one influencing the other (Kendall & Wickham, 1999).

The “primary building blocks” of a discourse are statements (*enonces*) according to Foucault (Mills, 1997). However, Foucault is not referring to any statement of speech. Dreyfus and Rabinow (1982) have coined the term “serious speech acts” to identify Foucault’s meaning. *Enonces* have undergone a process of validation, and have been confirmed as knowledge. They have an importance. “Statements are not like the air we breathe, an infinite transparency; but things that are transmitted and preserved, that have value, and which one tries to appropriate; ...things that are duplicated not only by copy or translation, but by exegesis, commentary, and the internal proliferation of meaning” (Foucault, 1972, p. 120). Foucault is interested in the different kinds of statements, the relations that statements have with one another and the rules that govern the function of statements.

There are rules which limit what statements can be said within a discourse, where they can be spoken and who can say them. Foucault referred to these as “rules of formation” (1972). Analysis of discourses involves the identification of the rules or conditions that a discourse is subject to.

Firstly, a discursive object emerges and is named or judged to exist within certain social and historical contexts. The phenomenon that is identified as a discursive object and its designated name are determined and generated by the theories, and the “conceptual codes and degrees of rationalization” of the discourse (Foucault, 1972, p. 41). For example, becoming pregnant brings a woman into the maternity practitioners’ domain. Therein, the circulating discourses regarding pregnancy and birth produce their

various determinations of the woman's status. Foucault (1972) terms such contexts "surfaces of emergence". The discourse analyst looks for the situations and places where individuals are differentiated from one another, for it is in such places that the phenomena are given the status of an object and thus become obvious to the eye and mind, able to be named and described.

Secondly, the formal groups or professional bodies that have the authority to designate discursive objects are called the "authorities of delimitation". They are deemed by society to have the knowledge and practice necessary to identify objects. When explaining who were the authorities of delimitation, Foucault (1972) identified the medical profession in the nineteenth century as the main authority that constituted madness as an object, and who could label, and delimit madness. Discourse analysis identifies and describes the institutions and groups of individuals who are given the authority to name and determine the limits of a discursive object.

The third aspect of the rules of formation were the "grids of specification" (Foucault, 1972). I interpret the term to refer to the classificatory systems that determine the divisions within or between discursive objects. Discourse analysis involves the interrogation of such grids, identifying and examining the terms and concepts that are routinely used to differentiate pregnant and labouring women from one another. Through this technique the discourse analyst gains insight into the ordering and the world of the discourse.

In addition to a discourse having rules of formation, Foucault (1972) argued that the emergence of a discourse was dependent on the conditions that allowed it to exist. Thus, there needs to exist circumstances which form connections with the discourse such as social and economic processes, institutions and classification types, which allow the object to be seen in that particular discursive way. As McNay states, discourses do not stand alone and need to be understood as "...an amalgam of material practices and forms of knowledge linked together in a non-contingent relationship" (1992, p.27). These conditions are what Foucault terms "non-discursive" factors that form the background, the context of the discourse. Foucault (1972) identifies non-discursive domains as "institutions, political events, economic practices and processes" (p. 162), and gives examples such as employment needs, unemployment issues, political policies, economic and demographic factors, and institutional context.

McNay (1994) points out that Foucault initially conceived that while discourse and the non-discursive factors were closely interrelated, Discourse preceded the non-

discursive domain. She points out that the notion of discourse as primary actually contradicted his claims regarding the surfaces of emergence and authorities of delimitation where the social and institutional context is given importance in the creation of the discursive object. However, in Foucault's later writings, the non-discursive conditions were seen to influence, maintain and support the discourse in a reciprocal relationship. McNay (1992) proposes that the change was a strategy for Foucault to avoid the issue of ideology. Ideology assumes that there is a truth that is hidden and that can be revealed through analysis: ideas obscure the material relations thereby obscuring the truth. By seeing the discursive and non-discursive domains reinforcing one another and working together, one does not aim to seek the hidden truth.

A discourse consists of statements that are different yet are linked together by rules regarding the enunciation of a discourse, which is the everyday act of speaking and practicing a discourse. Only specific people who hold a certain status may legitimately deploy a discourse or carry out a discursive practice. At the same time, they gain status from having the right to speak the discourse and from presuming that they speak the "truth" (Foucault, 1972). Enunciative rules also determine the subject position of the speaker and the site where a discursive statement may be made (Dreyfus & Rabinow, 1982). The speaker's subject position is determined by her/his relationship to the discursive object and, as such, shapes the speaker's roles and identities within the discourse. With respect to this study, the subject positions occupied by midwives and obstetricians within the scientific medical discourse may differ. The obstetricians may be accorded more authority and have different roles and relationships with labouring women than hospital midwives have. The speaker then, is part of the discourse rather than the discourse being part of the speaker (Shumway, 1989).

Discourses are not made manifest solely in words. They also become evident in practices, procedures and routines: "any discourse is intertwined at every point with the technologies and the practices of the disciplines and professions in which it is spoken" (Rawlinson, 1987, p. 375). Foucault refers to discourses as systems of thought and as discursive practices (1977). Discourses are performed. By this, I mean that discourses are practices embedded in and thus manifest in thoughts, words and deeds. Foucault says of discursive practices that "...they are not simply ways of producing discourse. They are embodied in technical processes, in institutions, in patterns for general behaviour, in forms for transmission and diffusion, and in pedagogical forms which at once, impose and maintain them" (1977, p.200). Therefore, practices do not merely

manufacture discourses. Discursive practices actually express discourses. The decisions that a maternity practitioner makes, and the actions they perform while caring for a labouring woman are discursive events.

Allen and Hardin (2001) urge that discourse be regarded as a concept or idea rather than being reified. Such a view is relevant to the carrying out of discourse analysis. It allows for discourse to be seen as something that is a consequence of human thought and practice rather than something that exists in and for itself.

Foucault's rule of tactical polyvalence of discourses, Shildrick (1997) notes, leads the discourse analyst to the recognition that there is never one overall discourse. More than one discourse exists and operates alongside others, each presenting different meanings and explanations which offset one another's power. Parturition, for example, is a discursive field comprised of multiple discourses which compete with one another to give meaning to pregnancy and birth and to organise the social practices, rules and processes related to parturition. Holloway (1984, p.239) makes the point that some discourses co-exist, having common effects yet multiple meanings. Therefore, as the researcher, I needed to identify and be open to the different discourses related to maternal age, and the ways in which they co-exist and compete with one another. The rule of tactical polyvalence calls into consideration the connection between discourses as bodies of knowledge and their interconnection with power.

## 2.4 KNOWLEDGE

In his preface to *The Order of Things* (1970) Foucault writes of how he was provoked by a passage he had found in which Borges had quoted from a Chinese encyclopaedia. The passage listed the classification of all animals into fourteen kinds. He wrote of his reaction,

As I read the passage, all the familiar landmarks of my thought – *our* thought, the thought that bears the stamp of our age and our geography – breaking up all the ordered surfaces and all the planes with which we are accustomed to tame the wild profusion of existing things, and continuing long afterwards to disturb and threaten with collapse our age-old distinction between the Same and the Other.

1970, p. xv. Emphasis in original

The above passage highlighted the changing nature of knowledge. The systems of thought that had been the basis of the Chinese classification were quite startlingly different from those used in the west today. The differences reveal that phenomena are named and given meanings that are not necessarily fixed in perpetuity but have the

potential to be temporary, and to be historically and socially situated. Foucault does not imply that present knowledge has progressed and that we know the truth in contrast to the Chinese author who employed the above classification. Rather, our present knowledge and understandings have the same potential for suspended certainty, and that what constitutes knowledge is contextual. In this study the different discourses and their criteria for constituting knowledge, are identified. However, my assumption that they are “the truth” is suspended.

According to Foucault, the historical development of ideas is not necessarily continuous and progressive. Foucault discourages the relentless search for origin and continuity in meaning. Instead, he urges that both continuities and discontinuities are taken account of. Discontinuities are not dismissed as aberrations. Gutting (1989) explains that Foucault does not want to state why discontinuities occur because of the potential to attribute causation at the level of human subjects and to overlook more significant complex and contextual influences. However, Gutting does see Foucault’s explorations of external factors, such as institutional structures in relation to knowledge and discourse, as an explanatory strategy. Additionally, Shumway (1989) sees that Foucault’s tactic of examining particular knowledges and practices within a specific historical period simultaneously illuminates both the differences and similarities between the past and present.

Thus an historical analysis of knowledge pertaining to maternal age from a perspective which employs Foucault’s ideas on change would consider discontinuities and continuities. Rather than looking for an author or subject who instituted the change, one would look for external factors such as the demographic patterns, the constitution of medical knowledge and practice, and professional interests.

#### **2.4.1 The connected-ness of power and knowledge**

Rawlinson (1987) terms the connection that Foucault sees between power and knowledge as a “chiasmatic binding”. Rawlinson employs the analogy of a dividing meiotic cell with its nucleic strands connected to one another: power on one side connected to knowledge on the other.

We should admit rather that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative

constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.

Foucault, 1979, p. 27

Foucault argues that power is not solely repressive. It has the capacity to create and produce knowledge. The relationship between power and knowledge is reciprocal, or as McNay (1992) terms it “non-dialectic”. Power and knowledge are mutually reinforcing. I interpret the relationship as one where the application and practice of knowledge produces new knowledge. In turn the new knowledge simultaneously justifies, augments and increases power (Rawlinson, 1987). For example, techniques such as observation and assessment provide the maternity practitioner with knowledge. The practitioner gains both knowledge about the individual woman and simultaneously adds to what s/he already knows. To be in such a position, to observe and assess the pregnant woman, the practitioner has undergone specific training, the acquisition of specific knowledge and skills, which has given her/him the legitimate power to be a practitioner. An implication of the power/knowledge relationship is that knowledge, including knowledge purporting to be neutral or abstract, is a form of power and control (McNay, 1992). Knowledge that claims to be the “truth” has particular effects of power.

#### **2.4.2 Truth and Knowledge**

Scientific medicine asserts that its knowledge is truthful because of the empirical and rational way in which its knowledge is constituted (Bunkle, 1992). Foucault, in his role as an historian of ideas, was particularly interested in the human sciences, especially medicine. In his *Power/Knowledge* (1980) essays, Foucault argues that until the seventeenth century the basis of power was derived from the God-given right of sovereignty. After this period the right to power began to shift to those who could claim truth derived from scientific knowledge. In identifying the historical rise of scientific truth and its relationship to power, Foucault disrupts the sense of certainty that has given science its status (Bunkle, 1992).

Foucault put forward the idea that truth was a social construction produced according to certain rules, within specific historical contexts. In doing so he challenged the “classical notions of the universality of truth” (Rawlinson, 1987, p. 374). Furthermore, Foucault argued that truth was interlaced with events of force and power. It is often those in power, and who will benefit from a claim to truth, who determine the criteria for claiming a statement to be a truth (McWhorter, 1999). Truth from Foucault’s

perspective can no longer be seen as neutral and objective (Rolfe, 2000). Therefore in the analysis of truth claims one needs to consider the political agendas associated with the claims. For example, in my analysis of the scientific medical discourse I need to consider what the different speakers will gain from positioning themselves in the discourse.

### 2.4.3 Discourse and power

The relation of power to discourse was initially overlooked by Foucault (Sheridan, 1980) and subsequently addressed in later works. Parker (1989) interprets the relationship between discourse and power as being one in which the rules of a discourse determine what qualifies as “true knowledge”, what is said and who may say it. In employing a discourse, social relationships are organised between the speaker of the discourse and the person spoken to or of. For example, an obstetrician during a medical consultation with a pregnant diabetic patient may draw on scientific medical discourse to diagnose the patient’s condition<sup>3</sup>. In this moment of social interaction, a power relation occurs which is determined by the discursive rules for constituting “true” knowledge. The doctor holds the knowledge of the medical scientific discourse and therefore is the legitimate speaker of the medical discourse. The woman is cast in the position of the subject of the medical discourse. This relationship between power and discourse is just one of the many strategic elements of discourse which this study aims to identify.

Discourse has the potential to make power vulnerable.

We must make allowance for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. In like manner, silence and secrecy are a shelter for power, anchoring its prohibitions; but they also loosen its holds and provide for relatively obscure areas of tolerance.

Foucault, 1978, p.101

Discourse brings objects out into the open and in doing so makes them vulnerable through exposure, by bringing them to people’s attention. For example, as

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<sup>3</sup> An existing condition of diabetes may complicate the wellbeing of the mother and her baby during pregnancy. Enkin, Kierse and Chalmers (1989) recommend that women with diabetes are given “meticulous care” (p. 106)

will be discussed further in the study, some women's reaction to the label of "elderly primigravida" was one of incredulity and derision. In being made audible and hence exposed the term was made vulnerable. In the above passage, Foucault also draws the reader's attention to the potential of silence. As I understand Foucault's notion of silence, it allows a way of thinking to remain hidden and less vulnerable. For example, a person's silence may be an act of opposition and not necessarily an act of submission.

Implicated in the power and knowledge relationship is truth. For it is the claim to being a truth that gives knowledge its status and power. Foucault termed truth "a thing of this world" (1980, p. 131). The criteria for truth are socially ascertained rather than universally predetermined and fixed. From this relativistic perspective, truth becomes problematic and potentially contestable. Foucault does not ask us to deny truth. He asks us to know and to name truth, to analyse truth as a political economy; to identify what criteria we use to judge what is true and what is not; to identify the processes by which we reward 'truth' or punish 'false' claims; to identify the positions in our society that are given responsibility for speaking the truth; to identify "the techniques and procedures accorded value in the acquisition of truth" (p. 131).

Foucault (1980) identifies truth's political economy in western societies as having five distinguishing characteristics. Firstly, the scientific discourse and its related institutions dominate the constitution of truth. Secondly, both economics and politics play a critical role in the demand for truth. The spread and use of truth is the third feature. In western society truth is widely dispersed and consumed as education and information. Fourthly, the production and transmission of truth is predominantly controlled by select political and economic groups, such as the universities and the media. Finally, truth is the basis of political argument and social confrontation. I interpret the implications of Foucault's proposal in relation to this study that I cannot ignore the pervasiveness of truth and its relationship to economics and power. The quest for truth, its production and dissemination are all influenced by power.

## **2.5 POWER**

From within Foucault's propositions for the analysis of power emerge his ideas of power. He contests theorists, such as Marxist and Liberal political theorists (Grosz, 1990), who view power as an object, the ownership of which is a binary division between groups or classes who have power and those who do not. According to such theorists the groups who have power are advantaged, while the powerless are

disadvantaged. In contrast, Foucault (1980) proposes that power is not a property. It cannot be owned by a person or a group (p. 98). Rather, power comes into being in its exercise when certain words, practices or behaviours are chosen over others. Power is brought into existence in the way that a person carries out a certain activity and the effects of that activity on oneself and/or on others. According to Foucault (1989), power passes through a person for that time, it does not reside permanently within.

Power pervades all social relationships, the everyday and mundane as well as more overt public and/or political activities. Power is everywhere because through its exercise it comes from everywhere (Foucault, 1981). The conscious or unconscious doing is power made manifest. Relations of power are intimately linked with social relations such as production, family and sexuality (Barker, 1993, p.77).

Foucault portrays power as always in motion, never static. At times, he evokes a picture of energy channels and at other times, a picture of “blood” circulating through the social body. “Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power” (Foucault, 1980, p.98). The network of power affects everyone: we are unable to step outside of it, to be free of it (Barker, 1993). However, power is exercised unevenly through the network so that certain people, such as doctors or pastors whom power passes through, are important within their domains of power relations (Foucault, 1989).

Power is not always negative or repressive. Foucault argues that if this were the case then people would resist. Instead, power can be positive, productive and pleasurable. “It is a total structure of actions brought to bear upon possible actions; it incites, it induces, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely” (1982, p.220).

The process of labeling a woman as an “elderly primigravida” is a consequence of the maternal age discourse being powerful. The label is taught in medical schools, is used in obstetric literature, and is spoken about amongst work groups. Power constructs the individual. As Foucault (1980) wrote, “In fact, it is already one of the prime effects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals. The individual... is an effect of power” (p.98). The process of naming permits a person to be categorised and known in a particular way. For example, the category “elderly primigravida” permits a woman who has become pregnant for the first time at the age of 35 or over to be identified as an

~~individual.~~ The label distinguishes her from younger women and carries with it certain expectations of her capability to give birth.

Foucault's concept of power challenges the assumption that maternity professionals will constantly maintain power throughout their relationship with the woman. Therefore, throughout data analysis, I needed to remain open to the possibility that power could be contested between women and professionals, and between professionals. As discussed below, I looked for evidence of the exercise of power in the choices that women make and in the everyday practices of the maternity professionals.

### **2.5.1 Technologies of power**

In his later writings Foucault (1988) focused on the analysis of how the human sciences were utilised and applied by people in order to "understand themselves" (p. 18). He termed the process of determining the truth in human sciences as "truth games" and the utilisation of human sciences as "technologies" when referring to the practice of enacting or employing the knowledge gained from the human sciences.

Foucault identified four types of technologies:

(1) technologies of production, which permit us to produce, transform, or manipulate things; (2) technologies of sign systems, which permit us to use signs, meanings, symbols, or signification; (3) technologies of power, which determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject; (4) technologies of the self, which permit individuals to effect their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality.

1988, p. 18

Each technology has a particular kind of domination and rarely operates independently. Two technologies that have particular relevance to the study are the technologies of power and the technologies of self. One technology of power is Foucault's concept of discipline. Discipline may be defined as:

a power exercised on one or more individuals in order to provide them with particular skills and attributes, to develop their capacity for self-control, to promote their ability to act in concert, to render them amenable to instruction, or to mould their characters in other ways.

Hindess, 1996, p. 113

Discipline is a form of power that emerged in the seventeenth century in institutions such as schools, hospitals, factories and armies. Large numbers of

individuals could be effectively trained and managed through disciplinary techniques. Discipline is both repressive and productive. While individuals may be constrained by a discipline it also aims to intensify their capabilities. For example, practitioners may be required to follow a set procedure in assessing pregnant women but one of its aims is to produce a high and consistent standard of maternity care for all women.

One technology of power that is evident in maternity care is the panoptic gaze. In *Discipline and Punish* (1977) Foucault wrote of the development of a “panoptic regime of control” (Arney, 1982, p.230). The Panopticon was a mechanism of power and a metaphor for a hierarchy of surveillance. Foucault’s concept of panopticism was derived from the architect Jeremy Bentham’s plan for a circular shaped prison, the Panopticon. The prison was designed to separate the prisoners and to instill in them a sense of being constantly surveilled. The prisoners had the potential to be subjected to a constant gaze of both the prison guards and of other prisoners. The prisoners were not the only subjects of the panoptic gaze. The prison guards were positioned so they too could be surveilled by the prison governor.

The effect of the Panopticon was to make unnecessary the need for force. Individuals’ knowledge that they may be being observed results in them regulating their behaviour. They comply with the norm. Foucault wrote of the effect of panopticism on the individual as:

He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection.

Foucault, 1977, pp. 202 – 203

Control over an individual’s behaviour is exercised by the individual him/herself. Arney (1982) points out that conformity is induced not by threat of punishment but by the threat of observation. Any deviations from the norm are corrected and “normalised”.

Health care is an area in which the panoptic gaze is exercised. Its practice extends from the examination of a person by a health professional, to people regulating their own health and to “... the control of whole populations in the name of public health, and in the quest to normalize such populations” (Cheek, 2000).

Technologies of the self refer to a practice or strategy derived from or supported by scientific knowledge (scientific discourses) that a person may employ on her/himself. Thus she/he becomes both the object and the subject of knowledge.

What is important about the idea of the technology of the self is that people subjectivize themselves; they willingly choose to become the subjects of a discourse because of the outcome of positioning oneself within it. The individual may bring about the change to his or her body, soul, lifestyle, or thoughts alone, or through the assistance of others. The consequence anticipated is a transformation to oneself; the accomplishment of an end state which is perceived as an ideal. Foucault's concept of technology of self has a particular relevance in being able to recognise that participants may willingly situate themselves within a particular discourse and in being able to identify what the desired outcome of their course of action is.

In his essay *Technologies of self* (1988) Foucault employs the term "governmentality". He uses governmentality to describe the link between the techniques of power that are applied to oneself and to others, and defines it as the process of regulating the conduct of others. One particular way in which power is exercised that is pertinent to the topic of maternal age is the political focus on health and reproduction.

### 2.5.2 Biopower

The term "bio-power" refers to power over life. Foucault (1978) suggests that in the seventeenth century politics began to focus on the life and wellbeing of people. He argues that biopower was an important element in the development of capitalism facilitating the changes in economics and production. The aim of bio-power was to produce docility and productivity both at an individual and at the greater population level. Gordon (1991) describes biopower as,

forms of power exercised over persons specifically in so far as they are thought of as living beings: a politics concerned with subjects as members of a *population*, in which issues of individual sexual and reproductive conduct interconnect with issues of national policy and power. Bio-power developed into two forms, which Foucault termed anatomo-politics of the human body and bio-politics of the population.

pp. 4 – 5. Italics in original

Anatomo-politics are the disciplinary practices that construct the individual body as a machine. Individuals' gestures, movements, behaviours and abilities are normalised, organised, and maximized to ensure that they are as productive and useful

as possible. The places where disciplinary practices occur are both in institutions, such as hospitals, and at a micro-level in everyday, taken-for-granted activities and habits (Sawicki, 1991). The division of a birthing woman's labour into stages and the "normal" times associated with each stage, and the interventions that may occur reflect the disciplinary knowledge and practices of anatomo-politics. Sawicki (1991) makes the point that anatomo-political power is not coercive. Rather, it is productive in that it creates desires by offering subject positions, identities, and norms by which to judge one's performance and appearance.

The scientific medical discourse's categorisation of first time birthing women aged 35 years or over as elderly primigravidas produces a particular identity of and for the women who fit its criteria. The practices operationalised in the care of elderly primiparas attempts to ensure that they give birth to a live and healthy infant.

The second form of biopower that has developed, bio-politics, is focussed at the macro-level of the population, which Foucault (1978) refers to as the "species body". Bio-politics of the human population is concerned with birth, morbidity, mortality, life expectancy and longevity and the factors that influence each of these. The purpose of the exercise of biopower, which over time has become that of the state, is to regulate the wellbeing and continuation of the biological body. Thus, the individual becomes part of the body politic, and childbirth a time when the interests of the state and the body coincide (Olssen & Papps, 1997).

In both forms of biopower, knowledge is gained from the exercise of power, and reciprocally power is gained from the amassing of knowledge. Hacking (1991) writes of the avalanche in printed numbers that occurred with the rise in biopolitics and the development of categories that ensued as a consequence of the need to sort and classify the biological and social data collected about human populations. Medicine and the human sciences have operated as mechanisms that have contributed to the knowledge deployed in the exercise of biopower. They have been "instrumental in constructing the modern conceptions of the subject and the very idea of what it means to be normal" (Olssen & Papps, 1997, p. 39).

One consequence of the state's exercise of biopower over the population is that it has produced political counter demands (Gordon, 1991). Just as the state has made demands on how people conduct their lives, people now turn these demands back onto the state. In relation to this study, the two areas where political counter demands may surface are prenatal diagnosis and birthing. The idea that people can resist technologies

of power stems from Foucault's notion of the "strategic reversibility" of power relations and introduces his concept of resistance.

### 2.5.3 Resistance

Foucault's earlier work has been criticised for depicting individuals as always being the docile subjects of power. In his later works Foucault further developed his concept of resistance and the potential for agency. For Foucault, power is a fragile, contestable force in that the anticipated outcome of the exercise of power can never be assumed as a certainty. Resistance co-exists with power. Indeed, resistance is a condition of power's existence (Grosz, 1990). Where power is exercised, the potential for resistance is formed; resistance is never absent from power (Foucault, 1980, p. 142). Therefore, the possibility exists that the person upon whom power is exercised may refuse its application or undertake some action to avoid or abstain from being part of the play for power, or attempt to disrupt the flow of power.

Foucault's notion of resistance makes transparent his concept of power. As Smart (1985) elucidates, a free subject is the pre-requisite for the exercise of power. Where there is no freedom, there is no power. Foucault (1982) makes the distinction between power and violence. The latter is associated with a closure of possibilities whereas power, as conceived by Foucault, exists when there is a field of possibilities. For a woman to either be identified or to identify herself as an "elderly" primigravida the possibility/freedom to deploy or accept the term needs to be present.

As the network of power lacks uniformity and has multiple sites so too has resistance. Resistance is paradoxical in that although one can expect it to exist in relation to power, where and when it exists may be unexpected. The stimulus for the occurrence of resistance is not always static. As Foucault posited:

Hence they [resistances] too are distributed in irregular fashion: the points, knots or focuses of resistance are spread over time and space at varying densities, at times mobilizing groups or individuals in a definitive way, inflaming certain points of the body, certain moments in life, certain types of behaviour.

Foucault, 1982, p. 96, brackets not in original text

The location of resistances is that occasionally they may be large binary divisions, such as gender or the Marxist notion of two classes, but more commonly resistances are numerous and local or individual. Individuals or groups may coalesce in relation to an issue but then they splinter. Alliances and membership shift and reshuffle. Implied in Foucault's concept of resistance is that it emanates from within us, triggered

by experiences and physical changes as we journey through life. My being labelled an “at risk elderly primigravida” ignited my indignation and stimulated me to seek a maternity practitioner who did not see me as old and therefore at risk. Foucault’s notion of resistance keeps open the possibility for power to be disrupted and challenged by the women and practitioners in this study. Their resistance is made evident in the discourses that the women and practitioners deploy in narrating their experiences.

A third aspect of Foucault’s concept of discourse was its relationship to individual’s identities.

## **2.6 SUBJECTIVITY**

Weedon (1997) describes subjectivity as referring to the “conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world” (p.32). Foucault argued that subjectivity is produced by discourse (Bury, 1998). When people occupy positions in discourses the meanings that they give to events or experiences are derived from those discourses.

Once we take up a subject position in a discourse, we have available to us a particular, limited set of concepts, images, metaphors, ways of speaking, self-narratives and so on that we take as our own. This entails both an emotional commitment on our part to the categories of person to which we are allocated and see ourselves as belonging ... and the development of an appropriate set of morals (right or wrong).

Burr, 1995, p. 145 - 146

Willig (1999) states that a person “takes up” a position as a subject (or an object) in a discourse in two ways. One way in which a person becomes a subject is when one, for some purpose, positions oneself within a discourse. A second way is when a person is positioned by discourse. An example of the latter is when a woman aged 36 and pregnant for the first time reads books that identify her as an “elderly primigravida”. “Here individuals are constrained by available discourses because discursive positions pre-exist the individual whose sense of “self” (or subjectivity) and range of experience are circumscribed by available discourses” (Willig, 1999, p. 114). Being positioned by a discourse may also occur in what Davies and Harre (1990) term “interactive positioning” whereby one is positioned by another person. For example, when a GP labels a woman an “at risk elderly primigravida”.

Just as there are multiple discourses there is the possibility of multiple subject positions. Subjectivity has the potential then to be contextual and contradictory. In a specific context a person might employ a discourse, which they then contradict on

another occasion. The existence of multiple discourses on a given topic, such as birthing, allows the possibility for contradictory or conflictory meanings to be attributed to life experiences. Holloway (1984, p. 238) urges that any analysis which considers subjective positioning in discourse must consider the investment that a person has in positioning her/himself in that discourse in comparison to another.

Subjectivity, like knowledge, is a historical product open to change and contest. Different discourses create different identities and different subjectivities. One example is the liberal-humanist discourse, which depicts subjectivity as a fixed, rational and coherent consciousness. In comparison, Marxism constructs true subjectivity as something which is repressed and altered by the capitalist mode of production (Weedon, 1997). As Hekman (1990) aptly states “the theme of Foucault’s analyses in his extensive corpus is the insight that there are no essential subject or objects, but only individuals caught in a network of historical power relationships” (p. 68). While there may be more than one kind of subjectivity, what form is available, say to a practitioner, is limited both by the social context and by power relations.

Discourses are realized in the words and actions of individuals. The various discourses compete with one another at the level of the individual. When an older woman becomes pregnant she may become the site and the subject of the struggle between the natural birth discourse and the scientific medical discourse. Each discourse may offer her a different subjectivity and different relations of power. If the woman chooses to have a home birth it may be seen that she has given her “allegiance” to the natural birth discourse (Weedon, 1997). “The political interests and social implications of any discourse will not be realized without the agency of individuals who are subjectively motivated to reproduce or transform social practices and the social power which underpins them” (p. 93).

The above concept of subjectivity as partial, shifting, contradictory and discursively produced informs my analysis of the texts produced by the women and practitioners. Before I outline my use of Foucault’s concepts, I discuss the issue of his view of agency.

## **2.7 AGENCY**

In her explanation of the relationship between subjectivity and power, Weedon (1997) draws on individual agency as a factor. The implications of Foucault’s concepts of power and subjectivity for human agency have proved to be contentious for social

theorists as he is viewed as having destabilised human agency; as having questioned the assumption that a person acts autonomously (Hekman, 1990). There seems agreement amongst several authors that Foucault did not deny human agency. McWhorter (1999) attributes their interpretation to the readers having a concept of power as a causative force external to humans. She suggests that Foucault conceived of power as an “event”. As discussed above, power happens when a certain action is carried out, or a particular decision made. When power is viewed as an event, human agency is not negated. Agency still exists. As McWhorter concludes, “as I read Foucault, he in no way compromises my ability to act as a politically engaged agent to minimize the forms of subjugation I suffer at the hands of others or my ability to criticize others and hold them responsible for what they do” (p. 79).

Sawicki (1991) and Weedon (1999) also interpret Foucault as implying the existence of human agency. They propose that the availability of various discourses and practices allow a person the potential to opt for one discourse over another. Not only are people capable of making a choice, they also have the ability to employ discourses and practices inventively. Weedon (1999, p. 102) identifies two factors necessary for resistance: a person’s memory and his/her “discursively constituted” sense of identity. Memories from a previous experience of pregnancy and birth may combine with a woman’s strong sense of self. Together the two may provide the opportunity for the woman to resist the status quo or to derive new meanings from the contradictions and struggles. However, Weedon points out that resistance can still occur when choice, based on awareness of contesting ways of thinking, is not available. For example, a woman who is not aware of the debate regarding the routine use of ultrasound may still refuse to have one.

In his later writings Foucault saw subjects as being agents, having “the power to make choices and to set goals” (Shumway, 1989, p. 154). However, the choices and goals are determined by one’s social context. Gordon (1991) also asserts that Foucault did not deny human agency. Foucault’s concept of power presupposes the capacity of agency because Foucault sees power as existing when people are free to act.

Hekman (1990, p.72) asserts that Foucault did not consider subjects to be “passive dupes” of the discourses that describe their subjectivity. She argues that the dichotomy between a self-determining subject and a completely socially constituted one is a product of modernist thought. The dichotomy separates an autonomous subject from

a passively determined subject, a division that Foucault (1982) challenges by merging a subject who is constituted with one who has the permanent capacity to react and resist.

In relation to this study, I have followed Hardin (2001) who finds a middle ground between the humanist notion of free will and the poststructuralist “discursive marionette”.

Subject positioning, however, is not necessarily intentional or deliberate. This is because the subject positions that are available to individuals also fold back and construct individuals. A person’s decision to take up one subject position over another is also determined by discourses that constitute people in ways that they *desire* some positions over others.

p. 16, emphasis in original text.

Hardin argues that while there is some measure of agency in the subject positions that a person may take up, the actual range of subject positions is constrained by the discourses available. She proposes that the potential exists for people to manoeuvre within subject positions. She suggests that there can be an interaction between people and the categories assigned to them: “how people interact with categories and how categories interact with people” (p. 16). For example, I found that while some of the women were categorised as “at risk” they still believed in their potential to give birth without intervention.

As revealed in this explanation of agency, Foucault’s theories have not been without their critics. Given the constraints of this study, my consideration of the critiques made of Foucault’s work is limited to two aspects which feminists and critical theorists have commented on. These are his concepts of power and truth which I briefly outline in the following section of the chapter.

## **2.8 CRITIQUES OF FOUCAULT:**

Foucault’s opposition to the critical theorists’ idea that power is binary and centralised has been identified as a short-coming. For example, Walzer (1986) argues that Foucault’s interest in micro-power denies the possibility for challenge and change at a class or state level. Similarly Allen (1996) considers that Foucault’s “account of power is insufficiently structural” (p. 279) to be able to analyse and explain the power relations experienced by women. Hartsock (1990) believes that Foucault’s construct of power renders systematic power invisible. Because Foucault focuses on the diversity of the nature of power and the distinctiveness of each context in which power is exercised, his analysis identifies how individuals and not social structures exercise and experience

power. By this means domination of a group, such as women, by another group cannot be identified.

Feminists, such as Fraser (1989), have voiced concerns regarding Foucault's notion of power as "all-encompassing" (Weedon, 1997). ~~That is,~~ the connections that exist between power, discourse and the constitution of subjectivity. According to Weedon their concern stems from their view that the ability to stand outside power is necessary as a basis for political action to effect change. When power is theorised as "necessarily repressive" (Weedon, 1997, p. 175), political action is incapacitated. Foucault however, constructs power as both repressive and productive.

Foucault's analysis has been criticised as being both nihilistic and relativistic (Hekman, 1990; Walzer, 1986). The accusation of nihilism stems from Foucault's discarding of absolutes, particularly truth, freedom and justice. Taylor writes of Foucault's rejection of freedom and truth in the following way:

The idea of liberating truth is a profound illusion. There is no truth which can be espoused, defended, rescued ~~against~~ systems of power. On the contrary, each system defines its own variant of truth. And there is no escape from power into freedom, for such systems of power are co-extensive with human society. We can only step from one to another.

1986, p. 70. Italics in original

Manias and Street (2000) point out that Taylor assumes that knowledge of the truth is necessary for emancipation to occur. Knowing the truth reveals how power is disguised and imposed. From Taylor's perspective the relationship between power and knowledge means that knowledge does not exist of and for itself, power is always implicated. No matter what knowledge one attains, power is always present.

Foucault's rendering of truth as relative and a social construct, Porter (1996) believes, dissolves the ability to evaluate knowledges against one another. Porter is concerned that in its application to health and nursing a Foucauldian perspective would critique new health care approaches as simply a "... different perspective forged by the power relations that shape discourse" (1996, p. 226). Claims of a new knowledge being an improvement to or demonstrating a greater understanding than previous knowledges ~~can not~~ be made.

Hekman (1990) suggests that the modernist and feminist charge of relativism cannot be easily resolved as their definition of relativism differs from Foucault's and other postmodernists. The modernists associate relativism with the jettisoning of ideas

of rationality, truth. They regard relativity as “an evil to be avoided at all costs” (p. 152). In comparison, postmodernists such as Foucault do not define relativism as the binary opposite of absolutism. Their view of relativism is more the idea that there is more than one form of “true” knowledge that is universal and timeless.

Walzer (1986) and Hartsock (1990) assert that Foucault deconstructs power and truth but does not give any values or theories to replace them. Porter makes the same claim, that “a Foucauldian analysis can tell us a lot about what is wrong with where we are, it can tell us very little about where we should go” (Cheek & Porter, 1997, p. 113).

I concur with the criticism that Foucault does not offer examples of an ideal society or core values to strive for. However, I do agree with authors such as Cheek (2000) and Barker (1993). Cheek (2000) argues that the knowledge gained from Foucault’s analysis in itself is valuable. His analysis reveals constraints that have become hidden and taken for granted. While Foucault does not provide a “grand vision” of how to prevail over power, Cheek believes that his theories do offer an insight into power and its outcomes.

Barker (1993) contradicts the criticism of relativism. He asserts that analysts employing Foucault’s concept of genealogy are:

forced to acknowledge the politics of all historical interpretations and assess a response to them on this basis. Rather than all histories being accepted as of equal value, each will be analysed by the genealogist in terms of its relation to both its politics and the function it has within ongoing struggles of domination

p. 74

Barker believes that this approach does require the analyst to choose an interpretation and to maintain engaging with “political practices that emerge at the level of tactics and strategy” (p. 74).

A second point that Barker (1993) makes is that Foucault did not suggest that different truths should be rejected without regard. Instead, the researcher employs “methodological scepticism” as a means of suspending belief in the discourses being analysed. This does not entail an indefinite and ongoing rejection of them. “Methodological scepticism allows the revelation of other possibilities and with them the end of hegemonic effects of already established interpretations” (p. 74). The suspension of truth does not mean the rejection of truth.

## **2.9 SUMMARY**

In this chapter I have broadly identified the main ideas of Foucault that are pertinent to my analysis of maternal age. I have shown the importance of his concept of discourse and its interconnected-ness to subjectivity, power, knowledge, and truth. Each inter-connection has relevance for this study and offers insights into the knowledge and practice of maternity practitioners and the experiences of women who have experienced pregnancy and birth at the age of 35 or over.

The following chapter describes the steps involved in the research. I explain the procedures used to identify and contact the participants, the ethical issues that arose and to produce the data. A further topic addressed in the next chapter is the application of Foucault's concepts of discourse, subjectivity and power to both the data collection and data analysis.

## Chapter 3: METHOD

Writing research informed by postmodern theory is not a simple process of outlining a theoretical position and then writing up the 'factual' issues. Rather it is bringing theoretical implications to bear on one's reading of the texts generated by fieldwork and developing reading, writing and analytic strategies which break with modernist sociological traditions.

Opie, 1999, p.227

### 3.1 INTRODUCTION

Discourse analysis falls under the qualitative research umbrella and according to Lupton (1999) is an interpretive form of content analysis<sup>4</sup>. The term discourse has "conflicting and overlapping" meanings (Fairclough, 1992, p. 3). Two examples that Fairclough provides are that in some cases discourse can refer to different kinds of language used in certain settings or, as in linguistics, to refer to extended samples of spoken language. Attention is given to the formal structure of discourse and the methods of producing and interpreting written and spoken language. In comparison, Foucault's concept of discourse pertains to the diverse ways of constructing knowledge and social practice.

There is no one method of discourse analysis. There are multiple approaches (Burman & Parker, 1993). Grace (1998) makes the observation that for each research project, a method appropriate for the research process is developed. She proposes that the same is true for discourse analysis; a relevant method is created to analyse the information gathered. The method of analysis utilised in this study is a critical form of discourse analysis. Fairclough (1992) distinguishes critical discourse analysis from non-critical discourse analysis by its exposure of how "discourse is shaped by relations of power and ideologies, and the constructive effects discourse has upon social identities, social relations and systems of knowledge and belief" (p. 12). In comparison, the non-critical discourse method will only describe language practices without investigating the link between language discourse and power. It is the elucidation of the linkages between discourse and power relations that produces a critical analysis of discourse (Janks, 1997).

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<sup>4</sup> Lupton (1999) describes content analysis as being "directed at identifying patterns in textual material and using this knowledge to draw assumptions about how messages and meanings are represented in and communicated through texts" (p. 450).

According to Parker (1992) discourses are found in texts which he defines as “delimited tissues of meaning reproduced in *any* form that could be given an interpretative gloss” (p. 6). Consequently, a wide variety of material can be used as texts by the discourse analyst. Examples of different kinds of texts are articles from journals, magazines or newspapers, poster, television programmes or interviews.

While I present the analytical methods derived from Foucault as a sequence of certain steps and specific questions asked of the data, it is important to note that Foucault’s own writings on method “avoid system and totality” (Apperly, 1997, p. 19). The author argues that this is part of Foucault’s jettisoning of methodical and totalising philosophies. My method then, is primarily derived from my reading of Foucault and secondarily, from a medley of discourse analysts, such as Parker (1992), Powers (1996) and Kendall and Wickham (1999) who have been influenced by Foucault’s concepts of discourse, power and subjectivity.

In the previous chapter I explained the epistemological and theoretical assumptions that provide the framework for my research. In this chapter, I explain the methods by which I collected and analysed my data.

### **3.2 PARTICIPANT SELECTION**

I wanted to ensure that my data contained diverse perspectives. I decided to talk to a variety of people who would have had experiences directly relevant to my topic. Coyne (1997) and Brink (1991) classify this type of sampling as purposive in that the criteria for selecting the participants is deliberate in suiting the requirements of the study. The criteria were: women who had experienced pregnancy and birth at the age of 35 or over; and medical and midwifery practitioners who had cared for women aged 35 or over and pregnant for the first time. Interviewing both women and maternity practitioners would add to the richness of my data by giving different, and possibly contradictory, views. However, my preliminary reading of the medical literature regarding maternal age had shown that there was little qualitative research regarding maternal age that included the texts of women who had given birth for the first time when aged 35 or over. My aim was to ensure that women’s experiences were visible. Table 3.1 shows types and number of participants interviewed for the study.

**Table 3-1**            **Participants Interviewed for the Study**

Type of Participant	Number
Women who had been pregnant and given birth for the first time aged 35 or over	11
Women who had birthed previously and subsequently birthed aged 35 or over	4
Independent Midwives	5
Hospital midwives	5
Obstetricians	4
General Practitioners	3
<b>TOTAL</b>	<b>32</b>

### **3.2.1 The Women**

The age criterion for selecting women was influenced by the International Council of Obstetricians and Gynaecologists' decision in 1958 to apply the term "elderly primigravida" to all pregnant women aged 35 or over who were birthing for the first time (Tuck, Yudkin & Turnbull, 1988). The first reason for interviewing only women who had already given birth, rather than women who were pregnant at the time, was to get a synopsis of their journeys through both pregnancy and birth. Medical literature identifies "elderly primigravidas" as being more at risk for developing a variety of problems during pregnancy, labour and postpartum (Roberts, Algert & March, 1994; Cunningham et al., 1996). By interviewing women who already had children I would be able to gain a sense about the extent to which the participants experienced the problems associated with being "elderly primigravidas".

The second rationale for not choosing women who were pregnant at the time was that the process of being interviewed might have added to any anxiety they were experiencing about birthing. It seemed, given the medical representation of "elderly primiparas", unethical to aggravate any concerns that they might have and to expose them to the idea that they might be more at risk than other women. Lee and Renzetti (1993) define a sensitive research topic as "...one that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and /or the researched the collection, holding, and /or dissemination of research data"(p.5). Included in their definition are topics that are "emotionally charged". I believe that the topic of genetic screening is both an emotional, and a personal moral issue. Indeed, one participant did relate how difficult the process of deciding about genetic testing was for her and her partner. Choosing to talk to women

after the event decreased the possibility of women feeling challenged about their decision-making by the researcher. A total of 11 women, who had been pregnant and given birth for the first time when aged 35 or over, were interviewed. Three had given birth in the 1980s and the remainder in the 1990s. Except for three, all of these women had chosen to birth at a hospital. One of the three home-birthing women had been under the sole care of a midwife. Another of the home-birth women had planned to have “shared care” whereby she had both a midwife and her general practitioner. However, the government’s introduction of the Lead Maternity Carer scheme in 1997 required her to nominate one principal carer and she chose the midwife.

I was also interested in women who had had previous pregnancies and births but subsequently had given birth when aged 35 or over. I wanted to gain a sense of whether being over the age of 35 had been of particular significance to them, whether being older influenced the women to perceive themselves differently. A further four women who had given birth when over the age of 35 and had previously had at least one pregnancy under the age of 35 were interviewed. One had given birth during the 1960s, two in the 1980s and one in 1997. Of these women only one had chosen to give birth at home.

There was no time frame for when the women had to have given birth to be in the study as I wanted to explore the similarities and differences in the way they talked of their experiences. For example, the woman who had given birth in the 1960s made no mention of the availability of screening for genetic abnormalities.

Both direct and indirect contact was used to approach women who fitted the selection criteria. Six of the women I personally knew through social networks. Four of these approached me after hearing about the topic of my research. Seven women were approached indirectly through friends and colleagues. Two women contacted me after they had read an article published in a local community newspaper, about another study and my research into “older mothers”.

After women had expressed an interest in my study, either directly to me or indirectly via my friends or colleagues, I sent each interested participant a copy of the information sheet (see Appendix 1), which invited her to be a participant. Two weeks after sending the information sheet, I telephoned each woman to determine her continued interest. When the woman confirmed that she wished to be a participant, an appointment was made for an interview.

### **3.2.1.1 *The Midwives***

I used word-of-mouth to identify self-employed midwives. Interviews were conducted with five midwives, three of whom were currently working as independent practitioners and one who was retired. The purpose of my inclusion of self-employed midwives (who I have called ~~as~~ independent midwives) in the research sample was to identify and explore their views on maternal age and parity, and their practices when caring for primigravidas/primiparas aged 35 and over. I was interested to find how the right to provide antenatal, intrapartum and postnatal care independently of medical practitioners had influenced their practice in relation to caring for “older” women. An additional five midwives, who within the past four years had worked as hospital midwives, were interviewed in order to highlight hospital practices in relation to maternal age.

### **3.2.1.2 *Medical Practitioners***

The local telephone directory was used to identify obstetricians and general practitioners in private practice. Private practitioners were chosen for their accessibility. I did not want to have to negotiate my way indirectly through hospital bureaucracy to approach practitioners. I telephoned several doctors whose names were familiar to me from my work with midwives, and a local women’s health group. I then briefly outlined my research, and asked if they would consider being a participant. If they expressed interest, I sent out the Information Sheet for Practitioners (see Appendix Two). On four occasions when I was unable to speak directly to the doctors, I sent out the information sheet as the initial contact. Two weeks after I had mailed out the information, if I had not received a reply, I then contacted them by telephone.

Four male obstetricians agreed to be interviewed. Three others who were approached declined, citing busy work schedules. Three general practitioners were interviewed, two female and one male. A fourth was approached but was not followed up as I found out that the practitioner had a heavy workload and it seemed inappropriate to pursue her further.

## **3.3 ETHICAL CONSIDERATIONS**

One of the first steps in my journey was to gain formal ethics approval for the research study. Ethics approval was gained from two committees: the Massey University Human Ethics Committee, and the Northern Regional Health Ethics Committee. The approval of the latter was necessary because of the inclusion of

midwifery and medical practitioners who had maternity access agreements with the Northern Regional Health Authority.

### **3.3.1 Informed Consent**

Informed consent was addressed in several ways and seen as an ongoing issue rather than taken-for-granted once the participant had agreed to be interviewed. A brief verbal description of the study was given to participants when I initially contacted them to determine their interest.

Two information sheets were developed (see Appendices 1 and 2), one for the women and the second for the practitioners. The information sheet was mailed out and each participant was given the choice of contacting me after they had read it or of waiting for me to contact them two weeks later. The aim of the time lapse was to provide participants with the opportunity to fully consider their involvement in the research and to discuss it with others, such as partners, if they chose to do so. The information sheet provided details of the research and explained what involvement was expected of the participants. It stated their rights and the anticipated benefits and risks of being part of the study, and the expected length of time that the interview would take. To avoid a sense of coercion and the assumption that their indicating interest implied agreement on their part to participate, the wording used on the information sheet “invited” participants to join the research study.

I learned to ring participants the day before and/or the morning of the interview to confirm whether they were still agreeable to being interviewed and whether the time was still convenient for them. On several occasions the independent midwives had to postpone our scheduled meeting either to be with a woman who had gone into labour or to see a woman about an antenatal or postnatal problem that had arisen. The second participant I interviewed was unable to contact me in time to let me know that she would have preferred another time.

At the beginning of the interview I would obtain the participant’s signed consent (see Appendix 3), having asked if there was any further information about the study that s/he needed before agreeing to take part. Their rights to have the tape turned off; to delete any sections, to refuse to answer any of the questions, and to withdraw from the study at any time were reiterated.

### **3.3.2 Confidentiality**

Participants were asked to choose a pseudonym by which they would be known in the research. During transcription any characteristics that might identify them were deleted or changed. The transcripts were then sent to the participants with a letter reminding them to check that they were satisfied that their anonymity had been maintained, and that they were satisfied with the information that was on the transcript. Audiotapes, and computer transcripts of the interviews were kept in a locked cabinet. Participants' names were kept separate from their pseudonyms by storing them in another location. As typists were employed to transcribe the tapes, they were required to sign declaration forms stating that they would maintain confidentiality (see Appendix 4).

## **3.4 THE INTERVIEW**

### **3.4.1 Content and Process**

I began each interview of the women who had given birth by asking them to recall their experience of pregnancy and birth. As they related their journey through their pregnancy and birth, the issues of genetic screening, choice of maternity practitioner, and place of birth usually arose spontaneously. These were explored in an effort to identify why the women made the decisions that they did. I also asked the women how they perceived their bodies, and their ability to carry a pregnancy and give to birth to a child. All the women chose to be interviewed in their homes. I found that the interviews with the women took on average one and a half hours.

Practitioners were asked for their views on women who were pregnant for the first time, and aged 35 or over and how they perceived the women's bodies and ability to birth a child. I also asked them to describe the practices that they routinely perform when caring for such women. This question usually elicited the topics of genetic screening, and anticipated medical problems associated with age during pregnancy and birth. If the practitioners did not initiate the topic of caesarian sections, I would initiate it by asking them for their views on older women having such a high incidence of these. Interviews with medical practitioners took on average 30 minutes as they mainly requested to be interviewed at their offices during work hours. Three saw me at the end of the day, two in clinic hours, and one during their lunch break. In comparison, the interviews with the midwives took on average about an hour to an hour and a half. One

midwife chose to be interviewed in her home whereas the other midwives chose to be interviewed at my workplace.

I wanted to interview my participants in a way that would avoid them feeling exploited. One way I could facilitate this was to let participants choose a time and place that was convenient for them. Other strategies I employed were to use a flexible guided interview process covering topics that were derived from the literature on older mothers and to give participants copies of interview transcripts and allowing them to make corrections to the material (implications of this are discussed below). According to Patton (1990), the interview guide method of having an aide memoire of topics that are to be covered allows the researcher the flexibility to go with the flow of the conversation. This form of interviewing allows the interviewer to seek clarification and reduces the possibility of being misunderstood (Sarantakos, 1993).

Minichiello, Madison, Hays, Courtney and St John (1999) identify the conversational style of interview as the recursive method. What is unique to the recursive method is that the flow of the researcher's questions is influenced by what has already been said by the participant. Its informal structure and process aims to draw out the participant's personal views and experiences. Overall, I found that the recursive method did facilitate an in-depth exploration of the practitioners' and women's perspectives. However, on one occasion when a practitioner could only see me for 15 minutes, I found that I had to be more structured if I wanted to address most of the topic areas.

I wanted to allow participants the opportunity to follow the thread of their thoughts and in a sense exhaust it. There were two reasons for this. The first was to give them equal control of the interview process. They could control what and how much was said about a given topic. The second was to assist my identification of the discourses that exist regarding maternal age, pregnancy and birth. According to Morse (1991) flexibility during interviews facilitates the drawing out of each participant's story.

One of the disadvantages of the interview guide method is that questions may be asked in varying ways so that the researcher is unable to compare responses across participants (Patton, 1990; Sarantakos, 1993). Morse (1991) suggests that attaining a balance between flexibility and consistency is difficult for the researcher. I did find this difficulty happened to me. I often found that to explore the topics identified above in more depth meant that I asked about them in different ways. However, by having

identified the topics before the interviews I was able to ensure there was some degree of standardisation of topics which were actually explored by all participants.

I adopted Morse's (1991) suggestion of referring to the interview guide periodically, "taking stock" of what topics had been covered and what still needed to be discussed. Morse identifies three types of questions that can be used during the interview process: comparative, generality and ubiquity questions. I found that I used all three. Comparative questions asked the participant to compare their own practice or perspective with that of others. Generality questions got the participants to state their views on a topic in order for me to assess whether participants supported general notions I had read about or not. For example, I would tell women that the literature described them as a cohort that was well read and that was keen to be well informed regarding pregnancy and birth. Then I would ask them for their views. Ubiquity questions, as defined by Morse (1991, p.194), assume that the participant shares the actual experience being discussed and asks them to describe their own personal experience. One example from my research was when I asked women what it was like to be pregnant at the age of 35 or over.

I wanted the participants to enjoy the interview process. I had hoped that it would be a positive experience for the women to revisit their births and for the practitioners to discuss their practice. In retrospect this was rather naive of me, particularly in relation to four medical practitioners who chose to see me during work hours. For me, the 15 to 40 minutes they allotted to me, were precious and had to be used effectively. I had to drive the interviews to ensure that the topics were covered. The opportunity to explore topics in depth was not always present. One specialist did express enjoyment of the interview, commenting that he did not often have the opportunity to discuss his practice.

Holloway and Wheeler (1996) recommend that when interviewing colleagues the researcher remain a "*cultural stranger* or *naive* observer (italics in original text) not assuming that there is a shared understanding and shared beliefs and values" (p.58). I found this particularly difficult to achieve with the medical specialists. Occasionally, I found myself not asking them to explain some of the medical terms that they used. This may have been due to two factors. The first was the pressure of time discussed above. The second was that I did not want to appear ignorant to them. The information that I had sent to them introduced me as a nurse lecturer as well as a researcher. Thus, I felt

there was an expectation that because I was a nurse I understood what they were talking about. I did not want to embarrass myself, and the institution that I worked for.

While interviewing women, the issue of self-disclosure became apparent. Reinharz (1992) raises the issue of researcher self-disclosure during the interview as being good feminist practice in that it may put the women at ease, empower the participant, or facilitate more meaningful discussion. I found that I did use self-disclosure for a variety of reasons. I realised that in my first interview that I had sometimes used self-disclosure inappropriately to fill the silences but mostly to create a sense of equality and shared giving. According to Reinharz, the value of self-disclosure is in its timing, and so I learnt from my first interview, to wait until the woman asked about me before I would self-disclose.

When I did use self-disclosure it was to convey to the woman that I too had had the same experiences, the same feelings, or the same dilemmas. It seemed important to acknowledge the sharedness of the issues to which pregnancy and birth expose women. Whether or not I did self-disclose depended on how similar I perceived the participant's views to be to mine. I knew that I believed strongly that birth is a natural process in choosing to have homebirths for my two children and midwife-only care for my second birth. I wanted to avoid appearing disrespectful or judgmental towards women whose views contradicted mine. If I wanted to develop rapport with my participants then I had to be non-judgmental, or neutral (Patton, 1990), about what they told me. However, when the women asked me about my experiences or beliefs I did share them.

My other concern was that the women might not discuss freely their views. It seems to me that in qualitative research, if the researcher is to draw out participants' views and experiences, she has to create the environment to encourage this. Patton (1990, p.279) states "The task of the interviewer is to make it possible for the person being interviewed to bring the interviewer into his or her world." However, it cannot be built on deceit, where the researcher knowingly lies to the participant. If a participant asked me about my experiences, then I told them, but I did not provide this information at the outset. Rapport and trust are integral to the interview method (Minichiello et al, 1999; Patton; 1990).

#### ***3.4.1.1 Discourse analysis approach to questioning***

Potter and Wetherell (1987) suggest that in order to elicit the different discourses that may exist on a subject, the dialogue between the researcher and the participant

needs to be an interactive two-way process. The researcher questions and challenges the statements made by the participant. The interview context becomes “a more interventionist and confrontative arena than is normal” (p.164). Discourse performs a function, and in such research the researcher’s aim is to identify the different discourses which participants deploy to account for their actions. I felt uncomfortable with the notion of challenging participants as I wanted to draw out their explanations and stories. Glesne and Peshkin (1992, p.86) identify the ability to be non-threatening as a “good interviewer quality”. It is required in order to assist the participant to feel free to express herself or himself, and to create a sense of safety for them. I found that Heslop (1997) affirmed my thoughts. She describes the discourse analyst as needing to have a “non-judgmental” relationship with her participants if understandings are to arise.

I believe that Potter and Wetherell (1987) have an agenda which challenges traditional quantitative psychological data collection methods. They want to move away from the fixed responses that psychology has employed and to move towards a more interactive process. I understand that in qualitative methodology fluidity and interaction in the interview process have been integral and accepted as legitimate. Furthermore, and more importantly, Potter and Wetherell (1987) suggest the challenging strategy in an attempt to elicit the different discourses that may exist regarding a phenomenon. My way of gathering different discourses was to interview the different people involved in the birthing process and to draw on both popular and professional literature.

#### ***3.4.1.2 Power relationships during the interview***

Webb (1993), in her review of feminist research, argues that during interviews the relationship between the researcher and the participant is inevitably one-sided. The researcher’s control over the research process plus her status gives the researcher more power. Although I agree with Webb in regards to who has control over the entire research process and the research product, I query the automatic assumption that the researcher has more power in the interview. Webb states that the one-sidedness is inevitable because the “researchers have a different status from those researched. They are usually more highly educated and so are more assertive and articulate” (1993, p.4). All my participants were professionals. The women had all had professional careers. I found them very articulate and well informed. I might have known more about the medical literature pertaining to maternal age but my gut sense told me that the interview process did not intimidate them. Indeed, I did not want them to be. I felt equal to them

because of their education and profession. As a health professional, I also felt equal to the midwives I interviewed. With the women, midwives and the female general practitioners, we were women of similar age, class and educational backgrounds.

In her discussion of power relationships between the researcher and the participants, Wolf (1992) asserts that feminists have an “enhanced understanding” of gender power issues through their involvement in political contests. There were times during the interviews with the women and the midwives when they spoke of power issues that I felt that I understood their positioning. For example, there were two occasions when women spoke of the negotiations and tensions they experienced in deciding whether to undergo prenatal genetic testing. While they were talking I was reminded of the discussions that my husband and I had had during each of my pregnancies. In relation to the midwives, I had written a submission supporting the introduction of a direct entry midwifery education for the women’s group that I belonged to. I also knew midwives who actively lobbied for the re-introduction of midwifery autonomy.

I found myself, however, feeling quite differently when I was with some of the male medical practitioners, particularly the specialist obstetricians. My interviews with them occurred in their offices. I sat in their client’s chair and they sat at their usual position at their desk. On one occasion the specialist and I sat on a sofa together. The change of the seating did make some difference but I believe that there were other contributory factors. Oakley (1981, p.55) defines “social distance” as the degree of similarity and equality between the interviewer and the interviewee. Social distance is determined by the extent to which gender, socialisation and critical life experiences are shared. Thus the degree of social distance between the women, the midwives, the female general practitioners and myself was minimal. In contrast, the specialists and I shared few of these variables. In fact, their gender and class might not only have increased the distance but have also created a stratified relationship.

I believe I also possibly positioned myself as the “submissive nurse”. The medical practitioners knew that I was a nurse, so there may have been, for both of us, a sense of collegiality, an expectation of shared culture. What I believe may have had a real influence on me might have been a few experiences I have had in the past as a nurse where a doctor has reprimanded me for speaking out. I have also been subjected to verbal abuse from a specialist. Furthermore, my nursing education occurred in the 1970s in the hospital-based training scheme when hospitals were organised in a rigid

hierarchical fashion, with doctors occupying a higher status than nurses, and nurses were seen as “doctors’ handmaidens”. Lee (1993) considers factors that can create issues of emotion and power during in-depth interviews. He suggests (employing the work of Laslett & Rappoport, 1975) that a situation can occur for the interviewer where s/he transfers past experiences on to the interviewee. Scheurich (1997) warns against perceiving that the interviewer has a position of total power and the interviewee as having only the potential to resist. The problem with this, he believes is the perpetuation of what he terms the “dominance-resistance binary”. From a postmodern perspective, he proposes that there is a third space, one of “chaos-freedom”, which is derived from the “wild profusion” of life’s activities and experiences, that both the interviewer and the interviewee bring to the interview, and that cannot be contained by the dominance-resistance binary. Unconsciously, I believe that when I was interviewing specialists who were older males, I transferred onto them my earlier experiences.

What this experience has highlighted for me is that Foucault’s notion of power as a circulating force in play (McHoul & Grace, 1993) is applicable to the interview process. The notion that during an interview the researcher always holds/exercises power and that the participant is always powerless and dependent on the researcher to share her power is suspended. One reason may have been that several of the obstetricians in my research were asserting their power as experts. When I compare their transcripts to those of the women and midwives, the obstetrician’s transcripts contain many lengthy explanations.

Furthermore, I found myself “charmed” by the obstetricians. They were pleasant and courteous. I cannot help but wonder if I was in a sense “disarmed” by them and whether this is a tactic that they consciously or unconsciously use with women. When relating my experience to a group of colleagues, two women said that they too had had similar feelings. The cumulative effect was that I became less confident to raise the topics in the same questioning manner with the male obstetricians than I had with my female interviewees.

Parker (1992) writes that data for discourse analysis can include many types of texts as well as interviews. The second type of textual material that was utilised in my study was literature drawn from a variety of sources.

### 3.4.1.3 Literature

I had identified that maternal age was discussed in three types/genres of literature: popular, such as books, magazines and newspapers; midwifery journals and textbooks; and, medical journals and textbooks. My system for gathering the medical and midwifery literature was to obtain copies of as many of the references written in the English language that were cited in recent publications as I was able to. In this way I worked from the present to the past. The midwifery textbook chosen was *Myles Textbook for Midwives* as it has been, and continues to be, a standard text for student midwives. Government documents that made reference to maternal age in relation to prenatal genetic diagnosis or maternity issues were also used as data. Magazine articles were collected in a less systematic and more serendipitous manner, however for reasons of manageability of data I have chosen to omit them from this study.

## 3.5 TRANSCRIPTION

Three women typists transcribed the tapes verbatim. I then read each transcript while listening to the tape recording and corrected any errors or omissions. Careful thought was given to how verbatim the final transcript would be and how detailed the depiction of the interview would be. Silverman (1993) notes that discourse analysis does not require the precision in transcriptions that conversational analysis does. Fairclough (1992) states that “it is always a matter of judgement, given the nature of the project and the research questions, what sort of features to show, and in how much detail” (p.229). I therefore decided that my analysis would only include the words that were used and not grammatical or phonetic features.

Opie (1995) writes of her participants reporting conversations that they had had and of how she chose to depict these conversations and the changes in pitch and tone so that the reader could gain a visual impression of the speaker’s style and performative content. She aimed to visibly capture the dramatic way in which her participants spoke of their work and to position them as powerful and moral players. However, I felt that the words were sufficient in themselves to convey the women and practitioners’ perspectives. Consequently, a series of dots were used to indicate pauses in the speaker’s flow of speech where they had paused to think, and bold lettering was used to depict emphasised words. Repeated words and “ums, mm’s” and other fillers were deleted, as were grammatical errors, as my focus was not on the performative function of the speaker. There were tensions between the need for valid transcripts as a verbatim

record and to avoid creating unnecessary discomfort or embarrassment for my participants when I gave them a copy of their transcript to read. Four people returned their transcripts for editing, one with quite detailed grammatical changes and the others with alterations to some of their statements.

One request presented me with a dilemma. How much control was I going to give participants over deletions of material from the transcripts? One participant asked for deletions of statements that she felt were not relevant to the topic. However, I had earmarked three of the statements to quote in my thesis. I had no similar examples in the other transcripts encapsulating the theoretical concepts that I had identified so clearly. I did not want to lose them. I decided to write to the participant, asking her permission to keep the statements in the transcript, explaining why I wanted to use them in my thesis. Fortunately, the participant consented.

### **3.6 ANALYSIS**

Davidson (1986) identifies three forms of analysis within the writings of Foucault: archaeology, genealogy and ethics. Each relates to the three areas of analysis that concerned Foucault during his lifetime. Systems of knowledge was the first of Foucault's analytical interests followed by "modalities of power, and of the self's relationship to itself" (p. 221). The first two domains were of particular interest to my study as I was interested primarily, in how women and practitioners represented maternal age in relation to pregnancy and birth. The two domains of archaeology and genealogy are not separate from one another: they can be used together to complement one another (Davidson, 1986; Kendall & Wickham, 1999). Kendall and Wickham (1999, p.30) write of archaeology as being like a photograph of a wedge of a discursive nexus, while genealogy focuses on the nexus's ongoing processes. Davidson (1986) makes the distinction thus:

Archaeology attempts to isolate the level of discursive practices and formulate the rules of production and transformation for these practices. Genealogy, on the other hand, concentrates on the forces and relations of power connected to discursive practices; it does insist on a separation of the rules for production of discourse and relations of power.

p. 227

My first exercise was to read and re-read every transcript to gain an overview and an understanding of the texts. Then I began organising them. I had to do this manually as I found that the Microsoft Works programme used by my first transcriber

did not mesh with the Word programme that I was using to write my thesis. I decided therefore to print hard copies of each transcript. I found working with the actual pieces of paper allowed me to move across and back from one transcript or transcript segment to another in a way that a computer screen did not.

Initially I had thought I might analyse the transcripts according to the category of speakers. For example, to analyse all the midwives' transcripts first before beginning analysis of the GPs. However, when I read across the transcripts I saw that the meanings given to discursive objects, for example birth, were not necessarily determined by the category of speaker. Similar meanings were apparent across the texts of the different categories of speakers (Lupton, 1999). For example, some of the women and medical practitioners, as well as the midwives, spoke of birth as an inherently safe process.

Keeping in mind Foucault's (1972) concept of discourses as practices which systematically form their discursive objects, and that speaking and writing are discursive practices, I decided that the first step to take in sorting the data was to read through the transcripts with the understanding that each one contained glimpses or fragments of a discourse (Parker, 1992). As I read the transcripts (and the literature), my first question of the data was "What objects and practices are being spoken of here?" As I began to identify objects such as birth, the older woman's body, the intellectually disabled baby and the practices surrounding prenatal genetic testing and intervention, I cut and pasted together copies of relevant excerpts from transcripts. Following Potter and Wetherell's (1987) suggestion to be as inclusive as possible since sorting has a pragmatic goal, I put all the excerpts on the same discursive topic for example, about birth, together. So as not to lose the context in which the extracted statements were made I also made a hard copy of each complete transcript, which I would refer back to.

My second sorting step was then to read through each group of excerpts and look for similarities and differences within each discursive topic. For example, reading through all the excerpts on the topic of birth, I found that some participants spoke of birth as a process that was potentially dangerous, whereas others depicted it as an inherently safe process. In this way, I was able to identify the different discourses that were deployed by the participants and to reveal the multiplicity of discourses that existed in relation to birth. Potter and Wetherell (1987) write of looking for patterns in variability and consistency. The researcher identifies both the differences in the structure and content of the statements, and the characteristics shared by statements. While I had an idea of what some of the discourses were before I embarked on

analysing my data, by these means I was able to identify further discourses deployed within the literature and by participants.

Parker (1992) writes that a discourse is interrelated with other discourses. There are points where a discourse may intersect with or involve the use of another discourse, or where it may imply another. He recommends strategies for assisting the identification and exploration of the differences and overlaps between discourses. The first strategy is to put the various discourses beside one another and to look for the different objects that they constitute. The second strategy is to discern where the discourses overlap, by looking for the same object and how it is being constructed in different ways. For example, further on in my analysis of the discourses regarding prenatal genetic diagnosis, I found that the women constituted the knowledge provided by the tests in quite different ways.

To gain a sense of the speaking positions, subjectivities or identities offered by the discourses, and the relations between the different speaking positions, I looked for the way in which women talked about themselves and the practitioners. Davies and Harre (1990) suggest that pulling out the sections where the speakers talk autobiographically can assist in identifying subject positions. From these segments, it may be able to ascertain how the speakers think of themselves and others.

Having completed sorting the data, my next step was to analyse each discourse. I posed the following questions, derived from the writings of Foucault (1972), Parker (1992) and Kendall and Wickham (1999). What objects, issues and practices are constituted by the discourse? What are the relations between the different speakers of the discourse? Where do the objects of the discourse come into being and in what places? What are the institutions implicated in the discourse? What are the conditions that allow the discourse to exist? What rules are there as to what constitutes the truth?

The archaeological questions asked of the data therefore are to do with what the rules of the discourse are, with what can be said, and with what cannot be said. There are limits as to the time and place when a certain group of statements can be expressed and be regarded as the truth (Hacking, 1986).

Genealogy also involves an analysis of the “history of the present” (Kendall & Wickham, 1999). Prado (1995) suggests that:

Genealogy must analyze the descent and emergence of morals, ideals, and metaphysical concepts, in order to show them and their like to be

neither discovered truths nor preordained developments, but rather the products of conglomerations of blind forces.

p. 38

Therefore, the question arises as to when do terms, for example “elderly primigravida”, appear or disappear? Prior (1997), when describing how he might apply a genealogical approach to the classification of causes of death, states that he would “trace the points at which certain illnesses have been admitted into the nosology and others expelled from it” (p. 69). I asked of my data when and what other factors became associated with “elderly primigravidas? What are the other discourses associated with “elderly primigravida /primiparas? What are their effects on one another?

Davidson (1986) writes that pursuing genealogical method impelled Foucault to make clear his rules for analyzing power. Following on from my explication of Foucault’s (1978, 1980) concepts of power in Chapter Two, the questions asked of power in this study are: Does power enable or constrain? What techniques or technologies of power are being exercised, and by whom? How does a discourse relate to the exercise of power and power to truth? What resistant discourses and tactics of power are there? How do they operate? Who are the speakers and what subject positions do they take up? Parker (1992) suggests that two questions related to power to consider are which people would benefit or lose from the use of a discourse, and who would want to advance the discourse or want it to dissipate?

I noted that Bungay and Keddy (1996), researchers interested in the method of experiential analysis, which is based on contemporary thinkers such as Foucault, describe a form of literature review that is different from the “traditional” review. Their review of the literature exposes the different discourses in play. Kendall and Wickham (1999) when describing Foucault’s “ordering tool” of archaeology write of how Foucault makes “continual recourse to the *archive*”(p. 25, emphasis in original text). Thus, the literature on maternal age became not just a means of justifying my research but became actual data for analysis.

I analysed the literature separately from the transcripts. My reason for this was that I wanted initially to identify the discourses in the literature and then to see if and how my participants articulated these. It was important to me that I read and analysed my participants’ voices away from the literature. I wanted to be free, in a sense, to have the opportunity, to listen to them speaking for themselves. I was aware that most of the literature was by overseas authors and that the history and context of New Zealand/Aotearoa might raise different issues and ways of thinking.

### 3.7 THE ISSUE OF VALIDITY

Validity is concerned with the standing of research per se in that research constitutes a knowledge that is different from other types of knowledge. Claims to the truthfulness of the research process and its findings are based on a procedure whereby information is gathered systematically. The information becomes “data”<sup>5</sup> which is then exposed to reason and analysis. The findings are, in turn, used to create a particular knowledge which is given the particular authority of being truthful or trustworthy.

Scheurich (1997) argues that “ the essential meaning of validity came to be the warrant of trustworthiness. If a research study had the appropriate validity, the results could be trusted.” (p. 81). He argues that underpinning the debate regarding validity/trustworthiness in qualitative research is the notion that there can be criteria for evaluating the validity of research. The criteria for evaluating validity are determined by the evaluator’s epistemological perspective. “Validity, therefore wears different epistemological masks” (p. 82). What the concept of validity perpetuates, he argues, is a binary dividing line that differentiates pieces of research from one another. Those judged as valid are included while those judged as invalid are excluded. As I understand Scheurich, he is making visible the power/knowledge relations that underpin the concept of validity, and the potential for the voices of the other to be excluded.

The issue of trustworthiness has become synonymous with rigour within nursing research (for example: Koch, 1994; Sandelowski, 1986 & 1993). The criteria for establishing qualitative research validity and reliability were derived from quantitative research (Koch & Harrington, 1997). However, their application to qualitative research has not been an unproblematic and necessarily relevant process (Krefting, 1991; Sandelowski, 1986). For example, Sandelowski (1993) questioned the assumptions underpinning the criteria for consistency or reliability. She argued that they are based on the assumption that there is only one “tangible” reality (p.3), which can be located by the researcher. A further issue that Sandelowski (1993) raised was the belief that reliability is a requisite for validity. Rather than seeing the differences as problematic for the validity of the research, she proposes that the researcher could explore them, questioning why they exist. Underpinning Sandelowski’s (1993) critique is the postmodern assertion that there are multiple truths, and multiple realities.

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<sup>5</sup> Defined in the *Oxford English Reference Dictionary* as the “known facts or things used as a basis for inference or reckoning” (Pearsall \* Trumble, 1996, p.362).

As highlighted by Koch and Harrington (1998) more recently, it has been proposed that the rigour of each research study be derived from the philosophical approach it employs. Choosing Foucault/postmodernism as my philosophical perspective threw the issue of validity into question (Lather, 1993). Postmodernism challenges the notion that “is possible to represent any aspect of reality in its entirety, speak for others, make truth claims, and attain universal essential understandings” (Cheek, 1999, p. 384). Rice and Ezzy (1999) identify that the relationship between the “observer and observed reality” (p. 31) is at the centre of the issue regarding validity and reliability in qualitative research. From a postmodernist perspective, the assumption that the data produced from interviews represents the “truth” is problematic. Crowe (1998) urges the qualitative researcher to be cautious in claiming the truthfulness of subjects’ recounting of personal experience. She argues that data collected by methods such as observation and interviews are cultural representations constrained by time, place and language. Participants’ accounts of their personal experiences, thoughts and feelings employ language that precedes and surrounds them and as such are also cultural constructions. In analyzing the discourses in relation to maternal age I am in a sense creating yet another discourse. In choosing a postmodern perspective I can only present my findings in a tentative manner, they are only partial understandings, limited truths. I do not assert that they apply to all women who have given birth for the first time when aged 35 or over, all midwives, or all GPs and obstetricians.

One strategy that has been employed in the past by qualitative researchers to ensure the “trustworthiness” of a qualitative study is the sharing of the analysis of the data with the participants and the gaining of their agreement. As Sandelowski (1993) suggests, this practice rests on the assumption that reality is external, that it can be agreed upon, and confirmed by others. The postmodern perspectives of reality as partial and constructed, and that multiple truths exist, contest such assumptions. However, I did decide to send relevant excerpts of my data analysis chapters to some of the participants. I had two reasons for not contacting all my participants. Firstly, the interviews were carried out four years ago. Hence contact with some of the participants was difficult as they had moved homes and had not notified me of their change in addresses. Some of the practitioners have changed their area of work. It may be that their experiences in caring for women aged 35 or over subsequent to my interview with them may have influenced their reading of my analysis.

The postmodern perspective of subjectivity, as explicated in Chapter Two is that it is unstable and contradictory, and so, the relating and interpretation of one's past experiences and practices does not necessarily remain static. Furthermore, Opie (1992) suggests that as the positions of the researcher and the participant are not necessarily identical, the participants may not engage with the text in the same way as the researcher. The latter may adopt a less descriptive and more analytic interpretation than the participant.

Throughout the process of data analysis I have shared my findings with a variety of people. On three occasions I have presented aspects of my findings to conference groups consisting predominantly of midwives. Twice independent midwives who participated in my study were present and after my presentation they supported my statements. On one occasion there was a variety of health professionals present, including a small number of GPs. On these occasions I have not encountered challenges to my findings. I have also discussed my research with colleagues. In addition, my supervisors have read each developing draft and have sought further clarification or challenged my interpretations of the excerpts.

One other research practice important to qualitative postmodern research is reflexivity (for example see; Heslop, 1997; Kendall & Wickham, 1999; Grbich, 1999; Opie, 1992; Parker, 1992). Yardley (1997) recommends the practice of reflexivity both as a means of making the researcher and the research process visible to the reader and of avoiding accusations of "covert prejudice" and "excessive idiosyncrasy" (p. 39), two processes which can undermine the quality of the researcher's analysis. Grbich (1999) describes reflexivity as a process that illuminates the social constructed-ness of the researcher's beliefs and the influences that the beliefs have on the relationships between researcher and participants and the researcher's interpretation. The researcher subjects her own beliefs to the same scrutiny as she does to those of her participants. Postmodern reflexivity also involves the recognition and analysis of the many layers, truths and voices (Cheek, 1999; Scheurich, 1997) present in the data.

I have, in Chapter One, related my experiences of pregnancy and birth as an "elderly" primipara, and have in this chapter also shown the various subject positions that I perceive myself to have adopted during the interview process. To facilitate an awareness of the different discourses, I have attempted to read widely and deeply on the topics related to maternal age and pregnancy and birth, and to weave the different texts into my interpretation. Furthermore, I have incorporated the strategy that Gilmour

(2001, drawing from Lupton, 1992) writes of, that is the inclusion of sizeable data excerpts in my thesis. Smythe (1998) calls this strategy “show and tell” whereby excerpts from interviews or other texts are included in the body of my writing and are followed by my analysis so that the reader can see and examine my work.

Opie (1992) warns of the potential for researchers to appropriate participants’ texts. She proposes several strategies to reduce the possibility of the researcher appropriating other’s texts. These include the researcher recognising the existence of multiple competing voices and including the contradictory statements made by participants, as these reveal the shifting postmodern subject. Another strategy is for the researcher to make evident the occasions when participants have emphasized a point by either repetition or by changing the intensity of their voice.

### **3.8 SUMMARY**

My aim in this chapter has been to make explicit the processes that I have followed in carrying out this study. I have explained how Foucault’s concepts of discourse, truth and power/knowledge, and his analytic process of archaeology and genealogy have been applied to this study. Foucault’s notion of power always being in play has brought to light the shifts in power positions that may occur during the research process, in particular the interview. I contend that the researcher may not always occupy a superior position to the interviewee. Personal experiences and other discursive positionings may intersect and overtake the position of researcher. In the next seven chapters I analyse the discourses identified in the texts collected and generated for the purpose of the study. In the following chapter I analyse the literature gathered from medical, midwifery and women’s health journals and textbooks in relation to the “elderly” primigravida/primipara.

## **Chapter 4: THE CONTESTED TERRAIN OF BIRTH AND MATERNAL AGE**

The persons and populations with which medicine concerns itself do not merely exist, sickly and mutely awaiting its attention: they are formed by differentiation.

Rose, 1994, p. 57

Genealogy, as the analysis of descent, painstakingly exposes the tiny influences on a body that, over time, not only produce a subject of a certain sort, a subject defined by what it takes to be knowledge about itself and its world, but a subject under the illusion that it is a substantial, autonomous unity.

Prado, 1995, p. 36

### **4.1 INTRODUCTION**

The purpose of this chapter is to foreground and explicate the discourses identified in the maternal age literature. The scientific medical discourse and the natural birth discourse were the two over-arching discourses evident regarding maternal age in relation to pregnancy and birth. These discourses oppose one another regarding the representation of women aged 35 or over and who are pregnant or giving birth for the first time. I aim by using an archaeological and genealogical approach to critique and disrupt the two discourses. Before I embark on my analysis of the literature, it is important to note that the focus of my analysis of the medical, midwifery and human sciences literature pertains mainly to the emergence and representation of maternal age.

My analysis shows that the scientific medical discourse, which identifies the 35 year old primigravida as being “at risk “elderly” primigravida”, is contested both by speakers within the scientific medical discourse and without. Debates from within medicine have a long history dating back to the seventeenth century. I show that more recently the natural birth discourse has created a space to oppose scientific medical discourse’s identification of the innate physiological process of aging as the factor that hinders women’s ability to journey through pregnancy and birth without encountering problems.

### **4.2 THE SCIENTIFIC MEDICAL DISCOURSE**

It is important to note that at the turn of the twentieth century the term “elderly” primigravida/primipara was not new. For example, Spain (1912) refers to being taught

at medical school that “childbirth in the “elderly” primipara is considerably more difficult than in the younger primipara and is to be dreaded by both patient and physician” (p. 421). In examining the early journal articles written in English, I found that the literature referred to was written in European languages such as German or French. The main source of literature on the topic of “elderly primigravida” was American and British obstetric and gynaecological journals. My analysis therefore will refer to practices in these countries as well as in New Zealand. It may be that the term “elderly primipara” and the way of thinking about such women was adopted from Europe. The context of the early twentieth century, especially in North America where the majority of medical articles on “elderly” primipara were written, appears to have stimulated and maintained the maternal age discourse. The emergence and domination of maternal age as an object of the scientific medical discourse within the medical and midwifery literature were made possible by the existence of several factors which are discussed below, specifically: the rise of obstetrics as a medical specialty, the increasing use of the hospital as the place for birth, and the rise of scientism.

#### **4.2.1 The conditions of existence for “older” primigravida/primipara to become a discursive object**

In Chapter Two I identified Foucault’s (1972) argument that for a discourse to emerge there needs to be conditions that exist, such as social conditions, which allow the object of the discourse to be named and talked about. Foucault’s rationale for identifying the conditions of possibility is derived from his belief that new ideas do not just “come to mind”. Rather, material conditions are necessary for ideas to emerge.

Several existing conditions facilitated the “elderly” primipara to be talked about within the context of early twentieth century. They included the practices of the obstetric profession during the earlier twentieth century, the establishment of the hospital as the place for women to birth, and the association between women’s socioeconomic status and preference for the care of obstetricians.

The first article published in an American medical journal on “elderly” primiparas in 1912 was written by Kate Spain. She states that she was prompted to write her paper because of the absence of the “elderly primipara” in American medical literature, even though the care of such women was a topic in medical school. For Spain, the process of publication had a particular significance. It was a means of formally bringing the topic to practitioners’ attention and of realising a subject of

interest to obstetric practice, in this instance, a group of women who constituted a problem by being outside of the norm of childbirth.

One professional practice of the American obstetricians was the oral presentation of their papers to their local or regional obstetrical and/or gynaecological society (see for example, Baird, 1952a, 1952b; Daichman, 1932; Fliehr, 1956; Freidman, 1955; Freidman & Sachtben, 1965; Geitmann, Fitzgerald & Zummo, 1948; Higdon, 1960; Nathanson, 1935; Randall & Champneys Taylor, 1949; Schulze, 1929; Stanton, 1956; Tew, Raleigh & Kuder, 1938; Weisl, 1953). A dual circulation process existed whereby the same paper was read to a local audience and then through publishing disseminated to a wider group of obstetric practitioners.

In New Zealand, the Obstetrical Society was established in 1927 (Gordon, 1955). The existence of such societies would have contributed to the emergence, spread and maintenance of the discourses. O'Dowd and Phillip (1994) write that the role of such societies was to keep their members informed of the changes in obstetric knowledge, and to exchange ideas. The practice of classifying the first time pregnant or birthing woman aged thirty or over "elderly primigravida" and "elderly primipara" respectively, identified the "older" woman as different. The categories would have created a distinct and separate space for "older" women in the maternity practitioners' knowledge and practice. The medical practitioners who attended the various societies' meetings and conferences would have heard the issues raised in the papers and, I suggest as a consequence, would have become more conscious of the women in their care to whom the labels applied. Thus, the obstetric and/or gynaecological societies and journals operated as surfaces of emergence: domains where "older" first time birthing women were made objects. "Older" women were rendered visible by the scientific medical discourse and thereby brought into the gaze of practitioners. The publication of the papers would have widened the pool of practitioners exposed to the practice of differentiating "elderly" primigravida/primipara as a group. Rose (1994) writes that:

to differentiate is also to classify, to segregate, to locate persons and groups under one system of authority and to divide them from those placed in another.

p. 58

Hospitals, which were the site of obstetric practice, were another condition that allowed the emergence and maintenance of the "elderly" primipara as discursive objects. Oakley (1984) and Harrison (1995) write that the earlier British lying-in

hospitals assisted the development and specialisation of the obstetric profession. Oakley (1984) posits that the hospital as a place for women to give birth assisted the rise of the obstetric profession. She states that hospitals "...established the principle of doctor control over client preferences, enabled clinical expertise to be taught to others, and set the stage for the later depiction of birth as potentially pathological" (p. 29). The hospital was the place where the obstetric philosophy of intervention was put into practice (Tew, 1995).

According to Tew (1995) by the early 1930s 60 to 75 per cent of births in various American cities were in hospitals. By 1935, in New Zealand, most women gave birth to their babies in public hospitals or private maternity hospitals (Kedgley, 1996). In 1938, the introduction of the Social Security Act provided free maternity care for New Zealand women facilitating the move to hospital births (Donley, 1986). One reason for the increase was a consequence of women being encouraged to birth in hospitals because of the superior care they were thought to provide (Tew, 1995). Furthermore, Tew proposes that birthing in hospitals instilled and perpetuated the belief in both women and practitioners that birth was pathological and therefore, needed to occur in hospitals.

The shift to birthing in hospitals facilitated the study of birthing women (Papps & Olssen, 1997). The obstetric information collected by the hospitals produced the data necessary for the studies. Information such as age, choice of practitioner, type of intervention would have become more accessible. Thus patterns, variations and comparisons in childbirthing would have been able to be identified and differences as well as criteria for norms established. The bringing of labouring women together would have created the opportunity for women over the age of thirty-five to be grouped together for their labours and births, and for the wellbeing of their babies, and to be observed and compared with those of younger women. For this reason, the move to hospitals as the place for birthing would have been a factor that made it possible for the discourses regarding "older" women to come into being.

Furthermore, Papps and Olssen (1997) argue, the hospital instituted a new form of biopower.

the hospital came to be the *site* which formalised the political responsibilities of the conjugal couple. In this sense, childbirth was never simply a discrete event separate from illness or from pathogenic

influences and it was not just convenience or accident that childbirth came to be medicalised.

p. 114, emphasis in original

The hospital was the place where techniques of power such as observation and normalisation were carried out. Here, the state's interests in the welfare of the population of the state coincided with the increase in power of the obstetricians and other sectors of the medical profession. The work of obstetrics facilitated the work and aims of the state.

Further conditions that contributed to the existence and maintenance of the "elderly" primigravida/primipara were the relationships between the woman's age, her socio-economic status and her choice of practitioner and place of birth. A more secure economic background would have meant women from the upper and middle classes were able to afford to pay for the services of a medical practitioner. Leavitt (1986) in her history of childbirth in America, suggests that upper and middle class women, because of their financial position, were more able to make "active" choices regarding their birthing needs. They were influential agents in the shift to women giving birth in hospitals during the 1920s and 1930s.

Leavitt (1986) found that at the beginning of the twentieth century, upper and middle class American women were choosing to have obstetricians and to birth in hospitals. Tew (1995) observed that American women from the "successful" classes were more "readily convinced of the advantages of obstetric interventions" (p. 53) and were therefore more likely to choose a medical practitioner rather than a midwife<sup>6</sup>. Upper and middle class British women were also more likely to choose a medical practitioner rather than a midwife (Tew, 1995). Dugald Baird, a regius professor, in 1952 identified Scottish upper class women as comprising the majority of women in Aberdeen who chose to delay childbirth and to be cared for by obstetricians. Quigley (1931), a doctor from New York, when writing about "elderly" primiparas noted that women who were in a better financial position were less likely to marry at a young age than women who were "less well to do". Several of the early American medical authors (Geittmann et al, 1948; Quigley, 1931; Tew et al, 1938) noted that the majority of "elderly" primiparas birthing in their hospitals were from the upper classes and chose to

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<sup>6</sup> A Wellington study of 250 mothers in 1975 found that middle and upper class women chose to pay for private specialist obstetric care rather than attend their GP, whose care was paid for by the state (Salmond, 1975).

be cared for by private obstetricians. Thus, I suggest that the relationship between age, economic status and choice of practitioner furthered “elderly” primigravidas/primiparas visibility amongst the medical practitioners, and subsequently extended the opportunity for obstetricians to observe and add to their knowledge and practice.

Women delaying childbirth, either deliberately or involuntarily, were an additional condition necessary for the existence of the “elderly” primigravida/primipara as a discursive object during the early twentieth century. A variety of factors may have allowed for this. One possibility is the use of contraception. Schulze (1929, citing Meyer, 1916), a lecturer at the University of California, gave contraception as a reason for an increase in women delaying childbearing during the 1920s. For New Zealand women during the 1930s various types of contraceptives existed such as diaphragms (Hercocock, 1991) and homemade pessaries (Kedgley, 1996). Hercocock (1991) notes that the accessibility of contraceptives was problematic as diaphragms and caps were expensive and difficult to obtain. To be effective they needed to be properly fitted and explained to women. Rowbotham (1997) notes that during the 1920s and 1930s birth control partly contributed to the decline in birth rate amongst upper and middle class British women.

The social and economic changes in the early twentieth century were also factors that may well have contributed to women delaying marriage and childbirth. The first three decades were marked by periods of unemployment, depression and the Great War. Harrison (1995) states that from the 1920s onwards social and economic conditions started to influence British couples’ decisions regarding birth control. British society as a whole became more interested in population issues and birth control. Kedgley (1996) writes that during the depression in New Zealand it was not uncommon for marriages to be postponed, and for married couples to delay having children. Marriage was viewed with caution during the early 1930s. According to Rowbotham (1997) the sales of contraceptives such as suppositories, douches and jellies were high. Spain (1912), Schulze (1929) and Nathanson (1935) all believed that the increase in “elderly” primigravida/primipara were because women were marrying later and this they saw as a direct consequence of the social and economic changes of that time.

Arney (1982) argues that De Lee, an influential American obstetrician, in an attempt to create an obstetric “superprofession” in the 1920s, advocated a binary division of normal/abnormal but other practitioners did not agree on this. The situation between the American and British obstetric professions was quite different with the

latter having developed quite clear boundaries of practice regarding the care of women who fell into one category or the other (Arney, 1982). In America however, the boundaries of practice were more blurred with GPs adopting obstetric practices. The outcome, Arney proposes, was that the American obstetricians pathologised birth, forseeing it as being potentially problematic, thus making it necessary for all women to be under the care of obstetricians.

In the New Zealand context the political interests in constructing birth as a pathological process were somewhat different. Parkes (1991) suggests that in New Zealand the constitution of birth as pathological occurred in the 1920s and was brought about by the high maternal death rate at the time. The change to viewing birth as a disease process was supported by GPs who wanted to increase their numbers of maternity cases. The New Zealand Obstetrical Society “promoted a medicalised maternity service as the ideal for New Zealand, with doctors in charge of all antenatal care and present at all deliveries” (p. 170). According to Mein Smith (1986) the lobbying of the Society members was instrumental in the trend to hospital birth after the 1930s.

Up until this period, due to the small number of obstetricians in New Zealand both obstetricians and GP-surgeons performed caesarian sections. Gynaecological surgery was the domain of general surgeons. However, in 1931 the first full-time professor of Obstetrics and Gynaecology was appointed to the medical school at Otago University and in the 1930s the move for obstetrics to incorporate gynaecology occurred in medical schools and base hospitals (Donley, 1986). The rationale for combining the two was evidence from endocrinology confirming the connection between many gynaecological conditions and hormonal states. Donley points out that the general surgeons contested the obstetricians’ take over of gynaecology until the 1960s. In 1963 National Women’s hospital opened which, Donley (1986) suggests, gave the obstetricians and gynaecologists a “solid power base” (p. 60).

The next move by the New Zealand specialist obstetricians was to centralise services and eliminate competition (Donley, 1986). Thus, women who had never given birth before and who were aged 30 and over were one of the groups of women claimed as obstetric territory. A document produced by the Maternity Services Committee

(1976), in which two of the committee's members, Professor Bonham and Dr MacKay<sup>7</sup>, surveyed New Zealand's maternity services from 1969 to 1974. In the document women are identified as being either high or low risk during pregnancy and birth. One of the Maternity Services Committee's findings was that not all "high risk" women were being referred for specialist care. Included in the "high risk" list are primigravidas aged 30, and all pregnant women aged 35 or over<sup>8</sup>. "High risk" women were "regarded as being *unsuitable* for delivery in a separate general practitioner hospital" (p. 40, emphasis in original). Such hospitals, where there was no specialist obstetrician or neonatal paediatrician, were only suitable for women who were expected to have normal births. The effect of the Maternity Service Committee's recommendation was to reduce the number of small maternity units and to bring about regionalisation of maternity services (Papps & Olssen, 1997). A later document produced by the Committee, *The Mother and Baby at Home: the Early Days* (1982), reiterated that regarding the care of primigravidas aged 30 or over consultation should occur with a specialist. In some cases, however, following consultation the woman may remain under the care of her GP. The position of the specialist obstetrician is the knowing and seeing subject, who determines which woman is high risk, requiring specialist care and which does not.

One further condition that would have to exist in order for "elderly" primigravida/primipara to emerge and remain in existence is the notion of what constitutes a "normal" birth. Such a concept would have been necessary in order for a woman's labour and birth to be evaluated and for the practitioner to determine when and what type of intervention was required. The extent to which the criteria for intervention became formalised is at this stage unclear. Leavitt (1986) comments on the anecdotal nature of the medical journal articles and this is evident in the early publications regarding "elderly" primigravidas. Authors discuss the literature and reflect on the experiences documented in each of their hospital records. Schulze, in 1929, used the quality of labour pains as indicators of the efficacy of "elderly" primigravidas' uterine contractions in expelling the fetus. Forceful pains were the type necessary for a

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<sup>7</sup> Professor Bonham was the Head of the Obstetrics and Gynaecology Post-Graduate School at National Women's Hospital, while Dr MacKay was from the Department of Health. Papps and Olssen (1997) note that 10 of the 14 members of the Maternity Services Committee, were members of the medical profession.

<sup>8</sup> The identification of certain groups of pregnant and birthing women as "at risk" reflects the overlap of the scientific medical discourse with the risk discourse. In order to avoid duplication I have chosen to identify and analyse the risk discourse in the following chapter.

successful labour. She qualified the pains of “elderly” primipara as “vague”, “infrequent”, “good”, “fair”, “poor”, and “inadequate”. Tew et al. (1938) also made reference to the quality of uterine contractions. They described the “elderly” primipara’s contractions as “desultory” which brought about a “weak unsatisfactory” labour. Such descriptions, although subjective on the part of practitioners, were based on behaviours and variables that could be observed and measured. Tew et al. (1938) criticised the “abstract angles” of some previous authors who discussed the economic and social factors related to “elderly” primiparas. They urged instead for more attention to be paid to the analysis of the actual data and to the “reporting of observations that might assist in formulating an intelligent basis for prognosis and treatment in their care” (p. 773).

The rise of scientific knowledge within the obstetric profession created the means by which the performance of the “elderly” primipara and her baby could be judged and normalised. What constituted legitimate knowledge in the scientific medical discourse was what was observable. Accumulated knowledge allowed for events in pregnancy and labour to be predicted and to be controlled. More recently, duration of labour is not cited consistently in the maternal age literature as a dependent variable of maternal age. Hansen (1986) alludes to lack of reliability as the reason for the demise of labour duration as an accurate measure of women’s capability. More objective reliable measures such as Small for Gestational Weight [SGA], which Hansen (1986) defines as weighing less than 2,500 grams at birth, and Low Birth Weight [LBW] have been utilised as indicators of “elderly” primiparas’ incapacities.

The criteria used to assess and assert the ageing process within “elderly” primiparas, and its subsequent detrimental effect on fetal/neonatal wellbeing and survival, do not remain static but are brought into existence as the technology and knowledge is developed. For instance, neither Spain (1912) nor Freeland (1915) made mention of caesarian section as a type of intervention that was routinely required by “elderly” primiparas. Apgar scores were invented in 1953 (O’Dowd & Philip, 1994) and were first employed in relation to maternal age by Horger and Smythe in 1977 as a measure of neonatal wellbeing. Neonatal care of premature babies was developed in the 1950s and the study of neonates started in the 1960s (O’Dowd & Philip, 1994). At this time umbilical catheterisation was introduced and the safe administration of oxygen therapy was set up. Such technology simultaneously permitted the opportunity for premature infants to be cared for, as well as for the observation and study of them as

objects of learning. In 1985 Kirz, Dorchester and Freeman first used neonates' admission rate to neonatal intensive care units as an outcome of maternal aging.

To briefly summarise, I have attempted to show that several conditions created the space for “elderly” ~~primigravidas~~ to surface in the obstetric literature as discursive objects. The purpose for my strategy is to show that the scientific medical discourse is fluid and shifting with societal, economic and demographic changes and technological developments influencing its transformations. Underpinning the changes, however, is the representation of a woman aged 35 or more years who has delayed the birth of her first child, either voluntarily or involuntarily, and who as a consequence is more likely to encounter difficulties during pregnancy and/or birth. Within the medical literature the reason for “elderly” primiparas' problems has been contested by two scientific medical sub-discourses; the maternal age discourse and the “defective body” discourse <sup>9</sup>.

#### 4.2.2 The maternal age sub-discourse

Implicit in the scientific medical discourse is the assumption that age is a fixed and internally driven biological process. In the maternal age sub-discourse maternal age is given the significance of being an independent variable, an essential uncontrollable factor that has effects on the woman's body. It is not seen as a consequence of living or of one's environment. Bromley (1988, p. 29) suggests that there is confusion between ageing as a cause and ageing as an effect so that aging has become “self-explanatory” and “metaphysical”. Correspondingly, the assumption that “older” women's bodies are different from younger women's is based on their “performance” during labour and birth.

Apparent in the maternal age discourse is the notion that women have two “lives”: one is their overall body life and the second is their reproductive life (or as Higdon (1960) terms it “obstetric age”). The latter is based solely on the period for which women are fertile. Hence, Evans et al (1997) are able to confidently define pregnant women aged over forty years “geriatric gravidas”. Such women are “old” in terms of their reproductive capacity: they are not far from reproductive “death”. Implicit in this view of dual aging processes, or of a life within a life, is the separation

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<sup>9</sup> I have decided to identify these as sub-discourses of the scientific medical discourse as they use the same criterion of scientific knowledge to constitute the “truth”. However, each sub-discourse constructs a specific object, that is, the maternal age sub-discourse constructs an aging female body and the defective body discourse constructs a reproductively defective body.

of women's reproductive lives from the context of their life experiences. The focus is solely on women's bodies and their reproductive role.

The age at which a woman became an "elderly primipara" remained undecided and contested in the American literature until 1958. Various suggestions were asserted based on the average age span of women's ability to reproduce. For example, in 1929 Schulze found that women had been labeled "elderly primiparas" from the age of 25 to 35 years. Freeland (1915) searched for a common denominator on which the criterion of increasing age could be based. He suggested that the time between menarche and menopause could be divided into two fifteen-year blocks, with the age of 30 as the dividing year. Waters and Wager (1950) argued that 35 was both a halfway point in life overall, and a common last third of reproductive life. In 1958, at a meeting of the International Federation of Obstetricians and Gynaecologists (FIGO), a decision was made to identify first time pregnant women aged 35 and over as "elderly primigravidas".

The call for a common definition was related to an argued need for scientific rationalisation. For example, Waters and Wager (1950) stated that "it is highly desirable from a standpoint of critical analysis to have a commonly designated and accepted age-group for late primiparity..." (p.302). Warren (1992) proposes that the development of obstetric risk criteria in relation to maternal age was based on mortality surveys carried out in 1956. Such surveys would have provided information for analysis and permitted the realization of groups at risk. FIGO which was established in 1954 aimed to advance scientific research and its direction across the international obstetric profession (Tew, 1995). The defining of 35 as the age when a primipara becomes "elderly" by FIGO would have allowed studies from different countries to be compared with one another and to add to a growing body of scientific knowledge. Tew (1995, p.65) states that an outcome of FIGO was the strengthening of obstetricians' power and influence.

Bromley (1988) identifies two common images of ageing. The first image is of the body that contains a fixed amount of energy, which over time declines. The second portrays ageing as a battle between health and disease with the latter eventually becoming triumphant. Both of these images have been and continue to be evident within the medical literature regarding "elderly" primiparas.

The early writers constructed the "older" woman's body as one of reduced force and in particular, flexibility. In 1912, Spain (citing Webster, year not cited in original text) attributed the "feeble uterine contractions" (p. 423) observed in "elderly"

primiparas to their age. With age the uterus becomes “slack and sagging” (Spain, 1912). The perineum and cervix is depicted as rigid and inelastic (Points, 1957; Randall, 1949). De Lee (cited in Quigley, 1931,) described the response of the perineum to birth as to “...tear in all directions like old rubber when stretched” (p. 234). Waters and Wager (1950) call the “genital tract” of the “elderly” primipara “obsolescent” and Freeland (1915) calls the uterus “senile”. For these authors, the “elderly” primipara’s reproductive system has reached its expiry date. It is decaying, if not already decayed.

In more recent literature, reference to the perineum and cervix has become silent with the focus placed on the uterus itself. The gaze has become even more specific, moving from macroscopic to microscopic, from organ to tissue, for now the gaze is on the muscle layer, the myometrium of the uterus and its arterial supply (Adashek, Peaceman, Lopez-Zeno, Minogue & Socol, 1993; Cnattingius, Forman, Berendes & Isotala, 1992; Cohen, Newman & Friedman, 1980; Naeye, 1983; Rosenthal & Brown, 1998). These authors attribute the increased need of “elderly” primiparas for intervention during labour to the ageing uterus.

Ageing is seen to affect the flexibility of the whole of the woman’s body. For example, Baird and Hutton (1958) suggested that tissue degeneration similar to “disuse atrophy” occurred with age causing the problems “elderly” primiparas experienced in labour and breastfeeding. McFadyn (1989) portrays the “elderly” primipara’s body as becoming stiffened and increased in rigidity which affects her ligaments and muscles. Consequently, pregnancy is a greater burden for the “older” woman and McFadyn recommends that she needs more rest than would a younger woman. In contrast, Baird and Hutton (1958) speculated that ageing may be brought about by a lack of cellular nutrition which, with research, could be rectified.

The second image of ageing, that of disease overtaking the body is also evident within the literature regarding the “elderly” primipara. In this image the “elderly” primipara’s body is pathologised. The medical conditions are either evidently existent at the time of becoming pregnant or are latent and manifest themselves during the course of pregnancy (Harrigan, Hartko & Szas, 1981). The two diseases most commonly identified in the literature associated with maternal age are hypertension and diabetes (Arthur & Kaltreider, 1956; Beazley, 1995; Cunningham et al, 1997; Hansen, 1986; Utian & Kiwi, 1988). It is argued that these diseases increase with age and complicate the course of pregnancy and the development and wellbeing of the baby.

What is evident in the above discussion is that the notions of diminishing force, lack of resilience and increasing pathology are actual assumptions upon which the “elderly” primipara sub-discourse is founded. The consequence of these assumptions is the belief that the body of the “elderly” primigravida is incapable of bearing and birthing her baby effectively. Furthermore the wellbeing of her baby is more likely to be threatened. The same consequences are envisaged for the “elderly” primigravida who has involuntarily delayed the birth of her first child. The cause of her problems however, derive from a different physical source.

#### **4.2.3 The defective body sub-discourse**

The defective body sub-discourse contests the maternal age sub-discourse with the argument that the reason for the “elderly” primipara’s problems in labour are not her age but the “abnormal” structure of her reproductive system. In 1929, Schulze (citing Meyer, 1916) put forward the argument that within the “elderly” primiparas’ group there were a significant number of women who “...would have had difficulty at any age but who marry late because of definite physical defects or who conceive late because of hypoplasia of the genital organs” (p. 824). The condition “genital hypoplasia” was believed to complicate the labour process and was manifested by a tight perineum, difficult cervical dilatation and “ineffective” labour pains.

A second theory proposed (Schulze, 1929, citing Jaroschka, 1916) was that there were two types of women who were disposed to dystocia (difficult or prolonged labour): “the woman with marked obesity, sparse pubic hair, a short neck, short fat thighs and large breasts with little parenchyma; and an aethenic type with delicate bones, pale coloring, poor nutrition and poorly developed body musculature” (p. 828). Evident in the typology was the idealisation of a body type that fell between these two extremes and which was optimal for childbirth. Obese and aethenic women had ineffective labour pains and consequently could not birth their babies without assistance. Schulze proposed that women’s physical type be documented in their obstetric records. Thus women’s body type had sufficient significance for Schulze to suggest it to be a predictive indicator of prolonged labour requiring intervention.

Implicit in Schulze’s (1929) statements is the belief that the structure of a woman’s body is an important key to her marriageability as well as her ability to conceive and labour without assistance. The two theories assume that a woman with any congenital physical defects is incapable of bearing and birthing a child normally.

Women with defective bodies were not intended to have children. As Tew et al (1938) stated, “We believe their behaviour in pregnancy and parturition is influenced by certain constitutional factors as well as some stigmata of genital hypoplasia, and these patients would probably not be ideal obstetric material subject matter at any age” (p. 779).

Although Schulze’s (1929) motive for identifying women who have physical or reproductive defects is to challenge the validity of maternal age as both a cause and a predictive indicator, for women categorised as obese, aesthenic or late “conceivers”, the result is that they are situated in the realm of abnormal and problematic. Spallone (1989) identifies dysfunctional and disabled reproduction as falling under the medical domain. Such women automatically require medical technology to assist them if they are to conceive and give birth.

Later American obstetricians (Arthur & Kaltreider, 1956; Daichman, 1932; Tew et al, 1938), drawing on retrospective analyses of their local hospital records of “elderly primiparas”, pursued Schulze’s (1929) hypothesis that women who had difficulty in conceiving also had difficulty in birthing. The two later studies compared “elderly primiparas” to the total clinic population, whereas Daichman (1932) only reviewed the “elderly” primiparas’ figures. While Daichman (1932) and Tew et al (1938) found evidence to support their hypothesis, Arthur and Kaltreider (1956) did not find any difference between the two groups. The variable of infertility was determined by the number of years between marriage and conception. For Arthur and Kaltreider, if a woman had not become pregnant within five or more years of marriage, she was placed in the “infertile” group. The assumption on which the grouping was based was that pregnancy is inevitable and normal in the first five years of marriage. Moscucci (1990) writes that early twentieth century gynaecologists saw women as existing totally for sexual functions, mentally and physically. There was no apparent recognition that women may have chosen to defer childbearing, and no consideration that women may also have had the capacity to control their fertility through contraceptive methods.

The defective body sub-discourse does not surface again in the “elderly primipara” literature for another 30 years. Barken and Bracken (1987) argued that in comparison to the past women were now “actively” choosing to delay childbirth and did not have the same history of infertility. To show that maternal age was not a predictor of preterm delivery and low birth weight, they compared the birth weights and preterm births of four groups of primiparas. There were two groups of younger primiparas (one group who had a history of infertility or spontaneous abortion and a second group of

those who did not) and two similar groups of “older” primiparas. Generally they found that “older” age did not significantly increase the risk of preterm delivery or low birth weight. The group of women aged 30 or over who had a history of miscarriages or infertility had a higher rate of preterm births and low birth weights than the younger women who did not have such history. The group of “older” women with no history of miscarriage or infertility had similar rates of preterm delivery and low birth weight as the same group of younger women. They suggested on the basis of their findings that some of the increased risk found in “elderly” primiparas may be attributable to a history of “reproductive problems”.

Studies by Tuck, Yudkin and Turnbull (1988) and Cnattingius, et al (1992) demonstrate the continued contest between the maternal age and the defective body sub-discourses. Cnattingius et al (1992) analysed the relationship between infertility and late fetal and early neonatal deaths. They found that women who had been infertile for more than three years had higher, but not statistically significant, rates of late fetal and early neonatal deaths. The incidence of infertility was more common in the “elderly” than in the younger primiparas. Overall, they found that maternal age increased the risk of low birth weight, preterm delivery and small for gestational age babies. However, the relationship between infertility and low birth weight and preterm delivery was not examined.

Although these sub-discourses contest and contradict one another as to the causes of fetal and neonatal problems, the object of their gaze remains the “elderly” primipara. Whether the cause is her infertility or her age, the problem is her body.

#### **4.2.4 The ageing uterus and body**

In this section, I identify and analyse the ways in which the maternal age sub-discourse realizes a uterus and body that is aged and the associated subject positions created for a medical practitioner.

The uterus is portrayed as having two functions. One is that of a muscular organ which has the major role in expelling the fetus from the mother’s body. The second function is that of an environment which nurtures the fetus, and is thus essential to the development of a healthy baby.

Ageing is made visible through the measurement and comparison of the “elderly” primiparas’ progress through pregnancy and birth. Foucault (1973) stated that “the clinical gaze has the paradoxical ability to *hear a language* as soon as it *perceives a*

*spectacle*. In the clinic, what is manifested is originally what is spoken”(p. 108, italics in original text). Although the uterus and various organs affected by ageing are not literally seen, the language that is used in a discourse to describe pregnancy, labour and birth actually creates or realizes the woman’s uterus and body. Inferences are made from the measurements of “elderly” primiparas’ performance during pregnancy and birth to demonstrate that their increased age has a detrimental effect on the uterus and female body. What becomes apparent in the realization of an aged body or uterus is the consequent necessity for an obstetrician or medical practitioner. In this way midwives are excluded as autonomous practitioners in the care of “elderly” primigravida/primipara.

Effective childbearing refers to a woman’s reproductive efficiency in terms of her ability to: become pregnant easily and quickly; maintain her pregnancy, and, give birth to a healthy baby with minimal intervention. The terms “effective” and “outcome” recur throughout the literature. They convey a concern with time and energy in relation to producing an output with minimal effort and cost to all involved. Martin (1987) asserts that the language of performance and efficiency is the application of the factory production model to birth. For example, Cunningham, MacDonald, Leveno & Gilstrap (1997) are able to term perinatal morbidity and mortality as “pregnancy wastage”. The effect for women, however, is that they are seen as labourers, producing goods.

The role of the doctors is to control the machinery of the uterus so that it is efficient and profitable. The “elderly” primipara’s body is reduced in its efficiency and productivity therefore, she requires the technology and expertise of the medical profession to assist her in her task: to compensate for her inadequacies. Continuing the metaphor of production, Randall and Taylor (1949) stated that they were “dissatisfied with their fetal salvage” (p. 1217). Waters & Wager (1950) also employed the term “salvage” when referring to the incidence of caesarian section in “elderly” primiparas. The fetus is the cargo, which needs to be rescued by the obstetrician from the wreck of the “elderly” primipara. The ageing body of the mother, because of toxæmia, is dangerous for herself and for the fetus. The aged body is unable to adequately nurture the fetus to a state of being able to sustain its own life, so that the baby is born too small or before time.

One example of the “older” primigravida as inadequate in nurturing the fetus is found in the eleventh and twelfth editions of *Myles Textbook for Midwives* (Williams, 1989 and 1993). The age of an “older primigravida” is identified as a risk factor for

placental insufficiency. Williams (1993) states that “ Placental insufficiency is more common in primigravidae aged over 35 years. For this reason it is usual to recommend induction at term to avoid additional risk to the fetus” (p. 390). The presence of the maternal age sub-discourse in midwifery texts highlights that midwives were included as legitimate speakers of the scientific medical discourse.

More recently, authors have expressed concern over the “elderly primiparas” use of resources from the antenatal through to the post-natal period (Cunningham, MacDonald et al, 1997). Holloway and Brock (1988) analysed births in England and Wales between 1977 and 1985, and found an increase in the number of women aged 35 or over choosing to delay childbirth. The routine practice, they noted, was for such women to be offered prenatal diagnosis of chromosomal abnormalities. On the basis of the trend to delay childbirth and the custom of offering prenatal screening, The authors predicted that in 2001 there would be about 70,000 prenatal cytogenetic tests performed. Their paper concluded that an increase in facilities for prenatal cytogenetic tests was required.

Berkowitz, Skovron, Lapinski and Berkowitz (1990) found that women aged 35 or over had a higher incidence of particular pregnancy complications and caesarian sections. The authors do not stipulate the actual treatments that the “older” women received during the antenatal or intrapartum periods for conditions such as gestational diabetes, pregnancy-induced hypertension, placenta praevia and uterine bleeding. Berkowitz et al conclude that “older” primiparas may contribute to a “higher incidence of maternal morbidity and greater health care costs” (p. 663).

The “elderly” ~~primipara~~ woman then, is costly in her use of resources. She requires more medical support and intervention if she is to go through pregnancy and birth with minimal morbidity and mortality, and to give birth to a healthy baby. Hansen (1986) recommends that women need to be aware of this, and so do their physicians. Authors such as Holloway and Brock (1988) and Rosenthal and Brown (1998) urge for the consideration of increased costs at the broader level of funding and service provision. The authors’ utilisation of the economics discourse with the maternal age discourse is used to justify their claims for increased funding. The two discourses overlap in their construction of the “elderly primipara” as problematic, one in terms of excessive costs and the other in her requirement of intervention.

The way in which the uterus is represented in the medical literature on “elderly primiparas” is in terms of its performance (for example, Spellacy, Milller & Winegar,

1986). Labour has been likened to an athletic performance (Baird et al, 1958; Hillard, 1982; Horger, Facog & Smythe, 1977). In this analogy, labour is portrayed as a time of sustained, powerful, muscular exertion. The term “athletic” refers firstly, to a time of competitive peak performance and secondly, to an event which the athlete has often specifically trained and become fit for.

The “elderly” primipara then is a competitor. Her fellow contestants are women who are younger than herself. Youth is the standard, the norm against which the “older” woman’s performance is evaluated. Paradoxically, the uterus is described within medicine as an involuntary muscle (Martin, 1987). The woman cannot control its action and force. No woman can train her uterus for labour. Nature is her trainer. Implied in the athletic construction is the existence of an inherent, yet time limited, ability. Younger women because of their age are in essence “trained” for the event of labour and “older” women because of their reduced ability are not.

#### **4.2.5 The “precious” or “premium” baby**

Towards the end of the nineteenth century obstetric mortality became defined as a social problem. The State was then seen as responsible for solving the problem of the deaths of mothers and their babies as were the midwifery and medical professions (Oakley, 1984). According to O’Dowd and Philip (1994, p. 22), maternal mortality rates have long been used as an indicator of the effectiveness of maternity care. From 1912 to 1980, duration of labour was one of the variables assessed in the literature as a measure of the uterus’ ability. Other variables identified were maternal morbidity, fetal presentation and position, fetal morbidity and mortality, congenital abnormalities and the type of intervention required during labour.

In the early twentieth century, the medical profession’s concern was directed more to the wellbeing of the mother. It was not until a few decades later that the obstetric profession’s concern shifted more to the wellbeing of the baby. In 1949, Randall & Champneys Taylor asserted that the infant of the “elderly” primipara was more likely to “bear the major risk” (p. 1218). Later, MacDonald and MacLennan (1960), in their analysis of the risks for the “elderly” primipara and her baby, found that maternal mortality was no longer a problem but argued that instead “the high perinatal loss is the kernel of the present day problem in the management of “elderly” primigravidae” (p. 448). MacLauchlan (1998) argues that the shift of attention to the fetus had two effects. One was that it has given the fetus a “sanctified state” and as such

appealed to the mother to seek antenatal care. The second effect was that it ensured the position of the obstetric profession and their role in the surveillance and monitoring of the fetus.

The words used to describe the babies of “elderly” primipara convey importance. Some authors state that they are of “more value” (Quigley, 1931; Schulze, 1929; Tew et al, 1938; Waters et al, 1950), or that they are “precious” (Fliehr, 1956; MacDonald & MacLennan, 1960). Other authors have described the pregnancy and birth of an “elderly” primipara as a “premium” or “precious” pregnancy (Hillard, 1982; Edge & Laros, 1993; Peipert & Bracken, 1993; Tuck et al, 1988). The words reveal a belief that becoming a mother is an important event for the “older” woman. The birth of her first child is made more significant by her decreasing fecundity. There may be no other opportunities for her to have another child. Therefore, it must be born alive and well by whatever means. Consequently, the assertion that the baby of an “elderly” primipara is “precious” is deployed as the justification for the practice of caesarian sections.

Silent in this valuing is the younger primipara and the potential for the existence of a double standard of practice. Because the younger woman has a greater opportunity for becoming pregnant, the above belief assumes that her baby is of less value. Therefore, the parameters for intervention may be broader. However, given the interests of the state in maintaining a healthy population, and the obstetrician’s interests in avoiding discipline should the baby be born damaged or dead, it remains unspoken as for whom the baby is more or less precious: the mother, the obstetrician or society.

#### *4.2.5.1 The discursive practices of the “elderly” primigravida/primipara sub-discourses*

A primary practice associated with the discourses is surveillance: the careful watching and examination of not only the mother but also her baby. During the antenatal and intrapartum periods the woman is assessed and examined.

The examination combines the techniques of an observing hierarchy and those of a normalizing judgement. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish. It establishes over individuals a visibility through which one differentiates them and judges them.

Foucault, 1977, p. 184

The medical eye, which examines the mother and her baby, draws on norms that are based on the behaviour and performances of younger women. Within the scientific

medical discourses, the criteria of age and parity situate any first time pregnant and/or birthing woman aged 35 or over, and her baby, into the domain of non-conforming, abnormal and at risk. As such, she is subjected to a surveillance that is different from that given to women categorised as normal. Prysak and Kisly (1997) recommend the practice of “extreme diligence” (p.300) when caring for “elderly” nulliparas. Hansen (1986) urges physicians to be aware of the increased risks associated with “older” pregnant women. Thus the future holds the potential for danger and its signs can be seen in the present, but only if the examiner is especially watchful and knows what signs s/he is looking for.

The woman submits herself to surveillance. In doing so, she is subjected to examination and becomes its object, the known. The practitioner is the one who has the knowledge to determine and the power to determine and classify. Through the process of examination, the practitioner comes to know the woman.

For Foucault (1977), the act of examination is a mechanism of discipline “the specific technique of a power that regards individuals both as objects and instruments of its exercise. This power is not triumphant, excessive, omnipotent, but modest, suspicious and calculating” (Sheridan, 1980, p.152). It is a system in which the “elderly” primipara is disciplined to conform to the normal. Her inability to maintain a healthy environment for her baby in utero and to birth and produce a healthy baby needs to be corrected so that these norms can be attained. In essence, this is a form of Foucault’s (1977) disciplinary punishment that attempts to lessen the space between abnormal and normal. The obstetrician is the maternity practitioner who can prescribe and perform the corrective interventions and the hospital is the only place where these interventions can occur.

A second practice associated with the “elderly” primipara discourses is that of caesarian sections. The mention of caesarian section is consistent throughout the “elderly” primipara literature. Caesarian sections were uncommon until the 1950s (Tew, 1995). Factors such as blood transfusions, antibiotics and modern anaesthetic techniques have contributed to making the operative procedure, once considered dangerous, safe (Savage, 1992). The “absolute indications” for women having caesarian sections are those when either the mother or baby’s life or wellbeing are threatened: for example, ~~placental~~ placental praevia, or abruptio placenta, and prolapsed umbilical cord. However, more recent studies have asserted that the obstetricians’ attitudes rather than maternal/fetal wellbeing contribute to the high incidence of sections (Edge & Laros 1993; Ezra,

McParland & Farine, 1995; Gordon et al, 1991; Peipert & Bracken, 1993; Tuck et al, 1988).

Kessler, Lancet, Borestein and Steinmetz (1980) compared primiparas aged 20 to 25 with two groups of other women aged from 35 to 39 and 40 and over. They found that the “older” primiparas had a higher rate of caesarian sections than did the “older” multiparas. In comparing the reasons for caesarian sections, Kessler et al found that the reasons cited for “older” primiparas caesarian sections were more to do with “the dynamics of parturition” and breech presentation (p. 167) whereas the “older” multiparas had a greater variety of reasons. Further findings were that the “older” primiparas were more likely to be induced and to have decisions made to have elective caesarian sections sooner in the course of labour than were the two other groups, especially if the women had a history of infertility or poor obstetrics. Kessler et al attribute the higher rates to the attitudes of obstetricians rather than clinical indications.

The researchers suggest that the obstetricians believe that the babies have a high social value. This belief is combined with the other belief that perceives the “elderly” primipara as potentially at risk. Thus when caring for “elderly” primiparas, the obstetrician may recommend that she has an elective caesarian or may decide to intervene before the signs of distress are established. The above researchers argue that maternal age in itself is being used as an indicator for caesarian sections.

Two conditions, dystocia (difficult/prolonged labour) and fetal distress, which have been used more recently, do not have clearly defined criteria (Savage, 1992). Tew (1995) asserts that the standard for what constitutes dystocia is “arbitrary”. Peipert & Bracken (1993) noted the subjective nature of diagnosing “failure to progress, dysfunctional labour and unspecified abnormalities of labour” (p. 201) in “elderly” primiparas. Rosenthal and Paterson Brown, (1998) inferred that the high rate of fetal distress documented in their data on “elderly” primiparas was brought about by the junior practitioners’ lack of experience and stress.

A diagnosis of fetal distress is often based now on continuous electronic monitoring which by itself may not be a consistently reliable tool (Savage, 1992; Tew, 1995). Savage (1992) states that even with the use of continuous electronic monitoring, agreement on a definition of fetal distress has not been reached. There is evidence that obstetricians may not correctly identify fetal distress (Savage, 1992). Babies born by emergency caesarian section because they had been diagnosed as having fetal distress were found at birth not to show signs of stress (Tew, 1995). Fetal blood samples have

been found to reduce the unreliability of continuous electronic monitoring but utilisation of such resources does not always occur (Savage, 1992).

Consequently, the potential for incorrect diagnoses and unnecessary caesarian sections exists. The majority of authors did not discuss the influence of obstetricians' attitudes or the possibility that some of the rationales for caesarian sections might have been subjective and socially constructed. Instead, the high rate of caesarian sections is interpreted as indicative of the "elderly" primiparas' inability to labour and birth within "normal" times. As a result, the practice of caesarian section because of the shifting parameters of its use constructs the "elderly" primipara as problematic and incapable.

The scientific medical discourse's representation of advancing maternal age as an intrinsic biological process that complicates pregnancy and birth in women aged 35 and over has in the last twenty years been opposed by the natural birth discourse. This discourse offers the "older" primigravida/primipara the space to resist the scientific medical discourse's identification of her as problematic and to remain undifferentiated from younger ~~women~~ primigravida/primipara.

### **4.3 THE NATURAL BIRTH DISCOURSE**

In comparison to the volume of scientific medical literature on maternal age the number of articles contesting the scientific medical discourse were few. Both the lesser number of such articles and the absence of the natural birth the medical literature may be evidence of its marginal status. The natural birth discourse's representation of birth and advanced maternal age is not regarded as having the same claims of veracity as the scientific medical discourse.

In this section I firstly outline the conditions that allowed the contesting discourse to come into existence in relation to maternal age. Secondly, I describe how its representation of birth risk offers "older" primigravida/ primipara and midwives subject and power positions that are different to those offered by the scientific medical discourse.

#### **4.3.1 Conditions of existence**

Opposition to the medical discourse's construct of "elderly" primiparas" surfaced in the midwifery and birthing literature in the 1980s. Several demographic factors contributed to the maternal age becoming an object of the normal birth discourse. The Society for Research On Women [SROW] (1984) noted that New Zealand women were following the international trend to delay the birth of their first

child until they were in their 30s. In their later 1991 publication SROW termed this change “the fertility phenomenon of the 1980s” (p. 1). In New Zealand the percentage of married women not having their first child within the first five years of marriage rose from five percent in 1960 to eighteen percent in 1981 (SROW, 1984). This trend has continued to the present time so that now in New Zealand the most common ages for childbearing are between 30 and 34 years (Statistics New Zealand, 1999). The increasing numbers of women choosing to delay giving birth to their first child would have brought about the perception that to be giving birth at the age of 35 or over was not an extraordinary event.

Various reasons are given for the trend towards women giving birth to their first child in their 30s. One major influence has been the availability of more reliable contraception. For example, the Pill had been introduced in the 1960s (SROW, 1984). Pool et al (1999), in their study of contraception in New Zealand, state that the pill has become the “pivotal method for the timing of the first birth” (p. 6) amongst New Zealand women.

Other changes in New Zealand noted by SROW in 1984 that contributed to women delaying childbirth were the increase in the number of married women remaining in the paid workforce, changing access for women to higher education, and the rise of the women’s movement. Ball (1999) found that New Zealand women’s educational attainment was a “powerful predictor of fertility timing” (p.42). The more education a woman had the less likely she was to have given birth to her first child at the age of 25 years. Ball suggests that the costs (both in terms of money and commitment) incurred in furthering one’s education have the effect of delaying the time in which one achieves financial independence and career development.

A further factor influencing women’s delay in childbearing identified by Ball (1999) is a move away from marriage and motherhood as the main sources of fulfilment for women. An important group in bringing about this change was the feminists who challenged the belief that motherhood was women’s sole role. The feminists are one of several groups who have deployed the natural birth discourse in their advocating for changes in women’s health and childbirth.

The Parents Centre began in 1952 (Coney, 1993a) as the Natural Childbirth Association. Drawing on the writings of Grantly Dick-Read, the organisation aimed to provide women with information about natural childbirth. Coney writes “This optimism was short-lived. The fledgling group soon realised that its ideas were perceived as

radical and dangerous by conservative in the medical and nursing professions” (p. 272). With the purpose of reducing opposition the name was changed to the Wellington Parents Centre with the aim of educating and empowering women through antenatal education (Guilliland & Pairman, 1995), and continues today as a national organisation.

According to Kedgley (1996) the rise of the feminist movement in New Zealand had resulted in women becoming more assertive. She writes,

The women’s movement was the catalyst for a renewed campaign, similar to the one Parents Centre had led in the fifties, for women to wrest control of birth from doctors and take charge of it themselves. It also rekindled interest in midwife-assisted home birth, which had almost disappeared since the 1950s, and sparked renewed opposition to the highly specialised technology which the medical establishment was increasingly using, even for routine births.

1996, p.239

Feminists asserted that women were entitled to experience birth as a natural process and to have control over the birth process. The increasing use of medical intervention they claimed eroded women’s potential. Feminism, I suggest, as one of the speakers of the natural birth discourse, created a possible space for women to oppose the medical discourse’s construct of maternal age.

The two other groups that brought the natural birth discourse into action were the home birth movement and the midwives. The Homebirth Association was formed in New Zealand in 1978 and was a reaction against the increasing medicalisation of birth. During the 1970s closure of small maternity hospitals reduced the opportunity for women to give birth in a low technological setting (Donley, 1993). The aims of the Homebirth Association were to ensure that homebirth remained an option for women and that women retained control in their experience of birth (Donley & Hinton, 1993). Guilliland and Pairman (1995) highlight the significance placed in the role and presence of the midwife: “[homebirth] members saw the achievement of their aims as directly linked with maintaining the midwife in her full scope of practice and were the group which specifically aligned themselves to the midwife.” (p. 14). Doctors were seen to constrain both the practice of midwives and abilities of women. The convergence of the women and the midwives deploying the natural birth discourse were integral to the re-introduction of midwifery independence in New Zealand.

Midwives’ autonomy had been eroded in the early 1970s with the passage of the 1971 Nurses Act. Donley (1986) asserts that through the Act, midwives were required to be maternity nurses working under the direction of doctors. Papps and Olssen (1997)

note that the everyday use of technology had served to ingrain the “medical model” in the midwives working in the maternity hospitals. Such experiences were consolidated by medical knowledge being the basis of midwifery education. Midwifery training was no longer a separate course but became part of a post-registration course, called the Advanced Diploma in Nursing, in which midwifery was one of several specialty options.

The mid-1980s saw the resurgence of midwives (Reiger, 1999). Several organisations, such as the Parents Centre and Homebirth Association, united together with midwives to lobby for the return of midwifery autonomy and for a direct entry midwifery course. 1990 saw the re-introduction of midwifery independence with the Amendment to the Nurses Act. As Donley (1995) writes, “the purpose of this legislation was to provide women with a wider choice of the underutilised options based on midwifery care, and to challenge women’s perceptions of birth” (p. 63).

The interests of such organisations converged in their pursuit to reclaim childbirth as a “normal human experience” (Treichler, 1990, p. 121) and in their claim that birth was not a medical event.

#### **4.3.2 The representation of birth**

The construction of birth mobilised and deployed by all these speakers was that it is predominantly a normal, natural physiological event that does not require the routine use of intervention. For example, Brewer in *The Pregnancy After 30 Workbook* (1978) wrote that pregnancy and birth:

belong in the realm of women’s concerns because they are normal functions for which our bodies are exquisitely adapted. ... Regardless of your age, it is realistic to expect childbearing to be one of the most pleasurable and healthful periods in your life. After all, you are an evolutionary creature with all of Nature’s past experience on your side.

p. 79

This construction inscribes women’s bodies as expert, honed and inherently capable of giving birth. Pregnancy and birth are seen to occur within the context of a woman’s life, her desire to become pregnant, her feelings about herself and her capability to journey through pregnancy and birth.

Where the natural birth discourse contests the scientific medical discourse in relation to maternal age is in the factors purported to cause the problems associated with maternal age. Instead of an intrinsic biological aging process, the speakers of the natural

birth discourse identify extrinsic factors, such as zinc depletion brought about by prolonged use of oral contraceptives, or already existing conditions such as diabetes or hypertension, as the causes of problems experienced by “older” mothers. Several authors suggest that assessment of an “older” primigravida’s risk should be individually determined and include her emotional and social situation as well as her health (for example, Cole, 1998; Warren, 1992).

Albers, Lydon-Rochelle and Krulewitch (1995) assert that the problem with using maternal age as a risk factor is that it is based on population characteristics and does not permit for accurate individual prediction. Age as a risk criterion was one of several developed in the 1950s (MacFarlane, 1992) from maternal and perinatal mortality rates. At that time the demands for hospital births were increasing. The purpose of the criteria was to identify which groups of women required hospital care because of anticipated complications and which did not. Warren (1992) believes that the criteria are outdated and no longer accurate for today’s women.

#### *4.3.2.1 Subject positions*

Authors deploying the natural birth discourse assert that being an “older” first-time pregnant woman has its advantages. Often the “older” mother is highly educated, she has established her career and has some degree of financial security (Cole, 1998). With regards to her health the “older” primigravida/primipara is concerned about her health and fitness and is more likely to seek early antenatal care (Langford, 1992). All these factors are considered to enhance a woman’s pregnancy outcomes.

Kitzinger (1994) encourages women aged 35 and over to be informed and to be assertive. She assumes that the acquisition of knowledge about pregnancy and childbirth combined with the awareness of the attitudes of the medical profession towards “older” women will address the power imbalance between doctors and women. Furthermore, Kitzinger suggests that because the “older” woman is more likely to be of a similar age to the obstetrician that this similarity will facilitate more equal power relations. In this way Kitzinger constructs “older” women as active participants who have the potential to challenge medicalisation of their experience and who desire information and control. However, not all women may want to take up this position and may desire the assurance that medical practice and expertise offers them.

Mansfield (1986b; 1986c; 1988) argues that “older” mothers are exposed to medical prejudice. One outcome of this prejudice, Mansfield (1986a) believes is that it

may have created a bias towards “older” women that has confounded research studies on maternal age. In her analysis of medical textbooks from the early 1900s to the 1980s she found that the textbooks consistently depict “older” women as having increased complications even though their depiction conflicts with the results from scientific and clinical studies. Prejudice towards “older” mother is compounded by the belief held by some medical professionals that the ideal time for childbearing is when women are younger (Mansfield, 1986a; 1988).

A second outcome of the bias against “older” women is the high rate of caesarean sections that occur without there being any indications for an abdominal delivery (Langford, 1992; Mansfield & McCool, 1986). These authors argue that obstetricians anticipate that “older” women will encounter problems and perform pre-emptive caesarean sections. “It appears that certain justifications in cases of midlife childbearing may have been biased as a result of physician expectations about what ought to be true of “older” women rather than what was in fact true” (Mansfield & McCool, 1986, p. 399).

The natural birth discourse emphasizes the woman’s subjective experience of pregnancy and birth. A woman’s emotional state is the key to a successful birth (Cosslett, 1994). The natural birth discourse purports that the “older” primigravida/primipara is vulnerable to excessive emotional stresses derived from the negative beliefs and attitudes that are held about increased maternal age. Such stresses are considered to be deleterious and contribute to the high obstetric intervention rate observed in “elderly primipara” (see for instance Mansfield & Cohn, 1986, and Warren, 1992).

The natural birth discourse offers the “older” primigravida/primipara the possibility to remain undistinguished from younger women on the condition that she does not have any underlying medical conditions that might cause complications. In this way the options of a homebirth and to a midwife as her maternity care are open to her.

Just as the scientific medical discourse asserts that the appropriate maternity care giver for the “elderly” primigravida/primipara is the obstetrician, the natural birth discourse identifies the midwife as the practitioner who will safeguard the “older” first time mother’s potential to give birth without unnecessary intervention. Guilliland and Pairman (1995) describe the midwife as a “knowledgeable companion and *Kaitiaki* or guardian of the normal” (p. 35). I believe that the authors’ avoidance of the term “expert” is deliberate in their aim to represent the midwife as a professional who does

not hold a superior power position in relation to the woman. Furthermore, the assertion that the midwife as the guardian of the normal is held to protect the “older” primigravida/primipara against unnecessary intervention. For example, Langford (1992) writes, “older mothers who have straightforward births mention how surprised some midwives are when no problems arise. The midwives attending these women bided their time and fortunately did not interfere with the efficient course of nature” (p. 5). Thus the “wait and see” approach is seen to avoid the anticipatory use of intervention associated with specialist obstetric care.

Stein (1985) studied the cases of 152 “healthy” women (both primigravida and multipara) aged 35 or over in the care of a New York Nurse-Midwifery Service over a four-year period. The women had been assessed for medical conditions such as diabetes and hypertension and had to remain in “good health” to continue in the nurse-midwives’ care. Stein attributes the natural birth techniques utilised by the nurse-midwives to the low use of intervention required by the women. The techniques included remaining mobile during labour and the second stage, continuing to eat and drink and adopting different positions such as squatting while giving birth. It is notable, however, that the primigravida in her study had a lesser percentage of spontaneous vaginal deliveries and a higher percentage of forceps and caesarian sections than did the multipara. Other critiques that could be made of her study were the small sample size, lack of statistical analysis and the use of a control group of younger women.

Speakers of natural birth discourse challenge and disrupt the scientific basis of the medical discourse’s claims that “advanced” maternal age results in poor pregnancy outcomes (Cole, 1998; Langford, 1992). Mansfield, one of the most prolific writers contesting the basis of the scientific medical discourse, critically analysed the methodologies of 104 studies dating from 1917 to January 1983. Mansfield (1986a; 1986b; 1988; 1989) found that the findings of only 39 per cent were methodologically valid. The remainder had serious methodological flaws such as small sample size, biased samples, no control groups and “...most importantly, a failure to control either methodologically or statistically for a number of confounding factors” (1988, p. 448). The majority of methodologically valid studies found that “older” women were not “reproductively disadvantaged” (p. 449). The common “disadvantage” for “older” women in comparison to younger women was a higher rate of caesarian sections. As discussed in the previous section of this chapter the decision to perform a caesarian has been found to have a high degree of subjectivity and thus the extent to which this

“dependent variable” reflects “older” women’s inability to birth is rendered questionable.

#### **4.4 SUMMARY**

In this chapter the two discourses evident in the literature which contest both the meaning of birth and the significance of maternal age have been explicated. Within the scientific medical literature there are two sub-discourses regarding at risk “elderly” primipara: the maternal age sub-discourse and the defective body sub-discourse. Both discourses share conditions that permitted, and continue to permit, their existence. Each has a different theory of causation but both overlap in their construction of the “elderly” primiparas as women who encounter medical problems during pregnancy and birth and who, because of their bodies create medical problems for their babies. The two discourses construct the “elderly” at risk primipara as their object and inform, and are informed by, the discursive practices of surveillance and caesarian section.

What has emerged is the construction of a younger woman who is the ideal. She remains silent, the binary other, the not said, implied in the words “older” and “elderly”. She is the norm, the standard against whom the “older” woman and her baby are compared. Her constructed idealism is derived from her youthful body which inherently has the ability to journey through pregnancy and birth without medical problems. However, in reality the younger woman is constructed from statistical norms which obscure not only the existence of variations within younger women but also those existent amongst “older” women. Regarding the athletic performance analogy, I would argue that the younger woman is also set up for failure.

The natural birth discourse contests and disrupts the scientific medical discourse’s construction of maternal age. It offers the “elderly” primigravida/primipara an alternative subject position and power relationship with maternity practitioners. In not distinguishing the “older” first time mother from younger women it offers her the choice of practitioners and places to give birth. She is not confined to the choice of an obstetrician or level three hospital.

The second issue associated with the maternal age is that of prenatal genetic diagnosis. In the following chapter my analysis of literature shifts to discourses that comprise the discursive field of prenatal genetic diagnosis.

## Chapter 5: THE DISCURSIVE FIELD OF PRENATAL GENETIC DIAGNOSIS

### 5.1 INTRODUCTION

The discourse that has brought chromosomal conditions into visibility and constituted them as pathological conditions is the medical genetic discourse. As Parker (1992) notes, although the process of discourse analysis conceptualises a discourse as discrete, in practice the deployment of a discourse refers to, presumes and invokes others. When analysing the practice of prenatal genetic diagnosis, it is important to note that while it seems a discrete practice it is embedded in several discourses which I tease out and analyse in this chapter.

In this chapter my analysis shows the connection between the development of prenatal genetic diagnosis methods and the legalisation of abortion in New Zealand. I then identify and explore the various discourses that work to sustain prenatal genetic diagnosis: the discourses of disability, risk, economics and neo-liberalism. I suggest that over time these various discourses and discursive practices have become enmeshed with one another to legitimate, promulgate and sustain the practice of prenatal genetic diagnosis for women aged 35 years and over. I propose that these discourses work together to give the genetic discourse an almost hegemonic status<sup>10</sup> so that the practice of making older women aware of the likelihood of their having a child with chromosomal abnormalities and the availability of prenatal genetic diagnosis is routine. Further, my analysis also shows that prenatal genetic diagnosis is a practice that is contested by groups such as the disabled rights movement, feminists, and parents of intellectually disabled children.

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<sup>10</sup> I draw here on Smart's (1986) reworking of Gramsci's concept of hegemony. The term hegemony is used to explain a consensual type of relationship in stable capitalist societies between a ruling group and its subordinates, in that the ruling class does not require force to maintain its position. Smart suggests that Gramsci's concept of hegemony requires reworking because of its slippage in meaning. Foucault's writings, Smart proposes, in particular the practices that subjectify and objectify people, both clarifies the meaning of hegemony and extends it. Thus, Smart writes of hegemony as contributing to or constituting a: "form of social cohesion not through force or coercion, nor necessarily through consent, but most effectively by way of practices, techniques, and methods which infiltrate minds and bodies, cultural practices which cultivate behaviours and beliefs, tastes, desires, and needs as seemingly naturally occurring qualities and properties embodied in the psychic and physical reality (or 'truth') of the human subject."  
1986, p.160

In my consideration of the procedures used in prenatal genetic diagnosis I have only included amniocentesis and chorionic villi sampling [CVS] because these are the tests used most commonly in New Zealand to identify chromosomal conditions such as Down syndrome. While maternal age has been identified as related to several chromosomal conditions, mainly Edward's syndrome (trisomy 18) and Patau syndrome (trisomy 13) (Berryman, Thorpe, & Windridge, 1995), Down syndrome<sup>11</sup> is the one that is most commonly identified in the literature and therefore will be the condition that I refer to. I traverse the history of Down syndrome in an attempt to show the shifts over time in its representation and the discourses from which they are derived. One of the conditions that facilitates the practice of prenatal genetic diagnosis is the legalisation of abortion.

## **5.2 PRENATAL GENETIC DIAGNOSIS**

Ruth Schwartz Cowan (1994) describes prenatal genetic diagnosis as a “sociotechnological system” which is comprised of auxiliary parts. These include abortion, amniocentesis and CVS, and the “medical delivery services that convince women to become patients” (p. 34). Each part is vital to the availability of prenatal genetic diagnosis. All these and more comprise the discursive field of genetic testing.

### **5.2.1 Abortion**

Rothman (1993) puts forward the idea that legalised abortion is a necessary requisite for prenatal genetic diagnosis as there is no treatment for chromosomal differences such as Down syndrome. The only option a woman has if she does not want to give birth to a baby diagnosed as having Down syndrome is to terminate the pregnancy. Moreover, both Green and Statham (1996) and Rothman (1993) argue, government funding of prenatal diagnostic tests such as CVS and amniocentesis only occurs because parents do choose to terminate pregnancies on the grounds of a “positive” fetal abnormality.

In New Zealand the abortion of fetuses thought to be potentially physically or intellectually disabled was not legalised until 1977 with the introduction of the Contraception, Sterilisation and Abortion Act. The introduction of the Act makes evident the changing attitudes towards abortion and possibly changing attitudes towards the intellectually disabled. In her analysis of the 1936 – 1937 Committee of Inquiry into

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<sup>11</sup> I have chosen to adopt the way in which the Down Syndrome Association, New Zealand, spell Down syndrome.

Abortion, Brookes (1975) makes no reference to the therapeutic abortion of babies considered to be at risk of physical or intellectual abnormality. The Committee's primary concern was to prevent women from dying from illegal abortions rather than the reasons for therapeutic abortion.

Prior to 1977 abortions were only permitted under the 1961 Crimes Act when the mother was considered to be at risk of becoming a "physical or mental wreck" (Facer, 1974, p. 2) should she continue with the pregnancy. The Royal Commission's report does make it apparent that prior to 1977 women, who were thought to be carrying an abnormal fetus, had been able to access abortion on the grounds that the birth of such a child would jeopardise the mother's health. The types of defects identified in the 1977 Royal Commission's report included inherited conditions or those caused by rubella, drugs or other environmental factors, for example, exposure to radiation. Down syndrome, along with other genetic abnormalities such as spina bifida, Tay Sachs and anencephaly are also identified.

One of the recommendations made by the Royal Commission was that an abortion could occur legally if "There is a substantial risk that if the pregnancy were not terminated and the child were to be born, it would have or suffer from such physical or mental abnormality as to be seriously handicapped" (1977, p. 283). With the passage of the 1977 Contraception, Sterilisation and Abortion Act, women who had undergone prenatal genetic diagnosis and thus were found to be "substantially" at risk of having an "abnormal" fetus were legally entitled to an abortion. Furthermore, such women were made an exception in being legally permitted to terminate their pregnancy after 20 week's gestation. In an attempt to standardise access to abortions, the 1977 Act took up the Royal Inquiry's recommendation that three certified practitioners should have to assess the woman's legitimacy to an abortion. Two of the three practitioners were to be medical practitioners. In this way, the medical profession is accorded the status to both interpret the law and to enforce it.

The validity accorded to the genetic discourse which constitutes the older woman as at considerable risk of having a baby with Down syndrome is evident in the Royal Commission's report and in the passage of the 1977 Act. The report specified women who are "beyond a certain age and, on that account, run a greatly increased risk of having a child with Down's Syndrome" (1977, p. 210) as one of a group of women for whom an amniocentesis is deemed an appropriate test. These women have "evidence" to prove that they indeed are at risk of having a child with abnormalities.

With regards to older women, their proof is the statistically calculated probability of having a Down syndrome baby. Reciprocally, the report and ensuing legislation, I suggest, legitimated the medical genetics discourse. Integral to determining an older woman's access to an abortion was the evidence provided by an amniocentesis that her baby did have an abnormal number of chromosomes.

### **5.2.2 Amniocentesis and CVS**

The procedure of taking amniotic fluid, during the fifteenth and sixteenth weeks of the prenatal period (Lynch, 1999), to assess the genetic and biochemical condition of the unborn baby was developed in the 1960s (Kolker & Burke, 1994; Paul, 1995). Cowan (1994) writes that amniocentesis took 15 years in its development before it could be made widely available. One condition Cowan states that delayed the development and availability of amniocentesis was that in 1960 only Copenhagen legally permitted "eugenic" therapeutic abortions. The ability to use ultrasonography to identify the moving fetus and the position of the placenta also facilitated the development and safety of amniocentesis (Rapp, 2000).

Initially amniocentesis was first used to identify the sex of the fetus. According to Farquhar (1996), amniocentesis became more "mainstream" when the numbers of women delaying childbirth increased and maternal age was added as an indication for amniocentesis. In New Zealand, Professors Bill Lilley and Mont Liggins first developed amniocentesis at National Women's Hospital in relation to their work in rhesus haemolytic disease (Fisher, personal communication, September 18, 2001). It was not until the 1970s that amniocentesis was performed for genetic testing. According to Fisher, only high risk women, which included women aged 37 years and over, were offered amniocentesis at National Women's. Amniocenteses were initially carried out only in the public hospitals until the 1980s when private fertility centres such as Fertility Associates were established. There was some discrepancy throughout New Zealand about the age at which women were offered the tests, as some areas used the age of 35 as the cut-off. In the 1990s the age was standardised to 35 years, partly to ensure equity and partly because the risk of one in 200 of having a child with genetic abnormalities was regarded as a "reasonable risk".

CVS<sup>12</sup> became available in New Zealand in 1981 (Birdsall, Roberts, Fisher, Beecroft & Bailey, 1992). Its earlier timing allows for less traumatic terminations to occur in the first trimester than for amniocentesis (Rapp, 2000). The likelihood of the woman miscarrying her baby as a consequence of CVS is one per cent, the same as with an amniocentesis. There is also a 2 per cent possibility that the woman may have a spontaneous miscarriage, one that occurs in the first trimester but is not caused by the CVS itself (National Women's Hospital, 2000). Older women have a higher rate of spontaneous miscarriages (Kolker & Burke, 1994).

In New Zealand both amniocentesis and CVS are available at no cost to women who meet one of the following criteria: having had a previous baby with chromosomal abnormalities; a nuchal screen or Maternal Serum Screen test that indicates that they are at high risk of carrying a baby with chromosomal abnormalities; or, they are aged 35 years or over at the time their baby is expected to be born.

More recently, a non-invasive test called nuchal screening has been developed<sup>13</sup>. Nuchal screening is carried out in between the eleventh and fourteenth weeks of pregnancy (National Women's Hospital, 2000). However, it does not give the woman the same surety of evidence as CVS and amniocentesis. Nuchal screening only provides the woman with a statistical risk probability. If an increased nuchal skin fold thickness is found, the woman then needs to decide whether she will have an amniocentesis.

Ultrasounds have become a routine feature of antenatal care (Kolker & Burke, 1994) and are regarded by women as an opportunity to see one's baby (Green, Statham & Snowdon, 1992; Taylor, 2000) rather than a method of screening or diagnosing abnormalities. The potential exists for nuchal screening to occur insidiously, without the woman's or practitioner's knowledge. Venn-Treloar (1998), a British doctor, realised that during a routine antenatal ultrasound scan that she underwent that the ultrasonographer had been measuring her baby's nuchal skin fold. She states, "I realised how close I had been to the receipt of non-specific information from a test that I had not consented to. If the baby had had Down syndrome I could have been told and been troubled for the rest of the pregnancy" (p. 1027). An incident was related to me by an

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<sup>12</sup> CVS is the process whereby a sample of placental chorionic tissue is obtained and tested for biochemical and genetic information. The test is performed in the first trimester of the pregnancy between the ninth and eleventh weeks.

<sup>13</sup> Nuchal screening involves the use of ultrasound to estimate the thickness of the skin at the back of the fetus' neck. As the thickness increases, so does the likelihood of the baby having a chromosomal abnormality (Martin, 1998).

independent midwife who had received an ultrasound report informing her of a “positive” nuchal screen result. The midwife had neither requested the screen nor discussed it with the woman. She felt obliged to relay the findings to the unprepared woman.

As referred to above, the ability to prenatally test the genetic condition of the fetus shaped the 1977 Royal Commission’s recommendations regarding the termination of fetuses found to be “abnormal”. The Royal Commission represented amniocentesis as a valid and reliable means of identifying the presence of abnormality during the antenatal period. They wrote,

In this way [i.e. amniocentesis] it is possible to establish, in the case of certain diseases, an absolute identification of a fetus affected with a serious disorder, inconsistent with normal physical or mental development, and with no prospect of responding to rational treatment.

1977, p. 208

No mention is made of amniocentesis’ fallibility: that sometimes a false “positive” or false “negative” reading can be made.

Amniocentesis, CVS and nuchal screening can be technologies of domination. They provide the means whereby the fetus is rendered visible. As tests, amniocentesis and CVS produce the fetus as the object of a hierarchical and normative gaze. The fetus becomes known in terms of its chromosomal make-up. It can then be qualified, classified and normalised through abortion. The discourse of medical genetics inscribes the abnormal fetus as different.

The medical genetic discourse and the disabled rights discourse offer-contesting representations of the significance of the prenatal genetic tests. The medical genetics discourse gives two meanings to genetic testing (Shakespeare, 1999). Firstly, genetic testing allows parents to avoid the “disaster” of having a child with chromosomal abnormalities. Secondly, genetic testing is represented as offering “narratives of optimism”. According to Shakespeare, one such narrative is the “narrative of hope” whereby affected families are offered a “cure” or “treatment”. Ironically the “cure” is preventing the birth of an affected child. In addition, the optimistic belief that women make their decision on the basis of free choice and informed consent is both misplaced and complacent. Women may not have access to full unbiased information or sufficient counselling following “negative” results.

From the perspective of the disabled rights discourse, prenatal genetic diagnosis is viewed as eugenic. Speakers of this discourse propose that the purpose of prenatal genetic diagnosis is to eradicate the disabled (Donley, 1994; Shakespeare, 1999). Concern exists that ethically prenatal genetic tests are the beginning of a “slippery slope” (Rothman, 1993). It is believed that by allowing the abortion of Down syndrome fetuses the way is opened for terminating other “genetic abnormalities” identified by developing technology. This perspective highlights the shifting and contextual nature of the definition of the boundaries between normal and abnormal.

For writers such as Finger (1984) and Saxton (1984) the performing of prenatal genetic diagnosis for the reason of aborting potentially disabled children promotes and perpetuates negative attitudes towards the disabled. The argument that prenatal genetic diagnosis lessens the economic and emotional burdens placed on the families of the disabled is questionable (Kaplan, 1994). Kaplan argues that research into the actual costs of disability has been insufficient to support this claim. The assumption that all disabled children will disrupt their families is contradicted by the views held by some families that their experience of disability has enriched them. By society continuing to support prenatal genetic diagnosis and termination without questioning the reasons for such practices, Kaplan states, the physical, economic and attitudinal barriers that contribute towards disability are perpetuated. These barriers are not necessarily a consequence of being disabled but are created by the discriminatory practices and attitudes held by society.

Feminists are another group who contest the routinisation of prenatal genetic diagnosis (Rapp, 2000). Feminists such as Corea (1985) and Rowland (1992) observe that the age for when women are offered amniocentesis has been gradually lowered since its introduction. Originally it was offered to women aged 40 to detect Down syndrome but now it is offered to 35 year old women. Moreover, prenatal genetic diagnosis is used to identify a wider range of conditions (Rowland, 1992). Klein (1988) argues that the guilt engendered by choosing to give birth to a child with chromosomal abnormalities can erode women’s control over their “procreative capabilities”. Early feminist authors such as Corea (1985) warned of the potential for some prenatal tests to become mandatory thus removing women’s choice. Indeed, in 1986 the state of California made it mandatory that the blood test for alpha fetoproteins be offered to all pregnant women before their twentieth week of pregnancy (Browner & Press, 1995). These authors observed 35 sessions where women were informed of the availability of

the test. Browner and Press found that “providers offer no more information than is absolutely necessary to make women aware of the test’s existence” (p. 314). Furthermore, they found that information was given in a way that encouraged women to have the test.

As Farquhar (1996) and Rapp (2000) point out, the problem with some of the feminist arguments is that they construct women as passive subjects of the prenatal diagnostic technologies. “This discourse of domination is not only impervious to the pleasures of stimulation that prenatal technologies offer women. It also ignores the way even dominant, routinized technologies unwittingly mobilize diverse opportunities for perverse appropriation and strategic opposition” (Farquhar, 1996, p. 169). Rapp (2000) argues for the recognition of science as a heterogeneous domain rather than a unified adversary.

My analysis thus far has only explored the connection between abortion and the technology that has facilitated the practice of prenatal genetic diagnosis. The interconnections between the medical genetics discourse and the practices of abortion and amniocentesis serve to legitimate one another. However, the representation of prenatal genetic diagnosis is made complex by the contesting discourses of feminism and the disabled rights movement.

The disabled rights movement argues that the meaning of disability is socially constructed and that historical, social and economic contexts influence its representation. In the following section the changing meanings of disability with reference to Down syndrome are described and analysed.

### **5.3 DOWN SYNDROME: THE CHANGING CONSTRUCT**

Braidotti (1996) identifies discourses that “express and explore a deep-seated curiosity about the deformed or anomalous body” (p. 290) as teratological discourses. The origin of the anomalous body, Braidotti asserts, is one question that such discourses entertain and devise the “wildest theories” about (p. 291). In the nineteenth century the teratological discourse regarding Down syndrome reflected the common process of classifying “monsters” as members of different, more primitive, less desirable, races. This theory was reflected in the idea that children born with Down syndrome had reverted to the Mongolian race was first mooted in 1844. Hence they were known as Mongols until the 1980s. Ironically, in Mongolia the same condition was known as “the European disease” (Stratford, 1989, p. 29).

Prior to the decline of feudalism people in the villages had supported their intellectually disabled (Stratford, 1989). The changing social organisation brought with it a reduction in the amount of support available to the intellectually disabled and as a consequence they migrated to the more urban areas. There they were labelled as “drifters”, the same category paupers and physically handicapped were identified under, and were more likely to be placed into institutions such as the workhouses and asylums.

Oliver (1990) argues that the rise of the capitalist economy required changes in the way human beings were thought of, some of which had implications for the disabled. In particular, Oliver proposes, was the way in which people were constituted as “able-bodied” and “able-minded” individuals (p. 45). Factories required workers who were able to manage machinery and who could “submit to the new work disciplines imposed by the factory” (p. 46). Because they were incapable of meeting these requirements, the disabled were then excluded from the work force and from society. Not only, however, were the disabled segregated from those who could work, they were pathologised. Through the overlapping of scientific knowledge, the establishment of hospitals and the need for the classification and control of the population, the disabled came under the gaze of the medical profession (Oliver, 1996).

The asylum cared for children with “mental retardation”, and, I would argue, the collecting of such children together created the possibility for the observation and classification of Mongolism to occur. The differentiation of Down syndrome from other types of intellectual disability was made by John Langdon Down in 1887 (Fergusson, 1995). Down was a physician who held the position of superintendent at an asylum in Surrey, England. Down (1887/1995) discerned through observation physical features and behavioural differences that were characteristic of Down syndrome.

In New Zealand, the government expected that the families of the disabled would primarily be responsible for their care (Tennant, 1996). Towards the end of the nineteenth century Tennant notes that there were increased numbers of intellectually handicapped being admitted to psychiatric institutions<sup>14</sup>.

In 1911, the Mental Defectives Act was introduced, differentiating the intellectually handicapped from the mentally ill (Millen, 1999). Tennant (1996) identifies the Act’s introduction as reflecting “the trend towards classification” (p. 15).

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<sup>14</sup> One example is the benevolent institution, established by Mother Mary Joseph Aubert’s Sisters of Compassion, which opened in Island Bay in 1907 and provided care for a variety of disabled people, including those with Down syndrome.

Seven classes of “mental defectives” were distinguished: those of unsound mind; the “mentally infirm”, “idiots”; “imbeciles”; the “feeble-minded”; epileptics and the “socially defective” (Millen, 1999, p. 3). The criteria for the classificatory grid were the degrees to which the intellectually disabled person was capable of protecting themselves from physical harm and their ability to enter into the workforce.

From the age of five, children who were classified as belonging to one of these criteria were supposed to live in mental hospitals and became the responsibility of the Director General of Mental Defectives. Millen (1999) writes that the Act’s focus was in the ‘public interest’ to lessen the burden on the children’s parents or guardians.

In the 1920s, the eugenics movement gained influence in New Zealand with their beliefs shaping the conclusions made by the 1924–25 Committee of Inquiry into Mental Defectives and Sexual Offenders. The theory that underpins the eugenics discourse is that human traits, that is intellectual ability, temperament and morals, are influenced by heredity (Paul, 1995). Eugenicists propose that persons identified as having the traits regarded as desirable are encouraged to have children and that those people with undesirable traits are dissuaded. According to Paul, Francis Galton, who is known for his work in statistics and eugenics, put forward several definitions of eugenics, one being: “the science which deals with all influences that improve the inborn qualities of a race; also those that develop them to the utmost advantage” (Galton, 1909 cited in Paul, 1995, p.3). Galton’s assertion that eugenics was a science, I suggest, was an attempt to legitimise it as a body of empirical and therefore truthful knowledge.

The eugenics discourse identified the intellectually disabled as inferior, degenerate and lacking in morals (Tennant, 1996). Such qualities were undesirable. Eugenicists were concerned that the intellectually disabled would erode New Zealand’s ‘racial fitness’ by being permitted to breed. Amongst the speakers and enforcers of the eugenics discourse were members of the medical profession (Millen, 1999), Dr Truby King the founder of the Plunket Society, being the most notable (Tennant, 1996).

“Mental defectiveness” was constructed as a permanent condition and incurable by medical standards (Millen, 1999). Medical practitioners played a significant role in the identification of children with intellectual disability (Tennant, 1996). Some family doctors, up until the 1920s and 1930s, advised mothers against seeing their newborn baby or taking them home.

Speakers of the eugenics discourse were not confined to the medical profession. Organisations such as the National Council of Women, the Plunket Society and the New Zealand Family Planning Association held eugenicist ideas (Coney, 1993b). Subsequent to the 1924 – 1925 Committee of Inquiry, measures were introduced that can be seen from a Foucauldian perspective as strategies of surveillance, categorisation and normalisation. They included “new legislation, mechanisms for classification, and institutions for training and detention” (Tennant, 1996, p. 14). These were technologies that would enhance the productivity of those intellectually disabled who were able to be trained, and ensure the continued productivity of their families.

Following the Second World War, the term eugenics acquired negative connotations and became less popular and visible (Tennant, 1996; Thom & Jennings, 1996). However, there is recognition that the origin of the medical genetics discourse was embedded within the eugenics discourse. The way which geneticists set themselves apart (and continue to do so) from the eugenics discourse is by disassociating themselves from eugenics’ attempt to overtly influence people’s reproductive rights (Paul, 1995).

Thom and Jennings (1996), in tracing the British history of genetics, write that eugenics was gradually “expunged from the polite world of science”. According to Thom and Jennings, Lionel Penrose was a key person in achieving this change. Initially he had been appointed Professor of Eugenics in 1945 but successfully lobbied to change his Chair’s title to Professor of Human Genetics. Penrose’s means of distancing human genetics was to constitute eugenics as illegitimate knowledge by presenting it as an unscientific ideology. In contrast, his human genetics was a science which was based on scientific strategies such as: “the collection of data, the use of numeric tables, the application of mathematical techniques” (p. 228). It is interesting to note that according to Thom and Jennings, Penrose did not consider mental defect to be a disease. Instead, it was “merely the expression of normal variation in the intellectual capacities of the human species” (p. 228). His construction highlights the existence of a discourse that contests the medical genetic discursive practice of dividing the types of chromosomes into the binary of normal or abnormal.

Paul (1995) highlights the slippage regarding the definition of eugenics. One definition refers to the practice of selective breeding, which, as Paul observes, portrays eugenics as innocuous. Another definition depicts eugenics in a more negative light. It identifies the state as instituting coercive policies regarding the type of children that one

may have. It could be argued that the softer version of eugenics contributed to the 1977 legalisation of aborting fetuses identified as having “abnormal” chromosomes. In her submission to the Royal Commission on Contraception, Sterilisation and Abortion, Dr Alice Bush writes:

I would not want to bring into the world a child for whom I have no love nor one who would be so handicapped that it could not lead a human life. Severe mental defect deprives a human being of the ability to make choices or to live as a human as opposed to any other animal. When mental defect can be diagnosed in the early months of pregnancy, I would consider the making of this diagnosis a proper indication for termination of pregnancy.

1975, p.2

For Bush (1975) the intellectual capacity to reason and choose is the quality that differentiates human beings from other animal species. A person with severe intellectual disability is deficient in this human capacity. The language of eugenics with its notion of inferiority is evident. It is clear that Bush includes Down syndrome in the category of severe disability as further in her submission she recommends that females with “mongolism” should be sterilised to prevent the possibility of their giving birth to a baby with the same condition.

The Royal Commission (1977) noted, based on evidence derived from several surveys carried out in New Zealand at the time, that societal attitudes supported the legalisation of abortion when “birth would probably result in a seriously deformed child” (p. 232). In describing Down syndrome children the Royal Commission stated:

Children born with Down’s syndrome have a much diminished life expectancy with an increased incidence of congenital heart defects and other congenital faults, and a twentyfold increase in the risk of dying from leukemia in childhood, particularly respiratory infections. They are all mentally retarded. The Down’s Syndrome children and adults present in the community are mainly those, who, by virtue of their lesser degree of mental retardation, have achieved some social adaptability. More severely affected cases are generally to be found in institutions.

1977, p. 209

The excerpt reflects the belief that intellectual and physical impairments diminish the quality of life of the person with Down syndrome. Kaplan (1994) suggests that when disability is constructed as a lesser quality of life abortion is then constructed as a benevolent action, “a kind of altruism” (p. 56). A life of potential suffering is a life not worth living. Abortion avoids this suffering. Kaplan questions whether disabled

people have been asked to offer their perspectives on their quality of life. While their voices remain marginalised, social policies have the potential to enact practices that hinder disabled people's quality of life and condone the practice of abortion.

Ironically, the Royal Commission's recognition of people with Down syndrome who are less afflicted and hence able to participate in society, ignored the fact that prenatal genetic diagnosis does not specify the actual severity of Down syndrome.

The construct of Down syndrome as a chromosomal abnormality emerged in the 1950s. Until 1959 Down syndrome was identified by observing the child's development and counting the number of Down stigmata manifested by the child (Stratford, 1989). In 1959 Le Jeune, a French cytogeneticist, identified the causal relationship between the common form of Down syndrome and trisomy of the chromosome 21 (Cowan, 1994; Stratford, 1989). The means of determining the existence of Down syndrome was no longer limited to the overt phenotypic characteristics. The scientific gaze could extend within the body to the cell nucleus. Access and interpretation of genetic information was restricted to experts such as the cytogeneticists, the doctors, researchers and laboratory technicians who could cultivate the fetal cells and interpret the significance of the chromosomes' structure.

The medical genetics discourse depicts genes as "blueprints" containing the information that determines the human condition. Farquhar (1996) notes that the gene model of medicine is changing the biomedical paradigm of disease. Genes are increasingly being identified as the cause of pathology. As a consequence, the diagnosis and treatment of disease is becoming more individualised. Thus the fetus identified as having a chromosomal disorder is judged as pathological and deviating from the natural order.

In the medical literature Down syndrome does not emerge in relation to maternal age until the 1950s (for example, Schmitz, McGowan & Smith, 1958; Stanton, 1956; Weisl, 1953), when, according to Thom and Jennings (1996), the relationship between maternal age and the incidence of Down syndrome was formally identified. The link between maternal age and Down syndrome was determined from the data gathered by the Galton Laboratory for National Eugenics in England.

The maternal age of 35 years has become synonymous with prenatal genetic diagnosis. As Green (1994) states, increasing maternal age is now recognised by most women as being a risk factor for something being genetically "wrong" with their baby. I found that when I used maternal age as a search subject in Medline and the Cumulative

Index for Nursing and Allied Health Literature [CINAHL] the search revealed a predominance of journal articles on genetic testing. Popular books on pregnancy and birth such as Anderson's *Pregnancy After Thirty* (1984), Kitzinger's *Birth Over 35* (1994), and Berryman, Thorpe and Windridge's *Older Mothers* (1995) all discuss the risk of women over 35 having a baby with Down syndrome. Similarly a search of some material available on the Internet, under the heading of amniocentesis, reinforced the link between increased maternal age and the risk of Down syndrome.

The medical genetics discourse constructs older women as being both at risk of having a chromosomally abnormal baby and, as being the cause of the baby's abnormality. The ova produced by females first begin their cellular development while the female fetus is in the embryonic stage (Kessling & Sawtell, 1996). During puberty maturation of the ova is completed. In contrast, male's sperm is "fresh", being continually produced. In this way the theory regarding Down syndrome may be seen to be gendered with older women's ova constructed as old, stale, inferior and pathogenic, in contrast to men's sperm which is comparatively younger, fresher and superior.

The link between aging ova and Down syndrome is rendered problematic by the occurrence of younger women giving birth to babies with Down syndrome and the knowledge that the extra chromosome 21 can come from ~~both~~ the father and the mother (Kessling & Sawtell, 1996). Kessling and Sawtell provide two theories to explain the increased incidence of Down syndrome in older mothers. The first is that all women are born with the same number of ova with chromosomal abnormalities. The normal ova are more likely to be "used" first, leaving a higher number of abnormal ova in the older woman. The second theory suggests that regardless of a woman's age, the same number of trisomic conceptions occur. However, the older body is less likely to miscarry than the younger body. The latter theory proposes that the body recognizes that pregnancy in the older woman may be the last or only one, and so works to retain the pregnancy. Both theories construct the woman's body as having the sentience to discern either the quality of the eggs or the significance of the pregnancy. Similarly, both theories construct the younger woman's body as biologically more efficient and effective.

Newton (1992), drawing on the findings of animal studies which showed that there was an increase of "sperm-derived" trisomies as the sperm aged, proposes that male sperm may well become aged if they are stored for too long in the genito-urinary tract. He argues that these findings may partly explain the high incidence of Down

syndrome of children born to older couples and unmarried teenage couples who are likely to have less frequent sexual intercourse than their counterparts.

Newton (1992) is one of the few authors who gives a brief discussion of external causes, such as hormones, environmental factors, and the possibility that parents of Down syndrome children may have a biological factor that makes them predisposed or “vulnerable” to having children with Down syndrome. These other causes though are made subordinate by their lack of supporting empirical evidence. Newton notes, “the part environmental factors, such as X-rays, chemicals and viruses, may play on some of these chromosomal events is as yet unproven” and in relation to a predisposition or vulnerability, “these observations need to be confirmed by further studies before firm conclusions can be drawn” (1991, p. 20).

The genealogical analysis of Down syndrome has revealed the interplay and influence of several discourses. Three further discourses intersect on the topic of prenatal genetic diagnosis in relation to the meaning of chromosomal “abnormalities” and in influencing the practices of maternity service providers. I firstly discuss the risk discourse followed by the economics and neo-liberal discourses.

#### **5.4 THE RISK DISCOURSE**

One of the most commonly cited references, which identifies the correlation between older mothers and Down syndrome, is the publication by Hook (1981). The data for Hook’s research was derived from three separate studies utilizing incidence rates from Massachusetts, New York State and Sweden (Hansen, 1986). The studies, however, did not take into account the number of spontaneous or therapeutic abortions of fetuses that might have occurred. Hook’s analysis determined that the incidence of “clinically significant cytogenetic abnormalities” increased as women got older.

In his article, Hook proposed that the incidence “rate”, which the *Oxford English Reference Dictionary* defines as “ a stated numerical proportion between two sets of things” (1996, p.1197), could be read to mean risk. Hook argued that while increased maternal age did not guarantee that a woman aged 40 would have a Down syndrome baby ~~but~~ it did increase the chance that she might. Hook proposed that at the age of 30 years women have a one in 953 chance of giving birth to a baby with Down syndrome. At 35 years the “risk” becomes one in 378 and at 40 years of age a one in 106 chance (Johnson & Christianson, 1999). Hook writes:

At least one assumption implicit in the discussion of live-birth rates is that the “rates” observed in past studies can be extrapolated as “risks” for women seeking counseling in the future.

1981, p.285.

I would argue that Hook reflects the move from determinism to probability that occurred from the nineteenth to the mid-twentieth centuries. Hacking (1991) suggests that during the nineteenth century there was a change in the way events in the world were explained. At the beginning of the nineteenth century statistics were used to argue that there were “unequivocal and uniform” social laws which determined human behaviours. By the mid-twentieth century, Hacking observes, the use of determinism diminished. The statistical discourse of probability was increasingly deployed as an explanation. Hook (1981) reflects the discourse of probability in that he draws on numerical data and statistical analysis to provide counsellors with a ratio of risk that they may pass on to women. While he implies that there is a relationship between maternal age and the incidence of babies born with Down syndrome, the actual certainty that an older woman’s baby will have Down is indeterminate.

Risk, when employed by risk analysts in the process of determining statistical probabilities, can be depicted as neutral. Its common meaning however, is one that implies danger, “it designates an objective threat” (Ewald, 1991, p.199). What constitutes a risk is socially determined: “nothing is a risk in itself [...] it all depends on how one analyzes the danger, considers the event” (p. 199). Hook’s statistical evaluation of the proportion of babies born with Down syndrome to women of specific ages becomes reconstituted as an event that can be predicted in terms of probability and also instantiates a negative view of Down syndrome. In being given the meaning of a risk, the act of giving birth to a baby with Down is foregrounded as an undesirable, dangerous event.

Lupton (1995) distinguishes between an external and an internal health risk. The former is one that is usually environmental over which a person has minimal control. An internal risk is one that occurs as a result of a person’s lifestyle. This latter concept implies the notion of choice and infers that the person has some degree of control over the factors that have contributed to his/her risk. It may be assumed that older primigravidas have consciously chosen to delay having their first baby. For example, in a recent article titled *The late baby boom: gambling with fate* Kalb (2001) reports that concern is increasing amongst various international medical fertility specialists about the trend for women to delay childbearing. These specialists plan to actively increase

women's awareness "educating women about how age can affect fertility – and what can go wrong" (p. A9), the increased likelihood of chromosomal abnormalities is one. The rhetoric of choice deployed in the article is used to enhance women's decision-making regarding the timing of childbearing and to urge them to consider having their babies prior to turning 40. The degree to which a woman can exercise choice over the timing of childbearing is debatable. As one of the speakers in Kalb's (2001) article mentions, women may be delaying childbearing until they have a partner and financial security. The extent to which these reasons are determined by personal motives and not social expectations is left unanswered.

In identifying maternal age as a predictable risk factor, the incidence of Down (and problems of infertility) can be avoided if the woman disciplines herself and prioritizes her desire to bear children. Lupton (1995) applies Ewald's (1991) links between risk and enterprise. People are seen as individuals who are thought to be able to take responsibility for their lives and wellbeing, and to maximize their potential. Women should "plan for the future" and "take judicious steps to ensure protection against misfortune, retaining responsibility for their affairs" (Lupton, 1995, p. 79).

## **5.5 THE ECONOMICS DISCOURSE**

Callan (n.d.) argues that cost is constructed as something that is negative where the state's resources are made use of and/or the welfare of the mother and other family members suffer as a consequence of having a disabled child. In contrast, economic benefits are viewed positively. Economic benefits are those savings gained by avoiding the costs that would have been incurred had the disabled child been born. Pursuing this line of evaluation leads one to conclude that abortion is a desirable cost-saving exercise. Kaplan (1994) argues however, that there is minimal evidence "... to support the assumption that abortion-based prevention will significantly reduce disability-related social costs" (p.54). She points out that the social costs historically associated with disabilities have been brought about by policies of exclusion from society. The public monies spent on disability have been employed to counterbalance the effects of societal and architectural boundaries that have lessened disabled people's opportunities and capacities.

Oliver states "... societies which produce very large economic surpluses will almost certainly have established elaborate mechanisms of redistribution; but who gets what amount will be significantly influenced by the ideology underpinning this

redistribution process" (p.24). The present day context is one of finite health care resources (Chapple, 1994). Limited funding imposes constraints on the quantity and quality of health care resources that can be provided. Furthermore, the notion of limited resources can foster an environment of competition between the different health sectors so that criteria such as cost-effectiveness and worthiness may come into play in determining the types of services provided. Chapple points out that cost-effectiveness as a criterion emphasizes the savings that can be made from terminating abnormal babies.

Callan (n.d.) makes it apparent that there are other financial costs incurred with genetic testing that may at times be overlooked, for example, the cost of terminating the pregnancy, unnecessary terminations from false "positive" results and travel expenses. He proposes that emotional and psychological costs such as fetal loss and grief also need to be considered in the equation. Oliver (1990) asserts that the concept of disability is culturally produced and socially structured. Meanings of disability vary across cultures and appear to be influenced by the amount of economic surplus produced by a society.

Tennant (1996) notes that since the 1980s there has been a move to reduce the New Zealand welfare state expenditure and to contract its responsibilities to other organisations. Levels of unemployment have remained high lessening the opportunity for disabled people to find work. Oliver (1990) records a similar restructuring of the British welfare state driven by the desire to "reduce our 'culture of dependency'" (p. 88). These changes reflect the rise of the neo-liberal discourse a discourse which has had implications for the practices regarding prenatal genetic diagnosis.

## **5.6 NEO-LIBERAL DISCOURSE**

According to Potter (2000) the neo-liberal discourse emerged in New Zealand in 1984 and has been furthered by subsequent New Zealand governments through economic and social policies and legislation. Neo-liberalism is a philosophy that maintains that "maximum social and individual prosperity and freedom (thus happiness) is ultimately achieved by opening all parts of the economy to be regulated, not by government intervention as in Keynesian welfarism, but by capitalist market forces" (Potter, 2000, p. 52). One important aspect of neo-liberalism is the state's minimal role with regard to tax, welfare and government intervention. Larner (1998) identifies five values that underpin neo-liberalism: "the individual, the freedom of choice, market security, laissez faire and minimal government" (p. 6).

The neo-liberal subject is constructed as an individual who is “competitive, self-responsible, self-disciplined, self-fulfilling, and economically efficient” (Potter, 2000, p. 53). Other qualities associated with a neo-liberal subject are rationality, the capability to make decisions, and the valuing of freedom of choice (Burchell, 1996).

The neo-liberal discourse is made manifest in relation to maternal age-~~is~~ in two types of government documents. One is the Public Health Commission’s [PHC] document titled *Congenital and Inherited Conditions* (1995) and the other is a series of documents developed for maternity service providers. I suggest that the three effects of the government documents are: the promulgation of informed choice; the second is the perpetuation of age as signifying difference and the referral to, and government subsidizing of, genetic screening and testing services.

The main stimulus for these documents was the National-led government of the time, and the introduction of the 1993 Health and Disability Services Act. The Act brought changes to the health structure, such as the establishment of Health Funding Authorities [HFAs], Regional Health Authorities [RHAs], and Crown Health Enterprises [CHEs], as well as the establishment of the PHC. The HFAs became responsible for purchasing services from the CHEs and other service providers such as independent midwives, GPs and obstetricians. I will explore firstly, the PHC document and then those regarding the provision of maternity service. I aim to show how the neo-liberal discourse acts to promulgate the medical genetic discourse and serves as a technology of power and a technology of self. As the former it aims to normalise and discipline practice.

Lupton (1995, p.4) identifies public health as consisting of knowledges, practices and discourses. It is socially constituted and determined by its social, political, and economic imperatives. Lupton argues that the phenomena that public health establishes and regulates are “risk”, “normality” and “health”. The purpose of the PHC was to advise the Minister on strategies that would assist in the early detection and prevention of congenital and inherited conditions.

The PHC’s reason for addressing the issue of congenital and inherited conditions was their “significant impact on public health accounting in 1990 for 23 percent of all infant deaths and 20 percent of all deaths of children under the age of five” (p. 6). Implicit in the document is the aim to reduce expenditure related to congenital and inherited disabilities. Kaplan (1994) believes that prenatal screening has been advocated

to be beneficial as it reduces the number of disabled people and thus reduces the cost of disability.

The PHC document identifies strategies for conditions that can be prevented, for example, taking folic acid to lessen the risk of spina bifida, and for the early detection of conditions such as Down syndrome. The relationship between aging and the increased incidence of chromosomal abnormalities is taken as an indisputable fact. The possibility that other factors, for example, environmental or lifestyle factors may contribute to Down syndrome is ignored. Furthermore, the emphasis is placed on women's aging and not men's. It is clear from the language used in the document that screening and testing for genetic abnormalities in older women is regarded as a strategy of prevention. For example, ultrasound is included as a "preventive measure".

The document identifies three prevention opportunities or prevention phases: pre-pregnancy, antenatal, and postnatal. I focus on the first two as these are when advanced maternal age is identified as times of increased risk. The prevention strategy suggested in the pre-pregnancy phase is education and counselling of children and adults who are made aware of the factors that can cause inherited and congenital abnormalities.

In the antenatal prevention phase non-directive counselling is recommended to catch those people who were not provided with information before becoming pregnant. As it is possible for birth defects to be detected in this phase, the PHC recommends that parents are made aware of the options and are not placed under pressure to terminate a pregnancy.

In the recommendations, people are constructed as rational, choosing beings, capable of absorbing, deliberating and then acting on the information. As stated above in relation to the risk discourse, the recommendation for young people to be educated about the risks of advancing maternal age assumes that women can make choices about when they wish to commence childbearing. Prospective parents are called on to be responsible and to participate by making informed decisions.

The document identifies the child with congenital and genetic abnormalities as burdensome. For example:

The health, education and social services, borne by the community as a result of birth defects such as congenital rubella and spina bifida, are substantial, but the main cost to society is borne by the parents. Much of that cost is real and tangible. ...Modern scientific knowledge and

diagnostic techniques can now prevent a number of serious birth defects at a cost to the community equivalent to that of caring for the person for a year, but as explained, this is a choice which only well-informed parents can make.

Public Health Commission, 1995, p. 6

The document here appeals to the rational subject who, drawing on knowledge, is able to compare the costs of each option and who is given the opportunity to make long term savings by preventing the birth of a burdensome child.

Snedden (1997), a mother of a Down syndrome child and a president of the Down Syndrome Association, contested the PHC's representation of disability. She argued that the PHC had emphasised the aspect of financial costs and savings and had omitted any reference to "the place of people in society, and the support available to them and their families" (p. 8). Snedden positions herself in the disability rights discourse which argues that the disabled have the right to be valued members of the community. Tennant (1996) identifies the beginning of an opposing voice to the disability discourse emerging in the post World War period. One example is the Intellectually Handicapped Children's Parents Association (which later became the Intellectually Handicapped Children's Society) which was formed in 1949. These organisations opposed the practice of institutionalising intellectually disabled children and aimed to advocate for the children and their carers.

In particular, the 1993 Health and Disability Act reformed the provision of maternity services and the system of payment to practitioners. Abel (1997, p. 154) argues that changes, such as the introduction of competitive contracting, were based on neo-liberal market principles. They echoed changes made by Britain and other western countries in an attempt to reduce health expenditure. Burchell (1996) identifies liberalism as setting out a particular relationship between the government and those whom it governs. He writes that "individuals are identified as, on the one hand, the *object* and target of governmental action and, on the other hand, as in some sense the necessary (voluntary) *partner* or accomplice of government" (1996, p. 23, italics in original). Consequently, the conduct of midwives' and doctors' practice is the target of the government policies. At the same time, these practitioners direct the health policies through their practices on to the women.

At this juncture it is important to note that the move in the New Zealand health services to ensure that practitioners conformed to the practice of informed choice was not solely derived from the neo-liberal discourse. Feminist discourses were also

influential in asserting the rights of women to be autonomous agents in determining their health care (Coney, 1993). In 1994 the Health and Disability Commissioner Act came into being as a consequence of the inquiry into the treatment of cervical cancer at National Women's Hospital. This was one of the recommendations made by Judge Silvia Cartwright who led the inquiry (Burgess, 1996)<sup>15</sup>. In 1996 the Code of Health and Disability Services Consumer Rights was developed by the Health and Disability Commissioner and made the rights of consumers to be fully informed, to make an informed choice and to give informed consent legally enforceable.

The second area of government documents where the neo-liberal discourse is deployed in relation to prenatal diagnosis and maternal age are the maternity services documents produced by the Health Funding Authorities [HFAs]. Section 51 of the 1993 Health and Disability Act sets out the contractual arrangements between HFAs and maternity service providers. It stipulates the services that must be provided by the practitioners in order for them to receive reimbursement from government funds (Burgess, 1996). One of the vision statements in the *Maternity Section 51 Notice* reads: "the HFA also wishes to ensure that all women are provided with appropriate information about the options that are available to them concerning health professional services available, place of birth and services they are entitled to receive" (1998, p.3). This principle has been subsequently adopted by the National Health Committee and reiterated in the *HFA Maternity Services Reference* (2000) document. The principle invokes maternity service providers to practice informed consent whereby women under their care are given the potential to be self-determining. However, the use of the qualifier "appropriate" permits the practitioner to use their discretion and determine what information is given to which woman. Thus, in deploying the medical genetic discourse, the practitioner is more likely to identify a 35 year old woman as being significantly more "at risk" and to subsequently inform her of the various screening and testing procedures available to her.

In the *HFA Maternity Services Reference* (2000) women's age is explicitly highlighted as an object of special significance in the service specifications, quality

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<sup>15</sup> The establishment of the Commissioner was a consequence of the inquiry into the treatment of cervical cancer at National Women's Hospital, and was one of the recommendations made by Judge Silvia Cartwright who led the inquiry (Burgess, 1996). The inquiry followed the women's health organisation, Fertility Action's, investigation into research being carried out at the hospital. Sandra Coney and Phillida Bunkle found that a number of women who had been attending National Women's Hospital for treatment of cervical cancer were unknowing research subjects (Coney, 1993; Federation of Women's Health Councils, 1993).

requirements section 3.1.2.5. This states that “services will be provided in a manner appropriate to the age of each individual woman” (p.9). By this means maternal age is constructed as a signifier of difference. In effect, this is a technique of power whereby women are made subjects of disciplinary power. Rose (1996) refers to techniques of power as techniques “... *for the disciplining of human difference*: individualizing humans through classifying them, calibrating their capacities and conducts, inscribing and recording their attributes and deficiencies, managing and utilizing their individuality and variability” (p. 105, italics in original). Through the processes of examination and classification, women’s ages are identified and employed to make them different from one another. By her age, a woman becomes knowable to the practitioner. Within the medical genetic discourse, a woman’s age of 35 or more renders her recognisable as being at risk and requiring specific care.

Associated with Section 51 are the *Guidelines for Referral to Obstetric and Related Specialist Medical Services* (Denny, 1997). The authors of the document were anonymous representatives from a variety of maternity service provider organisations. These were the New Zealand College of Midwives, the Royal New Zealand College of General Practitioners, the New Zealand Medical Association, the Paediatric Society of New Zealand, and the Royal College of Obstetricians and Gynaecologists. However, no women’s health or community organisations with an interest in maternity issues were involved in the consultation process. The document provides “guidelines for best practice” (1997, p. 2) for maternity service providers. In effect, by specifying the events that require the referral of women to specialists, the guidelines standardize and discipline the practice of the maternity service providers in relation to genetic testing.

The age of 37 is identified in this document as warranting a level 2 action for assessing fetal abnormality and chromosomal studies. Level two requires that the LMC **must recommend** to the woman that consultation with a specialist is justified. The wording compels practitioners to inform women aged 37 and over of their children’s risk of having genetic abnormalities.

Armstrong (1995) proposes that “surveillance medicine” endeavours to bring not just the abnormal but also the normal into its system of visibility. The gaze and activity of the new twentieth century surveillance medicine focuses on the whole of a population not just the pathological. It achieves the inclusion of all women by the “problematization of the normal” (p. 395). Secondly, in this construction chromosomal abnormalities have become “always present”. There exists the constant possibility that

any woman may bear a child with abnormalities. In constructing the potential of abnormalities as being always present, the justification for all women to be subjected to prenatal genetic diagnosis is made common sense.

Although it is stated in this document that the referral guidelines will not be used to discipline practitioners, it is clear in the *Maternity Section 51 Notice* (1998) that practitioners are expected to seek information from the guidelines when determining the need for a woman's referral. Should practitioners not meet the practice guidelines their contractual arrangements with the funding body might be withdrawn. The threat of discipline has the potential to control practitioners and to maintain the medical genetic discourse.

All the documentation generated in the care of women during pregnancy and birth is open to scrutiny (HFA, 2000). These include the claim forms, the Care Plans that LMCs are required to develop, as well as the day to day records made by all the practitioners involved in caring for women and their babies. Primarily, all the documents generated in the planning and provision of maternity services are for the purpose of claiming reimbursement.

The Care Plan is a comprehensive record of all the discussions and decisions made as to the future services that will be provided to the woman throughout her pregnancy and birth. The topics that are to be addressed by the LMC are specified. Two of the 28 items pertain to the referral for routine and other screening tests, and referral to diagnostic services. The referral for nuchal screening and/or genetic testing is implicit. The LMC keeps the Care Plan and the woman holds an updated copy. The Care Plan can become evidence should a woman lay a complaint against a practitioner (HFA, 1998).

Just as Bentham's jailers were subjects of the Panopticon's hierarchical gaze so too are the maternity practitioners. They are subjected to bureaucratic surveillance primarily through their claims for reimbursement of their services. The *Maternity Section 51 Notice* (1998) and the *Guidelines for Referral* (1997) are technologies of power (Rose, 1996). Both establish systems through which not only can the women be surveilled, but also the practice of midwives and doctors can be assessed, disciplined, and normalized.

## **5.7 SUMMARY**

Prenatal genetic diagnosis is constructed in the literature as a complex and contested terrain. It is rendered complex by the existence of multiple discourses, some competing and some overlapping, in their representation of disability.

I have argued in this chapter that the medical genetic discourse is made hegemonic by the intersection of the discourses of disability, economics and neo-liberalism. The latter enables the practice of informed choice. I have shown how the discourses of genetics, disability, economics and the neo-liberal discourse of choice have influenced government policies pertaining to the provision of genetic testing. These discourses cohere in legitimating and perpetuating the proffering of prenatal genetic diagnosis to all pregnant women aged 35 and over as part of their normal maternity care.

Having identified and analysed the discourses in the literature that construct maternal age as an issue relevant to pregnancy and birth, my analysis shifts to the texts of the women and maternity practitioners.

## **Chapter 6:    PRENATAL GENETIC DIAGNOSIS,                   COMPLEX AND CONTESTED**

We must conceive discourse as a violence which we do to things, or in any case as a practice which we impose on them; and it is in this practice that the events of discourse find the principle of their regularity.

Foucault, 1981, p.70.

### **6.1    INTRODUCTION**

In Chapter Five, I have argued that the medical genetic discourse constructs women aged 35 and over as being at a statistically higher risk than younger women of producing children who have chromosomal abnormalities, particularly Down syndrome. Unlike the practitioners whose role is to reproduce and transmit the discourse to the women, the medical genetic discourse interpellates older women as its subjects and its targets. It is women who must carry the onus for making the decision whether or not to undergo prenatal genetic diagnosis.

In this chapter, I show that the medical genetic discourse intersects with multiple discourses. Some of the women deployed the discourses of economics, medical genetics and disability to produce the subject position of what I have termed the “conditional mother/parent”. By providing women with knowledge about the presence or absence of chromosomal abnormalities, the medical genetic discourse, supported by legislation that legitimates the abortion of fetuses with abnormalities, allows women the opportunity to decide whether or not they continue with the pregnancy. Thus, becoming a mother is conditional on the status of the fetus. Rothman (1993) observed that the ability to choose which children one has dispels the myth of mothers being all-giving and all accepting. While prenatal genetic diagnosis suspends the assumption that all women subscribe to this myth, I show that some women still perceive themselves as having such potential. Analysis of the women’s texts indicates that while most of women positioned themselves within the medical genetic discourse, four of the women constructed themselves as women who wanted to become mothers regardless of the kind of child they might have. I have termed their identity as “unconditional mothers/parents”. This subject position is one that is created from the intersection of the discourses of medical genetics, female reproductive aging and mothering. I argue that

this position offers women a space that avoids the gaze of genetic surveillance and normalization of the fetus: a power tactic of elusion.

I propose in this chapter to firstly provide an overview of the women's choices and then, the manifold subject positions, constructions of the disabled child and the meanings of prenatal genetic diagnosis are described and analysed.

## **6.2 THE WOMEN'S CHOICES**

As Bergman, Thorpe and Windridge (1995, p. 116) point out, women over the age of 35 are very aware of the likelihood that having a baby with Down syndrome increases with age, thus reflecting the hegemony of the medical genetic discourse. With the exception of two women in the present study, Tui and Rebecca, all the women had considered the issue of having prenatal genetic diagnosis. Of the eleven primiparas interviewed in this study, only three women, Jo, Barbara, and Bernie, deliberately chose not to undertake genetic screening. Two of the four multiparas (Rosalie and Emma) also decided against having genetic screening.

The choice for prenatal genetic diagnosis is socially created as the development of technology has made diagnosis of genetic 'abnormalities' in the fetus a possibility (Reid, 1990). This is reflected in Tui's experience. In the 1960s, when she was pregnant with her fourth child, while she was "well aware" of the asserted link between maternal age and Down syndrome, the technology for her to be tested for chromosomal 'abnormalities' and neural tube defects did not exist.

Reid (1990) also states that the choice regarding prenatal genetic diagnosis is socially constrained. Factors such as money, societal attitudes towards "abnormal" babies, access to genetic diagnosis and knowledge can enhance or limit women's choice. For example, Rebecca had no recollection of her obstetrician discussing prenatal genetic diagnosis when she was pregnant at the age of 36, in 1989. At the time, she recalled that she was not aware of the association between maternal age and chromosomal "abnormalities". One inference that could be made from her experience is that her obstetrician may have believed that the likelihood of Rebecca having a baby with Down syndrome was not significant. In this way he did not treat her differently to younger women. Perhaps he was also influenced by her history of endometriosis and his belief that this pregnancy was her one opportunity to bear a child.

While Tui and Rebecca did not have to deal with the decision of whether or not to undergo prenatal genetic diagnosis, the remainder of the women who participated in this study did. It is to their texts that I now turn my gaze.

### **6.3 OBJECTS AND SUBJECTS OF THE MEDICAL GENETIC DISCOURSE**

The identity that the medical genetics discourse creates for the older woman is that because of her age she is at risk of giving birth to a child with abnormal chromosome numbers. Foucault (1982) writes of a technique of power which:

Categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him. It is a form of power that makes individuals subjects.

p.212

In its ability to identify chromosomes and statistically correlate the occurrence of chromosomal anomalies with specific factors, medical genetic knowledge marks itself as a scientific discourse, which is accorded the status of being a truth in our society (Foucault, 1980). Josie and Maggie's texts referred to the statistical evidence as something that they themselves must consider and make a decision on the basis of.

I knew the statistics weren't good.

Maggie, primipara

There is a side to that, 'Well this is a reality. These are the statistics that are available to us according to what we have collected.' I don't know what we should really take from that. But anyway, there is an element that, 'Here is the reality. This is the situation. This is something for you to consider.'

Josie, primipara

Hacking (1991, p.181) identifies statistics as a technology of power. By this he means that the information provided by statistics can be used to determine individuals' behaviour and to subject them to specific ends or control. The older woman becomes "objectivized" (Foucault, 1988, p.18), that is, she becomes an object of power. Hacking writes: "statistics has helped determine the form of laws of society and the character of social facts. It has engendered concepts and classifications within the human sciences" (1991, p.182). In relation to the older woman as a producer of children, statistical

analysis has identified her as more likely to produce potentially inferior, defective children.

Foucault uses the term “subject” in two ways. The first is as a person who is aware of or knows him/herself. The second is as a person who is the subject of a rule of power. With the exception of Tui and Rebecca, all of the women interviewed had considered the issue of prenatal genetic diagnosis either before or during the early stages of their pregnancy and had made a decision about whether or not to be tested. In this way they were all “subjects” of the medical genetic discourse. For most of the women their recognition of themselves as subjects of the medical genetic discourse had been self-imposed. That is, they had identified themselves as at risk of giving birth to a child with chromosomal “anomalies”. Their age and perceived risk status legitimated the women’s right to raise the topic with the practitioner. For example, Maggie stated:

I knew about amniocentesis. I relayed that to my GP and she said that that wasn’t a problem. She advised me as to when it would be done.

Maggie, primipara

For most of the women their GP was the practitioner with whom the first discussion regarding prenatal genetic diagnosis occurred. As shown by Maggie’s excerpt, the practitioner was the means through which women access both information about the tests and ~~to~~ the tests themselves. Women cannot refer themselves for an amniocentesis or CVS. They require a letter of referral from a maternity practitioner. Prior to midwifery autonomy in 1991 access to prenatal genetic diagnosis would have been solely through the medical profession. Now midwives may refer women for these tests.

For Josie, and Emma, however, positioning within the medical genetic discourse had not been a self-initiated experience. Their practitioner had read their age as a mark to discuss their risk status and the option of prenatal genetic diagnosis. Neither Josie nor Emma had considered the issue in relation to themselves prior to becoming pregnant. Josie had become pregnant while in America. As she explains below, Josie was confronted by the medical genetic discourse in its classification of her as an older woman:

You don’t realise that you are an older woman until you start reading the medical literature and realise that you are regarded as an older woman and you hadn’t thought about that. I guess that is because of the way society is now, that we are gearing to having children older. I

didn't feel unusual in doing that until I read that "Yes, your eggs are old" until I was pregnant and started reading literature regarding antenatal screening, and pregnancy screening and those kinds of things. I suddenly sat up and realised that there was an issue here. [...] What I felt it did, it created quite a **negative** beginning ... because it calls into question your trust in your body. It focuses on the negative, obviously.

Josie, primipara

Josie used the word "thrown" in the interview to describe how she was suddenly and unwittingly placed within the medical genetic discourse. Being confronted with such information created a stressful and negative beginning to her pregnancy. When listening to Josie's tape and reading her transcript I was left with the sense that Josie's experience had been more vividly retold than the other women's had. I believe this was a consequence of her being subjected to the discourse. A further factor was her lack of self-identification of being "old" and different from younger women. Observing societal trends Josie perceived that she was not uncommon in choosing to delay childbearing.

While the women were subjects of the medical genetics discourse, Josie was made a subject of the discourse in a way that violated her beginning journey of pregnancy. Her perceptions about herself and the flow of her pregnancy were disrupted and made questionable. She was forced to consider submitting herself and her baby to the discursive practice of genetic surveillance.

The one other woman who had not previously identified herself as a subject of the medical genetic discourse was Emma, a multipara. When I asked her about the issue of genetic diagnosis she recalled:

It came up. The obstetrician said that it wouldn't have been an issue. I suppose it was because I was in the in between age. Usually at the age of 40 they did feel that it was appropriate. We didn't want it.

Int: Had you thought about it beforehand?

Emma: No. I didn't see myself as an older woman.

Like Josie, Emma had not identified herself as being the age which would put her sufficiently at risk as to necessitate having an amniocentesis. In contrast to Josie, however, Emma's recollection did not convey the same sense of violation. For Emma, the obstetrician's view and her own coincided regarding her not being at risk of having a Down syndrome baby. The medical practitioner did position Emma within the medical genetic discourse but used 40 years of age as the criterion for having prenatal genetic

diagnosis. Therefore he recommended that she did not have to undergo the test. As will be explained in a later section of this chapter, Emma deployed a discourse that produced a position which contested the subject position produced by the medical discourse. Emma believed that the cause of Down syndrome was not necessarily a consequence of maternal age.

Lupton (1995) writes that people do not think of their risk in terms of objective statistical probability. Instead, their judgements are more likely to be based on subjective “ontological and cosmological” beliefs. While the women who considered whether or not to undergo prenatal genetic diagnosis identified themselves as being at risk, their texts revealed that their decisions were more likely to be based on their subjective assumptions of their desire to be a mother, their ability to mother a disabled child and the effect of a disabled child on their relationships with significant others. Only one woman deployed the economic discourse’s objective cost-benefit analysis in her rationale.

That all women, except two, either voluntarily or on the urging of their practitioners considered the issue of prenatal genetic diagnosis, I believe, reflects the hegemonic status of the medical genetic discourse. It has become common for women aged 35 or over to perceive themselves to be at risk of giving birth to a child with genetic abnormalities and to make a decision whether or not to submit themselves and their baby to prenatal genetic diagnosis. The texts generated from the interviews revealed that in explaining their decision the women positioned themselves in multiple discourses. One discourse that both facilitated some and constrained other women’s choices regarding prenatal genetic diagnosis was the familial discourse. The women who deployed this discourse constructed themselves as partners in the care of their children.

#### **6.4 MOTHERS AS PARTNERS**

Rapp writes:

The fact of decision making involved in amniocentesis reveals the existing gender negotiations within which a specific pregnancy is undertaken. There is complex choreography of domination, manipulation, negotiation, and, sometimes resistance in the gender tales women tell about their decisions to use or reject this piece of reproductive technology.

1993, p. 66

Women do not exist in isolation from others and often their decisions regarding prenatal genetic diagnosis may either take into consideration significant others or may be made in negotiation with others such as their partners (King, 1994, p. 100). Gregg (1995, p. 145) posits that the notion of a “fully autonomous actor is a myth”. In her study, she found that 15 of her 31 participants stated to her that they considered the feelings of their husbands or partners when making their decision about genetic diagnosis.

All but three women in this study deployed a familial discourse, positioning themselves as partners with their husbands. It is for this reason that I have identified the subject positions as mother/parent to show the potential influence that a woman’s partner may or may not have on the decision regarding prenatal genetic diagnosis. Within the familial discourse, the role and responsibility for providing material and emotional security to the child is one that is shared between the mother and the father. Except for two women (who were single mothers), all the women at the time of their pregnancies and births were in heterosexual marital relationships. These women positioned their husbands as having a voice in the decision-making and in doing so opened themselves to their husbands either affirming or vetoing their view. Their decision-making reflected the range of negotiations that Rapp (1993) refers to above. For some of the women, their husbands supported their decisions. However, for one, her agency was surrendered to her husband’s wishes.

Josie’s husband considered the possibility of having a child with Down syndrome and appeared quite certain that he would not be able to cope with such a child. The consequence of terminating the pregnancy following a positive result was quite evident. However, Josie was less certain. She explained her situation to me:

I have a partner ... whose way of thinking is very much medical model and reduce risks, reduce risks. But it [considering prenatal genetic diagnosis] made us confront the issue of, “Well, I couldn’t cope with a child that had Down syndrome.” From my partner’s point of view the issue was fairly clear cut for him. The issue was not as clear cut for me at all. ...And it is interesting to see the way the decision went in the end. And, as I say again, I don’t know whether I would choose to go that way the second time around because of that. It was **very** interesting the way it went. It certainly brought **all** those issues up, and they **had** to be confronted. [...] There are two of you involved. Yes, this is my decision. No, there are two of you involved. When you are in a relationship you are, presuming there will be two of you parenting for that time, it is two lives. Plus the rest; my partner

brought into consideration that it is the two of us, plus our families,  
... that will be drawn in to support and that kind of thing as well.

Josie, primipara

It is clear from Josie's statement above that a consensus between them was not reached. Her desire not to undergo amniocentesis and to keep the child no matter what the results was subordinated to her husband's.

In comparison, Katie, a multipara who was aged 36 when she became pregnant with her second child, was concerned for both the future care of the child and her marital relationship:

There was also, ... my husband was to have ... when I worked with disabilities, special needs adults, and I'm sort of, "Do we want one of these?" I don't know how he could handle that as an adult. One lady whom I worked with said, "You know there is a high proportion," and I read in the literature too, of people who do have a disability [in the family] of marriage failure. It's quite significantly high after a [disabled] child had been born. ... There are all these sorts of things that you have to consider as well. [...] You don't like to consider where your marriage will go if you did have a child with disability, but I mean the statistics are there, and it is pretty stressful anyway.

Katie, multipara

Both women were aware that their decisions had implications for the future of their relationship, both with their partners and with other family members. The consequence for both of the women was that their agency was diminished, and in Josie's case forfeited. Unspoken are the fears that if they chose not to have an amniocentesis or did not abort that they might be held accountable for whatever events occurred. The woman is compelled to decide between the child and her partner, between her positions as mother and as wife. Her loyalties and desires associated with these two positions are placed in contest with one another.

In positioning themselves in the familial discourse, women may also consider the needs of the disabled child's siblings. Tui, a multipara, had had her fourth baby in 1966 at the age of 41. In between the birth of her third and fourth child she had had a miscarriage. At that time, prenatal genetic diagnosis was not available. However, she was aware of the knowledge linking increased maternal age with Down syndrome:

If I had been able to test for Down, I don't think I would have carried on with the pregnancy. I would have been terribly upset but I felt that with the three children we had already, it would affect them too much, and also us. We wouldn't have been able to give so much time to our

three normal children if we had a poor little baby with Down syndrome. I don't know. It would have been a hard decision. We didn't have to make it fortunately.

Tui, multipara

Here, the discourse of disability intersects with the familial discourse. The disabled child is constructed as burdensome; the excessive consumer of parents' time and energy. Time is depicted as a limited resource and that the parents' desire to care for all their children equally. Consequently, children with a disabled sibling may be disadvantaged by their parents' inability to provide sufficient time and energy. Tui perceived that her course of action would probably have been to terminate the pregnancy. Her text also highlights the changes in considerations and choices that reproductive technology such as prenatal genetic diagnosis brings to women and their partners.

Two women, who made the decision not to undergo prenatal genetic diagnosis autonomously, deployed the familial discourse quite differently:

I don't think my husband and I even talked about it. I made that decision myself, which is a bit self-centered, but I felt that I was having the baby. Perhaps I should have asked him but I think he would have been of the same opinion.

Rosalie, multipara

I didn't tell his father [that she had decided not to undergo amniocentesis] because I know he never could have handled it. If the baby had been Down, he wouldn't have seen his father for dust.

Bernie, primipara

Rosalie identifies her entitlement to make the decision regarding prenatal genetic diagnosis autonomously as being derived from her biological ability to bear a child, and the main responsibility that she will have in the child's care. She believes that she and her husband share similar views and that therefore he would have supported her decision not to undergo prenatal genetic diagnosis and would have supported her if they had had a disabled child.

In contrast, Bernie did not envisage her husband's support for her decision not to have an amniocentesis. Nor would he, she believed, have supported a child with intellectual disabilities. I suggest that Bernie deploys the familial discourse to show how her husband would not have fulfilled the role of father to their son. She depicts herself as resisting her husband's wishes. Although not explicitly stated, Bernie may

have also believed that should a positive result for Down syndrome occur, her husband would have wanted her to have an abortion. Silence is used as a strategy to avoid her husband's coercion to have an amniocentesis and possibly an abortion. The prospect of her marriage ending and of having to raise the child by herself did not daunt Bernie. The desire to have a child foregrounds the desire to maintain a relationship with her husband.

When the subject positions of wife and parent are conjoined with the concept of parental energy as a capacity that is exhaustible, and the belief that parents bear the sole responsibility for the care and security of the burdensome disabled child, the interests of the different parties have the potential to compete for priority. Positioning oneself in the familial discourse as a wife and parent required the women to consider their husband's wishes in relation to their own with regard to having a child with Down syndrome. Thus, the potential for the woman's own desires to be fulfilled is either enabled or constrained. When her husband's wishes cohered with her own, the woman's choice was enacted. However, when there was disagreement, as in Josie and Bernie's texts, the outcome was influenced by which wishes were foregrounded. For Josie, her desire to maintain her relationship as wife and parental partner with her husband took precedence over her desire to become a mother. Her choice not to have an amniocentesis was subordinated. In contrast, Bernie's desire to become a mother was brought to the foreground and her relationship with her husband placed in the background.

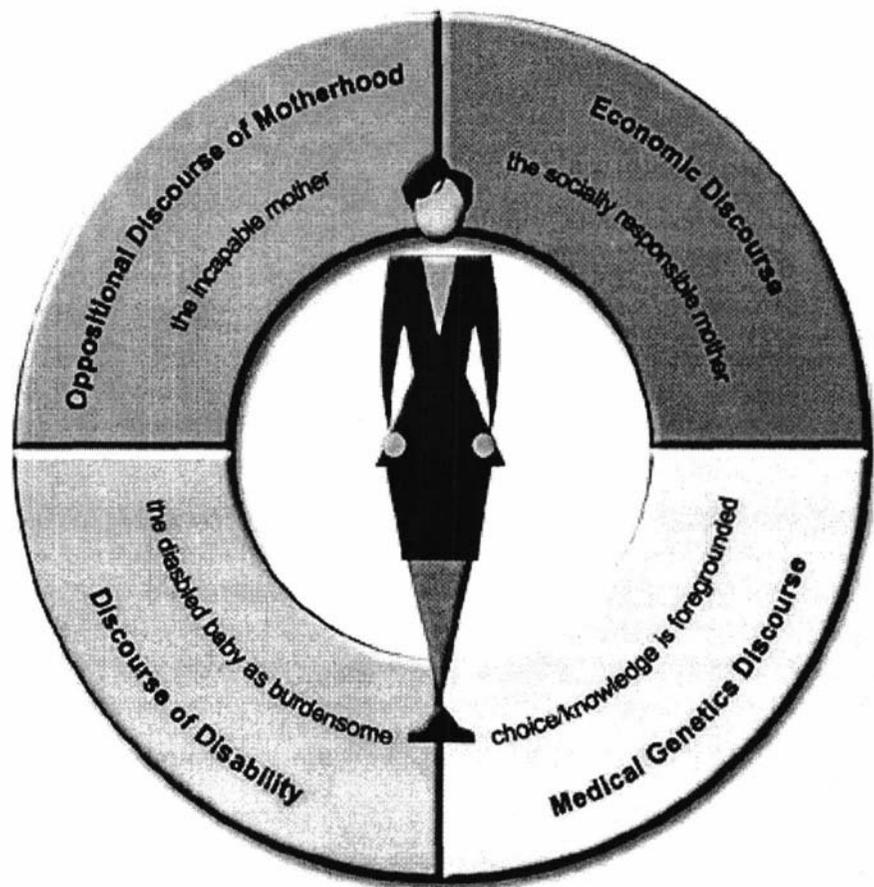
Bernie constructed herself as a woman who wished to become a mother regardless of whether her baby had genetic anomalies or not. Her willingness to accept the possibility of becoming a mother of a disabled child contrasted with that of other women whose deployment of the discourses of medical genetics, motherhood, disability and economics intersected to create a position of motherhood/parenthood as conditional.

## **6.5 THE CONDITIONAL MOTHER/PARENT**

This section describes and explores the voices of the seven women who chose to undergo prenatal genetic diagnosis. Their continuing on with the pregnancy was conditional on the fetus being diagnosed as not having abnormalities that could be detected by CVS or amniocentesis. For this reason, I have called them the "conditional mothers". This overarching subject position is one that I propose is a consequence of the intersection of the discourses of economics and disability. Figure 6-1 depicts the multiple subject positions produced by these women who decided to undergo prenatal

genetic diagnosis. Each of these discourses offers a woman a particular subjectivity in relation to her future child. The discourse of disability constructs a child that is burdensome. Similarly, the economic discourse depicts a child who is an excessive cost to society. These discourses facilitate the mother's examination of herself and her potential to care for such a child.

Figure 6-1 The Conditional Mother



Related to the way in which the women who underwent prenatal genetic diagnosis decided that their becoming mothers was contingent on the absence of abnormalities were their perceptions of the information provided by the test and of disability. These women viewed the knowledge provided by the test as valuable in that it gave them the opportunity to either choose whether or not to bear a child with abnormalities, or to avoid having such a child.

Of the women who positioned themselves as conditional mothers/parents, only Josie did not raise the issue of genetic diagnosis herself during her visits with her

practitioner. Michelle, Pip, Caroline, Grace, Maggie and Lara all initiated the topic when visiting their doctors. Foucault writes that technologies of the self:

permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies [...] so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality.

1988, p.18

The goal for these women (and/or their partners) then was not to have children with the abnormalities that could be detected through genetic diagnosis. The intersection of various discourses of disability, economics and motherhood provided the knowledge and subject positions in which the women located themselves and their babies in the practice of subjecting themselves to genetic surveillance.

### 6.5.1 The incapable mother/parent

The intersection of the discourses of disability and motherhood produced an identity I have called the “incapable mother/parent”. Five of the women identified themselves, and two women identified their husbands, as not having the capacity to care for, or to cope with, a disabled child. Maggie and Grace explained their reasons for having prenatal genetic diagnosis:

So, yes, I decided that I wanted to have a test because consciously I didn't think that I wanted to raise a Down's baby. That was really the only potential problem. [...] I thought I would not want to change my life to that extent. The sacrifice that it would take because before I had my son I imagined that you had your baby and then your life gets back to normal and you carry on.

Maggie, primipara

But I am not the person who would have been thriving with a Down syndrome child. I would have outed on that and aborted if I had known that. So, I guess that is why I did that. [...] I mean, you can run through all the spiritual stuff about why I should have it to teach me service, and why they should have it because of God knows what. But I am a very active person and it would just really cramp my style.

Grace, primipara

I had the test because of my age [39 years]. Probably because of the controversy around it and how deep down I felt that I couldn't cope with an abnormal child. It's very interesting that for every negative there is a positive. My boss actually said to me, “Even if this child turns out to be a Down syndrome, you will still love that child.” I

hadn't thought of it like that. I didn't know if I could. But I didn't want to take that risk either.

Michelle, primipara.

Motherhood signified for both Maggie and Grace the need to be able to give oneself up and to subordinate one's desires to those of one's child. In becoming a mother of an abnormal or disabled baby, they believed that a mother needs to be able to do this to an extent greater than if one had a normal child. Maggie and Grace use two words that connote special subordination: these are "sacrifice" and "service". Both words depict a relationship between the mother and her disabled child where the child is accorded higher value or positioning than the mother. The mother is the parent who works to meet the needs of the child which take precedence and priority over hers. However, the women question this meaning of motherhood. They reflect ways of thinking about motherhood that contest the notion that becoming a mother is fundamental to women's lives. McMahon (1995) writes that the depiction of motherhood as optional, and the rise of the rhetoric of individualism with its language of self-realisation, challenges the belief that it is appropriate for women, and other adults, to sacrifice themselves for their children and spouses.

Michelle and Lara stated that they believed that they could not cope with a disabled child. Michelle was uncertain of her capacity to love a mentally disabled child. When a colleague had told her that a mother's love for her child is unconditional and alluded to a mother's love as an automatic and essential process, Michelle remained unconvinced of her ability. To assume that she would be able to love was too hazardous. For these five women, the anticipated changes associated with having a disabled child, such as in lifestyle and personal resources, were regarded as too great for the women to bear.

Underpinning the women's perception of their capabilities were their beliefs about what constituted a disabled child. The main way in which the disabled child was depicted was one of excessive and prolonged burden to those who were responsible for caring for him/her. The particular disability implied in the women's texts was that of intellectual disabilities.

### **6.5.2 The disabled child as excessively burdensome**

Several of the women who decided to undergo an amniocentesis talked of the disabled child as being excessively burdensome for the parents and other family

members. Lara responded to my question about why she had decided to have prenatal genetic diagnosis, by voicing her desire not to have a baby with 'abnormalities' and by identifying the experiences that had shaped her desire:

In actual fact it was probably not necessarily just related to my age. I think it was because of being a nurse and when I was a student nurse. I was only about 18 and I worked in a children's ward. There were babies there that were microcephalics and hydrocephalics. They were in hospital for months and were really severely brain damaged and just left in hospital. They were about eight or nine months old, ... I can't remember if they had amniocentesis in those days, but whenever it was that I was first aware of amniocentesis, I always knew that if I had a choice of knowing and being asked to end a baby like that, I would. Even if I'd been only 18 or 20 and got pregnant I think I would have had it. because I just have such a ... I just felt that it was just so awful for those poor little babies to be brought into the world like that. That's just so hard for the parents to be ... with a child like that to bring up. I thought if you had a choice like it was an easy-way one. You didn't have to go through that, you know, for the baby and the parents.

Lara, primipara

As a student nurse in the late 1960s, Lara had cared for severely neurologically impaired children. This experience had left her with a strong sense of knowing that she did not want to have such a child. More recent experiences of working in the community had also confirmed her decision. She said:

With nursing you might be more aware because ... When you're visiting people who had big children, like an eight or a ten-year-old and they are still in nappies, an IHC [Intellectually Handicapped Child]. These parents, I don't know how they cope, particularly if they don't have any extended family, looking after these handicapped children that needed to be fed and toileted and bathed, and totally dependent. It would just be dreadful. And I think where is the quality of life for that child?

Lara, primipara

For Lara the meanings that she gives to the types of chromosomal abnormalities that genetic diagnosis identifies are those of children who have a prolonged childhood and are consequently dependent on their parents for a long period of time. She lists the cares, which are mainly physical, that parents are required to provide for their child. Oliver (1990) argues that the meaning of disability rests on the meaning of ability. Lara then, is constructing the normal child as one who is able-bodied and as one who is

capable of being physically independent at a certain age. This is the type of child that Lara desires.

As I read Lara, she considers too that the child may be aware of its dependence and as a consequence may be dissatisfied with its life. To be physically independent signifies for Lara a life worth living: if one is not capable of achieving independence then life is not worth living. While not wanting to ignore Lara's consideration of her child's quality of life, she is an able-bodied and able-minded person situating herself in the position of one who is not.

Lara's comment highlights the use of genetic screening as a practice of quality control (Gregg, 1995). If the baby is judged as not meeting the standards of "perfection", then it may be terminated. According to Gregg, one outcome of testing the quality of the baby is that the practice of genetic diagnosis, which is derived from the stigma and fears attached to disability, has the potential to heighten such fears and stigma. In this way, this discursive practice of quality control is perpetuated.

During her interview Grace also recalled her observations of Down syndrome children which had influenced her decision-making:

In Western Australia [in 1982] it seemed like there was more consciousness of Down syndrome invalid type people. They were more obvious in the public there than anywhere else I've seen in the world. So Down syndrome was a real issue visually in the society. Not that I would not have known what they were, but when you see the dither that they live in. In Australia there was a family who had six kids, beautiful, wonderful. The youngest was five or six, and the oldest would have been 16. I could see in the family, though they completely loved her, and were patient like you and I could only dream of, it was a big burden.

Grace, primipara

Grace's words create a picture of the ideal parental qualities that are required to care for a child with intellectual disabilities. An extraordinary amount of patience is one requirement that she identifies and one which she sees as being unattainable for most people, especially herself. Grace's judgement is based on the belief that her emotional capabilities are limited to those that she knows herself to have. Unlike Jo, who believed that the circumstances would generate the necessary mothering and coping skills, Grace does not trust her potential to cope with the extra demands that a child with Down syndrome would make.

Oliver (1990) identifies what he calls a “grand theory of personal tragedy” which underpins much of the thinking and policy-making regarding disability. This theory would label the diagnosis of chromosomal abnormalities, such as Down, as a tragedy for the parents and the child. Through this theory, the limitations of disability are overemphasized and the capabilities of the disabled remain unrecognized (Bricher, 1999). Oliver (1990) argues that personal tragedy theory maintains the status quo in terms of the economic and social structures in relation to disability. Thus, barriers such as societal attitudes towards disability remain. As Rapp (1988) points out, negative social attitudes and institutional boundaries act to constrain the quality of life that can be attained by a disabled person. Prenatal genetic diagnosis perpetuates these attitudes and practices regarding disabled people (Lippman, 1994).

The two women reflect the societal belief that the mother and the family bear the responsibility of caring for disabled children. Chandler and Smith (1998) exemplify this belief in that they state that should a woman decide against an abortion that her “decision carries serious consequences for the mental and physical health of the woman, for the future of the child and for all their associated family members” (p. 71). The authors, in naming the specific health issues for the mother, identify her as the principal family carer. Affected too are other family members. The disabled child is constructed as a negative figure, inducing stress and disease on those who care for her/him.

I have differentiated the disability discourse from the economic discourse defining the latter by its focus on the financial costs particularly for society. One participant used the economics discourse when speaking in relation to her decision to undergo prenatal genetic diagnosis.

### **6.5.3 The socially responsible mother**

As discussed in Chapter Five, the economic discourse overlaps with the medical genetic discourse. The economic discourse, I have argued constructs the subject as rational and responsible. In this section of the chapter, I show firstly, how the economic discourse overlaps the disability discourse’s construction of the child as a burden by constructing the disabled child as an excessive financial cost. Secondly, I argue that the economic discourse supports the practice of prenatal genetic diagnosis as a means of normalising society. Pip was the only participant who explicitly deployed the economic discourse and spoke of the financial implications of having a disabled child.

I think that it is sad that they [amniocenteses] are not automatically offered free of charge. I'm sure they cost the country, I don't know how much, \$500 per pregnant mother? It's still a lot cheaper than supporting an abnormal child through its natural life once it's born. So, I don't see why those tests are not offered to every pregnant female who would, or who agrees to, to have it.

Pip, primipara

In the economic discourse, the disabled child is depicted as requiring resources and financial support that exceed those required by children without abnormalities. Some of the extra resources utilised by disabled children include health care resources, special education needs, social benefits and “maternal production” (Callan, n.d., p. 6). Pip makes visible the cost of prenatal genetic diagnosis and compares it to the cost of the child. She believes that the cost of providing care for disabled children would outweigh the cost of providing free amniocentesis to all pregnant women regardless of their age. The emotional and psychological costs of loss and grief are not considered in her equation.

One connotation that is implicit in Pip's evaluation of an “abnormal child” is the child's degree of worthiness. She described her views on children with mental disabilities:

I mean, I don't know why we support these children. I know that that sounds cruel to some people ... but I mean a mother bird throws its weaklings out of the nest. I don't really see why society should support them to that extent if there is. If the brain's all right to me it doesn't matter, but if ...[...] anyone who needs extra help like the old psychopaedic hospital. That to me is hideous how those people are. If they know what they are like, I don't know. *But if I'd known I was going to produce something like that from birth.* So, I'd have no hesitation in going through amniocentesis.

Pip, primipara. Italic emphasis added

Intellectual disability constitutes weakness, that is, an inability to survive independently. Pip regards intellectual disability as more of a justification for terminating a pregnancy than physical disability, especially when she considers the severely affected children she associates with psychopaedic hospitals. Nonetheless, she does see society as being obliged to support people with mild disabilities. Charo and Rothenburg (1994) report that a less tolerant attitude is shown towards severe “mental retardation” than “moderate retardation”, blindness or paraplegia. The former is more likely to be aborted than the latter. Intellectual ability then has a special significance. A

child's intellectual capacity to develop and function normally is regarded as more important than its physical ability. As reflected in her use of the words "*something like that*" she constructs severely mentally disabled people as not completely human, as undesirable and therefore, not worthy of society's support. Pip's text echoes that of Bush (1975) who argued in her submission to the New Zealand Royal Commission on Contraception, Sterilisation and Abortion that "inability to make choices or to live as a human as opposed to any other kind of animal" (p.3) was an indication for abortion. Cognitive ability signifies humanity and the right to life.

Foucault writes:

for the marks that once indicated status, privilege and affiliation were increasingly replaced – or at least supplemented – by a whole range of degrees of normality indicating membership of a homogeneous social body but also playing a part in classification, hierarchization and the distribution of rank. In a sense, the power of normalization imposes homogeneity.

1977, p.184

Extra chromosomes are identified as deviations from the norm and as potential disruptions to society. If fetuses are judged to be only partially human, then the membership of these fetuses with "abnormal" chromosomes to society is suspended and their right to society's resources becomes questionable. By invoking the ruthless mother bird, Pip shows that the process of genetic diagnosis and termination of abnormal fetuses is inferred as being biologically determined, instinctive and therefore natural and right. Based on her calculation of economic costs and benefits to society, Pip chose to have an amniocentesis. As stated in an excerpt below, Pip believes that she would have terminated the pregnancy had the result indicated the presence of chromosomal abnormalities. In not wishing to burden society unnecessarily with an intellectually disabled child, Pip constructs herself as a responsible member of society.

The discursive practice of genetic diagnosis subjects the fetuses of women aged 35 and over to special surveillance. By applying the medical genetic discourse's specific typology and numerical norm of 23 paired chromosomes, fetuses whose chromosomal material varies in type or number are separated from the normal and judged to be abnormal. The follow-on practice of terminating abnormal fetuses encourages homogeneity, the aim of normalization. In the following section, I explore how the women who chose to have prenatal tests talked about the knowledge that the test provided.

#### 6.5.4 Knowledge as providing choice

Pip was quite explicit about the course of action that she would have taken had the tests indicated abnormalities.

I had that great needle, the amniocentesis test. Had those results come back as abnormal, I immediately would have asked to be aborted within those dates. I mean, there are now more tests that they can do, and so there should be because of progress and all that. Then I would have tried again. Instantly.

Pip, primipara

The amniocentesis then allowed the women the opportunity to have the healthy baby that they desired and to avoid having a child with chromosomal abnormalities. However, as Kolker and Burke (1994) argue, control over determining the health of one's future baby is illusory. Amniocentesis does not test for all possible abnormalities and sometimes trauma may occur during birth injuring the baby. Pip, in particular, views the development of prenatal tests as a positive feature of a modern obstetric science in its quest for progress and expansion of knowledge. She believes that the more knowledge that can be provided to parents is beneficial. Implicit in this view is her belief that a progressive society might have fewer abnormalities, which Shakespeare (1999) refers to as a "narrative of optimism".

With one exception, the women who chose to undergo prenatal genetic diagnosis had decided that if their CVS or amniocenteses had indicated the presence of chromosomal abnormalities they would have terminated their pregnancies. Katie, however, was ambivalent about what she would have decided should the results have shown abnormalities:

I don't know how far I would have gone to ... towards getting rid of the child that had an abnormality. I don't think that I could have, but ... I would have preferred to have known, ...you know, if something was going to be wrong with the baby. I wouldn't have done anything about it but I would have preferred to have known myself. [...] it would have to be something severely wrong because I don't think I could have lived with myself if I'd terminated the pregnancy. Not that I'm pro-life.

Katie, multipara

Katie's statement challenges the forgone conclusion that all women will terminate the pregnancy should they receive a positive result. She makes evident that context and conflict surround her decision-making. Her decision is dependent on

multiple factors including the views of her husband, which have been discussed in a previous section. The factors that influence her decision-making are not the simple and clear-cut binaries of normal and abnormal but rather the greys of degrees of disability. Furthermore, as Markens, Browner and Press (1999) found in their study, women who refused the opportunity to have the AFP blood test were not necessarily opposed to abortion. For Katie, her reluctance to terminate her pregnancy is not derived from beliefs that oppose abortion per se.

One other reason that Katie gives, however, for undergoing amniocentesis in her second pregnancy was the relief from stress that knowing gave her.

### **6.5.5 Knowledge as providing assurance**

For two of the women, Lara and Katie, the knowledge obtained from the amniocentesis allayed their uncertainty during pregnancy. As they each said:

Because of my experiences as a student nurse, I always felt strongly that ... [about having an amniocentesis] otherwise I would have worried myself just sick for the whole nine months.

Lara, primipara

I'm a bit more of a tense, sort of nervous person, I think. I like to know that everything is going to be fine, you know? I can't be relaxed about something, I have to know in my own mind. If I was like my husband and a bit more relaxed about birth, I think that I could have gone through the pregnancy and not worried. But because of the type of person I am, I needed to know.

Katie, multipara

Just knowing one way or the other was significant for Katie. Finding out if her baby did have abnormalities would have helped her to adjust and prepare for the baby before the birth. She believed that she would have been more stressed following the birth had she not known. Thus knowledge was valued for itself.

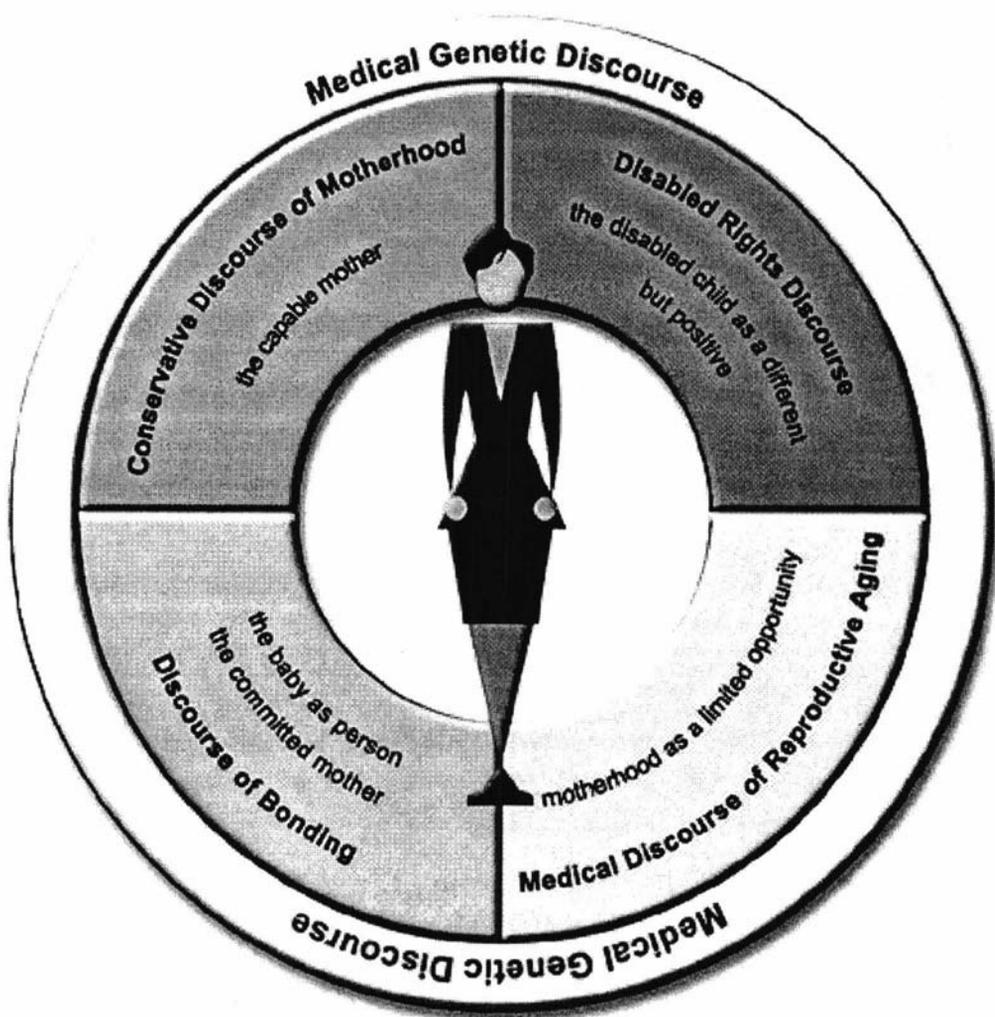
In identifying oneself at risk of bearing a disabled child, these women then evaluated their (and their partner's) ability and desire to care for such a child deploying multiple discourses. The knowledges that they deployed differed to those set out by the group of women I have termed the "unconditional mother/parent".

## **6.6 THE UNCONDITIONAL MOTHER/PARENT**

Most of the women who chose not to have prenatal genetic diagnosis also recognized themselves to be at risk of having a baby with chromosomal anomalies because of their age. The subject position of "unconditional mother/parent", I argue, is

produced by the intersection of several discourses which contradict those deployed by the “conditional mothers/parents”. These discourses are a mothering discourse which constructs the capacity to mother as an inherent and unlimited essence, the liberal discourse of disability and the medical discourse of female reproductive aging. Figure 6-2 illustrates the multiple discursive subject positions brought into being by these women. Each of these discourses produced an identity for the women which the women drew on to examine their ability to mother a disabled child in making their decision regarding undergoing prenatal genetic diagnosis. These women also deployed the medical genetic discourse whereby the risk of losing their baby as a consequence of the test was foregrounded as a concern. While not being against abortion it became apparent that the opportunity to have a baby/become a mother was important to these women.

Figure 6-2 The Unconditional Mother



In contrast to the women who chose to undergo either an amniocentesis or CVS, these women identified themselves to be capable of mothering a child with chromosomal abnormalities.

### **6.6.1 The capable mother/parent**

It emerged from Jo and Rosalie's transcripts that they positioned themselves in the subject position, which I have termed capable mothers/parents. Jo responded as follows when I asked her if deciding against an amniocentesis had been an easy decision:

I was prepared to just deal with whatever I had to deal with at the time. I mean, I know that with age the risk of things like Down are higher as you get older. I knew that the risk was higher but I was prepared to just see what happened and cope with that as and when. Interestingly with both births it wasn't until a little bit of time later, maybe hours later, that I stopped and really thought, 'Hey, this child is perfect. It wasn't the first thing I thought of when I saw the child or when it was born, 'Was it OK?' It just didn't enter my head when it was actually born. [...]. I'll just trust that I had the resources within me to cope with whatever baby I had. It didn't, I mean in the back of my mind, OK I was older and there was a bit more risk there, but it certainly didn't worry me a lot of the time.

Jo, primipara

Rather than find out during the prenatal period if her baby had chromosomal abnormalities, Jo adopted a wait and see approach. Her decision not to undergo prenatal genetic diagnosis was derived from her belief in her ability to cope with a Down syndrome baby. Jo perceives herself to have unlimited resources that are intrinsic to her as a mother. These would have emanated from within, stimulated by the birth of her baby. Jo makes no reference to requiring the assistance of others to care for her child. It is possible to read into Jo's statement a degree of accountability for her decision. As she had chosen not to determine the condition of her baby when there was the opportunity to do so, she would have taken responsibility for having a child with disabilities.

In explaining to me why she had decided against having prenatal genetic diagnosis, Rosalie referred to two families she knew of who had children with mental disabilities:

My husband has a cousin and another distant relative who are mentally disabled. So their families have had to cope with children who weren't Down syndrome but who have problems.

Rosalie, multipara

Her use of the words “have had to cope” points to how the families have found themselves in the situation of having to care for a disabled child. These families have been able to provide the care that the children have required. I read Rosalie as implying that her knowledge of such families gives her the belief that should she have a baby with Down or other mental disabilities that she will be able to care for it.

Both women constructed themselves as being resources. That is, they portray themselves as having the means to provide the care which their child needs. Rothman (1986) argues that the construction of mothers as resources reflects broader societal views that devalue both the mother and the child. She suggests that society expects the mother to accept responsibility for the care of her child. In doing so, society’s responsibility is minimised. Both Jo and Rosalie mirror their social context; they make no mention of requiring governmental or societal assistance. Instead they convey a sense of self-reliance. Glenn (1994) writes that mothering is a contested terrain. Different definitions of motherhood exist. A dominant model of motherhood, which has been popular in the twentieth century, is that mothering is the exclusive responsibility of one woman, usually the biological mother “for whom it constitutes the primary if not sole mission during the child’s formative years” (p. 3). The ideal mother is nurturing, devoted and self-sacrificing. Spallone (1989) identifies that this “ideology of motherhood” was constructed in Britain at the turn of the 20<sup>th</sup> century to ensure the reproduction of a “virile” population.

In addition to constituting themselves as capable mothers, the four women depicted themselves as committed to their babies.

### **6.6.2 The committed relationship**

Rothman (1993) found that one reason for some women deciding against amniocentesis was the way in which they viewed their child. For the woman her relationship to her baby is one of commitment; she is the mother of her child. She perceives herself as having a responsibility towards her child. As one of Rothman’s participants wrote, “At some point, I began to feel, more and more strongly, that this fetus *was my baby*, and as this emerged as a strong reality, it no longer depended on the baby’s health, normality or perfection. ... I was then committed to caring for the baby no matter what” (Rothman, 1993, p. 69, emphasis in original text). As a committed

mother, she is responsible for ensuring the livelihood of her baby and for accepting it no matter what the conditions are.

In perceiving oneself as committed to one's baby regardless, the process of amniocentesis, its purpose and the risks associated with it become problematic for the mother. The risks associated with amniocentesis are Rh sensitization, chorioamnionitis, injury to the fetus, leakage of the amniotic fluid and pregnancy loss. The latter is the most significant risk with an incidence rate of 0.3 – 1.0 per cent (Reece & Hobbins, 1999). Gregg (1995) and Markens, Browner and Press (1999) propose that the concept of risk is one constructed by the medical discourse. These authors argue that when women draw on the notion of risk to choose not to undergo either genetic screening or genetic diagnosis they are not necessarily resisting or rejecting the medical genetic discourse's construction of risk. Rather they are actually deploying it in their decision-making .

Barbara stated the following:

We looked into having an amniocentesis, discussed it with the specialist, and he said at my age, with no specific genetic problems in our backgrounds, that it wasn't really necessary. And, he felt that if I had the test it may induce a miscarriage, which since I had taken so long to get pregnant, it might not be such a good idea. But, he gave us all the information. We went away and made an informed decision not to have it, and it proved to be the right one. Just lucky.

Barbara, primipara

Barbara, in deploying the risk discourse, positions herself as a gambler, as a woman who chose to remain uncertain. She gambled on the odds that her baby would not have chromosomal abnormalities. Barbara's latter comment that she and her husband were "just lucky" with their decision-making shows both the contradictory and contestable nature of the risks surrounding prenatal genetic diagnosis.

For the four women who decided against having a prenatal diagnostic test, the possibility that they might lose their baby as a result of the amniocentesis was their main concern. The possibility of miscarriage was not talked of in the rational economic language of cost-benefit ratios but rather in terms of potential loss: loss of the baby and loss of the opportunity to have a baby. For these four women ensuring the baby's continued existence was paramount.

I mean, to have the amniocentesis itself is a risk. There are high risks of miscarriage.

Jo, primipara

I could lose him through doing it and that would be devastating because I was really clear that this was my last cut at it.

Bernie, primipara

The fact that my age at 39 I might not have had any more children after that, if I had had a miscarriage as the result of an amniocentesis. [...] With my second one, my GP was on holiday for the first few months. The fill-in doctor said, 'What about going to get a scan?' I said, 'No, This would probably be my last baby. So whatever happens, whatever is wrong, we will just do our best.'

Rosalie, multipara

For Bernie, Barbara and Rosalie, their sense of commitment to their babies was made more significant by the difficulties they had encountered in becoming pregnant or in their experiences of miscarriage. Barbara's history of infertility was suggested to her by her obstetrician as one reason for her not to have a prenatal genetic test. According to Rothman (1986), such recommendations are not uncommon on the basis that these women are more prone to having miscarriages following amniocentesis.

For women with previous miscarriages or who had difficulty becoming pregnant amniocentesis constituted a significant threat. Foregrounded in their concerns is that the process of obtaining a sample of amniotic fluid has the potential to jeopardise the baby by causing a miscarriage. Rosalie, Barbara and Jo depict their chance to have a baby as a limited or rare opportunity. Therefore, this pregnancy and this baby is one that should not be put in danger by electing to have an amniocentesis.

Rothman (1988; 1993) found that risk was a "constant refrain" given by the women in her study who decided against amniocentesis. She argues that the rational process of assessing risk is a socially acceptable justification for not having an amniocentesis. In comparison, women's reasons, such as their feelings, intuition or discomfort, are not regarded as legitimate. From a Foucauldian perspective, to situate oneself within a medical genetic discourse and employ a risk benefit analysis offers the speaking subject a claim to rationality and objectivity in their decision-making. The woman's choice not to undergo prenatal genetic diagnosis is more likely to be accepted and sanctioned. The deployment of a discourse which draws heavily on subjective knowledge however, is more likely to expose the woman's choice to challenge and to be discredited.

The production of self as a committed mother was closely connected to the way in which the women perceived the baby in itself and their ability to conceive and bear a baby. Three depictions of the baby emerged from the four women's texts: the baby as a person, the Down baby as positively different and, the opportunity to have a baby as a limited opportunity.

### **6.6.3 The baby as a person**

For Bernie, her decision not to have genetic diagnosis was influenced by her depiction of the baby as a person. She replied when I asked her about genetic diagnosis:

Once I had heard his heart beat I couldn't do it. I can remember sitting out there; I can see it clearly now. I can see it right in front of me sitting outside the surgery, and there was this whole busload of Down syndrome kids, and I had just decided that I wouldn't get it done. I could lose him through doing it and that would be devastating, because I was really clear that this was my last cut at it. Although now, on thinking about it, I mean it's quite possible I could have another one, no big deal. That timeline has changed. So, I didn't get it done because once I'd heard his heart beat, there was no way I could. I knew I couldn't abort him. It was clear.

The sonicaid is a device that is used by maternity practitioners to detect and listen to the baby's heart. The sound of the baby's heartbeat is made audible so that the practitioner, the mother, and any others who may be present in the room, can hear it. Bernie's experience of listening to her baby's heart sound appears to have influenced her identification of her baby as a living person and her commitment to his existence. Duden (1993), writes of how the fetal photography of Lennart Nilsson in 1965 gave the fetus an "aura of bodily presence" (p. 25). Similarly, the technologically enhanced sounds, which are objectified by the technology of the medical scientific discourse, are interpreted by Bernie as indicating her baby's existence.

### **6.6.4 Motherhood as a limited opportunity**

As discussed above, for all four women becoming pregnant constituted an exceptional achievement. Difficulty in becoming pregnant or their experiences of miscarriage, combined with the belief derived from the medical discourse of female reproductive aging that a woman's fertility was in decline by the age of 40 years, influenced the women's perspective toward being pregnant. Jo talked of becoming pregnant in the following way:

I was ready to shout from the rooftops. [...] As I said before particularly because I did get pregnant quickly once we wanted to. So I didn't have to say, 'Well, how long are we going to try for?' Or make any of those decisions. because obviously at 40 you haven't got many options as far as getting much help or adoption or anything like that, it's all virtually out of the question, I think, by then.

Jo, primipara.

At the age of 40, Jo understands her fertility to be on the decline. This is confirmed for her by her knowledge of adoption and assisted reproduction policies that do not accommodate women aged 40 and over. In New Zealand parents over the age of 40 are not permitted to adopt children under the government's social welfare system. Consequently, Jo, Bernie, Barbara and Rosalie, identify the opportunities to have children as limited, which influences their view of amniocentesis.

Bernie repeatedly referred to her son as a treasure. Her sense of commitment was heightened by her history of miscarriages. At the time that she was pregnant with her son, the pregnancy represented for her the only opportunity to have a baby. As a treasure, her son's life was both rare and precious to her and too valuable to jeopardise.

This valuing of the baby and the construction of self as having limited chances to bear a child influences the woman's perception of the significance of the amniocentesis. The intersection of the discourses of motherhood and biological aging produce a particular meaning to the prenatal genetic diagnosis procedure of amniocentesis. It is constructed as a procedure that brings considerable risk to the unborn baby. It is seen to be undesirable and hence to be avoided. A third way in which the baby was depicted was that if it was a Down's baby, its disability was not constituted as being inherently negative.

#### **6.6.5 The Down syndrome baby as different but positive**

Three of the women referred to the association between mental disabilities and maternal age. Jo made mention of Down syndrome and Bernie specifically talked of reflecting on the possibility of having a baby with Down syndrome.

We've got a Down's at work, a mild one. He's a character. And I thought, no, I'd just get on with it. ... I made the decision while I was living in W [another town] and I just let the time go so that it was just too late.

Bernie, primipara

As discussed above, while pondering her decision, Bernie had seen a group of children she recognized to have Down syndrome. It is evident in her statement that these children were not abhorrent to her. On seeing them, she did not change her mind. Similarly, her experiences of a workmate who had Down syndrome had not left her with a negative impression. Rather than constructing a child with Down syndrome as one who will be “unfulfilled, suffering and unable to take on responsible adulthood” (Reid, 1990, p. 316), Bernie constructs the person with Down syndrome as having positive, pleasurable attributes and the potential to participate in society.

Rapp (2000) proposes that the decision to abort a baby following a positive diagnosis is influenced by the understanding that the parents hold about the baby’s disability and how it is going to affect them. Rapp found that some parents expressed shock and revulsion on receiving a positive result. However, she noted that their information was often not recent or accurate. Although Jo, Bernie and Rosalie’s understandings of Down syndrome and other genetic abnormalities associated with maternal age were not explored in depth as part of this study, it is apparent in their statements above that the disabled child was not viewed negatively. The abnormal baby was constructed as different from others but was not perceived so negatively that it was unwanted. Emerging from the texts of the women who decided against having genetic diagnosis was the value attributed to the knowledge gained by undergoing the tests.

#### **6.6.6 Knowledge as unwanted**

One of the women, Jo, spoke of the lack of importance that the knowledge gained from amniocentesis had for her. She recalled that when her first and second child had been born it was not her first priority to determine whether or not they had abnormalities. After both births, her awareness that her baby was normal dawned on her sometime later. Later in the interview she said:

You know, if you’re going to know and not decide to do anything about it that’s got to be worse than finding out when it is born. My husband and I both agreed that was the way we would go, and I was quite happy about that.

Jo, Primipara

Unspoken is Jo’s belief that the knowledge of the presence of “abnormalities” would have disrupted her pregnancy. Having decided that she would not terminate the pregnancy, her circumstances would not have changed. Implied here is a sense that the pregnancy would have been endured, thus, the test offered no benefits for her.

Browner & Press (1995) found that a similar reason was given by women in their study who refused to have genetic screening. To continue through pregnancy with the knowledge that the baby may have “abnormalities”, for which nothing could be done, was seen by the women in their study as stressful. Jo emphasizes that her state of not knowing did not cause the remainder of her pregnancy to be filled with excessive worry or concern.

The inherent association made by the women between amniocentesis and abortion was influential in both Jo and Rosalie’s decisions for not undergoing amniocentesis.

I wasn’t prepared to terminate based on the results. I wasn’t prepared to make that decision. So to me there was no other decision.

Jo ,primipara

I’d had a miscarriage between the first daughter and the second. I didn’t want to have to make a decision either about whether to have an abortion because who wants to make that decision?

Int: Do you feel you belong to either camp of people who are pro-abortion or anti?

Rosalie: No. Not really because I can see both sides. I would hate to be in that position where I felt would I? Should I? It is very hard to say what you would do if a test showed up something wrong.

Rosalie, multipara

For both women, there was no purpose in having the test if they were not prepared to end the pregnancy should a positive test indicate the presence of Down or other detectable “abnormalities”. The outcome or action that results from the diagnosis constitutes the value of the test. From this perspective, the knowledge provided by the test is not valued or seen by Jo and Rosalie as a worthwhile investment..

Rothman writes: “It is generally understood that women can refuse amniocentesis if they see it entirely as a prelude to a potential abortion, and see abortion as wrong, a totally unacceptable choice – not a choice at all” (1993, p.65). Knowledge gained from having an amniocentesis then, has a second meaning, that of providing choice. However, as Rothman highlights, the existence of choice is contingent on receiving a positive result in that the woman then has the opportunity to choose whether or not she bears a baby with abnormalities. If, from the outset of their pregnancy, some women have decided that they will choose not to end the pregnancy should they receive

a positive test then no matter whether the test is positive or negative, choice does not exist.

The women's strategy is to remain what I will term "unknowing". Not knowing provides them with the space to continue their pregnancies. For Jo, the tactic of refusing to have prenatal genetic diagnosis allows her to wait until the birth of her baby. What is important is that the women deliberately denied themselves exposure to knowledge. In this, way knowledge that has been identified as negative, unnecessary and hence unwanted is avoided.

Remaining invisible, silent and accepted in the language of prenatal genetic diagnosis is the normal fetus. It is the existence of the abnormal fetus that is made visible, vulnerable and made tentative.

Furthermore, both Rosalie and Jo viewed the decision regarding abortion as being a negative one. Although they did not explicitly cite moral views on abortion, it is clear from their statements that they view the situation of decision-making following the amniocentesis' identification of abnormalities, and the aborting of their babies, as an unpleasant and an unwanted one. This decision is one of the most difficult ones that a woman may confront (Reid, 1990).

The association between amniocentesis and abortion is not an uncommon one made by women. For example, Gregg (1995) observed, for some women amniocentesis is a code word for abortion. Kolker and Burke (1994, p. 110) found that most of the women in their study were prepared to abort the abnormal fetus identified through prenatal genetic diagnosis.

The annexation of amniocentesis and abortion, I would argue, creates a space for women to resist by avoiding undergoing genetic surveillance. Their taking a stance that unconditionally accepts the fetus that they are carrying legitimates their avoidance strategy. Bernie's story in the following section provides us with an explicit example of avoidance as a technique of power.

## **6.7 THE STRATEGY OF ELUSION**

During the early stages of her pregnancy, Bernie moved to the city and had to find a new GP. She recalled that she had made the decision not to have amniocentesis following a visit to her first GP.

I'd made the decision in W and what I did was I just let the time go, so it was too late.

Bernie, primipara

Bernie used the limits of time in which an amniocentesis can be performed to ensure her choice. Made apparent in her decision is the double meaning that can be given to the six-week period during which CVS or amniocentesis can be performed. These periods of time can both be openings and closings. For women who desire the opportunity to find out if their baby has abnormalities, the six week period in which these tests can be carried out permits the acquisition of this information. In contrast, for women such as Bernie, this restricted period of time allows women to elude the tests. Bernie explained:

I got past it though, you see. I think I was past 20 weeks. I was a bit naughty because I was very borderline on the dates. It was getting critical time. I couldn't at that stage. I said to him, I couldn't.

Bernie, primipara

Bernie describes her tactic of elusion as one that is “naughty”. The *Oxford English Reference Dictionary* (1996) defines naughty as being used especially in relation to children and meaning “disobedient” and “badly behaved” (p. 965). Although her new GP did not rebuke her or comment on her not having the test, Bernie in this statement describes herself as a child who has not done what she is supposed to. She has disobeyed the rule of older women routinely having an amniocentesis. In this sense, Bernie has not been a docile body; she has actively resisted the practice of prenatal genetic diagnosis.

Chandler and Smith (1998) argue that prenatal genetic diagnosis has created a conundrum for pregnant women. They state, “it requires every pregnant woman to choose between carrying a baby that is untested and therefore potentially abnormal, or undergoing a test that could result in her having to abort a baby she may strongly desire to keep” (1998, p. 74). With the neo-liberal practice of informed choice, the decision regarding abnormality has come under the control of the mother. As Chandler and Smith suggest, this also has placed the responsibility for an abnormal baby on to the mother. She can decide whether it lives or dies. Jo, Bernie and Rosalie all refer to the enormity and undesirability of having to make this decision following a positive result. When making a decision to terminate a pregnancy, there are two possible identities with which women may associate themselves: the “unwilling, uncaring mother” and the “executioner of her own offspring” (p.74). In deciding against prenatal genetic

diagnosis, Rosalie, Jo and Bernie are avoiding such identities. However, they remain vulnerable to being positioned by others as mothers responsible for their situation. However, Jo and Rosalie counter the possible accusations of responsibility by constructing themselves as women who have the potential to cope with the extra demands that a child with abnormalities may make of them.

In deciding against prenatal genetic diagnosis these women have exercised avoidance as a technology of power. By avoiding genetic surveillance their babies were not exposed to the possibility of failure and termination.

Having considered the different discourses that overlapped with the medical genetic discourse, I now discuss how two women positioned themselves in a discourse that resisted the medical genetic discourse.

## **6.8 THE OPPOSITIONAL DISCOURSE**

With the exception of three participants, all the other participants appeared to make an implicit assumption that the character of older women's eggs was different from younger women so that the probability of older women conceiving babies with chromosomal anomalies increased. In this way the majority of participants deployed the medical genetic discourse in their texts. The two women, Emma and Rosalie, who distanced themselves from the medical genetic discourse were multiparas. Emma explained to me why she did not believe she was at risk of having a baby with chromosomal abnormalities at the age of 35:

I don't think it really changes things once you are 35. Although I think that this is where people have got it wrong. Just because you're 35 doesn't mean that you're going to have a Down syndrome or whatever. I don't feel that just because you're 35 you're going to have an abnormal baby. It can happen in your 20s.

Emma, multipara

Rosalie recalled that when pregnant with her second child at the age of 39, she felt that the likelihood of her having a baby with 'abnormalities' was low and she attributed this to her lifestyle:

I felt that the chance of me having a baby with Down's was pretty low, because I had always followed a healthy diet. I had read that X-rays and radiation, that a build up of radiation in the body could affect the genes of the eggs that the mother stores. I had had a few dental X-rays, but other than that very little. The fact that we had a healthy

lifestyle. We had eaten a lot of organic food. Even that I would think would help. It made me feel more confident, even if in reality it didn't.

Rosalie, multipara.

Rosalie constructs the changes in women's eggs as being brought about by external factors rather than as an inherent unstoppable biological process. She believes that her body will have had reduced exposure to the chemicals associated with non-organic products. Consequently, the genetic material within her eggs has not been affected. Her belief in the theory of the affects of pesticides and other chemicals used in food production on the human body also influenced her decision against having amniocentesis.

It is interesting to note, however, that in the last sentence of her statement, "*even if in reality it didn't*" Rosalie contradicts her belief. Her confidence that she would not have a Down syndrome baby because of her diet and lifestyle, she reflects, may have been misplaced. She alludes to the possibility that her second daughter was not born with chromosomal abnormalities because of chance. By contradicting her belief, the status of her experience as evidence that Down syndrome may be prevented by an organic diet is diminished. The medical genetic discourse remains unchallenged and superior.

A third aspect influences her decision-making and that is the wish not to have medical interference. When explaining her decision not to have an amniocentesis, at one point Rosalie said "*But also I didn't want to have any medical interference.*" Taylor (2000) makes the point that in choosing particular prenatal cares and kinds of birth, women are constructing identities for themselves. In this light, Rosalie can be seen to be positioning herself in more than one discourse to explain her reasons for not seeking prenatal genetic diagnosis. Here she draws on the normal birth discourse which argues against the use of unnecessary intervention during pregnancy and birth. For Rosalie, an amniocentesis signifies medical intervention that she regards as undesirable.

## 6.9 SUMMARY

With the exception of two women, it was common for the remaining 13 women in this study to have considered the issue of prenatal genetic diagnosis prior to their becoming pregnant. Their increased risk of having a child with chromosomal abnormalities was regarded by most of the women as an issue that women in their age group needed to have thought about. That the majority of women were aware of the

results of such medical epidemiological research and had thought about its relevance to them reflects the hegemonic nature of the medical genetic discourse.

In this chapter, I have identified two subject positions that the women deployed in recalling their decision regarding prenatal genetic diagnosis: the unconditional mother and the conditional mother. These contradicting views show that the mothering of disabled children is contested terrain. For the women who identified themselves as unconditional mothers, a desire for motherhood was dominant and was one that permitted them to perceive that their capacity to care for a disabled child was intrinsic and unlimited. Furthermore, their notion of a disabled child was one which resisted that of the discourse of disability. In contrast, the conditional mothers perceived their capacity for mothering as limited and the disabled child as excessively burdensome.

That the majority of women chose to undergo prenatal genetic diagnosis shows that the intersection of the discourses of disability and motherhood as a chosen role rather than dictated by biology, was dominant amongst the participants.

Whichever discursive position the women situated themselves in, I believe that it was a consequence of reflection and evaluation influenced by the women's perceptions of themselves and their ideas of living with a child with intellectual disabilities. The latter were based on both direct and indirect understandings. The positioning of self as mother is one of relationship with another, the child. Each woman assessed her capability to mother a disabled child and in doing so judged herself as being either capable or incapable.

For the two different identities, the meaning of the knowledge that the prenatal genetic diagnosis offered to them regarding the condition of their fetus was contestable. For the conditional mothers, the test result allowed them the opportunity to ensure that they gave birth to a child without chromosomal abnormalities. Only one woman, who remained uncertain about whether or not she would have terminated the pregnancy, saw the test as an opportunity for knowledge itself about the fetus.

I have argued that the position of unconditional mother offers women the opportunity to elude the normalizing gaze of surveillance. In perceiving that the importance of the fetus' life outweighs either the knowledge gained from, or the choice provided by the test, women are able to refuse having the test. In this way, a space for avoiding the test is created and the fetus escapes examination and possible termination.

In deciding whether to undergo genetic diagnosis, women are called on to evaluate themselves as mothers. For the women in this study, a variety of discourses

came into play in their consideration of prenatal genetic diagnosis. When explaining their decision the women situated themselves in multiple subject positions revealing the fragmentary, and sometimes contradictory nature of subjectivity.

The consideration of prenatal genetic diagnosis is one that I have shown to be currently almost compulsory for women aged 35 and over. Instrumental in ensuring that women are aware of the availability of prenatal genetic diagnosis are the maternity practitioners. In the next chapter I explore and analyse the discourses deployed by the practitioners when describing their practice of caring for pregnant women aged 35 or over.

## **Chapter 7: THE SURVEILLED PRACTITIONERS**

The bureaucracy of statistics imposes not just by creating administrative rulings but by determining classifications within which people must think of themselves and of the actions that are open to them.

Hacking, 1991, p. 194.

### **7.1 INTRODUCTION**

Analysis of the literature on prenatal genetic diagnosis showed that the medical genetic discourse is hegemonic. I have shown in Chapter Five that its status as scientific epidemiological knowledge and the overlap of discourses of economics, neo-liberalism and disability maintain the medical genetic discourse's position of hegemony. The overlap of the discourses, I suggest, produce the practice of ensuring that pregnant women aged 35 and over are made aware of their risks of giving birth to a child with chromosomal "abnormalities".

The time in which prenatal genetic diagnosis for chromosomal "abnormalities" can occur is in the first sixteen weeks of pregnancy. Given that there are only two genetic counsellors in New Zealand, I believe that the role of ensuring that pregnant women are informed about the possibility of their giving birth to a baby with genetic abnormalities habitually falls to the woman's midwife or medical practitioner.

In this chapter I argue that the practice of informing women aged 35 and over of their increased risk of giving birth to a child with chromosomal abnormalities is standard. It is a practice that is imposed on practitioners, and which practitioners in turn impose on women who meet the risk criteria. I show that the intersection of the medical genetic discourse with the discourses of neo-liberalism and law constructs subject positions that simultaneously identify the practitioners as agents and enforcers of informed choice, and as vulnerable to punishment. The medical genetic discourse authorizes the midwives and doctors as professionals who have the knowledge necessary to identify and inform the women of their risk status. The discourses of law and neo-liberalism intersect to discipline the maternity practitioners' discursive practice of informed choice, thus ensuring that each woman aged 35 or over considers the option of testing for Down syndrome and other chromosomal "abnormalities". As Lupton

(1995) argues, “the technology of genetic screening, therefore, acts as a highly individualized strategy of normalization” (p. 106).

## 7.2 MATERNAL AGE AS A SIGNIFIER

The woman’s age of 35 or over was a flag for every practitioner I interviewed to raise the issue of prenatal genetic diagnosis with the pregnant woman. When positioned as a maternity services provider within the medical genetic discourse, the practitioners appeared to be impelled to bring her situation of risk to the woman’s attention. For example, the following participants when asked about the care that they would provide to women aged 35 or above stated:

*I would offer genetic counseling or genetic diagnosis more for an older woman than I would for a younger woman. From 35 to 37 I would offer and say that this is a choice. But, I suppose from 38 or over 39 I would say, ‘Well, certainly think about it.’ ...*

Int: You talked of how up to 37 you offer. It seemed to me to be a subtle distinction in how you dealt with that?

Jane: Yes. I suppose that reflects my own bias. ... I would question whether it would be worth it for women up to 37. I think that there are risks with either chorionic villus sampling or amniocentesis in younger women. ... also how it changes their pregnancy and so on ... whether it is worth it. OK? So I suppose *I will offer it to them and say, ‘These are the risks. Think about it’*. But your risk, you are 35, there is 1 in 250, I think it is, it’s very low or it’s not likely. Once they are 40, 41, I think the risk is about 1 in 40. So it is much more appreciable.

Jane, GP, italic emphasis added.

All my patients, *I offer them an early scan at 11 weeks to see the nuchal fold thickness. You can assess chromosomal risk from the thickness of the tissue at 11 weeks and triple testing (maternal serum) at 14 to 15 weeks. To be effective it needs to be offered to all women. But specifically if a woman is over 35, I will say the risk of a genetic malformation is higher over 35, 36 than the risk of an amnio, so therefore it is justifiable, whereas I would not say the same thing to a 31-year-old. So I do treat them differently.*

Phillip, Obstetrician, italic emphasis added

The age of 35 and onwards has a special, but complex, significance for the practitioners. It signals the woman as being more at risk of having a baby with chromosomal abnormalities: as the woman’s age increases so does the likelihood of abnormalities. The statistical evidence that shows the relationship between age and chromosomal abnormalities is conceived of as an unassailable truth; a biological

inevitability, by all the practitioners. That it is constructed as a natural truth, an immutable process, incites the practitioners to bring it to older women's attention and to justify women's surveillance.

Corresponding to the increased epidemiological probability is the practitioners' intensification of urging. Their desire is to get the older woman to consider prenatal genetic diagnosis more seriously. For Phillip, and Henry, when a woman is aged 35 or over, they are more inclined to give the woman differently detailed information than they might a younger woman. For other practitioners, as illustrated by Jane, when a woman is 37 or over they want her to contemplate prenatal genetic diagnosis more deeply than they would have asked her had she been younger. Implicit in their construction of the woman is her cognitive ability to absorb information and reflect on and weigh the risks and benefits of undergoing the tests.

The italicised phrases of the excerpts above reveal the different power positions that can be adopted by the practitioners. The practice of *offering* the tests situate the women as partners in their relationship with them. However, as women's age increases, there are evident power relation changes. There is more of an attempt to provide information in a way that will influence the woman's actions. Jane stresses the increase in risks of having a baby with chromosomal abnormalities, whereas Phillip suggests that having the amniocentesis is vindicated as it poses less risk than having an abnormal baby.

The medical genetic discourse creates the space for maternity practitioners to be the information experts. This overlaps with the neo-liberal discursive practice of informed consent positioning the practitioners as the agents/ensurers of informed choice, and with the legal discourse to construct the position of vulnerable practitioner. I propose now to discuss and explore these three subject positions.

### **7.3 THE INFORMATION EXPERT**

Implicit in the voices of the practitioners was their position as authorities in relation to prenatal genetic diagnosis. The practitioners' authority is conferred on them by the maternity policy which requires women to have referrals from maternity service providers. No woman can access genetic prenatal genetic diagnosis independently of midwifery or medical practitioners. In this sense, the maternity practitioners become the authorities of delimitation (Foucault, 1972, p. 41-42). That is, they have the authority to identify the women who are entitled to prenatal genetic screening. Their position within

the discourses of pregnancy and birth and in the medical genetic discourse is one of the information expert. The practitioners have a thorough understanding of the variety of tests available, the relative significance of the tests, and the implications for women in having the tests.

Daniel, an obstetrician, explained his practice to me:

Normally if I saw someone who was 29, I would say, "Well, have you thought about the risk of Down syndrome? It is very small." They are not going to get any testing for it, unless there is some particular reason for it. So you are not going to bring it up to a sense of awareness if you can do nothing about it. But now there is maternal serum screening. Yes, they all have to be up with it. Therefore, you have to talk about the fact that this is not like an amnio, which gives you a yes or no answer. This is a risk categorising test. It will say your risk is that, or your risk is this and would you. Before you decide you want that test, you need to think about what you would do if this came back saying that you have a 1 in 50 risk, which is the average for a 37 year old, which is normally a risk high enough for us to offer you an amnio. Because there is a band wagon effect going to happen to maternal serum test, which comes back saying 1 in 50 risk. And yet you are 31, that is the 2 per cent risk, 98 per cent chance that the baby is chromosomally absolutely normal, but you are on a bandwagon. Do you turn up and have an amnio, which turns out to be fine, but you have taken a risk with the amnio? Do you want to be on that bandwagon? It is a real issue for them, of course, and I have to say, because of that bandwagon effect, I try and have mentioned it to 25-year-olds even. I do say, "Think about it, but I wouldn't encourage you to have this test" because of that bandwagon effect. Whereas for a 35 year old, or 34 – 36 year old who thinks, "Well, I am just getting to that time when I need to think about amnio, but I would really like to avoid it if I could." That is where the test is really proved good, because they come back saying, "Gee, 1 in 2,700 risk. That is pretty darn small. I'll accept that because I don't want to take on this 1 in 200 risk of miscarriage. It took me 18 months to get pregnant and I don't want to take that risk if I can get that much reassurance. Somebody is still that 2,700 but they are prepared to take that risk to avoid the risk of the miscarriage from an amnio. So that is where it is good. But because it is a test which is generally available everybody has to be told about it.

Daniel, Obstetrician<sup>16</sup>

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<sup>16</sup> When I interviewed Daniel the maternal serum alpha fetoprotein test was being trialled in New Zealand. This non-invasive blood test gives a woman the statistical estimate of the likelihood that she may be carrying a baby with Down syndrome or neural tube defects. As Daniel points out, the test does not give the woman a definitive result. For the period of the trial, the test was available free to all women. Due to its poor sensitivity and specificity, the government did not continue its subsidy and subsequently the maternal serum test has not been

Daniel's use of the term "bandwagon" is interesting and has a sense of ambiguity. One meaning that he conveys is the popularity of the test. Due to its general availability, he believed that all women would know of the test and would want to have it. In this sense, he constructs women as being subjects of desire as wanting to know the physical and mental status of their unborn baby, and as followers of the latest trends.

A second meaning that Daniel implies (and one that was echoed by all the practitioners) is that prenatal genetic diagnosis has a chain of repercussions for the woman. Should it, in the case of the maternal serum test, come back indicating a high probability of fetal abnormality, the woman needs to decide if she wants then to undergo a diagnostic test, an amniocentesis. The amniocentesis too has consequences which require her consideration: the chance of the procedure itself causing a miscarriage, and the chance that it may diagnose abnormalities. For Daniel, embarking on the test places the woman on this "bandwagon". Once she is on it there is no getting off. However, it is Daniel who constructs the test as a "bandwagon"; as a potentially unstoppable journey that must be pursued to its logical end.

As reflected by Daniel, all the practitioners believe that the woman must contemplate all the implications prior to making that first decision. The practitioners know the ongoing nature of the quest she is considering undertaking. It is their responsibility as expert to alert and guide her and to ensure that at the outset she examines her priorities and knows fully what she is undertaking. She must know whether she wants tentative or definitive knowledge or whether ultimately she wants a "normal" baby.

Not only are the practitioners experts of the ramifications and complications of the prenatal genetic tests, they also know the varying significance of these for women and their relationship to age. It is apparent that Daniel sees the maternal serum test as being problematic for younger women but possibly beneficial for older women. For the younger women it places them on the "bandwagon" and for the older women it may stop them from being subjected to the "bandwagon".

For midwives, the authority to refer women for prenatal genetic diagnosis is comparatively recent. This has been a consequence of both the implementation of midwifery autonomy and the introduction of the LMC scheme. Prior to the re-

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made freely available. Women, however, if they are prepared to pay \$70, may have the blood test if they desire (National Women's Hospital, 2000).

introduction to midwifery autonomy the medical profession had addressed the issue of prenatal genetic diagnosis. For example, Margie explained:

I suppose I welcomed the responsibility because I do like being an autonomous practitioner. I did not used to see women until they were 14 weeks. But now that things have changed I am seeing them [earlier]. Sometimes they ring me pre-conceptually and say, "What will I do?" That has made me gain a lot more knowledge, yes, because it was something that we did not have to deal with. So I have increased my knowledge hugely. I tend to use National Women's handouts and things because they do it very thoroughly. With teaching I tended to learn a bit more too. To start with I didn't have much knowledge. I probably have increased my knowledge a lot. But I wouldn't say that I have it all, at all, and if I need more then I will ring up the clinic and say, "Help me with this". Or I read a book.

Margie, Independent Midwife

The experience of women approaching Margie earlier in their pregnancy has placed an obligation on her to increase her knowledge so that she can respond to their questions. It is interesting to note her use of resources developed by a hospital which has a prenatal genetic diagnosis clinic. As discussed in Chapter Five a recent pamphlet developed by the same hospital perpetuates the medical genetic discourse's theory that the cause of increased chromosomal abnormalities in "older" women is a consequence of aging. In this light, Margie's practice of sourcing knowledge from the hospital may be seen to reflect the hegemonic nature of the medical genetic discourse and to facilitate its perpetuation.

As shown in Daniel's excerpt above, a repertoire of scientific, statistical knowledge is deployed by practitioners whereby the "facts" regarding the statistical probability of having a baby with chromosomal abnormalities are juxtaposed with the probability of having a miscarriage as a consequence of the amniocentesis. In this way women are exposed to the different "facts" which create the contradictions and tensions that surround the discursive practice of prenatal genetic diagnosis and informed choice.

#### **7.4 ENFORCERS OF INFORMED CHOICE**

For the independent midwives, GPs and obstetricians, the act of making the increased possibility of chromosomal abnormalities for older women explicit was standard practice. They perceived that ensuring older women's awareness was the practitioners' responsibility. As exemplified in Jane and Phillip's excerpts above, if the woman does not initiate the topic herself then the practitioners will. In this way the

maternity practitioners will consistently expose older women to the medical genetic discourse. The knowledge that is conveyed to the woman is her “risk” of having an “abnormal” child. The first choice that she is offered is access to the knowledge of whether her child is abnormal or not, and the second choice is whether or not she wishes to continue to bear an abnormal child. The provision of knowledge and the offering of choices to the woman come from within the neo-liberal discourse.

Implicit in the neo-liberal discursive practice of ensuring informed choice is the significance attributed to the act of verbally conveying information. Verbalisation makes visible the process of informed choice, the informing subject (the practitioner) and the informed subject (the woman). As speakers of the medical genetic discourse, the practitioners maintain and perpetuate their position as experts and enforcers of informed choice. The position of older women is similarly maintained as objects and subjects of the medical genetic discourse.

The act of speaking to is assumed to produce consciousness and knowing in the listener by knowledge being conveyed from the speaker to the listener. Should the informing practitioner not speak to the woman, then the practitioner has not provided an opportunity for informed choice. If the woman does not initiate through speech her questions or decision about prenatal genetic diagnosis, the practitioner assumes that she is not aware of the risk of abnormalities and subsequently the practitioner is impelled to speak.

It is important to note that the normal (negative result/baby without abnormalities) is not spoken of in any of the transcripts. It remains the silent, the invisible “other” from which the abnormal derives its meaning. By not speaking of the normal, the abnormal is constructed and thus made visible. The abnormal baby’s existence is made potentially undesirable and optional. To have the knowledge that things are normal is assumed to be an end in itself, a non-choice, and the desirable outcome.

The exercise of informed choice is seen as having the potential to empower women to allow them to make a decision. Women become free to make a decision or as Harding puts it; they become liberated. Harding (citing Haug, 1987) suggests that “an unquestioning acceptance of the categories nominated in medical discourse implies that knowledge is a neutral and transparent instrument, which once possessed will liberate the formerly oppressed. Knowledge appears neutral because it is constructed as external

to power” (pp. 140-141). As Ettore (2000) argues the recognition of causes other than age, such as environment, remains hidden.

In the discursive practice of informed choice, the knowledge brought to the foreground is scientific knowledge, which constructs the human body as a machine and the female body as a fetal container (Ettore, 2000). The older female body is depicted as one that as a consequence of the degenerative process of aging inherently carries a greater number of defective genes. The discourse of disability as a social construction and of causes other than biological aging are silent and thus marginalised.

The process of imparting information to the woman also involves the transference of responsibility from the practitioner to the woman. The woman is responsible for her decision. By this means, the practitioner has performed his or her ethical and contractual duty and is no longer responsible should the woman decide against prenatal genetic diagnosis and then give birth to a child with abnormalities. The woman as an autonomous and rational agent is the one who, on the basis of the information that the practitioner has provided her, makes the decision.

This depiction of subjectivity and the neo-liberal concept of informed choice are derived from the liberal political discourse, a form of humanist discourse (Weedon, 1997). Humanism implies that rationality is a universal feature of human nature. The subject is constructed as constant, sentient, and knowing. O’Malley (1996) states that the person who makes a rational choice views the situation/information in terms of costs and benefits. They assess and compare the potential benefits and the potential costs and make their decision on the basis of their evaluation. The rational decision is one where the benefits outweigh the costs.

In terms of specifically talking about screening, for some women they will self-select if there has been a clear family history that is relevant. In terms of a cut off age, I don’t think that there is one. I think it’s a grey zone, and as we know there is a graduated change of incidence of chromosomal abnormalities than those above. But that overall in pregnant women, ... women who do get pregnant there are going to be **more below 35** who actually have congenital abnormalities than those above. It’s just that the peak incidence is quite different *so that it **must be discussed in this day and age of informed consent with all women***, and hopefully discussed reasonably objectively in terms of the likelihood. The likelihood in New Zealand is that the public system will support amniocentesis or CVS beyond the age of 35, and that’s pretty much an international recognition of when it can be done free within the public system. That’s quite a **good** guideline to help women

make that decision. But I would certainly want to initiate that discussion if they hadn't done so themselves.

Henry, Obstetrician, *italic emphasis added*

Here, the practitioner may be seen to appeal to a woman's desire to be rational and to conform, when he refers to the government's support and international recognition of prenatal genetic diagnosis for women aged 35 and over. He appears to be implying that if the government is willing to pay the costs for such women to have the tests, thereby making the tests free and more accessible to this particular group of women, then there must be some sense or good reason for it. Prenatal genetic diagnosis for older women is in this way made normal (Browner & Press, 1995) and common sense. The inference is that if the government supports particular women having the tests then such women should give them serious consideration.

Emergent from some of the practitioners' transcripts was their belief that the woman was responsible for the decision regarding prenatal genetic diagnosis. For example:

I worry about terminations, it doesn't seem quite right, but it is devastating to have an abnormal child. So I think that the decision is the woman's really. She raises it.

Timothy, Obstetrician

It is an individual experience and it is for individual women to decide. All they need is information. They are perfectly capable of making the decision for themselves. I think that it is extremely arrogant of anybody to lecture somebody into having something that they may not feel is right for them. It assumes you know what their relationship is. It assumes you know what they want out of their lives. It's just an assumption of power. You've got no right to do that.

Jennifer, Independent Midwife

The practitioners aim to give women the space to come to their own decisions. However, there are differences in the way in which they position women. Timothy, for example, deploys a maternal discourse which positions women as the parent most responsible for the child's upbringing. In contrast, Jennifer clearly places women within the feminist discourse deploring the patriarchal practice of denying women their right to autonomy.

However, the practice of informed choice in relation to prenatal genetic diagnosis for older women is ironical. While it is a technique of power in which

women's right to be self-determining is recognized, I would argue that the neo-liberal concept of individual freedom of choice (Potter, 2000) combines with the medical genetic discourse to be a practice that individualizes women.

Foucault (1977) proposes that the consequence of discipline is individualization of the subject. By this I understand Foucault to mean that through the medical genetic discursive practice of prenatal diagnosis each woman 35 or over comes into visibility as an entity, as a woman who is at of risk of having an abnormal baby. Not only that, her decision about whether or not to pursue diagnosis, made on the basis of knowing what her options are and what the implications of her decision are, becomes known and registered in the practitioner's documentation. Thus the conduct of women aged 35 and over is brought into the visibility of the medical gaze and judged.

These have become both visible, the objects of a certain regime of visibility, and cognizable, no longer lost in the fleeting passage of space, time, movement, and voice but identifiable and notable insofar as they conform to or deviate from the network of norms that begins to spread out over the space of personal existence. [...] The person is produced as a knowable individual in a process in which the properties of a disciplinary regime, its norms and values, have merged with and become attributes of persons themselves.

Foucault, 1977, p. 105-106

The neo-liberal process of informed choice makes visible the woman's autonomy as a value and hence her responsibility for the outcome. Rothman (1993) argues that by individualising women, the other members of society are saved from having to collectively provide assistance to the needs of these women, "we make it the woman's own. She 'chooses', and so we owe her nothing. Whatever the cost, she has chosen, and now it is her problem, not ours." (p. 189). Except for Alice and Timothy, who mentioned the need for the partner to be consulted, all the practitioners believed that the decision regarding prenatal genetic diagnosis was one that must be made by the mother.

However, the degree to which the woman makes an autonomous decision based on neutral knowledge is questionable. Canadian researchers, Bouchard and Renaud (1997), propose that the medical profession both provides access to prenatal genetic diagnosis and determines the values pertaining to its use. I have shown above how the woman's age will determine the quantity of information given by the maternity practitioners to the woman. Henry, noted above, drew on the government's policy of

subsidy to legitimate older women having prenatal genetic diagnosis. Daniel stated what he would say to 37-year-old women:

I don't recommend to 37 year olds that they should have an amnio.  
What I say to them is most 37 year olds choose to. I put it as a choice,  
not as a "I think you should".

Daniel, Obstetrician

While Daniel implies that he does not suggest to older women that they should have prenatal genetic diagnosis, I would suggest that his practice of telling a woman that most women of similar age decide to undergo amniocentesis conveys a meaning of normalcy for older women to be subjected to prenatal genetic diagnosis. Intentionally or unintentionally, he is consolidating the medical genetic discourse and undermining the woman's autonomy.

One of the midwives and one of the GPs talked of how they encouraged women to think about the consequences of receiving a positive result:

I also ask them, "Would you do anything about it? You have to think if you do have the testing even if it is Down syndrome if you wouldn't change your mind, if you wouldn't alter the pregnancy, then don't do it".

Jane, GP

Jane's excerpt shows how she uses the same rationale as did some of the women for deciding against prenatal genetic diagnosis. I have suggested in the previous chapter that this is one strategy that may be used to avoid the normalizing surveillance of prenatal genetic diagnosis. However, the practice dismisses the reassurance that some women may gain from having the test or if they should receive a positive result, the possibility that they might view the knowledge as an opportunity to prepare for their baby. By calling on the value that a woman places on human life, such a practice does attempt to influence the woman's decision thereby undermining her autonomy.

The medical genetic discourse, in overlapping with the legal discourse, creates a third subject position that was articulated by the practitioners: the practitioner who is concerned about the possibility of being sued for the wrongful birth of a baby with chromosomal "abnormalities".

## 7.5 THE VULNERABLE PRACTITIONER

Foucault's concept of power as fluid and contestable, that everyone has the potential to possess comes to light in the context of the legal discourse. The potential always exists for the older woman to contest the professional's practice. Four of the practitioners talked of how they felt that their practice of informed choice had the potential to be surveilled by the mother particularly, if she was to give birth to a baby with abnormalities that could have been detected during the antenatal period.

I had a 29 year-old once who had a Down's baby and if that [maternal serum] test had been available then, she would have said to me, "Why didn't you offer me that test?" So you have to offer it to everybody.

Daniel, obstetrician

Daniel believed that he could have been held responsible for the birth of this baby who had Down syndrome. His example reveals how new technologies produce novel "conditions of possibility" (Balsamo, 1996, p. 98). The development of a screening test that is non-invasive and poses little risk to the woman presents the practitioner with a new scenario. The insertion of the legal discourse into the medical genetic discourse produces vulnerability to legal challenge. No longer is the potential for women to legally challenge him for neglecting to inform them of their risks of chromosomal abnormalities and prenatal genetic diagnosis options limited to older women. Now all women no matter what their age can claim the right to be informed of the opportunity to be tested.

Daniel also perceived that the general availability at that time of the non-invasive blood test placed an onus on him to make all pregnant women aware of its existence. The availability of technology, particularly when its access is facilitated by the government's subsidy, has the potential to constrain practitioners. Browner and Press (1995) found that following the State of California's legal mandate that every pregnant woman be offered the alpha fetoprotein maternal serum test by health professionals, that all the providers involved in their study observed the legal mandate.

The independent midwives, Rayna and Margie, and another obstetrician, Henry, echoed Daniel's sense of responsibility for ensuring the birth of a normal baby. I had asked Margie about a statement that she had made earlier:

Int: So there seems to be an issue of accountability with that example.  
[when one of her clients gave birth to a child with Down syndrome]  
Have I documented it, for example?

Margie: Yes, too right. Have I left myself open for criticism? It is that business about the perfect baby and that you, in a sense, are responsible, accountable for helping a woman to get a perfect baby. If you don't explore all that stuff with them in the beginning then you could be seen to be perhaps not doing your job properly.

Margie, Independent Midwife

The way in which Margie is responsible for women having babies without defects is to make certain that women have access to the technology that provides them with the opportunity to know whether they are carrying a baby with abnormalities or not. Thus not only ensuring women's opportunity to have choices but also that they do not have abnormal babies is an expected aspect of standard practice.

Int: Someone once wondered if in the future there may be legal accountability if it is not addressed, if they weren't informed of that?

Yes, that was my first panic reaction, [when a client who was an older mother gave birth to a baby who was diagnosed as having Down syndrome] Had we talked about it? I looked through the notes and I had mentioned it.

Margie, Independent Midwife

Margie exemplifies how some practitioners may fear that their practice of informed choice might come under scrutiny in the future has produced their defensive practice of documentation. Margie's example shows that the woman's earlier decision not to undergo prenatal genetic diagnosis remains captured and visible, something that the woman cannot renege on easily. The written notes became a fixed piece of evidence that vindicated Margie of responsibility for the "wrongful birth" of the "abnormal" child. The woman cannot contest responsibility for what has occurred.

Three of the practitioners mentioned the need to be rigorous in their documentation when addressing the issue of prenatal genetic diagnosis with women aged over 35:

Certainly when women get beyond the age of 35. I think that it's much more, it's **clearly, highly** relevant to be ... **very thorough** in those discussions and to **record** that you have made those discussions and to record whether they have wanted to act on them or not.

Henry, Obstetrician

Positioning themselves as vulnerable subjects produces the midwives and medical practitioners' practice of documenting the decisions made by women with regard to prenatal genetic diagnosis. Their practice also reveals the hierarchical nature

of surveillance. As the woman is placed under normative surveillance so is the obstetrician (Balsamo, 1996) and the independent midwife. Foucault writes:

the examination that places individuals in a field of surveillance also situates them in a network of writing; it engages them in a whole mass of documents that capture and fix them. [...] A 'power of writing' was constituted as an essential part in the mechanisms of discipline.

1977, p. 189

The Maternity section 51 contractual specifications have the potential to place practitioners' practice of informed choice under close examination. In turn, the specifications require the practitioners to monitor the pregnant women and to ensure older women's awareness of the likelihood of abnormalities.

However, it is not just the government agencies that watch the practitioners. It is the women themselves. Charo & Rothenburg (1994) identify the irony for maternity service providers that in exhorting older women to undergo prenatal genetic diagnosis their expectations are increased. The repercussion is that maternity service providers become more enmeshed in having to provide the tests because they are anticipating medical negligence suits. This was illustrated by Rayna, who said:

Basically everything you utter has to be written because that is what is going to happen. There are going to be a lot more court cases probably, different things. So, yes anything you talk about, even polycose tests. You have to write it down; discussed polycose test and date it.

Rayna, Independent Midwife

Arney (1982) writes of how the technology and other strategies that have been developed and employed by obstetricians to monitor childbirth have subsequently been used to control and surveil them. The women are in a more powerful position than the practitioners are. The practitioners' failure to inform women of the prenatal genetic diagnosis options available to them can lead to women seeking litigation under the 1994 Code of Health and Disability Services Consumer Rights. As Balsamo (1996) points out however, although the practitioners may construe themselves as vulnerable to discipline, one must not overlook that their position has been achieved through historical contests. They still retain more of a position of authority than do women.

While the medical genetic discourse was the dominant discourse within the talk of the practitioners, there was one practitioner, who did not position herself within it.

She took a stance which opposed the beliefs of the medical genetic discourse and this stance is discussed in the next section.

## **7.6 THE OPPOSITIONAL DISCOURSE**

When I interviewed Joanne, she had recently retired from midwifery practice. From 1992 she had only cared for multiparous women and from 1993 had acted as second midwife. Her clients had been women who had earlier had her as their homebirth midwife. Much of her practice then had been prior to the introduction of midwifery autonomy and had not been in the new role of Lead Maternity Carer. With the exception of Joanne, all the practitioners positioned themselves within the medical genetic discourse which locates the cause of Down syndrome with biologically induced changes of aging in older women's bodies. In contrast, for Joanne the cause of Down syndrome was older women's increased exposure to environmental pollution. Her oppositional positioning reflected the same beliefs as Rosalie in Chapter Six. Joanne outlined her beliefs and observations as below:

I do think that there are far more genetic 'abnormalities' now than when I first started to do homebirths. I think that you are looking at environmental pollution. You're looking at all your junk food, and you've got that combination. So you are deficient in vitamins and minerals. Then you are going to have far more genetic 'abnormalities'. [...] I see prenatal testing as akin to the nuclear issue, you know, like they never should have embarked on it. And, the other thing is what they need to do is instead of doing all that testing and one thing and another, what they really need to do is to clean up the environment. But instead of that, what they are doing is making it appear that there's something wrong with the woman. There's nothing wrong with the woman. It is wrong with your environment. But the thing is that it's going to cost these multi-nationals so much money to clean up the environment that it is better to put the blame back on these women.

Then the other thing is, another purpose of this genetic screening is that the whole idea of it is that if there is something wrong with the fetus then you're really supposed to terminate it. OK? Well, the thing is, if you don't and you have a baby that is retarded or what have you, then what they're looking at is that if you're going to go ahead and have this baby when you know it's not the full quid, then it should be eventually, ... it'll be your responsibility. Because you had the opportunity to do something about it and you didn't. That's what we are really looking at. And if it's something genetic, the insurance companies now are even looking at it, well, they won't insure it. That's the whole purpose of it. So, when you are talking about your perfect baby, it's not the fact that you may not be able to get pregnant again. It's the fact that you're supposed to have a perfect baby,

whatever it is. Something that's not going to cost the state anything in the long term.

Joanne, Independent Midwife

Joanne challenges the medical genetic discourse in that she argues that there is a link between a woman's dietary intake, her exposure to environmental pollution and the incidence of chromosomal abnormalities. Subsequently, she attributes the chromosomal changes in older women's eggs to exposure to external factors such as these and not to an intrinsic biological aging process. Consequently, the woman's body is the object that is made visible, and is constructed as the cause for such deviations and subsequently subjected to surveillance and normalization.

Joanne deploys a socialist analysis in her identification of the economic interests that benefit from remaining invisible and from the maintenance of women's bodies being viewed as the problem. It is more economically expedient, she argues, for women to be tested than for the companies producing the "junk food" and the pollution to change their production processes.

A second responsibility shift that Joanne identifies is that from the government to the woman. She proposes that in the future it may be possible for the government to refuse any support to the woman who has decided against prenatal genetic diagnosis. Similarly, she sees insurance companies refusing to insure people with disabilities which could have been detected through prenatal genetic diagnosis.

## **7.7 SUMMARY**

Analysis of the maternity practitioners' texts in regards prenatal genetic diagnosis has revealed the deployment of multiple discourses. The neo-liberal discursive practice of informed choice, which, as explained in Chapter Five, has permeated both policies and laws that apply to the maternity practitioners. The discourses of medical genetics, neo-liberalism and law overlap to provide the practitioners with manifold subject positions: the expert informer, the enforcer of informed choice and the vulnerable practitioner. The latter subject position has occurred as an ironic consequence of the other two discursive positions. The neo-liberal and legal discourses together reinforce and perpetuate the hegemony of the medical genetic discourse.

I would suggest however, that the legal discourse complicates the motives of the practitioners. Their interests in ensuring that pregnant women aged 35 and over are

informed of their risks may not purely be to ensure that women can exercise informed choice. Practitioners may also wish to avoid being punished for the wrongful birth of a baby with chromosomal “abnormalities”. They are in the invidious situation of being responsible for ensuring that women are informed

I have also identified a comparatively marginalised discourse that contests the medical genetic discourse’s theory of causation. This discourse proposes factors external to the woman’s body; factors which would involve complex changes that would implicate multiple social bodies.

The decision regarding prenatal genetic diagnosis is one that is dealt with in the first half of pregnancy. Having explored the texts of the practitioners and the women in relation to the practices and the choices concerning prenatal genetic diagnosis, in the following chapter I analyse maternal age in relation to pregnancy and birth.

## Chapter 8: WOMEN AS SUBJECTS OF THE MEDICAL DISCOURSE

There are many factors that can influence the degree of risk when you are pregnant. Your health history, your family's health history, and your partner's health history all determine the risk for you and your pregnancy. Other factors such as age, ethnicity, social or financial disadvantage, and lack of prenatal care can also impact on your pregnancy. You are considered high risk if: you are younger than seventeen or older than thirty-five....

Chism, 1997, p. 3.

### 8.1 INTRODUCTION

Chism (1997) identifies maternal age as a factor that has the potential to complicate pregnancy and threaten the wellbeing of the mother and her baby. In Chapter Four I argued that the identification of a primigravida/primipara aged 35 or over as older and "different" is an outcome of medical knowledge and power and reflects the belief that there is an ideal age at which women should give birth. The scientific medical discourse of maternal age classifies such women as "elderly primigravida/primipara" who require the consultation or care of an obstetrician. Her pregnancy and birth needs to be monitored and controlled to stay within the bounds of normal so that she and her baby are protected from illness and injury.

The purpose of this chapter is to explore how eight of the women deployed the scientific medical discourse. Two identities emerged from the women's texts: the older woman and the woman with an uncertain body. Underpinning the two identities was the construction of birth as an unpredictable event that could become potentially dangerous. This representation of birth combined with the women's identification of themselves as potentially incapable of giving birth without intervention to necessitate and legitimate their need to have specialist obstetric care and to give birth in a level three hospital.<sup>17</sup>

In this chapter, I show how the women were interpellated<sup>18</sup> as subjects of the scientific medical sub-discourses of "maternal age" and "defective bodies", which have been described and analysed in Chapter Four. I then describe and analyse the women's identities and constructions of pregnancy and birth. As a consequence of being identified as vulnerable and potentially incapable of giving birth without intervention

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<sup>17</sup> Arney (1982) lists a level three hospital as having the capacity to provide: care for uncomplicated labour and delivery, all types of complicated obstetrics, and neonatal intensive care.

the obstetric specialist was given special significance by the women. In the final section I relate and analyse how the women represented the specialists.

## 8.2 THE PROCESS OF OBJECTIFICATION AND SUBJECTIFICATION

The degree to which women actually self-identify and position themselves as being at risk is questionable. It became apparent in several women's texts that their positioning within the scientific medical sub-discourses was determined by others. For example, Barbara stated:

I was recommended to go to a specialist by my GP because of the lead up to my getting pregnant. She felt it would be better for him to watch over me, which proved to be the right decision. Also, because I had taken so long to get pregnant, you can't afford to have any mistakes, or if something needs to be monitored, you need to have it looked at immediately.

Barbara, Primipara

Rebecca's gynaecological specialist diagnosed her pregnancy.

My specialist was retiring. It was his suggestion for me to go along to this particular obstetrician ... because I've had so many difficulties throughout my life with periods and stuff like that. He decided that I would be better under a specialist.

Rebecca, Primipara

Barbara and Rebecca's histories of infertility and endometriosis were identified as pathological conditions and as factors that had the potential to impair and complicate their experiences of pregnancy and birth. Consequently Barbara and Rebecca were categorized as requiring the care of a specialist obstetrician. Implicated in Barbara's statement is a potential threat to the wellbeing of her baby whom it has been difficult for her to conceive.

The two women did not resist the suggestion to have an obstetrician as their maternity carer. Rebecca stated that she was unaware of the options available to her. Her words convey a sense of passivity, acquiescing with her gynaecologist's judgement, as she said, "*We just agreed with whatever he decided, because, I mean, you don't*

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<sup>18</sup> The notion of interpellation is adopted by both Parker (1992) and Weedon (1997) from Althusser (1971). Interpellation refers to how a person is hailed as a particular kind of subject by a discourse.

*know.*” He was the expert, he knew best, and she and her husband trusted his knowledge.

Donley (1986) noted that in 1982 infertility was included in the Maternity Services Committee list of risk factors that required a pregnant woman’s referral to an obstetrician. In 1997 the Joint Regional Health Authority Maternity Project, a group which was comprised of midwives, GPs, obstetricians and paediatricians, specified that referral to an obstetrician was required only when reproduction has been assisted. Thus, a shifting of the boundaries has occurred over the fifteen years reflecting the development of reproductive technology and the constructed nature of the degree of risk associated with it. As I ~~will~~ discuss in Chapter Eight, such policies compel GPs to either consult with obstetricians or to refer specific women to be in the care of obstetricians.

For three of the primiparas their age became the reason given by their GPs for having obstetric care. Jo, a primigravida at the age of 39, had gone to her GP to confirm her pregnancy. She found that her GP did not provide maternity care for pregnant women and she said that he “*immediately recommended that I go under a specialist because of my age.*” Jo’s doctor, like Rebecca’s, did not provide her with other available options of maternity care. She was not given any choice and in her lack of knowledge accepted his suggestion. Similarly, Pip recalled being referred immediately to an obstetrician by her GP on her visit. In comparison, she had anticipated being referred as she thought that specialist care was “*normal and that’s what happened anyway.*”

The third primipara, Lara recalled her first visit to her GP.

Being pregnant at the age of 37 didn’t feel really too unusual but when I went in to see the doctor he said, “Oh, quick, we had better get you into the services of a specialist quickly because you are older.” That seemed to be a major panic. I was only six weeks at the time and he made me panic a bit. I thought, gosh do I have something to worry about?

Lara, Primipara.

The GP’s concern catapulted Lara into recognising that according to a particular way of thinking she required specialist care. She was in danger of something going wrong. Interestingly, when she contacted the specialist she noted that he seemed more relaxed than her GP and was not concerned about her having problems through her pregnancy.

Henriksen and Heyman (1997) reported that some of the women who were participants in their study felt that maternity practitioners or peers had imposed the label

“old” on them. Windridge and Berryman (1999) found that the older women in their study were more likely to be classified as having a high risk pregnancy at their booking-in visit than were the group of younger women. However, the women were not told of their classification, instead it was indicated on their hospital charts. Thus, women may not always position themselves as the subjects and objects of the medical scientific discourse.

Six of the women named their GP as the person who made them aware that their age or gynaecological condition was a factor that could complicate their pregnancy and birth and who urged them to have an obstetrician. Davies and Harre (1990) write that the process of positioning often occurs in conversation. During their initial consultation with the GP the women were interpellated as subjects of the scientific medical discourse and its sub-discourses of maternal age and defective bodies. The women in recognising themselves as subjects of the discourses constituted their subject position as women potentially at risk.

The role of GPs in maternity care was lobbied for and secured by the medical profession in the late 1930s with the introduction of the 1938 *Social Security Act*. The Act constituted the welfare state and provided women with free hospital and medical care for the birth of their child. At this time the number of specialist obstetricians was few and the GPs were the main medical practitioners providing medical care. The medicalisation of birth increased as an outcome of the Act (Abel, 1997). Increases in the government’s maternity care payments in the late 1940s extended the feasibility of obstetric care for GPs as well as providing a way of adding to their patient base (Abel, 1997). Oakley (1984), in writing about the provision of antenatal care in Great Britain in the 1960s, states that “nobody could deny (or has been able to since) the GP’s signally important role as women’s first point of contact with the maternity services” (1986, p. 223). That all the women in this study, except one, visited their GP at the beginning of their pregnancy indicates that GPs in New Zealand share a similar importance. The women’s experiences show the importance of the GPs in maintaining the subjection of primigravidas aged 35 or over to the scientific medical sub-discourses.

In an interview Foucault stated:

...I am interested, in fact, in the way in which the subject constitutes himself in an active fashion, by the practices of self, these practices are nevertheless not something that the individual invents by himself. They are the patterns that he finds in his culture and which are

proposed, suggested and imposed on him by his culture, his society and his social group.

1987, p.11.

All the women in this study actively sought the care of maternity practitioners. Oakley's (1979) study found it was common for the women in her study to have their pregnancy confirmed by their doctor. She posited that the practice was a consequence of pregnancy becoming a medical condition. Farquahar (1996) interprets the practice of women seeking confirmation of their pregnancy from another authority as "women's loss of medical credibility about their internal states" (p. 163).

Just as people were accustomed to go to the doctor to have their symptoms diagnosed, so women went to have their symptoms suggesting pregnancy interpreted. Jordan (1997) identifies authoritative knowledge as "the knowledge that participants agree counts in a particular situation, that *they* see as consequential, on the basis of which *they* make decisions and provide justifications for courses of action" (p.58). Jordan describes a particular facet of authoritative knowledge as the active production and reproduction by its participants. Her description is similar to Foucault's recognition that people actively subjugate themselves to discourses. In visiting their GPs and heeding their advice, the women actively maintained the GP's status as a professional who has authoritative knowledge.

The GPs actively inscribed the women as potentially at risk and directed them towards the specialists. For the women, their doctor's status as qualified medical professionals, either as general practitioners in the community, or in Rebecca's circumstance the specialist gynaecologist, authorised their deployment of the scientific medical discourse and validated their assessment of the women as being at risk. Except for two women, Emma and Michelle, the maternity practitioner whom the women were referred to was an obstetric specialist. Beech (1992) identifies an obstetrician as a maternity practitioner who has expertise in dealing with the abnormal.

The quote from Foucault (1987) above also highlights the influence of a woman's social context. Lara remembered that:

Everybody I know personally, like friends, at an older age, all went under specialists because of their age, and supposed complications, potential complications. They went under specialists. And my GP, as I say, he immediately said, "Oh, you must go under a specialist." So, I just presumed that that was a normal thing if you were a bit older, an elderly primip.

For most of the women their colleagues and friends made having obstetric care commonplace. The standard person to go to when one was having a baby was an obstetrician. The four obstetricians interviewed for this study were aware of women's social connections being an important influence in their choice of practitioner. As one obstetrician related to me:

What I call the teacup referral system, and with maternity care in general that is not just specialist care and not just 35 plus, but all maternity care, the teacup referral system is the strongest of all. Not the professional referral system. That is a name I've dreamed up. Over a cup of tea they [women] talk about, "Who provided you with your care? I'm thinking about getting pregnant. Who did you go to? What was your experience like? What do you think of midwives, GPs, specialists?" That is where they form their views as to what kind of care they want: over a cup of tea. It is not derogatory. It is reasonable and real. I know that it is real because a lot of people who come and see me can tell me of six other people who've come to see me. I remember as an example, about four years ago, I saw two or three South Africans, and then all of a sudden every third patient was a South African. At one stage the same thing happened with a group of Jewish women.

Daniel, Obstetrician

He identifies ethnicity as a social grouping that has influenced women's choices, as did a second obstetrician Peter. Timothy and Henry also identified residential locality as a factor of social connection. They had noted that women from specific suburbs made up their private clients.

In visiting doctors, the women constituted themselves as women dependent on the knowledge and expertise of the doctor. The relationship between the woman and her GP was one where the GP felt confident in making recommendations to the woman about an appropriate carer. In the GP – woman relationship, it is the GP who exercises power in suggesting a specialist. The woman, in acquiescing to the GP, positions herself as a subject to power. This is not to say that the relationship between the woman and her GP remains fixed as such, for power is unstable. It can be reversed and altered.

The extent to which the women who participated in my study saw age as a complicating factor itself is questionable. When asked directly if their age was a particular concern or focus, the women replied that it was not, and I found that the topic was quickly dismissed. In Powell's research (1998), where she interviewed nine

“mature age” women both antenatally and postnatally regarding their expectations of motherhood, she identified that following the birth of their child the concerns the women had voiced prenatally about birthing became less significant. It may be that concerns in relation to pregnancy and birth are contextually dependent, reflecting the construct of subjectivity as changing and contradictory. “Some subject positions are more temporary or even fleeting, and thus ‘who we are’ is constantly in flux, always dependent upon the changing flow of positions we negotiate within social interaction” (Burr, 1995, p. 146). The possibility exists however, that for some of the women the issue of age itself was less significant than the issue of birthing per se. Therefore, one cannot assume that all women will see age as a factor that may contribute to problems throughout pregnancy and/or birth.

Having shown how members of the medical profession positioned the women in the medical discourse, I propose now to explore the different ways in which the women constructed their bodies and the process of birth.

### **8.3 THE WOMAN WITH THE AGING BODY**

The issue of maternal age emerged mainly in relation to issues such as choice of caregiver and place of birth. Four women articulated the maternal age sub-discourse during the interview. During the interviews I asked the women if they anticipated any problems occurring during pregnancy due to their age. Barbara replied:

No. Although I knew that any of the health risk problems attached to pregnancy you are more likely to find in older women like blood pressure ...from my point of view, age didn't make any difference. But the GP said to me, “That because of your age, women of your age are more likely to strike problems.” They are more likely to strike all sorts of problems over the age of 35, or at least this is what you read. That's what they say.

Later in the interview she added:

From the outside I probably knew I was a bit different because of what I had read. I knew I was in another group but I wasn't particularly worried about that.

Barbara, Primipara

Barbara makes a distinction between her own view of herself and that of others. She herself did not regard age as an antecedent to problems through pregnancy and birth. However, she was well aware that for her GP and others, such as the literature she refers to, her age was regarded as being a problem. Others fixed her identity as a woman

who was different from other pregnant women. Their voices came together in unison to identify her as potentially problematic. In fact, she and Emma talked of how they and their colleagues had laughed at the medical term “elderly primigravida” which had been used to describe their colleagues who were pregnant for the first time at the age of 35.

Barbara’s acknowledgement of the literature she had read, and her GPs referral, provides examples of the concept of intertextuality. Fairclough (1992) defines intertextuality as “the property texts have of being full of snatches of other texts which may be explicitly demarcated or merged in, and which the text may assimilate, contradict, ironically echo, and so forth” (p. 84). Barbara was made aware by various media of the view that a woman’s age may complicate pregnancy and birth. As both the reader and writer of texts, a person can read and rewrite texts in multiple ways. However, as Fairclough argues, the reader’s social context and relations of power limit the possible readings. In Barbara’s story there was coherence between the literature and her doctor. What she read created a sense of expectancy that she would require specialist care: a prediction that was fulfilled by the doctor.

Some members of Barbara’s family did have problems with high blood pressure. Within the medical discourse, hypertension is a disease associated with aging (Inch, 1989). The arteries gradually become narrowed and are thought to be unable to cope with the increased blood volume and other physiological changes that accompany pregnancy. According to Enkin, Keirse and Chalmers (1989) chronic hypertension, that is hypertension that the woman may have prior to pregnancy and which is not induced by pregnancy, is a major predisposing factor of pre-eclampsia (hypertension, plus protein in the urine and retained fluid) (p. 37). They posit that chronic hypertension in itself does not cause problems for the mother and her baby. The problems that do develop are caused more by the incidence of super-imposed pre-eclampsia. Hypertension that is brought about by pregnancy is more likely to occur in young women who have never given birth before.

If a woman is diagnosed as having high blood pressure, whether it is chronic or pregnancy – induced, because it is a sign of potential risk to the mother and her baby, it is recommended that she and her baby be monitored carefully. Cautious monitoring may bring the woman under the gaze of her maternity practitioner more frequently than a woman without hypertension. More recently in New Zealand, the Joint Regional Health Authority Maternity Project (1997) advises that Lead Maternity Carers (LMC) must recommend to pregnant women who have essential hypertension to consult with a

specialist. This consultation does not necessarily mean that the specialist takes over the care of the woman. Responsibility for future care depends on the woman's wishes and the "clinical situation".

Kitzinger (1991) cautions women reading her book on homebirthing that signs of pre-eclampsia may negate their choice of having a homebirth. Inch (1987), in her guidebook to childbirth for parents, lists hypertension as a risk factor both in Holland and in Great Britain that necessitates a hospital birth. In this way, different voices overwhelmingly coincide in their construction of hypertension as a potentially dangerous event for the woman and her baby. They unite in their recommendations for the woman to seek guidance from medical specialists, to be carefully surveilled and to birth in a hospital.

Lara's age of 37 was not an overt concern for either her specialist or herself until she came to term when her baby was found to be in a breech position. When she was two weeks overdue she recalled that her specialist:

... did another scan to just to see what size the baby was, just to estimate what weight she'd put on. He didn't like the baby getting too big, coming breech with an elderly primigravida who probably doesn't, um, I think your joints are all a bit tighter and you don't dilate or flex as well. I think that you have got to push your own barrow, I think. You probably don't kind of, I suppose it doesn't come out as well. I don't know if I'm imagining that. I suppose your joints are a bit stiffer. I'm not too sure who said that.

Lara, Primipara

In the above excerpt Lara deploys the discourse of aging. She perceives her body as having lacked sufficient flexibility and power to effectively birth her breech baby. Her age was one of the factors taken into consideration by her specialist in determining her need for intervention. When she was two weeks overdue the specialist decided that Lara should be induced because of her age. Lara was eager to try to birth her baby vaginally. She laboured for several hours until her specialist decided that her baby be born by caesarian section.

In the excerpt Lara conveys ambivalence about the beliefs regarding the older woman's body. She does not use the possessive pronoun "my" in speaking about her body to indicate a sense of ownership or identification with the body type described in the discursive concept of maternal age. Her phrases "*I suppose*" and "*I don't know who said that*", reflect that her knowledge of the older woman's body appears distanced. In

contrast, her age is one of the factors taken into consideration by her obstetrician in determining her need for intervention. His understanding of maternal age is conveyed as a certainty. When she was two weeks overdue Lara's specialist decided that she be induced because of her age.

Jo also utilizes the discourse of aging in identifying herself as being more at risk.

Jo: The risks of various complications are higher with age.

Int: Could you talk to me about those. What risks were you aware of?

Jo: I guess mainly caesarians, which are the result of any number of causes. But just generally, my understanding rather than knowledge, that there's your body. It's a bit less youthful and a bit less ready to just jump in and do the right thing.

Jo. Primipara.

Jo implies that birth is an innate, instinctive biological process. The body knows what to do and how to do it. Age however, erodes this instinctive ability. There is less vigour, and automatic initiation of birthing processes. Consequently, the older woman's body needs outside intervention in order to achieve birth. Her body needs to be stimulated and guided. Implicit in Jo's statement, in her use of the comparative "higher", is the belief that birth in itself is complicated no matter what age a woman is.

In conclusion, these women position themselves in the maternal age sub-discourse. They construct aging as an inevitable physiological process of deterioration that reduces their capacity to effectively bear children. Age is the cause of their bodies being the site of potential morbidity and mortality which may affect their wellbeing or that of their babies. The likelihood that they might have required intervention was a consideration. The women either positioned themselves and or were positioned by others as being persons at risk, as being in danger of encountering disease through pregnancy or requiring intervention during birth.

Within some of the women's texts was another kind of body inscribed as unable to journey independently through pregnancy and birth: the uncertain body. Some of the women as well as identifying themselves as aging women identified themselves as having an uncertain body.

#### 8.4 THE WOMAN WITH THE UNCERTAIN BODY

The common practice amongst the women was to visit a medical practitioner once they became aware of physiological changes indicative of pregnancy. However, two women, Rebecca and Michelle, did not know that they might be pregnant and had gone to their medical practitioners for other reasons. For example, Rebecca, had been diagnosed as having endometriosis some years ago. She had been told at the time that she would be unable to have children.

I was 36 when I found out I was pregnant. I got a huge surprise because I didn't think that I could. I went along to my gynaecologist and I said to him, "I think I'm pregnant." He said, "You can't be." I thought, "OK." He did the test and yes, I was pregnant. It's quite a shock when you don't think that you can.

Rebecca, Primipara

The second woman, Michelle, talked of having had endometritis and had assumed as a consequence, that it would be difficult for her to become pregnant. A third woman, Barbara, had experienced difficulties in becoming pregnant over a period of eight years and had been attending a fertility clinic. She and her husband had almost given up the thought of having a child and were contemplating going overseas when she became pregnant. For these three women becoming pregnant had not been an anticipated and planned event. The three were caught unawares amidst their plans for bringing up their partner's children, a new career direction, or plans for travel. Their experiences of endometriosis and infertility had created an uncertainty in their own ability to become pregnant. Yet, paradoxically, conception occurred naturally without their knowing or contrivance. In effect, these three women ~~were~~ either positioned themselves or were positioned by their practitioners in the defective body sub-discourse. As I have explained in Chapter Four, the problems that some "elderly" primigravida/primipara encounter during pregnancy and birth are attributed to the "abnormal" structure and functioning of their reproductive system.

A person's discursive positioning is influenced by her or his histories, desires (Holloway, 1984), memories and sense of identity (Weedon, 1997, p.106). From this perspective, it may be seen that for Rebecca, Michelle and Barbara, with regards to reproduction, their bodies had shown themselves to be unpredictable and problematic in their ability to perform. Their construction of the body as one of uncertainty is compounded by the constitution of birth as being a potentially risky event.

## 8.5 BIRTH AS POTENTIALLY DANGEROUS

For all of the women, both primiparas and multiparas, who positioned themselves in the scientific medical discourse, birth was seen as an event of potential danger to themselves and their baby. For Tui this threat was very real. In the late 1960s, Tui had become pregnant with her fourth child at the age of 40. Her first pregnancy had been affected by toxæmia and had resulted in her being hospitalised at 33 weeks and induced at 37 weeks.

She [the baby] was very tired and I had trouble. I couldn't pass water. I had a temperature and I had to have penicillin injections, and one thing and another. In fact, I think that in the really old days I might have died giving birth, and certainly the baby might have.

Tui, Multipara

The birth of her second child had not required intervention but for the third when proteinuria developed, her doctor had admitted her to the city's main obstetric hospital two days prior to the birth.

They could see how wide the cervix had dilated, so they decided to bring him on. Then they gave me another pitocin drip. So I decided that for this fourth one I was jolly well going to have a specialist right from the beginning, seeing that I had so much trouble.

Int: What did a specialist have that a GP didn't?

Tui: Well, of course he specialised in births and in cases of toxæmia and high blood pressure. I thought that if I'd had problems with the other three, and now I was older, I wasn't fooling around with private practitioners anymore. I would have the best right from the start.

Tui, Multipara

Tui went to a specialist who delivered at the city's level three obstetric hospital. Her history of toxæmia had given her actual experiences of birth being a threat to her and her baby's wellbeing. She had also heard stories of two women who had died during childbirth. Pregnancy and birth for her were actual events of ill health and potential death. Reid (1997), in her study of sixteen women who had experienced maternal critical illness, found that her participants voiced uncertainty regarding subsequent pregnancies. The possibility that they might suffer ill health during pregnancy or birth remained with them until they had given birth. This view Reid identified as being one that corresponded to the medical perspective that childbearing is only safe and normal in retrospect. In showing a commitment to the pregnancy, and an

attempt to minimize risks and maintain control, she noted that women fostered "...a working, trusting relationship with the medical personnel" (p. 93). Tui's strategy was to access the kind of practitioner whom she classified as "the best", which was specialist obstetric and hospital care. Her strategy reflects her attempts to reduce risk to herself and her baby.

Pregnancy and birth especially were thus constructed as events that could threaten the life and/or health of the mother and her baby. Compounding this was the belief that the course of pregnancy and birth could not be foretold. The outcome of birth especially could not be guaranteed to be normal.

## **8.6 BIRTH AS AN UNPREDICTABLE EVENT**

The belief that birth is dangerous is sustained by the belief that birth is unpredictable. "Adverse events are not only regarded as inevitable, but their timing is seen to be capricious and unpredictable" (Lane, 1995, p. 60). The not knowing whether one will require intervention created a sense of uncertainty for some of the women and influenced their choice of maternity carer and place of birth.

I certainly believe it's [birth] a mind over matter thing and I don't believe it matters whether you are young or old. It's an attitude thing how you cope with that. The only unfortunate part is medically that you don't know which way you will go. That is why it is important to have a good doctor whom you feel confident in. I can't thank my doctor enough for her expertise.

Michelle, Primipara

Firstly, Michelle dismisses age as a factor that influences birth. A woman's use of interventions, such as analgesia, is attributable to her being unable to cope with labour. Inferred in her statement is the assumption that if a woman utilises appropriate coping skills, she will endure the discomfort and work of birth. Therefore, one may predict that a woman will have a positive outcome if she can deal with labour. However, in the statement that follows Michelle contradicts herself. She regards birth as unpredictable because of the possible development of pathological conditions. From the medical perspective, at the onset of labour one does not know what the outcome will be. Medical intervention may be required, and it may not, only time will tell. The course of birth is beyond the woman's control and as such necessitates the presence of a medical practitioner.

Katz-Rothman (1991) argues that problems encountered through pregnancy and birth are viewed from the medical perspective as technical problems and as such require technical solutions. She terms this the “ideology of technology” which is derived from Descartes’ mind-body dualism and belongs to the “...technological society, with its values of efficiency and rationality, practical organization, systematizing, and controlling” (p. 34). Michelle implicitly dichotomizes the woman’s mind and body. The body will follow its own course of action. The woman has to contend with the sensations and effort that her labouring body confronts her with.

Barbara echoes Michelle’s belief that birth is unpredictable. She likens the event of birth to a horse race:

It’s horses for courses really. But I think that with a baby you really don’t know what road it is going to take and I set myself on a course to go with a person I perceived to be an expert.

Barbara, Primipara

Barbara parallels her choice of a maternity carer to that of a horse owner deciding what race suits her horse’s capabilities. I read Barbara’s labour and the birth of her child as the race-course and the maternity carer as the horse. As she was uncertain of the direction that her birth would take, Barbara chose an obstetrician in the event that problems occurred. To continue the horseracing analogy Barbara decided to make a “safe bet” and chose to have an obstetrician, whom she identifies as the expert.

## **8.7 THE SPECIALISTS AS EXPERTS**

For the women who located themselves within the at risk discourse, who considered that childbirth was unpredictable and potentially dangerous, their journey through pregnancy and birth was one of uncertainty. The way in which they gained confidence was through having the care of a specialist. Michelle used the term “specialist” to refer to her GP who had a post-graduate diploma ~~in~~ obstetrics and gynaecology. These GPs are able to practice techniques that are not within the midwives’ scope of practice, such as forceps deliveries. For the other women who deployed the at risk discourse, a specialist meant an obstetrician who was a member of a College of Obstetricians.

The specialists and their associations with hospitals and technology provided an important source of confidence for the women. As discussed above, Barbara had taken some time to become pregnant and she and her specialist thought that this was likely to

be the only chance that she might have to have a baby. The specialist had said to her that they needed to “go very carefully”. The care of a specialist offered Barbara the opportunity to be watched in a way that would recognise and quickly deal with any early sign of problems.

Because I had taken so long to get pregnant, you can't afford to have any mistakes or if something needs to be monitored you need to have it looked at immediately.

Barbara, Primipara

The role of the specialist was to monitor and to read her body. Being under the care of a private obstetrician gave Barbara direct access to her specialist. She did not need to worry about referral to a specialist via a GP or through the public hospital system. Also, being under the care of the specialist reduced the possibility of mistakes occurring. An expert has the knowledge and experience to make an accurate diagnosis. The promise of continuity of care also appealed to her in that no matter what time she needed him, he would be there for her. Overall, the specialist gave her confidence.

Lara also found the issue of avoiding mistakes an important aspect of having a private specialist. As a nurse, she had heard about babies who had sustained shoulder injuries as a consequence of forceps deliveries. Expertise offered her the promise of:

Getting a healthy baby out and without being damaged. You just want the baby to be delivered expertly and well [...] I think that being a nurse, I do like to think that I've got somebody around who knows what they are doing. I like to have a bit of faith in the person.

Lara, Primipara

Lara refers to the practice in public hospitals, which are also training hospitals for doctors, where doctors not yet qualified as obstetricians may care for women. It is important to her that the medical practitioner is trustworthy. However, she assumes that experts never make mistakes and that nothing is outside their control. This could place a heavy mantle of responsibility on the shoulders of an obstetrician and an unrealistic belief in their infallibility.

As Pip discovered, things do go wrong under specialist care. She recounted to me her experience of an epidural that had begun to affect her breathing:

I remember saying to my husband, “I can't move my arms. I can hardly breathe,” because it had affected the diaphragm or something. Because I had to think, “I have to breathe.”

Int: Good grief. That would have been frightening.

Pip: That was frightening. It was. And I thought, “Oh gosh, I’ve got to have energy to push this baby out, and this has happened. So, it was actually very frightening. I think other people must have got frightened because I was not given any more anaesthetic or any help at all to deliver that child. I couldn’t move my arms. I couldn’t move my legs by the time this thing had worn off. I had no further pain relief at all, and I was screaming, just like in the movies.

Pip, Primipara

The expert in Pip’s account was an anaesthetist rather than an obstetrician. It is likely that rather than the drugs going into the epidural space they went into the subarachnoid space (Inch, 1989). Pip’s story does highlight that expertise and the application of technology are not without problems. The cascade of intervention shows that the use of one technical strategy in labour may necessitate a whole series of others. Inch stresses that all aspects of intervention carry a potential risk to the mother and/or her baby. At various times in the twentieth century technologies have been introduced and have subsequently been found to be harmful to women and/or their babies (Olssen & Papps, 1997). Beech (1992) comments on the lack of questioning with regard to the use and incorrect use of obstetric technology by the media. She argues that such silence maintains the status quo whereby the public remains uninformed about the validity of such technology. Such silence maintains the legitimacy of the use and safety of obstetric intervention.

Rudge (1999, p. 168) employs the term “the allure of technology” when talking about the appeal of technology. Access to birthing technology offers the women the promise of being saved. For example, I had asked Pip how she felt about her age in relation to her ability to bear and birth a child. She replied:

It never worried me because I felt that in this country there was the expertise to help me if I became unwell or had any problems. There was the expertise in New Zealand to cope in dealing with anything that may have happened to me or to the infant.

...I felt that the hospital could deal with me and that if anything went wrong that all the equipment, the expertise and anything else was already on hand.

Pip, Primipara

Pip’s confidence was derived from the accessibility and range of expertise and technology. The assumed promise of rescue allowed Pip to embark on her hazardous

journey of pregnancy and birth. Abel (1997) suggests that the term “safety” has been employed as a discursive strategy by the medical profession to question midwifery autonomy. Similarly, for the women who were either passively positioned as subjects of the scientific medical discourse, or who actively positioned themselves as subjects, the promise of safety that obstetrical expertise and technology offered can be seen as a strategy to ensure the maintenance of obstetric practice.

It's the land of the unknown. You are guided by somebody who knows all about these things and knows supposedly what is best for you. This is my assumption. You know, he is sitting behind his desk saying, “I have booked you and da da da.” And you think, well OK then. That's fine.

Rebecca, Primipara

Rebecca likens first-time pregnancy and birth to travelling to new territory. She relies on the obstetrician as one who is familiar with the terrain. Rebecca positions herself as dependent on the knowledge of the specialist passively allowing him to make all the decisions for her. Michelle talked of having confidence in her caregiver. She said that “It's a bit of conditioning too. You still think that the doctor knows best”. Deferring to the authoritative knowledge of their practitioners is the expected behaviour of women.

Obstetric expertise and technology also appeal to women's rational and moral senses as was revealed when some of the women talked of why they did not choose to have their babies at home.

To me having a home birth was not the most important thing. The baby and the health and all that, that was more important than anything. OK, the ideal would be nice music, soft lights, candles and homebirth and everybody around and all that. Great. But to me I don't feel as if I have missed out. It's just not really an issue.... Maybe if I'd been ten or fifteen years younger I would have seriously looked at it. Particularly considering my mother's experience which was good....The most important thing is that the baby is healthy and I'm healthy as well, and able to take care of the baby. It's a minor thing really. [...] I just think because of my age it was probably seen as a sensible thing just because there are the risks of various complications that are higher with age.

Jo, Primipara

I have always felt more confident in being in a hospital where everything is at hand. If there's anything wrong with the baby, they have got the suction, oxygen, all the different trimmings and all the

specialists on hand. ... I wouldn't even have had the baby at Howick because if there are any complications then they put them into the main hospital. ...So I always thought for the baby's sake, if for nothing else I would always go to a big hospital"

Lara, Primipara

In an attempt to explain why, when surrounded by multiple discourses that give different meanings to objects and events such as birth, a person chose one discursive position over another, Holloway (1984) used the term "investment". By this she means that people derive "...satisfaction or pay-off or reward"(p. 238) from particular subject positions.

Holloway was looking to avoid the problems associated with the explanations of rationality and motivation. Post-structuralism, in arguing the influence of language on constructing subjectivity, problematizes the notion of a rational, coherent subject. Secondly, Holloway also believed that choice was a more complicated process than that conveyed by rationality. The concept of motivation as a determining factor was also viewed by Holloway as problematic because it signified the existence of biological drives such as instincts. In attributing causation to instincts, the mind-body dichotomy is perpetuated. While recognising that the term investment is itself not without problems, Holloway believes that it allows for consideration of the person's reason for situating herself in the scientific medical discourse.

These women had both an emotional and moral investment in their choosing of an obstetrician and a hospital birth. Their investment as subjects of the scientific medical discourse was the promised outcome of the wellbeing of their babies. Direct access to obstetric expertise and hospital technology assured the women of constant monitoring, early detection and treatment of any maternal, fetal or neonatal problems.

Morals, however, are also problematic as they are socially constructed. In the *History of Sexuality* (1978), Foucault argues that sexuality is a cultural construct and not an innate desire (McNay, 1992). Through the process Foucault termed "hysterization of women's bodies", knowledge and power strategies since the nineteenth century have focussed on women as a means of regulating society and ensuring the continuance of a population. Foucault writes of hysterization being a three stage process with the third stage occurring when the female body:

was placed in organic communication with the social body (whose regulated fecundity it was supposed to ensure, [...]) and the life of children (which it produced and had to guarantee, by virtue of a

biologico-moral responsibility lasting through the entire period of the children's education): the Mother, with her negative image of "nervous woman" constituted the most visible form of this hysterization.

Foucault, 1978, p.104

From this perspective, it can be seen that older women, in both being positioned by others, and in positioning themselves in the scientific medical discourse which constructs them as "at risk elderly" primigravida, have a moral pressure exerted on them to ensure that they take steps necessary to ensure the wellbeing of themselves and their babies. This is an aspect of biopower whereby women are seen as members of the population and their fecundity is a concern for national power and policy (Gordon, 1991).

## **8.8 SUMMARY**

Made visible in this analysis is the influence of women's GPs in subjugating older women to the medical discourse. Maternal age, infertility and endometriosis have become inscriptions; messages that can be read as indicating potential problems and that assign the women to the realm of the abnormal, potentially at risk, and consequently women who require special care. Grosz (1994) argues that the process of body inscription needs to be understood as "... literal and constitutive" (p.137). It is medical knowledge and language that has inscribed the women's bodies, and the medical profession who has the authority to "see" the potential for pathology and to inscribe the women's pregnant bodies as such.

I have shown that the majority of the women in this study did not oppose being positioned in the scientific medical sub-discourses of maternal age and defective bodies. The women accepted the authoritative knowledge of the GPs and obstetricians and the subsequent assessment of their age as a factor that might complicate their pregnancy and birth. I have suggested that the women's social context is influential in their active self-subjugation to the scientific medical sub-discourses.

The overarching construction of the sub-discourses was that women, especially older women, are not capable of giving birth without intervention. In perceiving themselves as potentially incapable, the care of specialists provided an important safeguard. They offered the women protection against the threat of their or their baby's health and life being compromised. The hospital and its technology offer the promise of safety to women and their babies. Such promises are especially significant for "older"

women who are identified as more likely to encounter problems during pregnancy and birth. I suggest however, that such representations of birth and “older” women’s bodies and the promise of safety make certain that obstetric practice is maintained.

Furthermore, the Foucauldian concept of biopower highlights the importance placed on women’s fecundity and the knowledge and power techniques developed to ensure the perpetuation of a population. Hence, women have a socially constructed moral pressure placed on them to make decisions that will safeguard both their own wellbeing and that of their babies. For women who are categorised as “at risk”, such as “elderly” primigravida/primipara, the hospital is the place of birth that such women should choose.

In the next chapter I examine the texts of the practitioners who deployed the scientific medical discourse, primarily its sub-discourse of maternal age. I explore the different subject positions and discursive practices deployed by the medical practitioners and hospital midwives.

## **Chapter 9: AGE, BIRTH, AND BOUNDARIES**

But there are potential risks, of that there is no doubt. There is no need to list them but in general let me point out that a first pregnancy and labour are truly untried events – there is no previous experience to base them on. It seems to me only common sense, therefore, to have your baby safely, in surroundings where help is immediately at hand, where baby can be monitored continuously and all the back-up facilities of specialist support for both you and your baby are available.

Anderson, 1984, p.82.

### **9.1 INTRODUCTION**

Discourses engage people as different types of subjects. In the previous chapter I have shown that the women who located themselves in the scientific medical discourse portrayed themselves as potentially unable to give birth without intervention. The way the women represented the obstetric specialist was directly in relation to how they assessed their birthing capabilities and the process of birth. Consequently the women represented the specialist as the expert who had the knowledge and skills necessary to identify and avert danger.

In this chapter, I explore and analyse how the obstetricians depicted themselves and “older” women. Burr (1995) identifies two choices that a person has when addressed by a discourse (because when one is addressed by a discourse the subjectivities of self and others are unavoidable): one can accept or resist. I show that through the discursive strategy of referral the midwives and GPs were made subjects of the medical discourse, bound to refer first time pregnant women aged 37 or over to obstetricians for consultation.

I firstly explore the various subject positions that the obstetricians constructed for women aged 35 or over and for themselves. Then I explore the connections between the women’s subject and power positions with intervention. The third section of the chapter identifies and explores the power relations between the obstetricians, GPs and midwives.

### **9.2 SUBJECT POSITIONS**

#### **9.2.1 The “older” woman as potentially pathological**

Three of the four obstetricians constructed “older” women as having the potential to encounter problems, mainly during labour. The effects of aging on a

woman's body and reproductive system were attributed to be the cause of problems, primarily during labour. For example, Timothy's reply to my question of how he saw "older" primiparas physically was:

Well, in my experience the pregnancy itself, antenatally, there are usually very few problems unless they have underlying problems, which of course do occur with increasing age. There are far more miscarriages, for example. There are more babies who are abnormal. So it is a question of testing for that if a woman chooses. Twins are more common. Some people's blood pressure has gone up by that time, or diabetes, or something else. But all that apart, most women whom I've seen over 35 as primips have actually sailed through the pregnancy very well and the problems have arisen in labour.

Very simplistically, not being at all intellectual or academic, I think that it is this. For the first time the muscle [the uterus] has to work. The first time to try to run 100 metres, you don't do it very well, and if you are 40 by the time you are running rather than 14, it just won't work very well. That is how it appears. The uterine muscle is not as efficient at 35 as it would be at 25. So, it gets into a spiral sometimes where the process of labour is slower. The contractions are less efficient. The soft tissues may be not as supple. The babies tend to turn to a posterior position. The labour gets longer and more drawn out, so you are then faced with intervening. That can mean drips and syntocinon for augmentation. Once they get to the second stage, they are usually pretty tired, and again the uterus doesn't necessarily work as well. Contractions aren't as expulsive as they are at a younger age, and so you are more likely to use forceps, episiotomy and epidural, or maybe a caesar.

So it is kind of a spiral unfortunately, that in most instances goes back to the way the muscle contracts so that it becomes ineffective uterine action. There is only so much you can do about that. It is a muscle that you can't train or tone up. You can look after yourself, take something if you wish. You can go to yoga classes and you can think positively. But uterine muscle is a wonderful thing which is involuntary. Unfortunately or maybe fortunately.

Timothy, Obstetrician.

Timothy's main focus is the ineffective action of the uterus that is brought about by aging. Rather than providing me with an in-depth physiological explanation of the cellular changes of the uterine muscle, he uses the metaphor of athletic competition to compare the effectiveness of an "older" woman's uterus with that of a younger woman. I had read about the same metaphor of athleticism in the medical literature. The uterus is constructed as a muscular organ which is beyond women's control. Its function is seen as instinctual and biological, as are the effects of aging. He

argues that nothing can be done to enhance the uterus' effectiveness consequently, "older" women's labours are often doomed to fail. It is inevitable that "older" women succumb to intervention.

Another obstetrician, Daniel, echoed the same medical conditions and cascade of intervention as had Timothy, particularly for "older" women who had gestational diabetes:

If you have, for example, gestation diabetes, you are more likely to have a big baby that won't fit through your pelvis, despite good control and good care. It is still twice as likely that the baby will be over 9lb, that the baby is more likely to develop stress in labour because your chance of induction is much higher. The chance therefore of an inefficient labour, and a prolonged labour, and a caesar are much greater and so on. So, undoubtedly those medical things influence intervention rates. I think they are the ones which are statistically more provable to be associated with age.

Daniel, Obstetrician

For three obstetricians, the woman aged 35 and over is the site of pathology that is an automatic consequence of her age. In his book *Human Ageing* (1988), Bromley discusses how aging is thought of as a process of deterioration and lists the following terms that are used in relation to aging:

To grow old, to develop the characteristics of old age; to retreat from a more developed, complex, or more fully grown state; to degenerate, to regress, to diminish, to become depleted, to fall into disuse; to withdraw; to become closed in, constricted, to wither, to languish, to lose vitality, to shrivel; to become degraded, to decay.

Bromley, 1988, p. 16

The way of thinking about the medical conditions of diabetes, hypertension and ineffective uterine action is derived from the general discourse of aging articulated by Bromley (1988). The scientific medical discourse identifies aging as a pathological process. The function of the pancreas becomes diminished causing diabetes. Hypertension is brought about by constriction of the arteries, and the uterus, as described by Timothy, loses vitality. Thus the "older" woman is rendered as pathological needs to be normalised through surveillance and intervention (Murphy Lawless, 1998).

Some practitioners however contest the criterion of 35 years, for example, Phillip:

It [maternal age] is a very arbitrary thing. I guess, in my mind, there is a cut off in terms of practical terms that 35 arbitrarily determines the age at which an amnio is offered at the level three public hospital. So, I feel that that is the only thing that really determines a different kind of strategy for looking after women. [...] I would say that 30% to 40% of first time mums are actually over 35. They are a sizeable proportion of my practice. The age in itself means nothing anymore. I guess, women in their mid-40s may present different risks. But women in their late 30s don't seem to have medical risks disproportionately higher than women in their 20s now, I think. So maybe the state of health of these women has changed.

Phillip, Obstetrician

Thirty-five years is no longer significant to Phillip as an indicator of risk. As these women comprise more than a third of his clients, they have become the norm for him. They are no longer a numerical minority, which would make them different from the women he would usually care for. Nonetheless, maternal age does represent risk to Phillip when women are “older” than 35, when they are aged over 40 years. Implicit in the second to last sentence of Phillip’s statement is the notion that risk is always present regardless of age; younger women are also potentially at risk.

### **9.2.2 All first-time labouring women are potentially problematic**

In his consideration of whether or not 35-year-old women are more at risk, I read Phillip as drawing on the incidence of medical conditions. Implicit then is the association between increasing age and an increasingly diseased body. While he contests the actual age, he does not question the belief that aging is associated with disease.

What is more indicative of risk for Phillip is women being pregnant and giving birth for the first time.

There is the propensity to develop pre-eclampsia, which is very rare in a multip. The process of labour will be very different; the need for extra pain relief; the need for intervention is greater. So, it is a whole different ball game.

Phillip, Obstetrician

Any woman making her first journey through pregnancy and birth is likely to be problematic. As this is the first time that she has experienced labour, the woman, no matter what her age is likely to be thought of as having a lesser ability to cope, to endure the pains of labour and to birth the baby herself.

In comparing first time birthing women with women who have birthed before, Daniel, an obstetrician said:

There is also an awful lot of unknown about things. I can't say, "You have these risk factors, therefore this is going to happen to you. That isn't going to happen to you because you don't have that risk." It is all wishy-washy stuff. "You have some risk factors therefore there are some increased chances of this, that and the other thing, but probably none of those will manifest." It is all so imprecise and it's a let's wait and see. Looking at caesarian sections as an example. Most C sections are not predictable antenatally.

Daniel, Obstetrician

The unpredictability of childbirth is contingent on its depiction as a disease-inducing event. As Hewison (1993) suggests, the scientific medical discourse constructs birth as dangerous. A birth can only be defined as having been normal after the event. Thus, all births are treated as potentially problematic. Birth is considered harmful because it is viewed as a stress exerted on the body and therefore it is like a disease (Rothman, 1991). Consequently, medical care is a necessity in order to contend with the processes of childbirth (Treichler, 1990).

In speaking of the problems associated with maternal age, and birth, the obstetricians identified themselves as clinicians who have the knowledge and ability to envisage the interior of the "older" woman's body and to locate the potential site of disease. In constructing the "older" primipara this way, especially in her need for intervention, the obstetricians are securing a place for themselves in the domain of abnormal pregnancy and birth.

### 9.2.3 The obstetricians as agents of normalisation

The obstetricians' role is to surveil and normalize. Peter, when I asked him if his antenatal care of "older" women was different from that of younger women replied:

No, I don't think there is anything specific in terms of frequency, but certainly in terms of screening tests, absolutely. Again the physical screening tests that we usually do, as you know: the pulse, the blood pressure, the abdominal examination, the vaginal examination. The standard ones, I do them on everyone. But it's just in the women over 35 that ... while they do have the higher incidence of diabetes and hypertension, of just a **whole range** of conditions that one must look for. So, I think that one just **has** to be more vigilant and then, when one comes across these conditions to act upon them appropriately. [...] it is really a matter of close monitoring and follow-up, so that higher incidence of intra-uterine growth retardation et cetera relates to

the higher incidence of hypertensive disease et cetera, so they would have more scans et cetera.

Peter, Obstetrician

Foucault (1979) identifies the examination as a disciplining technique that combines observation and normalizing judgement. In examining the pregnant woman's body by the various means described above, any maternity practitioner is observing the woman, comparing her with a standard that is based on medical knowledge. The woman is differentiated and categorised, judged normal or abnormal. In the exercise of the examination the woman is both the object and the subject of the practitioner's gaze. The woman is subjected to the power that the professional has as a holder of authoritative knowledge. She becomes the object under examination, an object of knowledge.

The practitioner, in this case the obstetrician, through the use of physical examination and diagnostic tests has the ability to "see" within the woman what is not immediately visible and to take corrective measures. The woman's condition is made normal. As Foucault argues, the process of examination and correction is not directed at "... expiation, nor even precisely at repression" (1979, p. 182). Rather it aims to follow the principle of a rule which is "... made to function as a minimal threshold, as an average to be respected or as an optimum towards which one must move" (Foucault, 1979, p.183). I suggest that the principle in this situation is the birth of a healthy, normal baby to a mother who is capable of caring for the baby.

The obstetricians spoke of their practice of watching the "older" primigravida more closely than they might a younger woman looking for signs of disease to manifest itself in the woman or in her baby. Should they detect them, then they are the practitioners who determines what course of action needs to be taken to normalise either the woman's or her baby's condition. The woman's age was not the only factor that brought about difference in practice. Some of the obstetricians spoke of how they had a different relationship with women who were private "patients".

### **9.3 THE RELATIONSHIP WITH PRIVATE CLIENTS**

During the interviews with the obstetricians I asked them about their relationship with their private clients. All four identified their relationship with women who accessed their care privately as different to that with women for whom they provided maternity care through the public health system. Firstly, the obstetricians identified the "older" women as having certain characteristics:

It is the continuity you get with the one-to-one, and if you've got an older woman as it were, they usually have read up about it. They are aware of the various risks and what the opportunities are, and to some extent, their rights. Unfortunately some of the women from lower socioeconomic areas have no idea that they have rights, that they can question us and say, "No, I don't like that." Or, "What the heck are you doing to me?" Whereas a lawyer from a high socioeconomic area is quite likely to say, "Why do you want to do that? I'm not going to agree with that. I want another opinion." She is far more likely to know the system, speak up and challenge you. That has been a feature of my practice that I have enjoyed.

Timothy, obstetrician.

The "older" woman accessing obstetricians privately is seen to be quite knowledgeable and assertive. Rather than always being in a position whereby she is passively dependent on the obstetrician's expertise, the woman is informed about aspects of pregnancy and birth and has certain expectations of what might be involved. Farquhar (1996) suggests that when similarities of education, race, class and cultural characteristics exist between doctors and women, the doctors are more likely to value the women's information. I propose that "older" primigravida may share several of these attributes and consequently obstetricians consider their requests more seriously than they might other women's.

Furthermore, the woman wants control over what happens to her. Peter spoke of the private relationship in the following way:

In terms of private/public, the relationship is **quite** different because there isn't the continuity of care in the public system. There are layers of people looking after the public patient. Whereas in private, it's very much a contract of ... that patient expecting **you** to look after her, or, if not you, an individual. [...] There may be a degree of self-selection that some of these women ... **perceive** that going privately they will be able to ... have a greater chance of influencing their caregiver according to their wishes.

Peter, Obstetrician

The private system offers women the certainty that they will have the same obstetrician caring for them during their pregnancy and birth. The public maternity care system does not offer the same guarantee of continuity of specialist care. Peter identifies that some women who want continuity of care also want to exercise power over what care they receive. Lazarus (1997) found in her study, which compared what poor and middle-class women wanted in their pregnancy and childbirth, that middle class women

wanted to have more knowledge and control over what happened to them than did the poor women.

Timothy positioned ~~women~~ as subjects desiring intervention:

What happens is that you do build up a relationship that allows the women to express what they are wanting. For many women, anecdotally a lot of medical practitioners who are women, and midwives, actually choose a caesarian section, and they might choose to be induced or they might towards term get very uncomfortable. They might arrange some help. They have to leave their work. So the pressures aren't very subtle to intervene.

Timothy, Obstetrician

Timothy depicts some "older" women, particularly those who are knowledgeable about the health system, as quite assertive in their request for intervention. Rather than wanting a natural birth the woman ~~to~~ use technology to achieve the kind of birth that they desire. The women know the types of intervention available and the kind of obstetric intervention that what they want. The obstetrician is the provider and is the means by which the women can access the technology and techniques they desire.

In depicting women as such knowledgeable and assertive subjects, the obstetricians identify themselves in a position of either equal power or subordinate to the women. Remaining unspoken is the obstetricians' position of authority and expertise within the scientific medical discourse.

The obstetricians, I believe, positioned "older" women as consumers. Lupton (1997) identifies consumerism as a neo-liberal approach that has been introduced into several countries including New Zealand. The neo-liberal discourse constructs a subject who is rational, knowing and autonomous, capable of calculating and choosing. Timothy refers to women who have wanted to have a caesarian section for reasons of convenience.

The assumption that all women make an "ideal-type consumer" decision when intervention is necessary is questionable. In her study of patients' attitudes towards their doctors, Lupton (1997) found that the majority of participants did not position themselves as consumers. "They still expressed a desire to conform to the 'patient' role and an unwillingness to approach the medical encounter from a position where they distrusted the doctor" (p. 374). She concluded that the subject position associated with the consumerist approach does not account for some patients' unconscious, unexpressed

dependence on their doctors. “It is as if ‘the consumer’ lacks the physically vulnerable, desiring, all-too-human body which is the primary object of medical care” (p. 380). I suggest that at times when pregnancy and labour do become problematic that “older” women may shift from “the consumer” to “the patient” position.

The private relationship not only positions the woman as a consumer and the obstetrician as a provider but also provides the context for the obstetrician to know the woman in a more intimate and caring way.

### **9.3.1 The obstetrician as friend and clinician**

The private setting produces an identity for the obstetrician which Timothy describes as type of friend:

It is a kind of different relationship. It is harder sometimes as a practitioner to shift from being a friend and sort of colleague and partner in this process, to being a clinician. I think it is a trap we can fall into very easily. We can get seduced. Assignment did a [television] programme on a midwife who got so close to the couple that she was in the home a lot, sharing birthday cakes, getting very involved. That makes it very difficult then if something goes wrong, to say, “Look, I’m sorry, but the baby is distressed.” Or, “This is happening.” Or “This is not working out.” So, something does happen, I would suggest mainly positively. If it leads to more intervention, it is quite likely that it’s the woman’s wish that intervention takes place, because you have a very good communication going. But it does open the way for a loss of objectivity and the opportunity for practitioners to manipulate the woman.

Timothy, Obstetrician.

In private practice, the obstetricians develop a relationship with the woman where they become privy to women’s wants. In a sense, they gain knowledge of each woman as a person and of her desires in relation to her pregnancy and birth, and the life that she leads. For Timothy, doing his best is to carry out the woman’s wishes, to support her in her decisions.

Timothy depicts being a friend as a double-edged sword. He sees the position of friend as easy and pleasurable because of its effortlessness, subjectivity and lack of discipline. But it can also become a trap making it difficult for the practitioner to argue against a woman who wants an elective caesarian for non-clinical reasons. Similarly, informing a woman that intervention is needed is also more difficult from a position as a friend. Timothy’s belief is based on the assumption that friends do not confront one another with the truth. In the position of friend, the obstetrician is more likely to allow

the woman to influence his conduct. However, as illustrated in Timothy's excerpt, in the friend relationship it is also easy for the obstetrician to influence the woman. The play of power can go either way.

To argue against the woman is to move away from her. It requires objectivity, discipline and the strength not to become enticed into intervening for the reasons that she provides. When Timothy does this he takes the position of a "clinician". Particular knowledge and a way of thinking is drawn on. Good and DelVecchio (1993) in their research into the learning experiences of medical students at Harvard University found that two of the discourses that the students articulated were those of caring and competence. The authors describe the caring discourse as one that "is a language of relationships, of attitudes and emotions, and of innate qualities of persons; it is a non-technical, commonsense language of interpersonal engagement, not a language of knowledge and facts" (1993, p. 93). In comparison, the discourse of competence is one that pertains to the knowledge and practice of the natural sciences, of employing value-free facts to reach a diagnosis and the acquisition of skills.

Good and DelVecchio (1993) observe that medical education perpetuates the juxtapositioning of caring and competence in the doctor-patient relationship. They have become a cultural institution associated with the tensions between nature and science, technology and humanism. Thus, competence and caring have become integral contradictions to the practice of medicine. Nevertheless, the authors propose, competency has precedence and plays an important part in various ways for the medical profession. They state, "the language of competence has come to be increasingly powerful in expressing the self-worth of the physician, in negotiating boundaries among specialties, and in providing the sole grounds for failures in medicine to provide benefit" (p. 94).

For Timothy, the ability to position oneself within the competence discourse is necessary for all these reasons. He asserts that moving from caring friend to competent clinician is not easy because it makes vulnerable the relationship that a practitioner has with the woman. The practitioner must override the woman. She is no longer a friend or partner. Timothy makes apparent the tension caused by moving between the contradictory discourses of competency and caring apparent. When the normal shifts to the abnormal, or the clinically justifiable becomes unjustifiable, the tension occurs.

I believe that while Timothy is aware of the potential for the practitioner to influence the woman, in his statement there is a bias towards the use of intervention, for

he argues that more often than not the woman is agreeable to having intervention. Furthermore, her agreement is the outcome of “good communication”. Implicit in Timothy’s idea of information-sharing is that both the woman and the practitioner are rational, power-sharing subjects who retain objectivity, are capable of weighing up information, and deciding what is best. As I have argued in the preceding section, women may not always remain positioned as the rational client but may shift in times of duress to the position of patient.

Phillip also associated knowing a patient well with a loss of objectivity and an increase in intervention. We had been discussing the incidence of caesarian sections in “older” primigravidas in the literature and private care. Phillip explained,

I guess that may be determined by the fact that more older women seek out private obstetric care and we know that private obstetrics care leads to a higher intervention rate. So it may be the caregivers that are determining that rather than the age of the woman. The fact that a woman armed with knowledge in making enquiries about their care, the response to that may be that you intervene more.

Int: What would go on in the caregiver’s mind here?

Phillip: Often it is not being objective enough in your assessment of what is going on, and the trouble with private care is that you actually get emotionally involved with patients, and you don’t assess what’s actually going on objectively. And there is too much personal feeling going on so that you actually take a very safety first option. I do that with my own patients. I am far more objective with public patients than I am with my private patients, and that maybe is what happens.

Phillip, Obstetrician

Knowing the woman shapes the way in which her labouring body is read by the obstetrician. Potential problems are identified earlier and pre-empted through the use of intervention. The use of standard criteria for caesarian sections is substituted for criteria that are more fluid, individual and contextual (see the following section, “the last chance” for the medical indications for caesarean section).

In this section I have highlighted the relationships between obstetricians and the “older” women as ambiguous, shifting and contextual. I have suggested that several discourses are in play which offer the women and obstetricians different subject and power positions. The private setting troubles the assumption that the decision to intervene is unfailingly based on objective, universal criteria.

One reason given by the obstetricians and hospital midwives for early intervention is the construction of the baby as “precious”.

#### 9.4 THE LAST CHANCE

In Chapter Four I identified the meaning given to the child of the “elderly” primigravida/ primipara in the medical literature as the precious or premium baby. I raised this in the interviews with practitioners. The practitioners argued against the idea that an “older” woman would value her baby more than a younger woman. However, what was precious was the “older” woman’s opportunity to have a baby.

I think that every woman would say that her baby’s precious. I think that time is precious. The time that they have got to have children is so shortened compared to people starting in their 20s. Knowing that that is their lot, that their one or two children are going to be their lot. There are going to be no second chances, you know, third or fourth chances if anything went wrong.

Claire, Hospital Midwife

I think that ... there is no doubt that the ... size of the family, the age of the patient can be well used, if it’s going ... to be used in balance, as to whether one would continue on with the labour or cease it at that stage. But those are factors that are commonly taken into account. So, I guess that’s one of the superficial indicators. But when it comes to the crunch and someone has been in labour for 14 hours, say, and they are aged 39 and they don’t expect to have another baby, ... and there may be no signs of foetal distress whatsoever, ... There may be no objective signs of maternal distress, apart from the emotional distress of having a long labour, that one would be more inclined to use the age and ... low parity, to tip the balance. ... I think that’s quite a realistic thing to say.

Peter, Obstetrician.

The metaphor commonly used in relation to women’s fertility is the biological clock (for example see Dockett and Beck, 1998). As Alice, the GP said, “It winds up and then it winds down”. Women’s fertility is finite, bounded by time and age. Bromley (1988) identifies the ages of 11 to 16 years when secondary sexual characteristics and reproductive functioning develop. On average, women experience menopause at the age of 49 years. At these times women’s fertility, as an intrinsic function begins and ends.

The metaphor of a clock implies the existence of a biological mechanism that is visible, audible and calculable. The concept of the biological clock constructs women as having a finite period of fertility. The concept of fertility as a limited resource works to create pressures on the woman and/or on the practitioner. Intersecting with the concept

of the biological clock to create a pressure are the societal beliefs of motherhood. Oakley (1980) argued that becoming a mother was “culturally equated with achievements of femininity” (p. 182). To have one’s own child was an expected standard for women and a mark of adult womanhood (Albury, 1999). It would seem that the practitioners are aware of these expectations that are placed on women or that women willingly take on for themselves. Every effort must be made to ensure that this first baby is born alive and healthy. Caesarian section is seen as the most effective means of intervention to achieve this end.

In deciding whether or not to intervene, Peter takes into consideration a variety of factors, none of them medical. The issue of increasing numbers of caesarian sections has received much attention (see Bulger, Howden-Chapman & Stone, 1998; Kirby & Hanlon-Lundberg, 1999; Stirling, 1998). The indications for a caesarian section can be absolute or relative (Savage, 1992). The absolute indicators include placenta praevia, and cephalopelvic disproportion, or as Churchill (1997) notes, where the baby cannot be born any other way. Dystocia and fetal distress are the two main relative indicators. Increasingly non-medical reasons are given for caesarian sections and lists maternal age as one reason (Churchill, 1997).

The timing of the decision to intervene is well documented, particularly in relation to the high rate of caesarian sections amongst “older” women. Some authors (Tuck & Yudkin, 1988) propose that doctors are concerned that this may be the “older” woman’s only opportunity to have a baby. They term the pregnancy a “precious pregnancy” (p. 236). The notion of limited opportunity is echoed by Edge & Laros (1993) who propose that the high caesarian section rate found in “older” primiparas is a consequence of “... physicians’ behaviour related to anxiety about pregnancy outcome in “older” women” (p. 1883). Earlier authors (Waters & Wager, 1950) believed that many of the indications for caesarian sections recorded in their study could be grouped under the heading of “high social value of the child” (p. 303).

Kirz, Dorchester & Freeman (1985) suggest that because these women are regarded as high risk doctors use a lower threshold for “terminating the pregnancy or labour” (p. 11). Similarly, Gordon et al (1991) felt that doctors may treat “older” women “more aggressively” because they believe that vaginal births have more complications in that age group. Ezra et al (1995) put forward the view that the decision to intervene is influenced both by the doctor viewing the “older” woman as high risk, and by the anxiety felt by the doctor and the mother.

A more complex hypothesis has been advanced by Peipert and Bracken (1993). They argue that there could be three reasons for the high rate of caesarian sections in “older” women. Firstly, “older” women’s cervixes may not dilate at the same rate as those of younger women. The different dilation rate is made apparent in the labour curves, which are read as being abnormal. Peipert and Bracken propose that rather than being abnormal, the labour curves could be normal for “older” women, and therefore not be indicative of problems. The second factor could be that some doctors are relying on outdated knowledge that, contrary to more recent findings, depicts the “older” woman as high risk. Thirdly, as I read Peipert & Bracken, they believe that during labour some sort of interaction occurs between the woman and the doctor. The doctor’s anxiety that for the “older” woman this first pregnancy may be her only one (a premium pregnancy) causes the doctor to make an early decision to perform a caesarian section.

Having identified and analysed the various representations and subject positions brought into being by the obstetricians as speakers of the scientific medical discourse, I turn now to the power relations between the midwifery and obstetric professions.

## **9.5 MAINTAINING PROFESSIONAL BOUNDARIES**

The term “boundary” refers to an abstract line that demarcates areas of practice for the different maternity practitioners. Arney (1982) in his historical analysis of American obstetrics talks of the line drawn between normal and abnormal birth prior to the 1940s. Midwives were seen to be the appropriate carers of women identified as “normal” and obstetricians the carers for women classified as “abnormal”. Donley, (1986) describes the midwife as a practitioner who “will utilise all her skill and experience to assist the woman to achieve a normal birth, if that is possible. Because of this, the midwife might be termed the ‘guardian of normal birth’” (p. 15). Related to the notion of the midwife as guardian is the line of midwifery accountability. The midwife is accountable to the woman and to her profession rather than to members of the medical profession.

It is no mere accident that Donley includes the following story in her book *Save the Midwife* as an example of how support during both pregnancy and birth assisted the woman to have a successful home birth:

A 35-year-old primigravida wrote of her supportive home birth: ‘I’ll never forget it. It was a wonderful experience, thanks to Liese’s yoga breathing classes, Daphne’s encouragement and the Homebirth

support group, to Wendy for being so determined about going swimming every day in our last month, to Alison [the doctor] for being brave enough to have confidence in a 'senile primigravida' in spite of the medical establishment...

1986, p. 20

Donley's decision to cite a 35-year-old primigravida, is a deliberate strategy to visibly contest the medical institution's belief regarding "older" primigravidas being at risk and therefore needing to be under specialist obstetric care and to give birth in a hospital. The strategy makes manifest the contested nature of maternal age and its relationship to discursive boundaries of practice and the associated place of birth. Implicitly, and sometimes explicitly, caught in the contest is the woman herself. In this section I show how the medical practitioners and hospital midwives talked of the discursive boundaries and the practices that maintained the discourse of maternal age.

### 9.5.1 The discursive practice of consultation

In the interviews with practitioners the practice of referring primigravida aged 35 and over to obstetricians emerged. Abel (1997) identifies the development of the Joint Regional Health Authority Maternity Project's *Guidelines for Referral to Obstetric and Related Specialist Medical Services* (1997) as a process of debate and contention. The guidelines specify conditions, that can influence or be influenced by pregnancy and childbirth, which require consideration by maternity practitioners and may require referral to specialist services. While obstetricians and Crown Health Enterprises (CHEs) supported the guidelines, GPs and midwives had opposed them (Abel, 1997, p.180). Their concerns were firstly that the professionals' own judgements about their scope of practice were not permitted by the guidelines. Secondly, the categorisation of women did not allow for the uniqueness of individual women's needs or individual practitioners' skill levels (see for example the College of Midwives National Newsletter, June/July, 1994). Instead, generalisations were made about the level of women's care based on the various conditions.

The final draft recommends one of three actions: may consult with a specialist, must consult with a specialist, and must transfer to specialist care. Some degree of play is permitted only in regards to the first action. This states that:

1 = The Lead Maternity Carer **may recommend** to the woman (or parents in the case of the baby) **that a consultation with a specialist is warranted** given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The specialist

will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

THA Maternity Project Team, 1997, p.5

Females under the age of 16 and over the age of 35 years are identified as having a condition that warrants level one action. The maternity carer is the one who determines whether or not the woman's case needs to be discussed with a consultant. Although the use of the word "may" allows for flexibility and the option for specialist consultation not to occur, the fact that maternal age is made manifest as a "condition" is significant in itself. Within the risk grid of specification, maternal age is retained as an object of the maternal age discourse.

Furthermore, the guidelines document (1997) reveals the intent to surveil maternity practitioners, especially when the guidelines are deviated from. Such documents are discursive practices in that they are derived from and reproduced by the medical discourse which constructs birth as potentially at risk. Foucault spoke of discursive practices as:

... not purely and simply ways of producing discourse. They are embodied in technical processes, in institutions, in patterns for general behaviour, in forms for transmission and diffusion, and in pedagogical forms which, at once, impose and maintain them.

Foucault, in Bouchard, 1977, p.200

Melissa, a hospital midwife, told of a situation when, as a community midwife, a 43-year-old woman who was pregnant for the first time was referred to her by the Clinic midwife. The woman had chosen the hospital domino scheme as a means of ensuring that she had continuity of care, that is she wished to have the same midwife care for her throughout her pregnancy, birth and postnatal period. Melissa recalled:

When I saw that she was 43 and having her first baby, I balked at taking her without discussing her case with an obstetrician. Because we have, in a way, more responsibility for the patients in the continuity system than the clinic midwives, in that they are far more likely to be seen by doctors just going through the clinic. Also in the continuity domino system we are really there to meet the needs of the normal, low risk sort of woman. I knew that seeing her in the street one would consider her a totally normal 43 year old. But I knew in this context [the hospital system] she would not have been considered entirely normal.

Therefore, it was protocol for me to approach the obstetrician and say, “How do you feel about this woman being cared for by a domino?” Because to some extent I know that they [the hospital obstetricians] feel that they are losing touch with these women when they are taken by the continuity midwife. To my surprise, he wrote this onerous, this long list of things that the woman had to do. She had to see me fortnightly from then on. I think that she was at 20 or 23 weeks. At 28 weeks she had to start seeing me weekly for the rest of the pregnancy. She had to have growth scans at 26 and 36 weeks. She had to have an induction at term if she hadn’t delivered by then. She was at risk of developing GPH. She was at greater risk of just about ...oh, retardation of fetal growth. He had a long list of things that she was at risk from. And this was without even meeting the woman. He didn’t have to do that, to write this incredible list of appointments that she was going to have to make. Now, that could have been a problem for her, but she was very focussed on doing the right thing. So, she didn’t resist this intensive programme of antenatal care that he had sent out. It was there to catch any changes in her. He wanted to make sure that she was being adequately screened, and boy, was she being adequately screened.

Melissa, Hospital Midwife

Melissa’s excerpt shows two different kinds of meanings of “normal”. One meaning exists outside the hospital and is derived from within the woman’s social context. Within her community, the everyday, the woman is viewed as normal, that is, she does not appear to be different from other women. In contrast, Melissa is aware that in the hospital’s context the woman is not “normal”. From the hospital’s perspective, the social meaning of normal as shown by one’s physical features does not constitute evidence. The woman’s deviation from normal resides within the body. It is invisible to the outside world; only hospital staff can “see” its existence.

Consequently, Melissa is constrained by the hospital protocol which specifies that midwives refer women over the age of 35 and pregnant to a hospital obstetrician. Papps and Olssen (1995) identify that in the hospital setting, or in this case the hospital system, midwives were required to request the expertise of obstetricians as the obstetricians had overall responsibility for the pregnancy and birth outcome. Melissa was required to seek his agreement for her to continue caring for this “elderly” primigravida as her practice is limited to women who are judged to have no obstetric risks. For her to continue to care for the woman, Melissa had to follow the care prescribed by the obstetrician. As Papps and Olssen (1995) observe, hospital midwives enact, and can become entrenched in the medical model’s ritual of surveillance and

monitoring. While Melissa may not have become entrenched, she did become ensnared and constrained by the medical discourse.

In this way, both Melissa and the woman were made docile bodies. The notion of docile bodies describes bodies becoming the object and target of power (Foucault, 1977) and through a variety of means becoming compliant and self-disciplining. The first means of achieving docility was by increasing the frequency of antenatal visits. Melissa was given a clear timetable of when she was to see and examine the mother and baby's wellbeing. This was more frequent than was the usual practice. The focus becomes not just the outcome of pregnancy but the actual process of pregnancy itself, the development of the baby and the ability of the mother to endure the strains of pregnancy. The second means of gaining Melissa and the woman's docility was by the obstetrician's specification of the possible risks that the woman was susceptible to and the various tests that had to be carried out. Melissa was given a clear brief to monitor for the occurrence of specific risks. She then became the judge of whether or not the woman and/or her baby were normal or abnormal. If Melissa was to take the obstetrician's place, then she needed to become his eyes, ears and mind; the judge of normality (Sheridan, 1980).

A further disciplinary strategy implicit in Melissa's story is that of the hierarchical gaze. The obstetrician is Melissa's superior. Although not explicit, the potential exists for him to judge Melissa's practice, especially if the woman or her baby should develop pathological conditions that require his intervention. In turn, Melissa watches the woman and her baby.

The two women's docility however, was also the means by which the woman achieved her choice for midwifery continuity of care, and Melissa remained caring for the woman. Both were enabled and constrained.

The practice of referral is a discursive practice that sustains the scientific medical discourse and its sub-discourses and the position of the obstetrician as the holder of authoritative knowledge and thus, the appropriate carer of the potentially abnormal "older" woman.

I think certainly once you are at 40, most people would get a specialist review, although it's a question of dotting the i's and crossing the t's so that it has been done. When booking at the hospitals they have a specific checklist, which they will actually send back to you saying they can't book this person because this thing hasn't been done yet. It might mean they [the women] need to have had a specialist review. A

specialist review often in those situations is just a general review. They look at women's general health, any past history, roughly any problems they might possibly have. Very often they don't come up with anything specifically different than we have already thought of. It's just a question, really, of just having, being able to then say, "Yes, she has been reviewed by so and so, who is happy, that this person can stay under generalised non-specialised care."

There are personal limits of what we can and can't do, so some GP's who have had a lot of experience with forceps deliveries and other things, they will be able to do that quite happily. Whereas others like myself, I didn't really have much experience at all, so anything to do with that, I would have got specialist care at the time. But at any time during a pregnancy, if things start to seem abnormal: if the blood pressure stays too high or goes too high; if you get pyuria ... if they are playing up, then we generally are quick to have a specialist review so that we then have a definite plan of action for the future. That's partly designed to try and give the woman, the best care and also to make sure we don't leave ourselves vulnerable to attack, and saying that really we were doing more than we would be sensibly expected or competent to do.

So, when you are taking care of pregnant ladies and their babies and delivery, you always have specific points where you personally draw a line and say "Okay, probably you would be fine, but at this stage we should get a review or hand over care." And there are some things that you would definitely hand over. You get a baby who has decided to stay breech at 36 weeks. Then, and certainly in a primigravida, that is something which basically from my point of view there is no question that you would hand over care. Other people if they have done a lot of breech births, they will still have to sort of hand over care but they may stay involved and look at things. But often you just need a review and if things are fine they come back.

Murray, GP

Murray, as a GP practicing obstetrics, had cared for only a few primigravidas aged 35 or over. In his experience, "older" women were very much a minority. At times the practice of specialist referral stipulated by hospital policy was a mere formality, an imposed requirement for him to arrange access to the hospital's services. It was not uncommon for him to find that the specialist provided no new insights into the pregnant woman's state. However, Murray's right to retain GP care was sanctioned by the specialist review. The authority and veracity given to the specialist's knowledge and judgement is made evident.

Intersecting with the medical discourse is the discourse of competence. The intersection of the two discourses create the subject positions that Murray speaks of: the

experienced and hence competent practitioner, and the inexperienced/incompetent practitioner. Murray identifies himself as the latter, and so elects to refer potentially pathological “older” women to the more proficient practitioners.

At these times, the referral to a specialist acquires different meanings. Rather than a bureaucratic requirement, Murray sees the possibility that the woman may require intervention as a necessity for her to receive what he calls “best care” that is, specialist obstetric care. However, by referring such women on, his level of inexperience remains the same, but the obstetrician has the opportunity to advance his or her skills. A second meaning given to the referral process is that its timeliness can avoid future litigation. The GP (or midwife) has recognised his/her limits of practice and called in the appropriate carer, the obstetrician.

The professional boundaries of practice are made visible in the referral guidelines but their interpretation and implementation provide opportunities for constraint, contest and manipulation.

## **9.6 STRATEGIES OF OPPOSITION**

Foucault (1982) argues that an analysis of power needs to consider power as a “multiple mobile field of force relations” (p. 102). From this perspective, one considers the potential for the referral process not to remain a static and uncontested strategy of power. Within the talk of all the midwives and one of the GPs, there emerged a strategy that attempted to oppose and manipulate the referral process by selecting specific practitioners to consult about “elderly” primigravidas. Melissa told of how she would work around the referral requirement:

The thing was that the way I would get around this sort of thing was that I would go to the other obstetrician around at that time. Probably public holidays or something, they weren't running clinics on that day and I would usually go to him because he is older, mellower. I feel that he tends to reflect on the woman's situation far more intuitively. Yes. He has had such a lot of experience that when you present him with facts about a woman's life, he will think those things over. He will be very aware of the impact of perhaps more frequent visits or more frequent tests on the woman's life, and will discuss that with you, if not the woman, I felt, slightly more realistically in fact about life and all its complications. [...] You could have control over the obstetricians you dealt with by choosing the obstetrician you wanted in that particular case.

Int: That's an interesting amount of control for you to have isn't it, in the hospital system?

Melissa: Yes, and I don't think that midwives exercise it all the time. I mean you walk into the Delivery Unit and you look to see who's on duty, the Consultant Registrar, and your heart either picks up or drops occasionally because you think, "Oh, if I have any medical complications this is my medical back up." I think all midwives look at the next tier up in the team, what kind of approach does that person take to particular problems.

Int: But it sounds that in your position as the Continuity Midwife, you didn't have to go with who the consultant was on the day. You could actually choose which consultant.

Melissa: Yes, and I usually did, you know if it was in my power to do that. I would choose.

Melissa, Hospital Midwife

Although the practice of referral is still reproduced, Melissa chooses an obstetrician whom she knows to understand the implications of increased monitoring for the woman. He brings to his practice an intuitive and holistic way of assessing the condition and future needs of pregnant women. Rather than adhering rigidly to the hospital's protocol, the obstetrician adapted them to each woman's case. It is the woman's interests that are met.

However, it is important to note that the hospital's protocols do not appear to be overtly challenged by Melissa, the midwife, or the obstetrician. Instead the protocols remain a broad framework determining the type and frequency of tests and visits that specific women require. Simultaneously, the position of the obstetrician as the holder of authoritative technical knowledge is maintained. The midwife continues to be positioned as a practitioner who is limited in her scope of practice. Her knowledge is bounded in the realm of normal.

Such boundaries also exist for GPs. Jane talked in a similar way of how she uses the referral process:

I usually try and have them go privately to a particular obstetrician. He is very good. With one woman he said, "Hopefully you will probably not see me," to her.

Jane, GP

Her tactic is also one of manipulation in that while Jane is seen to be accessing specialist opinion, she does this in a way that avoids the women's exposure to medical practitioners who might subject the "older" woman to the medical discourse. Jane went on to briefly explain such practitioners:

I think that there are some obstetricians who are so problem-oriented that. ...I've had obstetricians, I'm thinking of one time with team obstetricians, their attitude was "Oh, well." The woman ended up with forceps.

Jane, GP

Jane believes that such practitioners have the potential to underestimate "older" women's capability and to intervene unnecessarily. By referring women to obstetricians whom they know do not see age as an indicator of problems, both Jane the GP and Melissa, the midwife, allow women to escape the normalizing surveillance of the medical discourse. Their women are not judged by age alone, and assessed and categorised as at risk. Thus, Jane and Melissa manipulate the referral system to suit their clients. Rather than acquiesce and subjugate themselves to the medical discourse, they draw on their local knowledge of practitioners. In this way, the "older" woman remains positioned within the natural birth discourse and is categorised as not at risk and, therefore, can be in the care of the midwife or GP.

## 9.7 SUMMARY

The medical discourse identifies a woman aged 35 who is pregnant or giving birth for the first time as potentially problematic and requiring either consultation with or the care of an obstetrician. However, the constructed identities of "older" women and practitioners are revealed in this chapter to be multiple, contradictory and competing. The context of the private relationship complicates the subject and power positions that an obstetrician may adopt. In this setting, the discursive position of caring practitioner may bring to the foreground the subjectivity and desires of the "older" woman. Decision-making for the obstetrician then may become more intricate and in tension with the discourse of competency. Consequently, the decision to intervene may be for reasons that are subjective, contextual and individualised.

Referral guidelines and hospital policy serve to perpetuate the medical discourse representation of maternal age. While referral guidelines affirm the authority of the obstetrician and identify the "abnormal" as the obstetricians' domain, their interpretation is open to play and contest. Midwives and GPs may manipulate the notion of referral selecting practitioners who do not identify the "older" primigravida as potentially problematic.

The natural birth discourse offers positions for practitioners and "older" women to contest the medical discourse and its construction of "elderly" primigravidas. In the

next chapter I will explore the natural birth discourse and the subject and power positions that were articulated by the women and midwives.

## Chapter 10: THE CAPABLE WOMAN

They [recent oppositions] are struggles that question the status of the individual. On the one hand, they assert the right to be different and underline everything that makes individuals truly individual. On the other hand, they attack everything that separates the individual, breaks his links with others, splits up community life, forces the individual back on himself, and ties him to his own identity in a constraining way.

These struggles are not exactly for or against the “individual”; rather, they are struggles against the “government of individualization.”

Foucault, 1982, pp. 211 – 212

### 10.1 INTRODUCTION

Foucault posited a rule of “tactical polyvalence of discourses” (1978, p, 100) to argue that multiple discourses circulate and contest the meaning of objects. Cosslett (1994) has identified two dominant discourses that compete over the meaning of childbirth: the medical discourse and the natural birth discourse. The natural birth discourse constructs birth as a normal physiological event. Peterson (1984) states that the term “normal birth” has two different meanings: the statistical meaning of “normal” generated by what occurs in most cases of birth, and “normal” meaning birth without medical intervention.

I have shown in Chapter Four that the natural birth discourse was evident in the midwifery and feminist literature, and that it offered older women and midwives identities and power positions that challenged and contrasted with the scientific medical discourse. In relation to maternal age, the natural birth discourse offers a space for older women to remain undifferentiated from younger women; to be a woman who is pregnant for the first time, who has the same capability and potential for an unproblematic birth.

In this chapter I draw on interviews with six of the women, the hospital and independent midwives, and two GPs. The data from the interviews revealed that although a synonym for the natural birth discourse is the midwifery model (Griffin, 1994; Pairman, 1998; Rothman, 1991), the maternity practitioners who positioned both themselves and older women within this discourse included two of the GPs.

Firstly, in this chapter I explore how the women and practitioners constructed birth and then show the different subject and power positions that the natural birth

discourse produced for the speakers. I also show that some of the speakers adopted strategies that kept in play the paradoxical possibility that on occasions labour and birth can become problematic and might require intervention.

Six of the women deployed the natural birth discourse in their recollections of their journey through pregnancy and birth. Four of the women were pregnant with their first child at the age of 35 or over, and two of the women were pregnant with their second child: Katie at the age of 36, and Rosalie at the age of 39. Three of the primiparas, and one of the multiparas had planned home births while Bernie and Katie had planned hospital births. All six had a GP and/or a midwife as their maternity practitioners.

The women who deployed the natural birth discourse identified themselves as capable of giving birth without intervention. Similarly, the practitioners believed that a primigravida aged 35 or over had the same potential as younger women to birth without intervention. The women's confidence was derived from two constructions: their bodies as reliable and birth as a natural process.

## **10.2 THE RELIABLE BODY**

I asked all the women if their age had been significant for them in relation to their pregnancy and birth. The women who deployed the natural birth discourse ~~they~~ replied that their age had not been a concern. Two of the women derived their belief that their pregnancy and birth was not a matter of concern by virtue of their wellbeing. Rosalie recalled that with her first pregnancy her practitioner (a GP) had commented on her health and lifestyle in relation to her ability to give birth without intervention.

I was 34 when I became pregnant but turned thirty-five shortly afterwards. I never really thought about how old I was because I was only just over 30 in my mind. It was when someone at work asked something about whether the doctor was taking special care of me because of my age. I replied that he wasn't. I really felt that that was the case. I remember my GP said to me at four months, "We'll have to book you in at W [the local level one hospital]". I asked him if they would deliver me there because of my age. He replied, 'I don't see why not. You are in good health and you look after yourself.'

Rosalie, Multipara.

In Rosalie's case her history of wellbeing and lifestyle were determined by her GP to constitute her not to be at risk and as such will, not require intervention. As such it also served to justify her giving birth at her local level one hospital where specialist

obstetric and anaesthetic interventions were not readily accessible. Rosalie's self-image resonated with his assessment and offered her a position of certainty when questioned by a colleague.

Josie also drew on her health and lifestyle as more significant factors than her age in determining her, and her baby's, journey through pregnancy and birth:

With regards to how things were going to go for me, with regards to my health and the health of my child during my pregnancy, I didn't feel that from what I read particularly or from the people who I was involved with as carers, that my age was a real problem. It was something that my health and my baby's health had more to do with my lifestyle than my age. Being 35, that wasn't an issue.

Josie, Primipara

Both Rosalie's and Josie's practitioners foregrounded the women's overall wellbeing and the care that they took of themselves rather than their age. These self-care practices were judged by their practitioners to produce bodies that were trustworthy and were indicative of the fact that Josie and Rosalie were capable of giving birth without intervention.

In addition to constructing their bodies as reliable, the women perceived birth to be a normal biological process.

### **10.3 BIRTH AS A NATURAL PROCSS**

For the six women who utilised the natural birth discourse, birth was spoken of as an innate process that women were capable of doing without routinely requiring medical intervention.

I've always had this idea that I would like to birth in a natural way, and that pregnancy is something that should be enjoyed and handled by myself. Because that is the way women have always done it, up until 20 or 30 years ago.

Maggie, Primipara

As represented by Maggie, all six women articulated this concept of birth. The women used the fact that women have been successfully giving birth for centuries without routinely requiring medical intervention as proof that natural birth is an effective process. The construct of birth as a natural process, represents birth as an innate physical event executed by the woman's body. Birke (1998) proposes that bodies should be ascribed as organisms. This way of thinking about the body permits it to be

seen as having agency. I suggest that the way in which birthing is constituted in the natural birth discourse, it does assign agency to women's bodies. The advantage of assigning agency to the body, Birke believes, is that the body and its interior, is then viewed in more positive ways contesting the oppression that women face. Arms (1975) defines natural birth as "simply the full experience of the normal sequence of events flowing without interruption from any external disturbance or interference" (p. 186). The woman's body contains the knowledge of how to birth. It is for the woman and those around her to have faith in the body's ability and to let the process unfold.

The natural birth discourse does not differentiate an older primigravida from younger women. It affirms her identification of being competent to give birth without inevitably requiring intervention, and the choice of a midwife or GP, and a home birth is vindicated.

#### **10.4 WOMEN AGED 35 OR OVER AS NOT DIFFERENT FROM OTHER WOMEN**

Correspondingly, all of the midwives and two of the GPs who believed that birthing was a normal process did not identify the woman's age of 35 or over as constituting a risk for the mother and the fetus during pregnancy and birth, as exemplified by Donna:

When I first started thinking about this: do I treat anyone differently? I don't think so. I would check everyone out for hypertension, anaemia, or whatever. I don't necessarily think that I would do anything more scrupulously with the over 35s. I mean general health stuff, I suppose. But no, I wouldn't. I think that say every woman has the potential to develop GPH.

Int: Through the medical literature there is quite a lot about how problematic elderly primigravidas are.

Donna: Yes, I know. But if you are doing regular antenatal visits. What you are asking me is, do I treat them any differently? What I am saying is that I treat everybody the same. I mean, I wouldn't ignore it but I wouldn't necessarily get them in twice a week just because they are over 35. If they are showing some signs of anything then yes, maybe. But I wouldn't necessarily think that they were going to have an abnormally long labour, or that they would be difficult in labour. I think that it is very dangerous to make judgements about people.

Donna, Independent Midwife

The practitioners who positioned themselves in the natural birth discourse did not differentiate women from one another on the basis of their age. As reflected by Donna, they assessed each woman as she personally experienced pregnancy and labour. Changes in their practice occurred only when signs indicating problems for the mother and/or her baby's livelihood became evident. They did not use the woman's age to pre-judge and predict her journey through pregnancy and birth nor to predetermine the antenatal care that they would give her.

When discussing whether older women had longer labours than did younger women, Julie stated:

The time of the labour to me isn't an issue because you know that you are going to look at the woman's wellbeing throughout the labour, and the baby's wellbeing throughout. You are going to be listening to the baby, watching the liquor if there was any. If she was post-mature, you would take as much care of her if she was 39 or 40 as you would 10 years younger. You can get women of 25 who have 72-hour labours. And you can get women of 40 who have three-hour labours. Maybe if the research supports the fact that they have longer labours overall, well, so be it. But what difference does it make? Because the way you work it out with the woman [is] "What's the best thing to do here?"

Julie, Independent Midwife

Similarly, when talking about the association between increased maternal age and caesarian section, Alice, a GP, said:

You can't go into labour thinking that that's what is going to happen. You have to give everyone a trial of labour. So, I think that it's silly to say this is a special group because you are not going to make decisions based on the group. You can only make decisions based on what happens in labour.

Alice, GP

Julie and Alice echoed Donna's views. Increased maternal age did not predict an increased labour time which then might have indicated the need for intervention. Julie specifically refers to the obstetric practice of dividing labour into a series of stages and the ideal time in which each stage should be achieved. Martin (1987) identifies this as the application of industrial time to the birthing process. It is clear that Julie opposes the assessment of a woman's labour based on such standards. She argues for each woman to be assessed in her own right and on the criteria of maternal and fetal wellbeing.

In questioning the practice of predicting women's labour and type of delivery on the basis of their age, Alice uses the obstetric language of "trial of labour". This term is used in relation to women who are regarded as potentially requiring intervention (such as a woman whose baby is in a breech position). Rather than having an elective caesarian, these women are given the opportunity to labour and birth without intervention but within specific parameters set by the practitioner. In a sense, women's ability to not require technological assistance is physically tested. However, Alice's use of this term is in the context of her not prejudging an older woman's ability for birthing naturally. Every older woman should be given the opportunity to show her capability.

For the practitioners who deploy the natural birth discourse, the possibility of a normal birth remains open until shown otherwise. Changes in the midwives' and GPs' practice are determined by events as they unfold rather than being predetermined by signs such as maternal age.

Four of the five hospital midwives, Jill, Deanne, Claire and Anna, used the terms "bailing out" and "copping out" when speaking about the use of intervention, particularly in relation to the decision to perform a caesarian section. Evident in their deployment of the terms is their opposition to the technical and interventionist nature of obstetric practice (Davis-Floyd, 1992; Rothman, 1991) An example comes from Anna's transcript. I had asked her to explain what she meant by "a short trial of labour":

Mm, say she hasn't progressed after some hours, then maybe an obstetrician would bail out and do a caesarian earlier than they would with somebody younger. I think that that would probably stand up. You know, like you were looking at those instances of the caesarian section being high, a lot of them would have been for that.

Anna, Hospital Midwife

Within the scientific medical discourse, the time in which a woman takes to progress through the stages of labour is prescribed (Murphy Lawless, 1998). Intervention is likely when a woman exceeds the boundaries of the "normal" time for each of the stages. Murphy Lawless (1998) argues that the length of time that a woman is in labour is evidence of an absolute rule which does not take account of individual women's labour pattern. According to Murphy Lawless, the introduction and use of time as a criterion has facilitated the medical profession's power and control.

The hospital midwives had observed that at times the doctor's decision to intervene during labour occurred earlier for "older" women than it had for younger

women, revealing discriminatory practices towards women on the basis of their age. “Older” women are judged to be incapable of giving birth without intervention.

In the hospital midwives’ deployment of the natural birth discourse, the obstetricians are seen to “abandon” labour without reason. The scientific medical discourse’s practice of early intervention is viewed to deny “older” women the opportunity to continue to labour and to possibly give birth autonomously. One further outcome of early intervention, I suggest, is that it perpetuates the discursive construct of “elderly” primigravida/primipara as a group of women incapable of giving birth.

In highlighting the nature of decision-making regarding the use of intervention as prejudicial and subjective, the hospital midwives contest the scientific medical discourse’s claim that “elderly” primigravida/primipara are “at risk”.

Also revealed in the above data excerpts is the strategy of surveillance by two of the GPs and all of the midwives. They are constantly monitoring the woman and the baby’s conduct, observing and listening for the signs that indicate their wellbeing or deviation from wellness. The woman and her baby are the objects of the practitioners’ gaze. Maternal and fetal deviations from wellbeing are the criteria that require the practitioners to recommend whatever interventions they deem necessary.

It became apparent that most of the speakers in this discourse were actively opposing the medical discourse. The two following statements from two midwives illustrate the conscious step being taken to avert the classificatory dividing practices that are part of the medical discourse:

I just find that women are just women having babies. I don’t look at them like that, except that I am more mindful that I know the medical profession looks at them like that.

Margie, Independent Midwife

What is alright anyway? What does it matter? Why is it important that she is classified as at risk? Why put her in a class? She is just a woman having a baby. Why would you have to categorise her?

Julie, Independent Midwife

Rothman (1991) identified the midwifery model as a view of pregnancy and childbirth that opposed the medical view. The midwives are explicitly aware that their discounting of a primigravida’s age of 35 or more is contrary to that of the medical discourse. However, Lane (1995) argues that critics of the medical discourse have not discarded the usefulness of risk assessment. The medical criteria used to evaluate a

woman's risk incorporate " ... age, parity (number of other live children) previous history of post-partum haemorrhage, previous stillbirth, a history of caesarean section and adverse medical history" (p. 60). In comparison risk, as determined by the natural birth discourse draws on a broader range of factors.

## **10.5 FACTORS THAT CONSTITUTE RISK IN THE NATURAL BIRTH DISCOURSE**

While maternal age was not regarded as a factor that might influence the woman's experience of pregnancy and birth, the practitioners who positioned themselves within the natural birth discourse did identify other indicators of risk. Griffen (1994) points out that these risk factors are holistic and situational. For example, Jane, a GP, and Joanne, an independent midwife:

I think nutrition and emotional attitude and physical fitness and exercise ... but really attitude and nutrition would be the top two things that pinpoint, that would determine outcome.

Jane, GP

I think that it isn't necessarily the fact that you're getting older. I think that it depends on what your lifestyle and nutrition is like. I think that if you've had poor nutrition, well, you can have just as many problems when you're younger as when you are older.

Joanne, Independent Midwife

The independent midwives, echoed Joanne and Jane's consideration of a woman's environment, nutrition and lifestyle as influential factors on maternal and fetal wellbeing.

Psychological and emotional factors such as the woman's relationships, feelings, experiences and knowledge were also identified as potential determinants of maternal and fetal wellbeing. The midwives and one GP explicitly articulated their beliefs that the woman's mind (her emotions knowledge and memories) could influence her body, especially during labour. Emotions such as fear and anxiety, in particular, could hinder the progress of labour (Lane, 1995). The sources for these emotions can be varied. For example, one midwife said:

What you are told as a child affects your perception of birth. What your mother tells you about birth, what you read tells you about it. It's influenced by a lot of things as to how you see yourself going through labour and delivery. If you see it as completely normal and you are going to be fine, you can still have a long labour but you are not as

afraid. [...] Occasionally you will have a woman who wants a home birth who's had a previous difficult time. So when you come to the point in labour when she might have had an epidural, she might get really frightened. So, you have to talk them through that and say, 'This is what you wanted to do. You wanted to birth at home and once you get through this, once you get past where you had the epidural, you will be all right. Your body can actually do this.' If you can talk them through that then they are usually fine.

Julie, Independent Midwife

What is clear here is the midwife's belief in the interrelationship between the mind and body, thus contradicting the Cartesian mind-body dualism (Grosz, 1994). If the woman's self-belief is maintained, she will reach her goal of giving birth without intervention. Cosslett (1994) identifies that a woman's state of mind is the key to achieving a natural birth. The natural birth discourse in this way makes the woman's subjectivity both visible and significant to the birthing process.

Pregnancy and labour are constructed as being dependent on a complex interplay of multiple factors. This construct contrasts with the medical discourse which, as argued in the previous chapter, identifies risk in the older woman as emanating from an intrinsic biological aging process. The natural birth discourse identifies factors extrinsic to the woman's body which act to detract from the potential for her to achieve a normal birth. From this perspective, there exists the possibility, once the risk factors have been identified, for strategies to be adopted which may normalize the woman's body and reduce the need for intervention.

Older women were seen by the midwives and the two GPs to be particularly vulnerable to societal and some practitioners' attitudes towards them as older mothers. Lane (1995) suggests that the assumption of prevalent and unavoidable risk might be considered a factor that causes problems. The independent midwives believed that the notion of older women being at risk may be so commonly accepted that older women are repeatedly subjected to people stating such views. For example:

Probably their GPs have undermined their confidence, and talking to some of their friends. Because some of the older women tend to go for a specialist straight away. They think they need a specialist, and it is their family and friends who have said to them, "Well, you are older. You do need a specialist."

Rayna, Independent Midwife

Rayna had observed that it was not an uncommon practice for older women to be under the care of obstetricians. She reflected above on women either being referred

by their GPs or independently seeking the care of obstetricians. What Rayna is also referring to is the hegemonic nature of the medical discourse which constitutes maternal age as a significant risk factor. Consequently, to be under the care of an obstetrician is thought by some older women to be the norm. However, as believed by the midwives and one of the women in this study, the effect of such norms on the older woman is to undermine her confidence in her own ability to give birth to her baby without intervention. Julie recalled the following example of how the labelling by others affected older women's self-perceptions:

What made them [older women] fearful was the number of people who told them that they were at risk. I remember one who said that there was nobody in her whole pregnancy that did not mention the risks of being older. ... Every person she spoke to talked to her about the risks of being old, and **that** would generate the fear. You start to get treated like you are a time bomb waiting to blow up.

Int: Did she talk about what people had said to her?

Julie: No. It was just this generalised fear of being old. She had never considered herself to be old. Suddenly she was having to think, "Am I really old?"

Julie, Independent Midwife

Fairclough (1992) proposes that metaphors construct reality in an essential way. He writes that "how a particular domain of experience is metaphorized is one of the stakes in the struggle within and over discursive practices" (p. 195). Here Julie's use of the metaphor of a time bomb creates a picture of an older woman being harmful both to herself and her baby. Becoming pregnant as an older woman has set off a countdown towards self-detonation. No one knows exactly when the woman is going to self-destruct and cause damage or death to herself and/or her baby. There is little that the woman can do. All she can do is wait, powerless. Those around her tread carefully, watching, and waiting. She will either inevitably trigger herself off or an expert might be able to avert her "explosion".

The effect of being told that she was at risk has triggered off in the woman erosion in her self-confidence and fearfulness. She had begun to consider that as an older primigravida she might be unsafe and dangerous both to her herself and her baby. This belief supports the practice of older women giving birth in hospital where specialists and life supporting technology and techniques are easily accessible. The options of having a midwife or a home birth appear unfeasible.

In asserting the woman's belief in her ability as a fundamental requirement for natural birth, and the influence of the mind on the body, the space to contest the medical discourse's identification of increased age constituting risk is opened:

What comes first? Is it the way that women are treated because they are more than 35 years of age? So, are they already disempowered because people say to them, "You are 35. That means that you are at risk". So is it a self-fulfilling prophecy or is that they are generally at risk because they are more than 35 years old?

Margie, Independent Midwife

Both Margie and Joanne employed the notion of a self-fulfilling prophecy to contest the medical discourse's identification of older primiparas as being at risk. They proposed that a positive belief in one's ability constituted empowerment while a doubt or lack of belief in oneself eroded one's potential. Being told that she was at risk caused the woman to actually become at risk during her pregnancy and/or labour.

Power is constituted as a psychological force, or a sense of control, that can be given or taken away by others. The woman's ability to maintain a position of power is constructed as being dependent on her social context. Her mind, I believe, is seen to be porous, pervious, and vulnerable to the words of others. There is no boundary between her context, mind and body. But I suggest such openness does allow for the potential of events to go either way. The possibility of a natural birth is reliant on maintaining the woman's subjectivity as capable and in control. In this way, she is positioned as an active partner in the birthing process.

## 10.6 THE WOMAN AS AN ACTIVE PARTNER

Rather than being positioned as a passive object of surveillance and subject of medical technology during the antenatal period, the woman is given the responsibility to incorporate changes to her lifestyle. In making suggestions for changes to diet or exercise, the practitioner appeals to the woman's goal of having a natural birth<sup>19</sup>. The woman is hailed as a responsible partner, willing to make the necessary changes to her lifestyle. In the following excerpt Maggie speaks of the techniques she adopted to try to prevent a perineal tear:

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<sup>19</sup> It is important to note that women who positioned themselves in the medical discourse also spoke of taking care of themselves. For example, Jo, Lara, and Barbara talked of exercise and yoga.

I thought that I would not tear, that I would be fine, as I had done yoga throughout my pregnancy. I did a lot of exercise. I wasn't very good about it, but I did try and do perineal massage regularly. I can remember thinking at the time, "I don't know if this will actually help or not." [...] I don't think I did it enough. If I had been more frequent with it I might not have torn. The advice was to do it in the last six weeks and by that stage I had got tired. I was quite keen on massaging my belly to avoid stretch marks. I did that and I never got any. All the way through I felt that I took responsibility for myself.

Maggie, Primipara

Throughout her pregnancy, one of the self-disciplines Maggie implemented was to massage her perineum as a preventative practice. Other strategies Maggie lists were yoga and exercise. In the excerpt, she shows the way in which she constitutes her subjectivity as a woman who plays an active role in maintaining her well-being to enhance the potential for her having a normal birth. She recognizes herself as being a responsible partner.

For some women though, the practitioners' expectations may not necessarily be congruent with those that the women have of themselves. Josie remembered that the midwife spoke to her:

I don't know whether part of that is the normal confidence-building approach to help a woman build self-esteem and that kind of thing: giving you the impression that they feel that you will cope and handle everything. Because there were a few times there that I felt, 'No, I'm not' and, 'You are assuming a little too much of me here.' I can't say that I know whether that is age or someone having already got to know me a little, deciding, feeling and treating me that way.

Josie, Primipara

Josie was uncertain if she was being identified by the midwife as someone who was confident and capable because she was an older woman or because the midwife perceived her as such. Both positionings were not always congruent with Josie's feelings about herself. Her self-perceptions were contradictory to those held by the midwife. The potential existed for the relationship with her midwife to be disrupted and for Josie to feel overwhelmed by, and to reject what was anticipated of her.

One independent midwife, Margie, recalled an experience when a older primigravida had rejected her as one of her maternity carers and had instead chosen to be under the sole care of an obstetrician:

I was in the situation recently where a woman [...] probably was 35 and had a history of infertility. She was going to an obstetrician as well, and in the end she decided that she wouldn't have me look after her. It was basically because of what he would tell her and what I would tell her would be the opposite. She actually did say that she felt worse after she had seen me than before. [...] She did say when we finished talking about it, that it was the fact that I was too naturally focused for her, because she had been infertile for such a long time. [...] I suppose I thought I was trying to encourage her to be strong in that she could do it. Whereas I don't think she wanted to be like that. If the obstetrician wanted her to be induced, then that is how it should be.

Margie, Independent Midwife

Margie and the obstetrician practitioner had constructed the woman's capabilities in contradictory ways. The words that Margie later used to describe how the woman felt moving between the two practitioners were "conflicted and confused". Margie's presumption that the woman would be an active partner capable of giving birth by her own efforts did not appeal to the woman or resonate with her self-perceptions or estimation of her body's ability. The woman's way of dealing with this situation of conflict was to reject the subject position that Margie was locating her in.

In identifying the woman as an active partner, the midwives constituted their own subject and power positions.

## **10.7 THE MIDWIFE AS THE FACILITATOR OF NATURAL BIRTH**

The place of the midwife is depicted as being essential in attaining the woman's goal of a normal birth. Julie, when talking about risk factors depicted herself as encouraging a woman to reach her goal of having a home birth. She represents the midwife as a supporter, exhorting the woman to achieve the goal that she had set for herself. Julie describes herself as informing the women so that they can anticipate the difficult times that occur during labour and persevere to achieve their aim. Implicit is the midwife's belief in the woman's innate ability to achieve her goal of a normal birth. Through the implementation of such practices, the possibility of birth without intervention is kept open.

In order to identify potential risk factors, I believe, the practitioner needs to make observations of the woman and to listen for and elicit relevant information from the woman. By such strategies the practitioner gathers knowledge of the woman, assesses and judges her and in doing so exercises power. Foucault (1981) suggests that

the strategy of the confessional is one of the main ways in which truth is produced. Arney (1982) believes that the strategy of confession is employed during the antenatal classes which emphasize natural birth and encourage the women to share their expectations and fears as part of the preparatory process. While confessing is an act that a woman may willingly submit to, it conceals a strategy of power as it is not conducive to an equal power relationship between the woman and the practitioner. The practitioner is the one who has the power. She determines which questions will be asked of the woman and then judges the woman's responses.

The agency of domination does not reside in the one who speaks (for it is he who is constrained) but the one who listens and says nothing; not the one who knows and answers, but the one who questions and is not supposed to know.

Foucault, 1981, p.62

In order to assess the risk, the practitioner will need to ask questions of the woman, for example, her diet and lifestyle. The practitioner's status as expert, gives her the authority to question and examine the woman. In answering truthfully, the woman willingly submits her life to the practitioner's examination and suggestions on the changes needed to benefit her and her baby. Through the process of confession, the practitioner has the opportunity to increase her knowledge and her power.

Foucault writes in his essay *The subject and power* (1982):

What defines a relationship of power is that it is a mode of action that does not act directly and immediately on others. Instead, it acts upon their actions: an action upon an action, on existing actions or on those which may arise in the present or in the future.

p. 220

For Foucault (1982; 1994), the exercise of power is not synonymous with evil. Rather, it is a relationship between two players with one attempting to influence the conduct or actions of the other. The practitioner attempts to influence either or both the present and future behaviour of the woman. As a practitioner within the natural birth discourse, the midwife or the GP has the power to formulate and inform the woman of the strategies to maintain a healthy pregnancy and achieve a normal birth. In some situations this may be quite overt.

My midwife was very non-intrusive. She was here, but not in my face. She let me get on with it. Towards the end of the first stage I was

dilated but that last bit just didn't happen. And she dealt to it. I'm not sure exactly what she did, but she fiddled around a bit and then she said, 'OK. You can start pushing now.' She did whatever needed to be done manually. I did struggle with the pushing, and at one point I can remember her giving me a talking to and saying, 'Look. Right. You have to get on with this. It is not going to go away. There is no way out of this now except push.' I was finding it was easier to ride through the contractions and not do anything, because pushing hurt.

Maggie, Primipara

The power relationship between Maggie and her midwife is made clear in this excerpt. Throughout her labour, Maggie's midwife was close by, monitoring her and reading her behaviour. In essence, she was subjecting Maggie to a "midwifery gaze" and assessing Maggie's wellbeing and progress. Foucault (1982) proposes that a power relationship can only be expressed when the person on whom power is being exerted is recognised as someone who is capable of acting. Therefore, for a power relationship (as defined by Foucault) to exist between the midwife and the woman, the midwife must see the woman as having the ability to exert influence over herself and others. When it became evident that Maggie was not progressing, her midwife physically and directly intervened, possibly manually pushing the lip of Maggie's cervix out of the way. In this moment, the midwife acted on Maggie's body, but I would argue it did not constitute an act of violence. Violence implies force, a negation of one person's intentions or desires by another. "... it closes the door on all possibilities" (Foucault, 1982, p.220). In Maggie's retelling, I do not read her as being thwarted by the midwife. Rather, the midwife assists in Maggie's desire to birth at home.

The midwife then signalled to Maggie to commence pushing. Subsequently, it became apparent to the midwife that Maggie was not pushing effectively. At that time, Maggie's midwife disciplined her, telling her that she could not escape the effort and discomfort associated with pushing. To achieve her home birth, Maggie had to consider the midwife's statement: she was being urged to change the way in which she was approaching the birth, physically and emotionally. Maggie was the one who had to act; who had to discipline herself to stop struggling against the contractions. At all times of the labour, Maggie was the subject of the midwife's gaze and intervention. She seemed however, to be a willing subject, incited and persuaded by the midwife in her goal to achieve a natural birth.

In this section, I have shown that practitioners who deploy the natural birth discourse position themselves as facilitators of normal birth assisting the woman to

achieve her goal, of giving birth to her baby under her own powers. The power relations that exist between the woman and her practitioner are in play. The woman is given the space to follow her bodily urges but there are times when the midwife will exercise power and direct the woman's behaviour. The play of power keeps the possibility of medical intervention in the background.

## **10.8 MAINTAINING POSSIBILITIES**

Evident in some of the transcript texts were practices which showed that while the natural birth discourse and its discursive practice of home birth oppose the scientific medical discourse, the women and the midwives did not completely reject the need for intervention. Some practitioners and women constructed birth as paradoxical that is, they constructed the physiological process of birth as one that can take its own brute course and endanger the life and health of the mother and/or her baby. The necessity for intervention may not be evident at the outset of labour but may become manifest as labour and birth progress. This paradoxical meaning of birth, I argue, keeps in play both the natural birth discourse and the medical discourse. It keeps in suspense the complete belief that all births will be natural, and shapes practices that keep open the possibility for intervention and a natural birth. Instead, wherever birth happens will be the best place, and whichever practitioner is involved will be the best practitioner for that particular birth.

In recalling her antenatal discussions with her independent midwife, Maggie remembered that:

My midwife did give me a talk at some point towards the end about having to accept the possibility of going to the hospital if there was a problem. She said, "I don't see any reason why there should be, but if there is I want you to think about it."

Maggie, Primipara

The midwife wanted Maggie to be mindful of the possibility that hospital intervention might be necessary. In doing so she constituted birth as unpredictably problematic. The midwife kept visible the dual meanings of birth giving it a sense of suspension. The idea of birth as a natural event is kept in the foreground while the representation of birth requiring intervention is kept hovering in the background. The different outcomes are kept in play.

The midwife also asked that Maggie “accept” the possibility of intervention. The use of the word “accept” conveys several meanings. One meaning asks that Maggie regard hospital intervention favourably; that she not see it as a negative experience. The other meanings conveyed are that Maggie consents to being transferred or that she submits to the necessity for intervention and tolerates the midwife’s suggestion that she transfer to hospital.

The anticipated outcome of transfer to hospital is the birth of a live infant and a healthy mother and baby. Drawing on Foucault’s concept of biopower, the midwife may be an accomplice in its practice. Gastaldo (1997, citing Hakosalo, 1991) defines biopower as “the use of mechanisms of control and coercion ‘for the productivity and health of human bodies and populations’, based on a view of them as ‘resources and manageable objects’ ” (p. 114). By suggesting to the mother that she accept transfer, the mother is less likely to resist the midwife’s suggestion and is more likely to agree readily that it is necessary. Harm to the wellbeing of the mother and/or her baby is avoided and their productivity and health are ensured. Furthermore, the threat of litigation is avoided for the midwife.

Donna, an independent midwife, also spoke of how she sometimes warns some older women who are determined to have a home birth of the possibility of needing to transfer to hospital:

They sometimes want things to be absolutely perfect, and straight, and follow the books and stuff. It is my experiences that over 35-year-olds have done a lot of reading and are a lot better educated. [...] Sometimes I have to get a bit more realistic with them about what their expectations are. I am thinking about clients who have said, ‘I will have a home birth, no matter what.’ [With one client] from quite early on I had to say, ‘Yes, I am prepared to support you in this option for a home birth. But things [sometimes] don’t go so well and there always is a bit of an unknown factor, and you have to be prepared for a different birth scenario.’

Int: Would you say that to all women or because she was an elderly primigravida?

Donna: I would say it to all women, because I don’t want women to be devastated at the end of the day when it doesn’t go the way they planned.

Donna, Independent Midwife

Crouch and Manderson (1993) observe that labour has become a “symbolic representation” for womanhood. They suggest that since the physical threats to the mother and her baby that were historically associated with birth no longer exist to the same extent, the process of birth has become more of a focus than the outcome. “The experience of birth is now valued as the ultimate proclamation of an esteemed, naturally granted state...” (p. 65). A second point that the authors make regarding home birth is that it now signifies the ideal type of birth. A woman’s natural self and potential are made evident in achieving a home birth. However, for a woman not to attain this ideal may result in feelings of “betrayal” and inadequacy. To reduce the likelihood that women (both regardful and regardless of their age) experience such erosion of self-esteem, Donna urges home-birthing women to be open to the possibility of hospital intervention.

The midwife, however, may not always be the instigator of the woman’s awareness that problems might occur during labour. Two of the home birth women employed tactics that showed a mindfulness of the paradoxical nature of birth. Grace organized for a tour of the level three obstetric hospital in her area prior to the birth of her daughter and discussed her needs with the charge midwife and a member of the medical staff. Josie had decided for herself to see an obstetrician during her pregnancy.

All throughout pregnancy and early labour, I knew absolutely that if there was any problem, or any reason, that there should be consideration of having the baby in hospital. And that was fine. It really was. And we had our back up specialist organised as well. [...]

Int: Why did you want to touch base with the obstetrician?

Josie: I guess it was the thought that I wanted to know who was going to be there and who was going to be assisting with my birth. If there was going to be a situation where things weren’t going well and we were “going to need intervention” then I felt that I would love to have the choice of having somebody that I **knew**, and I knew that their philosophies somewhat met with ours (midwife and myself). That s/he was going to be the carer who was there. To have that choice really appealed to me. Rather than, with having chosen a home birth, having that feeling that, “Oh, here is a failed home birth arrived in hospital.” You know, “These irresponsible people.” [Rather] that it was someone who very much knew that this was a **very** informed decision. That this is what we were doing with the knowledge that if things weren’t going well, that the home birth wasn’t going to be an option once baby started, then this was going to be the care that we went with.

Josie, Primipara

Josie did not want to wait until problems occurred and thereby have to access an obstetrician whom she did not know or who did not support her idea of birth. Through this strategy her identity as a woman who believes in the body's natural ability to birth and who wishes to be an active participant in the birthing process remains intact. Josie's tactic highlights the fact that the natural birth discourse may not be one that can only be spoken by midwives, GPs and women; there exists the potential for it to be deployed by the obstetricians who agree to support women, such as Josie, choosing home births.

A second point that Josie makes visible, I believe, was her awareness that transfer from home to hospital might make her vulnerable to the surveillance and discipline of hospital staff, by being labeled as "irresponsible" and a "failed home birth". Home birth is portrayed as a test in which a woman succeeds when she is able to give birth without the technology and expertise that is available in the hospital. Failure is when she is incapable of this and requires intervention to ensure the wellbeing of herself and her baby.

Josie sees women's choice of home birth as being judged by the hospital staff and falling into categories of morally right or wrong. One meaning of irresponsible is "acting or done without due sense of responsibility" (Pearsall & Trumble, 1996, p.745) with responsible meaning "... morally accountable for actions; capable of rational conduct," (p.1228). Josie believes that home birth is considered by hospital staff to be a decision that lacks rational judgement in that the woman has not considered all of the eventualities. These include the types of intervention that can only occur in a hospital setting. Josie wishes to show that she is rational and responsible and that she has thought through, and is aware of the possibility of requiring intervention. Jakobsen (1991) noted in her study of women who had chosen to birth at home that the option of home birth became less desirable for three of the seven women when they heard of a woman who had had a stillbirth. They felt that if a misfortune occurred while attempting to birth at home that they would be more likely to blame themselves or to be blamed by others. She stated "These kinds of reactions show that, even though home birth to some degree is quite acceptable, it is also considered to be deviant from the norm of hospital birth" (p. 45).

Being illustrated by Maggie and Jakobsen (1991) is the maternity hospital staff's practice of surveillance of homebirthing women. The scientific medical discourse is a disciplinary system which has established a law regarding where birth should take place

and what practices should occur during childbirth. Foucault (1977) writes of the practice of discipline:

It enjoys a kind of judicial privilege with its own laws, its specific offences, its particular forms of judgment. The disciplines established an 'infra-penalty'; they partitioned an area that the laws had left empty; they defined and repressed a mass of behaviour that the relative indifference of the great systems of punishment had allowed to escape.

p. 178.

Hospitals are locations where the medical discourse is dominant. Women who choose to birth at home are held to have transgressed this medical law. Foucault further states that "What is specific to the disciplinary penalty is non-observance, that which does not measure up to the rule, that which departs from it. The whole indefinite domain of the non-conforming is punishable" (p. 178). Thus, home birthing women may be judged (or can anticipate being judged) by the hospital staff to be "irresponsible" and non-conforming. Josie's tactic of finding a supportive obstetrician during her pregnancy is, I believe, not only an attempt to retain control but is also an attempt to subvert the hospital staff's surveillance and "punishment".

Josie reveals that the assumption that women who position themselves in the natural birth discourse and who choose to birth at home also completely reject the possibility of hospital intervention is misplaced. Recognition of the paradoxical nature of birth is also evident in the literature. For example, domiciliary midwife Joan Donley (1986) in *Save the Midwife* writes that 85% of births can be normal. Donley's percentage also indicates that 15% of births require intervention. In her book *Immaculate Deception* (1975) Suzanne Arms' final chapter describes a woman pregnant with twins giving birth in her local birth centre, which has emergency equipment and access to an obstetrician on call. As Griffen (1994) and Rothman (1991) observe, birth is an act of balancing intervention and non-intervention. Keeping the possibilities open is one means of maintaining balance and is one carried out primarily by those who are involved in home birthing.

The above discussion has identified women's and midwives strategy of keeping the possibility of the medical discursive practice open. Three of the independent midwives also spoke of keeping the possibility of a home birth open. Donna, Margie and Joanne recalled situations when they had cared for "at risk" women. Each of the women had requested that the midwife support them in choosing a home birth. Most

practitioners might not have supported the women's desire to have a home birth. Donna remembered her client who was pregnant for the fourth time:

She had been induced with the other three [previous pregnancies]. Two had had severe intra-uterine growth retardation, and one had been an anencephalic and had died after two days. Appalling social circumstances, no money, nothing. But she said to me when I first saw her, "I'm sick of hospitals and the way they tell me what to do. I want to have a home birth." So I said, "OK, these are the factors, and if you do have the intra-uterine growth retardation again, I'm sorry but I have to do this, and you have to do this, that and the other, and look after yourself." She had the most fantastic home birth with a healthy baby.

Donna, Independent Midwife

As exemplified by Donna's text each of the women for various reasons did not want to birth in a hospital. The three midwives knew that in agreeing to the women's request for a home birth they were exceeding the boundaries of their practice. Margie spoke of her limits as: "I did take on more than I could, because in theory a midwife looks after a woman without any risk factors." The primary role of midwives is to care for women who are "experiencing a normal pregnancy, labour, birth and postnatal period" (Guilliland & Pairman, 1995, p. 34). In undertaking the care of "at risk" women, and in supporting their desire to birth at home, the independent midwives both contest the boundaries of professional practice and the medical model of risk. Lane (1995) writes, "it is unlikely that the debate about safety relative to setting and location will be resolved satisfactorily because the definition of risk, or what criteria should be employed to determine level of risk, is a contested terrain" (p. 58).

Joanne's excerpt below exemplifies what may happen when a midwife takes on the care of "at risk" women. I had asked Joanne how she viewed the issue of maternal age she replied with the following story:

Well, like I told the professor of obstetrics and gynaecology one time when I had to transfer a 35 year old primigravida in for a transverse arrest. He called me out into the corridor, you see, and he said, "What do you mean trying to deliver a 35 year old primigravida at home?" And I said, 'Well, I think that nutrition is far more important than age.' And so he said, "Well, I'm not asking you. I'm telling you." Then he started telling me about his standards and my lack of them.

Joanne, Independent Midwife

Transfer of the woman from birthing at her home to the hospital however, brought Joanne's practice under the scrutiny of the hospital obstetrician, and not just any obstetrician. He was the professor of obstetrics and gynaecology who held high political positions both in the hospital and in the medical department of the city's university. He was responsible for undergraduate and postgraduate obstetric and gynaecological education and for the medical obstetric and gynaecological services of the hospital. The hospital was the institution that endorsed his position and which gave him the authority to assess Joanne's practice. He had the authoritative power to confront Joanne and to challenge her practice based on his judgement that she lacked professional standards. In the context of the hospital as a disciplinary institution, the professor had the power to discipline her. Joanne, the domiciliary midwife, was expected to listen and take heed of what he said. She should not let primigravid women aged 35 birth at home.

Not only did the hospital endorse the professor's position but it also provided a physical space for the link between the language of discourse and its practice, and its enactment in everyday routines, protocols and policies to occur. In turn the hospital routines and procedures reproduce the scientific medical discourse and its power relations (Parker, 1992). In entering into the domain of the scientific medical discourse, Joanne's resistant position was made both visible and vulnerable.

In her position of expert and lead maternity carer, Donna was quite direct and explicit about the strategies that would be put in place should the baby's wellbeing become compromised. Similarly, Joanne and Margie knew that should the boundaries of maternal and fetal wellbeing be breached that transfer to obstetric care would be required. By extending the boundaries of their practice, the midwives facilitated the women's choice and provided them with the opportunity to birth at home. The possibility of a natural birth was kept open. However, in overtly contesting the scientific medical discourse, the midwives expose themselves to the possibility of criticism and challenge.

## **10.9 HOME BIRTH AS A DISCURSIVE PRACTICE OF OPPOSITION**

Home birth, in removing the woman from the gaze of the medical discourse, is seen to overtly spurn and resist the technology and expertise that the medical discourse is held to offer. For example, Donley (1992, p.4) identifies home birth as a political

action because it contests technological childbirth. Josie talked of home birth in the following way:

Home birth was an issue that I feel would be the same no matter what age I was. Perhaps, I don't know. It was an issue with regards just going through, looking at what pressure that comes on from many people's views. Certainly from a medical view in that you are taking a great risk and that you are doing something dangerous. Medical model view versus this is usually a normal ... a normal birth is usually an experience that technology won't enhance.

Josie, Primipara.

Josie's comment shows the contentious nature of her choosing to have a home birth. She is well aware of the contradiction between the medical and the natural birth discourses. The place of birth also becomes contested because of the contradictory ways in which the two discourses construct birth. Each discourse constructs the other as potentially harmful. The natural birth discourse assumes that unnecessary medical intervention may threaten the wellbeing of the mother and her baby (Inch, 1989). In contrast, the medical discourse assumes that home birth is potentially harmful in its lack of immediate access to specialist obstetric and neonatal support.

Rosalie's first child had been born at a level one hospital four years earlier. When she became pregnant for a third time, having had a miscarriage in between, she chose to have a home birth. She gave several reasons for her choice.

I decided that there were more chances of infection in hospitals, infecting the baby and me. Plus I wouldn't be away from my other daughter. It would be a continuation of home life. It wouldn't be a big disruption for her. I just liked the idea of it and the familiar surroundings. I was also right into natural things. [...] I follow my natural leaning towards more natural things. Non-interference: I felt that in hospital you are more likely to get more interference.

Rosalie, Multipara

Rosalie identified the hospital as a place of possible contamination. She believed that the large numbers of postnatal women brought together in the hospital increased the number of infective organisms and therefore the likelihood of becoming infected. In contrast by having a home birth, she and her baby are more likely to remain isolated from such nosocomial infections. Rosalie echoes authors such as Inch, (1982) and Kitzinger (1991) in her view that a stay in hospital as an unwelcome break that places physical and emotional stresses both on her and her children

For all five of the women who chose to birth at home, control was linked to minimising the possibility of technological interference. Control was identified by Jakobsen (1991) as the most important reason given by the seven women in her study choosing a home birth. In a study of thirteen Manawatu women who planned to have a home birth, one of the grounds given for having a home birth was to retain control over the birth and decision-making (Griffin, 1994). Maggie spoke of her reasons for having her son at home:

I remember reading about home births and natural environments. I know that is where I got the stuff from and it is something that has stayed with me

Int: So you chose a home birth for a natural labour and birth?

Maggie: Yes. That combined with the fact that I had this great fear of going into hospital and having people do things for me and it being out of my control. I wanted it all to be my thing, my partner's, my baby and my thing, not someone else's territory.

Maggie, Primipara

Maggie was desirous to give birth without intervention and to retain power over whatever happened during her labour and the birth of her baby. The hospital is seen as a place which threatens her autonomy. Others come in and takeover the work that her body has to do. Birthing at home prevents Maggie from losing control. It is her space and she can authorise what intervention can or cannot occur.

Jakobsen (1991) highlights the paradoxical nature of natural birth in that for the woman to retain control she must give up control of her body. For the woman's body to go through the natural birthing process it needs to be free from any physical and psychological encumbrances. Part of gaining and maintaining control is having control over one's environment, that is who is present at the birth. Jakobsen found that people's presence could influence a woman's labour. As the woman's home is her space, she can determine who is present. This is important if the woman is to "work with" her labour process (p. 91). Josie reflected on her experience of a home birth in this way:

I have a strong feeling that the environment that you birth in affects the birth process. I think that you have to be very, it's not just self-assured, but very able to just go within yourself and focus within. To be able to go through birth in an environment like a hospital and not be radically influenced by everything that is going on around you, I don't know. [...] Being in my home meant that I was able to be more

myself than I probably would have been able to in a hospital environment.

Josie, Primipara

Birthing in one's home allows the mind-body connection to work in a productive way so that a natural birth is achieved. Home birth creates both a physical and mental space for women. It allows them to avoid the unwanted invasion of body and mind that the hospital's routines and policies may expose them to. At home the women are not vulnerable to the presence of unwanted others, such as hospital consultant obstetricians, registrars and house surgeons who comprise the hospital obstetric team and who can interfere with women's bodies and minds thwarting birth from occurring naturally.

For older women then, the discursive practice of home birthing allows them to avoid being labelled "elderly" and considered potentially problematic. They can actively oppose the medical discourse's construction of birth as inherently pathological (Griffin, 1994) and identify with the natural birthing discourse that invests them with the capability to birth without necessarily requiring intervention.

## **10.10 SUMMARY**

In this chapter, I have described and analysed how the natural birth discourse opposes the medical discourse and in doing so offers older women the space to be judged as "normal" and not to be divided from younger women or distinguished as "other". They retain the opportunity to choose practitioners other than a specialist obstetrician, and to give birth in their own home.

Speakers of the natural birth discourse assert external factors rather than an intrinsic aging process are the cause of problems encountered by older primigravidas. The mind-body connection makes older particularly vulnerable because they may be subjected to statements made by others who do identify them as being at risk. Exposure to such beliefs are considered to have the potential to undermine the older woman's belief and hence her ability to give birth without intervention. In constituting the subjectivity of the older woman as vulnerable to outside comments, the role of the midwife is one of encouraging and affirming the woman's ability.

The natural birth discourse constructs most women as inherently capable of giving birth. Women are encouraged to believe in their capability and are positioned as

active and influential partners in the birthing process. These expectations may be daunting for some women who do not identify themselves in this way.

The assumption that women are always equal partners has been disrupted in this chapter. While the natural birth discourse contests the medical discourse constructs of birth and the older primigravida, the practitioners who deploy the natural birth discourse use the same power strategies of surveillance and normalisation as the practitioners who deploy the medical discourse. In both discourses women are subjected to the gaze of the “expert” maternity practitioners. In addition, the natural birth discourse sanctions the use of the confessional strategy as means of producing information about the woman. The process of the confessional affirms the status of the practitioner as expert and adds to the practitioner knowledge and power potential.

I have shown that while birth as a healthy and normal process is foregrounded, for some women and practitioners, the construction of nature as a brute force, which can take its own course, reveals the unstable and partial character of the natural birth discourse. When the health and lives of the mother and/or her baby are judged to be in danger, the context changes. Birth becomes potentially pathological and the transfer to hospital and the use of medical intervention become appropriate. For some of the women and the practitioners their position was neither solely within the natural birth discourse nor within the medical discourse. In being mindful of the potential for a changing context, the strategy that they adopted was one that I have called “keeping the possibilities open”. The possibility of having a home birth and a hospital birth were kept open. For one woman, planning for the likelihood of a hospital birth allowed her to maintain her identity as “moral” and “responsible” and therefore to subvert the hospital surveillance and punishment she anticipated would be meted out to her.

## **Chapter 11: CONTEST AND COMPLEXITY**

Maybe the target nowadays is not to discover what we are, but to refuse what we are. We have to imagine and to build up what we could be to get rid of this kind of political “double bind” which is the simultaneous individualization and totalization of modern power structures. ... We have to promote new forms of subjectivity through the refusal of this kind of individuality which has been imposed on us for several centuries.

Foucault, 1982, p. 216.

### **11.1 INTRODUCTION**

I chose a Foucauldian analysis for its potential to expose the diverse discourses that comprise the discursive field of pregnancy and childbirth in relation to maternal age, and to challenge the “taken-for-granted” aspects of the routine practices associated with the care of such women (Cheek, 2000). Another outcome of a Foucauldian approach is the identification of new discourses that ~~that~~ resist the potential constraints of dominating discourses. The aim of this chapter is to review the findings of my study. I firstly discuss the complex and contested nature of both genetic testing and childbirth and how discourses offer competing and diverse subject positions for first time primigravida/primipara aged 35 and over and for maternity practitioners. Secondly, I overview the strategies of resistance that women and practitioners engaged in as a means of evading and subverting disciplinary surveillance and normalisation. Following this I explore the implications of the study for practice and education. I focus on the strategy of counter-discourses as a means of destabilising the authority of the dominant scientific medical discourses related to pregnancy and birth for women aged 35 and over. Lastly, I discuss the limitations of the study and suggest topics for future study.

### **11.2 PRENATAL GENETIC DIAGNOSIS: A COMPLEX ISSUE**

Historical analysis foregrounded the changing meanings of Down syndrome and showed their contextual and constructed nature. Analysis of the literature regarding prenatal genetic testing revealed that the development of the technology was interconnected with and facilitated by the eventual legalisation of abortion. Underlying the development was the intersection of the medical genetic discourse’s representation of Down syndrome as a chromosomal “abnormality” and of increased maternal age as a significant risk factor in causing Down syndrome.

Prenatal genetic diagnosis is a technique of surveillance (Sawicki, 1991). I have shown that multiple discourses comprise the discursive field of prenatal genetic diagnosis and that the discourses deployed by the women are different from those deployed by the practitioners.

The women's texts revealed a diversity of discourses brought into play to explain their decision whether or not to undergo genetic testing. Competing discourses of motherhood and disability offered contesting representations of motherhood, disability and prenatal genetic diagnosis. The outcome of the practice of informed choice and the hegemonic status of the medical genetic discourse is that "older" women are compelled to consider the possibility of giving birth to a disabled baby, particularly one with Down syndrome. At the outset of pregnancy they must project themselves as mothers of such a baby. There is no means by which they can escape this assessment of themselves and their future child.

For the women who underwent prenatal genetic diagnosis their continuing with the pregnancy was conditional on the results of the CVS or amniocentesis showing an absence of "abnormal" chromosomes. Most of these women judged themselves to be incapable of meeting the extra demands that a disabled child would place on them as its mother. In their representation of the disabled child, the conditional mothers drew on a discourse of disability, which emphasizes the dependency of the disabled on their family and society (Oliver, 1990). Oliver argues that dependency is itself a social construction and has been brought about by economic, political and social factors. In contrast, the women who chose against undergoing prenatal genetic diagnosis deployed a different complex of discourses and constructed the disabled child in words other than the binary opposites of abnormal and dependent. Instead the child was seen as positively different. In contrast to the women choosing prenatal genetic diagnosis who were silent on this issue, the unconditional mothers deployed a discourse of reproductive aging through which they identified the opportunities for them to become mothers as limited.

For the practitioners a different complex of discourses was brought into play. The discourses of neo-liberalism, and law cohere to support and enforce the interpellation of "older" women as both objects and subjects of the medical genetic discourse. The practitioners construct themselves as enforcers of informed choice, relaying relevant information about the tests on to the women. The legal discourse positions the practitioners as vulnerable to discipline through lawsuits for the wrongful birth of a disabled baby and so sustains the neo-liberal and liberal feminist discourses

practice of informed choice. However, the legal discourse, I suggest, has the potential to complicate the two other discourses in terms of the practitioners' motives. For some practitioners their interests in informing the women are more complex and not solely to ensure that women are enabled to make an informed choice but to also protect themselves from being subjected to legal discipline and punishment.

### **11.3 PREGNANCY AND BIRTH: A CONTESTED ISSUE**

Two competing discourses were evident in both the literature and interview texts: the scientific medical discourse and the natural birth discourse. Each discourse constructs the process of pregnancy and birth in a specific way, which has implications for how the capabilities of women's bodies are perceived by practitioners. The two discourses also offered different and contesting subject positions for the various maternity practitioners speaking the discourse. The discursive representations were echoed by the women in how they perceived their ability to undergo the processes of pregnancy and birth without requiring intervention.

#### **11.3.1 The scientific medical discourse**

The scientific medical discourse constructs birth in itself as being problematic. Increased maternal age is also constructed as a complicating factor and in its overlap compounds the construct of birth as inherently dangerous to depict birth for the "older" woman as even more at risk. The scientific medical discourse consequently identifies the appropriate place for "elderly" primigravida/primipara to give birth is in a level three hospital where specialist obstetric staff and technology can be easily accessed. Specialist obstetricians are deemed to be the ideal maternity carers because of the inevitability of "elderly" primigravida/primipara requiring intervention. In determining caregiver and place of birth, the scientific medical discourse constrains "older" women's choices and maintains boundaries of professional scope of practice, the obstetrician assigned the caregiver for women at risk.

For the women who deployed the scientific medical discourse, their positioning as objects of the medical discourse was, for most of the women, assigned to them by the medical practitioners whom the women accessed in the early stages of their pregnancy. However, for the women their identification as "being at risk" was not regarded as an alien imposition. Some of the women had perceived birth as a potentially complicated event prior to becoming pregnant at the age of 35. Similarly, others were already aware

of their age as a medical issue. Therefore the medical practitioners, the authoritative speakers of the medical discourse, confirmed the women's understanding.

With the belief regarding birth as a potentially dangerous phenomenon, the women desired to assure the birth of a live, healthy baby and to maintain their own wellbeing. The choice of an obstetrician was seen, as one woman stated, as "insurance", "the horse for the course". To provide for the possibility that birth might become abnormal, the obstetrician was viewed as the practitioner whose scope of practice straddled both the normal and the abnormal birth. The obstetricians have a repertoire of techniques and technology to assist the mother in the birth of her baby, particularly the ability to perform a caesarian section.

As discussed in Chapter Nine, the obstetricians constructed "older" primigravida/primipara as potentially pathological and as having limited opportunities to become mothers. Such representations confirm the position of the obstetrician as the appropriate maternity carer. However, the subject and power relationships between the woman and practitioner become ambiguous and complicated in the private setting.

The context of private practice permits the opportunity for the woman to either exercise power over the obstetrician or share power with the obstetrician. Some of the obstetricians portrayed "older" primigravida/primipara as adopting the neo-liberal discursive position of informed and assertive consumers and positioning the obstetricians as providers of technological birth. In this relationship the women desire control over birth and thus attempt to influence the obstetricians' conduct. The obstetricians deployed a further discourse, a discourse of caring, where they develop a close, more subjective, relationship with women. In positioning themselves more as friends rather than clinicians, the use of intervention becomes more complicated and ambiguous. Some obstetricians identify themselves as more likely to acquiesce to women's desires for intervention, or to sway the woman to accept intervention, or to make the decision to intervene earlier during the course of labor. Such paradoxical use of intervention reveals the unfixed nature of reading the labouring body. It highlights the subjective nature of practitioners' decision-making and contradicts obstetrician's claim to being objective and utilising intervention on scientifically justified grounds.

### **11.3.2 Natural birth discourse**

The natural birth discourse competes with the scientific medical discourse in its construction of birth as a normal physiological process. Most women are identified as

capable of giving birth without necessarily requiring intervention. The woman's body is regarded as trustworthy and capable. Maternal age is not identified as a risk factor and so when located in this discourse, the "older" woman is offered a subject position that contradicts and opposes that offered by the scientific medical discourse. She is not categorised as "at risk" and therefore is not different from younger women. Rather than limiting "older" women's choices to specialist care and birth in a level three hospital, a variety of options in relation to caregivers and birthplaces remain open to her. The potential exists for midwives and GPs to be autonomous practitioners in providing care to "older" women.

Papps and Olssen (1997) state that the procreative body is a site of struggle between obstetricians and midwives. Maternal age is one issue in which the contest between these two groups is made manifest. "Older" primipara may become, wittingly or unwittingly, the subjects of this contest. The recollection of Joanne, the Independent midwife, (described in Chapter Ten) of being challenged by the professor of obstetrics when she transferred an "elderly" primigravida to from home to hospital, provides an example of when this contest becomes overt. The hospital midwives' accusation of "bailing out" also reflects the contest between midwives who position themselves in the natural birth discourse and obstetricians.

A further consequence of the contest between maternity practitioners is, I propose, the dualisms that are seemingly perpetuated by the natural birth and scientific medical discourses, such as the capable/incapable bodies, or birth as a medical/natural event. As Barker (2000) argues, dualisms such as the mind/body are derived from the Enlightenment's opposition of reason and human nature. The dualisms provide the basis for modern ideas of rationality and science. I believe that what I have shown is that some practitioners and women may position themselves in the space between the natural birth discourse and the scientific medical discourse. Their practice is not an "either/or". Rather their practice is more of a "both/and". The brute reality of birth's unpredictability makes evident a space of play between the scientific medical discourse and the natural birth discourse and permits practitioners and women to keep on the horizon of their thought the potential for birth to both uneventful and problematic. Positioning oneself within the space also allows the "older" primigravida/primipara to retain a degree of knowledge and control over the events that may ensue during childbirth and to resist the constraints associated with the label of "elderly" primigravida/primipara.

## 11.4 STRATEGIES OF RESISTANCE: EVADING CATEGORISATION

Gordon (1994) writes of Foucault's concept of resistance: "there is always something in the social body, and in each person, which evades or wrestles with others' attempt to act on our own ways of acting" (p. xx). Thus the potential for resistance is everywhere. Resistance has been shown in this study in the various acts of evasion deployed by some of the participants. In Chapter Ten, midwives and a GP talked of referring "older" women to obstetricians who did not judge these women to be "at risk" purely on the basis of their age. Although they would observe the recommendation (in the case of the hospital midwife the hospital protocol and for the independent midwives and GP the Health Funding Authority's referral guidelines document) to consult with an obstetrician when caring for "older" women, they would choose an obstetrician who shared their view of maternal age. In this way they were able to retain care of the women and were able to keep open the possibility of a natural birth.

Another practice of resistance is that of a strategy of elusion whereby several women resisted undergoing prenatal genetic diagnosis. As argued in the Chapter Five, the practice of prenatal genetic diagnosis is a disciplinary practice in which the quality of the future child is assessed and determined to have a "normal" or "abnormal" number of chromosomes. I have shown that the multiple identities and meanings that some women gave to themselves, children with Down's syndrome, and prenatal genetic diagnosis created the space for them to elude surveillance.

A Foucauldian analysis has facilitated the recognition of maternal age as a shifting, historical and social construction that complicates pregnancy and birth for women and practitioners. Rather than examine the texts for a meta-narrative, a shared meaning across the texts, a Foucauldian analysis has brought to light their contradictions, complexities, contests and diversities. In particular, I have foregrounded the multiple and contested meanings of maternal age, birth, motherhood, prenatal genetic diagnosis and disability and the complexity that ensues. Women's decisions regarding place of birth, caregiver and prenatal genetic diagnosis, and the practices of maternity practitioners reveal a complexity of discursive subject and power positions. In addition, Foucauldian analysis interprets strategies of elusion as acts of power. Women and practitioners' actively attempt to resist the scientific medical and medical genetics discourses' technologies of power by drawing on contesting discourses.

## 11.5 IMPLICATIONS FOR PRACTICE AND EDUCATION

The following implications stem from Foucault's concepts of truth, discourse, subjectivity, knowledge and power that have been explicated in Chapter Two. I firstly draw on the writing of Willig (1999) who suggests the use of discourse analysis as a means of social critique and empowerment and then on McWhorter's (1999) interpretations of Foucault's practice of counter-memory and pleasure as strategies of opposition. Finally, I consider the implication of Foucault's idea's of the social construction of knowledge and the discursive production of subjectivity for practitioners both in relation to themselves and when caring for "older" primigravida.

Willig (1999) identifies three ways in which discourse analysis has been used to bring about social and political change as a means of: social critique, empowerment and, a guide to reform. The latter two involve social critique as a part of their process. As a means of social critique discourse analysis can reveal how language "conspires" to justify and maintain unequal power relationships. How discourse analysis as social critique works to bring about social and political change is by publication of its findings<sup>20</sup>. While no publications have resulted during the process of undertaking this study, several presentations on prenatal genetic diagnosis and the natural birth discourse have been given at conferences attended by health psychologists, midwives and medical practitioners. Feedback from midwives and a general practitioner indicated that my findings reflected their experiences and practice. It is anticipated that publications will follow in the future.

To effect empowerment discourse analysis needs to bring to light the discourses that challenge dominant discourses and the advancement of subversive practices and spaces of resistance (Willig, 1999). In Chapters Six and Ten, I have identified the strategies of elusion as practices of resistance. By refusing prenatal genetic diagnosis the women actively escape the medical genetic discourse's practices of surveillance and normalisation. I have shown how the natural birth discourse offers women the space to resist categorisation as an "elderly" primigravida/primipara. Furthermore, the strategy of keeping possibilities open, which allows for "older" women to have the opportunity to give birth without intervention, has been foregrounded .

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<sup>20</sup> The audience becomes aware of how language works in perpetuating certain kinds of power relations and can use such knowledge to oppose ruling discourses. However, it is up to the individual listeners to determine the kind of oppositional actions they undertake.

The Foucauldian concept of counter-memory refers to the recollections of events that reveal gaps in official knowledge where official explanations do not quite fit or cover (McWhorter, 1999). Such recollections provide the place for forming new networks of power and knowledge by locating and gathering together similar memories, a process that Foucault terms “counter-remembering”. The strategy of counter-memory may reveal the suppression of certain knowledges or the social construction of an identity. McWhorter (1999) proposes that the practice of counter-memory provides the potential to facilitate opposition to domination through ~~by~~ “the construction of alternative networks of meaning, it helps provide a “place” from which to analyze oppressive forces and to think through strategies to oppose them” (p. 1999).

The collection and analysis of stories of other “older” primigravida/primipara who have given birth without intervention would challenge the scientific medical discourse’s representation of “elderly” first time mothers as incapable and problematic. Analysis of the literature showed the proposition that information is limited in that the implications of prenatal genetic diagnosis for society and for disabled people remain silent (Rapp, 1993). In the same way, the gathering of women’s/parents’ narratives of caring for children with chromosomal “abnormalities”, such as Down syndrome, may provide more diverse representations of disability.

Rothman argues (1993) that while the decision to undergo prenatal genetic diagnosis and selective abortion remains private, society does not have to take responsibility. Debate on the topic remains sporadic and I believe, needs to occur at a broader societal level. Maternity practitioners in their position of experts and enforcers of informed choice are in a position to stimulate such a debate.

McWhorter (1999) has adopted Foucault’s notion of pleasure as a means of opposing the regimes of normalisation in relation to sexuality. She writes:

We need to find ways to continue to grow in capability, even in sexual capability, ways to be strengthened and enabled, that don’t make us more docile, more disabled at the same time. Growth, development, change must be fostered, but it must not lead to a narrowing of behavioral possibilities. In short, instead of rejecting disciplinary practices altogether – which we could not in any case do – what we need are disciplinary practices that we might engage in carefully, deliberately, but with modifications that militate against standardized outcomes. Instead of refusing normalization outright, we need to learn new ways to use the power of its disciplines to propel us in new

directions, which might (or might not) eventually establish something outside normalizing power networks.

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Perhaps the use of this strategy may alter the meanings of maternal age and prenatal genetic testing. The link between CVS or amniocentesis and abortion may be severed. Perhaps the test results may allow women who receive a result showing that they may have a baby with chromosomal abnormalities to continue with their pregnancy and use the knowledge to enhance their capabilities, to access support and further information.

Foucault's political agenda was to create a way of thinking that regarded "everything as dangerous" (Gordon, 1994, p.xix). What this meant was neither a skepticism towards everything nor a compelling search for absolute truth but rather an approach to power and knowledge that involved careful and specific investigation. Such an approach could be part of practice and education. Practitioners' exploration and awareness of the constructed and contextual nature of meaning, such as birth and maternal age, needs to be encouraged. Likewise, careful examination could be used to critically consider new discursive practices before they are incorporated into practice. Analysis should include the subject and power positions that the discourse offers to women and practitioners as well as uncovering the non-discursive conditions that maintain the existence of the discourse.

In Rothman's (1993) seminal research into women's experiences of prenatal genetic diagnosis, she surfaces the philosophical argument, the "slippery slope" (p.228). This perspective opposes prenatal diagnosis and selective abortion on the grounds that as the ability to diagnose genetic "abnormalities" improves, the number of identifiable diseases will continue to increase creating the questions of: where will it stop? What will constitute abnormality? An example of the "slippery slope" occurred for me recently when I had an informal debate with a health practitioner about the hypothetical possibility of prenatal diagnosis of diabetes mellitus. The practitioner located himself in the neo-liberal discourse and saw this as an opportunity for the mother to make the choice about whether or not to bear a child with the potential for developing diabetes. In comparison, I positioned myself as a mother having to make that decision with the knowledge that diabetes, although presently cannot be cured, can be managed effectively. In another conversation about the same topic, a person raised the issue of the economic cost of diabetes to the person and society.

With the development of genetic testing and technology, such as high-resolution ultrasounds and nuchal screening which provide the opportunity for non-invasive prenatal screening, both the range of conditions and the type of tests are increasing. While this gives “older” women less invasive means of determining the presence or absence of Down syndrome and other abnormalities, there also exists the potential for these to be extended to all pregnant women. To a certain extent this already exists with the practice of ultrasounds routinely performed at eighteen weeks to confirm the delivery date of the baby in New Zealand. It is possible in the future that maternity service providers may be given the responsibility to ensure that pregnant women are aware of the genetic conditions that may be diagnosed prenatally.

If postmodernists regard power as unstable and contestable, then questioning is an ongoing process. In relation to the development and use of birthing technologies and prenatal genetic diagnosis such questions could be: who will determine what technological or screening devices are used, whose interests are being silenced, or excluded, how is power being exerted?

While the majority of women in this study were aware of the relationship between maternal age and the increased incidence of chromosomal “abnormalities”, the experiences of Rebecca and Josie in Chapter Six serve as reminders for practitioners not to assume that all “older” women will know of prenatal genetic diagnosis. In particular, Josie’s experience of feeling confronted with the information and her depiction of it as a negative one shows that practitioners have an invidious role in introducing such knowledge to women.

Drawing on Foucault’s notion of subjectivity as partial and shifting, practitioners need to be aware of the complexity and possible unpredictability of the discourses that pregnant women may take into consideration in making decisions. Gregg (1995, p.125) states that the medical genetic discourse’s model of choice emphasizes risks and benefits. I have shown in this study that women’s decisions are more complex than this. The contradictory discursive positions that women may be faced with both in relation to prenatal genetic diagnosis and maternal age may make for ambiguity, contradiction and tension.

In the same way I have brought to light the rich field of discourses deployed by the practitioners. Maternity practitioners need to be aware of the complexity of discourses that influence their practice. Discourse analysis offers practitioners one

means of highlighting the existence of multiple discourses and determining areas of overlap, competition and contradiction, and possible sites of resistance.

## **11.6 LIMITATIONS OF THE STUDY AND SUGGESTIONS FOR FUTURE RESEARCH**

It is highly probable that there are hospital midwives who do position primigravida and primipara aged 35 and over in the scientific medical discourse and obstetricians who do not. A greater number of hospital midwives and obstetricians as participants may have revealed more diversity amongst these two groups of practitioners in their ways of thinking about maternal age in relation to pregnancy and birth.

One limitation of the study was that none of the women who participated in this study had children born with physical or intellectual disabilities. Neither had any of the women who had undergone genetic tests received a positive result. Such participants may have added to the discourses articulated pertaining to prenatal genetic diagnosis. Similarly interviewing women from a variety of cultures and socioeconomic groups may have extended the range of discourses.

In addition, as the aim of my study was not to explore fully the reasons for women's decisions regarding prenatal genetic testing, my identification of the discursive positions produced by the women may not be a full representation of their complexity. Therefore the findings from this thesis are partial and local.

As identified in the literature analysis, the reasons for caesarian sections being frequently performed on "older" women have been contested in the medical, midwifery and women's health literature. Some of the interviews with obstetricians did reveal that at times the interplay between a woman and her obstetrician might give rise to the decision to deliver the baby by caesarian section. Qualitative research in the future could explore the relationship between the woman and her obstetrician, especially with the number of caesarian sections continuing to increase. An analysis of the different discourses could reveal the discursive positions taken by the women and obstetricians.

While much research has been done in relation to women's perspectives on prenatal genetic diagnosis overseas, there does not appear to be have been many studies carried out in New Zealand. The provision of free genetic testing and abortion for pregnant women who meet the criteria as discussed in Chapter Five makes New Zealand women's context and access quite different to those of women in other

countries. For example, American authors such as Rothman (1993) identify access as an issue for lower class women. A study that included women from different socioeconomic and ethnic groups would bring to light the existence of other meanings of disability and prenatal genetic diagnosis.

I have suggested that the legal discourse has the potential to compete with the liberal feminist discourse in practitioners' interests in ensuring that women are informed of their risks and options. A further area of research would be exploring the implications of the legal discourse on the practice of informed choice by maternity and other health service practitioners.

Lastly, I noted in Chapter Four that there was a paucity of research in pregnancy outcomes for "elderly" primigravida/primipara who received care from independent midwives. A prospective study of the pregnancy outcomes of primigravida/primipara aged 35 and over "~~older~~" who were in the care of independent midwives offers the potential to challenge the scientific medical discourse. Furthermore, a similar study which involved a variety of maternity caregivers and places of birth would allow for a comparison and evaluation of practitioner's practices during pregnancy and childbirth. Combining qualitative and quantitative methodologies would enrich the findings of the study.

## **11.7 CONCLUSION**

The use of a discourse analytic approach derived from Michel Foucault's concepts of discourse, power/knowledge and subjectivity has brought to light a complex array of discourses in play in relation to first time pregnancy and birth for women aged 35 and over. The relationships of the various discourses to one another was of overlaps, intersections or contradictions in the meanings that they produced for maternal age, pregnancy and childbirth, disability, motherhood and prenatal genetic diagnosis.

Correspondingly, analysis revealed a diversity of subjectivities that were offered by the discourses and deployed by the women in their accounts of pregnancy and birth and by the practitioners in the descriptions of their practices regarding first-time pregnant women aged 35 and over. The complex, contradictory, and fragmentary nature of subjectivity has been highlighted in this study and behoves practitioners to remain aware of the multiple interests that influence their practice and also women's decision-making.

Foucault's concept of power as always in play, always contestable, calls for consideration of the strategies of resistance as well as strategies of power. Such strategies have been foregrounded in this study and have shown that disciplinary techniques such as prenatal genetic diagnosis and specialist referral systems have the potential to be contested by women and practitioners.

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# APPENDIX I

## INFORMATION SHEET FOR WOMEN

### *PREGNANCY AND BIRTH FOR WOMEN OVER THE AGE OF THIRTY-FIVE AND OVER*

Thank you for taking the time to consider whether or not you wish to join in this research study.

My name is Debbie Payne. I am a nurse lecturer at the Auckland Institute of Technology. I am enrolled in a PhD programme in the Department of Nursing and Midwifery, Massey University.

My supervisor is Dr Cheryl Benn who is a midwife-lecturer at Massey University. She can be contacted on 443 9700.

#### **Purpose of the study**

My study is about the experiences of pregnancy and childbirth for women who have given birth when over the age of thirty-five. My interest in this subject stems from my own experiences as a woman who has had her children when over the age of thirty-five.

Having looked at the literature I have found that for women who are aged thirty-five and over, the stories of their experiences of pregnancy and birth are lacking.

I am approaching women who have had experiences of pregnancy and childbirth when aged thirty-five or over. I would like to talk to women who have had their first child when over thirty-five. I also want to speak to women who have given birth both before and after the age of thirty-five.

The time since the pregnancy and birth has happened has no limits as I would like to explore if there have been any differences in women's experiences over time. The place also is not relevant as this may reveal different experiences. My only requirement is that the people involved in my study are fluent in conversing in English and therefore able to relate their experiences in some depth to me.

#### **What would be expected of you**

If you accept my invitation and consent to participate I would like to interview you for approximately one hour, at a time and place that is convenient for you. With your permission, I would like to tape the interview. At the beginning I will ask you to choose another name by which you will be known. I will also check if there are any further questions about the research you wish to have answered. Please be aware that you can ask me questions about the research at any time. Before we start the interview I will ask you to give your written consent to being involved in the research.

My opening question to you will be “What were your experiences of pregnancy and childbirth when you were older than 35 years ?” From there on I intend to follow the topics and issues as they arise. However there are issues such as : genetic screening, place of birth and choice of caregivers which I will ensure are discussed during the interview.

At anytime during our conversation you have the right to ask me to turn the tape off , and to delete or withdraw something that you have said. You will always have the right to refuse to answer any particular questions and to withdraw from the study at any time.

Following the interview the tape will be transcribed, either by myself, or by a typist who would be required to sign a declaration of confidentiality. I will then send you a copy of the transcript. You have the right to delete any thing that you do not wish to be part of the study and to make any corrections. We will then decide together if there is a need to meet again for another conversation.

The transcript will be kept in a locked cupboard. Only my supervisor and myself will read your transcript. At the end of the research you may have the tape returned to you if you wish or the tape will be archived at Massey University for a period of 5 years and then destroyed.

The information that you provide me with will be used to develop my research thesis. Parts of the thesis may be published in professional journals, or used in conference presentations. Your anonymity will be kept as only your pseudonym will be used.

### **Your Rights as a Participant**

You have the right to:

- refuse to participate
- to ask for the tape to be turned off at any time.
- withdraw from the study at anytime.
- ask for any further information about the study that occurs to you at anytime.
- refuse to answer any particular questions.
- be given access to a summary of the findings from the study when it is concluded.
- provide information on the understanding that your name will not be used.

### **Benefits Discomfort and Risks**

It is not anticipated that there will be any benefits for you as a participant except the possibility that you may enjoy the opportunity to talk about your pregnancy and birthing experiences.

Likewise, it is anticipated that there will be no risks from being involved.

However, there may be some discomforts such as: the time taken for the interview; or the triggering of unpleasant recollections / experiences. If this happens you can choose whether or not you would like me to give you the names of organisations or individuals who may give you the support you require.

If you have any queries or concerns regarding your rights as a participant in this research you may contact the Health Advocates Trust, phone 638 9638.

If you have any queries you may contact me at:  
Work: 307-9999 extension 7112 ( which has a 24 hour answerphone),

My work address is: Debbie Payne  
Faculty of Health Studies  
Auckland Institute of Technology  
Private Bag 92006  
Auckland 1020

If you have any queries or concerns about the research that would prefer not to discuss with me please contact Cheryl Benn at Massey University, phone: 443 9700.

Unless you prefer to contact me before, I will contact you in two weeks time to ask whether you would like to be a participant in my study. I will not contact you before this time. It is important to me as a researcher that you feel under no pressure to be involved in the research.

Debbie Payne

## APPENDIX II

### INFORMATION SHEET FOR PRACTITIONERS

#### *PREGNANCY AND BIRTH FOR WOMEN AGED THIRTY-FIVE AND OVER*

Thank you for taking the time to consider whether or not you wish to be a participant in my research.

My name is Debbie Payne. I am a nurse-lecturer at the Auckland Institute of Technology. I am enrolled in a doctoral studies programme in the Department of Nursing and Midwifery at Massey University.

My supervisor is Dr Cheryl Benn who is a midwife-lecturer at Massey University. She can be contacted on 443 9700.

#### **Purpose of the research**

This research is about how the age of women influences their pregnancy and childbirth. The age focus of this research is on women who are aged thirty-five and over and includes women who are pregnant for the first-time and women who have had previous pregnancies.

In reviewing the literature I have found that the research has not explored practitioners' views and how these influence their practice when caring for women who are over the age of thirty-five and pregnant. The purpose of interviewing practitioners is to explore usual practices when caring for such women. It is not my intention to assess the standard of practice.

I would like to talk to practitioners who provide antenatal and birthing care to women over the age of thirty-five, as well as practitioners who, although a midwifery or an obstetric qualification is held, choose not to do so and refer these women to other practitioners.

A second group of practitioners I would like to talk to are those who no longer practice but who have in the past provided care for such women. I believe that they will give me valuable insight into how the care of pregnant and birthing women over the age of 35 has changed over time.

#### **What would be expected of you**

If you accept my invitation and consent to participate I would like to interview you for approximately one hour, at a time and place that is convenient for you. This research does not have the level of resourcing to compensate you for the loss of earnings you may incur should you choose to be interviewed during your work time.

With your permission I would like to tape the interview. At the beginning of the interview I will ask you to choose a pseudonym by which you will be known. At this

time you may ask any further questions about the research. Before we commence the interview I will ask you to give your written consent to be a participant in the study.

My opening question to you would be :“What care do you provide for pregnant women who are over the age of thirty-five?” From there on I intend to follow the topics and issues as they arise. However there are issues such as : genetic screening, care of women who have had previous births; place of birth; and primary caregiver which I will ensure are discussed during the interview.

At any time during our conversation you have the right to ask me to turn the tape off, and to delete or withdraw something that you have said. You will always have the right to refuse to answer any particular questions and to withdraw from the study at anytime.

Following the interview the tape will be transcribed either by myself, or by a typist who will be required to sign a declaration of confidentiality. I will then send you a copy of the transcript. You have the right to delete anything that you do not wish to have as part of the study. We will then decide together if there is a need to meet again for another conversation.

The transcript will be kept in a locked cupboard. Only my supervisor and myself will read your transcript. At the end of the research you may have the tape returned to you if you wish or the tape will be archived at Massey University for a period of 5 years and then destroyed.

The information that you provide me with will be used to develop my research thesis. Parts of the thesis may be published in professional journals, or used in conference presentations. Your anonymity will be maintained as only your pseudonym will be used.

### **Your Rights as a Participant**

You have the right to:

- decline to participate.
- refuse to answer any particular questions and to withdraw from the study at anytime.
- ask any questions about the study at anytime during participation.
- turn the tape off at any time.
- provide information on the understanding that your name will not be used.
- be given a summary of the findings of the study when it is concluded.

### **Benefits, Discomforts and Risks**

It is not anticipated that there will be any benefits for you as a participant. Likewise, there are no risks anticipated. However, there may be some discomforts such as: the time taken for the interview and checking the transcript; or the triggering of unpleasant recollections / experiences. Should this occur I will have a list of organisations or individuals that you could choose to contact.

If you have any queries or concerns regarding your rights as a participant in this research you may contact the Health Advocates Trust, phone 638 9638.

If you have any queries about the research you may contact me at:  
Work: 307 9999, extn 7112,

My work address is: Debbie Payne  
Faculty of Health Studies  
Auckland Institute of Technology  
Private Bag 92006  
Auckland 1020

If you have any questions or concerns about the research that you would prefer not to discuss with me please contact Cheryl Benn at Massey University, phone: 443 9700.

Unless you contact me before, I will contact you in two weeks time to ask whether or not you would like to be a participant in the research. I will not contact you before this time. It is important to me as a researcher that you feel no pressure to be involved in the research.

*Debbie Payne*

## APPENDIX III

### CONSENT FORM

#### *PREGNANCY AND BIRTH FOR WOMEN AGED THIRTY-FIVE AND OVER*

**Researcher:** Debbie Payne

**Participant:** \_\_\_\_\_ **Age: (years)** \_\_\_\_\_

English	I wish to have an interpreter	Yes	No
Maori	E hiahia ana ahau ki tetahi tangata hei korero Maori ki ahau	Ae	Kao
Samoan	Oute mana'o e iai se fa'amatala upu	Ioe	Leai
Cook Island	Ka inangaro au I tetai tangata uri reo	Ae	Kare
Tongan	'Oku fiema'u ha fakatonulea	Io	Ikai
Nuiean	Fia manako au ke falaaoga e tagata fakahokohoko vagahau	E	Nakai

I have heard and understood an explanation of the research project I have been invited to take part in. I have been given, and I have read, a written explanation of what is asked of me, and I have had an opportunity to ask questions and to have them answered. I understand that I can ask any questions about the study during participation. I understand that I have the right to withdraw from the study at any time and to refuse to answer any particular questions. I agree to the interview being audiotaped and understand that I have the right to have the tape recorder turned off at any time and/or have sections deleted from the tape. I understand that I will be given access to a summary of Debbie's research study findings when it is concluded. I agree to participate in the research study under the conditions set out in the Information Sheet.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*In my opinion consent was given freely and with understanding*

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## APPENDIX IV

### TRANSCRIBER'S DECLARATION OF CONFIDENTIALITY

I..... hereby declare that any information that I am privy to in the course of my being employed as a transcriber for the research being carried out by Debbie Payne will remain confidential.

I will not discuss any aspects of the research with any person other than the researcher.

Such discussions will be focused on seeking clarifications only.

Signed.....Date.....

Witnessed by.....Date.....