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Caesarean section in the absence of clinical
indications: Discourses constituting choice in
childbirth

By

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Abstract

This poststructuralist qualitative study explored the discourses constructing women's choice for a caesarean section in the absence of clinical indications, in the talk and texts of women, midwives, an obstetrician, professional journals and the media publications. The study affirms inscriptions surrounding choice in childbirth are shaped discursively through a multiplicity of discourses underpinned by social and institutional practices. With advances in technology, childbearing women have a greater variety of options from which to choose. Controversial, is the option of a caesarean section, regardless of clinical need. The issue is depicted in both professional and popular discourse as contentious, complex and contradictory. Its momentum into the 21st century, as a new object of obstetric discourse, has been played out on a number of platforms.

In this thesis I draw from the theoretical ideas of French philosopher Michel Foucault, to examine this complex debate. I argue there is a volatile moment in the history of childbirth in which an explosion of discourses have sculptured choice for a caesarean, in the absence of clinical indications, out of a repartee of autonomy, convenience, desire, fear and risk. In this precarious moment, new meanings joust with the old on a shifting terrain awash with rhetoric that co-opts, competes, and contradicts to bring about a caché of mutable 'truths'.

Whether caesarean, as an optional extra, can be explained in terms of a libertarian imperative, an embodiment of lifestyle, the satiation of desire, the attenuation of fear or the avoidance of risk, the democratisation of this choice has exposed a pathologising paradox, whereupon the normal emerges as the abnormal, and the abnormal emerges as the normal. The deconstruction of choice through a poststructuralist lens has enabled insight into how contradiction and contest befall the 'order of things' and in so doing, provides new openings for contemplating the discursive positioning of women through the competing discourses of childbirth.

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Table 2.1.

Caesarean, Normal Births & Operative Deliveries: Aotearoa New Zealand37

Glossary and abbreviations.

Glossary.

Aotearoa	Aotearoa is the name for the land tenured by Maori before a it was named New Zealand by a Dutch explorer. The dualism of Aotearoa New Zealand recognises the co-existence of “two realities in one land”. (Reid & Cram, 2005, p. 35).
Caesarean section.	An incision into the abdomen and uterus through which the babies are extracted. Various referred to as <i>cesarean</i> (absent ‘a’ denotes its American idiom) or its shortened version c-section. In the current study the British vernacular - <i>Caesarean</i> is used.
Cattlehorn caesarean section,	Caesareans attained by the having an infuriated animal tear open a woman’s pregnant uterus (King, 1895, in Frazer, 1987, p. 74). Cattlehorn lacerations were speculated by some as preferable to the surgical operation.
Craniotomy	An opening into the cranium of the skull. A destructive technique once used to crush babies skulls to enable its passage through the birth canal.
Elective caesarean	A general term given to a caesarean prior to the onset of labour.
Iatrogenic	A disorder brought about by the effect of medical intervention.
Maori	The indigenous, ‘first’ peoples, of Aotearoa New Zealand.
Medicalisation	In relation to women, “...the process whereby western medicine turns its gaze toward aspects of women’s lives and bodies renders

them problematic and focuses attention on treatment to achieve a cure.” (Carryer, 1997, p. 152).

Multigravida	The term designated to a woman who has one or more pregnancies.
Multiparous	The term designated to a woman who has given birth to more than one baby.
Nulliparous	The designated term for a women who has never given birth.
Pakeha	A person of European decent living in Aotearoa New Zealand.
Primigravida	The term for a woman who in her first pregnancy.
Primiparous	The term for a woman who has given birth for the first time.
Pubiotomy	An opening of the symphysis pubis joint of the pelvic bones to increase the size of the birth canal.
Tangata whenua	The Maori name for the people of the land, in reference to the ‘first’ peoples in Aotearoa New Zealand.
Te Tiriti of Waitangi	The name given to the Maori translation of the founding document of Aotearoa New Zealand. Also referred to by its English translation, as the Treaty of Waitangi.

Abbreviations.

ACOG	American College of Obstetricians and Gynecologists.
ACNM	American College of Nurse-Midwives

BOH	Board of Health
DHB	District Health Board
DOH	Department of Health
FIGO	Federation of International Gynecologists and Obstetricians
HFA	Health Funding Authority
ICM	International Confederation of midwives
IVF	In vitro fertilization
MOH	Ministry of Health
NICE	National Institute for Clinical Excellence
NHC	National Health Committee
LMC	Lead Maternity Carer
Midwife's talk	A broad term to describe the discussion from midwives as a whole group.
Women's talk	The term as above to describe the women's focus group as a whole.
Tom	Pseudonym given to the specialist obstetrician who took part in an individual interview.
MWFGSE	Midwives focus group – self employed midwives
MFGDHB	Midwives focus group -District Health Board or hospital midwives
WFG1	Women's focus group 1 – The first focus group held for childbearing women participants
WFG2	A second separate focus group of women.

MWFGm1	Midwives focus group member (m) 1. The designation of the first midwife in a sequence of an interaction.
MWFGm2	Second midwife speaking in an interaction.
WFG1m1	The first member in the first women's focus group 1 speaking in a sequence of an interaction.
WFG2m3	The third member of women's focus group 2 in a sequence in the same interaction.
Use of brackets such as (dis)enabling;	Brackets interposed within words denotes the fluid nature of language and thought. Appropriated from Surtees ideas around 'nomadic border crossings (2003, p. 12) in that I blur the boundaries between states symbolised through bracketing . I also draw from Lupton's (1999, p. 133) discussion of liminality to allude to a state of flux in meaning.

Chapter 1. Introduction to the thesis.

1.1. Introduction.

The discursive construction of the choice of caesarean section, as an alternative birth mode, regardless of clinical need, attests to a volatile moment in the history of childbirth in which an explosion of discourses compete on a shifting terrain for a ‘truth’ about how babies are to be born. Framed within a mantra of autonomy, this choice of birth mode has sparked off considerable debate in both professional and popular discourse. It is through this controversial domain that birthing women’s decisions for childbearing are negotiated.

In Aotearoa New Zealand, events triggered by the home birth movement in the 70s and the Cartwright report (Cartwright, 1988) in the 80s, culminated in significant legislation in the 90s that changed decision-making in childbirth forever. Foremost was the implementation of changes to the 1990, Nurses Amendment Act, reinstating midwives’ right to practise independent of medical supervision. These changes provided women with greater choice in childbirth including continuity of care provided exclusively by a midwife. Moreover, the appointment of a Health Commissioner in 1993 - a recommendation of the Cartwright Report - was the precursor to the Code of Health and Disability Services Consumer Rights 1996 (Health Commissioner, 1996) that sanctioned the right of consumers to make decisions about their health care (hereafter known as the ‘Code’). The consequential endorsement of women's autonomy in childbirth shifted the focus of decision-making from a paternalistic approach to one in which decisions became the prerogative of the consumer.

Since the enactment of the Code, ideals regarding women’s autonomy in the prevalent discourses of childbirth, are now taken for granted. Up until the early 1990s, the debate surrounding choice in childbirth largely centred on choice of caregiver and place of birth (Department of Health [DOH], 1989; 1990). An unintended consequence to emerge from women’s sovereignty over their childbearing experience is the apparent perception in both professional and popular media, that women have the right to elect a caesarean regardless of need.

A caesarean section, in the absence of clinical indications, has an assortment of labels in the professional literature, including 'request caesarean' and 'maternal request'. Penna and Arulkumara (2003), proffer a definition of a non-medically indicated caesarean by relating it to what it is not, a medically indicated caesarean.

A caesarean section is medically indicated when a significant risk of adverse outcome for mother or foetus is present if the operation is not performed at a given time. In this situation, the balance of risk of adverse outcome without caesarean delivery outweighs the risk of adverse outcome from caesarean delivery. In contrast, non-medically indicated caesarean is for reasons other than a risk of adverse outcome (p. 2).

Simply, a non-medically indicated caesarean section is one performed when there are no risks of adverse outcome to either the woman and or her baby. These forms of elective caesarean have been portrayed in popular culture as either 'social caesareans' (Vandenberg, 2002, p.1) or 'designer deliveries' (Cole, 2002, p. 1) and as a lifestyle choice implied in the term 'Too Posh To Push' syndrome (Marsh, 2002, p. 4). Social caesareans are so named for their convenience factor. The metaphor of a designer delivery presupposes certain subjection through an affinity with celebres. The idiom of 'vaginal bypass' presumes a desire to remain "honeymoon fresh" (Kitzinger, 2001, p. 284). The trend has triggered controversy in both professional and media discourses (Cole, 2002; Coney, 2001; Daily Telegraph, 2001; McCurdy, 2001; Patterson, 2003; Vandenberg, 2002) in which it is represented as complex, contentious and contradictory. On one side of the divide are words of warning of the risks of this major abdominal operation, while on the other side are calls championing women's autonomy regardless of risk.

Similarly, the history of maternity services is steeped in contention. Knowledge of the historical events that have carved out the present provides insights into how ideology and serendipity can have as much impact on truth value as the objectivity and certitude of knowing. Reverberating here is that hackneyed adage that 'history always repeats itself'. It is to an overview of the history of maternity services in Aotearoa New Zealand, that this introduction now turns.

1.2. History of Maternity services in Aotearoa New Zealand.

The early history of maternity services in Aotearoa New Zealand portrays a struggle for control of childbirth which has been well documented in the critiques of Mein-Smith (1986), Donley (1986; 1998), Belgrave (1991), Parkes (1991) and Papps and Olsen (1997). These authors attest to a ponderous struggle between the Health Department and private medical practitioners. The Department's philosophy was that childbirth was a normal life event and as such maternity services should be under state control. This was frenetically opposed by the said practitioners who claimed that childbirth was dangerous and hence should be managed by a doctor (Donley, 1986; Mein-Smith, 1986; Parkes, 1991). These struggles can be traced back to a number of milestones that have shaped the provision of maternity care to the current day. First was the introduction of Listerism¹ in New Zealand in 1872 by Duncan MacGregor (Dow, 1991). Second was the registration of midwives in 1904, a marker for the state run St Helen's maternity hospitals. Third was the introduction of "Twilight Sleep," the *raison d'être* for the establishment of the Obstetric Society and prelude to the medicalisation of childbirth in Aotearoa New Zealand (Donley, 1986; Mein-Smith, 1986, p. 41). Fourth was the scandal in 1923 of the Kelvin Hospital deaths in Auckland and finally, a Review of the Maternity Services in 1937, the recommendations which formed the basis of the Social Security Act of 1938 (Mein-Smith, 1986; Donley, 1986; Papps & Olssen, 1997).

1. 2. 1. "Get to work and have the place ready in a fortnight."

Most women in Aotearoa New Zealand up until the early 1900s had their babies either at home or in small private 'lying in' homes run by lay midwives (Board of Health, 1976; Donley, 1986; Manson & Manson, 1960; Mein-Smith, 1986; Parkes, 1991). Prior to 1904, these 'handy women,' whose only qualification was their own experiential knowledge of birth, provided care for women. In cases of economic scarcity, a neighbour or relative sufficed (Board of Health, 1976; Manson & Manson, 1960). At the end of the 1800s, alarming maternal and infant mortality rates heralded important changes in maternity care (Manson & Manson). MacLean (1964) records a puerperal

¹ Listerism is the name given to the introduction of antiseptics into surgical procedures by Joseph Lister, a Scottish surgeon who introduced the technique in 1867.

death rate in 1872 of 4.26 per 1000 births. By 1880 the maternal mortality rate was at a low of 3.93 rising to 7.31 in 1885 (Board of Health, 1921). These figures did not include Maori maternal mortality as prior to the 1920s there were no reliable statistics with regard to Maori women (MacLean, 1964). Brookes (1991) indicates this erasure of Maori women from statistics was testimony to an ideological climate of the time, in which Maori women were largely ignored, based on their culture and geography.

In 1885, Dr D. MacGregor, Inspector of Hospitals, who earlier in 1877 introduced the notion of Listerism into New Zealand (Dow, 1991), appointed Grace Neill as assistant inspector of Hospitals to help instigate necessary reforms in public health. Neill was particularly concerned about the plight of women who could least afford maternity care services (Manson & Manson, 1960). One of her reforms was the State Registration of nurses in 1902 and midwives in 1904. Her intention was to raise the status of these professions by implementation of a state exam which would guarantee competency to practise (Neill, 1961). The passage of the Midwives Registration Act in 1904 received the backing of the Premier at the time, Richard Seddon (Manson & Manson, 1960; Mein-Smith, 1986; Parkes, 1991). With the passage of the 1904 Act, midwifery came under state control (Cooper, 1998). Faced with a dual concern for how these midwives would be trained and how financially disadvantaged women could afford these practitioners, Neill lobbied Seddon for what she saw as a solution; state run maternity hospitals for working men's wives who would ostensibly pay three pounds for two weeks tenure in hospital, in exchange for the training of midwives. "Get to work and have the place ready in a fortnight" was Seddon's reply (Manson & Manson, 1960, p. 51). Suffice to say, that fortnight happened on the 29th of May, 1905 in Wellington (Manson & Manson, 1960).

In the biography of his mother, Neill (1961) recounts how the passage of the Midwives Registration Bill, in 1904, met with resistance, the driving force of which lay with the "BMA" (Neill, 1961, p. 54). It is assumed that Neill is referring here to the British Medical Association, which had established a branch in New Zealand. Coercive attempts to thwart the Bill, "when there was likely to be a thin house" (1961, p. 54) would have been successful if it had not been for the perspicacity of the Minister in charge, the Hon. George Fowlds. Sensing such machinations, Fowlds sent a messenger to Neill's residence at ten o'clock in the evening, summoning her to the House of

Representatives. An ailing Neill rose to the challenge and presented her case and the Bill was passed largely without any amendments (Neill, 1961, p. 161).

Following the passage of the Midwives' Registration Act 1904, the first St Helen's was launched in Wellington in 1905 (Neill, 1961). Neill recounts that, despite the ensuing success of St Helen's, the concept of having these institutions available for the training of midwives only was a bone of contention for both the Dunedin branch of the British Medical Association (BMA) and the Otago Medical School. Cognizant of the lack of facilities or "clinical material" for medical training, pressure began to mount for the admission of medical students into St Helen's. This was vigorously opposed by Grace Neill, who deemed, with Seddon's support, that St Helen's be "...solely for the comfort of working men's wives and the training of midwives, not the convenience of embryo doctors" (Neill, 1961, p. 56). Neill's plan was to place St Helen's in the charge of a matron, responsible to the Department of Health (Cameron, 1961, in Neill, 1961). Bitter opposition to St Helen's being solely the domain of midwifery training sparked off a tension between the medical professions and midwives that has continued to the present day.

The enactment of the 1904 Act and the subsequent proliferation of St Helen's hospitals around the country gradually saw the 'handy women' phased out over the next 20 years (Donley, 1986). Manson and Manson (1960), cite a passage from MacGregor, after the passage of the Midwives Act that is testimony to how these women were devalued in some quarters.

With the passing of the Midwives Registration Act, 1904, the day of the dirty ignorant careless women who has brought death or ill health to so many mothers and infants will soon end (Manson & Manson, 1960, p. 50).

MacGregor's proclamation was, as history informs us, to be transitory. Although evidence suggests that some improvements accrued in the puerperal death rate in 1913 with a low of 3.5 per 1000 births (MacLean, 1964), it was to be another 25 years before "death or ill health to so many mothers and infants" would end. Over time MacGregor's edict set in motion the perpetuation of derogatory and unsubstantiated claims that would be used to typecast midwives (Mein-Smith, 1986; Parkes, 1991). As history would later

reveal, this tendency became part of an orchestrated political tactic in the battle over childbirth (Mein-Smith, 1986; Donley, 1986). In the years to follow the reforms of 1904, a perturbing image of a political struggle between rival factions for control over maternity services was to unfold.

1. 2. 2. 1904 - 1939: The power and the glory?

In 1920, a rise in the maternal mortality rate was a cause for concern (MacLean, 1964; Mein-Smith, 1986) and was the impetus for the Board of Health, in 1921, to set up a Special Committee to investigate the reasons behind these rates (Board of Health, 1921; MacLean, 1964; Mein-Smith, 1986). Amid a range of conditions, puerperal septicaemia was identified as being a major cause of maternal mortality (Board of Health, 1921, p. 345). Several contributing factors were implicated, suggesting an inability of the individual to resist virulent pathogens, alongside unsuitable surroundings and the increased utilisation of instrumental deliveries. The latter was put down to “medical men” under pressure from relatives and friends (Board of Health, 1921). While the committee echoed the Department of Health’s concern about puerperal sepsis being the major cause of maternal death, Mein-Smith (1986) is critical of the manner in which it had tactically absolved doctors of any blame for its transmission. Rather she alludes to a surreptitious link being made between puerperal sepsis and an individual’s predisposition for the disease.

Convinced that puerperal sepsis was largely preventable, the Department of Health, implemented a series of reforms aimed at reducing the maternal mortality rate from the disease (Mein-Smith, 1986; Parkes, 1991). These reforms were met with considerable resistance, largely from some private practitioners, unwilling to accept that puerperal sepsis could be spread by cross infection and a reluctance to pay for the cost of upgrading practices to meet safety standards (Mein-Smith, 1986). These events occurred amid a growing resentment toward state control over medical practice (Gordon, 1955) and were later to uncover an early resentment of midwives’ involvement in maternity care. Gordon who had embraced the theory that puerperal sepsis was an “autogenous” infection, dismissed the Department of Health’s stance on puerperal sepsis as a theory that “...suited the would-be founders of a state maternity services staffed by midwives

only” (p. 161). This allusion to midwifery as a threat, not only provides insight into the contestable nature of childbirth at the time, it also shows how self-interest took precedence over contemporary knowledge. The lives of women lost through this ideological contest, depicts a shameful lesson from Aotearoa New Zealand’s past.

1. 2. 3. The Kelvin Episode and legacy of H-Mt 20.

The struggle for control of the maternity landscape is a cogent reminder of how the positioning of midwives and obstetricians as adversaries, has impacted on the health of childbearing women. This was most palpable in 1923, when four out of six women died from puerperal sepsis, between September and November, at the privately owned Kelvin hospital in Auckland (MacLean, 1964). The incident sparked public outrage and an inquiry that led to the Report of the Kelvin Commission in 1924. This report, which treated the incidence as one outbreak, instead of three separate cases (MacLean, 1964) acknowledged negligence on the part of doctors, for their failure to notify the Department of suspected cases of puerperal sepsis. Despite the report vindicating the Department of Health’s concerns about the standards of care in private maternity hospitals, the commission effectively exonerated the doctors involved (MacLean, 1964; Mein-Smith, 1986). Another unusual twist was the displacement of culpability on to the medical officer of health, for not acting promptly enough to take preventative action. MacLean’s (1964) own analysis of the case defends both the medical officer of health and the ‘well-managed’ Kelvin hospital, reconciling that blame cannot be attributed to anyone. He contradicts himself however, when he endeavours to cast aspersions on midwifery practice in the following account:

The hospital, judged by the standards of the day, was well equipped, adequately staffed and well managed. Blame for the sequence of events cannot be attributed to anyone, least of all the medical officer of health, who could not have taken any action that would have prevented a single one of the cases. The cause of the trouble went far deeper, and was to be found in the low standard of midwifery then prevailing in the country (MacLean, 1964, p. 303).

Mein-Smith (1986) is critical of the commission’s distortion of events, particularly its silence over the link between puerperal sepsis and the common use of forceps deliveries

at Kelvin hospital. The Department for years had been cautioning practitioners about this link (Mein-Smith, 1964). Apportioning blame to midwives as MacLean (1964) has done is a hollow argument, given Mein-Smith's contention that midwives did not use forceps. Moreover Mein-Smith questions the originality of the Commission's report, in that none of the proposals stemmed from the investigation per se, but from the Department of Health's own recommendations from the 1921 Committee of Inquiry.

Following the release of the Kelvin report in 1924, Paget, in his role as inspector of hospitals, embarked upon a campaign of vigorous reforms. One strategy was a publication "The general Principles of Maternity Nursing Including the Management and Aseptic Technique of Labour and the Puerperium" also known widely by its abbreviation H-Mt 20 (MacLean, 1964; Donley, 1986; Mein-Smith, 1986). H-Mt 20 was a standardized aseptic technique for nurses and midwives to adopt when caring for women in labour. Donley recounts the implications of this rigid procedure for women:

Under the H-Mt 20 regulations women could no longer be delivered in labour rooms. At the crisis moment of full dilatation, they were transferred panting to the 'theatre' to have their cleanly shaven pubic area swabbed with antiseptics and draped with sterile linen while their 'deliverer' scrubbed up to catch the baby. Then the baby was cleaned and dressed in sterile linen before it was given to the mother (Donley, 1986, pp. 44–45).

While midwives and nurses shouldered a legal obligation to abide by the principles of H-Mt-20 under the Nurses' and Midwives' Registration Act of 1925, its implementation in 1927, was a tactic used by Paget in the hope that its principles would be adopted by doctors (Mein-Smith, 1986). Mein-Smith suggests that more direct methods had the potential to fuel an uneasy tension already present between the Department of Health and the medical profession. H-Mt 20 was to remain in place for over four decades. Donley (1986) argues that the imposition of H-Mt 20 highlights a tendency to find a scapegoat (midwives) for an organization's inability to solve a problem created by others (the medical profession) in the first place.

With the introduction of the Nurses' and Midwives' Registration Act in 1925, another reform implemented by Jellet, as Consulting Obstetrician to the Department of Health,

and Paget, was the standardisation of midwifery training and the provision of a 'maternity nurse' (MacLean, 1964; Mein-Smith, 1986). Resistance to changes provided for in the Act, came from doctors who feared that it would mean a more superior training for midwives and maternity nurses over doctors (Mein-Smith, 1986). This fear was short lived as Jellett's (1927) campaign for better facilities for the training of medical students in obstetrics was realised with the establishment of a full time Chair of Obstetrics and Gynaecology at the University of Otago in 1931 (MacLean, 1964; Mein-Smith, 1986). Parkes (1991) asserts that the Nurses' and Midwives' Registration Act, 1925, set in motion the midwife's passage from independent practitioner to doctor's assistant. Significant in the structure of the Nurses' and Midwives' Board, formed to administer the 1925 Act, was the imbalance of midwifery representation with greater authority lying with nursing and medical professions (Papps & Olsen, 1997). Membership necessitated only one midwife on the board with the chair of the board vested with a medical practitioner who had the casting vote (Papps & Olsen, 1997). Such was the order of things until the establishment of the Nursing Council under the 1971 Nurses Act (Papps & Olsen, 1997).

1. 2. 4. Prelude to the Committee of Inquiry into Maternity Services.

Having achieved many of the reforms aimed at making maternity care safer during the Depression years, the Department concerned itself with a significant increase in the rate of deaths from septic abortion during the years of the depression (MacLean, 1964; Mein-Smith, 1986). Although opposed to induced abortion, the Obstetric Society in 1936 requested a commission of inquiry to look into the death rate from septic abortion (Mein-Smith, 1986). The Government duly responded with the establishment of a Committee of Inquiry into Abortion Services, chaired by Dr D. G. McMillan, MP for the Labour Party (Mein-Smith, 1986; Board of Health, 1976). Mein-Smith (1986) contends that this initiative was a significant chapter in the history of medical politics, reflecting a shift in the power relations between the State and the medical profession. In a curious turn of events, the focal points of the inquiry, deaths from puerperal sepsis and recommendations for birth control clinics, paled in significance (Mein-Smith, 1986; Smyth, 2000). "Instead, McMillan redirected the inquiry towards maternity services, as a politically

acceptable way of creating incentives which might deter women from limiting their families" (Mein-Smith, 1986, p. 115).

1. 2. 5. 1937 Committee of Inquiry into Maternity Services.

The Committee of Inquiry into Maternity Services in 1937 is portrayed by Donley (1986) and Mein-Smith (1986), as a façade for the policies of the Obstetrics Society. Donley (1986) and Mein-Smith (1986) each provide independent yet congruent analysis of events surrounding the Inquiry. Alluded to in their accounts is the committee's sidestepping its original brief, to one that veered off down a path to examine birthing services in both the private and public spheres. Its brief included the extent to which anaesthesia was used in public maternity hospitals, the district nursing service in relation to maternity and whether the training of midwives and maternity nurses was in line with the needs of the country (Board of Health, 1938, p. 2).

Both Donley (1986) and Mein-Smith (1986) bestow matching accounts of the contrivance of the Department of Obstetrics and Gynaecology at Otago University to eliminate midwives from maternity services. Mein-Smith (1986) suggests the motive for such a tactic is aligned with an increased utilisation of midwives during the Depression years, as many women could not afford doctors' fees. In interpreting Mein-Smith (1986), fear of the possibility that midwifery service would become the norm was purported to be the inspiration behind the Obstetric Society implementing a policy that ensured doctors were present at all births. The strategy for achieving such a feat would be the availability of pain relief to all women. Ironically, the success with the low mortality rates in St Helens' hospitals supported Jellet's notion that midwives provided superior care compared with that of doctors. Paget (1938) also acknowledged midwives as highly skilled practitioners, proposing that the reduction in maternal mortality would not have been possible without them. For Paget, the demands of an increasing birth rate necessitated increased numbers of midwives and maternity nurses.

Despite the success of St Helen's under the jurisdiction of the Health Department, consistent attempts were made to bring them under the control of hospital boards

(Donley, 1986; Mein-Smith, 1986). Donley (1986) and Mein-Smith (1986) report how Mary Lambie, Director of the Division Nursing at the time, resisted the move. With the successful transfer of two St Helen's in 1933 and the concomitant threat to midwifery training, a concerned Lambie successfully froze further transfers before her retirement in 1950. St Helen's had come to symbolise a midwifery advantage over medical students, an untenable possibility for Professor Dawson at Otago Medical School, who in 1933, began to push for the appointment of resident house surgeons in St Helen's in Dunedin (Mein-Smith, 1986). In a report to the Obstetric Society in 1934, he states:

In the public maternity hospitals (ie, St Helens and Hospital Board Hospitals) it is considered the attention is satisfactory, with midwife service for all cases with medical attention available for ante-natal work and obstetrical difficulties. This, of course, does not fit in with our resolution that every case should have a doctor and obstetric nurse, but we consider that this section will, in the process of time, conform to our ruling that the maternity hospitals in our larger centres will have a resident house surgeon (Dawson, 1934, p. 26-27).

While the Department of Health was in favour of midwives attending women having normal births (Jellet, 1938) some members of the Committee of Inquiry voiced objections to the current training of midwives (Donley, 1986). These were justified on the grounds that their training was unnecessarily detailed when much of their work was in conjunction with a doctor. Further suppositions around midwifery caseloads interfering with the training of medical students and intakes of midwives for training being surplus to the community, were also made (Board of Health, 1938, pp. 91 -108). Recommendations from the report of the committee included provision of maternity care by a doctor with a midwife in attendance; greater priority be given to medical student training; the establishment of large maternity hospitals in each main centre, providing access for doctors to enable women to be attended by the doctor of their choice; availability of full pain relief and the consideration be given to a benefit to cover hospital and medical expenses (Board of Health, 1938, pp. 102 – 111). Supervision of the large maternity hospitals was to be under the jurisdiction of a medical practitioner with obstetric experience and would have responsibility for the 'treatment of board cases' and training maternity nurses (Board of Health, 1976).

In 1939, the Labour party spearheaded the Social Security Act, 1938, committing to a welfare state which ensured free maternity care for all women under the doctor of their choice (Donley, 1986). Such egalitarianism, Mein-Smith (1986) suggests, cemented the medicalisation of childbirth, securing maternity care by a doctor as the right of all women. Also in place were pro-natal incentives, such as pain relief as required, 14 days rest in hospital following birth and a family benefit scheme to guarantee population growth for the future of the nation (Mein-Smith, 1986). In effect the Committee of Inquiry into Abortion Services was the 'Trojan Horse' for the Obstetric Society. In reading Mein-Smith (1986) the artful dodging of deaths from septic abortion and birth control issues was a *coup d'etat* for the Society. Further with complete pain relief for all women safely ensconced under the Social Security Act of 1938, came the proliferation of "Twilight Sleep" under the fervent tenacity of Doris Gordon (1955). Gordon's ardent fortitude in propagating twilight sleep flew in the face of antipathy, largely because of its link to puerperal sepsis through necessitating the use of forceps (Mein-Smith, 1986; Donley, 1986). Other alternatives paled in significance when it came to obliterating a woman's memory of her birth experience. Such was the legacy of the "Twilight" years.

1. 2. 6. The Twilight Years.

Gordon (1955), impressed with Simpson's (Professor of Midwifery at Edinburgh University) discovery of the use of chloroform in childbirth, later adopted a new technique evolved by a Professor Gauss at the turn of the century in Germany, which came to be known as "Twilight Sleep". It was a relatively unknown technique in New Zealand at the time, using a combination of morphia and scopolamine to guarantee an unconscious state when giving birth. By her own admission, Gordon (1955) used twilight sleep; once the privilege of upper class women; "with impunity" (p. 147). In her autobiography "*Back-blocks Baby-doctor*" she proudly reflects: "It took wellnigh fifty years for giving even whiffs of chloroform in the final stage of labour to seep down to middle-class mothers" (1955, p. 148).

The Department of Health issued warnings of its dangers, to both women and babies, with the author of one departmental publication pondering its popularity if more apt labels such as "The Dope Delivery Method" or the "Half-Dead Baby System" had been

attached to its promotion (Mein-Smith, 1986). The Department preferred a less noxious form of pain relief through a Murphy's inhaler that could be administered by midwives. Jellet's (1927) observations were that it "...reduced the suffering of patients as to make forceps very seldom necessary" (1927, p. 208). His words went unheeded and because wealthy women demanded complete pain relief, the Murphy inhaler was short lived (Mein-smith, 1986; Donley, 1986). Undeterred by the warnings, Gordon (1955), mostly self taught in the use of "Twilight Sleep," introduced the technique in Eltham in 1918, "with nothing but humiliating results" (p. 149). These humiliating results were less to do with risk than with the loss of face through her trial and error implementation. As Gordon repeatedly tested her theory on unsuspecting women, she "lived to see it accepted as scientific fact" (1955, p. 150) a fact that history would later denounce. Nevertheless the final trappings to Gordon's long ambition for national recognition of pain relief were completed in an amendment to the Social Security Act, 1951, guaranteeing financial provision for anaesthetics (Donley, 1986).

From 1938, childbirth in Aotearoa New Zealand became an established medical event, in a hospital setting. These events took place under a visage of compassion for women. Resistance however came from those not convinced by this veiled concern. Dissatisfied with the McMillan report's dismissal of liberalising abortion laws and birth control clinics, the Sex, Hygiene and Birth Regulation Society continued a campaign for women's right to plan their families (Smyth, 2000). Moreover, the formation of the Parents Centre in 1952 undermined the medicalisation of childbirth by advocating for antenatal education, drug free childbirth, partner support during labour, rooming in and demand feeding (Coney, 1993). In 1967 the Aotearoa New Zealand branch of the international La Leché League was formed to promote breast feeding which had suffered under hospital routines (Coney, 1993; Donley, 1986; 1998). In the struggle for control in childbirth, midwives were caught in the crossfire between the Health Department's reforms and the medical profession's tussle for power. The ripple effect from the Nurses and Midwives Registration Act in 1925, the machinations of the Committee of Inquiry into Maternity Services in 1937 and subsequent enactment of the Social Security Act 1938, set in motion the (re)positioning of the midwife as an obstetric nurse (Donley, 1986; Mein-Smith, 1986; Parkes, 1991).

1. 3. History of Midwifery in New Zealand.

The history of midwifery in New Zealand has been largely shaped by the provision of maternity services *viv a vis* the medicalization of childbirth. Four interesting sources in the literature paint an acrid account of the ‘herstory’ of the struggle for control of childbirth and the eventual appropriation of maternity services by the medical profession (Mein-Smith, 1986; Donley, 1986; Papps & Olssen, 1999; Parkes, 1991). Erosion of the profession became more evident as their training became more entrenched under the wing of nursing (Donley, 1986). The need for an organisation to represent their concerns compelled many midwives to seek membership with New Zealand Trained Nurses Association [NZTNA] who over time began the exclusion of maternity nurses with no prior nursing registration (Donley, 1986; Mein-Smith, 1986). With the decline in numbers of direct entry midwives with time, a devastating impact on the workforce followed, resulting in the closure of 270 maternity beds in 1935 (Donley, 1986). These events were exacerbated by the extended timeframe for maternity nurses’ training, forcing many women to abandon their training. The consequential staff shortages were to have far-reaching effects for the baby boom in the aftermath of World War II and occasioned a Committee of Inquiry into Maternity Hospital Staffing in 1946, at the behest of the New Zealand Obstetric & Gynaecological Society (N.Z.O.G.) (Donley, 1986; Editor, 1947).

Donley (1986) infers a hidden agenda in that the N.Z.O.G. seized the opportunity to go beyond its brief (again) with regard to the place of midwives and midwifery education at St Helen’s. The outcome of the inquiry, allegedly with the help of the New Zealand Registered Nurses Association (NZRNA), was the creation of the Nurse-Midwife (Donley, 1986). Certification of the nurse-midwife would take three years, culminating in a registered general and obstetric nurse who was then eligible to undertake six months training in midwifery to complete her midwifery registration (Donley, 1986). Donley (1986) attests this repositioning of midwifery within nursing was viewed by Mary Lambie as a threat to midwifery who stalled its advancement until 1957. Flora Cameron, Lambie’s successor, was responsible for transferring the maternity content of midwifery training into the nursing curriculum where it stayed until 1979.

1. 3. 1. A midwife is a nurse...

The inevitable transfer of St Helen's hospitals to Hospital Boards in 1969, symbolised the fulfilment of the goals of the 1946 Committee of Inquiry chaired by Dr T.F. Corkhill (Editorial, 1947). Donley (1986) points out that the final stage of repositioning midwives as maternity nurses would have been irreparable had it not been for the unwitting exclusion of domiciliary midwives' contracts, held with the Department of Health. In an attempt to rectify this irritation, the Maternity Services Committee in 1982 recommended that domiciliary midwives' "...contract be with the Hospital Boards rather than the Minister of Health." (Board of Health, Maternity services Committee, 1982, p. 22). This recommendation, consummated in 1982, was a mere formality as midwifery independence had been lost with the enactment of the Nurses Act of 1971.

The Nurses Act replaced the Nurses and Midwives Board with the Nursing Council of New Zealand. Erased from its title was the word midwife (Papps & Olssen 1997), a sombre reminder of how midwifery had become subsumed by nursing. It was to be another 20 years before midwifery became a separate profession from nursing and its independent status restored. Subsequent changes to midwifery education in 1979, brought about the transfer of midwifery education from hospital based programmes into tertiary institutions (Donley, 1986). A midwifery qualification became a Diploma in Maternal and Child Health, with a midwifery option, the clinical component of which paled in significance to earlier courses (Donley, 1986).

In the fullness of time, the closure of many small maternity units, an ambivalence toward the increasing dependence on technology and limited choices available to childbearing women, in 1978 led to the creation of the Home Birth Association (HBA) (Donley, 1986; Stridd, 1991). As an effective lobby group advocating change in the maternity services in Aotearoa New Zealand, it exposed dubious obstetric practices (Donley, 1986). Diminishing numbers of midwives resulted in many positions, formerly the domain of the midwife, being taken up by registered nurses (NZNA, 1989). A further threat came in the form of a midwifery policy statement in 1981, the brainchild of nurses in the NZNA, in which the status of the domiciliary midwife was erased, a

move subsequently reinforced by the introduction of the Nurses Amendment Bill in 1983 (Donley, 1986). In defining the role of the midwife in New Zealand, the policy statement had annexed the World Health Organisation's definition that stated 'A midwife is a person... to read 'A midwife is a nurse...' (Donley, 1986; Papps & Olsen, 1997). Donley (1986) recounts how the 1981 policy statement became a critical incident in the recent history of the profession. Several developments ensued.

1. 3. 2. The Nurses Amendment Act 1990.

The incident sparked off the formation of the "Save the Midwife" campaign initiated by a group of home birth women in Auckland which brought about a new resurgence in midwifery. This was particularly germane in that it emphasised the importance of working in partnership with women. The incident also highlighted the power NZNA had in undermining the role of the midwife. The Act reunited hospital and domiciliary midwives in pursuit of a common goal, to save the midwife (Donley, 1986). Importantly it beckoned the need for an independent organization to represent the interests of the profession, the corollary of which was the formation of the NZ College of Midwives in 1989 (Donley, 1986; Guilliland, 1989). Cognizant of the events that had shaped midwifery practice in New Zealand, an *ad hoc* committee, representative of the midwives' section of the NZNA in 1986, set about to revise the controversial policy statement. The result was a revised Midwifery Policy Statement in 1989, which was based on both a national community and professional needs analysis. It identified crucial factors in laying down a clear policy for the future of midwifery in Aotearoa New Zealand (NZNA, 1989, p. 5). Recommendations from the report included greater choice of birth place, a direct entry task force to look at midwifery education, continuity of care for women, an amendment to the legislation to restore midwifery autonomy in caring for childbearing women and the involvement of consumers in decision-making (NZNA, 1989). The 1989 Midwifery Policy Statement represents a significant milestone in shaping both the current practice of midwifery and the future of maternity services in New Zealand. It also provided a backdrop out of which grew a model for partnership, one that represents the cornerstone of midwifery practice in Aotearoa New Zealand today.

Alongside this backdrop was the second wave of feminism, a movement that had been steadily growing since the 60s calling for the right of women to make choices in matters concerning their reproductive and sexual health (Bunkle, 1998). In an alliance with the HBA and consumer activists, the tide was right for the introduction of the Nurses Amendment Bill, by the then Minister of Health, Helen Clark (Donley, 1990). The Bill was passed into legislation in 1990 with the concomitant undertaking of increasing choice in childbirth and the restoration of autonomy to midwives to work independent of a medical practitioner (Clark, 1990). It also paved the way for more individualised maternity care and enabled women to have greater choice of birth place and caregiver throughout the childbearing experience.

1. 3. 3. Contemporary midwifery practice in Aotearoa New Zealand.

Up until 1990, the history of midwifery, in Aotearoa New Zealand had been a tortuous journey of struggle with the medical profession for the control of normal childbirth. The Act highlights a volatile moment in the history of the profession. As an effective and powerful force in the provision of maternity services its time had come. The events that foreshadowed midwifery's eclipse should come as a sober reminder to current and future generations of the conditions that have served both to erase and legitimise midwifery practice today. In 2003 around seventy eight percent of women registered with a midwife as their Lead Maternity carer [LMC] (Ministry of Health, 2006). Midwifery practice in New Zealand is currently legislated for in the Health Practitioners Competence Assurance Act [HPCAA] (2003). The enactment of the HPCAA in 2004 replaced the Nurses Act 1977 and subsequent amendments to the Act in 1990. With the changes to the latter, midwifery attained parity with General Practitioners (GPs) in providing maternity care (Pairman, 2002). Important too was an amendment to section 54 of the Nurses Act, 1977 that authorised direct entry midwives, who had completed a midwifery qualification, to practice midwifery on the same grounds as those midwives who also have a nursing registration. The three year Bachelor of Midwifery degree now provides the framework for midwifery education programmes in New Zealand and entry to the profession is through this portal.

To practise in New Zealand the midwife must have an Annual Practicing Certificate (APC) issued by the Midwifery Council of New Zealand [MCNZ] (MCNZ, 2006). The

APC ensures midwives are fit and competent to practise (MCNZ, 2006). The Midwifery Council was established through the Health Practitioners Competence Assurance Act [HPCAA] 2003, taking over responsibility for the regulation of midwifery from the Nursing Council of New Zealand in 2004. The scope of practice of a midwife is prescribed by the Midwifery Council pursuant to section 11 (1) of the HPCAA and reflects the autonomous nature of the role of the midwife in Aotearoa New Zealand throughout the entire childbearing process. The profession's values are expressed in its philosophy, which reflects the profession's orientation toward childbearing women and midwifery practice (New Zealand College of Midwives [NZCOM], 2005). The philosophy of NZCOM was initially drawn up by the members of the Midwives' section of the NZNA prior to the formation of the NZCOM in 1989 (NZNA, 1989) and subsequently adapted by the NZCOM to include the concept of partnership. Partnership lies at the core of midwifery autonomy and has come to symbolise a shift in power relations in the childbearing encounter (Donley, 1989; Guilliland & Pairman, 1995).

Midwifery's professional status could not have been possible without the commitment shown by consumers to bring about change in maternity care. Midwifery has shown its commitment to its side of the partnership by involving consumers at a national, regional and community level within its regulatory educational and professional bodies (Tully & Mortlock, 2005). Midwifery's project of partnership, in embracing the centrality of women, reflects the profession's feminist inclination toward disrupting the hierarchical order of things (Tully, Daellenbach & Guilliland, 1998). In 2004, Midwifery's tortuous journey back to independence was consummated with the launch of the Midwifery Council and the replacement of the Nursing Council of New Zealand as the statutory body governing the practice of midwives. The conditions of its possibility came about amid a broad socio-political and economic climate that had taken place in Aotearoa New Zealand (Tully & Mortlock, 2005). These include the Home Birth Association and its sisters in the women's movement who lobbied for change in maternity care and women's health generally. Much of the debate centred on women having choice and control over their bodies. Decades of discontent materialised in a media exposé of an experiment involving women with cervical cancer (Coney & Bunkle, 1987), culminating in an inquiry that uncovered dubious unethical practices and provoked public outrage. Out of the convergence of the inquiry and calls for cost constraints in health services, a

Health Minister sympathetic with a feminist appeal and the need for flexible consumer related services, came policies relating to the provision of maternity services that served the interests of the state, midwives and consumers (Tully & Mortlock, 2005; Pairman & Guilliland, 1995). It is at this precarious site, upon a shifting terrain of maternity services, that midwifery has come to settle, for the moment.

1. 4. Contemporary maternity services in Aotearoa New Zealand.

Since the 1950s, New Zealand women have been influential in generating changes in the maternity services provision (DOH, 1989). Since the implementation of the 1990 Nurses Amendment Act women in New Zealand (NZ) have an extended range of maternity services from which to identify their options including continuity of care exclusively provided by a midwife. Further, in 1994, a review by the Regional Health Authority (RHA) of the Section 51 notice of the Health and Disabilities Services Act (1993) was undertaken as part of their responsibility for purchasing maternity services in NZ (Central Regional Health Authority [CRHA], 1996).

The outcome of the review was a formal notification, in July 1996, of the new maternity services Section 51 notice of the Health and Disability Services Act (1993) which brought an end to the existing provision and payment of maternity care. A modular payment replaced the fee for service, which was previously claimed from the Maternity Benefit Schedule by both doctors and midwives. A significant change was the 'new' provision that rendered budgetary and clinical responsibility to a Lead Maternity Carer (LMC) who could be a midwife, GP, or obstetric specialist (CRHA, 1996). The new Section 51 was an attempt by the government to contain the increasing costs of the maternity budget and provided a set of comprehensive service specifications for the provision of maternity care by a LMC (NHC, 1999). These arrangements affirmed a woman's right to make choices in pregnancy and childbirth by requiring health care professionals to provide women with information about the range of alternatives available in maternity care. This achievement was not without considerable and contentious negotiations (NHC, 1999).

New changes continued to characterise the maternity landscape between 1996 and 2000. In 1999 the National Health Committee undertook to review maternity services for the

Minister of Health, Bill English, under a National government (NHC, 1999). The review was purported to arise out of concerns among consumers, health professionals and providers about the delivery of maternity services under the guise of examining the impact of changes brought about through the new Section 51 notice which took effect from July 1996 (NHC, 1999). While the report was generally positive with over 85% of women expressing high satisfaction with their labour and birth care as opposed to 6% of women unhappy with their care, it tended to concentrate on the negative aspects of the review. One major concern was the withdrawal of LMC GPs as primary maternity care providers for reasons largely around "...increased risk of litigation, the changing nature of primary care and, in particular, the use of after hours general practice services that impact on GPs' tolerance of 'on call' maternity care" (NHC, 1999, p. 49). Despite women reporting the highest levels of satisfaction with LMC midwives, the NHC (1999) alluded to the notion of having LMCs work in teams with another person, who would ensure continuity of care during labour and birth, coordinating the care throughout the childbearing experience. This point was later picked up by the Health Funding Authority [HFA] (2000) in its maternity services reference document and echoed the ideological and political concerns about midwives working independently of GPs, the undercurrents of which characterised so many maternity reviews in the past. While some aspects of the report were effective in exposing important deficiencies in the service for Maori and Pacific peoples and inpatient as well as rural services, overall, the principles of the report tended to be a reiteration of the issues that precluded the changes to the wider maternity strategy embedded in the Section 51 notice.

After consultation with the wider maternity community the HFA (2000) chose not to adopt the principle proposed by the NHC (1999). While the authority acknowledged problems within the existing service model, it deemed these resulted from constant challenges to the service necessitating a need to maintain the current system, while at the same time rectifying the gaps within. The HFA (2000) concluded its report with a statement that acknowledged New Zealand as an international leader in the manner that it has modelled its maternity system (p. 63).

A follow up survey in 2002 by the Ministry of Health [MOH] (2003a) found an improvement in the service overall, attributing the levels of satisfaction reported by women to consolidation of the current model of maternity care and improvements in the

provision of services. The introduction of the New Zealand Public Health and Disability Act (2000) precipitated further change with a provision for the re-establishment of 21 District Health Boards (DHBs) and the replacement of the 23 Hospital and Health Service Boards which were in existence at the time (Ministry of Health [MOH], 2000). The changes resulted in the disbandment of the Health Funding Authority whose functions were integrated into the Ministry of Health and the DHBs. Section 51 was replaced by the Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act (2000) which became effective in 2002 (MOH, 2002). Section 88 sets out the terms and conditions for the provision of maternity services that are nationally consistent for primary health care in New Zealand, as well as service specifications for maternity facilities (MOH, 2002).

1. 4. 1. An uneasy alliance.

The events leading up to the review of the maternity services was an indication of the continued surveillance midwives are under from their medical colleagues and is testimony to the contested terrain of childbirth. Embedded in the struggle is an anxiety aimed at the midwife as an LMC. The period between 2002 and 2005 signified an ominous calm, only to be broken in November 2005. The media broke the news of the release of a coroner's findings of two perinatal deaths involving midwife LMCs (Editor, Dominion Post, 2005; Richardson, 2005; McDonald, 2005; McGloughlan, 2005). Despite there being an interval of several years between these tragic events, the events were constructed as as occurring concurrently and within the current context. The report indicted the profession of midwifery as a whole and pointed the finger at the education of midwives.

Three recommendations emerged from the inquests (Perinatal and Maternal Mortality Review Committee [PMMRC], 2005). One concerned the independent review of the maternity service, including a national audit to be undertaken. This aimed to establish maternal and perinatal morbidity and mortality outcomes within maternity services and independent midwives' practice. The second was a call to re-integrate midwives under the umbrella of GPs obstetrical services and the third was a call to review midwifery education (PMMRC, 2005) echoing the NHC proposal of urging maternity care

professionals to work in teams. In response to the first recommendation, the PMMRC suggested deferring the independent appraisal of the Maternity Services Scheme until completion of the reviews of midwifery education programmes, the section 88 notice and the National Audit (PMMRC, 2005). The committee acknowledged that the Midwifery Council was already reviewing midwifery education and articulated a view that the establishment of a national database for perinatal deaths would be problematic as it would not be effective until the database's commencement in July, 2006.

In response to the PMMRC report the Ministry of Health (2006) responded with a report on the current state of Maternity Services in the country. The MOH (2006) report acknowledged that overall maternity services were working well in the delivery of care for women and babies. While the report indicated that a comprehensive review was premature at that point in time, it recommended an integration of primary maternity care into primary health care and Primary Health Organisations to promote effective relationships between midwives and GPs thus ensuring the best care for women (MOH, 2006). Implicit in this proposal is an unproblematic, idealised notion of teamwork that does not take into account the team as a site of hierarchical power-knowledge struggles and turf protection (Opie, 2005) much of which echoed the *raison-d'etre* for changes to the system in the first place.

1. 4. 2. Women's autonomy and caesarean section.

The shifting terrain upon which the maternity care in Aotearoa New Zealand functions is located within a broader trend of an increasing reliance on the use of technology in the birthplace. In relation to the present study the rise in caesarean section rates (CSRs) was a particular concern to emerge out of the National Health committee [NHC] (1999) report. Traditionally caesarean has been viewed as a surgical intervention, medically indicated when the wellbeing of women and their babies were at risk. Attitudes have now changed with the growing perception that women have the right to elect to have a caesarean in the absence of clinical indications (AlMufti, McCarthy & Fisk, 1996; Cotzias, Patterson-Brown & Fisk, 2001; Harer, 2000; Patterson-Brown, 1998). The topic is represented in the multiple and competing discourses of childbirth and is contentious, as is evident in both professional and popular media discourse. In recent

years the debate appears to have reached an impasse at the juncture of two parallel arguments. One has to do with the safety of caesarean *vis a vis* the risk of labour and the other concerns the primacy of women's informed choice regardless of risk (Bewley & Cockburn, 2002a).

The conditions of possibility for such a moment are manifold. Most salient has been the construction of caesarean as an alternative birth option under the mantle of a wider discourse of autonomy. Consistent with the history of maternity services, presented earlier in the chapter there is a positioning of midwives and obstetricians as adversaries within a contested terrain of childbirth. In this shifting historical and socio-political landscape there is a prophetic (re)positioning of healthy childbearing women in the sick role for primary and subsequent pregnancies. It is my belief that as the topic is played out in the professional and popular literature women's choices will increasingly reflect discursively constructed subjectivities. In a poststructuralist world, women have a range of subjectivities and subject positions which they can choose to occupy (Weedon, 1997; Court & Court, 1998; Davies, 1994; Hardin, 2001) and these are negotiable within a medley of constraints and options, in and between available discourses. In relation to childbearing, women may be positioned by, as well as position themselves within, the various discourses of childbirth and that these chosen subject positions may be contiguous with their desires. These (re)positions may include a natural birth advocate ebbing and flowing with nature, a fashion trailblazer that is 'too posh to push' or a self-governing individual who desires to programme her birth to suit a busy work schedule. Therefore depending on the conditions of their social context, women can benefit from positioning themselves in a range of discourses in proximity that do not necessarily occur in concordance (Hardin, 2001; Lupton, 1994; Weedon, 1997). This notion of multiple subjectivities confirms birthing women as a diverse group who do not share the same beliefs and preferences for childbirth.

1. 5. The thesis of the thesis.

My interest in the topic began after reading the Report of the Review of Maternity Services (National Health Committee [NHC], 1999). Of particular concern was the rise in caesarean section rates (CSRs) with elective caesarean accounting for much of the increase. Wide variations in CSRs had drawn attention to factors beyond biology

thought to be behind caesareans (NHC, 1999). I realised that midwives face a tremendous challenge in keeping birth normal juxtaposed against their duty to uphold a woman's right to make an informed decision. As I pondered how midwives would reconcile these competing values, it was obvious that an unintended consequence of upholding women's choice for an unnecessary caesarean was to position women in the sick role for both current and subsequent pregnancies. Prior to embarking on my PhD, I had presented a paper to my peers entitled, *Caesarean in the absence of clinical indications: Implications for midwives* (Douché, 2001). An evaluation of the session identified that the topic had significant implications for midwifery practice. Of the 30 midwives who attended 73% rated the topic as 'highly relevant'. I concluded that this was ample incentive to explore the topic further.

As stated in the introduction of this chapter, an unintended consequence of the right to autonomy in childbirth has been the perception in popular and professional literature that women have the right to elect a caesarean regardless of need. Within this space knowledge regarding a caesarean section in the absence of clinical necessity has become contestable, mutable, constitutive, independent of evidence and highlights the existence of multiple discourses constructing women's choice of birth mode. Therefore the purpose of the current study is to explore the different discourses that construct the choice of caesarean in the absence of clinical indications. More specifically the aims of the research are to explore how professional and popular culture influences the decision to have a caesarean where there are no clinical indications and to identify the discourses through which this choice of birth mode is constituted.

I argue this contemporary juncture represents a volatile moment in the history of childbirth, in which an explosion of discourses around autonomy, convenience, desire, fear and risk, sculpture the choice of a caesarean section as an alternative birth option. In this precarious moment new meanings joust with the old on a shifting terrain awash with rhetoric that co-opts, competes and contradicts to bring about a caché of mutable 'truths'. It is against this convoluted landscape of converging discourses that women's choice in childbirth is constituted. I draw on the theoretical ideals of post structuralism to unravel the fluid, fragmented and fragile nature of the debate within the context of autonomy and subjectivity in order to show how choice is constituted in and through a façade of rhetoric. Examining the ways language constitutes new ways of

conceptualising choice and deconstructing choice within the context of subjectivity and wider discourse of autonomy will enable midwives and other maternity care providers to contemplate how women position themselves and are positioned by discursive childbirth practices.

1. 5. 1. The (post)structure of the thesis.

This chapter presents a history of the the maternity services of Aotearoa New Zealand, as they have evolved from around the turn of the century, until the present day. Evident in this montage is how meanings become contingent upon particular social, political and economic events at particular moments in time and how multiple and expedient ‘truths’ are sequestered in staking a claim for occupational control in childbirth. Midwifery’s history tells a poignant tale of how it became caught in the crossfire between the State, the medical profession and nurses’ professionalizing strategies and that these clashes continue today. Chapter One concludes with an outline of how the structure of the thesis is configured.

Chapter Two situates caesarean within its contemporary socio-political context and traces its history to enable an appreciation of the perturbing events of the past that have shaped the evolution of the procedure today. The relevant literature is explored to provide an overview of how the procedure came to be constituted as an alternative birth mode. I identify an explosive debate in which caesarean becomes a site of struggle for control in childbirth and show how meanings are contingent upon particular social, political and economic conditions at a particular moment in time. Rapid advances in reproductive technology meant a greater tendency to resort to the procedure. Over time caesarean, once undertaken as a last resort, came to be represented in some texts as an optional extra for childbirth. Contextualising the reconfiguration of caesarean, in the 21st century as an alternative birth mode, highlights how this birth represents a site of ideological tension within and between the discursive practices of childbirth.

The study is situated within a poststructuralist epistemology and Chapter Three provides the philosophical foundation for the research. I draw on the ideas of Michel Foucault (1936-1984) around discourse, power, knowledge and subjectivity. I show how

discourse, power, knowledge are inextricably linked to the construction of reality around the choice of caesarean, when there are no clinical indications and how the positioning of women in and by the competing discourses of childbirth, reflects their discursively constructed subjectivities. Foucault's ideas around genealogy impelled me to map the trajectory of events that led to the ideology of consumer sovereignty today. I explore the material conditions that are necessary for ideas to emerge around autonomy and subjectivity and the discursive field of caesarean, in the absence of clinical indications. The chapter also incorporates a discussion of feminist poststructuralist insights into how meanings are inscribed upon women's bodies and how these inscriptions frame women's corporeal experience. I draw attention to the potency of media discourses in shaping how women position themselves in relation to childbirth and conclude Chapter Three with a synopsis of the significance of rhetoric with regard to constructing a reality around childbirth.

In Chapter Four an explanation of the methodology of the research as it is situated within the qualitative paradigm is provided. The chapter includes strategies for data collection along with a description of the research process. I argue that my chosen methodology provides legitimacy for a plurality of truths in that knowledge is contextualised. For this reason a poststructuralist focus lends itself to a variety of 'readings' of texts enabling the complexity and contradictions surrounding caesarean, where there are no clinical indications, to unfold.

Drawing from the historical events and theoretical ideas embedded within the preceding chapters, Chapter Five maps the conditions that have made possible the promise of elective caesarean as an alternative birth option in the current context. I trace the emergence of elective caesarean when it first surfaced as an object of medical discourse in Aotearoa New Zealand and as such set in motion the process of pathologising vaginal birth. I attest to the modes of authorisation for circumscribing the boundaries around physiological birth and how these events have been played out in an endeavour to procure legitimacy for a non-clinically indicated elective caesarean alongside 'grids of specification' that encode an elective caesarean, as an alluring alternative to vaginal birth. Salient is how the accord of discourse-power-knowledge is inseparable in bringing about 'truth.' As a prelude to the study's findings, in Chapter Five I identify an array discursive strategies to show how discourse, power, knowledge are interlinked in

the construction of a new configuration of caesarean. I reveal how in the interests of popular appeal and control in childbirth the media is procured to enable the translation of medical knowledge into commonsense knowledge. I contend the culmination of these discursive events has implications for the fragile status of vaginal birth.

Chapters Six, Seven and Eight present the findings of the study alongside their interpretation within the context of the literature. They are framed around the surge of discourses that emanated from the talk of women, midwives, an obstetrician and the texts of professional and popular culture to show how the discourses of autonomy, convenience and desire, fear and risk, converge and compete to (re)formulate the choice of caesarean, in the absence of an indication. In Chapter Six women's choice in childbirth 'speaks' through the discourse of autonomy. I argue that in championing women's autonomy in childbirth the signification of autonomy evokes simultaneous celebration and apprehension. Hence behind this choice of birth mode lies a disquiet that an increase in the primary caesarean rate will lead to a less healthy population of childbearing women in the future.

In Chapter Seven the discourses of convenience and desire informs the choice of a caesarean in the absence of clinical indications. Here I argue that having control over life events has appeal in a rapidly changing convenience culture in which the temporality of desire anticipates the promise of instant gratification. I show how shifting notions of control in the context of childbirth exemplify how meanings are predicated within a particular socio-cultural and historical milieu that serve to disable a universalism that has the potential to fix a truth about women's desires for control in childbirth.

Chapter Eight proffers the discourse of fear and risk implicated in the choice of a non-clinically indicated caesarean. Here I argue that fear and risk have become ubiquitous and disabling discourses as contemporary society becomes increasingly preoccupied with safety and litigation. The interaction of these discourses invokes images of the fragile nature of normal vaginal birth. I show how the discourse of fear and risk has opened a *Pandora's box* inside which vaginal birth is destined to become abnormal and caesarean increasingly normal.

Chapter Nine concludes with a discussion of the discourses that emerged from the views of the women, midwives and an obstetrician. The chapter depicts how power-knowledge embedded within language construct reality within the shifting terrain of childbirth. I argue that there is a volatile moment in the history of childbirth in which an explosion of discourses fashion women's choice of birth mode. I argue that a post-structuralist approach to research opens space for alternative ways of viewing the world and invites us to examine our own positions of power and truth. The implications and limitations of the study are acknowledged along with implications for future research into this tentative space of (un)rest. It is to the (his)story of caesarean section that the following chapter now turns.

Chapter 2. Background and literature.

2.1. Introduction.

In Chapter One, an overview of the study provided insight into the development of the maternity services in Aotearoa New Zealand with the view to situating the study within its socio-political-historical context. Chapter two more specifically situates the transformation of caesarean from a necessary surgical intervention, when the wellbeing of women and their babies were at risk, to a positive right regardless of indication. It explores the background literature to the study which was undertaken in two stages. The first was to explore a background to the scope of the topic and situate it within a framework of what is currently known about the choice of caesarean, in the absence of clinical indications. The second stage was undertaken concomitantly with data analysis, for corroboration with the study's findings.

The literature search included a variety of electronic database searches; Ovid, Ebsco, Academic Elite, Cinahl, Pubmed, MIDIRS, social science, social policy, networks such as MIDWIFERYRESEACH, Google Scholar and back chaining from journal articles, newspapers and popular magazines pertinent to the topic were also integral to the search. The search began under key headings such as using both Anglo-American spellings of 'caesarean / cesarean', 'c-section', 'caesarean section on demand', 'maternal request for caesarean', boolean and/or 'maternal request' and / or 'non-clinically indicated caesarean,' 'caesarean and choice,' and / or 'women's request,' 'designer deliveries', 'Too posh to push,' 'informed choice / consent,' 'decision-making', 'discourse and caesarean section', 'discourse analysis,' 'childbirth discourses.' Philosophy and feminist journals, formal / informal word of mouth, caesarean library alerts, Blackwell Synergy library alerts, Archives NZ, data bases of Midwifery and medical publications and Pub Med. Time constraints limited the literature search largely to the mid 1990s and beyond, with the exception of some principal seminal and historical texts.

The story of caesarean depicts a barbaric and tortuous narrative, assuaged contemporaneously through technological advances. Chapter Two addresses current

trends and the wider debate within and outside the discursive practice of obstetrics. Included in the discussion are questions surrounding practitioner preferences for the procedure, the issue of women's request and risk factors implicated both for caesarean and vaginal birth. Contemporaneously, while there is little doubt that caesarean is as safe as it can be, it is fitting to probe into its history, to appreciate the poignant events of the past that have shaped the evolution of the procedure to the present temporality.

2. 2. History of Caesarean.

Four complementary historical accounts of caesarean were drawn from, to map the early traces of caesarean to the current time (Churchill, 1997; Donovan, 1978; Radcliffe, 1967; United States National Library of Medicine, [USNLM] updated, 1998). Radcliffe's (1967) account outlines the development of caesarean from the 1600s until 1967, while Churchill's (1997) chronicle, by her own admission, is currently the most thorough compilation thus far. Churchill (1997) goes beyond the historical facts to provide an exposé of the socio-political context that has shaped the evolution of caesarean up until the present day. She also incorporates her extensive research into the experiences of women who have undergone a caesarean, to provide a comprehensive practical guide for informing women. In this sense Churchill's book supersedes four other useful handbooks for women and care providers (Donovan, 1978; Meyer, 1979; Rosen & Thomas, 1989; Young & Mahan, 1980).

As childbirth consumers, Donovan (1978) and Meyer (1979) offer accounts from their own experiential knowledge of caesarean to inform, prepare and empower women should they be confronted with the future possibility of a necessary operation. Rosen and Thomas (1978), an obstetrician and free lance writer respectively, proffer an informed account of the procedure, with the intent of dispelling 'the caesarean myth' aimed at reducing unnecessary caesareans. Little over ten years on, Young and Mahan (1980) continued the task in a more pragmatic manner. Young, a consultant / educator in maternal and child health and current editor of *Birth* and Mahan, a professor of obstetrics and gynaecology, provided a candid account about caesarean and introduced non-clinical indications such as convenience, financial considerations, pragmatism and fear of litigation.

Legend testifies to caesarean as being named after Julius Caesar, hinting to Caesar being the first to be born via this mode, a myth that historians have now laid to rest, particularly given its barbaric antiquity (Churchill, 1997; Donovan, 1978; Radcliffe, 1967; USNLM, 1998; Young & Mahan, 1980). In tracing the origins of the procedure back as early as 715 BC, Churchill's (1997) sources reveal that the practice was initially carried out, for religious purposes, as a post-mortem caesarean, so mother and baby could be buried separately. Sporadic accounts of the operation prior to the 16th century bear witness to occasional infant survival; rarely mentioned is maternal survival (Churchill, 1997; Frazer, 1987). So rare was it for women to survive the operation, some countries forbade its use and those who dared to carry out the surgery on living women, faced accusations of cruelty, even murder (Churchill, 1997; Donovan, 1978; Radcliffe, 1967; Frazer, 1987). Furthermore the dominance of the Catholic Church in Europe, over matters such as childbirth, gave priority to the life of the baby so it could be baptised (Churchill, 1997; Radcliffe, 1967). Churchill purports sacrificing the life of the mother prevented the entry of the infant's soul into purgatory. This religious dictate may have accounted for the disparity in maternal survival rates between Great Britain (GB) and the Continent. In the case of the former, the operation was carried out earlier in labour when the mother was less moribund. Nonetheless, those that did survive were often maimed for life or met their demise through septicaemia, often due to the customary and cumbersome practice of limiting anatomical closure to the abdomen only (Radcliffe, 1967).

Opposition remained throughout the 18th century although some gained sanction for cases such as contracted pelvis (Churchill, 1997; Radcliffe, 1967; Frazer, 1987). In Great Britain, Churchill identifies, success was measured in maternal survival. Babies were often sacrificed through the alternative practice of craniotomy. Frazer (1987), Churchill (1997) and Radcliffe (1967) provide similar accounts of the first recorded successful operation performed in Ireland in 1738, by a midwife, on a woman, Alice O'Neale, who had been labouring for 12 days. Recounting from Young (1944), Churchill explains that after unsuccessful endeavours by midwives to deliver the baby, desperate relatives, summoned the help of Mary Donally, a midwife known in her community for her achievements in removing deceased infants. In a failed bid to deliver the baby vaginally, Mary Donally performed the operation. Churchill (1997) cites from

Duncan Stewart, a notable surgeon, in 1747, an account of Alice O'Neale's recovery, some nine years later.

Particularly poignant is that much of Mary Donally's achievement has been hidden from history. Concealment of this midwife's achievements around this time has been well documented in the literature and corresponds with the ascendancy of the male-midwife in the 18th and 19th centuries (Donnison, 1988; Ehrenreich & English, 1973). Churchill (1997) attests to attempts made to discredit Mary Donally's success a century after the event in some accounts. These have included labelling Donally as an 'ignorant Irish midwife' and the attribution of her success to chance as opposed to judicious practice. Frazer (1987) offers an explanation of such an erasure.

However, since no qualified person attended the delivery or witnessed the events, it has generally been discounted (Frazer, 1987, p. 73).

Frazer's (1987) text highlights an assumed epistemological superiority of male midwives at the time that not only excluded women's knowledge (Dalymia & Alcoff, 1993; Donnison, 1988; Ehrenreich & English, 1973) but also discounted that of 'unqualified' witness accounts. In this light, an irony is that much of the condemnation of caesarean, was its trial and error status at the hands of barbaric, opportunist and ignorant men. The preference for "cattlehorn" caesareans (Frazer, 1987, p. 74) is testimony to this brutality. Citing Young (1944), Churchill provides the first hint of needless caesareans, in a critique by William Dease in 1783 of those 'anxious to establish a reputation' (cited in Churchill, 1997, p.9).

From 1799 came the eventual formulation by Hull, of indications under which the procedure may be justified (Churchill, 1997). These indications were to be the forerunner of cephalo-pelvic disproportion, rupture of the uterus, malpresentation, abnormality of the baby and included ectopic pregnancy (Churchill, 1997, p. 12) and have remained largely consistent ever since. The procedure nonetheless continued to provoke censure well into the nineteenth century. Such was the condemnation of the procedure in Great Britain that few obstetricians dared to attempt it (Donovan, 1979; Churchill, 1997; Radcliffe, 1967). A shift in attitudes unfolded after the publication of a book entitled *"Observations on the caesarean section and on other Obstetric*

Operations" by Radford in 1865 (Churchill, 1997, p. 22). Radford, who was assumed to have an abhorrence of craniotomy, drew attention to the implications the timing of the operation particularly early in labour, had for the health of both mothers and babies. He justified the procedure as "imitating nature." Be that as it may, given the low survival rate and the absence of anaesthesia at the time, it is incomprehensible to think of a woman having to make a choice between the life of her baby and her own life, even worse, having someone else make that decision for her. What is evident throughout Churchill's history is that attitudes towards caesarean were more lenient outside GB, namely Europe and the United States of America (USA). Churchill (1997) attributes this popularity abroad to the emergence of statistical data that indicated increased maternal survival rates for these regions.

2. 2. 1. Improvements in the technique.

Two remarkable discoveries in the first half of the Nineteenth Century changed the course of caesarean (Radcliffe, 1967). First, in 1843 both Oliver Wendall Holmes in the United States of America and Ignaz Philipp Semmelweis from Austria in 1847, quite independently set in motion a crusade against sepsis, maintaining that it could be spread by cross-infection. Important was the subsequent discovery that puerperal sepsis had a significant impact on the maternal mortality rate (Radcliffe, 1967). Second, according to Radcliffe (1967) that same year, was the discovery by Morton, an American dentist, latterly a surgeon, that ether could alleviate the discomforts of surgery. Ether was later to be replaced with chloroform, a quicker acting and more potent agent than the original ether (Radcliffe, 1967). In that same year, Simpson, Professor of Midwifery at Edinburgh in Scotland, introduced chloroform into the domain of childbirth. While there was much ado about its use, Radcliffe (1967) reports that much of this opposition died down when it became known that Queen Victoria had used it for the birth of her eighth child, the Duke of Albury in 1853.

From the 1850s, antiseptic techniques were instigated, including the use of sterile suture materials, introduced by Lister to reduce the potential for maternal death from infection (Radcliffe, 1967, p. 92). Further improvements in the actual technique included amputating the uterus at the cervix, introduced by Eduardo Porro, in 1876, followed by

the introduction of rigorous application of *Listerism* into gynaecological surgery by Lawson Tait in 1898. These innovations led to decreases in maternal mortality from haemorrhage and peritonitis, respectively (Churchill, 1997; Radcliffe, 1967). Radcliffe (1967) notes that Sanger's technique further transformed the operation by suturing the uterus in addition to the abdominal incision. Churchill (1997) explains this important development in the evolution of the operation enabled future pregnancies, an impossibility with Porro's technique. Nonetheless, Sanger's operation caused some disquiet among some obstetricians because of the risks of bleeding, infection, intestine and abdominal wall adhesions and above all, the rupture of the scar in subsequent pregnancies. This concern was later reflected in Craigin's (1916) famous dictum, "once a caesarean always a caesarean" (Churchill, 1997, p. 40). The pronouncement was a cautious warning, to those considering a primary caesarean, because the procedure may subject women to a caesarean for all future pregnancies. Churchill (1997) reports that a major breakthrough in the procedure came in 1882 through Kehrer, a German obstetrician (Lurie & Glezerman, 2003) who developed the lower segment operation in Germany. After undergoing many refinements it was introduced into the United Kingdom in 1921 (Churchill, 1997).

The combination of events occurring in the late eighteenth century had a significant impact on the maternal mortality rate so that by the early part of the 20th century the increased safety of the procedure led to a greater acceptance of it. As the maternal survival rate increased, so too did the impetus for caesareans. The trial and error endeavours of the 19th Century gave way to the rapid advances in technology throughout the 20th Century that led to the increasing safety and hence popularity of the intervention. Today a comprehensive review of contemporary techniques for performing a caesarean, can be found in Hema and Johanson (2001). Its safety has been predicated on the introduction of antibiotics, improvements in intravenous therapy, advances in neonatal technology and in anaesthesia (Francome & Savage, 1993; Hema & Johanson, 2001).

2. 2. 2. Caesarean section in Aotearoa New Zealand: Early history.

In the context of Aotearoa New Zealand's early obstetrical history, Tait's reputation was reported in the New Zealand Medical Journal (NZMJ) by F.B.Batchelor, in January, 1889 under the title of "Notes on the cases of Tait's operation with remarks" (Dow, 1991). The first successful operation in Aotearoa New Zealand appears to have been performed by W.M. Stenhouse (1898) in 1890. The operation involved a 26 year old woman with a contracted pelvis and previous history of craniotomy with her first baby. The author provides some interesting insights into the thinking about caesarean, at the time, both at home and abroad. While Stenhouse is critical of needless use of the operation, he is equally critical of the practice of craniotomy and embryotomy, procedures commonly utilised in Great Britain. Almost a decade on, Batchelor (1898) gave a detailed and dramatic account of a 'successful' medically indicated caesarean he performed in 1897.

It was not until the turn of the twentieth century, that surgeons felt confident enough to perform a caesarean, largely because of the risk of postoperative complications such as peritonitis (Gordon, 1955). As spokesperson for the Obstetrical Society, Gordon (1926) was an advocate for the use of caesarean and wanted to impress upon the public that "...labour itself was a surgical operation..." (p. 69).

As caesarean began to gain in popularity in the 1920s, Jellett, consultant for the Health Department, became concerned over what he deemed to be an abuse of caesarean. He attributed this to obstetrical ignorance as a result of inadequate training. He cautions the profession in his "Report of the Consulting Obstetrician."

In fact in the most skilled hands, the operation in healthy patients is followed by a mortality of nearly 2 percent, and that in those that recover the prospects of a future normal delivery are impaired is overlooked (Jellett, 1927, p. 31).

Throughout the 1930s and 1940s sporadic details indicate no clear picture of caesarean section rates in Aotearoa New Zealand. The lack of data may be due to its designation as the forte of general surgeons, prior to the formation of the Obstetric and Gynaecological (O & G) Society in 1940 (Donley, 1986). Under the auspices of the

O & G Society, post graduate training in O & G began to flourish in the 50s (Donley, 1986) foreshadowing an increasing predisposition toward caesarean. An article in the NZ Medical Journal in 1960 by Dunn, echoed Jellet's concerns of 1920. In his publication entitled "Sequelae of Caesarean Section" Dunn (1960) claimed that many indications for caesarean were the result of interventions. He cautions his readers that "...the risks of failed induction, uterine inertia, cervical dystocia, prolapsed cord, uterine infection and traumatic bleeding are too often disregarded – they must all be accepted as iatrogenic" (1960, p. 183). Dunn (1960) was also concerned about the negative effects following caesarean, such as longterm debility and nervous stress, voluntary sterility, infertility, a reduction in fecundity and of the impact these had on family relationships.

It was not until after 1964 that sufficient data on maternity services and so caesarean section rates in New Zealand became available (Board of Health, 1976). The caesarean section rate (CSR) in 1971 was 4 percent. This was thought to be well within world standards of 3.5-5.0 percent (Board of Health, 1976, p. 29). The highest regional rate was in Otago with 6.3 percent and while in excess of world standards this appears of little concern to the Maternity Services Committee of the Board of Health.

2. 3. Caesarean section: Current trends.

Over the last three decades caesarean section rates (CSRs) in Aotearoa New Zealand have steadily increased (Board of Health, 1976; Bulger, Howden-Chapman & Stone, 1998; Ministry of Health, 2003). The National Health Committee (1999) identified wide variation in the rates of caesareans within ethnic groups, socio-economic position, providers and regions (NHC, 1999). These findings parallel overseas trends (Francombe & Savage, 1993; Ministry of Health, 1999). *Table 2.1* depicts the trend for caesarean in Aotearoa New Zealand between 1971 and 2003 and includes a corresponding pattern for normal births and operative deliveries. Of note are improvements in the capture and codification of data, that have taken place over time (MOH, 1999) enabling greater breakdown and consistency of reporting. In *Table 2.1* operative deliveries comprise forceps deliveries, vacuum extractions and vaginal breech births (New Zealand Health Information Service [NZHIS] for Ministry of Health [MOH] 2003; 2006).

Table 2.1. Caesarean, normal birth & operative deliveries: Aotearoa New Zealand trends 1971 – 2003 (%)

Year	1971	1988/9	1994/5	1997	1997/8	1999	2000	2001	2002	2003
Source	Board of Health 1976	Bulger et al, 1998	Bulger et al, 1998	HFA 1999	MOH 1999	MOH 2001	MOH NZHIS 2003	MOH NZHIS 2003	MOH NHIS 2004	MOH NZHIS 2006
Type of Birth										
C-section										
Acute	-	-	-	11.3	-	13.3	13.6	14.2	14.3	14.3
Elective	-	-	-	6.5	-	7.1	7.2	7.9	8.4	8.8
Total	4.0	11.7	15.3	17.8	18.2	20.4	20.8	22.1	22.7	23.1
Normal	-	-	-	69.9	-	68.7	68.4	67.6	66.7	67.4
Operative	-	-	-	12.2	11.5	11.0	10.8	10.3	9.6	9.5

Significant in table 2.1 is the association of the steady rise of caesarean with a subtle decrease in normal birth and operative vaginal deliveries. The trend is patterned along similar ethnic and regional differences identified by the NHC report of 1999. Lowest rates of caesarean were found among Maori and Pacific women, with highest rates among Asian and European women (MOH, 2003). Wide variations in caesarean rates between District Health Boards (DHBs) ranged in from 14.2% in Northland to 29.9% in Southland DHBs (MOH, 2006, p. 31). These findings are interesting in the light of Section 88 notice of the New Zealand Public Health and Disability Act (2000) and the Code of Health and Disability Services Consumer Rights (Health Commissioner, 1996) both of which have affirmed the right of women to make choices in childbirth. For example, provider variation has highlighted a pattern of caesareans along ethnic and socioeconomic lines signalling preference as having primacy in relation to clinical concerns (MOH, 1999, p. 32).

In specifying recommendations for appropriate technology for birth, ratified at the Fortaleza conference in Brazil (1985), the World Health Organisation [WHO] (1985) could find no justification for any region to have caesarean section rates above 10%-15%. Despite the unanimous adoption of the Fortaleza recommendations, the Caesarean section rates (CSRs) continue to rise into the 21st Century with predictions in the popular press, by one British obstetrician, that by the year 2010 over half of all women will choose a caesarean as an alternative birth mode (Johnston, 2001; Coney, 2001; Parsons, 2002).

2. 3. 1. Indications for caesarean section.

Francome and Savage (1993) have categorised medical indications as *Absolute* and *Relative*. For example, absolute indications refer to those events that preclude a vaginal birth such as is the case with placenta previa and cephalo-pelvic disproportion. Relative indications are those where decisions are based on individual assessments and the experience of the attending practitioner. Of these categories, the four major medical indications for caesarean most frequently identified in the literature (Keeler & Brodie, 1993; Francome & Savage, 1993; Broadhead & James, 1995; Enkin, Keirse, Renfrew & Neilson; 1995; Churchill, 1997; Bulger et al., 1998; Dickinson, 1999; National Institute for Clinical Excellence [NICE] 2004; Rosen & Thomas, 1989; Sachs, Kobelin, Castro and Frigoletto, 1999; Tan, Devendra & Tan, 2003; Thomas & Paranjothy, 2001) are repeat caesarean, dystocia / failure to progress, foetal distress / compromise and breech presentation. In Aotearoa New Zealand these are thought to account for 67% of all caesareans (Bulger et al., 1998).

Authors of a United Kingdom (UK) report on the National Sentinel Caesarean Audit [NSCSA], Thomas & Paranjothy (2001, p. 1) comment that while wide variations between units exist, of the major indications for a c-section, 14% are related to repeat caesarean, 20% are associated with dystocia, 22% related to foetal compromise and 11% are undertaken for Breech presentation. Despite assertions to a lack of consensus around medical indications (Hall, 1997) these indications have remained largely consistent over time. However the increase in caesarean rates has been attributed to a lowering of the threshold for decisions to perform a caesarean (Leitch & Walker, 1998).

Leitch and Walker's retrospective descriptive study examined reasons behind the rise in caesarean section rates along with changes in indications, comparing years 1962 and 1992. They concluded that a greater willingness to resort to caesarean behind increased CSRs as opposed to changes in the management of labour.

The growing preference for repeat elective caesarean is implied by increased CSRs (Broadhead et al., 1995; Churchill, 1997; Dickinson, 1999; Kamal, Dixon-Woods, Kurinczuk, Oppenheimer, Squire & Waugh, 2005; Wilkinson, McIlwain, Boulton-Jones & Cole, 1998) based on a woman's previous obstetrical history and therefore considered to be a relative indication for caesarean (Francombe & Savage, 1993). The choice of an elective repeat caesarean is assumed to be predicated upon the association of vaginal birth after caesarean (VBAC) and concerns about the possibility of uterine rupture (see for example NICE, 2004; Mozurkewich & Hutton, 2000). However, variations in caesarean rates, between countries, regions, units and clinicians, have drawn attention to factors beyond biology thought to be behind increases in caesarean births.

2. 3. 2. Indications beyond biology.

Bulger, Howden-Chapman and Stone (1998) investigated the CSR from the National Minimum Data Set (NMDS) and found a steady increase in CSR from 11.6% in the year 1988/1989, for hospital births to a rate of 15.3% in the year 1994/1995 (Table 2.1). They identified wide variations in caesarean rates within regions, ethnic groups, socio-economic status, providers and regions. These variations cannot be explained by biophysical factors alone (Francome & Savage, 1993). The increasing age of childbearing women is frequently implicated (Albers & Lydon-Rochelle, 1995; Bell, Campbell, Graham, Penny, Ryan & hall, 2001; Curtin & Kozak, 1998; Marwick & Lynn, 2001; Rosenthal & Paterson-Brown, 1998; Thomas & Paranjothy, 2001) and has only recently been pipped at the post by a new study, implicating paternal age as an independent risk factor, for increasing CSRs (Tang, Wu, Liu, Lin & Hsu, 2006). Day of the week also features with most births occurring midweek (Curtin & Kozak, 1998; Wagner, 2000). More specifically in the US, Tuesday is cited as the most popular, with Sundays as the least popular day for giving birth (Curtin & Kozak, 1998). Regional

differences and hospitals are also implicated as influencing choice (Curtin & Kozak, 1998; Johnson & Ansell, 1995; Hodnett, 2003) as is fear of litigation (Francome & Savage, 1993; Kirkham & Stapleton, 2004; Symons, 2003; Wagner, 2000; 2002; Weaver, 2004), birth attendant, obstetrician factors, place of birth (Francome & Savage, 1993; Hodnett, 2003; MacDorman & Singh, 1998; Olsen & Jewell, 2003; Poma, 1999) and private versus public providers (Bertollini, Dilalla, Spadea & Perrucci, 1992; Roberts, Tracy & Peat, 2000; Tracy & Tracy, 2003).

These variations tend to reflect differences in obstetric practices rather than differences in the population of women they serve (Francome & Savage, 1993; Enkin, Keirse, Renfrew & Neilson, 1995) and signal a shift in indications beyond biology. Most notable within these discursive practices is the revelation that the lowest rates for caesarean are found among women who have been traditionally represented as having the greatest risk for birth complications (Bulger, Howden-Chapman & Stone, 1998; Johanson, Timini, Rigby, Young & Jones, 2001). Bulger et al's (1998) concerns about the rising CSRs are shared by Wagner (2000) and resonate with the World Health Organisation (1985) recommended CSR between 10% and 15%. Similarly in the USA, the Department of Health and Human Services aimed for a reduction in the CSR to 15% by 2000 (Sachs, Kobelin, Costa & Frigolletti, 1999; Lancet, 1997). Sachs et al (1999) dismiss the WHO recommended rate as arbitrary claiming that it has little relevance to the current context, a point hotly contested by Wagner (2000). Wagner argued that there was nothing arbitrary about the recommendation. He asserts that the range was attained through consensus, representing around 20 countries, following a review of the published work on the topic. Analysis of variations between countries of maternal and perinatal mortality rates, were matched against each country's CSRs. The basis for Wagner's (2002) argument is that countries with especially low mortality rates had CSRs around 10%. Moreover a CSR above 10% had little impact on lowering mortality rates. Wagner (2000) adds that the agreed upon top of the range at 15%, took into account high risk populations.

2. 4. The great debate.

In the wider medical literature an entrenched debate continues. On one side are concerns for the increasing CSR largely on the grounds of the relative safety of a

vaginal birth (Enkin, Kierse, Neilson, Crowther, Dudley, Hodnett & Hofmeyr, 2000; Francombe & Savage, 1993; Wagner, 2000; Hemininki, 1997; Hillan, 2000; Idama & Lindow, 1999; Stirrat & Dunn, 1999) while on the other side is a resistance to lowering the CSR. This is largely based on the relative safety of an elective caesarean or in favour of women's choice (Al Mufti, McArthur & Fisk, 1996; Gabbe & Holzman, 2001; Gonen, Tamir & Degani, 2002; Paterson-Brown, 1998; Cotzias, Paterson-Brown & Fisk, 2001; Sachs, Kobelin, Castro & Figoletto, 1999). It is at this juncture that the debate seems to have shifted its focus to make way for two key arguments identified by Bewley & Cockburn (2002a). One has to do with the safety of caesarean *vis a vis* the risk of vaginal birth; the other concerns the primacy of a woman's autonomy *vis a vis* informed choice, regardless of risk.

2. 4. 1. Tortured evidence.

Fuelling much of the debate was a statement by the president of the American College of Obstetricians and Gynecologists advising colleagues to respect women's choice of caesarean (Harer, 2000). Harer appeals to his colleagues to disregard the 'statistics' in favour of giving women what they want. What on the surface seemed a beguiling campaign to obliterate paternalism, appears somewhat empty when up against little scientific basis for the choice caesarean when there is no clinical justification (Hemininki, 1997; De Mott, 2000). It is for this reason that De Mott (2000) fervently argues that offering an elective caesarean as a matter of choice is a "Blatant misuse of power" (p. 264). He openly alerts his readers to the power dynamics that can occur in the obstetrician – woman encounter and its impact on decision making. Wagner (2000), a vociferous critic of unnecessary birth technology, in particular caesarean (Wagner, 1994; 2000; 2001; 2002), accuses its proponents of accentuating the choice of caesarean and diminishing its risks by "...torturing the data until they confess to what the authors want" (2002, p. 368). He chides Harer for his editorial accolading Sachs, Castro and Frigoletto's (1999) promotion of caesarean, as a matter of choice. Wagner also draws the attention of his medical colleagues to the omission of a regular chapter on maternal mortality in relation to caesarean from the UK Confidential Enquiries into Maternal Deaths of its 1998 report (p. 1677). He suspects obstetric politics behind the move, a matter already seized upon under the vigilance of Hall & Bewley (1999). Hall and

Bewley (1999) refuted the rationale behind the omission that blamed a diversity of indications and erroneous 'denominator data' as reasons. They argue that such an erasure is unjustifiable, considering there was nothing new about these variables (Hall & Bewley, 1999).

2. 4. 2. Choice as patriarchal control?

More recently, within medical discourse, the debate has reached an impasse (Feinmann, 2002). Some would argue that there are no ethical grounds for an elective non-clinically indicated caesarean (Bewley & Cockburn, 2002a; Federation of International Obstetrics and Gynaecology [FIGO], 1999; Minkoff, Powderly, Chervenak & McCullough, 2004) while others argue that it is ethically justifiable, in that a woman's choice for a caesarean, in the absence of clinical indications, should be respected (American College of Obstetricians and Gynecologists [ACOG] 2003; Al Mufti, McCarthy & Fisk, 1996; Hickl, 2002; Lancet, 1997). Somewhere in between is poised neutrality, attempting to bring about balance (Penna, 2004). Amid the contention are those who advocate the choice, provided women are fully informed (ACOG, 2003; Amu, Rajendran & Bolagi, 1998; Drife, 1997; Paterson-Brown, 1998) and arguments as to whether women are being appropriately, even adequately informed (Churchill, 1997; Kirkham, 2004; Stapleton, 2004; Wagner, 2000) particularly about the realities of recovery from the operation (Hillan, 2000). These arguments are pitted against those who report high levels of satisfaction with both the decision and the procedure (Mould, Chong & Spencer, 1996; Edwards & Davis, 2001). While other studies report similar results, they were more circumspect; suggesting that while the majority of women may have expressed satisfaction there was still a high proportion of women who hadn't (Graham, Hundly, McCheyne, Hall, Gurney & Milne, 1999; Turnbull, Wilkinson, Yaser, Carty, Svigos & Robinson, 1999). Interspersed with these studies are piqued commentaries and letters to the editor, in professional journals, as to who is leading the charge; the media, women or obstetricians? (Anderson, 2001; 2002; Castro, 1999; Hillan, 2000; Kitzinger, 1998, 2001; Robinson, 1999; Stirrat & Dunn, 1999; Young, 2003). Anderson (2002) provides scenarios where the rhetoric of choice is a 'smokescreen' for patriarchal control over childbirth.

2. 5. Who is leading the charge?

Social science research in Brazil, a country that has one of the highest CSRs in the world, has unveiled an apparent façade that positions culpability for high CSRs on maternal requests (de Mello E Souza, 1994; Hopkins, 2000). For these researchers, in-depth analysis of women's request for caesarean revealed that caesarean was not their preferred mode of birth. Similarly both Castro (1999) and Hillan (2000) suspect maternal requests are swayed through subtle attempts by obstetricians, to influence women. Castro suspects the construction of the choice of caesarean, is a motto of distinction for the privileged few that will ripple out, for others to follow. Kitzinger (1999; 2001) too is cynical about the rhetoric surrounding choice in that the same enthusiasm for respecting women's choice is not directed toward homebirth. For Kitzinger obstetric discourse has rendered choice a commodity. She is critical of the use of rhetorical devices for the marketing of caesarean as such. Kitzinger (2001) sees the discourse around choice as a strategy appropriated to serve the interests of others and it is for this reason that she calls for the deconstruction of choice (p. 284).

Allegations that maternal requests are obstetrician driven, led Irvine (2001) to explore National Health Service (NHS) obstetrician and gynaecologist (O & G) views on the issue. In a survey of London O & Gs (response rate of 83.6%, n=168) Irvine (2001) found requests for caesarean to be women led. Further analysis of comments provided in the questionnaire revealed O & G frustration with women requesting caesareans, despite 'extensive counselling'. Likewise Kiran and Jayawickrama (2002) canvassed the views of O & Gs in England, Wales and Scotland. Of the respondents (72%, n= 108) one third conceded O & Gs to be responsible for the increase in CSR, while the majority blamed women and the media. However Kiran and Jayawickrama (2002) argue the futility of castigating women and the media. Their reasons being the number of O & Gs within the obstetric community, promoting this preference along with the number of publications citing caesarean as the preferred mode of birth among female O & Gs. Yet another study undertaken in Wales (Marx, Wiener & Davies, 2001) attempted to quantify the influence of maternal choice on CSRs utilising a visual analogue scale. A score of 5 was purported to tip the balance from obstetrical indication to maternal request. These researchers found that maternal choice accounted for 49% of scores,

implicating maternal request as a force behind increased CSRs, leaving 51% of scores implicating obstetricians behind the rise (Marx et al., 2001). The scores however need to be regarded with caution as many categories were chosen on the basis of relative or 'soft' indications, with only 6.6% (n=5) attributed to 'patient choice alone category' (Marx et al., 2001, p. 125).

Anderson (2001) is critical of Marx et al's, (2001) study. In a judicious appraisal of their research utilising the criteria set down by Gamble and Creedy's (2000) literature review around maternal request, Anderson points to flaws in Marx et al's methodology. She is also concerned that attributing blame for the rising CSRs to women will become 'self-fulfilling' and in effect may underrate the obstetrician effect upon the CSR.

2. 5. 1. Practitioners' personal preference.

Significant in the emergence of an obstetrician effect is Al Mufti, McCarthy & Fisk's (1996) survey of obstetricians' preference for an elective caesarean for themselves or their partner should they have an uncomplicated, singleton, cephalic (head first) presentation, at term, with their first baby. Of the obstetricians who responded (n = 206), 17% (n = 33) chose elective caesarean (Al Mufti et al., 1996; 1997). Of those who chose this option, 31 % were female, and 8% were male.

This much cited survey appears to have taken on a 'truth' of its own despite its shortcomings (Hall, 1997; Kitzinger, 1999; McGurgan, Coulter-Smith & Donovan, 2001). Through a visage of the scientific-meets-avant-garde, Al Mufti et al's (1996) study is held up as justification for offering the choice of caesarean to all women. With repetitive publication and citation in both medical and popular discourse, the study has attained (unwarranted) legitimacy (Decker, 1998). What is astonishing is the credence given to its findings, despite these indicating that most obstetricians would prefer a vaginal birth. Of particular interest, and alluded to by Kiran and Jayawickrama (2002) is that female O & Gs have been flagged, by proponents of non-clinically indicated caesarean, as a point of reference, for championing their cause. Since its first appearance in medical discourse, Al Mufti et al's (1996) study has unleashed a flurry of publications, eager to measure up to the benchmark despite its methodological

drawbacks. The follow-on effect of the study in shaping caesarean as a choice of birth mode is revisited in Chapter Five.

In an endeavour to find a balance, Dickson & Willett (1999) keen to hear from midwives about their preferences, directly approached 135 female midwives working in the UK. They found that 96% (n=129) would aim to have a vaginal birth. Likewise in Ireland, McGurgan, et al., (1999) sought to broaden the parameters of Al Mufti et al and Dickson and Willett's (1999) study while seeking both obstetricians and midwives preferences as to birth mode. In the case of the former, their aim was to investigate generalisability of the survey throughout the Republic of Ireland. In the case of the latter, it was to improve the approach to data collection, through anonymous questionnaires and incorporate reasons for practitioner preference. Using the same criteria as Al Mufti et al's (1996) survey, McGurgan et al., (1999) found that, after controlling for gender, only 7.3% of obstetricians and 7.5% of midwives, in the Republic of Ireland, reported a preference for caesarean. As with Al Mufti et al's (1996) study, more female than male obstetricians chose a non-clinically indicated caesarean. Obstetricians' preferences from McGurgan et al's study, were subsequently reported in McGurgan, Coulter-Smith and O'Donovan (2001) adding to an abundance of similar quests.

Following Dickinson and Willett (1999) and McGurgan, et al., (1999) between 1999 and 2005, over seventeen publications surveyed practitioners' preferences for mode of birth. Of the literature perused relevant to the current study, two similar yet different themes emerged. One concerned surveys eliciting whether or not obstetricians would select a non-clinically indicated caesarean for themselves or their partners (Bergholt, Ostberg, Legarth & Weber, 2004; Gabbe & Holzman, 2000; Gonen, Tamir Degani, 2002; Groom, Paterson-Brown & Fisk, 2001; Jacquemyn, Ahankour & Martens, 2003; Land, Parry & Wilson, 2001; McDonald, Pinion & Mcleod, 2002; McGurgan, Littler & O'Donovan, 1999; van der Does & van Roosmalen, 2001; Wax, Cartin, Pinette & Blackstone, 2005; Wright, Wright, Simpson & Bryce, 2001). The second theme encompassed surveys designed to elicit preference for birth mode with regard to a woman's request for a caesarean, regardless of need (Bergholt, Ostberg, Legarth & Weber, 2004; Cotzias, Paterson –Brown & Fisk, 2000; Ghattii, Chan & Guise, 2004; Gonen, Tamir & Degani; Kwee, Cohlen, Kanhai, Bruinse & Visser, 2004; van der Does

& van Roosmalen, 2001; Wax et al., 2005). These categories are not mutually exclusive as some overlapping is evident in reporting. Of the studies that canvassed obstetricians' preferred choice for either their partner or themselves, responses in favour of caesarean ranged from 1.4% (Bergholt et al., 2004) to 46% (Gabbe et al., 2000). Likewise studies surveying obstetricians' favourable responses toward a woman's request for a caesarean ranged from 1.4% (Bergholt et al., 2004) to 69% (Cotzias et al., 2000). Overall most studies showed the majority of obstetricians preferred a vaginal birth.

Where studies overlap in eliciting both types of preference, a large discrepancy existed between those in favour of caesarean for self or partner and those who felt it was the woman's right to choose (Wax et al., 2005; Gonen et al., 2002; McDonald et al., 2002). Wax, et al. (2005) found obstetricians' favouring caesarean for themselves or partners, was relatively low (21.1%) when compared with 84.5% willing to perform a caesarean on request. Gonen et al. (2002) found only 9% of obstetricians would choose a caesarean for them or partner, whereas 45% would support women's right to choose. Similarly, McDonald et al. (2002) found only 15.5% would choose the procedure for themselves or their partner, while 54% agreed that women should have this option. Of note in McDonald et al's (2002) study is that all obstetricians who had personally experienced a previous vaginal birth, would choose that option for subsequent births.

For all the studies canvassing obstetricians' preferences, reasons favouring caesarean were many and varied. Avoidance of perineal, pelvic floor damage (Bergholt et al., 2004; Cotzias et al., 2000; Groom et al., 2001; Jacquemyn et al., 2003; Land, Parry & Wilson, 2001; McDonald, Pinion & Mcleod, 2002; Wright et al., 2001; Wax, Cartin, Pinette and Blackstone, 2005), the possibility of anal or urinary incontinence (Bergholt et al., 2004; Jacquemyn et al., 2003; Land et al; Wax, et al, 2005), sexual dysfunction (Bergholt et al., 2004; Wright et al., 2001; Land et al., 2001; Wax et al., 2005), fear of labour/childbirth (Wright et al., 2005; Wax et al., 2005), uncertainty of outcome (Kwee et al., 2004;), fear of litigation (Cotzias,et al., 2000; Kwee et al., 2004) desire to be in control (Groom et al., 2001; Wright et al., 2001), negative outcome or risk to baby (Groom et al., 2001; Jacquemyn et al., 2003; Land et al., 2001 ; Wax et al., 2005), previous negative experience (Wax et al., 2005), fear of pain (Bergholt et al., 2004; Groom et al., 2001; Jacquemyn et al., 2003; Land et al., 2001; Wax et al., 2005), no

desire for a vaginal birth (Kwee, et al), women's autonomy or right to choose (Bergholt et al., 2004; Gonen et al., 2002; Kwee et al., 2004), convenience of scheduling birth, daytime obstetrics or control over time (Bergholt et al., 2004; Groom et al., 2001; Jacquemyn et al., 2003; Land et al., 2001; McDonald et al., 2002; Wright et al., 2001; Wax et al., 2005) and client pressure (Cotzias et al., 2000). In one study where the majority of obstetricians favoured caesarean, this preference was veiled behind reservations. For example of the 69% of Cotzias et al's (2000) obstetricians who agreed they would perform an elective caesarean based on an uncomplicated singleton pregnancy at term, 27% said they would reluctantly concede and 60% claimed that they would counsel women about the risks of caesarean.

Significant in Wax, Cartin, Pinette and Blackstone's (2005) study is that around 80% of the respondents were in favour of a Randomised Control Trial (RCT) suggested by Ecker (2004) and NICE (2004) for settling the debate between elective caesarean and vaginal birth. Perturbing here is the propensity for a physiological process to be touted in competition with a major abdominal operation, as a means of settling a contentious argument. There is no mention of how obstetrical practice can improve outcomes for vaginal birth, suggested for example by McDonald, Pinion and Mcleod, (2002).

Proponents of caesarean, regardless of need, tend to obfuscate matters by accentuating the safety of caesarean and the risks of vaginal birth (Cotzias et al., 2000; Groom et al., 2001). The implications of this push toward caesarean are far reaching, as is exemplified in a case cited in the *Anchorage News* online (Potempa, 20th July, 2005). The article cites a case in which an experienced O & G had her medical licence suspended, pending an investigation in which she had to defend her practice against allegations that her preference for vaginal birth versus caesarean, put her patients at risk. In what appears to be a trumped up charge, against her, Colleen Murphy was held to account for having a caesarean rate of around 9% when the national rate was 20 – 25 %. During her hearing, Murphy faced aspersions that she tended to put the women's needs before those of their babies (Potempa, 2005). The story brings into focus the 'safety of the norm' (Konner, in Berg, 1988) the idea that a practice is acceptable because of its routine occurrence regardless of its safety. As such the case highlights as problematic normalising strategies within disciplinary and social practices.

In evaluating O & Gs preferences for birth mode the aforementioned studies offer a range of perspectives and agendas that sculpture competing and contradictory truths about the choice of caesarean, as an alternative birth mode. Wide variations exist between practitioners, regions and countries, yet on closer inspection the majority of O & Gs' preferences tend toward vaginal birth. While the linkage between practitioner's preference and performance remains a tenuous one, it nevertheless has implications for decision making. It is at this nodal point that the future of vaginal birth is precariously perched. It is therefore opportune to turn to women's preferences.

2. 5. 2. Women's preference.

The issue of consumer choice in childbirth, once the ambit of birth place and caregiver, has now extended into the realm of maternal preference for elective caesarean as a choice of birth method (Atiba, Adeghe, Murphy, Felimingham & Scott, 1993; Hickl, 2002; Ryding, 1993; Mould, Chong, Spencer, & Gallivan, 1996; Amu, Rejendran & Bolagi, 1998; Young, 1999; Wagner, 2000). Taking into account regional variations including variations between units, Thomas & Paranjothy (2001) report maternal requests represent around 7% of the overall c-section rate (CSR) in the UK. Drawing on the NSCSA figures, the National Institute for Clinical Excellence [NICE] (2004) report that 'maternal request' is now the fifth most frequent reason for undertaking a caesarean.

While many writers view maternal requests to be a significant factor behind the rise in the caesarean rates (Churchill, 1997; Bulger et al., 1998; Ministry of Health, 1999; Jackson & Irvine, 1998; Marx, Weiner & Davies, 2001), others (Gamble & Creedy, 2000; 2001; Hildingsson, Radestad, Rubertson & Waldstrom, 2002; Hopkins, 2000; Weaver, 2004) suspect these accounts may be overstated in light of a tenuous association between these factors. In the context of Aotearoa New Zealand, Bulger et al. (1998) suggest that over half of the caesareans in this country may be viewed as medically unnecessary. The convenience of scheduling birth around other life events is often cited as a reason for such requests (Kirby & Hanlon-Lundberg, 1999; Al Mufti, Mc Carthy & Fisk, 1996; Bewley & Cockburn, 2002), and the allure to remain 'honeymoon fresh,' (Kitzinger, 1998; 2001; Bewley Cockburn 2002b) is gaining appeal. Moreover parental expectation for a perfect baby is rapidly being received as

justification for promoting caesarean as a panacea to the risks of vaginal birth (Paterson-Brown, 1998; Sachs, Kobelin, Costa & Frigoletti, 1999; Steer, 1996).

A point of reference for analysing the scope of maternal request comes from a critical and comprehensive literature review by Gamble and Creedy (2000). These researchers tabulated the research literature on women's request for caesarean according to study, design, sample, the time of data collection and by whom data was collected. Overall, Gamble and Creedy (2000) identified 10 studies that explored women's preference for birth mode. Accounting for methodological and conceptual variations among these studies, Gamble and Creedy (2000) found few women actually request caesarean in the absence of clinical indications. Methodological differences such as caregiver involvement in data collection, timing of data collection with regard to post hoc rationalisation, may have led to an over-reporting of women's choice of caesarean as a preferred birth mode. Gamble and Creedy (2000) allude to a bias with the caregiver collecting data as this may affect how women report their degree of decision making. Obstetricians may also influence the coding of indications, particularly where they feel pressured by policies regarding CSRs. The implication here is that there is a diffusion of responsibility from the obstetrician to the woman. Gamble and Creedy (2000) cite studies (Hemminiki, 1990; Perez, 1989) that have uncovered disparities between reasons given in women's medical notes and what women actually reported. Furthermore, they reveal the codification of maternal request appeared to be a default category, where ambiguity of indication exists. Gamble and Creedy's (2000) alert that failure to ask for underlying reasons for women's desire for a caesarean, may lead to erroneous assumptions surrounding maternal requests.

A subsequent study by Gamble and Creedy in 2001, undertook to investigate the incidence of women's preferred mode of birth, including reasons for their choice found that of the women recruited into their study ($n = 310$), 93.5% of women reported vaginal birth as their preferred birth mode, while 6.4% preferred a caesarean. The reasons given for the choice of caesarean largely centred on a previous traumatic experience. Women's choice for a caesarean, in the absence of medical indications, comprised of only 0.3% of women. Instead of viewing choice as a simply a matter of equipoise, Gamble and Creedy (2001) found a tendency for some maternity care providers to downplay the long term risks of caesarean and that few women are aware of these risks. Moreover, they fathom

that much of the medical literature is biased in favour of women's preference for caesarean framed within respecting that choice. Little interest, Gamble and Creedy (2001) report, lies in respecting women's choice for a vaginal birth.

Hildingsson, Radestad, Rubertson and Waldestron's (2002) prospective Swedish national survey, that measured a wide range of variables, investigated women's preference for caesarean among 3283 women in early pregnancy, during 1999 – 2000, and concluded that few women (8%) desire to have a caesarean. Women's preferences in Sweden were embedded more within a blend of fear of childbirth, such as a previous traumatic experience, and socio-demographic factors, than a desire for autonomy. Their research vindicates Gamble and Creedy's (2000) interpretation of the literature, that the current preoccupation with maternal request for caesarean, in the absence of clinical indications, may overshadow the obstetrician factor behind the increasing CSR.

Weaver (2000a) uses both qualitative and quantitative methodologies to explore what caesarean means for women, midwives and obstetricians. In an initial analysis of interviews with 47 women, Weaver (2000a) identified that representations of birth are reinforced in everyday talk, through other women's stories and the media. While women in the study held vaginal birth as an ideal, Weaver (2000a) found the desire for a vaginal birth was enmeshed dichotomously with an opposing proposition in favour of a caesarean. Concerns for the safety of the baby and averting the prospect of an emergency caesarean were key reasons why women were in favour of caesarean. Women in her study perceived a vaginal birth was risky and perceived it was selfish to privilege personal desires ahead of their babies. In the final analysis of the project, Weaver and Stratham (2005) affirmed women's perception of caesarean the safer option. Fear and risk were governing factors in their decisions. Furthermore women may take on board, off-the-cuff expressions from their care providers, such as asides pertinent to their baby's size, which may become 'internalised' and unabated. Weaver and Stratham (2005) also found women had difficulty in raising fears with maternity providers and that for a substantial number of women, the risks of caesarean were not discussed. It is this erasure of risk around caesarean, they conclude, has by default the potential to reinforce the perception of caesarean as the safer option.

The salient element in all of the above (substantial) studies is that despite the lack of evidence to support the drive to establish women's request as a justification for caesarean, what stands out is that a disproportionate amount of time, financial backing and publication space has been devoted to making maternal request for caesarean, regardless of need, happen.

2. 6. Risks of caesarean.

Alluded to in the discussion thus far, is that women's choice has become a new object in the struggle for control over childbirth. In the wrangle, proponents of caesarean, as an alternative birth option, convey caesarean as an emblem of safety. Notwithstanding improvements in the technique, caesarean is still a major operation and carries greater risk than a normal vaginal birth (Enkin, Keirse, Neilson, Crowther, Duley, Hodnett & Hofmeyr, 2000; Hillan, 2000). Furthermore, for healthy women, who have no need for intervention, the procedure necessitates a prophylactic workup prior to surgery, to stave off any iatrogenic impact of the operation, which may itself be iatrogenic. What is particularly germane is that these healthy women will be positioned as 'at risk' in subsequent pregnancies.

Since the beginning of the current decade, a steady stream of literature reviews have attempted to uncover and untangle the evidence surrounding the choice of elective caesarean, in the absence of need (Bewley & Cockburn, 2002b; Minkoff & Chervenak, 2003; Jackson & Patterson-Brown, 2001; Leslie; 2004; McFarlin, 2004; National institute for Clinical Excellence [NICE] 2004; Penna & Arulkumaran, 2003; Wax, Cartin, Pinette & Blackstone, 2004), each with their own interpretation of the facts. American writers, Minkoff and Chervenak (2003) and Wax et al's (2004) comprehensive review, suggest that the evidence is insufficient to routinely endorse the procedure. Notwithstanding their reticence, these writers support women's choice for caesarean, provided they are fully informed. Penna and Arulkumaran (2003) are more wary of the trend, suggesting maternal request for caesarean, is a privilege as opposed to a right. These US reviews are complemented by a thorough examination of the evidence from a midwifery perspective, framed within a cautionary note (Leslie, 2004; McFarlin, 2004). Likewise in the UK, Bewley and Cockburn (2002b) offer an equally extensive

critical evaluation of the available evidence and warn their readers of the harm that may face women and babies in both present and future generations.

Jackson and Paterson-Brown (2001) also provide a factual account of the physical sequelae of caesarean. However the tenor of their text is less cautionary. While they acknowledge the significant morbidity of caesarean, their exposé is somewhat diluted with a rider that ricochets back to the risks associated with a vaginal birth. In a rather spurious statement that evades the long term sequelae of c-section, they call for more research to examine the "...true, current risks of this increasingly common and popular method of delivery" (Jackson & Paterson-Brown, 2001, p. 58). By whom this mode of birth is rated 'common and popular' is curious given the findings of the NSCSA that identified vaginal birth as the preferred mode for most women (Thomas & Paranthjothy, 2001). It is obvious that Jackson and Paterson-Brown's (2001) rhetoric targets obstetricians and shows how the power of language knows no bounds.

Alongside the pursuit for caesarean as a birth alternative, is an earnest undertaking to report the risks of the procedure. These endeavours are evident in a series of reviews of the research, articles, actual research publications, educational debate and opinion expressed in journal commentaries. With some studies, analyses are confounded through blurring the boundaries between elective c-section and emergency caesarean (Minkoff & Chervanak, 2003; Wax et al., 2004). Even so, evidence from systematic reviews suggests that when compared to a normal vaginal birth, the maternal mortality rate with caesarean birth is considerably higher (Enkin et al., 2000).

2. 6. 1. Mortality.

While in some situations maternal mortality, linked to caesarean, can result from conditions that led to the operation in the first place, Hall and Bewley (1999) make a case for examining direct fatalities that occur as a consequence of factors related to the procedure itself. After analysing direct maternal deaths rates per million, per mode of birth in the UK, between 1994 and 1996, they found significant differences in the relative risk for elective caesarean and vaginal birth. The relative risk for elective caesarean was 2.84 (CI of 1.72 – 4.70) compared with a vaginal birth of 1.0. Tamzin

and Arulkumaran (2002) corroborate this link between caesarean and maternal death in citing Drife (1997) analysis of the *Confidential inquiries into maternal deaths in the UK*. These writers report that of the five deaths attributed to postpartum haemorrhage between 1994-1996, four occurred after caesarean section and one as the result of an assisted vaginal birth.

In a review of the literature of maternal mortality Jackson and Patterson-Brown (2001) found a paucity of current evidence concerning direct deaths from caesarean. Of interest Hall and Bewley (1999) were excluded from their review. In summarising findings from the literature, Jackson and Patterson-Brown's (2001) conclusions are rather obfuscated in that they suggest the absolute risks from caesareans are not discernable because of incomplete data in the UK. Despite Hall and Bewley's (1999) more recent analysis, Jackson and Patterson-Brown (2001) cite a South African study by Lilford et al (1990) who found a risk ratio of deaths linked to emergency caesarean of 1.7 (95 % CI, 0.5-6.0) compared with an elective caesarean (p. 50). Further data has been extrapolated by NICE (2004) utilising Lewis and Drife's (2001) analysis from the *Fifth Report of the Confidential inquiries into maternal deaths in the UK*, between 1997- 1999. NICE (2004) reported a mortality rate of 16.9 / million for vaginal births compared with 82.3 / million c-sections, with a risk ratio of 4.9 (95% CI 2.96 - 7.97). NICE's (2004) analysis however did not ascertain risk separately for precursor events necessitating caesarean or from the procedure itself.

Minkoff et al. (2003) analysed data Lewis and Drife's (2001) analysis for elective caesarean and proposed a relative risk of 2 for caesarean, compared with a vaginal birth. Drawing from Lucas, Yentis, Kinsella, Holdcroft, May, Wee and Robinson's (2000) new classification of urgency for caesarean that explicates the risk level associated with scheduled caesarean, Minkoff et al. (2003) determined a lower mortality among women who had scheduled caesarean, than those who underwent vaginal births of 1/78,000 for a scheduled caesarean which he claims was lower than vaginal birth. From their analysis, Minkoff et al. (2003) imply that it is better for a woman to have an elective caesarean than face the possibility of greater risk of death from an emergency one particularly for women who elect trial of labour. More recently, Wax, Cartin, Pinette and Blackstone (2004) report fatality rates, directly linked to caesarean, as less than for vaginal birth.

Bewley and Cockburn (2002b) had earlier expressed concerns that a more lenient attitude toward an elective c-section may give the illusion of safety and this will have implications for labouring women, should the ceiling for emergency caesarean be lowered. The consequence of lowering the threshold for an emergency caesarean has the potential for a vicious cycle "...whereby high emergency caesarean section rates fuel further loss of confidence and raise caesarean section rates, making elective caesarean section relatively more attractive." (Bewley & Cockburn, 2002b, p. 597).

With regard to babies, research directly linking elective caesarean for low risk women, directly to infant mortality, has been scarce (McDorman, DeClercq, Menacker & Malloy (2006). In one systematic review, absolute risk of neonatal mortality after planned caesarean was reported by NICE (2004) to be no different to that of a planned vaginal birth with a relative risk of 1.1 for c-section (CI 0.1, 8.4) compared to vaginal birth. McDorman et al. (2006) hold the benchmark for being the first to examine neonatal and infant mortality rates for birth mode. In McDorman et al's (2006) highly innovative, comprehensive, population based study, using the criteria established by 'Healthy People 2010', for low risk women, these researchers examined the birth outcomes of neonates and infants for a planned primary c-section and planned vaginal birth. Low risk women were designated as those carrying a singleton baby at term in a vertex presentation. McDorman et al. (2005; 2006) used the term 'no indicated risk' for women who met the 'Healthy People 2010' criteria and who had no reported medical risk factors or complications in labour. These researchers used nationally linked data sets for births and death for infants and neonates for 1998 – 2001 birth cohorts (McDorman et al., 2006) and compared the outcomes with women of no indicated risk. Primiparous and multiparous women were included in the study. McDorman et al. (2006) found that the neonatal mortality rate for delivery by caesarean was 1.77 per 1000 live births, compared to 0.62 for vaginal births. They discerned the mortality rate for a planned caesarean to be almost three times that of a planned vaginal birth and that the extent of this difference was only moderately reduced after adjusting for demographic and congenital abnormalities (McDorman et al., 2006).

2. 6. 2. Morbidity.

Variations in maternal morbidity are a feature in some research reports. Some writers (Wax, Cartin, Pinette, Blackstone, 2004; Allen, O'Connell, Listen et al., 2003) use the controversial term breech trial [TBT] (Hannah, Hannah, Hewson, Hodnett et al., 2000) as a yardstick (see Fernandes, 2004; Glazerman, 2005 and Kierse, 2003 in Chapter Five). In this trial, little difference in morbidity, between a planned vaginal birth and a planned elective caesarean was found. With regard to a caesarean birth, other writers warn of the possibility of peri-partum hysterectomy (NICE, 2004), bladder injury and adhesions with regard to caesarean (Dodd, Crowther, Huertas, Guise & Horey, 2004), cutaneous endometriosis (Scholefield, Sajjad & Morgan, 2000; Bewley & Cockburn, 2003) and a greater incidence of rehospitalisation (Thompson, Roberts, Currie & Ellwood, 2002). Admission to hospital was largely associated with uterine infection, wound complications, cardiopulmonary and thrombo-embolic disorders, as well as problems with gallbladder and appendicitis (Lydon-Rochelle, Holt, Martin, & Easterling, 2000; McFarlin, 2004).

Notwithstanding the biophysical implications, there is an abundance of literature on the psychosocial implications of caesarean birth (Churchill, 1997; Clement, 2001; Hillan, 1999; Murty, 1993). Furthermore evidence associating delayed initiation of breast feeding with caesarean is beginning to emerge (Rowe-Murray & Fisher, 2002) as well as risks for women and their babies in subsequent pregnancies. Links to increased risk of placenta previa and placenta accreta in successive pregnancies is beginning to surface in the medical literature (Ananth, Smilian & Vinzileos, 1997; Amu, Rajendran & Bolaji, 1998; Upadhyay & Buist, 1999; Rasmussen, Albrechtsen & Dalaker, 2000; Lyden-Rochelle, Holt, Easterling & Martin, 2001; Hemininki & Merilainen, 1996; Miller, Chollet, & Goodwin, 1997; Usta, Hobeika, Abu Musa, Gabriel & Nassar; Silver, 2005) with a 'modest risk' for ectopic pregnancy (Hemininki & Merilainen, 1996). Likewise is a small but serious risk of uterine rupture in subsequent pregnancies (Dodd, Crowther et al, 2004; NICE, 2004; Mozurkewich & Hutton, 2002) Other writers have found an association with voluntary and involuntary infertility (Jolly, Walker & Bhabra, 1999; Mollison, Porter, Campbell & Bhattacharya, 2005). Increasingly emerging are implications of caesarean, for neonatal outcomes and longterm consequences for babies.

Many authors report respiratory problems in infants delivered by caesarean section (Bailit, Garrett, Miller, McMahan & Cefalo, 2002; Bulger et al, 1998; 1998; Dessole, Cosmi, Balata, Uras, et al, 2004; Fogelson, Menard, Hulsey & Ebeling, 2005; NICE, 2004; Fogelson, Menard, Hulsey & Ebeling, 2005; Richardson, Czikk, da Silva & Natale, 2005; Wagner, 2000). Furthermore, studies have shown caesarean is associated with unexplained stillbirth in subsequent pregnancies (NICE, 2004; Smith, Pell & Dobbie, 2003). Reports of perinatal intra-operative complications for babies, such as skin lacerations are also beginning to surface (NICE, 2004; Dessole, Cosmi, Balata, Haas & Ayres, 2002; Uras et al., 2004; van Ham, van Dongen & Mulder, 1997).

Taken together, the above factors raise doubts as to whether caesarean births, in the absence of medical indications, can be justified when there is little scientific evidence in the literature to support it. Given the negative sequelae of the operation and the fact that women are expected to recover from major abdominal surgery concomitant to the demands of caring for a new baby, it is not surprising that proponents of caution (Bewley & Cockburn, 2002; Enkin et al., 2000) advise that these risks can be minimised by restricting the procedure to situations where it is clinically indicated.

2. 7. Risks of vaginal birth.

As referred to above, while not unique to vaginal birth, postpartum haemorrhage is a life threatening incident resulting from substantial blood loss around the time of birth, necessitating careful monitoring and emergency management (Tamizian & Arulkumar, 2002). More specific to a vaginal birth is shoulder dystocia, an event in which the shoulders of the baby become impacted behind the symphysis pubic bone of the pelvis (Basket, 2002). Basket (2002) reports that the incidence of shoulder dystocia can range from 0.2 – 2% of vaginal births and can result in perinatal asphyxia and death if methods for predicting and subsequent management are delayed.

Recently there has been a controversial shift away from the risks of caesarean to an emphasis on the risks of vaginal birth. Supporters of elective caesarean have conveyed fear of pelvic floor damage and sexual dysfunction as reasons for their preference. While sexual function may be important for some obstetricians, this may not be true for

all women (Barrett & McCandish, 2002). In a review of research examining mode of birth in relation to sexual health, Barrett and McCandish found little evidence to suggest the primacy of caesarean over vaginal birth, in relation to women's sexuality. The increasing tendency to align vaginal birth with pelvic floor disorders (O'Boyle, Davis & Calhoun, 2002) has the potential to create a culture of fear among professionals and childbearing women (Bewley & Cockburn, 2002b). Bewley and Cockburn (2002b) allude to the current preoccupation with pelvic floor dysfunction which has grown to "...mythological proportions" (p. 597). Such angst is reinforced by the media (Laws, 2004; Parson, 2002; Song, 2004) with metaphorical devices such as "a nice clean cut" (Alexander & Bouvier-Colle, 2001) are tactically appropriated by experts, in professional and popular culture. The inducement for an elective caesarean has symbolic appeal, particularly for women who view the messiness of childbirth as distasteful. Circumventing the potential for pelvic floor injury has become foremost in offering the choice of caesarean in the absence of clinical indications (O'Boyle et al., 2002; Wax et al., 2004).

Prophylactic caesareans are promoted as the solution for protecting women from an imperfect interior and obstetricians from litigation (O'Boyle et al., 2002). The emergence of endo-anal ultrasound has the capacity to increase the detection of 'occult' anal sphincter injury and its use in routine postpartum assessment has been alluded to (O'Boyle et al., 2002). The evidence is both compelling and unconvincing, with opinions deeply divided (Bump, 2002). These opinions are often tangential to evidence or evidence that may be filtered through the ideology of the reviewer (Bewley & Cocburn, 2002b; Bump, 2002).

Where evidence exists to suggest that the risk between urinary incontinence is higher in women who gave birth vaginally when compared with women who have given birth by elective caesarean, caution has been expressed as to its use as justification for increasing caesareans (NICE, 2004; Rortviet, Daltviet, Hannestad, & Steinar, 2003). Some researchers have doubts as to the protective function of elective caesarean in preventing urinary incontinence (Buchsbaum, Chin, Glanz & Guzick, 2002; Chaliha, Khullar, Stanton, Monga & Sultan, 2002; Faundes, Guarisi & Pinto-Neto, 2001). Buchsbaum et al. (2002) have shown that urinary incontinence can occur in women who have had caesarean, in women who are nulliparous and women who have not been exposed to

pelvic floor damage. Faundes et al. (2001) found that caesarean did not prevent urinary incontinence and conclude that women should not be led to believe that the risk of urinary incontinence, premised upon a weakened pelvic floor, can be avoided through a caesarean. Moreover, as women get older differences between cohorts are cancelled out (Buchsbaum et al., 2002; Rortviet et al., 2003). Other researchers attribute leakiness of urine during pregnancy as a risk factor for postpartum urinary incontinence (Stainton, Strahle & Fethny, 2005).

Research on faecal incontinence is also inconclusive (NICE, 2004). Some have shown a compelling link with vaginal birth (Fynes, Donnley, Behan, O'Connell & O'Herlihy, 1999; McArthur, Bick & Keighly, 1997) while others are less categorical (Lal, Mann, Callender & Radley, 2003; MacArthur, Glazener, Wilson, Herbison, Lang & Lancashire, 2001). Lal et al. (2003) found that anal incontinence occurred with both elective caesarean and vaginal birth (5% versus 8% respectively) and while they acknowledge the impact secondary tears have on faecal incontinence, like Stainton, et al (2005) they also point to pregnancy itself as a factor in pelvic floor dysfunction. Hojberg, Salvig, Winslow, Bek, Laurber & Secher (2000) suggest too that childbirth may play less of a role, with other factors coming into play, such as age. Hojberg et al. (2000) measured flatal incontinence and found that the passage of flatulence at least once a week was associated with anal sphincter tears and a birth weight over 4000g. As an aside, a study of male partners' patterns of flatal emissions would offer interesting insights as to whether flatulence following childbirth was patterned along sex lines.

Whereas some writers recommend an elective caesarean to circumvent pelvic disorders (Brent & Bost, 2000; Fynes, Donnley et al, 1999) others are more cautious (Girard, 1999; Bowen & Ockendon, 1999). The liberal use of episiotomy was found by Schlomer, Gross & Meyer (2003) to hold three times the risk for faecal incontinence. Some point the finger more specifically at the midline episiotomy (Signorello, Harlow, Chekos & Repke, 2000) others call for the routine use of episiotomy to be abandoned (De Tairac, Panel, Masson & Mares, 2006). Wagner (2000) suggests impatience with second stage of labour, leading to unnecessary interventions such as forceps and episiotomy may be a factor. De Leeuw, Struijk, Vierhout and Wallenburg, (2001) found forceps delivery as a risk factor for third degree perineal injury. Moreover some researchers draw attention to the positive benefits of birth position during labour and its

implications for a reduction in perineal injury (de Jong, Johanson, Baxen, Adrians, van der Westhuisen & Jones, 1999; Shorten, Donsante, & Shorten, 2002).

2. 8. Conclusion.

Chapter Two situates caesarean in a historical, social and political context and attests to its barbaric beginnings. History depicts the role of the church as sanctioning its *modus operandi*, resulting in disparate practices between continents, as to who should be sacrificed dependent upon which was the more dominant institution, the State or Church. These disparities highlight how disciplinary practice occurs in a historical socio-political context. Low maternal survival rates, led to condemnation of caesarean, in favour of alternative equally sinister procedures. In Aotearoa New Zealand, the ‘truth’ about caesarean can be traced to as early as the 1890s. The first surface of its emergence, as an alternative birth mode, was made possible in and through the discursive practice of obstetrics, consequential to establishing the Obstetric Society with its desire for medical autonomy. Autonomy for women was to remain deep beneath the surface of professional struggles for several decades.

Increased caesarean rates concomitant with variations in practices suggest factors beyond biology behind the rise. This has led to an explosive debate in the professional literature. For some authors, lack of strong evidence is immaterial. As the risks of vaginal birth are trumpeted amid an accrual of fear and uncertainty, the risks of caesarean are downplayed. It is at this nodal point that the future of a vaginal birth hangs in the balance. Bypassing the vagina has become a new form of surveillance in obstetric discourse with more natural functions coming under the medical gaze.

Caesarean’s momentum into the twenty first century has been bolstered by a call for women’s autonomy in childbirth, the displacement of the risks of caesarean onto vaginal birth, fear of an imperfect interior and the prediction that by 2010, fifty percent of all caesarean sections will result from maternal request. Knowledge of these historical events provides a snapshot of how ideology and disciplinary practice can impact on truth value, a matter of consequence in the proceeding chapters. As bearers of ‘truth’ we need to be cognisant of how our philosophical perspectives channel our

knowledge of the world. It is the construction of knowledge that is the focus of Chapter Three.

Chapter 3. Bodies of Knowledge: Philosophical foundation.

3. 1. Introduction.

A key line of reasoning in the preceding chapters has been in providing a context for situating the emergence of women's choice of caesarean, as an alternative 'birth' option. This contextualising has enabled insight into the events that have made possible this providential practice, as a new object of obstetrical discourse. Against this backdrop, evidence based understandings of risk drift along on a shifting terrain of competing 'truths', in a joust for the legitimacy of knowledge, to channel understandings of childbirth into an eventual (single) truth. Upon this volatile epistemological landscape, lies my own ideology for the acquisition of knowledge. As bearers of our own ideological position, we need to account for the theory of knowledge that underpins our research practice (Crotty, 1998; Denzin & Lincoln, 2000; Harding, 1987; Schwandt, 2000). Questions of epistemology tackle the 'how' 'who' and 'what' of knowing. Issues such as 'who' can know and what criteria beliefs have to meet before they enable legitimate knowledge (Harding, 1987) govern the nature of research.

In reading the work of French philosopher, Michel Foucault (1926-1984) and followers (Weedon, 1997) I have come to the understanding, for now, that people's view of the world is shaped by a multiplicity of discourses within professional and popular culture and that these are reinforced by various social and institutional practices. Weedon indicates that embedded within discourses are a blend of talk, texts and iconic images that offer an array of subject positions out of which identities are sculptured. For this reason I situate identity within the notion of subjectivity, that is, a shifting entity in process, as opposed to an identity characterised by unity from which knowledge springs eternal (Weedon, 1997). Discourses too are specific to a particular historical and socio-cultural context and as such meanings are not fixed for all time. A case in point is the shift in meaning from a caesarean, as a necessary intervention, when the wellbeing of women and their babies were at risk, to the perception that women have the right to elect one regardless of need, purely as a matter of choice (Flamm, 1995; Lancet, 1997; Paterson-Brown, 1998).

The overall aim of this study is to explore different discourses that construct the choice of a caesarean in the absence of clinical indication, with the view to opening up a range of possibilities for understanding its complex and contradictory nature. This chapter draws on the theoretical ideals of poststructuralism in particular the ideas of Foucault's work around subjectivity, discourse, power and knowledge which provide the theoretical foundation for my research. Before interpreting Foucault's key ideas, I provide a brief overview of the nature of knowledge in general and map of the trajectory of events that led to the ideology of consumer sovereignty today. The chapter also incorporates a discussion of feminist poststructuralist insights into the fluid nature of women's bodies of knowledge. Chapter Three concludes with a consideration of rhetoric and the strategies to name that which cannot be named.

3. 2. The nature of knowledge.

Just as researchers need to justify their philosophical position, when practising research, midwives need to justify the knowledge that informs their practice. In this growing climate of evidence-based practice, knowledge and research have become inseparable and therefore it is judicious for a midwifery researcher to have an understanding of the nature of knowledge. What constitutes 'legitimate' knowledge is largely circumscribed by the paradigm the researcher embodies. Denzin and Lincoln (2005) draw from Guba (1990) a definition of a paradigm simply as, "...a basic set of beliefs that guide action" (p. 22). These basic beliefs, underpin the ontological, epistemological and methodological assumptions of the researcher. Denzin and Lincoln have aligned these principles to three central questions (p. 22) the answers to which help locate the researcher's philosophical position.

- Ontological questions ask: What kind of being is the human being? What is the nature of reality?
- Epistemological questions ask: What is the relationship between the inquirer and the known?
- Methodological questions ask: How do we know the world, or gain knowledge of it?

For example, a realist ontology assumes a “real” reality which “out there” awaiting discovery (Crotty, 1998; Guba & Lincoln, 2005, p. 203) by an autonomous rational and fixed (individual) being (Mansfield, 2000). Juxtaposed to this ontology is an objectivist epistemology, predicated on the assumption that truth and meaning reside in their objects independent of any consciousness (Crotty, 1998). The researcher is independent of the object of their inquiry and follows a prescribed (scientific) method, such as experimentation, to ensure objective and certain truth (Crotty, 1998). Knowledge gathered is free from contextual blemishes, presumably to facilitate making generalisations about the social world (Denzin & Lincoln, 2005, p. 11-12). Likewise a relativist ontology that posits multiple subjectivities bring about diverse realities as meanings are constructed through social processes. Allied to this ontology is a constructionist epistemology that rejects the idea that reality resides in the objects of inquiry (Crotty, 1998). It is at this juncture that Smith and Hodkinson (2005) proffer a change in our epistemological metaphors “...from those of discovery and finding to those of constructing and making...” (p. 921).

Constructionism may take on many forms and is easily confused with constructivism (Crotty, 1998; Schwandt, 2000) as distinctions between the two are not clearly evident in texts. Schwandt (2000) a proponent of constructionism, is quite candid about the confusion and provides several examples of how the terminology is (mis)used. He views psychological constructionism as primarily concerned with individual acts of cognition in constructing knowledge, while social constructionism, takes on board the socio-cultural and historical context in the process. Within their taxonomy of paradigms, Guba and Lincoln’s (2000; 2005, p. 193-196) use the concept of constructivism. Yet in the body of their discussion they make no distinction between the terminology of constructivism and constructionism, suggesting that these authors view these terms as interchangeable. Their taxonomy, however interchangeable, reflects an individualist focus, building toward consensus. Reference to the socio-political nature of knowledge is not evident in their schema. Longino (1993) a proponent of socially produced knowledge, warns that the pursuit of consensus can be at the cost of silencing oppositional positions (p. 114). While constructionism implies the subject constructs meaning through interactions with objects (Crotty, 1998) a post-structuralist perspective views reality as constituted within discourse and disciplinary practices (Weedon, 1997).

In relation to my own philosophical position, my research draws from the theoretical ideas of post-structuralism in that it is my belief that peoples reality is shaped discursively through the discourses they encounter. The thinking of Foucault (1972) has uncovered the notion that the subject does not create reality through its interactions with objects, nor is the subject the origin of knowledge from which meanings come to light. Foucault (1972) states that reality is already 'out there' and so is imposed on the subject through systems of power and knowledge, inherent in the discourses and discursive practices which the subject enters into. For Foucault, discourses do not simply reflect reality, as with linguistics, but are "practices that systematically form the objects of which they speak" (Foucault, 1972, p. 49). This discursive approach is criticised for assuming subjectification is a passive process, a product of language, at the exclusion of active agency (Fairclough, 1993; McNay, 2000). Postmodern feminist writers however, suggest women have a range of subject positions available to them, which they can occupy within the context of structural constraints (Court & Court, 1998; Davies, 1994; Hardin, 2001; Lupton, 1994; Weedon, 1997). Thus some discourses are more powerful than others in upholding particular realities by claiming to have authority over particular knowledges (Jordan, 1997). Obstericians for example have claimed authority over what constitutes a normal birth (Jordan, 1997). As such, divergent realities are possible contingent upon one's status within a particular social group.

The notion of multiple subjectivities affirms women's heterogeneity with regard to their social positioning and preferences in childbirth. It is at this juncture that postmodern feminists are mistrustful of 'grand narratives' that posit an individual's identity as coherent and unified, from whom knowledge is instigated and fathomed as a 'universal truth' (Weedon, 1997). My chosen methodology gives legitimacy for a plurality of truths. This is not to say that all explanations of reality are of equal importance as differences are both enabled and constrained by broader social structures such as class, gender and the degree of cultural capital within a particular social group (Phibbs, 2001; Williams, 1995). For instance, in relation to the current study choice of caesarean, as in the case of middle class women, is mediated through their access to capital resources (Liamputting, 2004; Zodoronzyj, 1999). Moreover I believe that discourses are not mutually exclusive but rather intersect with a wider network of social and political relations (Weedon, 1997). Therefore the meaning women give to childbirth is informed discursively through these multiple discourses, institutional and social practices in

which they are imbued. However some discourses have greater cultural legitimacy than others. For example within the discourses surrounding childbirth the propositional (masculinised) knowledge of the obstetrician, assumed to be objective and value free, has greater cultural capital than the (feminised) practical knowledge of the midwife and the experiential (subjective) knowledge of women (see Dalymia and Alcoff [1993] later in this chapter). Masculinist constructions of childbirth as a pathological event are privileged over feminised constructions of childbirth as a normal life event. Within the dominant discourse of childbirth, it is the obstetrician who is qualified to speak on where and how women give birth through their position as expert knowers. It is my belief that how women are positioned in and by the competing discourse of childbirth reflects their discursively constructed subjectivity. Women who choose a hospital birth are positioned as responsible subjects, while women who choose a home birth are positioned as irresponsible subjects in and through the dominant discourse of childbirth.

My personal stance in relation to caesarean, as a birth mode, is that it is a necessary operation when the lives of women and babies are at risk. However it is a major operation that bears greater risk than a normal vaginal birth and while the procedure is as safe as it can be at this current moment, women who undergo the operation are expected to cope with recovery from major abdominal surgery, alongside the demands of caring for a new baby (Douché, 2001). I therefore contend that in choosing a caesarean section, in the absence of clinical need, women have been interpellated¹ into medical discourse. Moreover, the notion of multiple subjectivities affirms women as a diverse group who do not share the same social positioning, beliefs and preference for childbirth. It is an appreciation of these diverse realities that is at the heart of the midwifery and feminist project.

3. 3. Modernity and autonomy.

As discussed elsewhere in this thesis, in Aotearoa New Zealand, the sovereignty of the individual has played a significant role in health policy decisions, particularly childbirth. Safeguarding an individual's right to choose, is central to modern

¹ Interpellation is a term first coined by the philosopher Althusser to describe the way in which the subject is produced as an effect of ideology. It is used here to refer to the act of calling something into being (see Carryer, 1997).

libertarian discourse about the free and self-governing individual, a notion that can be traced back to the enlightenment era (Cheyne, O'Brien & Belgrave, 2000; Mansfield, 2000). In order to unravel the meaning of choice within the context of subjectivity and the wider discourse of autonomy, I was impelled to map the trajectory of events that has led to the ideology of consumer sovereignty today. This enabled me to position subjectivity in an historical and cultural context.

3. 3. 1. The sovereign individual.

Mansfield (2000) contends that it was around the 17th century, in the European context, that the self emerged in its individuality, aided and abetted by the philosophy of René Descartes (1596 – 1650), spurred on by the introspective efforts of Jean-Jacques Rousseau (1712 - 1778) and the rationality of Immanuel Kant (1724 – 1804). In the search for 'truth' Descartes proposed a set of principles and in the process of applying his first principle *vis a vis* accepting as false those things that could not guarantee certitude, he discovered that in order to think, one must be 'something.' The upshot of this profound discovery beckoned his famous axiom, *I think therefore I am* (1637, p. 32 – 33).

And noticing that this truth –I think therefore I am – was so firm and so certain that most extravagant suppositions of the sceptics were unable to shake it, I judged that I could accept it without scruple as the first principle of the philosophy I was seeking (1637, p. 32).

The implication of this 'thinking thing' was to bring about an order of things in which the mind became a centre from which 'truth' emanated and held privilege over the body. This binary separation of mind from the body came to dominate modernist thought (Clare & Hamilton, 2003). While Descartes heralded in the beginnings of the sovereign self, as the basis of all understanding, it was Rousseau (1712 –78) who ushered in notions of the self-sufficient individual, having absolute freedom over individual experience (Mansfield, 2000). Rousseau held that through solitude and introspection, individuals could find liberty and the truth about the self. Kant viewed the self as only starting from a base of self awareness, the 'I', from which 'I' can actively integrate perceptions of the world and make sense of these (Mansfield, 2000). Descartes' notion of a 'thinking thing' (Descartes, 1993, p. 79), Rousseau's

autonomous individual, and Kant's rational individual, set in motion an ideology around liberty and the progression of ideas, notions that have become commonplace in Western societies today (Parker, 1997; Mansfield, 2000). Importantly the ensuing 'age of reason' became the forerunner of modernist thinking, an era that embraced at its very epicentre, the sovereignty of the individual over knowledge. The extent to which this ubiquitous entity has been constituted is summed up succinctly by Mansfield (2000):

Our philosophies of science, our theories of organisation of society, our sense of morality, purpose and truth all partake of the same emphasis on the individual not only as a social quantity, but as the point where all meaning and value can be judged. This individuality is described as a freedom, and we still direct our most serious political ambitions toward perfecting that freedom. It also operates as a duty, however. Our personal desires must fuel the economy. Our individual ambition must make our nations rich and powerful (p. 21).

Right away Mansfield's citation alludes to a contradiction between the state of a free and autonomous individual and an individual shaped by their socio-political context.

3. 3. 2. The sovereign consumer.

It was in the domain of political economic theory that the worth of the autonomous individual became so celebrated (Mansfield, 2000). What came to be known as classical liberalism was promulgated by the political philosophies of Hobbes (1588 – 1679) and Locke (1632 – 1704) and advanced via the work of philosophers James Mill and Jeremy Bentham, throughout the 18th Century (Cheyne et al., 2000, p. 70). Classical liberalism was to become a powerful political and social force with far reaching implications for their contemporary followers (Cheyne et al., p. 70). Ideals such as the primacy of the individual, supremacy of the market and the belief that social benefit comes about through the expression of individual self interest, leapt to prominence (Cheyne et al., p. 70). The modern-day insignia to classical liberalism, is neo liberalism, idiomatically referred to as the 'new right' and seated at its helm is the sovereign consumer (Cheyne et al., p.79; Cockburn, 1998).

Mansfield's (2000) account of the development of the self provides captivating insights into how individuality journeyed through time to come under the scrutiny of a range of disciplines, no less than in the field of psychology. Early work in the realm of psychoanalysis introduced notions of the unconsciousness and the irrational. While this discourse challenged the ideal of the conscious and rational individual, the underlying assumption of the individual as a fixed and fathomable entity prevailed (Mansfield, 2000, p.9). Humanist discourse has a more teleological twist, where the focus is on the self, striving throughout its life span, in search of its authenticity, with the view toward self-fulfilment and self-actualisation (Potter & Wetherell, 1987). Allied to these discourses is the existentialist view that exemplifies the supremacy of human consciousness in transcending the notion of a fixed entity (McHoul & Grace, 1997). Liberal feminist discourse parallels humanist discourse, in embracing the idea of a free and autonomous individual, so long as women have equality with men. The assumption here is that gender inequalities are thought to be surmountable, using Harding's (1987) vernacular, by 'adding women'. Decentering the individual of liberal humanism is central to feminist poststructuralism (Weedon, 1997; Shildrick, 1997, p. 153).

3. 3. 3. Enter the Subject.

Up until now the discussion has largely centred on the mainstream views of an autonomous decision-maker based on modernist views of the self-governing individual. These views however leave the notion of subjectivity unchallenged. From Mansfield's (2000) reading, the privileged status of the sovereign individual cannot be taken for granted. Post-modernism, and more specifically poststructuralism, marks its point of departure from liberal humanist discourses in repositioning the 'self' within the notion of subjectivity. The term 'subjectivity' "...replaces the commonsense notion that our identity is the product of our conscious self-governing self and, instead presents an individual's identity as the product of discourse, ideologies and institutional practices" (Danaher, Shirato & Webb, 2000, p. xiv-xv). In this regard the individual shifts from being a self determining separate entity to a socio-cultural subject, continually being constituted through the discourses within which it is imbued (Fairclough, 1993; Weedon, 1997, p. 33). By implication the individual becomes a subject through

techniques of power (Foucault, 2003). Drawing on the work of Foucault, Weedon contends, subjectivity is accorded a particular status when uttered through discourse.

Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconsciousness and conscious mind and emotional life of subjects which they seek to govern. Neither the body nor thoughts and feelings have meaning outside of their discursive articulation, but the ways discourses constitute the minds and bodies of individuals is always part of a wider network of power relations, often with institutional bases. (Weedon, p.105).

Weedon's analysis infers power relations and institutional practices, as being implicated in the creation of the self. These networks vary with time and place and it is for this reason that the subject is considered to be in process, changing, and fragmented, even contradictory (Weedon, 1997; Davis, 1994; Grosz, 1994; Danehar et al., 2000).

3. 3. 4. Subject positions.

The contradictory and fragmented self, accordingly, is thought to come to light at the intersection of multiple discourses and discursive practices (Shildrick, 1997) from which emerge a plurality of meanings and subject positions as implied earlier. In the discursive practice of childbirth for instance, midwifery and obstetric practice each convey different meanings around childbirth. Midwifery discourse offers childbearing as a normal physiological process, in which women choosing a midwife LMC may be positioned as normal birth believers. Simultaneously a midwife may be positioned discursively as an expert or facilitator of normal birth. Likewise obstetric discourse views birth as normal only in retrospect, therefore women who choose to have a homebirth may be positioned as risk takers, while the obstetrician is simultaneously positioned as a specialist in abnormal birth. Childbearing women may be positioned by, as well as position themselves within, the various discourses of childbirth, and the subject positions adopted may be contiguous with their desires. Within the context of the current study, the discourses of autonomy, convenience and desire, fear and risk are powerful forces for constituting choice in childbirth. These positions may include a homebirther, a fashion trailblazer 'too posh to push,' or a self-governing individual who programmes her birth to suit a busy work schedule. Through discourse of fear and risk

women's childbearing bodies are constituted as faulty, positioning birthing women as fearful and risky. Women's interpellation into these discourses acts as a powerful inducement to safeguard their babies well being. Within these discourses babies are also simultaneously positioned as precious and at risk.

Therefore depending on the conditions of their social context, women can gain from being positioned and / or positioning themselves in a range of available discourses (Hardin, 2000; Lupton, 1994; Weedon, 1997). These writers imply that this active positioning in and by competing discourses suggests women's subjectivity as not necessarily passively assumed. Similarly a subject conceived of as duped by one discourse, may be reconciled with another that offers a wider scope of subject positions (Hardin, 2000; Sawicki, 1991). Recognition of interchangeability in subject positioning is a postmodern trade off relative to the disquiet that agency is assumed to be as a product of language (Fairclough, 1993; Lupton, 1994; McNay, 2000). This tension seeks redress in the words of Weedon:

Although the subject in post-structuralism is socially constructed in discursive practice, she nonetheless exists as thinking, feeling subject and social agent, capable of resistance and innovations produced out of the clash between contradictory subject positions and practices. She is also a subject able to reflect upon the discursive relations which constitute her and the society in which she lives, and able to choose from the options available (1997, p. 121).

Thus far, the discussion has arbitrarily referred to postmodernism and poststructuralism as if these two moments are interchangeable. A revisit to earlier statements about modernist discourses, suggests that theoretical knowledge takes the form of a grand narrative that assumes such knowledge to have universal application (Easthope, 1998). Postmodernism and poststructuralism are two events that have awakened modernism from the complacency it has enjoyed for vast moments in time.

3. 4. Postmodernism.

Postmodernism is said to be a critique of modernism, rather than a shift from one particular historical era or other (Brooks, 2002; Mansfield, 2000; Parker, 1997;

Shildrick, 1997). Early appropriations were in art and architecture, latterly embraced by philosophy, cultural theory and feminism (Easthope, 1998; Weedon, 1997; Brookes, 2000) and in discourse theory as “the new horizon of our cultural, philosophical and political experience” (Laclau, 1998, p. 63). Postmodernist philosophers disrupt modernist notions that knowledge is incremental, progresses as a function of time, and that truth is established through positivist modes of inquiry to ensure objective and verifiable knowledge (Easthope, 1998).

While Neitzsche’s (1964 [1873]) challenge to the nature of truth, signalled an early critique of modernism, it seems that postmodernism’s emergence as a philosophical force to be reckoned with, was thought to materialise largely through the work of theorists such as Jean-Francois Lyotard (Mansfield, 2000). In Lyotard’s (1979) exposé of knowledge as a site of contest and critique of a ‘grand narrative’ to explain society, he argued that knowledge can no longer be contingent on one overriding theory for its legitimation. Two presiding narratives identified by Lyotard are the narrative of emancipation of Marxist ideology and the triumph of scientisation by positivism (Easthope, 1998; Lyotard, 1979). According to Grant (1998) these narratives have crumbled under the weight of critique and conflict resulting in “fragmented groups engaged in short term struggles” (p. 30). Where postmodernism refers to a critique of modernism then it goes without saying that poststructuralism is a critique of structuralism (Clare & Hamilton, 2003).

3. 4. 1. Poststructuralism.

While poststructuralism comes under the canopy of postmodernist thought, a poststructuralist project is sceptical of the primacy of language as the structuring principle of society (McHoul & Grace, 1998). Structuralism can be traced to Ferdinand de Saussure (1857 – 1913), a Swiss linguist, whose theory of the structure of language laid the ground work for its wider application in society (Giddens, 1997). For de Saussure (1974 [1959]) language was a system of signs, governed by rules. The basic unit was the sign composed of two elements, the signifier (sound image) and the signified (concept). Language was also conceived of in terms of differences where the meaning of one term is relational, to the meaning of another, albeit an arbitrary

relationship. “In language, as in any semiological system, whatever distinguishes one sign from the others constitutes it.” (de Saussure, 1974 [1959], p. 121).

Laclau (1994) transfers this ‘system of differences’ over to the notion of identity. For Laclau such a system has both possibilities and limits and its limits presuppose an exclusionary potential. Implied here is that difference is tantamount to identity, in that the identity of elements within a system is different in relation to the other elements (p. 169). Laclau captures this ensemble of differences under the mantle of an ‘empty signifier.’ An empty signifier is “...a signifier without a signified” (p. 167). It has the potential to cancel out differences in a ‘chain of equivalence’ that unites a system (Laclau, 1994, p. 170). What comes to mind here is the word ‘freedom’ that signifies a plurality of meanings. In this sense I interpret an ‘empty signifier’ as resembling a metonymy, a general trope to displace differences between elements in order that they come together for a common goal (Laclau, 2000, p. 79). Given that the sign is arbitrary, the language system itself is understood to be fixed (Potter & Wetherall, 1987; Weedon, 1997). De Saussure (1974[1959]) has been criticized for failing to take into account the potential for a multiplicity of meanings that exist within a socio-political context and liable to change with time (Potter & Wetherell, 1987; Weedon, 1997). Furthermore, according to Derrida, because of differences embedded within the signs, meaning is open to interpretation and therefore is always *deferred* (Derrida, n.d., in Weedon, 1997, p. 24-25).

Shildrick (1997) is critical of feminists who perpetuate the dichotomous tendency to see modernism and postmodernism as either / or moments. The feminist project is not to usurp the ideals of modernism but rather to “expose the slippage in their supposedly foundational status” (p. 153). Poststructuralists, particularly feminist poststructuralists, consider that historically, knowledge is generated upon binary dualisms (Kent, 2000) in a hierarchical configuration, in which the dominant term is favoured relative to the subordinated term (Derrida, 1988, p. 21). Derrida (1967), one of the first to interrogate these forms of thought, argued that subjectivity is constituted in the absence of the ‘other’. Structure according to Derrida (1967) has been rendered neutral in the process of ascribing it a centre or point of presence. Binary oppositions seek to sustain a presence or centre of being. The space between dichotomies however, is not that stable, which is exemplified in the case of the binary division of gender. The work of Seidman

(1993) and Phibbs (2001) shows that the gay liberation movement and intersexuality respectively, challenge the notion of binary dualisms, and in doing so, disrupt the sex-gender binary that privileges heterosexualism over its 'other', homosexualism and intersexualism. Poststructural feminists such as Grosz (1994) and Shildrick (1997) have drawn from the contribution of Derrida's work to bring about the concept of 'polymorphous' subjects as a means of decentering the notion that identity is based on binary oppositions. Reversing and displacing these systems of thought is the project of deconstruction (Derrida, 1988).

3. 4. 2. Deconstruction.

Derrida disrupts the structuralist commitment to a presence, by declaring that there is no fixed point or centre. Deconstruction is a means through which hierarchical relations veiled behind such dualisms can be revealed (Derrida, 1988). Hardin's (2001) interpretation of Derrida suggests that the 'reading' of a text, from a deconstructionist perspective, is an act of 'decentering' in so far as the centre / presence becomes destabilised thus opening up the text to a plurality of meanings. Deconstruction of text invokes a 'reading' of the effects of a discourse and how some knowledges have primacy over others (Hardin, 2001). Searching for absences in text is also the task of deconstruction (McLeod & Nola, 1998). By interrogating language systems the poststructuralist project has uncovered power relations embedded within the production of knowledge. In opening up texts to a variety of readings, new and alternative ways for understanding the complexities and contradictions, inherent within the multiple and competing discourses of childbirth are made possible.

3. 5. Discourse - Power - Knowledge.

The work of Michel Foucault (1926 – 1984) has shaped much of poststructuralist thought today (Mansfield, 2000; McHoul & Grace, 1998; Shildrick, 1997; Weedon, 1997). For Foucault discourses are bodies of knowledge, inextricably linked to power, in that knowledge is an outcome of power in that power is important for authorising what counts as knowledge (Carabine, 2001; Foucault, 1979; Lyotard, 1979; McHoul &

Grace, 1998). Thus “...it is in discourse that power and knowledge are joined together” (Foucault, 1978, p. 100). Each is discussed separately to extrapolate the key ideas embedded within.

3. 5. 1. Discourse

Foucault (1972, p. 199) disassociates himself from structuralism. His examination of discourses has moved language systems beyond the terrain of de Saussure’s structural linguistics, toward disciplines and disciplinary practices that have the potency for enabling what can be said and thought (McHoul & Grace, 1998). McHoul and Grace distinguish between disciplines and disciplinary practices, where disciplines are “bodies of knowledge” and disciplinary practices are “forms of social control and social possibility” (1998, p. 26 & 27).

The space which a discourse inhabits is referred to as an *episteme*. Foucault (1972) explains an episteme as an “...indefinite field of relations...” (p. 211). Danher et al (2000) interpret this field as a space or territory within society that is utilised in particular ways, amid a wider field of relations and organised through discursive formation. In reading Fairclough (1993), I take this to mean that the discourses of midwifery and obstetrics occupy a space within the discursive formation of the human sciences, in the ‘field of play’ of childbirth. The disciplinary practice of midwifery is regulated by the Midwifery Council of New Zealand. Under the auspices of the Ministry of Health, the Midwifery Council set the conditions for midwifery’s scope of practice, in consultation with the midwifery profession, through the New Zealand College of Midwives (NZCOM). Midwifery takes place in a ‘field of relations’ that included among others, women, consumer groups, obstetricians, pharmacists and laboratory personnel.

Foucault’s (1972) interest lay with enoncés or statements of discourse. For Foucault, statements are not stable components of discourse; rather they have specificity to a particular socio-historical context. The following quote, in a loquacity that epitomises Foucault, provides insight into the complex ‘field of use’ and why statements cannot have absolute ‘repeatable materiality’.

This repeatable materiality that characterises the enunciative function reveals the statement as a specific and paradoxical object, but also as one of those objects that *men* produce, manipulate, use, transform, exchange, combine, decompose and recombine, and possibly destroy. Instead of being something said once and for all - and lost in the past like a battle, a geological catastrophe, or the death of a king – the statement as it emerges in its materiality, appears with a status, enters various networks and various fields of use, is subjected to transferences or modifications, is integrated into modification, is integrated into operations and strategies in which its identity is maintained or effaced. Thus the statement circulates, is used, disappears, allows or prevents the realisation of a desire, serves or resists various interests, participates in challenge and struggle, and becomes a theme of appropriation or rivalry (1972, p. 105).

Foucault's analysis disrupts the traditional empirical notions of a universal law governing language, that is the prerogative of a sovereign individual or 'an *a priori* authority of knowledge.' (1972, p. 79). He proposes instead that we should "seek the rules of its formation in the discourse itself" (p. 79). These rules governing the formation of enunciative modalities, involves a network of relationships between the status of the speaker, the institutional sites that gave discourse its legitimisation and the position the subject occupies when speaking (Foucault, 1972). Fairclough (1993) understands enunciated modalities as kinds of discursive activities that operate a particular discursive formation, activities such as "describing, forming hypotheses, formulating regulations and teaching" (p. 43) and it is through these activities that subject positions are formed. Statements are enunciated through the activities of the field of relations and have simultaneity. For instance, as inferred earlier, they can position a midwife as a health care professional, while simultaneously positioning the woman she cares for, as a consumer of midwifery services. The effect of these discursive activities and subject positions is to decentre the sovereign subject as the origin of discourse (Fairclough, 1993) and is clearly evident in the words of Foucault himself:

Thus conceived, discourse is not the majestically unfolding manifestation of a thinking, knowing, speaking subject, but, on the contrary, a totality, in which the dispersion of the subject and his discontinuity with himself may be determined. It is the space of exteriority in which a network of distinct sites is deployed (1972, p. 55).

Statements enunciated within, for example, the disciplinary practice of midwifery are contingent upon a system of rules within a discursive formation and subject to a variety of

conditions in order to be declared legitimate (Hook, 2001). While these conditions render unto a particular discourse certain regularity (unity) within, there is a wider network of relations external to a particular discourse that has an effect. These relations sanction the conditions of possibility for a discourse to make such statements. As such, discourses are not mutually exclusive, but intersect and interconnect at diverse and multiple sites within an array of institutional and social practices (Powers, 2001; Carabine, 2001). In reading Foucault, (1972, p. 162) these are the “non-discursive domains” of discourse which provide the conditions of possibility for the formation of things. Statements articulated in enunciated modalities authorise what can be said, as well as not said and are best understood by the rules that govern their functioning (Foucault, 1972; McHoul & Grace, 1998).

3. 5. 1. 1. The Formation of things.

The rules which lay down the circumstances for the functions of a discourse in any particular system of formation are what Foucault calls *rules of formation*. Foucault (1972) defines these as,

... a body of anonymous, historical rules, always determined in the time and space that have defined a given period, and for a given social, economic, geographical, or linguistic area, the conditions of operation of the enunciative function (p. 117).

Foucault identified four elements common to any particular discursive formation and subject to its rules (Foucault, 1972; McHoul & Grace, 1998; Powers, 2001a). These include objects, modes of statement or enunciative function, concepts and thematic choices or strategies to guide theoretical decision making. McHoul and Grace (1998) more specifically describe objects as those things that are of interest or ‘produced’ in discourse. Objects of midwifery discourse, I envisage, could be the study of partnership or claims to the meaning of ‘normal birth’. Modes of statements are operations or techniques used to deal with these objects, such as the New Zealand College of Midwives’ (NZCOM’s) philosophy, standards for practice, codes of ethics, decision points and the Midwifery Council’s Competencies (2004) for entry to the register of Midwives. McHoul and Grace (1998) interpret these concepts as the terms that are intrinsic to the language of a particular discipline. In the context of midwifery, the use of terms *woman* as opposed to *patient*, *baby* as opposed to *foetus* and other

conceptualisations such as *women centeredness*, *continuity of care* and *informed choice* are concepts intrinsic to the language of midwifery. By thematic choices, McHoul and Grace (1998) mean the various assertions including assumptions, theories, available hypotheses, that guide decisions around theoretical options. For example, the assumption of partnership with women would extend to midwifery research involving women participants and veers a study toward the inclusion of feminist ideas. The rules of formation that formulate the conditions of possibility for the elements of discourse to appear and take on meaning are aligned along three mechanisms (Foucault, 1972). These are ‘surfaces of emergence’, ‘authorities of delimitation’ and ‘the grids of specification’ (p. 41-42).

3. 5. 1. 2. Surfaces of Emergence.

For the formation of an object it is necessary to trace when it first appeared, what Foucault (1972) refers to as ‘surfaces of emergence’, the conditions that allow the emergence of objects of inquiry when they first appeared (p. 41). These surfaces of emergence are historically and socially specific. By tracing the emergence of psychiatric discourse in the 19th century, Foucault was able to show how the object of psychopathology was constructed and transformed through a system of rules and a complex web of relations, in ‘different forms of discourse’ (Foucault, 1972, p. 41). Psychopathology emerged not as a pre-existing object, waiting to be discovered, but materialised through discursive conditions that enabled it to be differentiated, described and categorised within a field of psychiatric discourse.

In these fields of initial differentiation, in the distances, the discontinuities, and the thresholds that appear within it, psychiatric discourse finds a way of limiting its domain, of defining what it is talking about, of giving it the status of an object – and therefore making it manifest, nameable, and describable (Foucault, 1972, p. 41).

Implicit here is a ‘different form of discourse’ the tangent emergence of a discourse from an adjacent discourse with which it shares a certain proximal relationship (Powers, 2001a, p. 57). In reading Powers, a case in point is the discourse of obstetrics budding from the foundations of the natural science and the philosophy of empirical analytic science. In the context of the present study, the initial differentiation of caesarean

section, in the absence of clinical indications, as an object of obstetric discourse is mapped in Chapter Five. Within the context of midwifery discourse, ‘partnership’ is an object of midwifery discourse, first appearing in the late 80s, its initial differentiation began through (re)productions in commentaries of the discipline (NZCOM, 1989; Pairman and Cameron, 1990; NZCOM, 1993; Guilliland & Pairman, 1995; Freeman, Temperley & Adair, 2004).

3. 5. 1. 3. Authorities of delimitation.

Foucault (1972) also highlighted the importance of identifying ‘authorities of delimitation’ that set the conditions of possibility for how things are spoken about. The use of exclusionary mechanisms such as ‘opposition and rejection’ works to isolate what can be known about things such as madness and its opposite, reason (Hook, 2001, p. 524). For example the modernist notion that reason is attributable to men only is disrupted by Diprose (2000) who proffers that men are not the embodiment of reason by nature, rather by definition at the exclusion of the feminine (p. 119). Authorities of delimitation are institutions comprising professional groups with the recognised authority for circumscribing the “manifest, nameable and describable” object (Foucault, 1972, p. 46). For example the obstetric profession is the designated authority for setting the limits as to what counts as knowledge in the discourse of childbirth. Obstetric discourse affiliates with legal discourse to sanction this authority by setting out the rules and limitations for other practitioners such as those laid down in Section 88 of the NZ Public Health and Disability Act (Ministry of Health, 2002) hereafter referred to as Section 88. Anything falling outside the norms of childbirth requires the midwife to refer on to an obstetrician, the authority of delimitation. Obstetric discourse holds the authority to differentiate when a woman needs a caesarean.

3. 5. 1. 4. Grids of specification.

Another tool recommended by Foucault (1972) for analysing what governs the conditions of possibility for objects of discourse, is the identification of ‘grids of specification’ or systems of differentiating and categorising how objects are analysed and specified in discourse. The Diagnostic and Statistical Manual of Mental Disorders

IV (DSM- IV) is a system of differentiation for codifying psychiatric diagnoses (Powers, 2001a). Powers explains diagnoses are then incorporated into clinical practice, the regular occurrence of which becomes normalised. An attempt to classify caesarean, in the absence of clinical indications as ‘no indicated risk’ (DeClercq, Menacker & MacDorman, 2005) has surfaced recently. The increases in caesarean rates, diagnosed in this code, have the potential to normalise this practice. Moreover maternity care, for instance, is ordered on a primary, secondary and tertiary level according to the classification specified in the referral guidelines, as set out in Section 88. Thus caesarean for ‘no indicated risk’ represents a paradox. As a major operation it necessitates tertiary level care for healthy childbearing women. This need for a systematic ordering of objects reflects the linear development of knowledge inherent in modernist assumptions. For those concepts that cannot be named there is always the metaphor (Nietzsche, 1964[1873]) and other rhetorical devices which are examined at the end of this chapter.

3. 5. 2. Knowledge.

In both his books *The order of things* and *Archaeology of knowledge*, Foucault (2002; 1972 respectively) opens up new horizons for viewing claims to knowledge. He awakens his readers to the arbitrary nature of knowledge, in particular, scientific knowledge, and disrupts the traditional empiricist notions that attribute statements to a sovereign subject or an *a priori* authority (1972, p. 89). Foucault also makes palpable modernism’s clambering to smooth a path toward progression and universal reason. Foucault (2001a) interrogates ‘reason’ suggesting that the interrogation of rationality should always remain central to philosophical thinking. Foucault’s intent is not to denounce rationality, preferring instead to expose its ambiguities.

It was the basis of flamboyant rationality to social Darwinism that racism was formulated, becoming one of the most enduring and powerful ingredients of Nazism. This was, of course, irrationality, but an irrationality that was the same time, after all, a certain form of rationality (2001a, p. 358).

In noticing that empirical knowledges did not follow a rational sequence accorded to the continuity of ideas, Foucault (1984a) unveiled the discontinuity of discourses to show

across history, that scientific knowledge was not necessarily progressive and accruing as a function of time. As McHoul and Grace (1998) succinctly posit:

Foucault's analysis of scientific change as discontinuous shows that it is not seamless and rational; that it does not progress from stage to stage, getting closer and closer to the truth; that it is not guided by any underlying principle which remains essential and fixed while all around it changes (p. 4).

The notion that there is a primordial beginning to truth, assumes that all will be revealed in the fullness of time, through the orderly sequencing of events and analysis (Foucault, 1984a).

The 'will to truth' is contingent upon a range of institutional and social practices, the 'material conditions of possibility' that underlies the production of truth (Hook, 2001, p. 524). For Foucault, truth is embroiled in a 'battle' to separate out the division between what is true and what is false. Such a joust, can be understood as "...a matter not of a battle "on behalf" of the truth, but of a battle about the status and the economic and political role it plays" (Foucault, 1984, p. 74). Having won the battle for truth, sanctioning of a discipline's knowledge becomes a social event, reinforced through social and institutional practices; the 'material conditions' that make it possible (Fahy, 2002). In the joust to separate truth and falsity, Hook suggests the 'will to truth' has been displaced with the 'will to power' (2001, p. 524).

3. 5. 3. Power.

The sanctioning of what or whose knowledge counts implies a multiplicity of power relations linked to the production of truth. Foucault's conception of power is unique in that he sees power as being exercised rather than being possessed (Sawicki, 1988; 1991). The latter is characteristic of a juridico-discursive model of power, which assumes a hierarchical configuration in that power is the possession of certain individuals in society, centralised through institutions and understood as essentially repressive (Sawicki, 1988, p. 164). Here power is conceived of in a binary with freedom and implies freedom is possible when power is eliminated (Laclau, 1993, p. 83). In my interpretation of Laclau, power and emancipation are two sides of the same

coin. Both are inextricably linked in that emancipation cannot be distinguished from power because the process of emancipation is in itself power; “the very condition of emancipation” (1993, p. 101). Laclau (1993) is quick to suggest that this does not mean this depiction of emancipation as impossibility. Rather, the constitution of emancipation as power will instead, render emancipation as a site of multiple struggles within society, consequential to multiple and fragmented “powers” affiliated to “a plurality of contingent and partial emancipations” (Laclau, 1993, p. 101). Laclau’s reading deconstructs the binary of power versus emancipation and while it not clear as to whether he conceives of power as a productive or a repressive force, his theorising does have some recourse to Foucault’s conception. Foucault (1984a) takes the view that aligning power with its legal counterpart is essentially a limited perception of power. His conception of power is that it is ubiquitous and productive and as such is amenable to resistance:

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

Disciplinary power operates in a way whereby it remains invisible and in doing so invokes an approach for self-surveillance (Fahy, 2002). Self surveillance is thus a technology of power that is embedded within the rubric of governmentality.

3. 5. 3. 1. Governmentality and the technologies of power.

In his lecture on *Omnes et singulatim, toward a critique of critical reason*, Foucault (2001b) set out to trace the conditions that led to the development of governance within society. What he unravels is a complex relationship between two antagonistic modalities of power: individualised (pastorship) and centralised (the state) power (Foucault, p.300). Using the anthropomorphisms of Plato, Foucault identifies two possibilities for how these forms of political power came about: one uses the metaphor of the good shepherd tending to the welfare of his flock; the other envisions a void whereby the gods, the shepherd or king (whoever) can no longer tend to the needs of

every individual in the 'flock.' With the latter comes a pressure for individuals to look after themselves, an abysmal state, as there was no one to ensure social cohesion within the community.

Foucault's (2001b) tracking of political power in society has provided insights into how technologies of power have materialised through disciplinary and institutional practices, sanctioned by the state. Taking for example the modality of pastorship (shepherd – flock system) the individual had a moral obligation to obey the shepherd, because it was the shepherd who was responsible for the individual's welfare. Moral veracity was attained through self examination, having guidance over matters of conscience and through the confession. Within the centralised modality (State – citizen system) the individual was legally obliged to obey the city. Shepherds in the form of doctors and scholars were on hand to offer guidance on good citizenship. In linking "...total obedience, knowledge of oneself and confession to someone" (p. 300) individuals were beguiled en route for self regulation. It was the merger of these two systems of thought that laid the foundations of the modern state, the "tricky combination of individualisation techniques and totalisation procedures" (Foucault, 2001b, p. 332).

These ancient techniques of political power, that is knowledge of each and every citizen and the administrative apparatus to manage it, materialised over the many centuries. The pastoral function of the church was replaced by state institutions, such as medicine and the police, to guarantee productive and healthy citizens (Foucault, 2001b). The trajectory of events that followed from circa 17th century, necessitated new ways of governing populations. Of interest for Foucault was how knowledge, developed alongside disciplinary power and in contiguity with the technologies necessary for its collection (McHoul & Grace, 1998, p. 71). At the interface of these technologies is a mechanism operating which Foucault refers to as 'bio-power' or 'power over life' (Foucault, 1978, p. 139).

3. 5. 3. 2. Bio-power.

Investment in life was necessary for economic order (Foucault, 1978). Bio-power evolved along two dimensions with the view toward economic efficacy. The first

involved the deployment of disciplining the body in order to maximise its usefulness and docility. The second followed on from the first to involve a system of regulations deployed to control the populations as a whole (Foucault, 1978, p. 139). For the State, these technologies of power and ensuing 'regimes of truth,' made economic sense. Foucault articulates bio-power's interface with a political economic ideology:

This bio-power was without question an indispensable element in the development of capitalism; the latter would not have been possible without the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of the populations to economic processes (1978, p. 140 – 141).

Danehar et al, (2000) point out an irony, of how the Enlightenment ideals of liberty and progress, folded back on populations, to produce 'docile bodies'. The pre-emption of individual freedoms through the transference of much of the State's regulatory function to 'surrogate agents' (p. 76) was an economically efficient means of ensuring control of populations. Sawicki (1991) simply refers to bio-power as the range of ways in which the State regulates bodies, through sets of discourses and practices governing the individual body and the health and welfare of the population. Assigning women in the nineteenth century with the responsibility for family and the task of regulating future populations in keeping with societal expectations was an example of bio-power (Danaher et al, 2000; Foucault, 1984b). Contemporaneously within the regulatory framework of Section 88, women's individual childbearing bodies are monitored to ensure healthy future populations. The recording of life events such as births and deaths is yet another manifestation of bio-power (McHoul & Grace, 1998).

3. 5. 3. 3. Technologies of the Self.

A derivation of governmentality includes 'technologies of the self' (Powers, 2003, p. 231) and is represented as persuading individuals, in the name of empowerment; to take responsibility for their health and the choices they make (Powers, 2003). Another technique is the internalisation of the panoptic 'gaze' (Fahy, 2002, p. 7). Drawing on Foucault's (1979) ideas around disciplinary power, Fahy uses Bentham's panopticon, an observational tower employed in prisons, to explain the material effects of surveillance on prisoners. Under the panoptic 'gaze' prisoners were arbitrarily

observed, unable to tell when observations would take place and as a consequence would adapt their behaviour in congruence with their perception of the expectations of their onlookers. Through this technique the prisoners adopt a form of self surveillance and are rendered 'docile.' The trade-off was the avoidance of penalty. Fahy views the panoptic gaze as akin to the medical gaze. Both forms have been intensified by technology. In the case of childbearing women, Fahy (2002) discerns that in order to obtain the rewards of childbearing, such as the promise of a safe birth or pain free labour, women internalise surveillance techniques. It is this panoptic compliance that renders women as docile subjects (Fahy, 2002) and has application in antenatal, intranatal, and postnatal assessment, as set down in the NZCOMs (2005) handbook for practice. Health promotional strategies such as health education and informed choice are relatively recent appropriations of bio-power (Powers, 2003). The co-opting of consumers as freely choosing individuals, into self monitoring and in control of their health, shifts the onus of responsibility for health onto the individual and in doing so conceals socio-political factors implicated in health and illness (Dew & Kirkham, 2000). Bio-power is never absolute in its controlling of 'docile' bodies. Its fluid nature comes about through the plurality of meanings and societal truths, contesting the nature of the body. It is for this reason that there are always counter discourses proffering resistance (Danaher et al, 2000).

3. 5. 4. Resistance.

Foucault (1978) claims "Where there is power there is resistance" (p. 95) and conceives resistance, too as ubiquitous, within a shifting terrain of power – resistance networks. The mutuality of power-resistance is not ensnared within a binary opposition, between those in power and those who are not. Foucault's (1978) conceptualisation of how power moves in society culminates in the possibility of multiple and fragmented 'powers.' For example a plurality of struggles, within the field of health, is evident when various professional bodies make claims about their knowledge and expertise in an effort to secure some authority over the work they do (Papps & Olssen, 1997; Tully & Mortlock, 2005). Changes implemented in the 1990 Nurses Amendment Act, as discussed in chapter one, grew out of a groundswell of resistance from consumer groups and midwives in response to the growing medicalization of childbirth (Douché, 1997; Papps & Olsen, 1997; Tully & Mortlock, 2005) and attest to multiple sites of

power and resistance. Powers (2001b) articulates the complex manifestation of power in the social milieu, with a lucidity that nicely unfolds its reciprocity with resistance.

There is no central point from which all power emanates. Instead, power consists of a continually shifting web or grid of individual positions of tension between power and resistance. Because of the inequality of the tension, local and unstable states of power and resistance are constantly being created, dissolved, reversed, and reshuffled (p. 15 – 16).

Within this ‘shifting web’ of power-resistance, such states may go unnoticed for as Foucault asserts, “...power is tolerable only on condition that it masks a substantial part of itself. Its success is proportional to its ability to hide its own mechanism” (1978, p. 86). Such mechanisms of power can be mapped through unravelling the conditions of its (im)possibility *vis a vis*, genealogy (Powers, 2001b; Carabine, 2001).

3. 6. Genealogy.

Genealogy is a method for tracing the conditions that made possible the emergence of phenomena within discourse (Carabine, 2001). In analysing the order in which objects emerge in discourse, Foucault (1972, p. 50-53) poses a series of questions in relation to who is speaking? From what authority and qualification do individuals speak? What is the speaker to gain from speaking and what institution has sanctioned the individual’s right “...to proffer such a discourse?” (1972, p. 50). Foucault was seeking “more” to discourse than its representational features. In explaining genealogy Carabine (2001) describes the “more” of discourse.

Genealogy is about tracing the history of the development of knowledges and their power effects so as to reveal something of the nature of power/knowledge in modern society. It does this through the examination of discourses and mapping the strategies, relations and practices of power in which knowledges were embedded (p. 277).

The implication here is that genealogy is a means of understanding the historical context of how things have come to be in the present. As such it has been dubbed as “a history of the present” (Carabine, 2001, p. 277). A case in point is how the discursive

constitution of the choice of caesarean, as an alternative birth mode today, regardless of risk, was made possible through the disciplinary, social and institutional practices in the past. A genealogical exploration of its discursive construction and the material conditions that made it possible is the focus of Chapter Four. It is to feminist knowledges and the conditions of their impossibility that the discussion now turns.

3. 7. Feminist 'bodies' of knowledge.

Harding's (1987) much cited work, *Is there a feminist method?* attests to how a theory of knowledge can limit what counts as truth. Accordingly epistemology in the traditional sense, has served as a powerful reference point for who can know (Harding, 1987, p. 3). For example, during modernity women were excluded as knowers and their knowledge subsequently devalued (Dalymia & Alcoff, 1993). While feminist epistemologies vary in their critique of masculinist science, they are united in their critique of androcentric assumptions inherent behind scientific knowledge, particularly the separation of truth from its cultural context, along with limiting who can know (Harding, 1987).

Dalymia and Alcoff (1993) show how women were once excluded as knowers. These writers argue that 'traditional women's knowledge' otherwise known as "old wives tales," has been epistemologically discriminated against because it lacked the appropriate conventions that necessitate 'proper' knowledge. In showing how obstetric knowledge came to dominate midwifery knowledge, Dalymia and Alcoff distinguish between propositional, practical and gender-specific experiential knowledge. Propositional knowledge is formulated around propositions (*p*) that privilege a cognisant knower (*s*) schematically expressed as "S knows that *p*". Epitomised as knowing *that*, propositional knowledge is considered to be scientific in that this knowledge is codified, formulated through rules and encapsulated as traditionally a male event. Conversely midwives' knowledge was practical, based on knowing *how*. Dalymia and Alcoff contend that obstetricians success in gaining control of childbirth in the 19th century was possibly more to do with the "triumph of propositional knowledge over practical knowledge" (p. 223) than the technological tools at the time. As was the case for most women, midwives' exclusion from academia meant midwives lacked the

vocational training that educational institutions offered and were thus designated as ignorant and illiterate. Dalymia and Alcoff question the nature of this epistemic discrimination, given the empirically based knowledge midwives gained through observation of their experiences.

But in what sense could midwives be regarded as ignorant and unqualified and their claimed knowledge labelled as “superstition”? Their skill was based on a combination of direct empirical sources, practice, experience, and a reliance on the body of beliefs accumulated by the acknowledged community of experts on childbirth (that is other midwives) – not unlike the knowledge of modern scientists (p. 222).

For Dalymia and Alcoff (1993) midwifery knowledge didn't count because it was “oral, practical and experiential”, not expressed in terms of propositions, not coded or amenable to rules of its formation and as such midwives were misconstrued as having no knowledge. Skills gained from their experience both working with women and their own embodied experiences of childbirth were disregarded.

Gender-specific experiential knowing, proposed by Dalymia and Alcoff (1993), is knowledge attained through the embodiment of an experience; what it is for a woman x to have an experience e (p. 228). This knowing from within or ‘perspectival’ knowledge, is akin to an inner feeling a woman has experiencing childbirth. Dalymia and Alcoff effectively argue that knowing *how* and gender specific experiential knowledge are ‘epistemic states’ (p. 231). They highlight the “paradox of definition” in that examples of knowledge are recognised in accordance with how they fit with the definition of knowledge; a definition they believe is limited in scope as it effectively blocks other forms of knowing. In arguing for knowing *how* and gender specific experiential knowing, to have cognitive status, I interpret that their solution sits somewhere between knowing *that* and knowing *how* as the integration of theory and practice.

Thus a genuine instance of knowing how is a skill in which the subject has such a nascent grasp of the rules and principles underlying her activity that enable her to “recognize” a clear formulation of them, and it is the latter that makes her simple skill cognitively relevant (p. 236-237, authors' emphasis).

Here Dalymia and Alcoff (1993) state that the cognitive status of gender specific experiential knowing is contingent upon acknowledging and grasping ‘subjective facts’ in relation to a particular subjective perspective. As is evident in contemporaneous curricula and the Midwifery Council of New Zealand (MCNZ, 2004) competencies for practice, greater emphasis is placed on integrating knowing *that* with knowing *how*. Contemporaneously midwifery discourse has become contiguous with the discourse of obstetrics. The point of their convergence can be found at the juncture with evidence based practice. Midwives now stand astride both the discourse of old wives’ tales and the discourse of obstetrics to speak from both a propositional and experiential knowing. Despite this closing of the epistemological gap, empirical analytical science remains the authoritative form of knowledge in the discourses of childbirth.

3. 7. 1. Material bodies.

Feminist accounts of the body, manifest in a multiplicity of modes (Brook, 1997; Weedon, 1997) and represent a shifting terrain of rich diversity and critical debate (Du Plessis & Alice, 1998; Brooks, 1997). Modernist discourse of the body has largely centred around the body as a biologically determined entity (Kent, 2002). At this juncture the body is composed of borders to maintain a separation between its inside-outside zones (Grosz, 1994; Shildrick, 1997). While these writers accept the importance of the body’s biology, they point out that meanings are inscribed upon the body which frame the nature of corporeal experience. For instance in mainstream discourses gender is categorised into two different types of bodies, male and female based on sex (biological) differences and assigned social functions based on these differences (Kent, 2000; Phibbs, 2001; Weedon, 1997). Meanings emergent from these different body types, have become naturalised and relegated as common knowledge. These commonsense understandings of the body become embedded within social relations, where they remain largely unchallenged (Weedon, 1997; Kent, 2000). For example, how bodies are represented in professional and popular discourse, shapes the experience of having and living in a body (Carrier, 1997; Kent, 2000, p. 188; Lupton, 1994, p. 13). These poststructuralist feminists challenge the notion of “biology is destiny” (Grosz, 1994) suggesting that meanings of what it is to be a man or a woman are products of social processes and discursive practices. This discursive approach is at

the heart of Foucault's conception of the body as a product of discourse-power-knowledge (Williams & Bendelow, 1998a).

Williams and Bendelow (1998a) however, argue that while Foucault has critically engaged with the material effects of disciplinary practices, the physicality of the body is effectively erased. "We can never know the biological or material body in the 'raw' so to speak, only through the filter of this or that discourse" (Williams & Bendelow, p. 35). They consider the 'discursive' approach to the body, as a passive conception of the body and emphasise the need for an analysis of the body that not only takes into account the discursive, but also the corporeality of the body. Implicit here is a focus on embodiment, which has relevance to the present study, in so far as how women's birthing bodies are represented in and through both social and disciplinary practices (Kent, 2000). As such embodiment has taken on increasing importance in feminist discussions (Carrier & Rhodes, 1998; Longhurst & Johnston, 1998; Grosz, 1994; Phibbs, 2001; Wetherall, Potts & Gavey, 2004). As an embodied practice, childbirth occupies a contestable site in which a plurality of shifting meanings are inscribed upon the body, fuelled through the availability of reproductive technologies and the media (Kent, 2000).

3. 8. Media bodies of knowledge.

Bodies also come under the gaze of popular culture and it is here that texts and iconographic images of idealised body shapes are constituted. Popular culture is often interchanged with the mass media and encompasses "...entertainments watched, read or participated in by hundreds of thousands or millions of people." (Giddens, 1997, p. 584). In this space, bodies are discursively produced through stories in magazines, advertisements, television series, pop idols; pornography, the internet and gymnasiums (Williams & Fahy, 2004; Healy, 2006; Kent, 2000; Lupton, 2003; & Longhurst & Johnson, 1998). These discursive practices are effective in the incarnation of ideal body forms that may not necessarily mirror reality, but nevertheless construct women's experience and expectations of what an ideal body should look like. An article recently appeared in the mainstream media euphemistically entitled "*A cut below*" (Healy, 2006, E5) signalling the constitution of women's sexual bodies through pornographic

imagery. The article, is a marker for designer vaginas, commodifying female genital reconstruction as “...the latest bit of feminine real estate...” (Healy, 2006, E5). This event cannot be analysed as a mere “surface projection” (Foucault, 1978, p. 100) of the power behind the adult entertainment industry in creating this corporeal panic, but rather something of a ‘tactical polyvalence’ in which “ a multiplicity of discursive elements that can come into play in various strategies” (Foucault, 1978, p. 100).

In reading Foucault (1978) alongside Healy (2006) these discursive elements include the discursive practices of gynaecological and cosmetic surgery. These events illustrate the potency of the media in representing a particular kind of ‘truth’ about women’s sexual bodies and is a topic of discussion in Chapter Seven. The key here is that in this field of play, discourses are not to be conceived of as simply a binary between a dominant discourse and a non-dominant one, but rather, how power is differentially effected in discourse, through a ‘field of forced relations’ that guarantees neither durability nor homogeneity (Foucault, 1978, p. 100–101).

Discourses are tactical elements or blocks operating in the field of force relations; there can exist different and even contradictory discourses within the same strategy; they can on the contrary, circulate without changing their form from one strategy to another, opposing strategy (Foucault, 1978, p. 101 - 102).

Media discourses have significance to the current study in that they serve as a potential force in shaping how women position themselves in relation to childbirth. For some childbearing women, popular culture, in the form of magazine stories, may serve as their chief source of knowledge about childbirth (Williams & Fahy, 2004). Williams and Fahy’s study entitled, “*Whose interests are served by the portrayal of childbearing women in popular magazines*” implies the appropriation of tactical polyvalence in the discursive construction of childbirth. Here patriarchal, obstetrical and capitalist interests are served through the manner in which childbirth is spoken of. For example, constituting women as passive and compliant, in stories, particularly those stories spearheaded by celebrity first time ‘mothers’ conjuring fears about childbirth, creates a space for the advertising market in selling product and print, while at the same time promoting obstetrical care for low risk women. Implicit here is a tactical polyvalence embedded within media accounts in which different discourses

converge within the same strategy veiled behind popular culture's necessary recourse to and appropriation of rhetoric. It is in advertising however that rhetoric has a most evocative sting. Bender and Wellbery (1990) explain its operation.

Advertising in particular works by condensation and montage to shatter those sequences of cause and effect integral to the construction, representation and comprehension of personal identity (Bender & Wellbery, p. 32).

As a form of communication, rhetoric, is omnipresent and not just the prerogative of popular culture. Its permutations are in all knowledge whether science, medicine or politics (Bender & Wellbery, 1990; Laclau, 2000).

3. 8. 1. Rhetorical (de)vices.

In ancient times, the art of rhetoric was a discipline, hailed by Aristotle as a social practice, gained through formal education, for the purpose of negotiation and persuasion in social interaction (Bender & Wellbery, 1990). Bender and Wellbury (1990) explain classical rhetoric came to be dominant in Europe until its marginalisation during the Enlightenment and Romantic eras, only to be reborn through modernity. The scientific and romantic denouncement of rhetoric as futile largely centred around Descartes' notion of the "cogito" and certitude: "The cogito, the unshakable foundation of certainty, generates at once the impersonal or abstracted subject of science and the creative, self-forming subject of Romanticism" (Bender & Wellbery, 1990, p. 11). As the discourse of empiricism flourished, importance was placed upon neutrality, representation and transparency of discourse. Concomitant at the time was the emergence of the printing enterprise and its implications for the augmentation of the notion of an "author." It was at this historical moment that classical rhetoric met its demise (Bender & Wellbery, 1990). Bender and Wellbery suggest the 'conditions of impossibility' for the survival of rhetoric - objectivism, subjectivism, liberalism, literacy and nationalism, Enlightenment ideals - (1990, p. 23) ironically fold back on themselves, to be destabilised by the socio-cultural transformation of modernism and the subsequent return of rhetoric.

Modernism no longer possesses a reliable standard of representational transparency; even so called observation sentences are recognised as

theory-laden; and the history of science itself has come to be viewed less as a progressive discovery of the fact than a series of constructions accomplished within the framework of governing conceptual paradigms (Bender & Wellbury, p. 23).

Bender and Wellbury (1990) suggest that rather than see Modernism as the age of the new rhetoric, it should be viewed it as an age of rhetoricality. Rhetoricality's point of departure from rhetoric lies in its position as "...a generalised rhetoric that penetrates to the deepest level of human experience" as opposed to its traditional status of a rarefied form of speech within the confines of a disciplinary practice (Bender & Wellbury, 1990, p. 25) through the use of the metaphor.

Metaphors are rhetorical devices that are appropriated to construct 'reality', rendering the impalpable into what is palpable, thereby moving language beyond descriptive tropes toward a potency of meaning (Fairclough, 1993; Lupton, 2003; Trudge, 1998). It is a trope that bridges the gap between what can be named and what cannot, the comprehensible and the incomprehensible. Metonymies also shape reality by displacing particular elements in language with a universal term to stand in for many (Billig & MacMillan, 2005). Headlines in popular discourse are metaphorically appropriated to invoke different interpretations around childbirth. One such appropriation is the pun "Too Posh to Push," to convey that celebrities such as Posh Spice, a member of a famous British pop group known as the Spice Girls, are too 'posh' to give birth by conventional means. The effects are complex; one in particular evokes images of women as *chic* trend setters, capitalising on the accoutrements of a consumerist society, hailing women ostensibly down a path toward progress.

Lupton (2003, p. 59) warns that metaphors are not neutral but rather devices that have an epistemological function with regard to conceptualising and constructing reality. Nietzsche (1964[1873]) makes a cogent point and questions whether language can adequately express reality.

When we talk about trees, colours, snow and flowers, we believe we know something about the things themselves, and yet we only possess metaphors of the thing, and these metaphors do not in the least correspond to the original essentials (p. 178).

Essentially, what I read in Nietzsche (1964[1873]), is knowledge, that is the ‘the will to truth,’ (Foucault, 1978) comes to us through metaphors. Metaphors are neither stable nor durable, meanings which change through time and space. This point is taken up by Billig and MacMillan (2005) when explaining the journey from metaphor into idiom in political discourse. A case in point is the ‘smoking gun,’ with its evocation of aggression. As such metaphors can be “rhetorically mobilised” in support of ideology or importantly, “metaphorical idiom can also dull literal meaning to the point of ideological concealment” (Billig & MacMillan, 2005, p. 478). As a rhetorical device for conveying meaning through association, metaphors have the capacity to conjure up a plurality of ‘truths’. The significance of rhetoric goes beyond popular discourse to bring about its effect. The use of the euphemism “natural caesarean,” (Healy, 2005) neutralises the impact of this major operation, the ideology of which is unpicked in Chapter Four.

3. 9. Conclusion.

The chapter has drawn from the theoretical ideas of postmodernist thought, more particularly poststructuralism, to provide a philosophical lens, through which my analysis of the discourses constituting caesarean as an alternative birth method, took shape. Unpacking these ideas, enabled the discursive possibilities for understanding the topic, as it rests momentarily, on a contentious, complex, contradictory and shifting terrain. The philosophical ideas of Michel Foucault inform the research. Foucault disrupts modernist notions of infinite continuity of discourses. How objects emerge in discourse and the discursive strategies for (re)producing truth along with its conditions of possibility, have importance for the ‘history of the present’. As socio-cultural and biological discourses contest the meaning of childbirth, the mechanisms through which ‘truths’ are created are exposed and in the process opportunities are opened up for the contemplation of how commonsense notions are (trans)formed into uncritically accepted truths.

Discourse-power-knowledge is a central feature of Foucault’s philosophy. These elements are inextricably linked and shed light on the manner in which technologies of power have the potential to transform the choice of a caesarean section, for no clinical

reason, through a process of normalisation. Feminist thinking also informs the research and will complement the poststructuralist lens through analysing how caesarean, as a choice of birth mode, is talked about from women and maternity practitioners' diverse perspectives. As such, poststructuralism opens spaces for alternative ways of viewing the world and invokes us to examine our own positions of power and our truth claims. Through the strategy of deconstruction, the hidden meanings of language are revealed, as are rhetorical devices that name the 'unnameable' and shape meaning in both professional and popular discourse. It is to the research methodology, the process for gaining knowledge of the discourses that constitute the choice of caesarean, in the absence of clinical indications that the next chapter now turns.

Chapter 4. Research Methodology.

4.1. Introduction.

The emergence of caesarean as an alternative birth mode as the new object of obstetric discourse has confirmed the inextricable link between discourse-power-knowledge when claiming the truth about events. Discourse-power-knowledge is central to the work of Foucault, whose theoretical ideas have guided the choice of methodology for the current study. The mechanisms, through which truths about the choice of caesarean, as an alternative birth mode, were created, are explained. A Foucauldian discourse analysis dovetails nicely with a poststructuralist worldview and therefore is an appropriate strategy for this study. Clare and Hamilton (2003) reinforce my decision in that they state that discourse analysis (DA) makes possible the "...opening up of texts or social practice to a variety of readings" (p.156). In this chapter I describe the process by which the study was undertaken. I include the recruitment and selection of participants, the application of the Treaty of Waitangi to the research partnership, ethical considerations, data collection and analysis of childbearing women, midwives' and an obstetrician's talk and texts, as these relate to the research methodology.

4. 2. Embarkation: the research aims.

The trend of caesarean section as an alternative birth mode has become part of an international drift yet while the topic received much attention in the literature, evidence to suggest maternal request behind caesarean section was unconvincing (Gamble & Creedy 2000; Kitzinger, 2001). What had unfolded in both professional and popular literature was a contentious debate warranting further scrutiny. The contradictory nature of the debate highlighted multiple discourses constructing women's choice in childbirth. I therefore favoured a qualitative methodology to enable the controversy to unfurl.

An indepth understanding of aspects that influence womens' choice for caesarean in the absence of need is the focus of this research project. It therefore follows that the overall purpose of the current study is to explore the various discourses constituting

the choice of caesarean in the absence of clinical indications. More specifically the study aims to:

- explore how professional and popular culture influence the decision for a caesarean in the absence of clinical indications and
- identify the discourses in professional and popular culture that influence a woman's choice for a non-clinically indicated caesarean.

4. 2. 1. Participants.

While it was not my intent to obtain a representative sample of participants, from which generalisations could be made to the greater population of women and maternity care providers, I did want a full range of voices to inform the study. I therefore needed a sample in concordance with the exploratory nature of the research. Informed from my reading of Barbour (2001) and Cluett and Bluff (2000) I chose to use purposive sampling to enable a diversity of views. Cluett and Bluff (2000) explain purposive sampling as "Selecting participants who have knowledge of the topic being studied" (p. 214). Because recruitment included women of childbearing age and not necessarily those who had firsthand experience of a caesarean, it was assumed women were interested in the topic. For maternity carers, it was expected they would have knowledge of the topic under study.

Women of childbearing age in the general population, midwives who were both case loading and hospital midwives and obstetrician and gynaecological specialists, from an urban setting, were invited to participate in the study. An urban setting was chosen because of the full range of maternity services available to the prospective participants. Initially general practitioners (GPs) were considered key informants, but little response to the recruitment process indicated a lack of interest. This was foreseeable, given that many GPs had withdrawn from maternity care (National Health Committee, 1999). In 2001, 73.1% of Lead Maternity Carers (LMCs) were midwives, while only 9.6% were GPs (MOH, 2003, p. 116). Midwives were therefore considered crucial informants, as were obstetric specialists because of their point of reference in the decision to undertake a caesarean. At the time of submitting the research proposal women's request for caesarean, was largely speculative. Recruitment therefore focussed on seeking childbearing women from the population

as a whole with the intent of capturing a wide range of participants. In actuality, the outcome was a relatively homogeneous group of European / Pakeha women. The process of recruitment was logged and maintained in tabular form as a means of tracking responses.

4. 2. 2. Recruitment.

Recruitment for childbearing women into the study, commenced soon after ethics approval was received in September, 2002. I had hoped to attract enough women of childbearing age for at least two focus groups. Between 6-12 was regarded as an effective size, for a focus group to enable participation from individual group members (Krueger, 1994; Stewart & Shamdasani, 1990; St John, 1999). I therefore aimed to recruit 24 women of childbearing age. Childbearing women, from the general population who did not necessarily have personal experience of choosing a non-clinically indicated caesarean, were accessed through an advertisement placed in a local regional newspaper and Parents Centre news-letter (appendix 2). The reason for not targeting women, who had actively chosen caesarean, in the absence of clinical indications, was because of the controversial nature of the topic. Speculation in the popular media, around the time of proposing the research, about celebrities being to “posh too push” (Daily Telegraph, 2001) had the tendency to encode this mode of birth behind a veil of reticence. Therefore numbers of women who had experienced a non-clinically indicated caesarean by choice, were envisaged as being too few to warrant an indepth exploration of the issue. This is consistent with Gamble and Creedy’s (2000) findings in which few women actually request caesarean for no apparent reason. Moreover by targeting the general population of childbearing women there was a greater possibility a diverse range of perspectives on the topic including those of women who actively chose a caesarean for no clinical reason.

The newspaper, in which the advertisements were placed, colloquially known as a “freebie”, was chosen for its large distribution and readership throughout the metropolitan region. Within a fortnight of the initial placement of the advert, eighteen women expressed an interest in receiving an information package. Interest for further information was indicated either by returning a request slip attached to the

advertisement, or through making contact by telephone or through email. The same advertisement was inadvertently placed in another local paper by an enthusiastic media 'rep' capitalising on the original advertisement and drew a further two potential participants. A request by the editor of the aforementioned "freebie" for a short article was submitted in a section on maternal health. This latter approach led to a further seven responses. Taken as a whole, the number of women who expressed interest in the study amounted to twenty seven. Of this number eighteen women returned their consent form. As the consent forms came in the women who chose to take part in the study were allocated to one of two focus groups. I had aimed for around nine members as an effective size for each focus group, this number being equidistant between six and twelve as suggested above. A total of twelve women participated in the study. Two separate focus groups were held, each comprising six members. More specific details of the focus groups are presented under focus groups in section 4.5.3. – 4.5.7 of this chapter.

Recruitment of health care professionals was through advertisements placed in their professional body's regional newsletters such as the regional branch of the College of Midwives' and the Maternity Providers (MATPRO) newsletter. Midwives were also accessed through regional meetings. In addition, permission was gained to place advertisements on staff notice boards and individual practitioners' pigeon holes in maternity units of two District Health Boards (DHBs) in the region (appendix 3). Apart from advertising strategies within the DHBs, recruitment of Obstetrician and Gynaecologist (O & Gs) specialists was through individual letters of invitation, sent in February - March, 2003. Sixteen O & Gs were contacted through the Registered Medical Practitioners' & Medical Centres' section in the public phone book. Six responded, one of whom wrote to say that he was no longer working in obstetrics, leaving five who requested an information pack which was duly sent. Few midwives responded to this stage of the recruitment process.

Having had no response from the O & G recipients of the information packs, follow up was sent in the form of a letter in July, 2003 and a phone call three weeks later. An August 2003 diary entry recalls my attempts at follow up. I felt these were futile endeavours as O & Gs were either on holiday or too busy to respond to my messages. Eventually one O & G replied, most apologetic and explained that workplace

pressures had indeed prevented correspondence and suggested I ring back in a couple of months when things settle. Another diary note of January, 2004, records my frustrations regarding the O & G follow up. All too soon, my efforts became punctuated between work commitments, other recruitment obligations and data analysis of my work already in progress with the women's transcripts. I diverted my energies to the recruitment of midwives. In November of 2005, a letter offering O & Gs a final opportunity to take part in the research was sent. My efforts were rewarded promptly, with a reply from one O & G who was most willing to participate. An information package was duly sent to the O & G and following the return of the signed consent form, an individual interview was arranged.

A second attempt to recruit midwives was undertaken at a NZCOM regional meeting and the subsequent posting of yet another advertisement in the September, 2003 edition of the NZCOM's regional newsletter. Additional invitations were once again placed on staff notice boards in the maternity units of the already mentioned DHBs. The result was an enthusiastic response from self-employed midwives. A total of eight self employed midwives were sent information packs about the study. Six midwives indicated their consent by returning their consent forms. The remaining midwives on followup declined to participate because of their busy schedules. On the day of the their focus group interview for self employed midwives one midwife was called to a birth leaving a final balance of five midwives to partake in the group discussion. Lack of response from hospital midwives was attributed to staff shortages. I made the presumption that pressure to take part in the research could further add to staff stress so subsequently softened my approach to recruitment. Concerns expressed over the potential absence of the voices of hospital midwives, prompted a colleague, who straddled both the DHB and LMC domains, to campaign for participants, on my behalf. I could see no conflict of interest with her gesture as she has no allegiance with management at the DHB. In the fullness of time, a keen group of midwives from one DHB willingly volunteered. Overall the total number of midwives recruited into the study was eleven with ten able to participate.

In summary a total of twenty five participants took part in the research. Two focus groups were held for childbearing women in the general population, each comprising of seven members. Ten midwives participated in two focus group interviews, each

comprising five self employed and five hospital based midwives respectively. The remaining participant was an O & G who shared his ideas in a face to face guided interview.

On reflection recruitment was at times protracted with some groups of potential participants more responsive than others. What became apparent in the process was the need to tread carefully, as there can be a fine line between the vigour of follow up and the pressure placed upon participants to partake in research. The response from women was encouraging and reflected a high level of interest in the topic. Implied here is the value of advertising in regional newspapers for recruitment purposes. Even so, the use of the media as a portal for recruitment, begs the questions of what are the views of women who did not respond to the advertisement? Moreover, who has access to regional publications? Significant by their absence were women representative of Maori, Pacific peoples and Asian communities. This disparity may be explained as a lack of interest in the topic as around the time of recruitment, Maori and Pacific peoples women are represented as having the lowest rates for elective caesarean sections (Capital & Coast District Health Board, 2002). These results were echoed at a national level (MOH, 2006) suggesting a disparity between Maori and Pacific peoples women and non-Maori and Non-Pacific peoples women in accessing specialist elective surgery. The absence of Asian women was interesting in light of this group being represented as having the highest elective caesarean rates for the region (Capital & Coast District Health Board, 2002). Also absent were women who chose to have a caesarean, in the absence of clinical indications, for the reasons already addressed.

Interest from maternity care providers was more piecemeal compared to the responses from the women who responded. The delayed response from midwives was puzzling in light of the professions' endorsement for the research as discussed in Chapter One. I can only assume heavy workloads as thwarting their interest. This may have also been the situation for the O & Gs as their initial flurry of interest had promise. Interest however appeared to wane concomitant to receipt of information packs about the study. Implied here was reluctance on the part of this group to become involved given the controversial nature of the topic. Nonetheless added value would have come from a greater presence of O & Gs notwithstanding the vivacity of the debate within the obstetrical literature.

4. 3. Te Tiriti O Waitangi and the research partnership.

In Aotearoa New Zealand, the Te Tiriti O Waitangi (Treaty of Waitangi) is the nation's founding document. Signed in 1840, to protect against the exploits of colonisation, the Treaty represents a covenant between Maori peoples (Tangata Whenua) and the British Crown (Dew & Kirkham, 2002). At the heart of the Treaty are three articles. Derived from these articles are three principles; partnership, protection and participation (Royal Commission on Social Policy, 1988). Tangata Whenua holds a unique place in Aotearoa New Zealand, as the First Peoples (Ramsden, 2002) of this place. Despite the Crown's obligations inherent within this contractual arrangement, ensuing governments failed to live up to its promise. The impact of this neglect manifests in the widespread disparities in Maori health today (Durie, 1998; Reid, Robinson & Jones, 2000). It is these historical and socio-political events that have provided the context for cultural safety within the disciplines of midwifery and nursing in this country (Ramsden, 1995; 2002). Cultural safety calls into question the asymmetry of power relations inherent within health service encounters, the central precept being the notion that the seat of power lies with the recipients of the health services (Ramsden, 1995; 2002). Partnership, a core competency of the profession of midwifery in Aotearoa New Zealand (New Zealand College of Midwives, 2005) is assumed to equalise power relations in professional encounters. Despite some initial debate within the profession, as to whether partnership is a real or ideal construct (Benn, 1999; Fleming, 1998; Lauchland, 1996; Skinner, 1999) the basic tenets of partnership echo those of a collaborative relationship between the researcher and the researched.

In qualitative research the ethical dimensions are intensified through the intimate relationship between the researcher and participants. In reading Kearns and Dyck (2005) these writers contend that research must be culturally safe, based on the premise of partnership. "To be culturally safe in research is to enter partnership with another person or members of a population group in which they allow you to participate in co-creating a deeper understanding of the world..." (p. 86). The co-creation of knowledge sits comfortably with my epistemological position that is

supportive of a reduction in the distance between the researcher and the researched and the historical and socio-political context behind knowledge acquisition. This challenges the epistemological stance of empiricist science that assumes knowledge to be outside the socio-cultural context (Ryan, Carryer & Patterson, 2004). In creating knowledge about the nature of how the choice for a non-clinically indicated caesarean is constituted, the researcher and the researched share insights into the discursive elements that construct this mode of birth.

While the focus of the current research was not based on ethnicity *per se* but on specific issues involving childbearing women and health care professionals in the general population, issues related to research involving Maori must be addressed when undertaking research in Aotearoa New Zealand. This has much to do with past research practices that have had little benefit for Maori (Jahnke & Taiapa, 1999). While issues related to research involving Maori women and practitioners were considered prior to starting the project, no participants who volunteered for the study identified as Maori, when asked to identify their ethnicity. One possible explanation for this absence is that caesarean in the absence of clinical indication, may be of little consequence for Maori women, given that statistics from the regional report on maternity mentioned earlier, describe Maori women as having the lowest elective caesarean rates section overall groups of women (Capital & Coast District Health Board, 2002). Notwithstanding the acontextual nature of the above report, Maori women may be reluctant to take part in research because of research practices in the past that may not have served their interests well (see Kearns & Dyck, 2005). This may be especially so for focus group research, for while there is the potential for the diffusion of power relations between researcher and participants (Wilkinson, 1998) talk in focus groups occurs within a context which may mirror the dominant cultural assumptions of the wider social milieu. It is for this reason that midwives in Aotearoa New Zealand, have an ethical responsibility to honour the principles of partnership, protection and participation, an obligation that also applies to research practice.

4. 4. Ethical Considerations.

Accountability for respecting the rights and dignity of participants is an important obligation of every researcher. History attests to the blatant abuse of the rights of participants involved in research on the interests of those doing the research (Cartwright, 1988). The Cartwright (1988) report provided the impetus for the Code of Health and Disability Service Consumer Rights (Health Commissioner, 1996) these rights extend to those taking part in research. Researchers not only have a moral obligation to respect the rights and dignity of participants but also a legal duty to do so. As I was currently not in practice as a midwife, I did not anticipate any conflict of interest or role conflict undertaking this research.

4. 4. 1. Monitoring.

In keeping with the spirit of the above code, the research proposal was submitted to both the Massey University Human Ethics Committee (MUHEC) and Wellington Ethics Committee (WEC) for approval. Approval was granted by both committees pending some minor amendments and each committee was notified of any significant changes that occurred during the period for which approval was given. Two changes were necessary. These included a request for a co-facilitator and a request for a confidentiality agreement should I require technical assistance. These changes were subsequently granted by the WEC and MUHEC (appendix 1). The data gathering and analysis processes were reviewed with the researcher's supervisors at regular intervals and my work in progress was monitored through the doctoral research committee in the form of six monthly reports. An annual report was submitted to the Wellington Ethics Committee as was the requirement of the approval process.

4. 4. 2. Informed consent and research setting.

Those participants who registered their interest in participating in the research were sent an information package about the study. Separate information packages were designed for each specific group of participants (a composite is in appendix 4). The

information included a participant consent form, which they were asked to sign and return to the researcher in a stamped addressed envelope provided (appendix 5). A signed consent form indicated that participants had been fully informed about the research and gave their consent to participate in the study. Upon receipt of the consent forms, a letter was sent to each volunteer thanking them for agreeing to participate in the study and provided details of the date, time, venue, what to expect from the session and a map of the location depicting where to park and the venue entrance. An interview guide, which formed the basis of the field notes, was also included (appendix 6) accompanied by a media article entitled *Too Posh To Push* as a gesture to stimulate ideas around the topic. The article was not included in the O & G's package, as by that stage the slogan had become *passé*.

The setting was a mutually arranged venue. The women and self-employed midwife members of the focus groups chose to attend a focus group at Massey University Wellington campus. For women it was more convenient to attend on the weekend for childcare and parking purposes. For the independent midwives, parking and the convenience of a known location were factors in their choice. For DHB midwives and the O & G, permission was granted to hold a focus group within the DHB for the convenience of these participants. Refreshments were provided by the researcher for the focus group sessions. The offer of refreshments did not eventuate for the individual interview.

4. 4. 3. The Right to Anonymity and Confidentiality.

Prior to consenting to take part in the study, participants were informed that absolute confidentiality could not be guaranteed, as there is always a risk of disclosure outside of the group. To minimise this potential, participants were asked to sign a group confidentiality agreement at the commencement of the focus group sessions (appendix 7). The narratives that made up the study's findings from the focus groups formed an aggregation of individual accounts. In the event where data collection involved an individual interview, a pseudonym was used in the data analysis. The principle of autonomy and confidentiality also involved the use of place names. For additional protection, the digital data were transferred as a separate voice file onto the

researcher's computer hard drive. Those key personnel authorised to view the data, did so on the basis of signing a prior confidentiality agreement (appendix 8). A separate confidentiality agreement was provided for the co-facilitator (appendix 9) and for a technical assistant (appendix 10). The latter was required for initially downloading data files during the process of transcribing the audio recordings.

Anonymity and confidentiality had the potential to be threatened when one member was intercepted as she arrived at the commencement of the session with a friend whom she wanted to include in the group. After some discussion about informed (unhurried) consent and possible ethical implications for the others in the group, both women departed, philosophical, albeit somewhat disappointed about their plight. Both expressed a desire to take part at a future date, should another be held. The information pack was duly sent. When the prospect of another focus group was offered, the gesture was declined. The event was my first encounter with untoward events that had the potential to undo the research ethic of "first do no harm" (Davidson & Tolich, 2003, p. 81) including the potential for psychological injury.

4. 4. 4. Protection from harm.

While I had received ethical consent from two Ethics Committees, ethical approval, I was soon to learn, was just the tip of the iceberg (Tolich, 2002; 2004). In reading Tolich, while external confidentiality and by implication, protection from harm may be assured through an ethics committee, internal confidentiality is more complex. Potential for harm can occur from insiders harming insiders, in particular, when insider identities can be recognised in the final report. This also had significance for the focus groups where the promise of confidentiality could not be guaranteed despite group contracts and confidentiality agreements. While every endeavour was made to minimise potential to breach internal confidentiality in the focus groups, there was some solace in the aggregated nature of the individual accounts. For the O & G specialist, I had a concern with the size of Aotearoa New Zealand, as Tolich, has noted, more specifically with the region in which the research took place. As a relatively small community of maternity care professionals, I saw this as a potential threat to the anonymity. While the O & G participant was happy with his pseudonym

(Tom), I resolved to do what Minichello, Aroni, Timewell and Alexander (1997) suggest and that was to erase any identifiable characteristics such as sensitive information subsequently disclosed when I came to do the data analysis. Special attention here was given to erasure of specific position held, age and ethnicity of Tom.

Attention was also needed to monitor group dynamics to ensure that each member of the group had an equal chance of being heard. Each session included time at the end for debriefing. Members were referred to the information pack for contact numbers for myself along with my supervisors and Chairperson of the Massey University Human Ethics Committee, should any concerns arise about the research process or their rights as a research participant.

4. 4. 5. Other rights.

Other rights included the right to decline to participate in the research project, the right to refuse to answer any particular questions and the right that any information they provided was on the understanding that their names or individual identifying information, would not be used unless they gave permission for me to do so. In the first women's focus group (WFG1) one participant asked that an excerpt in the transcript not to be used for fear that something she said could be traced back to her. She was reassured that the relevant section would not be used. Participants were also informed that they could ask any questions about the study at any time during their involvement and that they could withdraw from the study at any stage. Further they could have a summary of the findings at the conclusion of the study. Participants in the focus groups were informed that if they withdrew from the focus groups, their comments made during the focus group sessions were unable to be removed from the audio recordings or transcripts of the group's discussion.

4.5. Data Collection.

Focus groups were the strategy for data collection for childbearing women, and midwives. A one to one interview was undertaken with the specialist obstetrician. An interview guide, was used to guide each discussion and reviewed after each session for

modification as appropriate. The interview guide was adapted from Krueger's (1994) taxonomy of questions, employed to channel discussion in both the focus groups and the individual interview (appendix 6). As an *aid de memoire* interview guides were used to channel the flow of the discussion. Davidson and Tolich, (2003) too recommend such an aid for interviewing in qualitative research. Davidson and Tolich suggest interview guides work best for formulating introductory questions, themes to be covered, and can act as a prompt to guard against the potential for a 'staccato' effect during interview sessions. The interview guides formed the basis of the field notes.

4. 5. 1. Audio Recordings.

Interviews were recorded using an Olympus DS-320 digital dictation machine, using an external conference microphone, which was downloaded directly to the researcher's computer. The DS-320 was then connected to the researcher's PC by means of a modem and the data files were downloaded. The data files were then sent via a secure website, utilising passworded procedures, to Sound Business Systems (SBS) LTD in Auckland. This company was chosen for its reputation for transcribing sensitive material from key agencies at government level and also because it has a File Upload Facility (FUF) which allows clients to easily transfer their images, sound or text files to the SBS server in a secure fashion. The company and key staff had signed confidentiality agreements. When the transfer is complete SBS receive an e-mail notifying them of the file to pick up. The file is then transcribed and a Microsoft Word text file is created which is then emailed back to the researcher for analysis. The transcriber was required to sign a confidentiality agreement, prior to handling the data. The text was then analysed simultaneously with the sound facility.

4. 5. 2. Field notes.

Field notes were taken by the co-facilitator, to maintain a record of the context of the group and individual interviews, so as to capture aspects that are not picked up on sound recording (Krueger, 1994). A format for these notes was designed around the

interview guide as suggested by Kreuger. Each page had two columns, one for summary key points and one for emergent ideas. The co-facilitator, Jane (pseudonym), and I followed each session with a debrief noting possible modifications for subsequent sessions. The field notes, along with a map of members seating arrangement drawn up at the end of each session, also provided a valuable *aid de memoire* of the context.

4. 5. 3. Focus Groups.

Two focus groups were held to accommodate the numbers of women participants who volunteered and one focus group each for self employed and DHB midwives. Group interviews were chosen because of their potential to yield a rich source of data beyond that of an individual interview (St Johns, 1999) particularly when there is little known about the topic (Stewart & Shamdasani, 1990). Focus groups are more frequently advocated as an appropriate research method in feminist research (Madriz, 2000; Webb & Kevern, 2001; Wilkinson, 1998). These writers suggest that much of their value lies within the synergy of the group in generating interactive data that emanates from the exchange of ideas. These ideas come through a blend of everyday talk that emerges in group settings, typically arguing, laughing and joking amid anecdotal experiences. Through this vernacular shared meanings are revealed that are unattainable with individual methods.

Wilkinson (1998) finds the methodology of an individual interview to be problematic because what people say is discursively produced in specific social contexts. She is critical of researchers who have tended to present their results, from focus groups, as data from a one-to-one interview. For Wilkinson focus groups have many benefits for feminist research. These include, "...addressing feminist ethical concerns about power and the imposition of meaning; generating high quality, interactive data; and offering the possibility of theoretical advances regarding the co-construction of meaning between people" (1998, p. 111).

As a research method, I was at ease with the choice of focus groups largely due to what seemed to me to be diffusion of power relations within a group situation,

particularly between the researcher and the researched. This is not to say that these power relations are completely absolved, for as Wilkinson (1998) indicates, they can still surface further into the research process during for instance, analysis and writing up. I was nonetheless aware of the asymmetry in relation to my benefiting from the research in terms of my qualification. With this in mind, I ventured forth into my first focus group, accompanied by the simultaneous sentiments of apprehension and enthusiasm tugging at my senses. Despite my initial hesitancy the women in the focus groups shared their experiences and ideas and affirmed for me what St John (1999) and Wilkinson (1998) had noted earlier about the quality of the data.

Prior to the start of the focus groups, each member signed a group confidentiality agreement. This was followed by a brief preamble, outlining the session and included an overview of the research. After some talk around a group contract and a sequence of introductions, in all cases a lively discussion began. Each group was informed that if there were any issues arising from the meeting they wished to discuss in private, they could see me after the session or ring me at a time that was convenient for them. They were also reminded of their right to leave the session should they want to. No participant expressed the desire to leave the focus groups during the process of data collection. The size of each group membership excluded the co-facilitator and my self as our membership was constant throughout each group with the exception of the hospital midwives session which Jane was unable to attend. The group contract generally involved a gentle reminder to have only one person speaking one at a time and a conference microphone aided the clarity of the recording. Careful attention was paid to ensure every one had a chance to be heard and not be swamped by more dominant voices and despite the liveliness of the conversations this did not appear to be an issue. At the conclusion of each focus group a summary of the key themes to emerge from the discussion, was provided for validation by the group, along with the offer to peruse the transcript. No one chose to view the lengthy transcripts, preferring instead a summary of the content of the event. Feedback was positive from both Jane and group members, when phoned in the week to follow.

4. 5. 4. Women's focus group 1.

Women's focus group 1 (WFG1) took place on 22 March, 2003, at 1pm on the Wellington Campus of Massey University. Seven women of childbearing age attended the first focus group. Of these seven women, two were childless, one in the planning stages and one undergoing fertility treatment. Three of the women had young babies, ranging between nine and twenty months. Two were pregnant, one with her first baby, the other pregnant with her second. One woman had previous experience of an emergency caesarean. I was impressed by the cohesiveness of WFG 1, given the diversity of opinion among these women.

The dynamics worked well and surfaced issues that had not been taken into account, such as eliciting male partners' views as this factor was deemed to have an influence of the choice for caesarean, largely because of heavy work schedules. Key themes to emerge were validated and feedback from Jane was assuring. A perusal of the field notes offered reinforcement should the quality of the recording be an issue and feedback one week out from members was positive. A summary of the transcript was duly sent out to each member.

4. 5. 5. Women's focus group 2.

Women's Focus group 2 (WFG2) took place on 3 May, 2003, at 1pm on the Wellington Campus of Massey University. Nine women consented to take part in focus group two. One had to withdraw because of a sick infant. Another, accompanied by a friend, withdrew for reasons referred to earlier, leaving seven women plus an exuberant two year old child and baby of four months. Six of the women had experienced childbirth, two of whom had undergone a clinically indicated caesarean section. The remaining one member had currently no plans to have any children in the immediate future. Following the necessary preliminaries that had served as the yardstick for each focus group, the discussion began. From the start I had wanted to provide an 'interview' that flowed as I felt the conversation was a little stilted in the first focus group. I was also cognisant of the child's vitality in the background stemming the flow of conversation at fairly frequent intervals, yet pleased to have the

child's presence in the room, as it is against this backdrop that the discursive field of women's talk takes place. The baby nestled in his mother's arms throughout the session. Evaluative feedback from Jane was again assuring. An overview of the key themes was corroborated before the group disbanded. As with WFG1, one week out I rang around to see if there were any issues arising out of the focus group. While one member could not be contacted, feedback from the remaining group members again was positive.

4. 5. 6. Self-employed midwives focus group.

The first midwives' focus group (MFGSE) took place on the 18 December, 2003. A total of 8 self-employed midwives, all current in practice, requested information packages, of which six returned their consent form. One midwife was unable to attend because of a birth, leaving five members for the focus group. Two of these midwives were educators who continued to have a caseload of women; two were self employed practising largely as LMCs and one was a postgraduate student, practising as a locum. The midwives ranged in age from between 30 and 55 years. All were considered experienced midwives with a mean of 23 years practice and most were known to each other. These midwives were able to provide valuable insights from their tacit understandings through their work with women and O & G specialists.

Feedback after the one hour eighteen minute long session, and one week out, was positive. As with the women's talk, I constantly reflected on the effect of my position as a co-informant of the group simultaneous to my position as the researcher while at the same time feeling somewhat of a neophyte in facilitating focus groups. My reflection was appeased when one midwife fed back on email: "I think you were an expert facilitator. A lovely relaxed group and you let it go and wound us in just perfectly. I wasn't even aware of what you were doing so engrossed was I in the topic..." While this was the verification I needed to progress my apprenticeship with facilitating focus groups, my vigilance as to the impact of me as researcher remained on 'full alert'.

4. 5. 7. Hospital midwives' focus group.

The hospital midwives' focus group (MFGDHB) took place on the 4th of April 2004. Five hospital midwives expressed interest in an information package and subsequently consented to take part in the study. All ranged in age between 39 to 58 years, worked within various settings within the DHB, bar one, four had practice experience of more than ten years. Like their self-employed counterparts, hospital midwives were able to provide similar insights from their tacit understandings through their work with women and O & G specialists but also from their 'insider' knowledge of caesarean section in hospital settings.

Cognisant that some members had limited time, an artefact of staffing levels mentioned earlier, preliminaries were quick and the discussion proceeded without further ado. All midwives were known to each other which was reflected in the lively debate that followed and reticence had little bearing on the discussion. At the end of the fifty three minute session, feedback was that members enjoyed the session with the desire for another opportunity to meet again. It was agreed that the prospect of another meeting would be evaluated should there be any issues arising from the transcript.

4. 5 .8. Individual Interview: O & G specialist.

One O & G specialist participated in an individual interview on 13th of February 2006. The venue was the O & G's office, a quiet environment from which a relaxed and effortless interview was undertaken. Tom (pseudonym) drew on his specialist knowledge and experience of working as an O & G. As with the other sessions, the meeting began with a brief preamble, outlining the session and included an overview of the research. A semi-structured interview, facilitated by an interview guide, channelled the flow of the discussion. Tom was keen to share his knowledge and so the session commenced with little ado. The difference between the focus groups and individual interviews was plain. Fewer preliminaries in the interview meant less time restraints; fewer participants meant less monitoring of group dynamics and while it stands to reason that power relations are diffused between the researcher and the researched in the presence of multiple participants, my contribution toward the

individual interview was that of an occasional prompt. Inherent in my methodology is the belief that knowledge is socially constructed. I pondered briefly over Tom and my epistemological differences at their broadest levels. Questions such as how positivism, the discourse in which obstetrics has traditionally been located, would sit with my poststructuralist focus, invoked an interesting contemplation, given that the nature of reality is inherently different within each of these inquiry paradigms (Crotty, 1998).

4. 6. Discourse analysis.

Discourse analysis (DA) sits comfortably with me, as my epistemological unfolding has led me to consider that meanings of words and things are shaped by the various discourses, such as those occasioned through talk, professional encounters and the media. Discourse analysis has been described simply as “the study of talk and texts” (Wetherell, Taylor & Yates, 2001, p. i) and in the current study I explored the ‘talk and text’ (and beyond) of childbearing women, professional and popular cultures. While approaches to discourse analysis are many and varied, Taylor (2001) has identified four approaches available for researchers.

The first approach views language as a system in which meaning is contingent upon a system of rules, such as in linguistics where the component parts (linguistic units) of the language system are of interest (Yates, 2001). From this perspective language is reflective of reality as opposed to creating it (McHoul & Grace, 1997). In the second approach, emphasis is on how language is used in interaction *vis a vis* sequenced contributions from each speaker (Taylor, 2001; Wooffitt, 2001). Here a conversational analysis (CA) of the ‘to and fro’ of patterns of naturally occurring talk is the focus (Taylor, 2001; Wooffitt, 2001). Context is assumed to be largely irrelevant (Baxter, 2002a) and meaning is thought to be both created and constrained in interaction. In the third approach to DA, the constitutive nature of language as opposed to its interactive capability is the focus. Recurring, stable patterns of talk about phenomena to emerge from language are referred to as ‘interpretive repertoires’ (Potter & Wetherell, 1987; Wetherell, Taylor & Yates, 2001). Context becomes important as meanings are specific to a particular topic or issue at a specific moment in time within a particular socio-cultural context (Taylor, 2001). It is at this site that

the boundaries between the third and fourth approach become blurred. Still, Hook (2001) is critical of Potter and Wetherell's interpretation of DA, reasoning that they overlook the material conditions that limit discourse. Furthermore, he argues that their concept of 'interpretive repertoires' privilege individualistic accounts which reinstate the author as creator of the text, an event erased by Foucault.

In the fourth approach outlined by Taylor (2001) emphasis is on how language is related to social and disciplinary practices within a wider historical and socio-political context. In Taylor's (2001) reasoning the aforementioned boundaries blur at a site in which critical discourse analysis (CDA), informed by Fairclough (2001), and a poststructuralist discourse analysis (PDA) informed by Michel Foucault. Baxter (2002) draws a line in the sand between CDA and PDA, for while they share much in common, their point of departure seems to be in how discourse operates in its reconstruction of reality. A CDA views discourse as a dialectical process, with an emphasis on the discursive reconstruction of the materiality, outside of discourse, whereas with a PDA, emphasis lies with discourse as 'anti-materialist' in that discourses function as practices that discursively constitute their objects (and realities) of interest (Baxter, 2002, p. 830). As such, subject positions are suspended in a continual (re)construction and possible (re)definition in competing discourses. Differences also exist in how power is conceived. With CDA, power is envisaged as a binary possession between those who have and those who don't have it, whereas within PDA power is more diffuse in its operation and can be taken up through multiple sites of subject positioning and resistance (Baxter, 2002). Baxter (2002) also calls to account, CDA's potential recourse to a 'grand narrative' through its engagement with emancipatory social theory.

...in Foucault's memorable terms, any theory or research paradigm, by virtue of its emancipatory desire to be 'right', contains a 'will to power' and therefore a 'will to truth'. An emancipatory discourse, as it becomes more established as mainstream, would in time become a 'totalising' or imperialist one,... (p. 830).

While I had found Fairclough's work (1993; 2001) exceedingly helpful in explaining much of the technicalities of discourse analysis, CDA's recourse to a totalising

approach which didn't bode well with my own (nascent) understanding of post-structuralism.

Powers (2001a) has incorporated into her goals of DA, a power analytic which can materialise as inconsistent and contradictory features within the discourse. Accounting for inconsistency and contradiction in discourse has the potential to uncover assumptions behind taken-for-granted 'truth,' thus opening up new configurations of possibilities within relations of power. Powers offers the view that situating discourse in the wider networks of power relations, summons questions as to whose interests are being served or not served by the discourse and what processes and strategies are co-opted for their (re)production and (re)circulation. The fourth approach to DA is enunciated through the texts of Baxter (2002), Carabine (2001), Hooks (2001) and Powers (2001a). This approach focuses on relations of power that enable and constrain what people can say and do. It was the pooling of these theoretical ideas, informed by Foucault, that formed the theoretical basis of my analysis. These readings of 'other' readings forced me to challenge myself as to whether I have interpreted them faithfully and how will I know if I have. How the choice for a non-clinical caesarean section was constituted by the differing discourses and discursive practices at a particular moment, was identified from the transcripts from each interview. These were reinforced through links to professional and popular discourses.

4. 6. 1. Data analysis.

Because there is no one method for analysing texts to identify discourses, my analysis pooled ideas from the texts of Carabine (2000), Payne (2000), Surtees (2003), Hook (2001) and Powers (2001a). Powers provides a comprehensive explanation of DA as it applies in the domain of health. Both Powers (p. 54) and Carabine make palpable a genealogical analysis in locating events within a historical context and the conditions of possibility for a discursive practice to come about; for example as posited in Chapter Five, a "natural caesarean" (Healy, 2006, p. E5).

Initially I had considered a software package for managing the data and a perusal of NVIVO provided insights into how data is managed. After a series of internal monologues about the benefits of technology, I decided to begin with a manual

process. Although cumbersome at first, attachment to my data seemed to be more palpable when compared to the remoteness of a programmed approach. This awareness stemmed from my use of a statistical analysis programme for quantitative data in my Master's thesis as I recollected how detached from the data I had become over time. Opie's (2003) sentiments about this detached mechanical process, was in accord with my intuitions.

The commencement of my data analysis began with an overall question that initially seemed patently obvious but was necessary to maintain focus; what are the discourses that constitute the choice for caesarean for no clinical reason? From that one overriding question, the analysis evolved to other related questions; what are the recurring themes identified within and across participants' talk and text? These questions gave me a base from which to move forward. Other questions were framed around the key points raised by Foucault (1972) who was interested in who is speaking? From what institution is the speaker authorised to speak? I also explored how power relations materialised in the production of knowledge around caesareans and whose interests this new configuration of caesarean serve. Nevertheless I found my initial journey into applying DA to my data a daunting prospect. With no quick fix in sight, I read widely in search of a framework beginning with seminal works that had shaped the application of DA (Foucault, 1972; Carabine, 2000; Fairclough, 1993; Potter and Wetherell, 1987; Powers, 2001). Foucault's (1972) challenge to discourse-power-knowledge was compelling. Potter and Wetherell (1987) taught me much about the theoretical explanations around language and lured me into thinking about DA. Fairclough helped me locate certain technicalities within discourse analysis and Carabine was living proof that a Foucauldian DA was possible. Power's (2001) interrogation with the dominant discourses within the domain to health had even more direct application. Following Minichiello, Fulton and Sullivan (1999, p. 37) and Davidson and Tolich (2003) I resolved that data collection and data analysis are best served when these occur concurrently, as is the practice of qualitative research. This prized ideal was not always achievable as momentum was lost through the displacement of my analysis by work commitments.

The seating plan of the participants mentioned earlier, was a valuable prompt that maintained a graphic connection to members of the focus groups. Data from the focus

groups and interview were transcribed verbatim. While awaiting transcription, listening to the audio recordings kept me connected to the talk and provided me with an overall sense of the session. The advantage with the digital dictation machine was that it could be transcribed into a Microsoft word file and read juxtaposed with the audio component. Field notes were scanned for additional cues. The first transcript was something of a trial and error exercise as I grappled with correcting the data, a task that eased with time. Transcripts were then read and re-read in order to become acquainted with the data (Carabine, 2001). From here I began the process largely by intuiting themes and jotting times alongside in the left hand column of the transcript so that these were easily matched to the audio recording for easy retrieval, an instant facility of the Olympus DS-320. Ideas that came to mind when listening to and reading the transcripts, were recorded in the right hand column of the transcripts. Other notations were recorded in diaries or contingently placed on loose sheets of paper and post-it slips, depending where I was in time and space. Colour coded 'post-its' were invaluable for identifying themes in the transcript prior to their tabulation. All things considered, the purpose of these additional sources was to keep tabs on my ideas as they emerged, a practice that became quite unwieldy after a while. Once an idea was securely attached to my analysis, serious culling of what at times seemed endless scrawling, was necessary to give me a sense of progress and the illusion of order.

All transcripts were initially analysed separately. The transcripts of the focus groups were lengthy scrolls and at times consisted of dislocated passages of talk. This affirmed for me that conversations do not necessarily occur in an ordered fashion. The summaries were an important first stage of my analysis in that they helped to assemble and organise my data as well as provide a basis for the second stage of my literature review. Analysis here was rudimentary and descriptive based on the themes that had (re)surfaced. These were supported with excerpts of talk from the transcripts and the summaries were compiled as soon as possible to maintain the recency effect of each session. The summaries were duly sent out with a covering letter to each participant in a stamped addressed envelope, for verification as to their accuracy. Participants were informed that these themes were provisional and would develop over time due to the nature of the data analysis. Members were asked to return the summary of the

transcript within 15 days of the inscribed date, after which I could assume that I had their permission to proceed with data analysis.

The decision to summarise the transcripts was taken in consultation with my supervisors, because these were time consuming and cumbersome documents. I was reminded of the tension Payne (2001) faced over sending verbatim transcripts back at the risk of inducing awkwardness for participants faced with reading them. This became evident in the grammatical corrections to Tom's text when his summary was returned. Participants were however offered the opportunity to read the transcripts should they wish. Suffice to say this offer was not taken up.

Following verification of the summaries, data analysis became increasing more layered with meaning, particularly as I corroborated themes with the literature. Themes were then extracted and tabulated against each focus group interview in order to have an overview of commonalities and differences between and across focus groups. Page numbers of the transcripts were included in the table against each theme for ease of reference when revisiting ideas. Recurring themes identified were clustered into similar meanings. The clusters of meanings formed discursive themes (Huygens, 2001) that came to represent the prevailing discourses that constitute women's choice for a caesarean in the absence of clinical indications and through a process of condensation these themes were coded at an embryonic level before inductively arriving at my sense of what a discourse was, a sense achieved as my knowledge from the literature grew. This phase of my literature search was undertaken both to support these discursive themes and to offer a multiplicity of 'truths' about caesarean as an alternative birth option. I discovered an explosion of discourses since my first incursion with the literature, from both popular and professional sources. The explosion of literature around the topic that had emanated since beginning the study, required extensive indexing of authors and cross indexing alongside the objects that surfaced from the analysis. These sources from the literature were integral to the analysis of the interviews. My discourse analysis is a critical approach and so opens up opportunities for a rigorous debate on how the choice of caesarean impacts on the health of women and the future of maternity services. The discourses of autonomy, convenience, desire, fear and risk were identified from the data analysis.

4. 6. 2. Media Text.

Stories about caesarean, in popular culture, were also considered along with rhetorical devices, in a variety of forms, the appropriation of which invoked different meanings around this birth mode. While the internet was recognised as a growing force within popular culture, at the time of writing this chapter, it was decided to concentrate on those print media distributed to the masses in public spaces, such as display stalls in supermarkets and shop counters, as opposed to those available through cyberspace. In the fullness of time, web-based sources took on greater prominence, and were used serendipitously. For the purposes of this research, popular culture included print sources in the form of daily newspapers and weekly magazines, readily available across the counter of corner stores and supermarkets. Media discourses were varied and contradictory and the purpose of their utility was to examine how the choice for caesarean is represented in these discourses and examine the manner in which they function alongside other discourses to bring about a particular effect. Banner headlines served to intensify interest in the trend for caesarean as an optional extra in the childbearing marketplace (Kitzinger, 2001). The influence of media texts, in the constitution of the choice of a non-clinically indicated caesarean, is woven through Chapters Six, Seven and Eight.

4.7. Disembarkation.

The choice of a caesarean, as an alternative birth mode, was constituted in and through the several prevalent discourses from the texts of women of childbearing age, midwives and a specialist obstetrician, along with the texts of professional and popular culture. The discourses identified highlighted the contention and contradictions that are inevitable undercurrents in a sea of plural meanings. The texts showed a multiplicity of ways for understanding the complexity of caesarean, in the absence of clinical indications. The issue of representing these ‘truths,’ authentically, was an absorbing and reflective task that had become all the more intensified through the pruning required as a function of the editing process.

4.8. Conclusion.

Chapter Four explains how the research was carried out. Inherent in the process is an obligation for the researcher to act ethically. Importantly ethical approval is just the ‘tip of the iceberg’ as potential harm can surface throughout the research process. The historical and socio-political events in Aotearoa New Zealand provide a context for researchers to be culturally safe by addressing the asymmetry of power relations between the researcher and the researched. The methodology chosen makes no claim for a single truth but gives legitimacy to the plurality of ‘truths’ for understanding how the choice of caesarean is constituted in and through the discourses of childbirth. A poststructuralist methodology is an appropriate means of attempting to unravel the meaning of choice of caesarean within the context of subjectivity and the wider discourse of autonomy. A poststructuralist focus lends itself to a variety of ‘readings’ of texts and social practices as well as enabling the complexities and contradictions of the topic to unfold. Sharing ideas with my co-researchers enabled each of us to profit from the synergy of their accounts and has been a humbling, profoundly apprehensive and exhilarating experience. In the next chapter, I provide a portal into the analysis chapters to follow, in the form of an abridged genealogy of the discursive construction of an elective caesarean section, as a choice of birth mode, as it is played out in professional and popular discourse.

Chapter 5: Resurfacing caesarean: an alternative birth mode?

5. 1. Introduction.

From its beginnings, the embattled pathway of caesarean, as uncovered in Chapter Two, is testimony to the struggles for ‘truth’ that surround this social and disciplinary practice. These struggles occur within an historical context and history attests to its grim past. The tenets of the Catholic Church in Europe during the 16th & 17th Centuries led to a disparity in maternal versus infant survival rates between Great Britain and the Continent. Significant in this history and embedded throughout Chapter Two is how the ‘truth’ about caesareans is constituted in historically situated discourses, within a particular socio-political context and contingent upon the particular institutional practices that dominate at a particular moment in time. The current debate around women’s rights versus the rights of their unborn child, can thus be traced back in time, to shed light on the discursive and non-discursive events that have shaped their (im)possibility in the present.

Chapter Five provides a transition into the data analysis chapters to follow. It draws on the ideas in the previous chapters to map some of the events in the 19th and 20th centuries that have set in motion the emergence of caesarean, as a ‘birth’ alternative in the current moment. A deconstruction of professional and popular discourse reveals how discourse, power and knowledge intersect on a number of platforms to bring about their effects. What unfolds is a moment when the will(to)power of a few proponents, competes, co-opts and contradicts, to bring about new ‘truths’ in an attempt to promote the choice for a caesarean as an alluring alternative to vaginal birth. The material conditions that have made this option possible and the discursive strategies utilised in the process are the focus of the discussion. First is a brief ‘history of the present’.

5. 2. The emerging surface of elective caesarean.

Understanding the historical context behind struggles for ‘truth’, provides insights in to how the objects of discourse, for example the choice of caesarean in the absence of clinical indications, have come to be in the present (Carabine, 2001; Powers, 2003).

As revealed in Chapter Three, mapping such a ‘history of the present’ is referred to as genealogy (Carabine). For Carabine “Genealogy is about tracing the history of the development of knowledges and their power effects so as to reveal something about the nature of power-knowledge in modern society” (2002, p. 277). Furthermore as revealed in Chapter Three, objects of discourse are contingent upon a system of rules for their formation. This system is aligned along three planes of analysis; surfaces of emergence, and authorities of limitation and grids of specification (Foucault, 1972). Foucault reasoned that it was necessary to trace the conditions that made possible the emergence of objects when they first appeared in discourse. For this reason the surface of emergence of an elective caesarean in Aotearoa New Zealand has relevance.

As early as the 1890s, within the context of Aotearoa New Zealand, Stenhouse’s (1898) account provided evidence of the emergence of what was believed as the first “successful case of caesarean section” in the country. In so doing, he alludes to a tension between the discursive practice of craniotomy in obstetrics and caesarean sections. His repugnancy of craniotomy opens up space for the first seeds of an elective caesarean to be sown.

Are we justified in destroying a strong and healthy child in utero, when it has been demonstrated that Caesarean section carefully performed will in all probability save both lives? At all events should it not be proclaimed that hysterotomy should no longer be looked upon as *dernier resort*, but should be left to the choice of the surgeon – in other words, should become hereafter an operation of election? (p. 230).

Women’s involvement in decision-making was not evident in texts at this time; being the prerogative of the physician based on what he viewed as in the patients’ best interest, in this case, the mother and child. The surgeon is acting out of beneficence for an otherwise healthy infant, steering a course toward finding a balance between the right to life for both mother and baby. In some institutions however the practice of craniotomy was replaced by the likewise abhorrent practice of a pubiotomy in preference to a caesarean (Mein-Smith, 1986). Spearheaded by Doris Gordon, a Taranaki general practitioner, who engineered the formation of the Obstetrics Society formed in 1927 (Donley, 1998) this practice waned as caesarean gained popularity throughout the 1920s (Mein-Smith, 1986, p. 87). In Aotearoa New Zealand, the first

hint of a debate between caesareans in favour of vaginal birth appeared in medical discourse around 1925. In a paper delivered to the Taranaki Division of the British Medical Association, Gordon (1926) exemplifies the inextricable link between discourse-knowledge-power.

So long we broadcast the idea that labour is a simple natural process, so long will the public evade antenatal attendances and criticise the doctor who asks for assistance in difficult cases. Rather should we disperse the knowledge that, what was once a normal physiological process, has in the onward march of human development been converted into a process that is abnormal and pathological, that even the so called normal case of today is fraught with pain and penalty, that birth and death go hand in hand, and that the least deviation from the normal mechanism calls for the presence of a second doctor so that proper anaesthesia and asepsis may be maintained (p. 69).

Gordon's (1927) text constructs the need for and therefore choice of a caesarean within the discourse of fear of 'pain and penalty' to serve the interest of the budding disciplinary practice of obstetrics and an emerging 'authority of delimitation' for what can be said about childbirth. Gordon, felt that "The matter of public opinion is one of the greatest perils in maternity work in New Zealand" (p. 68). In Gordon's text, her demonising of the public voice becomes an exclusionary strategy (see Hook, 2000, Chapter Three) in the marginalization of birth as a normal process. The context, within which Gordon was speaking, was against a backdrop of a colonialism in which she was canvassing for obstetric specialists in maternity work. For the general practitioner, this would mean protection of his / her professional reputation in the face of negative public opinion should s/he seek assistance 'in a difficult case'. The task for Gordon was therefore to constitute birth as a pathological process in order to sway the colony into thinking that human development must keep pace with technology.

As caesarean gained in popularity, resistance came from Jellet (1927) in his role as consultant for the Department of Health (DOH) in an address to the Timaru branch of the Medical Association (MA). Jellet (1927) expressed concern about the abuse of caesarean which he attributed to ignorance and improper training. At this historical moment, it is evident in Jellet's (1927) text that caesarean has become a site of struggle for budding (obstetric) disciplinary and institutional (DOH) practices.

The abuse of caesarean section in obstetrical practice, and accompanying neglect of well-recognised methods of obstetrics are coming to assume very serious proportions throughout the world generally. The causes are to be found in the ease with which the operation can be performed by anyone who has acquired a general surgical technique. The fact that even in the most skilled hands, the operation – in healthy patients – is followed by the mortality of nearly two percent, and in those who recover the prospects of a future normal delivery are impaired, is overlooked (p. 210).

Jellet's reference to "well-recognised methods", presumes he is referring to craniotomy, pubiotomy and forceps deliveries. His warnings of caesarean abuse and epidemic resonate at a global level today (Barros, Vauhan, Victora & Huttly, 1996; Diniz & Chacham, 2004; Flamm, 2000; Francombe & Savage, 1993).

Jellet's (1927) concerns for the "prospects of a future normal delivery" come to light, some three decades later, in an article from the New Zealand Medical Journal by Dunn (1960), an obstetric specialist and clinical research assistant at National Women's Hospital in Auckland.

An unwillingness to have too easy recourse to caesarean section stems not only from concern at the increased mortality and morbidity but also from apprehension as to problems in the indefinite future. These are mainly the risk of uterine rupture in a subsequent pregnancy and probability that the patient is doomed to have caesarean deliveries thereafter (p. 180).

Dunn goes on to address the implications of the operation for women's reproductive health in the future including "...harmony of married life" (p. 180). Excluded was acknowledgement of the debilitating effects of the procedure for women when recovering from the operation. From the text of these writers is a sense that despite an 'easy recourse' to caesarean by some obstetricians, caesarean was spoken about largely as a surgical intervention, necessary to avoid destruction and death for women and babies. These warnings of the implications of the liberal use of caesarean for future healthy populations, served to be prophetic.

5. 2. 1. The emergence of caesarean as a women's choice.

The construction of birth as pathological (Gordon, 1926) presumes women's faulty biology. Here birth is viewed as a mechanical process in which the female body is akin to a machine, capable of breaking down (Ehrenreich & English, 1978; Kent, 2000; Kitzinger, 1998; Lupton, 1994). The emergence of the term 'prophylactic' caesarean Felman and Freiman (1985) signals a shift from a mechanical to an engineering conceptualisation of the operation, from surmounting problems as they occurred to controlling events so as to avoid the potential for problems (Schwartz, 1990). The term 'prophylactic' caesarean, was first proposed by Felman & Freiman in response to a litigation case in the USA, and exemplifies not only a shift in conceptualisation in caesarean over time, but also is a reminder of how the political context shapes knowledge and, in so doing, draws attention to the fragile and fluid nature of discourse. Nevertheless the debate around unnecessary caesareans in the literature continued throughout the 80s, pointing to some disquiet around women requesting caesareans (Hall, 1987; Johnson, Elkins, Strong & Phelan, 1986).

In the 1990s attitudes began to change with the growing perception that women have the right to elect a caesarean in the absence of clinical indications. More controversial was the active promotion of an elective caesarean, as a birth option, routinely for all pregnant women, in a landmark letter to *The Lancet*. Justification for the promotion of caesarean as an alternative birth mode came under the pretext that obstetricians were choosing the operation for themselves or their partners (Al Mufti, McCarthy & Fisk, 1996).

Sir – In obstetrics in the UK there is an increasing emphasis on patient choice, embodied in the Government document, *Changing Childbirth*. The debate on consumer choice has centred on low technology birth but should logically be extended to maternal requests for caesarean section. There is a general assumption that high rates of caesarean section reflect unnecessary intervention. However we have observed that obstetricians and their partners when pregnant often chose elective caesarean section in the absence of any clinical indication (p. 544).

The letter, introduced in Chapter Two, draws on government documents with regard to consumer choice, long ignored by obstetric discourse, as well as logic to legitimate its

claims. This highly cited, controversial letter has been positioned in some professional journals as authoritative knowledge and was subsequently published in the *European Journal of Obstetrics and Gynaecology and Reproductive Biology* in 1997. It describes a London based survey that canvassed obstetricians' preference for mode of birth, for their first baby, should they have an uncomplicated pregnancy with their first baby. As Chapter Two attests, most astonishing has been the manner in which the results of the study had been embellished to champion a cause. It can be recalled from Chapter Two of the obstetricians who responded (n=206) only 17% (n=33) chose elective caesarean as their preference. The majority (31%) of these were female obstetricians compared with 8% males. Eighty eight percent of the respondents, who chose caesarean as their preferred mode, based their reason on fear of perineal damage, while 58% of these were concerned about the long term effect of vaginal birth on their sexuality. What is of interest is that only 39% were concerned about fear of damage to the baby and 27 % expressed a desire for scheduling the timing of birth. Despite the small number of obstetricians choosing a caesarean (Dickson & Willett, 1999) the results have been reified to represent a significant number of female obstetricians. In their article the following year, Al Mufti et al. (1997) reproduces a similar message.

Our findings have implications for the way obstetricians counsel their patients regarding mode of delivery and for caesarean rates in general. They raise questions of whether caesarean section should be offered to all pregnant women, an option apparently available to all obstetricians. In this era of patient choice, should information regarding the potential benefits of elective caesarean delivery be given to women? (p. 4).

Al Mufti et al's (1996) study alleged that the majority of obstetricians choosing caesarean, did so for fear of the long-term consequences of vaginal birth on sexual functioning. Implied here is either that vaginal birth does not carry a risk for the baby, that some sources would deem (Paterson-Brown, 1998) or that a desire for a perfect interior takes precedence over the welfare of the baby. The publication launched a contentious debate in the literature (Amu, Rajendran & Bolaji, 1998; Bastian, 1999; Kitzinger, 1998; Robinson, 1998) that has continued into the first decade of the 21st century (Bewley & Cockburn, 2003; Wagner, 2000). Also already noted in Chapter Two, a flurry of similar surveys followed. Despite the controversy, Al-Mufti et al's (1996) letter, was a significant turning point in that it brought the debate out into the

open, shifting it from the professional arena into the public domain as is evident in the texts of Coney (2001), Kitzinger (1998), Laws (2004) and Parsons (2003).

5. 2. 2. The resurfacing and legitimating prophylactic caesarean.

Paterson-Brown (1998), a consultant in obstetrics and gynaecology for a large hospital in London, fuelled the debate in her commentary in the *British Medical Journal* under the heading “Should doctors perform an elective caesarean on request”? to which she replied, “Yes, as long as the woman is fully informed” (p. 463). Here Paterson-Brown tends to downplay the risks of caesarean, attributing these largely to those performed under general anaesthetic when a woman is in labour. Greater emphasis is placed on the risks of vaginal birth for women and babies. Drawing from the discourse of autonomy Patterson-Brown links into Al-Mufti et al’s study (1996; 1997) to champion women’s choice:

We should respect woman’s choice if it is fully informed, if she expresses a logical reason for wanting a caesarean section and if she can demonstrate an understanding of the implications of the procedure. We should not be dictating to women what they should think, nor should we be judgmental of their values if they happen to differ from our own.

This does not mean that obstetricians should become technicians at the mercy of women’s choice. But that they should be partners in the process of decision-making. There is no room for complacency with such incomplete evidence, and further research is needed; but on the basis of available evidence the concept of prophylactic caesarean section being outrageous has been shattered by the fact that almost a third of female obstetricians would choose it for themselvesⁱ. Prophylactic Caesarean section can no longer be considered clinically unjustifiable and it now forms part of accepted medical practice (p. 463).

Paterson-Brown’s (1998) misuse of Al Mufti et al’s (1996) statistics; “...almost a third of female obstetricians...” fabricates her (tenuous) case, because of an earlier admission in her text that states “This group [*female obstetricians*] is clearly unrepresentative of women as a whole...” (p. 462). Moreover her subtext privileges expert preference over women’s preference, with the inference that because a third of female obstetricians choose the procedure for themselves, it must be good. Furthermore she has positioned

childbearing women as autonomous individuals, capable of making rational decisions after receiving all the information, a hollow assertion, given the lack of evidence to support the procedure for low risk women (Hemminiki, 1997). The underlying assumption in Paterson-Brown's text is that women can articulate a logical argument after weighing up the evidence as to the risks and benefits of caesarean versus vaginal birth. While Paterson-Brown's sentiments toward women's autonomy are commendable, she reassures obstetricians who fear being repositioned as technicians "at the mercy of women's choice" (1998, p. 463). Although Paterson-Brown (1998) gained some support (Howard, 1999) this was largely offset by the number of counter arguments (Amu, Rajendran & Bolaji, 1998; Zulueta, 1999; Norman, Crowhurst & Plaat, 1999; Stirrat & Dunn, 1999; Idama & Lindow, 1999; van Roosemalen, 1999). Of interest, Patterson-Brown (1998) endeavours to resurface, legitimate and normalise the choice of a prophylactic caesarean, as an object of obstetric discourse.

In a counter argument that followed, Amu et al. (1998) provide a substantial discussion about the risks and longterm consequences for future pregnancies, of elective caesarean, somewhat played down by Paterson-Brown (1998). Amu, et al., are in accord with Patterson-Brown regarding inconclusive evidence around the risks and benefits of each birth mode but are more cautious in favour of vaginal birth.

No proper data exists about the risks and benefits of elective caesarean section versus labour in uncomplicated pregnancies, looking at multiple medical outcomes as well as psychological, social, and economic implications. Obstetricians do not always know best: no doctor can know whether a mother or foetus will be damaged in labour: and current surveillance tests are not always reliable indicators of poor outcome (p. 464).

While these writers too defend women's right to make choices in childbirth, unlike Paterson-Brown they are not convinced that women have a choice, because of what they perceive as lack of evidence and doubt whether women's interests will be served longterm. They conclude with an appeal for the provision of adequate information for women based on the available evidence, about each method of delivery. Significant here, is the first surfacing of a moment when vaginal birth is pitched against caesarean in terms of safety. This is a poignant and prophetic marker for a campaign down the

track to challenge a planned vaginal birth and planned elective caesarean, to a dual in the form of a Randomised Controlled Trial (RCT) (Ecker, 2004; Wax, Cartin, Pinette & Blackstone, 2004).

5. 3. The will to truth.

Al Mufti et al. (1996; 1997) and Paterson-Brown's (1998) pioneering commentaries, unfolds a complex and contentious crusade, of subtle and not so subtle attempts to pitch a planned caesarean against a planned vaginal birth. One subtle attempt, Term Breech Trial (TBT) carried out by Hannah, Hannah, Hewson, Hodnett, et al., (2000) is a case in point. First published in 2000, the TBT, a RCT, set out to measure a range of peri-natal and maternal outcomes, by comparing data from a planned caesarean with a planned vaginal birth, for women presenting with a breech at term (Hannah et al., 2000). The study spanned 121 centres in 26 countries and randomly assigned 2088 women, with a singleton breech presentation, to either a planned caesarean or planned vaginal birth group. The TBT was acclaimed as having bolstered previous similar studies, to become the gold standard of best evidence in making a case for planned caesarean for all breech presentations (Hannah et al., 2000). Its publication in the *Lancet* (2001) received a barrage of responses, signalling an inkling of the controversy that was to follow (Leung & Pun, 2001; Preuru-srsen, 2001; Uchide & Murakau, 2001; Cunha-Fiho & Passos, 2001). The controversy was to continue for another five years (Kierse, 2002a; 2002b; 2003; Hodnett & Hannah, 2002; Walkinshaw, 2003; Bearad, 2003; Fernandes, 2004; Levesque, 2004) with one analysis calling for the withdrawal of the original trial (Glezerman, 2005).

Lumley (2000), one of the first to review the TBT, found the inability to hold constant variations between setting and countries, such as the skill of attendee clinicians with breech presentations and peri-natal mortality rates, posed a problem for the applicability of the overall findings (Lumley, 2000). Despite these methodological flaws, Lumley's (2000) review took a soft line. Keirse (2002a) was not so circumspect. He waited for the "dust to settle" before proffering a somewhat piqued critique. Keirse claimed the trial was biased from the start, particularly when it preordained to give vaginal breech its last opportunity to prove its worth. In a

comprehensive review, Keirse exposes among its methodological flaws, questionable ethical practices in particular with inconsistent reporting of results between publications. His critique was hotly contested by Hodnett and Hannah (2002) who attributed Keirse's antipathy down to the study's findings not being in accord with his own beliefs. Keirse's response was swift. His parody of Hodnett et al. (2002), Keirse (2002b) concludes the dispute.

It is human to uncritically accept results that confirm one's beliefs. It may even be human to adapt the results to conform to one's beliefs. However, when the results of a randomised control trial cannot remain consistent from one report to another, belief should end! (p. 220).

Walkinshaw (2003) in admonishing *Birth* for publishing Keirse's review, takes umbrage at what he sees as serious accusations targeted at clinicians involved in the trial, himself included. His concern appears to have more to do with research etiquette than research critique. Keirse's (2003) retort to Walkinshaw illustrates an important point; the danger of an uncritical acceptance of research, particularly that deemed to be the 'gold standard' of evidence.

The primary purpose of my commentary was to make people sit up and think before agreeing with the Term Breech Trial collaborators that we need similar research to give vaginal birth "*its best, and perhaps last chance to be proven a reasonable method of delivery*"¹ "*even for uncomplicated cephalic presentation*"² (Keirse, 2003, p. 71, authors italics).

As indicated in Chapter Two, a breech presentation clearly represents a relative indication for a caesarean, it is therefore not the intent of the current study to dispute this modus operandi. It is merely to show the struggles and strategies used to (re)position caesarean, in the absence of clinical indications, as an alternative to a normal vaginal birth. It is for this reason that Keirse's (2002a; 2002b; 2003) disquiet is significant. It marks the turning point for 'uncomplicated cephalic presentations' to come under the gaze of an RCT. His concern is reinforced by the fact that Hannah (2002) as the lead researcher of the TBT, co-authored a systematic review for the

¹ Hannah, M., Hannah, W., Hewson, S., Hodnett, E., Saigal, S. and Willan, A. (2000). For the Term Breech Trial Collaboration G. Planned caesarean section versus planned vaginal birth for breech presentation at term: A randomised multicentre trial. *Lancet*, 356, 1375-1383.

² Hofmeyr, G. and Hannah, M. (2002) Planned caesarean section for term breech delivery (Cochrane Review). In: *The Cochrane Library*, Issue 3. Oxford: Update Software.

Cochrane Library, that endorses the need for further research comparing other obstetric complications, “ *even uncomplicated cephalic presentations*” (Keirse, 2003, p.71, citing Hannah et al., 2002). Hannah (2004) inevitably turns her attention toward maternal requests for non-clinically indicated caesarean. Here she co-opts the American College of Obstetricians and Gynaecologists (ACOG) ethical endorsement of an informed choice for an elective caesarean to support her case, whilst acknowledging that most women prefer a vaginal birth .

However, if a woman without an accepted medical indication requests delivery by elective caesarean section and, after a thorough discussion about the risks and benefits, continues to perceive that the benefits to her and her child of a planned elective cesarean outweigh the risks, then most likely the overall health and welfare of the woman will be promoted by supporting her request (Hannah, 2004, p. 814).

Hannah’s (2004) support for maternal request for a caesarean triggered round two of the debate in the literature. One critic (Fernandes, 2004) illustrates the level of contention within obstetric discourse.

It was with utter dismay and surprise that I read Mary Hannah’s commentary on planned elective caesarean section.¹ Given that there has never been any scientific proof of benefit from unindicated surgery, how can the literature for indicated procedures be used to justify our willingness to acquiesce to the wishes of the consumer? []. I find it rather hypocritical that we misuse and contort the literature to justify this approach and then turn around and call ourselves scientists practicing evidence based medicine (p. 13).

Speaking from his position as a forensic pathologist and O&G at McMasters University (USA), Fernandes (2004) alludes to the tenuous nature of evidence around unnecessary caesareans and the dubious use of the literature to serve the interests of certain groups. Autonomy has gained some ground at its juncture with evidence-based practice. Its success for the moment is relative to the ideological struggles veiled behind commonsense notions of choice in childbirth. In the words of Foucault (1978), the success of power “...is proportional to the ability to hide its own mechanism” (p. 86). Fernandes’ (2004) resistance to the TBT is supported by Glezerman (2005) in his follow-up analysis of the trial.

¹ Hannah, M. (2004). Planned elective cesarean section : a reasonable choice for women? CMAJ. 170 (5): 813-4.

In his analysis, which incorporated new findings subsequent to the trial, Glezerman (2005) affirmed accusation of serious methodological flaws, recommending that the original TBT be withdrawn. The future of the “rise and fall” of the TBT has yet to be revealed in the fullness of time. What has been left in its wake is a debate around the need for a RCT between a planned uncomplicated singleton vaginal birth and a planned uncomplicated singleton caesarean (Ecker, 2004; Lavender, Kindom, Hart, Gyte, Gabbay, & Neilson, 2005; Inoue, 2005; Wax, Cartin, Pinette & Blackstone, 2005). Most bizarre has been the co-optation of this trial to justify unnecessary caesareans. The saga has unravelled a ‘will to truth’, at the intersection where the discourse of obstetrics converges with the discourse of empirical analytic science (see Powers, 2001a) to establish a new truth about caesarean, in the absence of clinical indications, co-opting the discourse of autonomy to summon its appeal. What is called into question is the status of knowledge that is attained under the banner of the gold standard of evidence. Such is the nature of the ‘will to knowledge’ that the propagation of ‘truth’ can “...often cause mistaken beliefs or systematic misconceptions to circulate” (Foucault, 1978, p. 12). It is little wonder women’s decision-making in the current temporality, sits at the edge of a precarious moment.

5. 4. The will to power.

Since the controversy triggered by Al Mufti et al. (1996) there has been an interesting regularity in subsequent publications that highlight how Foucault’s concepts of discourse, power and knowledge are inextricably linked in the production of truth. What appear to be seemingly innocuous publications turn out to be a covert attempt to (re)construct reality. Common to these publications is the (re)appearance of two of the key proponents of women’s choice for a caesarean, in the author section. These protagonists are Nicholas Fisk, and Sara Paterson-Brown (1998). Fisk and Paterson-Brown joined forces with another researcher (Cotzias, Paterson-Brown & Fisk, 2000) to canvass the opinion of the wider obstetric community in England and Wales, as to their propensity to perform a caesarean on request. Cotzias et al’s (2000) findings are discussed in Chapter Two. Of interest was the absence of any reference to either of the co-writers in the bibliography section of this study. This has importance, considering

the influence these writers' publications had in shaping the debate around offering caesarean regardless of risk particularly as Cotzias et al's commentary resonates the sentiments of Paterson-Brown (1998). While it is possible that modesty may preclude their mention, germane is 'the said' and 'the not said' (Foucault, 1972, p.28). The 'said' in the small print of Cotzias et al's article, directs correspondence to Paterson-Brown, despite Cotzias' accreditation as first author. Cotzias et al's study reaffirms a moment which symbolises the primacy of women's choice for a caesarean over evidence-based medicine in medical discourse.

This survey demonstrates that a majority of obstetricians are now prepared to agree to maternal request for CS in the absence of obstetrical indications. Accordingly, such agreement or at least acquiescence, cannot be considered medico-legally negligent. Instead, the risk-benefit ratio is changing; research and audit increasingly document the sequelae of labour and vaginal delivery to both the baby and the mother's pelvic floor, and the safety of elective pre-labour CS has improved under regional analgesia with thromboprophylaxis and antibiotic cover. If a well informed woman decides she wants to accept extra risks of CS for the sake of her baby and pelvic floor, our study shows that almost 70% of consultants in England and Wales would go along with her choice (2000, p. 16).

Almost at once there is a contradiction in that while riskiness of caesarean is implied in the publication, well informed women are supported in their risk taking. This begs the question as to whose interest is being served in privileging this risk taking. Embedded within Cotzias et al's (2002) 'will to truth', (Foucault, 1978) 'extra risks' of caesarean' are quickly masked by a 'will to power' (Hook, 2000) in a subtle swerve toward the perils of vaginal birth. An elective caesarean for an uncomplicated pregnancy is given acceptance through 'safety of the norm' whereby an activity is acceptable by virtue of it becoming a routine (Konnor, 1988, in Berg, 1998, p. 170). As such it liberates the obstetrician from the potential of malpractice should things go wrong? Who then gets blamed?

A further (re)appearance of authors Paterson-Brown and Fisk, surfaced two years later in a study by Groom, Paterson-Brown and Fisk (2002) mentioned in Chapter Two. Although the study's aims were to ascertain whether obstetricians' attitudes had changed since the Al Mufti et al. (1996) study, undertaken in 1995, I suspect a

normalising strategy through the (re)circulation in the professional literature. In response to criticism about representing only London-based obstetricians, the study was extended to include obstetricians in the UK as a whole (Groom et al., 2002) and found that obstetricians' attitudes had not changed. Despite the findings representing a small sample of the population of obstetricians in the study, Groom et al. (2002) detract from this methodological flaw, by corroborating with a commentary about obstetricians' preferences, solicited during a conference in America, that depicted 46% of obstetricians would prefer elective caesarean (Gabbe & Holzman, 2000).

Another tactical ploy to ripple around the world was a prediction by Fisk (2001) at an international conference, that around half of all women will choose a caesarean by 2010 (Coney, 2001; Johnston, 2001; Parson, 2003). Spilling over in to popular culture it had the effect of creating a new object of consumer discourse, a tangential discourse (Powers, 2003), designed to strengthen the materialisation of caesarean as a birth mode. More recently, in Fisk's co-optation of the media for the (re)production and (re)circulation of a new truth about caesarean emerged a new (re)construction, the 'natural caesarean'.

5. 5. The Naturalizing of Caesarean: Every bit as magical.

The appropriation of one discourse, generally a marginalized discourse, has been described elsewhere, and is known to be a discursive strategy by the dominant group to reposition its control over a field of play such as childbirth (Arney & Neil, 1982). Such a strategy was revealed in a press release that appeared recently in the British press, *The Guardian* (Morehead, 2005) and represents a historical moment for the normalisation of the choice of caesarean, in the absence of clinical indications. The article entitled, "Every bit as magical" uses the rhetoric of natural birth to invoke images of the splendour and magic of a caesarean. The subtitle of a press release was in itself revealing: *A British doctor is challenging convention to pioneer the 'natural' caesarean. Joanna Morehead watched one baby's slow and gentle arrival.* The subtitle of the text positions a British doctor (Fisk) as an expert to bolster the story's newsworthiness. The concomitant use of two diametrically opposed discourses are

blended together to gain appeal with a wide audience of readers. Morehead sets the scene in the first paragraph.

The scent of lavender fills the air and classical music is playing quietly. On the bed Jax Martin-Betts, 42, is calm, focussed and in control. With the birth of her second child just minutes away, the midwife Jenny Smith, is giving her a massage. Her husband Teady McErlean, is whispering words of encouragement: just a tiny bit longer, and our baby will be in our arms.

It could be a natural birth at any unit in Britain, but we are in an operating theatre at Queen Charlotte's and Chelsea hospital in west London, and the birth we are about to witness sounds a contradiction in terms: a "natural" caesarean (p.1/4).

In this tactical polyvalence, the seductive tenor of the text has the intent of luring the unsuspecting reader into the world of magic. Its not-so-satirical literary genre, is a carefully constructed account, situating caesarean, the pinnacle of childbirth intervention, as a natural event. More than this, it constructs caesarean as a romantic event. The text draws on the neo-liberalist discourse of autonomy to position Jax Martin-Betts as in control. Jenny, the midwife is positioned as witch, channelling the magic that encodes a natural caesarean within the symbolism of lavender-scented-classical-music- room, with a massage to boot. An interesting paradox lies beneath the text in that while it draws on the discourse of natural birth, it concomitantly positions natural birth on the margins. Its lowly location signified through the use of the adjective 'any' to maternity unit. By implication a natural caesarean is positioned in an elite setting, the prerogative of the privileged. An irony here is that midwives have been traditionally demonised in the dominant discourse of obstetrics and through the rhetoric of magic. Foucauldian feminists (Fahy, 2003; Lupton, 1999; Sawicki, 1991) would proffer Jax, as being entrapped between the technologies of power and the technologies of self in that a deal has been reached between her desire for a natural birth and a disciplinary power that has rendered her 'docile' body useful in providing knowledge about a natural caesarean.

An adept explanation of the procedure follows. It is well articulated to reflect the knowledge of a skilled technician that appears to go above and beyond the call of duty for the popular press. Getting the media on side is premeditated ploy, because in this particular discourse, such a 'facticity' comes without challenge (Wilkinson &

Kitzinger, 2000, p. 421). In reading Wilkinson and Kitzinger, it would appear that Fisk's narrative within the text is a well fashioned 'work up' with the intent of persuading through demystification and thus putting caesarean, within women's reach. The discourse of the media has become a new surface of emergence for making statements about caesarean and it would appear the targeted audience would be those with a privileged right of entry to the institution in which the event took place. Following the description of the operation, Morehead (2005) continues with an even more redolent tone:

This groundbreaking approach to surgical delivery – Fisk calls “skin to skin caesarean” or “walking the baby out” – has been pioneered by him partly in response to the rising caesarean rate, which according to recent statistics reached a new high at 22.7 % (of deliveries in England, 2003-04) (p. 2/4).

The use of the metaphorical device such as 'walking the baby out' conjures up and exploits every parent's dream to see their baby's first steps. The article constructs “skin to skin caesarean” as a breakthrough, as if Fisk is opening up a new terrain, when in fact the midwifery literature has been calling for skin to skin contact, initiating breast feeding and generally greater opportunities for parents to be involved in a caesarean for over a decade (Coggins, 2003; Churchill, 1997; Hillan, 1993; Rowe-Murray & Fisher, 2002). The following passage from Coggins (2003) corroborates these sentiments in midwifery discourse.

Advocating women's choice is central to the midwives role,^{1, 2} yet women requiring caesarean birth often feel choices have been taken away from them^{3, 4}. Many choices available to women in normal labour are equally relevant to women undergoing a CS. For example, it is still possible for a woman to determine the sex of her baby for her self. Also providing she is receiving regional anaesthesia and is therefore awake she may also hold her baby immediately and initiate skin to skin contact or feeding, although this is dependent on the baby's condition^{5, 6}. (p. 77)

¹ United Kingdom Central Council for nursing midwifery and Health Visiting.

² Gibbins, Thompson (2001).

³ Wagner (2001).

⁴ Clement (1995).

⁵ Carrucan (2001).

⁶ Rowe-Murray & Fisher (2002).

Silent in Morehead's article is the contingency of the baby's condition. Fisk does offer a commentary on the disparities between couples experiencing normal childbirth and couples undergoing caesarean. He too reinforces midwifery and childbirth advocates by presenting opportunities for greater parental participation during the procedure. Fisk challenges the rapidity with which babies are delivered in conventional caesareans.

Obstetricians are too hung up on getting from the point of incision to the birth of the baby as quickly as possible: that's been the benchmark of a skilled surgeon. But I'm challenging that because from the baby's and from the parents' point of view, it is not very helpful (cited in Morehead, 2005, p. 2/4).

Fisk is co-opting natural birth and midwifery discourse in advocating for a greater involvement for women and their partners undergoing caesarean while challenging his colleagues to do the same. The power analytic here is the co-optation of a marginalised discourse and its incorporation into the dominant discourse (Arney & Neil, 1982; Powers, 2001a). Powers unfolds the effects of power operating in this field of play.

When marginalised discourses come under the scrutiny by more powerful discourses, the possibility exists that they may be co-opted into the dominant discourse. Sometimes marginalized discourses are co-opted without much alteration, in which case they may be said to have been *incorporated*. On the other hand, the marginalized discourse may undergo extensive alterations by being co-opted, which renders it completely sterile as an alternative subject position available to people (2001a, p. 62, author's italics).

Furthermore, Powers (2001a) points out that when meaning is ascribed to an object of discourse there is an assumption that there was no meaning prior to this ascription. On the surface commonsense would accolade this 'naturalising' of caesarean as a breakthrough in the humanising of what has been conceived of as a dehumanising process. The beguiling imagery of "Every bit as magical" has the force to lure women into the romanticism of a caesarean. While there may have been good reason for Jax Martin-Betts to have a caesarean, it is in this field of play that the discourse of the media and obstetrics draw from the discourses of the natural and the romantic culture to give caesarean greater appeal. The effect is to beckon in the possibility for consumer demand for this 'naturalised' birth as a matter of choice. In this historical moment, caesarean has become the product of an orchestrated nexus of social and disciplinary

practices; the linchpin between a woman's desire for the natural, symbolised by all the trappings of magic and romance, and the creation of a new form of knowledge attained through women's 'docile' bodies. Within this contestable terrain, Fisk endeavours to compete with his peers to constitute new knowledge of caesareans. It has attained legitimation through the media which will ensure it ripples into the wider culture where it will be (re)produced in the social practice of childbirth.

This split in the governance of what counts as the truth about caesarean is central to Foucault's analysis of discourse (Hook, 2001, p. 524) where caesarean has come to represent the contested and shifting terrain of 'truth' within the discursive practice of obstetrics. Hook's reading of Foucault around how truth is willed exemplifies how new knowledge is possible.

'The will to truth' (the way in which knowledge is put to work, valorised, distributed) makes for a vital component in the workings of a successful discourse, and as such a nodal point of analysis. The strongest discourses are those that have attempted to ground themselves on the natural, the sincere, the scientific – in short, on the level of the various correlates of the 'true' and reasonable (p. 254).

In the context of the previous discussion, Fisk's downward co-optation of the natural, to support an emerging discourse, has relevance to Hook's assertion about how truth is willed. The material effects of 'the will to truth' lay down the conditions of possibility for caesarean to take on a new meaning. This new knowledge about caesarean has been enabled by hooking in to the discourse of popular culture and natural birth. Its success has yet to be determined, yet it has the hallmarks of accomplishment. What is evident in the naturalising of caesarean is the cosseted nestling of rhetoric back into arms of empirical science.

5.6. Conclusion.

Chapter Five has uncovered a complex array of strategies that have brought to the surface the possibility of a non-clinically indicated caesarean, as a new object of obstetric discourse. Highlighted, is how discourse, power and knowledge are tied inextricably in the production of truth. In the pursuit to construct caesarean as an alternative to vaginal birth, the 'will to truth' has been deposed by the 'will to power,'

contingent upon the material conditions of its possibility. These events have taken place over time and on number platforms. Foremost is the construction of childbirth as a pathological event and an inference of women's faulty biology. Moreover, as the safety of the procedure improved, so too has the confidence of clinicians to perform it. With the relative safety of the elective caesarean compared to the risks of an emergency one, came the notion of prophylaxis through a tactical polyvalence with the discourse of obstetrics, litigation and risk management. Under the banner of autonomy and an ideology around the 'safety of the norm,' the promotion of caesarean has spilled over into popular culture. Essentially, women's choice has taken primacy over risk. New risks are brought into play and the media is wooed into a campaign awash with rhetoric and co-optation. In this precarious moment the status of a planned vaginal birth hangs in limbo. How the 'readings' of women's, midwives' and an obstetrician's talk are woven into this convoluted tapestry are the focus of Chapters Six, Seven and Eight. It is to the construction of choice through discourse of autonomy that is the focus of Chapter Six.

Chapter 6. The Discourse of Autonomy.

6.1 Introduction.

The discourse of autonomy was identified in this study as an over arching discourse from the talk of women midwives and an obstetrician. The concept eludes attempts at operational definition and measurement, due to its intangible nature (Keenan, 1999). Despite this ambiguity, efforts to fix the concept continue. Keenan defines autonomy as, "...the exercise of considered, independent judgement to effect a desirable outcome" (p. 561). With regard to the current study, this definition implies an inextricable link between autonomy and choice, in that, in effecting "a desirable outcome," that is choosing a desirable birth mode, choice is predicated upon an informed decision. Jones's (2000) definition, of autonomy as; "The capacity to be rational and in control of liberty and freedom" (p. 177), assumes that individuals are capable of self-government, free to act in their own best interest, provided interests do not encroach on the interests of others (Johnstone, 2004). Again, in the context of the current study, following Johnstone, autonomy intersects with moral discourse to position childbearing women as "autonomous choosers" (p. 38) capable of making rational decisions about their birth mode. Choice therefore speaks through the discourse of autonomy.

In health care settings, autonomy finds its expression in claims to certain rights to which health service users are entitled (Johnstone, 2004). These entitlements can be negative rights, in that a consumer has the right to refuse an intervention such as a caesarean; or can be conceived of as positive rights that imagine a right to demand an intervention (Bewley & Cockburn, 2002; Minkoff, Powderly, Chervenak & McCulloch, 2004; Wax, Cartlin, Pinette & Blackstone, 2004). A poststructuralist understanding proffers that objects of interest to a discourse such as autonomy, are fluid in nature, are historically specific, within a particular socio-political context and as such meanings are destined to change with time (Weedon, 1997). Weedon's analysis infers power relations and institutional practices, as being implicated in the creation of the self. These networks vary with time and place and it is for this reason

that the subject, within poststructuralism, is considered to be in process, changing, fragmented, even contradictory (Weedon). The contradictory and fragmented self is thought to come to light at the intersection of multiple discourses and discursive practices. In this chapter I argue how women's choice reflects their discursively constructed subjectivity within the complex, contentious and contradictory discourse of autonomy. I show choice of birth mode, birth place, practitioner, decision-making are contingent upon adequacy of information, and the impact on the media emerged as essential elements of autonomy and support these ideas from the professional and popular literature. I also argue how commonsense ideals of autonomy blur the manner in which the choice of an unnecessary caesarean is represented and in whose interests its valorisation serves. First is an overview of autonomy along with its blurry permutations.

6. 2. Resurfacing autonomy: I choose therefore I am.

In consumerist discourse, Massumi (1993) parodies Descartes' axiom "I buy therefore I am" (p. 7) as a testimony to how consumption safeguards the individual as an existential being, well into the future and beyond. Massumi's thespian stance has reverberations closer to home in the choice of a "designer delivery". In offering a caesarean as a birth option for their consumption, women's fear of the unknown (a condition of groundlessness) is eased, 'I choose therefore I am' becomes the motto against the wider discourse of libertarian humanism and in choosing a caesarean, women are guaranteed unity with self within the (re)productive market.

Ethical discourse reads autonomy as an adjunct to responsibility and confers moral agency on the individual in that having the freedom to exercise autonomy is a good thing (Draper, 1998; Lindbladh, Lyttkens, Hanson, & Ostergren, 1998). Jones (2000) is careful to distinguish between freedom and autonomy. For example if we were to apply her distinction to earlier discussions with regard to the sovereign individual of the enlightenment, Rousseau's self-sufficient individual could act freely, while Kant's rational individual would account for 'his' behaviour. It can be assumed from Jones' (2000) distinction that the autonomous individual has the freedom to act, so long as they are accountable for their decisions. Premised here is that autonomy is a universal

concept shared by those who have the ability to account easily for their decisions (Johnstone, 2004).

In the current research, in relation to autonomy one reason why women would choose a caesarean, for no clinical reason, was simply stated as;

.. it's just choice. It's just like any other choice (WFG2, p. 8¹).

The statement positions choice as a taken-for-granted edict and reflects the degree to which the discourse of autonomy has become naturalised within society through commonsense (Weedon, 1997) notions of choice. A plurality of meanings emerged, disrupting notions the choice of a caesarean as a universal concept. For some participants the choice was viewed as a privilege, in that those who choose it should pay for it. Another conceives choice as a positive right and therefore should be available through public health. These opinions are implied in the excerpts to follow.

And that it's all choice. I don't think it's a choice. If you've got no need, why is that a choice you're allowed? I think if you want it you should pay for it. Sorry. (MFGDHB², p. 9).

I think people should have the choice, but if you want to opt for an elective caesarean then you should fund it yourself (WFG1, p. 11).

If they want to make that choice, personally I feel they should pay for it (WFG2, p.23).

Why should you be penalized for wanting your caesarean against a natural birth. Who is to say that my reasons aren't really as justified? (WFG2, p. 30).

It therefore stands to reason, women's right to choose a caesarean, as a birth mode, has become a vexed question in a wide range of literature sources (Bewley & Cockburn, 2002a; Kitzinger, 2001; Minkoff et al., 2004; McFarlin, 2004; Weaver and Stratham, 2005). Rights discourse would claim, in the interests of autonomy, that practitioners have a duty to respect a woman's request for a caesarean in the absence of clinical

¹ An explanation for focus groups truncation is provided in the glossary and abbreviation section in p. xi of this thesis. For example WFG2, p. 8 represents womens' focus group 2 on page 8 of the second womens' focus group transcript.

² MFGDHB represents midwives focus group of midwives from the DHB.

indications. However there is no legal obligation for a health care professional to provide a caesarean, in the absence of clinical indications, simply because of the limited evidence to support the practice (Bewley & Cockburn, 2002a; FIGO, 1999; Minkoff et al., 2004).

Feminist theorists take issue with modernists' notions of autonomy based on rationality because of its propensity to universalise all women, ignoring differences based on cultural, gender and class (Johnstone, 2004; Edwards, 2004). Many argue that the concept of rationality emerged during the 'age of reason' and was attributed mainly to men (Baier, 2000; Diprose, 2000; Johnstone; Parker, 1997). Baier (2000) ponders whether in fact autonomy was intended for women. Citing from Kant's *Metaphysics of Morals*, sec. 46, she ponders, "What did Kant, the great prophet of autonomy say in his theory about women? He said they were incapable of legislation, not fit to vote, that they needed the guidance of more rational males" (p.93). Moreover, commonsense notions of choice tend to mask power relations veiled behind its constitution (Aubury, 2000; Kitzinger, 2001; Weedon, 1997). Both Aubury and Kitzinger draw the reader's attention to the way in which the language of choice has become commodified and appropriated, in the interests of self-serving groups in society. Implicit in discourses promoting the choice of caesarean as a birth mode for no clinical reason (Al Mufti, McCarthy & Fisk, 1996; Cotzias, Paterson-Brown & Fisk, 2000; Paterson-Brown, 1998; Steer, 2001) is an alluring appeal to competence in decision-making.

Crowe (2000) nicely depicts the link between neo-liberal economic discourse and the enterprise of autonomy in the constitution of the self within a wider network of power relations. For Crowe neo-liberal economic discourse requires the individual to be economically (re)productive in order to contribute to society. In so doing individuals are expected to conform to a unitary and stable norm of a self, in order to govern one's activities and subject positions. These demonstrations of restraint are enacted upon the body to bring about docile bodies that are of use to society. As individuals learn to self-govern, overt force is unnecessary. Personal desires come into line with social values, so long as the individual is a rational and reasoned thinker, capable of an idiom that is both literal and objective. Crowe offers, those who fail to conform to such norms are rendered irrational. Her thesis provides insight into why childbearing

women desire to conform to social norms of rationality. Not to do so would render them irrational and position them as irresponsible, lacking in self control.

6. 2. 1. Women and babies: A fragile autonomy.

As presented in Chapter One, In Aotearoa New Zealand, the right of consumers to make informed choices has been sanctioned in Right 7 of the Code of Health and Disability Services Consumer Rights, 1996. Under clause 1 of the Code, health service providers have a duty to give effect to those rights. More specifically, these rights have been affirmed in the service specifications under Section 88, of the New Zealand Public Health and Disability Service Act, 2000, for childbearing women. Then again Right 4 (3 & 4) of the ‘Code’ respectively asserts that consumers have the right for service provision to be in accord with their needs and “...in a manner that minimises the potential harm to, and optimises quality of life of, that consumer.” (Health and Disability Commissioner, 1996). The extent then, to which this autonomy is secured, rests for the moment uneasily within the discursive practices of childbirth.

Weaver (2002) alerts us to the fact that autonomy in childbirth cannot be taken for granted. Where women exercise control over their childbearing experiences, they are often positioned as forfeiting the interests of their babies for their own ends. As such childbearing women, Weaver indicates, are not entitled to the same rights as other adults. This tension came to light during the O & G’s (Tom) interview to reflect the convergence of the discourse of autonomy with the discourse of maternal foetal medicine.

When you talk of autonomy, you’re talking about the Georgetown mantra of ethics; that would be autonomy, justice, benevolence and non-maleficence. If you can address these, and the main one [in this context] is autonomy. We are going to have to consider autonomy of the mother versus autonomy of the foetus. And that is an ethical debate, that the foetus has no autonomy. So, it is really looking at maternal autonomy in the form of requests (Tom, p. 10).

Within Tom’s text an ethical debate unfolds between the rights of a woman and the rights of her baby. While the debate currently is not justiciable, women and babies are

positioned as separate entities, each striving for their own autonomy. The effect of this representation places women and babies in a competitive alliance (Kitzinger, 1999). Such an adversarial positioning highlights the fragility of women's autonomy and should serve as an ominous sign for women in the light of the American experience of court-ordered caesareans, often constituted upon dubious grounds (Irwin & Jordan, 1987).

Poststructuralist feminist discourse (Weedon, 1997) confronts the notion of separation and autonomy, in relation to childbearing women, (Kent, 2000; Schmied & Lupton, 2000). Schmied and Lupton (2000) argue that the notion of the human subject as a separate entity ignores the fluid nature of the relationship between the woman and her baby. Drawing on the work of Shildrick (1997) and Young (1984), Kent (2000) also makes a case for how the pregnant woman contradicts notions of autonomy and individualisation, because the boundaries between the inside outside of the body, during pregnancy, have become blurred. Fragmentation, has become central to the experience of being pregnant and it is possible for a woman to simultaneously view herself as herself and yet not herself (Kent, 2000, p. 199; Schmied & Lupton, 2000, p. 38).

From a health policy perspective, Lindbladh et al. (1998) have put forward a convincing argument that both autonomy and responsibility are moral standpoints representing privileged positions in society. The privileged position of autonomy is evident when certain behaviours are censured over others (Lindbladh et al., 1998). These writers reveal the appropriation of autonomy to justify a certain ends in the interest of dominant values, as is evident when risks for women in the higher socio-economic groups tend not to be subjected to the same moral condemnation as women of lower socio-economic status. Draper (1998) too alludes to a paradoxical relationship between autonomy and safe decision-making, in that a competent individual can take huge risks provided that they understand the nature of those risks.

In Chapter Four, the construction of caesarean as an alternative birth mode, revealed a complex and tactical means of how discourse-power-knowledge are inextricably linked to the production of truth. Foucault (1984a) proffers that seeking the social, occupational and political positions held by those who claim the right to say what

counts as the truth, was important for understanding the context of these truth claims. For example, the shift to championing women's choice from a paternalistic stronghold is seen by Coney (2001) as selective and contradictory.

Doctors have not exactly proved passive in other areas of medical practice, why the submission to women's demands here? They have actively discouraged water and home birth, rather than supporting the Holy Grail of "choice." The argument that doctors are just the instruments of the will of women does not stack up (Coney, p.C6).

The subtext of Coney's commentary, suggests a tendency by some obstetricians, to warp the logic of decision making, when choosing a caesarean for no reason other than choice. Acquiescing to women's demands has the potential to both normalise this mode of birth and marginalise women who choose a home and or water-birth. Moreover there are possible implications in future, for women who choose a vaginal birth regardless of setting. This privileging of one option while disregarding another overshadows a contradiction as to who benefits from the language of choice, when there is no equipoise.

Libertarian values of freedom and autonomy were evident within the women's talk in a variety of forms, some convoluted and circumspect. This is captured in the text of one member in WFG2.

...it is a personal choice whether you decide if you want to have an epidural, or you decide that you want your baby at home or in the car, or at the zoo, or whatever. Do you know what I mean, but when it comes to electing to have a caesarean, then we need to say 'do you realise this is not really the best option?' Think about it. Maybe there's a way of saying to these people, talk to someone who has had a caesarean and see what the experience is like. (WFG 2, p. 28).

Inherent in this text is a convergence of the discourse of autonomy and the discourse of empowerment. Initially the choice of where to have a baby has been trivialised to maintain the remnants of freedom of choice around birthplace, not necessarily limiting it to a hospital. A salutary tenor follows, questioning the validity of caesarean as an alternative and beacons women to access other women's experiences. In light of Irwin

and Jordan's (1987) analysis of court ordered caesareans, this guidance has profound implications for women's autonomy. Irwin and Jordan indicate that pregnant women are an isolated group, because they lack the support of a collective organisation when compared to a well organised collectives, in this situation, hospital professionals. "It is this community and not birthing, women that determines the structure of childbirth and the acceptable practices" (Irwin & Jordan, p. 328). Women's right to refuse an intervention such as a caesarean is abolished, along with their fragile autonomy.

6. 3. 1. Choice of birth place.

Emergent from WFG1 was the issue of privatising maternity care so as to accommodate a range of desired options for giving birth. One woman proffered a solution as a consequence of her dissatisfaction with her hospitalisation.

I'm kind of hoping that eventually there will be a way for women to have the financial means and want to be able to have their babies in a private hospital [...] so putting aside the issues around user pays and access to those kind of things, I think that something's missing in the current arrangements...(WFG1, p. 14).

Such a facility was viewed as alleviating strain on the current health system by leaving public facilities free for those who need them. Here autonomy intersects with the discourse of neo-liberalism to increase the availability of choice in the childbearing market. While what appears to be sound commonsense on the surface, this may not necessarily have the desired outcome in a market driven economy. Such a system has implications for 'moonlighting' where private specialists divide their time (unevenly) between the two sectors (Dew & Kirkham, 2002). Dew and Kirkham found waiting lists to be longer in regions which incorporate private facilities.

In relation to childbearing women in this study the desire for private maternity facilities is an expression of their lifestyle choices and expectations around consumption (Ryan, Carryer & Patterson, 2004). Liamputting (2004) argues higher rates of caesarean were found among middle class women and substantiates Roberts, Tracy and Peat's (2000) findings that the resources available to middle class women

for example, rendered them greater access to private doctors and ironically more susceptible to interventions.

Different preferences for models of care revealed a polarisation between midwives and O & Gs, during a discussion in WFG1 with regard to having out-of-hospital units run by midwives for women desiring a natural birth.

...so I think the trouble with that [birthing unit] model is, with the best of intentions things don't always go to plan... (inaudible)... and that may limit your options. Where as I would much rather see a more comprehensive unit where you have obstetricians and midwives. I get really sick of this polarisation...(WFG1, p. 17).

Paradoxically a birthing unit, in midwifery discourse, is thought of as enhancing birth options, whereas in women's talk such a setting was considered as limiting choice. Midwives and obstetricians are constituted as adversaries within the field of play of childbirth. Current evidence from a Cochrane review provides a more positive account of out-of-hospital settings (Hodnett, Downe, Edwards & Walsh, 2004; Olsen & Jewell, 1998). Banks (2000) proposes that despite the abundance of evidence endorsing, for example, the safety of home-birth for 'low risk' women, the issue remains polarised and that these polarities have more to do with the maternity provider's ideology of birth, than with the principles of science.

In WFG2 the relationship between hospitalization and intervention was represented metaphorically in a similar debate around birth place.

(WFG2m 1¹) Once you get into the system, it's very easy, all the intervention is there, it's very easy to just take whatever you can get and they offer you pain relief and you say, yes I'll have pain relief. You're on the slippery slope then.

(WFG2m 2)...why do you say that you're on the slippery slope?

(WFG2m 1) Maybe just the snowball intervention, one intervention usually leads to another. If you have electronic foetal monitoring you are three times more likely to have a caesarean than if you don't have it.

¹ The meaning for the notation WFG2m1, WFG2m2 and WFG2m3 is provided in the 'Glossary and Abeviation' section of this thesis on p. xi. For example WFG2m1, WFG2m2 and WFG2m3, denotes focus group member 1, 2 & 3 in an interaction.

(WFG2m 3) Do you think it's because the people that are there to assist birth lose their nerve. They think there might be something wrong so I'll [sic] intervene, whereas if they were at home they wouldn't have the option and they would think of another way to manage the matter (WFG2, p, 19).

Here the slippery slope is a metaphor used to describe the cascading impact of intervention that WFG2m3 believes to be a consequence of hospitalisation. The interaction is significant for highlighting the manner in which these women have (in)formed their knowledge from within the social context of the focus group and was emphasised by Wilkinson (1998) in Chapter Four. As the interaction unfolded so too did questions of practitioner confidence. The trajectory of the knowledge to emerge from in WFG2 has been corroborated in the literature with regard to birth in hospital, as mentioned above, and is not limited to public institutions. An Australian study by Roberts, Tracy and Peat (2000) in which obstetric intervention rates between private and public obstetric facilities were examined, found that intervention including caesarean rates were significantly higher in the private facilities than public ones for the same cohort of low risk women.

6. 3. 2. Choice of care giver.

Midwives and specialists were positioned as adversaries in the text of women's talk. This state of affairs can also be traced to popular culture, such as Time Magazine, in which rhetoric associated with military themes, 'Battle Over Birth' (James, 2004) 'Maternity Wars' and 'Hail Caesar' (Time Europe, 2004) epitomise how the choice of a non-clinically indicated caesarean has become a war zone of competing interests. Shared care arrangements between midwives and obstetricians were constructed as desirable in the talk of the women who contributed to the focus group discussion. Obstetricians were believed to offer greater options than midwives who catered for normal birth. Implicit here is the juxtapositioning of choice with technology. It was for this reasons that one woman in focus group 2 believed that the current system of a midwife as LMC had narrowed down women's choice in maternity care.

Some women were capable of “sussing” out a sympathetic obstetrician whom they felt would comply with their choice for mode of birth. Such a discursive strategy was both suspected and affirmed in the following interaction.

(WFG2m1) I also wonder these days whether women who decide early on that they want an elective caesarean get themselves an obstetrician who is sympathetic and [] it might be for some other reason, but really it's an elective caesarean and they get that on the public health system.

(WFG2m2) I purposely made sure that the doctor was going to be sympathetic if I decided.. So yes I can see that women would do that (WFG2, p. 24)

The construction of a ‘sympathetic’ obstetrician who is complicit with women’s requests for caesarean as a birth option was a product of WFG2. Similar motives have been affirmed in research by Behague, Victora and Barros (2002) who argued that some women, particularly women with socio-economic power, align themselves with highly medicalised childbirth, largely because they perceive it to be of superior quality. Indeed these sentiments are affirmed in the self-employed midwives’ talk.

I don't know if those [affluent middle class] women actually choose midwifery care or if they go straight to a consultant. I can't imagine why they would come for care (MFGSE¹, p. 3).

Implied in the above text is that (those) women who request a caesarean, as a matter of choice, are positioned in the text as middle class and assumed to have easy access to obstetric specialist care, in preference to total midwifery care. These sentiments are congruent within the analysis of women’s talk and embedded throughout the popular media. Obstetric care is awarded a status beyond midwifery care, the latter being toppled in a contested and shifting terrain of preferences.

Choice of birth attendant is known to have an impact on the choice of a caesarean (Francombe & Savage, 1993; Roberts, Tracy & Peat, 2000). Who is leading the charge is a topic of contentious debate in professional journals and explicitly expressed in the following texts:

¹ MFGSE is a truncation of midwives focus group comprising of self-employed midwives.

I've purposely gone to a specialist because I feel I can say, I want a caesarean or I want to try and have a natural birth. I haven't made that decision yet (WFG2m1, p. 6).

While on the other hand the influence of the obstetrician is overt.

Every second week that I go to my specialist it's "...are you having a caesarean or a natural birth?" [] I haven't decided. Time will tell (WFG2m2, p. 6).

Studies that have examined the risk profile for caesarean, have found that despite there being a decrease in risk profile of women, for caesarean over time, caesarean rates continue to rise, implicating factors beyond the population of childbearing women, such as obstetrician and institutional features (Bailit, Love & Mercer, 2004).

Notwithstanding these revelations most members of the women's talk focus groups tended toward a preference for natural birth but generally agreed that a private option for those who can afford to pay was important. Women, it was asserted should have the right to choose the care they want if they are able to pay for it. Even better would be the notion of co-payment to facilitate this choice. In the following conversation a tension surfaces between proposer and resistor of such a proposal.

(WFGm1) I'm quite happy to pay \$1800 to an obstetrician for the care I get because I'm quite happy with it and comfortable with it. I'd really get pissed off if someone said no, you do not have the right to choose how you get the care you want. Now I find that really communist.

(WFGm2) I just find that it pushes the prices up, you know. I think it's inevitable. Because if women are prepared to co-pay, then why would you provide that service to a woman who didn't have the means to make an additional payment? And I think that's really ...it allows the obstetrician or provider to basically set their own rates...(WFG2, p.26).

WFGm1 epitomises the constitution of the sovereign consumer against the wider discourse of neo-liberalism. Not to have choice is tantamount to communism which by implication is positioned as the enemy of neo-liberalist ideology. The effect of this

positioning is to invoke a political panic. WFGm2 takes on an egalitarian stance in an attempt to both assert and assuage the precarious self governing subject.

The desire for private maternity services brings to light Tudor Hart's (1971; 2001) "Inverse Care Law" an edict that refers to the manner in which the availability of services are accessed by those least in need of them, yet accessed least by those with the greatest needs. This law has considerable utility for childbearing women, given that the majority of childbearing women are healthy adults. Tudor Hart has implicated neo-liberalist ideology behind the construction of market driven medicine in delivering its services. "The inverse care law is not a law of nature but of dehumanised market economics." (Tudor Hart, 2001, p. 19). Tudor Hart is adamant that neo-liberalist economic policies, notwithstanding the public sector, have achieved little in the way of health gains. Market forces ideology is to be suspected when healthy women choose caesarean for no clinical reason, particularly as studies implicate institutional and obstetric practices behind the rising caesarean rates as opposed to the characteristics of the population they serve (Francombe & Savage, 1993; Bailit et al., 2004; Lee, Khang, & Lee, 2004).

Fougere (2001) identifies a confusing moment in the history of Aotearoa New Zealand's health reforms, as the government endeavoured to weave the threads of market forces into the fabric of its public health system. It is against this field of play, that consumerism became a hot bed of courtship, contention and contradiction (Fougere, 2001). Public outrage occasioned a rethink that led to new forms of organisation and pressure to return to egalitarian ideals. One of the unintended consequences of this strategy was the contending of new and enterprising opportunities for doctors. At the frontier of public and private interests, the borders had become hazy "...introducing new issues of accountability for the 'private' deployment of 'public' money" (2001, p. 1240). Signalled here is the positioning of autonomy and consumerism in an uneasy dynamic with consumers lulled into a false sense of autonomy through the discourse of the market. Both Grace (1991) and Powers (2003) bring to light how that in the construction of the subject as a consumer and health as a product, two unlikely discourses come together to simultaneously empower and control the customer. For example in summoning the consumer of health services into the discourse of health promotion, consumers are positioned as

empowered subjects, free to make (healthy) lifestyle choices. These choices are in compliance within the economic goals of the dominant discourse of health management (Grace, 1991; Powers, 2003).

6. 4. Informed choosers.

In Stapleton's (2004) research the main information needs for women with regard to caesarean, covered a range of practicalities to reflect the realities of recuperation from major surgery. Information needs included issues around pain relief, postpartum assistance, clarity around driving restrictions, emotional affect, loss of independence, post operative complications, preoperative teaching of how to cough following surgery and familiarity with hospitalisation (Stapleton, 2004, p. 104). Given the impact of this major surgical procedure on the health of women and their babies, it is no wonder that it has gained the reputation, coined by Stapleton as the 'mother of interventions' (p. 104). More ominous are findings from review of the literature for the Cochrane database of systematic reviews aimed at establishing the adequacy and efficacy of information for pregnant women about caesarean (Horey, Weaver & Russell (2005). Horey et al. (2005) were left to conclude that information to inform women about caesarean had little effect upon caesarean rates.

While it is presumed that an informed choice is contingent on the quality of information provided, a key question that has been raised, in the professional literature, is whether a vaginal birth is in fact a choice at all, by virtue of its status as an inexorable physiological event (Harris, 2001). This clearly places doubt as to whether the option of caesarean for no clinical reason, is a valid choice, given there is still insufficient evidence on the safety of caesarean to warrant it (Bewley & Cockburn, 2002b, 2004; Harris, 2001; Minkoff et al., 2003; Penna & Arulkumaran, 2003).

6. 4. 1. (Un)informed autonomous subjectivities.

A consistent thread, woven through the women's talk, was a perceived lack of available information from which childbearing choices could be made. Information regarding caesarean was considered to be of greater benefit when provided much earlier in pregnancy. The following interaction in WFG1 reflects the need for more information to be available for women.

(WFG1m1)...but I think what people were saying before [] there's not a lot of information, organised information out there for women in relation to choices and a caesarean, planned caesarean information could be part of that.

(WFG1m2) I think information about caesareans generally would be quite good because when we were at the last minute suddenly faced with one and had a consent form waved under your nose [] if you know a few months earlier you have been given quite a bit of information [] if things go wrong " well it might be a caesarean and this is what happens and these are the side effects".

(WFG1m3) There are little pamphlets, you know, we're all given little pamphlets but nowhere did it say ...major abdominal surgery... (WFG1, p. 20 - 21).

The implication in the talk is that caesareans' status as major surgery is downplayed. This downplaying of the risks of caesarean is confirmed in the international literature (American College of Nurse-Midwives, 2006; Baxter, 2007; Young, 2006). From the midwives' talk, withholding information is viewed, as an act of protectionism (Braun & Gavey, 1999) in that women are set up, so as to avoid their disappointment or failure.

(MFG3m1) You don't really want to worry them too much because they might end up having one.

(MFG3m2) Then you think about those women needing therapy when they didn't achieve a normal birth. Women birth really well and are really strong and it's just the relief and the sense of strength and amazement. You know it transforms them forever compared when something is done to them. You want to say, this would be the best outcome, but at the same time you don't want to freak them out as they might feel that sense of failure. It's that balance (MFG3SE, p.20).

Here the midwife is represented as holding the balance between failure and satisfaction. The issue also arose in MFGDHB where resistance to protecting women from the realities of a caesarean became obvious.

(MFGm1)... I felt it was my responsibility as a midwife teaching antenatal classes to give them some information on caesarean sections, and so at least if they did end up having one, at least they knew that they couldn't drive until six weeks, or they could have all of these problems.

(MFGm2) Like infection, the driving thing, how it impacts on you post-natally.

(MFGm3) How do you do your washing, how do you deal with your baby?

(MFGm1) Absolutely.

(MFGm2) Infection, itchiness for months and, it's terrible..

(MFGDHB, p. 22-24).

As the discussion flowed in MFGDHB, women were transformed from a position as uninformed choosers, incapable choosers, unable to take in information beyond the actual birthing experience.

(MFGm1) Women are not being counselled about all those factors

(MFGm2) I'm sure

(MFGm3) But women won't take information about the postnatal process. You know that, they're simply focussed on the birth and they do not take in that information about what happens afterwards (MFGDHB, p. 26).

This construction of women as subjects incapable of taking in information concerning events beyond birth, is a common stereotype and backed up in the literature (Stapleton, 2004; Kirkham & Stapleton, 2004). The same construction of events came to light in the women's talk.

(WFGm1) Although to be fair ... I don't think for those having a baby, I don't think any one truly thinks about what the recovery is going to be like.

WFGm2) ...I think women having social caesars, you know, concentrate on what's going to happen during the actual

procedure but after that, you know, there's no – there's probably very little information and it's not important to them at the time because they're just concentrating on the baby (WFG1, p. 8).

Women's disinterest with regard to information needs may have less to do with lack of foresight and more with avoiding that which they perceive as irrelevant (Wiggins & Newman, 2004). Wiggins and Newman (2004) suggest, their ambivalence toward taking in information may be because the information has limited relevance to their unique experience which may be partial or is counter to their own tacit understandings. In midwives' talk one midwife prompts colleagues of the need to respect a woman's previous experience.

Yes, I've never had anybody who came straight out with no previous section that said, I want to have a caesarean, but then again, there's quite a different feeling when they've had one before. You kind of have to respect their experience and play around with all that type of aspect of the previous experience, but you don't necessarily do that when they haven't had one (MFGSE, p.2).

Implicit in the midwife's narrative is the respecting individual women's tacit understanding from their life experiences, when supporting women in their decisions. A salient reminder of the diversity among women in their positioning as autonomous decision-makers.

Concern about the lack of information, available to women about the consequences of elective caesarean in the USA, prompted a series of articles, initiated by the American College of Nurse Midwives (ACNM) with the aim of guiding decision making for both 'proponents and opponents' of this choice of birth mode (Shah & Williams, 2004). At the forefront was a concerted plea for midwives, in an alliance with the Maternity Coalition for Action, to join forces against the increasing medicalisation of childbirth.

McFarlin (2004) in the same publication reminds practitioners of their ethical responsibilities toward their clients. These include obligations to ensure fair and equitable allocation of resources, respecting a women's autonomy in decision-making, offering choices that will do no harm, promote good and foster trust between women

and their caregivers in making appropriate decisions. These ethical values are contingent upon truthfulness and fidelity in that the decisions made in the present have implications for future temporalities with the possibility of remorse that can only be realised in retrospect.

6 . 4. 2. (Mis)informed remorseful subjectivities

Decision regret with reference to the choice of a caesarean is not uncommon in the childbearing experience. This was borne out in the women's and midwives' talk and corroborated by Stapleton (2004) in her research into informed decision-making. Importantly Stapleton argues, the realisation of an erroneous decision may have a lasting impact on a woman's sense of self. One midwife reported how women she had looked after recently, had regretted their decisions to have an elective caesarean based on what amounted to the realities of the operation being 'out of sync' with their informed expectations.

I've just been to theatre with three of them [women] recently who now regretted having elective caesarean sections because of the cold wait, the concerns and worries about the up and coming operation and to add insult to injury, the Caesarean section epidural didn't go that well, the post-op care afterwards didn't go that well (FGMWSE, p.).

These women's remorse signals the importance of 'truth telling' in preparing women for surgery and the (re)positioning of repeat caesarean as a major abdominal operation. Acknowledging the impact repeat caesarean has for recovery, is necessary so as not to diminish the impact of the procedure on women's recovering bodies, their ability to cope with a new baby and the prospects for women's future childbearing. Women as autonomous selves have become repositioned as remorseful subjectivities as a consequence of misinformed choices. Yet again the regret highlights the fragility of women's autonomy. Hemminki (2006) stresses that women will make decisions based on the benefits to their babies. Trust in their health care professionals is essential in order to avoid the possibility of regret; rights are less of a priority.

Another woman recounts a friend's experience of 'decision regret' following her request for a repeat caesarean.

And I've got a girlfriend who right from the beginning said she was going to have a caesar, that was how it was going to be, and she had one and now she regrets it now. She felt that she never bonded with baby and she didn't realise quite how tricky it would be afterwards. Her husband had to have a lot of time off work and to lift - her baby was large anyway, but, you know, a lot of dramas afterward (WFG1, p. 6-7).

This poignant account provides insight into the reality of repeat caesarean as a major abdominal operation, for both women and their babies as well as the intangible costs for significant others. Suffice to say the woman chose a vaginal birth in a subsequent pregnancy with a positive outcome. The account epitomises what Zodorznyj (1999) has identified as a 'critical reflexive moment', which has implications for future decisions in subsequent births. Implicit here is a repositioning of subjectivity as a consequence of experience. Waldenstrom (2004) supports the view that women's beliefs about their birthing experience can change over time. Feelings in the initial stages may be clouded by relief with the outcome of the birth and joy at seeing baby. While both Zodorznyj (1999) and Waldenstrom (2004) utilise different methodologies, they corroborate the fact that the birth experience has implications for future childbearing. Taking into account women's unique life experience and women's styles of gathering information as identified by Wiggins and Newman (2004) has important implications for decision making and minimising regret.

6. 4. 3. Information gathering styles.

Women are a diverse group and as such there is no 'one approach fits all' when evaluating information requirements. In their study of women's understanding and utility of evidence-based information pamphlets, Wiggins and Newman (2004) identified five types of approaches to obtaining information. These included 'voracious gatherers'— generally women having their first baby with an insatiable need to pursue all available information; 'readers,'— women who may have been voracious readers with their first baby and rely on reading to inform their knowledge using a variety of sources; 'listeners'— who rely largely but not exclusively on verbal

information from health care professionals; ‘old hands’– who have ‘been there done that’ and lastly ‘waiters,’– women who had a reticence about too much information. These women tended to adopt a ‘wait and see — cross that bridge when they came to it’ — approach as opposed to confronting the future. Each typology has implications for the dissemination of information and as such the nature of informed decision-making. Wiggins and Newman, while acknowledging the ethical imperative of informed decision-making, question the ethics on the one hand of offering choice to women, while on the other hand, taking it away *vis a vis* disciplinary and institutional practices that fail to provide women centred maternity care. Too often these practices stand in antithesis to the ethical duty of doing no harm. It is for this reason the ethical principle of non-maleficence sits awkwardly alongside autonomy. However as has already been addressed, exercising autonomy is presumed to be a good thing (Draper, 1998). *A propos* of childbirth, it has been found that women differ in their preferences for responsibility in respect to the decisions they make (Douché, 1997; O’Cathain, Thomas, Walters, Nicholl & Kirkham, 2002; Kirkham & Stapleton, 2004).

6.5. Decision making.

The endorsement of women's autonomy in childbirth, through legislation, has effectively changed the course of decision-making from a paternalistic model to one in which decision making became the prerogative of the individual woman based on an informed choice (Charles, Gafni & Whelan, 1999). Whereas a paternalistic model is viewed as the prerogative of the physician based on what s/he views as in the ‘patient’s’ best interest, an informed choice model is the prerogative of the client. With the latter, the practitioner refrains from the decision-making to avoid imposing his / her values or preferences on any decisions made (Charles et al., 1999). Technical knowledge resides with the practitioner, while personal preferences reside with the client. These shifts in meaning of decision-making have evolved recently with the presumed intent that client’s autonomy will be enhanced when actively involved with decision-making, as is evident in Tom’s talk.

I think the bottom line there was, as I said earlier, that women should be discouraged from elective caesarean sections for non-medical reasons. However one has to discuss the validity, the pros and cons, and then respect the choice of

the woman. We have moved from a patriarchal medical system to a consumer based medical system, and in consumerism the client is always right! Our duty then is not to discourage people but to give them information, upon which they can make reasonable, informed choices (Tom, p. 4).

Tom is reflective of this pendulum swing between these decision making styles and draws on consumerist discourse to point out that the customer 'is always right'. His sentiments are those reflected in the ACOG's (2003) ethical statement and the publications of proponents of caesarean as an informed choice (Al Mufti, McArthur & Fisk, 1996; Cotias, Patterson-Brown & Fisk, 2002). In championing women's choice, for a non-clinically indicated caesarean, these writers have opened up new opportunities for consumerism in childbirth. Defined as "...the efforts of consumers to assert their self-determination and to have power to participate responsibly in decisions made about their health" (Dew & Kirkham, 2000, p. 149) consumerism implies empowerment through the right to participate in health care decisions. Ironically these writers point out, such aspirations arose out of dissatisfaction with medical dominance over health matters, in the first place. Worthy of note is O'Cathain et al's (2002) research that set out to describe childbearing women's perception of the extent to which they exercised informed choice. Only 14% (n = 165/1201) of the women preferred to make a final decision without reference to a health care professional.

In a shared decision making model both practitioner and client take responsibility for the decisions (Charles, Gafni & Whelan, 1997). The configuration of information is a two-way exchange in that the health care provider must fully inform the client about options, while the client fully informs the practitioner of her individual preferences about what she believes is worth, or not worth, having. This model is commensurate with the tenets of the midwifery partnership, a model for midwifery practice in Aotearoa New Zealand, based on the premise that women, as equal partners, share the responsibility for decisions about their birth experience (Guilliland & Pairman, 1995; Pairman, 1999). Criticism of the shared decision model calls into question the imbalance of power relations inherent in clinical interactions (Gwyn & Elwyn, 1999). These authors allude to the possibility of subtle coercion operating in clinical decisions, by suggesting that a shared decision is a euphemism for an informed

decision, managed according to practitioner preference. In order for a shared decision to take place, there needs to be a choice between two valid options (Gwyn & Elwyn, 1999; Lewison, 2000). In O’Cathain et al’s (2002) study, the majority of women (83%) wanted some form of shared decision-making. The majority of these women were from a higher socio-economic position in terms of education and a non-manual occupation.

While these decision-making models may offer differing ways of how health professionals can enable women’s choices, it cannot be assumed that these models can be generalised to all, as imagined in liberal humanist discourse. Frith (1996) indicates that the application of these theories to midwifery can be problematic, for while events can result in some decisions being made on a woman’s behalf, it has to be kept in mind that the majority of childbearing women do not have their autonomy compromised through illness. Moreover women’s decision-making in childbirth presents a pastiche from which there are multiple sites for understanding the process of informed consent. O’Cathain et al. (2002) highlight the complexities in evaluating the outcome of decision-making in maternity care in that perceptions of an informed choice and actual choice are two different events. Further, these writers point out, there are wide interpretations in the ways women may make sense of their encounters with health professionals.

6. 5. 1. Women’s relational decisions.

Importantly decisions around childbearing form part of a tapestry that weaves together the temporalities of a woman’s past, present and future as well as her relationships with others. This relational view has urged Edwards (2003) and others (Held, 2000) to adopt an approach to ethical decision-making that takes into account the context of women’s lives. The need for a relational approach, to decision-making came into play during the midwives’ talk.

I think it’s to do with the counselling, the way women are counselled, the information that they are given plays a huge part in their choice, and they of course come with all the stories from their friends and relatives and other people, which can sway them in various directions, but the way they’re

counselled is so important and so variable (MFGDHB, p. 18).

Women's decision-making styles will come through the discourses available to them which will in turn shape the direction of their choices. The taking into account of women's relationships with others, goes beyond rights discourse, to view women and their wider social field.

Stapleton (2004) explains how women consider their choices in relation to their ongoing domestic relationships. Edwards (2004) found in her study women's preferences for decision-making were relational-based, as opposed to rights-based. Edwards (2003; 2004) explicates a problematic with 'rights' discourse in regard to decision-making. Rather than battle out their rights women, preferred instead support, in their encounters with health care providers. Edwards (2003) as well as others (Schmied & Lupton, 2000; Weaver, 2002) have exposed a tension between women's decision-making based on relational decisions and those based on normative rights. It is with the latter that women are confronted with subjugating their rights for the rights of their unborn child. Weaver has already signalled an anomaly with autonomy in that it is in this space, that women are not entitled to the same rights of other adults. Edwards (2003) calls for an ethical framework "...that understands that decisions are ethical journeys that join up a person's social context with their experiential embodied and intellectual knowledge" (p. 4).

6. 5. 2. Decisions based on Values.

The decisions women make will have potential repercussions not only for a satisfying birth experience, but for the woman's ongoing relationships within her family (Edwards, 2004; Raynor & Bluff, 2005; Stapleton, 2004) and are to a large extent based on the values a woman holds. In the women's talk it emerged that women seek out practitioners whose values accord with their own. Knowledge of each partner's values within the childbearing encounter is fundamental to shared decision-making and to the establishment of trust (Guilliland & Pairman, 1995; Pairman, 1999; Edwards, 2003). The following excerpt from midwives' talk brings to light how one

midwife understood how women make decisions based on their values as opposed to logic:

(MFGm1) One thing with my research is that people don't make decisions rationally. We try as hard as we can to give the information objectively and we think that if we tell women objective information, giving the science, the balance and the options and the possibility of things going wrong, or not going wrong, we can kind of assume if we do that, then women will make the right decision. In actual fact decisions are made on values and not on logical insight in general (MFGSE, p.13).

In the above excerpt women are initially positioned in the text as rational choosers. This is contingent upon the amount of information they receive. Implied here is that the more information a woman is given the more rational will be her decision and accordingly the more autonomous she will be. Further into the text, a shift in emphasis comes into view that questions the worth of logical insight in favour of decisions made from values. It becomes evident that it may be more germane to ask women what it is they value about giving birth.

(MFGm1 continuing) The question was, what is it that women are valuing about giving birth now that makes this whole trend to intervention inclusive. I kind of think that if we talk to women more about what they're valuing and what they think is special about their experience and what they value in their life, then that may be a better way to understand what they really want and say, these are your options and these are the risks of either decision that you make (MFGSE, p.13).

The midwife's narrative reflects a greater sense of mutuality in decision-making.

Taking into account what is important for each women, recognises the diversity of women's experiences. For midwives too, there is a diversity of views as is evident in the following challenge.

(MFGm2) The thing is that if a woman comes here on your doorstep and says, I want a Caesarean, then I would say that the reason she's doing that is emotional. Right there, if there is an

emotion like fear involved, right there you can't really say that she's making a rational choice (MFGSE, p. 14).

The midwife's resistance MFGSEm1 in the above excerpt reflects an expectation of the rationality inherent within rights-based decisions. Here the analogy of fear was used to exemplify how one's emotions can prevail over reason, and by implication, are prelude to irrational choices. A woman's constitution as 'irrational' positions the midwife as a regulator in controlling a woman's choice and as such creates a potential for an uneasy alliance 'with women'. With emotionality constituted as a feminine attribute and rationality attributed as a (superior) masculine one, women are in danger of being stereotyped as inferior to men (Stewart, 2004; Parker, 1997).

Examining a person's decisions, based on their values, opens up new spaces for midwives and women to talk about birth. In the continued interaction, MFGSEm1 negotiates a path through the shifting terrain of normal birth (Surtees, 2004) and repositions herself in partnership with women.

(MFGm,1) It's fascinating. People that do make those sorts of decisions [choice of caesarean], I find they're very interesting to look after because...I have to find out more about them (MFGSE, p.14).

The effect has been to diffuse a potential tension between her view and MFGSEm2's view, while maintaining both the tenets of feminism (embracing diversity) and midwifery (being 'with women'). It has been noted by Surtees (2004) there are many sides of the midwife-woman partnership. She conceives of the relationship as a 'partnership in action' to account for its unstable nature that comes about through the discursive constitution and multiple subjectivities and positions that midwives and women take up (p. 179).

The ensuing conversation focussed on the first visit as the most appropriate time for assessing women's desires for their birth to ensure abundant opportunity for the resolution of any disparity between the midwife's and woman's goals for birth as well as providing ample opportunity for opting out should differences be irreconcilable.

..there must be room to negotiate...(MFGSE).

Important for midwives to contemplate is the ascendancy of desire and the role it plays in defining what is normal for women as well as midwives (Surtees, 2004).

6.5.3. Personal Preferences.

In Al Mufti et al's (1996) benchmark study (see Chapters Three and Five), obstetricians were asked their personal preference regarding mode of delivery for their first baby if it was an "uncomplicated singleton cephalic presentation at term" (p. 2). Similarly in the current study, when women, midwives and Tom, were asked if they were to imagine themselves having a normal pregnancy, at term, with baby's head well engaged, what their preference would be between a vaginal birth and a caesarean section, there was a variety of responses. Most participants imagined that they would opt for a vaginal birth, while some conceded the possibility of choosing a caesarean. Sample responses are typified under each focus group.

(WFG1m1) It [requesting a caesarean] wouldn't occur to me.

(WFG1m2) No.

(WFG1m3) Me neither.

*(WFG1m4) can see why some women would be tempted
(WFG1, p.20).*

(WFG2m1) Definitely natural. I wouldn't even consider a caesarean. It wouldn't even come into my head. I'd be saying to the doctors, keep those mowers away from me. Don't cut me open again.

(WFG2m2) I would consider a caesarean, I would, because I just really believe in the woman's choice. I think as a society we should be really open to people with different ideas and I value your opinion as much as you value mine. I would like to think that I would have the choice without any kind of criticism, when you have no idea of what you're getting yourself involved in. I would just like to elect the option that was best for me and just be able to get on with it (WFG2, p. 29).

Since the controversy around women requesting unnecessary caesareans surfaced, substantial studies have found an association between caesarean and maternal request to be tenuous (Gamble & Creedy, 2000; Hildingsson, Radestad, Rubertson & Waldestrom, 2002; Hopkins, 2000). In the background chapter of this thesis it was shown that Gamble and Creedy along with Hildingsson et al. (2002) found few women actually request caesarean in the absence of clinical indications. In the UK, Thomas and Paranjothy (2001) report maternal requests represent around 7% of the overall caesarean rate. Similarly, midwives studies indicate few midwives would choose a caesarean (Dickson & Willett, 1999; McGurgan, Littler & O'Donovan, 1999) as shown in Chapter Two.

When midwives in the focus groups were asked a similar question to the women, again a range of views surfaced, some tentative others more definite.

(MFGm1) That's a very difficult one J---- eh?

(MFGm2) Well it's not that difficult, because when I had my baby twenty years ago, I chose hospital birth and I chose an induction, I chose an epidural, but I wouldn't choose that now. So if I was a different person at a different age and everybody was choosing elective Caesarean sections, I would probably choose an elective Caesarean. Not given what I know now, but given the fact that I was a young woman having a baby, and if I was a midwife, given my age, my vulnerability, I wouldn't do it now, but I might have then, who is to say? There are vital things that change how we think about things. Certainly if I was having one now, I would have a home birth (MFGSE, p. 27).

The midwife's experience illustrates how the spatial and temporal dimensions of birthing influence decision-making as to the choice of birth mode. The midwife has (re)positioned herself from an array of possible subject positions that have become available through time. This repositioning as a consequence of experience echoes Zodorznyj's (1999) critical reflexive moment that was discussed previously in this chapter. Waldenstrom (2004) also found that for some women, beliefs about their birthing experience can change over time. In reference to childbearing women, this has implications for subsequent pregnancies. One midwife, however, was defiant of attempts to constitute herself as a risky subject.

Well I had my first baby eighteen years ago and I was a midwife and had been for a considerable time. I demanded a vaginal birth for my breech baby. I think the answer for me is no I wouldn't choose a Caesarean section. Even thinking back then, even eighteen years ago, there was quite a lot of pressure on me to have a caesarean section. A Caesarean section and an epidural was the last thing that I was ever going to contemplate, regardless of the position I was in.

I would do the home birth now (FGMSE, p.28).

The above scenario shows how the midwife resisted pressure to have a caesarean for what was considered a relative indication at the time. Implicit is the construction of a self as a stable and unitary being, as evident in her continued defiance of the dominant discourse of obstetrics' marginalisation of home birth. One midwife from the DHB drawing from her sister's experience was unequivocal:

(MFGm1) No, no.

(MFGm2) My experience, my sister has had four babies and she's had a very difficult forceps and then a caesarean and then two vaginal deliveries, and she said she'd go for the vaginal birth every time (MFGDHB, p. 27).

Because the question had limited bearing experientially for Tom, his response was more circumspect. After some discussion of the aforementioned preference studies, Tom's response tended toward an informed choice based on risks and benefits of a vaginal birth versus caesarean, foremost around a discussion about pelvic floor dysfunction in relation to a vaginal birth compared with a caesarean. He draws from a study discussed in chapter two.

...and if she insists then we would need to document that, a discussion has taken place, regarding the risks and benefits and [] I would agree to doing an elective caesarean section. We haven't even touched on the []the risks associated with anaesthesia (Tom, p. 9).

When asked about documenting an indication in the client's notes, Tom replied,

I would still write maternal request [] because I think it will be very, very rare that an obstetrician would ask the patient "would you like a vaginal delivery or a caesarean section?" (Tom, p. 9).

Following a discussion comparing midwives' and obstetricians preferences', one self-employed midwife raised an interesting point of difference between the practices of these two disciplines.

That's probably because midwives see birth differently and obstetricians see birth when it's difficult. Of course if you only are there when you have to haul the baby out and pop the baby out, you're dammed well going to see birth as being abnormal and difficult. I think yeah, if I was an obstetrician and that's how I only ever saw birth then I would say yes, Caesarean section is the way for me. Given our experience, of seeing that birth can really work for women, it can be very empowering and amazing and powerful. I wouldn't choose a Caesarean (MFGSE, p. 28).

The tenor of the text positions midwives and obstetricians in diametrical opposition, not so much based on ideological differences between the two professions, rather more to do with each ones experience with birthing women. The midwife's standpoint, takes into account the diversity in respect to each discipline's experiential knowledge. Some would argue that because midwives' tenure with women is short term, they are not cognizant of the longterm effects of vaginal birth which obstetricians pick up in their coupling as gynaecologists (Cassell, 1999; Mmomo, 1999). Against this complex and contested terrain, the desire for midwives to keep birth normal, offset by the desire for freedom of choice in the birth 'space', signals a tension between two highly prized ideals inherent within Midwifery's Code of Ethics (NZCOM, 2005); their responsibility not to interfere with the normal process of pregnancy and childbirth, as well as accepting the right of each women to control her pregnancy and birth experience (p. 10).

6. 6 . Cultural diversity and choice: same but different.

The choice of caesarean as an alternative birth mode, as part of an international trend, is located in a cultural context, where meanings attached to freedom of choice in childbirth are similar for some contexts and different for others. For instance women in Switzerland and the Netherlands do not share the same fervour for freedom of choice in childbirth as their UK, Asian and Aotearoa New Zealand counterparts. Reflections around cultural diversity was a feature of the data to emerge.

(WFG2m1) I think its fantastic in New Zealand, the huge difference between here and Switzerland is the amount of information you get here.

(WFG2m2) It's better here is it?

(WFG2m1)Yes. Amazing (WFG2, p. 27).

Another woman in the same conversation reflected upon her perceptions of childbirth in the Netherlands.

(WFGm1) Very natural, very uncomplicated.

(WFGm2) So a normal family event in the home?

*(WFGm1) Yes and they don't seem to over complicate it.
(WFG2, p. 27-28).*

In the cultural context of the Netherlands, childbirth is positioned as a normal family event, situated largely in the home. Those from contexts outside the Netherlands 'found it even more difficult' having been used to a culture in which they had greater options from which they could choose. Within the Netherlands caesarean is not offered as an option, even with a previous traumatic experience. Smulders (2002) a Dutch midwife, corroborated this view at a NZ College of Midwives (NZCOM) Conference.

*Either you have a normal birth and 'get on with it' or you have complications and nature will decide for you
(Smulders, 2002, p. 6).*

According to the NZCOM, Smulders sees little chance that The Netherlands would implement the concept or adopt the notion of "Informed Choice" because of the illusory nature that choice represents when it is grounded in "fear and insecurity" (NZCOM, 2002, p.6). Here childbirth is positioned as an inevitable physiological process. Choice in childbirth is not within the philosophical ideals of Dutch midwifery practice or the agenda of institutional practice. There are no alternatives to this physiological process. Intervention is used judiciously when the process strays from the inevitable path. However, while in 2000 the caesarean rate in the Netherlands has

remained within the WHO recommendations (see Chapter Two) at 13% (Kwee, Cohlen, Kanhai, Bruinse & Visser, 2004) these writers indicate an apparent trend toward women's request for a caesarean section. As pointed out in Chapter Two, Kwee, Cohlen et al. (2004) found 9.6% of obstetricians were willing to perform a caesarean on request and concluded that if a woman so desires a caesarean, there is always a gynaecologist willing to perform one.

Apparent within the texts of the DHB midwives' focus group were multiple accounts of Asian women implicated behind requests for caesarean. These accounts were reinforced through statistical analysis from the region in which the research was undertaken. Findings within the region show that those Asian women had the highest total caesarean rate at 29.0% and the highest elective caesarean rate at 8.7%, compared to all other ethnic groups (Capital & Coast Health Board, 2002). One midwife from the DHB had been approached by a couple, from China. Her rendition of their expression of the choice for a caesarean is conveyed as follows:

...that was their choice, they said that that was what they were going to have, and I said it's not normally done unless there's clinical indications. But they were saying where they had come from they had that, and this is what they wanted, and I did say to them, that was something that you actually discuss with the person who's looking after you, because it's not commonly done in New Zealand without clinical indication (MFGDHB, p. 3).

Findings outside of the cultural context of Aotearoa New Zealand, suggest that maternal requests for caesarean is a common practice among young women in Asian countries, particularly in China and particularly in the private sphere (Lee, Holroyd & Ng, 2001; Leung, Lam, Thach, Wan & Ho, 2001). Juxtaposed to this trend were factors that have commonalities in other contexts, some of which were brought to life in women's talk. These included the desire for a positive birth outcome, socio-economic position in society, the right to autonomy and more specifically, beliefs around auspicious occasions. Liamputtong (2005) has found the 'too posh to push' slogan has transcended ethnicity to settle on a socio-economic landscape for the privileged, as was evident in the talk of one midwife. For her the mantra of 'too posh to push' infers a different cultural expectation based not on ethnicity, but on social class.

One woman, recently arrived from the UK shared her insights with WFG2 into attitudes of urban women in that country.

I think it's a cultural thing. I would say elective caesareans would be the choice of birth mode for working women in London because that is just the mentality of the people in the city and the pace [of life] (WFG2, p. 22).

Tom draws on his overseas experience also and has found a similar cross cultural experience.

...if a patient came from a higher socio-economic background the chances of a request was much higher than patients who did not come from [that] background. And that would predominantly mean Caucasian, white and Asian patients... (Tom, p. 4).

While Tom was talking about his experience overseas, well educated and white, Caucasian and Asian middle class women were woven through the text as implicated behind requests for caesarean section. These representations of women from 'other' cultural contexts highlight the different constructions of the concept across cultural boundaries. More than this, they are an expression of the appeal caesarean has among diverse groups of women with similar and different interests. Caution however must be taken not to 'other' others in their "absent presence" (McLeod & Nola, 1998; Riggins, 1997). In reading McLeod and Nola (1998) women from outside the dominant culture of Aotearoa New Zealand, are positioned as the 'other' in relation to that culture. The danger here is in rendering women outside the cultural context of Aotearoa New Zealand as homogenised subjectivities when they may in effect represent a similar privileged position to the dominant group. Drawing from Riggins (1997) implied in the texts is an ambivalence of 'other' as while these women are present in the text of the participants, their voices are absent within the voice of the dominant culture speaking for them. Riggins cautions, that the voice of the dominant group, can become the embodied 'truth,' despite its status as an incomplete representation of the 'other's' reality.

6. 7. Women's choice: a rhetorical question.

In Chapter Three the significance of rhetoric was conferred in bringing about effects, such as the use of language, to neutralise the impact of major abdominal surgery. The euphemism, a 'natural caesarean' is a case in point, the ideology of which is unpicked in Chapter Five. Moreover it is assumed that behind the rhetoric of women's 'right to choose,' women have access to the necessary information. However it has been found that the manner in which information is presented does not guarantee 'real' choice, as it can be hedged to fit the practitioner's own ideology (Edwards, 2004; Harding, 2000). In Midwives' talk, there was a sense that under the mantle of 'women's choice' women were being unfairly blamed for leading the charge toward the rise in unnecessary caesarean.

The 'women's choice' is used as the cover up for women having a lot of intervention and it's coming from midwives, as well as the medical sector. Thinking back to the review situation, I hear people, when you question them about epidural rates, or induction of labour rates, they invariably cite women's choice. I think that there is obviously an element of women's choice in there. However, is their choice based on really clear and informed decision-making. Invariably I don't believe that it is because we are all biased with the information we give to women. There are some of us that will try really hard to give balanced advice, but you're still going to be influenced by where you stand (MFGSE, p.12).

The midwife from MFGSE clearly spells out how the standpoint of the practitioner is not just seen as a discursive strategy in the constitution of women's choice, but that practitioners sequester women's choice to conceal their own biases. It is at this juncture that women's autonomy is exposed as a fragile construct of the prevalent discourses of childbirth. Edwards (2003) is one of many who have shown how the rhetoric of choice has not lived up to its promise. Like Weedon (1997) and Kitzinger (2001) she also comprehends choice as being hijacked to serve the interest of others rather than the interests of those it was intended to serve. Through being seen to meet as opposed to trigger childbearing women's demands, disciplinary power is rendered invisible (Fahy, 2002; Powers, 2003) and tolerated due to its ability to "mask a substantial part of itself" (Foucault, 1978, p. 86). Arney and Neil (1982) depict the manner in which the obstetric profession was able to regain its power in the face of challenges from the natural birth movement in the 50s.

By reformulating its field of power around a new patient object, obstetrics would reconstitute its patient-object. The reformulation could occur because there was an important conjunction between the demands of the natural childbirth and obstetrics' interest in maintaining control over birth. In fact, natural childbirth would be made a component of obstetrics' new modality of control (Arney & Neil, 1982, p. 12).

In interpreting Arney & Neil, the appropriation of the discourse of autonomy, has reformulated choice as a marketing enterprise. As such, choice becomes obstetrics new modality for control. It is this discursive strategy that has prompted Kitzinger (2001) to call for the deconstruction of choice. In deconstructing the rhetoric of choice, power relations veiled behind language are exposed. In championing for women's right to choose (a caesarean), obstetricians are constituted as the good guys in the field of childbirth. It can be argued that within the discourse of obstetrics, autonomy has come to resemble an 'empty signifier' (Laclau, 1994), a metonymic device for cancelling out its differences. It is at this juncture that choice in childbirth rests for the moment, between rhetorical and political strategies that occasion what is said and what is not said (Foucault, 1972), to bring about a certain truth about caesarean in the absence of clinical indications.

6.8. Conclusion.

Women's autonomy in childbirth has received its legitimation discursively through the discourses of popular culture, the disciplinary practice of midwifery and obstetrics and institutional practices such as the legal institution and health ministries. Inherent within the talk and texts of these discourses is a perception that childbearing women are exercising their autonomy in childbirth by electing to have a caesarean, regardless of clinical need. The incitement of autonomy into medical discourse as a mechanism of choice, has doubled back on itself, as a form of control. In this historical moment the valorisation of a caesarean has positioned natural childbirth uneasily in the domain of childbirth. Informed decision-making becomes obfuscated as the realities caesarean is downplayed in favour of its benefits. As such the complex and contradictory nature of this mode of birth has opened up possibilities for (re)examining autonomy as a new ethical frontier. Events so far convey an uneasy alliance between the ethical ideals of

respecting autonomy, doing no harm and justice for the equitable distribution of health resources. Moreover, the fostering of consumer sovereignty in the marketplace, sets the conditions of possibility against which demand for 'high tech' private birth facilities can be kindled. In a shifting historical, socio-political climate the current 'order of things' cannot be taken for granted. Institutional practices informed from a convergence of dominant discourses may once again 'free up' the market to give the consumer what they want.

In championing women's reproductive rights, the signification of autonomy evokes at once a celebrated yet disturbing event that is gaining momentum. Celebrated in that women's autonomy has shifted ground from a paternalistic stronghold; disturbing in that caesarean is increasingly represented as the preferred birth mode for women of low obstetric risk. Of note is that an increase in the primary caesarean rate, will in effect lead to a less healthy population of childbearing women in the future. In Chapter Seven, I argue how the discourse of convenience and desire sit along side of the discourse of autonomy in strengthening the choice for caesarean, in this contested field of play.

Chapter 7. The Discourse of Convenience and Desire.

7. 1. Introduction.

In just over a decade the notion of choice in childbirth has shifted in focus from choice of caregiver and birth place, to birth mode. The choice of caesarean when swathed alongside the discourse of autonomy has a certain rhetorical appeal. This appeal is all the more intensified when greater options are made possible for self-governing women. Scheduling birth around life events and bodily aspirations, invokes an instant gratification, secured through the discourse of convenience and desire. These two discourses emerged from a compilation of the talk and text of women, midwives and an obstetrician. Convenience and desire are aligned in mutuality with imminence and efficacy, elements that have come to represent a desire for the containing the self alongside its bodily activities, in the present moment. I show how these discourses (inter)act to invoke images that depict the fragile nature of normal birth, as it is perched precariously at the frontier of a technological eruption and sexual panic. Having control over time and events has appeal in a rapidly changing convenience culture, in which the temporality of desire anticipates the promise of instant gratification.

7. 2. The convenience culture and the desire for control.

In the talk of women and midwives, the desire for control over time and events emerged as grounds for justifying the decisions for a caesarean in the absence of clinical indications. This has to do with the convenience of scheduling the birth around particular dates and events such as work, conferences and the family. In these instances giving birth is positioned as ancillary to a busy lifestyle and as indicated in the previous chapter, for some women, childbirth no longer holds centre stage (Klien, 2004). Caesarean on demand in this sense is seen as a logical chain of events in what Klien alludes to as a 'quick – fix culture'. Implicit here is a 'convenience culture' in which women choosing a caesarean purely as a birth mode are constituted as self-orientated to the present.

In industrialised societies, time is of the essence, giving direction and duration to the organisation of daily life (Giddens, 1997). Allied here is the modernist notion that over time, societies improve as a result of progression in knowledge and with new knowledge comes technical advancement (Parker, 1997, p. 11). Following Berson (1967), Parker (1997) proffers that the concept of time, within modernity, has both an inner and outer dimension. The inner dimension is a sense of a duration, or experience of immediacy, which is formless, but given meaning through outer time. Parker explains that the latter is a temporality that is socially constructed. Outer time occurs in an ordered sequence, separated into past, present and future orientations and is both linear and measurable. In 'high modernity' (Giddens, 1991, cited in Parker, 1997) time has a futures orientation, but in postmodernity the boundaries between these orientations have become blurred, manifesting in "...a temporality of presentness among a plurality of other temporalities" (Parker, 1997, p. 14). This may have relevance to the development of a 'convenience culture' whose sights are neither orientated toward a past or a future. For some childbearing women, choosing a caesarean, may indicate a self orientated to the present and this 'presentness' has pre-eminence over future, including future pregnancies. The temporal expediency of a caesarean, as a birth option, has been made possible through the technological advances of modernity, what Davis-Floyd (2001) calls the "technocratic imperative" (p.10) which she asserts is a need not only to improve on nature but to ultimately control it. At the time of writing, control over time has eluded most attempts to constrain it. None-the-less, scheduling events in advance has come close to achieving this end.

7. 3. Controlled Subjectivities.

The notion of having control over ones childbirth experience, as the prerogative of middle class women, has recently emerged in popular culture (see Parson, 2002). Parsons, writing in the *Dominion Post*, is unequivocal in sanctioning this privilege through the media.

Middle class-women aren't electing to have a Caesarean because they're frightened; oh, no. They are exercising their right to consumer choice. If they know the date they're due to give birth,

they can tailor their work to the very last hour and give a precise date of return (Parson, 2002, p. B8).

The convenience of scheduling in advance leaves no surprises and these social caesareans offer a deliverance from uncertainty through controlling the birth process. This need for control over birth also emerged from WFG2 as one member recounted her sister's desire for her birth option.

I had a non-elective caesarean section but my sister [] would like an elective caesarean and I said to her, having gone through a caesarean section that I didn't understand her at all. Why would you want to do this? She said there were a couple of reasons, firstly she's afraid of pain and secondly, she likes to feel that she will be in control of the process. I laughed at that. [] I've been talking to her about it because to my mind, I desperately wanted a natural birth and when I have another child I'll be working all out for that and to me there are just so many positives to having a natural birth and having gone through a caesarean, it's the last thing I want to do again (WFG2, p. 2).

Inherent in the text two diverse meanings around control in childbirth emerge. The interaction has some resonance with a study carried out by Davis-Floyd (1994a) in which control materialised as an embodied practice, dichotomously patterned along two opposing models of childbirth; the technocratic and home birth models. When examining the relationship between women who chose either one of these models, Davis-Floyd found that most middleclass women, in particular professional women, embraced technology as a 'liberating force'. By choosing a technocratic birth, professional women were able to "make things happen" (1994a, p. 1130). Davis-Floyd (1994a) argues that for some professional women, the choice of a caesarean over natural birth rested on the Cartesian notions of the superiority of mind over body. Thus the imperative of a rational mind makes for sovereignty over the birth process. Zadoroznyj (1999) found that control in childbirth was manifestly different for middle class compared to working class women. Middleclass women were positioned as actively involved in decisions surrounding their first birth, while their working class counterparts were positioned as being more fatalistic. Further, middleclass women are enabled greater choice in childbirth because of their greater access to capital resources (Liamputting, 2004; Zadoroznyj, 1999) such as private obstetricians.

Timetabling birth to fit into one's schedule depicted a need to actively control when baby was to be born.

I think it's a time thing []. You know, she and her husband wanted to be absolutely sure when the baby was being born, so at 39 weeks they had a caesarean, and she said, you know from the family's point of view it was a kind of let down, because, you know, kind of to the hour when he was born and it really left no surprise, you know no element of chance really (WFG1, p. 2).

Within this extract a temporality of 'presentness' competes with that of delayed gratification, the impact of which can only be realised in retrospect. Alluded to in the text is a sense that the element of chance was at the cost of missing out on the perceived wonder that natural birth holds for women. In WFG2, the need for control over time prompted a response from another member of the group who herself had experienced a (necessary) caesarean. Signalled here is an important distinction between control over time and control over the birth process.

But the control you have with a caesarean is only time. That's all. You don't really have any control over the rest of the process (WFG2, p. 15).

The control a woman has over the birth of her baby when she chooses a caesarean was interpreted as tentative. These meanings of what it is to have control in childbirth are historically situated in so far as they change over time. For instance, around the 80s and 90s, calls for women to have control over their childbearing experience received much attention in the discourses of childbirth (Douché, 1997). Ironically these calls were in response to dissatisfaction with intrusive technology in the birth place. Zadoroznyj (1999) corroborates this view of meanings around control in childbirth shifting within particular socio-political contexts over time, particularly as a consequence of experience. In the current study a caesarean was identified as being the birth mode of choice for professional women.

7. 4. Professional (re)productive subjectivities.

The convenience of scheduling birth around a busy life style for professional women has been well documented (Bewley & Cockburn, 2002b; Davis-Floyd, 1994a; Klein, 2004; Penna & Arulkumaran, 2003). Professional women were identified more than

other groups, in the women's, midwives and obstetrician's talk as the group most likely to request a caesarean for no clinical reason. True to Parson's (2002) capricious genre, professional women may feel that they can't afford to let the process take its course. The pretext here is that the arbitrary nature of giving birth will have an impact on work commitments, as one woman conveyed.

But what about a different side of the argument for professional women for whom the birth of the baby is just one step in a long process. It's about convenience, like how it could affect the business. I can't afford to have the baby on these dates. I have a conference to book, a deal to clinch.

(WFG2, p. 7).

Professional women are constituted in the text above as active, productive and reproductive time managers. Childbirth is positioned as an ancillary event as opposed to the main event. Davis-Floyd (1994a) recounts in her study, one professional woman booked her caesarean "...between her conference calls" (p. 1137). In short, childbirth has become decentred from the centrality of women's lives. These (re)productive subjects appear to be situated in urban spaces where the fast pace of life seems most noticeable. Drawing from her experience in the UK, one woman in WFG2 provided insight into her impressions of the pressures for career women in the UK.

...elective caesarean sections would be the birth of choice for working women in London because that is just the mentality of the people in the city and the pace. Work is the rule and family comes secondary to that. It's career, career, career every time (WFG2).

As urban professionals, women negotiate their professional and parenting positions outside the discourses of motherhood. In light of their divided (re)productive selves, caesarean is easily perceived as the acme of childbirth enabling a rapid return to productivity. The influence of the discourse of convenience, in shaping professional women's childbirth choices, also emerged from Tom's interview.

(T) We've got to look at women who are career orientated these days, and look at child birth as a choice rather than a necessity.

(J) As an ancillary to other things in their life?

(T) That's correct, that's correct. I mean if you have a CEO who's a high powered business person, to her pregnancy and childbirth is part of the maternal instinct, at the same time it is an encumbrance on her career. She would rather have a surgically delivered baby, knowing that she is going to spend a week or so in hospital and then she gets home without having to bother with the anticipation of the expected date of delivery and then inductions and all the problems that go with it. We have a fair number of patients requesting inductions, purely for social reasons and these are usually career driven. They are teachers who need to get back to school, people who are involved in business who need to get back to work. (Tom, p. 6).

In Tom's text the ability to have control over when baby can be born (re)positions childbirth as secondary to other life events such as having a career. Professional women are constituted as thwarted by their biological destiny. The uncertainty around time of birth has the capacity to impact on work commitments. Hence the convenience of scheduling birth in advance, reconciles the arbitrary nature of childbirth and its impact on productivity in the work place.

In Davis-Floyd's (1994a) study, for professional women, the desire for control in childbirth was generalised across lifestyle patterns, in that professional women tended to be well organised with respect to planning and time management. Yet, despite the immense achievements women have made in the last few decades, their changing status has unveiled new pressures (Bewley & Cockburn, 2004). While these women have stepped outside the discourse of motherhood, they are up against a subtle resistance when it comes to maintaining their position in the workforce. Such a scenario was the experience of one woman, in the study who worked for a legal firm. For her, the competitive nature of legal work is often beset with strict and structured case loading, a practice she felt to be indifferent toward women employees as parents. Thus, in industrialised societies the convenience of caesarean is imagined as a cost-effective concession that will guarantee economic productivity. Implicit here is Foucault's (1978) notion of bio-power and 'docile' bodies. Drawing from Foucault, economic efficacy is achieved by disciplining the body and so optimising its docility and (re)productivity. In WFG2, encouraging women to resist pressure from employers who insist on a timeframe for giving birth emerged from the interaction.

I have a really good employer and he said to one of the other directors [when asked how long she would be on parental leave] He said, well she could be gone any day but she'll be back, don't worry. That's what a professional woman should say. I'm a professional woman and that's what I should say to my employer. You're actually entitled to a year and they have to keep your job open now. The fact that you can't give them a firm date is almost irrelevant, because as I say, you could end up by being run over, any of us could be run over by a bus (WFG2, p.7).

Timetabling pressures from employers prompted an analogy that transcends the gendered signification surrounding birth; that of being hit by a bus. An uneasy alliance with neo-liberalism comes into play as women defend their right to combine their professional and parenting roles in the marketplace. In universalising women, rights discourse assumes women are entitled to the same privileges as men. The need to defend a woman's right to work and parent, highlights a nexus of power relations in the gender division of labour, as well as a concomitant tension concerning women's personal and professional positioning in society.

A counter notion linking socio-economic interests, including professional women, with rising caesarean rates, comes from Sweden (Hildingsson, Radestad, Rubertsson & Waldenstrom, 2002). Hildingsson et al. (2002) disrupt this stereotypical representation of professional women, arguing that this view did not match their sample. In this large national survey, between 1999 – 2000, Hildingsson et al. found that only 8.2% of women had a preference for caesarean. Women in their study, who requested a caesarean for no clinical reason, tended to be less advantaged, smoked, were anxious and had a fear of childbirth. Weaver (2000) too has found that numbers of women seeking caesarean for matters of convenience, were few. Rather, in her work in progress, obstetrician convenience was implicated behind so called maternal requests (Weaver, Stratham & Richard, 2001). As already indicated Gamble and Creedy (2000) caution that failure to examine reasons behind women's requests for caesarean may lead to erroneous assumptions and possibly detract from obstetrician factors behind increasing caesarean rates.

In the midwives' talk, professional women were simultaneously positioned in the discourse as older, controlled, efficacious, erroneously informed and highly educated subjectivities. These multiple subjectivities became apparent in MFGDHB.

(MFGm1)...some[women] would be older working women, they need to know when something's happening and feel as though they've got some sort of control over the actual process. And I suppose some of them view the caesarean section as; you arrive at eight o'clock in the morning, business is done by nine... (FGMWDHB, p.4).

(MFGm2) Business done by nine...

(MFGm3) It does raise questions though about whether women are being informed about possible infections and other complications... [Several voices at once].

(MFGm1) It's huge.

(MFGm3) And I think often they are not really counselled sufficiently about that, the ones that do have Caesarean sections.

(MFGm4) I would not necessarily agree with that because I think the kind of women who are asking for the induction of labours or the caesarean section elective are well educated women. They are definitely getting older in age and we are getting an older group of women now, so I think they are well informed but they still choose to, it's almost like take away fast food to get back to the office (MFGDHB, p.4-5).

Highlighted is a plurality of views discursively positioning women in the text. Some are contradictory, concomitantly positioning women as older (mis)informed decision-makers. The metaphor of a 'fast food culture' enables women's desires for convenience to be understood. Caesarean is positioned as expeditious; a product alongside other commodities in the market (Kitzinger, 1999). Kitzinger is critical of how the medical profession has transformed caesarean, as consumer choice has urged a deconstruction of the concept.

7. 5. Public-private divide(d) subjectivities.

Where in the previous section, work commitments were implicated in shaping women's choice for a caesarean, family needs also surfaced, largely mediated through male partners as in the case of WFG1.

*I guess it is working to family commitments in terms of, you know, what their partner's work schedule is like and when family can be there and yeah...
(WFG1, p. 5 - 6).*

Like a friend of mine's husband the other day [he said] Why couldn't they just schedule a caesarean... [] it was just a male way of looking at it, you know real pragmatic. You know you could have it this date and you could get it all done and he'd be off and everyone would be happy.... to what extent men play a role in it... I mean, often with my girl friends their husbands had quite a significant role in that decision, because of his work commitment. That's how they approach life...(WFG1, p. 6).

Men are positioned as pragmatic operators and the convenience of scheduling birth is just a logical by-product of the 'technological imperative'. Implied in the text is a gendered division between these two spheres of life, where women have traditionally been positioned in the private (home) sphere and men in the public (work) sphere (Giddens, 1997). While on the surface, women are positioned as having parity with men in the public sphere, in the private sphere women's desires for birth mode are surrendered for the interests of their male partners. This gender divide was more blurred in Davis-Floyd's (1994a) study for professional women, opting for a technocratic birth. This was attributed to a more egalitarian relationship that women were perceived as having with their male partners, presumably based on the value of the capital resources they bring into the relationship. In spite of this egalitarianism in social relations, the masculine body politic continues unabated. Currently slogans of liberal feminist discourse that resonated throughout the latter part of the 20th century suggesting that 'girls can do anything' have now become transposed as 'girls do everything'.

In the competitive work ethos of public life, caesarean may be viewed as the most efficacious means a rapid return to productivity and a promise of promotion. However

a surface tension becomes apparent within WFG2 over the struggle to find a balance between profession and family.

(WFG2m1) [t]he only way they can efficiently do this is to book a caesarean

(WFG2m 2) I sometimes wonder why these women have children at all because it seems to be an inconvenience in their working life.

(WFG2m 3) Perhaps they are quite neutral about it and perhaps it's their partner that really wants to have children. That is certainly the case for me with him [pointing to her baby] and I'm back at work at the moment and my husband is at home

(WFG2m 4) With my situation, because I am stock broker and investment adviser and if you miss a beat you miss a beat, but you can miss a beat sitting right in front of your computer...

(WFG2, p.8).

The uneasiness around women, who desire to simultaneously have children and work, brings to light the positioning of motherhood as a natural state, mutually exclusive to holding down a career. The effect is a fragile coexistence of a woman's professional commitments alongside the random nature of childbirth that positions women in the discourse of biological determinism; a discourse that assumes women have a fixed essence and are naturally inclined toward motherhood (Grosz, 1994; Kent, 2000). Feminists challenge the notion that 'biology is destiny' which, they contend, justifies gender divisions and hence women's subordination in society (Grosz, 1994; Abbott & Wallace, 1997). WFG2m3 follows with a counter discourse in response to the disquiet about women who straddle the spheres of home and work. This discourse disrupts the notion that the providence of women lies exclusively within the domain of the private sphere and is reinforced by WFGm 4 who implies that 'missing a beat' is not unique to motherhood. The effect of WFGm 4 is to neutralise the discourse of essentialism with a discourse of parity suggesting that missing a beat can happen across genders.

Midwives talk too, revealed planning around family events and the influence of the partner in MFGSE at two separate occasions in the conversation.

I've had a lot of women actually say they like the idea of the planned date, organising the family around that date. It's useful to know that you have mother-in-law to look after the children on that

date, have holidays and things. There is a lot of that around (MFGSE, p. 3).

(MFGm1)I've not had the experience where a partner has been frightened of having a normal birth and they have made the decision.

(MFGm2) That would be domestic violence wouldn't it? (Facetiously said)

(MFGm1)I believe it would be, if the partner demanded you had an elective caesarean without clinical indication (MFGSE, p. 23).

Albeit it a facetious statement, an interesting aspect to emerge was the conjecture of male partner's control over when baby should be born, as domestic violence. Nonetheless two deeply entrenched narratives of patriarchal control, essentialising women, recently appeared in mainstream media, serving to (re)position professional women back in to the private sphere (Laws, 2005; Westfold, 2005). Laws's commentary entitled "Finding a cure to Hurried Woman Syndrome" while trivialising women's position in society, was the lesser demeaning of the two articles, veiled behind satire and sympathy. Westfold was more blatant. His letter to the editor entitled, "Go back to your homes" (Westfold, 2005) appeared in the features box "Letters to the editor" (Dominion Post, April 30th, 2005) depicting an aggressive attack on professional women for assuming the same benefits as men in society. Women's natural roles are constructed as wife and mother; feminists are positioned as demons and alongside single mothers and blamed for sabotaging the 'order of things' such as the demise of western society today. Whether the motive of the editorial motive behind the publication of the letter represents an implicit patriarchal fear, that woman have a legitimate claim to the same advantages as men, Westfold's letter has the hallmark of a lampoon. Its accompanying iconography, depicting a woman circa 1950s deep in darkest domesticity, further entrenches this stereotypical position of woman. Nevertheless the letter has been given legitimacy through its prime location in a widely published newspaper.

This (re)emergence of patriarchal power is a salutary reminder of the precarious nature of the achievements of women's movements over the last century. Importantly, the above sentiments are a cautionary tale as to why these gains cannot be taken for

granted. As Bewley and Cockburn (2004) have indicated, these hard won accomplishments, both in terms of personal and economic sovereignty, have been at the expense of a fragile and thwarted subjectivity. These writers suggest that in a patriarchal culture, efforts aimed at retaining these gains, have triggered a new set of fears with respect to loss of control, the effect of which may be a driving force behind some women's request for caesarean, as a matter of choice.

7. 5. 1. The convenience of daylight obstetrics.

The convenience of scheduling birth around life events also has appeal for advocates of 'daylight' obstetrics. While not especially overt in the talk and texts of the participants, its incremental appearance in professional journals is ominous, as if it were silently awaiting its eventuality. In recalling factors beyond biology, implicated in the choice of caesarean as discussed in Chapter Two, obstetrician convenience is to be suspected when most births occur midweek (Curtain & Kozak, 1998; Wagner, 2001) and more specifically in the USA when Tuesday is cited as the most popular day with Sunday the least popular day for births (Curtain & Kozak, 1998). Many suspect that obstetrician convenience is driving the trend (Hopkins, 2000; Langer & Villar, 2002; McFarlin, 2004; Potter, Bergio, Perpetuo, Quadros, et al., 2001; Weaver, Richards & Stratham, 2001). As a surfacing enterprise, 'daylight' obstetrics' also has potential appeal for hospital administrators (Shah, 2004). Sachs, Kobelin & Figoletto (1999) provide a compelling argument for caesarean section in favour of vaginal birth with respect to cost. These writers justify the cost of a caesarean under the banner of shorter hours in caring for women in labour and the convenience of the utilization of facilities in peak hours. Sachs et al. (1999) argue that a labour unit parallels an intensive care unit in relation to sharing similar costs and when compared to an elective caesarean the cost of a vaginal birth is greater. These costs, they proffer, are intensified in situations of prolonged labour or where a trial of labour requires a caesarean section. It is for this reason that Shah (2004) warns of potential for hospital administrators to capitalise on this discourse of convenience by downsizing birthing units at night and weekends if the concept of daytime obstetrics takes hold. Thus the desire for convenience represents a double-edged sword for women and maternity providers.

7.6. Desire.

For some women the desire for control over life events may have less allure than the desire for control over bodily activities. The meaning of the choice for caesarean as a marketable product has been made possible at a site where convenience and desire merge with the discourse of consumerism. Within this space caesarean, as an alternative birth mode, is constructed as a commodity, competing with other desired goods and services in the (re)productive market (Kitzinger, 1999; 2001). Some would argue that consumption is a powerful force in inciting desire and shaping identity, as opposed to the sovereign individual making choices in the market place (Cosgel, 1992; Massuni, 1993). Williams and Bendelow (1998c) paint an image of the self, created through insatiable desires “...within consumer culture our relationship to commodities is predicated less upon real need than their inexhaustible ability to incite desire” (p. 73). By implication the desire for freedom of choice for a caesarean enables uncertainty of self to be pacified through the consumption of new technologies. Nonetheless, the competitive advantage of consumerism is its endorsement of consumer options (Neuwelt & Crampton, 2005) and in so doing captivates consumer desire.

Resistance to the endorsement of caesarean as a marketable commodity within the state funded health system in Aotearoa New Zealand emerged in WFG2. As a form of consumption, a caesarean for no clinical reason, was referred to in the same genre as cosmetic surgery and excluded from the realm of tax payer funding.

We're talking about electing to have a caesarean here, so I kind of liken it almost to plastic surgery []. Why should the government, or why should we as tax payers pay for that person's choice...[] ?
(WFG2, p. 32)

Kitzinger (2001) is critical of consumerist (advertising) discourse that fuels consumptive desires and calls for the deconstruction of choice, based on its designated status in selling products.

Caesarean section is promoted in the USA as a way of ‘keeping your vagina honeymoon fresh’. It is referred to in the press here as the ‘sunroof option’, and invariably treated as life-saving for

the baby, and a safeguard for the mother's health and sexuality.
(p. 284).

It is at this juncture that the embodied nature of consumer desire becomes apparent.

7.6. 1. Embodied sexual subjectivities.

Traditionally, mainstream discourses of the body have largely viewed the body as a biologically determined entity (Kent, 2000). Kent (2000) points out that while there is no disputing the bio-physicality of the body, meanings are also important in that they frame the nature and experience of a biological body through language. Therefore how bodies are represented in professional and popular discourse shapes how bodies are experienced (Kent, 2000; Lupton, 1994). As such, iconographic images have the potential to create a symbolic panic around bodily events such as pregnancy, particularly as slender thresholds of tolerance are lowered in a culture of shifting bodily ideals. For this reason, some feminist writers have taken an interest in the materiality and symbolic significance of the body (for example, Kent, 2000; Grosz, 1994; Hird, 2003; Shildrick, 1997). The archetype of this blending of the corporeal and the symbolic is the pregnant and birthing body within the embodied practice of childbirth (Kent, 2000, p. 193).

7. 6. 2. Embodied disdain.

The current study suggests possibilities for (dis)embodiment where there is a threat to body containment. Stories around vaginal birth ventured into a frank discussion around sexuality in WFG2. Drawing on the experiences of a friend who had had two previous vaginal births, one woman in WFG2 spoke of a disdain that birth had symbolised for her. Suggested here is a dissonance between the corporeal and symbolic significance of the birthing body attributed to the 'undignified' nature of giving birth.

..because she didn't like giving birth. She didn't like the whole process, the whole pain and the whole undignified manner of it. She decided when it was going to happen, she wanted a private room and

she says now it was the best decision she's made and she preferred having the caesarean to the natural birth (WFG2, p. 15).

In interpreting Grosz's (1994) notions of "corporeal flows" (p. 203) vaginal birth epitomises for this woman, a loathing for the messy, leaky, noisy process of birth and suggests a perception around a caesarean as clean, contained and quiet. This embodied panic, brought about by the disdain of vaginal birth, evokes a desire for restraint of body and a space to enable a unified sense of self. This uneasy state attests to the significance of the body in shaping women's experience of childbirth. For Grosz, women's corporeality carries a caption of "seepage" in all its "corporeal flows" (p. 203). Containing of bodily flows beckons the need for a private space.

The desire to remain 'honey moon fresh' (Kitzinger, 1999; Bewley & Cockburn, 2004) as alluded to earlier, emerged from a consumerist discourse to evoke a sexual panic in which the signification of vaginal birth is constructed as pugnacious to the self, in its struggle to maintain unity. The presence of this reality is very palpable from the text of another women in WFG2 about the reasons for her friend electing to have a caesarean.

...she doesn't want her sex life affected. She feels she wants to be tight. She has no intention of breastfeeding because she wants her breasts to stay the same way. This is how she feels. She wants to have a caesarean and she feels that she will then still be the same person. She's not violated or changed (WFG2, p. 9-10).

In this space, presentness (Parker, 1997) has precedence. There is no temporality of future outside of the present, such as the relationship between breast feeding and the health of the baby. Bewley and Cockburn (2002b) are unsympathetic toward the popular myth around the part caesarean plays in keeping the vagina 'honeymoon fresh' and question how much of the self can be found in the vagina. They suggest factors beyond physiology that come into play between partners, such as the transition to parenthood and cite Barrett, Pendry, Peacock et al. (2000) who found sexual (dys)function and postpartum resumption, similar across all modes of birth. Bewley and Cockburn (2002b) contend that acquiescence to a request for a caesarean is of little value and fails to take into account genuine concerns around adaptation to the changes childbirth brings. The assumed primacy sexuality holds is

diminished in the following by a woman in WFG2, who after experiencing a caesarean became a strong advocate for vaginal birth.

The sex life goes right 'out the window' when you've had a caesarean []. Tell your friend to get a life (WFG2,p. 10)

Resistance also became apparent when the notion that pelvic floor exercises have a restorative function specifically after vaginal birth.

You still have to do pelvic floor exercises even if you've had a caesarean section, which surprised me when the physiotherapist came and said, have you started doing your pelvic floor exercises and I said, I've had a caesarean. She said sorry lady, it doesn't make any difference. Your body has actually changed and everything is widened for a natural delivery. I wasn't laughing because of that, it was really that there is no difference. The sex life really does go out the window. Well it did for us anyway for a while and you actually develop a completely different relationship (WFG 2, p. 11).

The woman's account in the text above, subverts the 'regimes of truth' (Foucault, 1984) that wilfully make links between an imperfect inner sanctum of the vagina and mode of birth, particularly alongside suggestions that by undergoing genital enhancing procedures, women's relationships will be enriched (Lloyd, Crouch, Minto, Liao & Creighton, 2005).

Evidence, some of which was introduced in Chapter Two, that suggests that caesarean has a protective function against pelvic floor dysfunction, has been found to be inconclusive in an extensive systematic review of the research around sexual dysfunction and birth mode by Hicks, Goodall, Quattrone and Lydon-Rochelle (2004). Despite methodological variations Hicks et al. (2004) concluded that a spontaneous vaginal birth presents a low risk for sexual problems postpartum. These researchers contend that where a linkage was apparent, this was attributable to an expedited delivery, such as an instrumental vaginal birth or caesarean during labour. For this reason Hicks et al. recommend techniques for minimising the impact of these interventions should they be necessary. In assessing the linkage between vaginal birth and sexual dysfunction, findings are often confounded by ambiguity as to any clear distinction between a spontaneous vaginal birth and instrumental birth. The construction of vaginal birth as a threat to sexual function is juxtaposed to a fear

incited by its association with an uncontained leaky body. Its invocation has surfaced a relatively new enterprise in the discourse of reconstructive surgery; the emergence of designer vaginas.

7. 7. Designer Vaginas: a tactical field of play.

The significance of designer vaginas is its emergence as an object of cosmetic surgery created out of a desire for a perfect interior. Natural birth has been implicated as causing wear and tear on the integrity of the vagina, while caesarean has been touted as a means of by-passing the problem. In media discourse, women's (dis)embodied sexuality has been constituted as a "latest bit of feminine real estate" dilapidated with time and usage, "in need of renovation, beautification and rejuvenation" (Healy, 2006, E5). Healy is speaking as a features writer for a national news publication. This beaconing of corporeal panic has surfaced a multiplicity of discourses operating in a 'field of force relations' sharing a common strategy (Foucault, 1978, p.100-101), the valorisation of designer vaginas. Drawing on Foucault's concept of 'tactical polyvalence' these discourses include; the discourse of pornography, with its template for the perfect vagina; the discourse of gynaecology, with its authorised knowledge of women's (re)productive parts; the discourse of cosmetic surgery, with its disciplinary power "to give a nice clean look" (Matlock, in Healy, 2006, E5) and finally the discourse of popular culture, with its invocation of a pornographic fascination in the imagination of a male partner. These unlikely allies converge to bring about a particular truth about women's bodies. Woven into this tapestry is the discourse of obstetrics, with its promotion of the need for a caesarean to reconcile the panic induced around vaginal birth.

A paradox at once reveals itself, in that studies that have attempted to come up with normative data on the size and shape of women's genitalia, have been to no avail, because of wide variations in women's genital dimensions (Lloyd et al., 2005). Normalisation of women's genital size has important implications for women's bodies and to date no means of quantifying a norm for the embedded sense of vaginal tightness has been established. Nevertheless there are reports in the literature that suggest a preoccupation with the 'ideal' genital size and shape (Lloyd et al., 2005; Essen & Johnsdotter, 2004; Sarwer, Cash, Williams, Thompson et al., 2005). In the (re)construction of the perfect genitalia, media

images tend to be from a 'highly selected' (Lloyd et al., 2005) population of women, whose images, no doubt, have been resourcefully crafted for the camera.

The will to normalise female genitalia has come to light in Healy's (2006) article. What is salutary is her seemingly callow exposure of how female genital surgery is very much experimental.

To do so [grant a reasonable request] requires an understanding of what is normal and what is, by society's current definition, beautiful. When it comes to female genitalia, the standard of beauty, at least, is an evolving standard. And that leaves plastic surgeons little firm basis for deciding which patients are unstable and should be turned away (p. E5).

The irony is the surgery is only available for reasonable and stable subjects who are prepared to pay a substantial amount of money, \$US10,000 – \$US25,000 (Healy, 2006) for their docile bodies to be used in the service of cosmetic reconstructive discourse. Aesthetically pleasing (and perfect) genitalia (see Sawere et al., 2005; Choi & Kim, 2000) is the latest object of interest to come under the gaze of reconstructive discourse. Paradoxically, ideals for this new object of interest have been constituted through discourse of pornography. Interestingly breast surgery, like genital surgery, also takes its ideals from pornography. These ideals receive legitimation through the discursive practice of medicine, a practice contingent upon normative data (sorely lacking) and deemed to be evidence based. Healy reveals one authority of delimitation that attempts to bring into existence normative standards for the appearance of female genitalia.

Dr Matlock is perhaps clearest in his definition of female genital beauty. The porn stars his patients most frequently hold up as exemplary, says Dr Matlock, sport "a nice clean look", with a smooth clitoral hood hugging the clitoris like "a piece of paper draped tightly around a pencil" and petite, wrinkle-free labia flanking a "slit-like introitus" (or vagina) that appears never to have endured the indignities of childbirth (Healy, p. E5).

Protecting the vagina in the face of this adversity (childbirth) presupposes the primacy of coitus over other embodied practices such as birthing and menstruation (Baun, 2004). Thus the coital imperative is given legitimacy through the disciplinary practice of obstetrics by prescribing elective caesarean as a means of circumventing the potential for pelvic damage

(for example, Al Mufti et al., 1996). Braun draws attention to the fact that the constitution of the vagina as a receptacle, invokes notions of passivity and space and that this space, despite it being a potential space, has taken on the signification of a heterosexual space. In managing desire, the self walks a fine line between control (self containment) and capitulation (loss of control) (Bordo, 1990). Thus maintaining a constant vigil becomes increasingly difficult within a consumer culture that is awash with temptation. Bordo argues that in taking on the 'accoutrements' of a masculine world, women may experience empowerment through an opportunity to "...embody qualities – detachment, self-containment, self-mastery, control – that are highly valued in our culture." (p. 105).

Ongoing discussion highlights a counter discourse that neutralises discourses that link the problems of the pelvic floor with vaginal birth.

(WFGm1) In terms of urinating I definitely notice a difference. For people who have had caesareans, how does that affect their pelvic floor in terms of urinating?

(WFGm2) I find that if I sneeze now and I haven't been to the toilet, it leaks. [...] I've been really fit in my life, having been an athlete, so I shouldn't have any problems with my pelvic floor, but as soon as I'm pregnant, bang, it all changes. Having had a caesarean, I was actually quite surprised how weak that whole area was after the birth (WFG2, p. 12).

The resistance shown by WFGm2 toward the association between vaginal birth and urinary incontinence is compelling and is corroborated in the professional literature (Foldspang, Hvidman, Mommsen & Nielson, 2004; Faundes, Guanisi & Pinto-Neto, 2001) and discussed in Chapter Two. Foldspang et al. (2004), examined the risk of incontinence associated with mode of birth and found that urinary incontinence during pregnancy was a precursor for postpartum incontinence. However, because the majority of births, are vaginal births these writers suggest the link is more apparent than real.

7. 8. Mediacentricity.

As with the experiences of friends the media is often the first source of knowledge about childbirth for many young people, often before they contemplate parenthood (Williams & Fahy, 2004). Media discourses serve to encourage the trend, by drawing attention to Victoria Beckham and other celebrities who have undergone the operation. In the women's talk the influence of the media was seen to polarise opinion but at the same time provide legitimation through normalising the choice. Further it was recognised that there was a lack of balanced information and that such bias had implications for the caesarean rates. These ideas were captured in the following interaction from the women's focus group.

(WFG1m1) I think [the media] encourages a polarisation of opinion. That's the first thing it does. I think also to a certain extent it does give permission to some women to make that choice, because they're starting to see growing numbers [] of support. Like if other people are doing it, then It's okay. So I think it will probably impact on the numbers of people who choose...

(WFG1m 2) It becomes like a normalising effect doesn't it?

(All) Mm. It definitely [does]...(many speaking at once)

*(WFG1m3) I think the trouble [with the media] it's not responsible reporting and there is actually sufficient research to justify what they're saying, or sufficient information on the pros and cons, whatever, given. It's different from just, you know, "too posh to push", which is a great quote. I mean, it really is good, but as you say, it does end up with people fitting into camps, and makes a lot of unpleasant judgements about women.
(WFG1, p. 5).*

In WFG2 came a sense that the media should provide greater balance in its reporting. With the increasing regularity of the procedure others will follow in the belief of the "safety of the norm" (Konnor, in Berg, 1988). Silent in media reports, are the real reasons why celebrities are choosing caesareans.

I think I can [see it as a trend] because of the publicity with the people like Victoria Beckham and the reason they choose to have caesareans. My feeling is that there's not enough information out

there in the media about the downsides of having a caesarean and the fact that it is a lot more risky than a vaginal birth. I think if there was a more balanced view [] in the media, I think the numbers would not be so high (WFG2, p. 21).

Meaning is further shaped by drawing upon expert opinion to give newsworthiness to a story (Lupton, 1995). Media coverage of the prediction made by Fisk (Coney, 2001) earlier referred to suggesting that by the year 2010 around 50% of all women will choose an elective caesarean section was a case in point. The appropriation of an authority figure, in the discourse of foetal maternal medicine, as an expert news source and its appropriation by media discourse, serves to hasten the trend. The increasing regularity of commentaries in both professional and popular discourse has the potential to transform this prediction into an expectation. Thus the effect of media discourse simultaneously sanctions and censures a non-clinically indicated caesarean, through glamorising and admonishing strategies.

The effect of this sanction is to set the demand for caesarean by normalising the possibility of the choice of caesarean as an alternative birth mode (see Chapter Five). Greater options for women have been made possible, not merely through the 'advances' in technology, but also through the 'freedom' of the press. The effect of the censure is to stigmatise women who have had caesareans, immaterial of need. As such all women undergoing an elective caesarean are constructed as homogeneous and positioned as 'bad' choosers or irrational decision-makers. What is not said, is that caesarean is a major abdominal operation with implications for postpartum recovery, subsequent pregnancies and future childbearing choices.

Weedon (1997) is critical of the strategies appropriated by the media which effectively erases the possibility for resistance to the meanings conveyed, rendering these even more plausible. One particular strategy is the assumption of a universal 'audience':

The most common of these is the implicit assumption of a collective subject: we are all the reasonable, moral individuals for whom the text speaks. This is a strategy which is hard for the reader to resist. She finds herself placed in a position which implicitly endorses the meanings and values of the article as just good commonsense or as eminently reasonable (Weedon, p. 98).

This normalising strategy is never more evident than in Williams and Fahy's (2004) study that questions whose interests are being served in popular representations of childbearing women in women's magazines. In this tactical field of play, Williams and Fahy found a somewhat convoluted link between patriarchy and capitalism shaping childbearing women's subjectivities. Ideals about what it is to be feminine and how to be 'good' *vis a vis* a compliant childbearing woman, dovetails into stories that are framed around products that capture the market through advertising sponsorship. As addressed elsewhere, celebrities are often appropriated as role models to optimize compliance to a desired norm. For childbearing women, an affinity with celebres may bring into play the 'promise' of pain free birth (Williams & Fahy, 2004), a caesarean to boot.

7. 8. 1. Desire in popular culture.

Women choosing such a caesarean are represented, in some media accounts, as taking advantage of the frills technology has to offer. Technology dons the mantle of a lifestyle accessory enabling the scheduling of birth around important bodily performances and life events. The newsworthiness of caesarean was unmistakable in the barrage of articles taking up space in media publications. Convenience and the desires of the rich and famous are no more apparent than in an excerpt from *Time Magazine*, an international publication.

Actress Elizabeth Hurley had one. So did supermodel Claudia Schiffer. Ex-Spice Girl Victoria Beckham and singer Toni Braxton had two each. TV mom Patricia Heaton had four. They're so popular among the upper class in Brazil that the only way you won't get one in Rio de Janeiro, as the joke goes, is if your doctor gets stuck in traffic.

What all these women had are C-sections. Not the emergency caesareans that have been performed for hundreds of years to rescue babies from women in medical crisis. (Legend has it that Julius Caesar was born this way.) Rather, they had an increasingly popular modern-day variation: planned scheduled operations for all sorts of less-than-critical reasons. One young college student arranged her baby's birth to avoid conflict with her final exams. Another woman was convinced a C-section would ensure that her child's head had a nice round shape. Others are terrified of labour pains and

complicated deliveries or want to avoid the wear and tear on their bodies. Some, as the British tabloids have put it, are simply too posh to push.

Whether or not the label fits, more and more women – and not just celebrities like Maddonna, actress Kate Hudson and Live with Regis & Kelly co-host Kelly Ripa – are taking charge of their childbearing these days and avoiding the vagaries of natural birth (Song, 2004).

In popular culture, the trend has gained substantial ground since the cautionary tale first hit the headlines (*Daily Telegraph*) in 2001. The tenor in Song's text is one that incites the glamorisation of caesarean. Celebrities continue to be used to bolster news stories. Song (2004) hints of a logical progression of this discursive practice, from its appropriation as a life-saving procedure, to its manifestation as a 'modern-day' fashion statement. Reasons for caesarean are manifold, ranging from examination schedules, aesthetically pleasing cranial shapes for babies, fear and disdain of vaginal birth to the avoidance of 'wear and tear' on the body. Intimated in the text is that women are reflecting their discursively constructed desires. It is in and through popular culture that ideals of what is desirable are crafted (Kent, 2000). An effect of Song's genre is to downplay the impact of this major operation for women. Natural birth is positioned as nebulous, to be circumvented in favour of major abdominal surgery.

A slightly different spin came to light in an article in a national weekly newspaper, with wide appeal in Aotearoa New Zealand. Boldly headed "*US mums too proud to push*," parodying the metonymy "Too Posh to Push," its subtitle "C-sections cut to core of vanity" (*Sunday Times*, 2004), added to its augur. In this news story, the desire for the perfect (interior) body, cranial shape, scheduling of life events, has become displaced with a desire for the perfect (exterior) pregnant body. Celebrities, Sarah Jessica Parker and Madonna, are constituted as *objets d'art*, against which the 'product' can be measured. The excerpt that follows illustrates a woman's embodied corporeal panic and brings to light the power relations enmeshed behind the 'body politic' (Foucault, 1984, p. 175).

"I have always been extremely fit and I'm very concerned about gaining weight and having my body "forever changed" as a result of my pregnancy," a woman from California wrote recently to Stacy Quarty, a health adviser at franklypregnant.com.

Her obstetrician had agreed to perform a caesarean at 38 weeks.
“But I really want to have a baby ASAP so my hips don’t get too big. Do you think it’s unreasonable to shop around for another ...that will do the C-section earlier? Is it healthy to get a C-section at 36-37 weeks?” she added (*Sunday Times*, 2004, A19).

Most bizarre, is that the subject of the article has her desires for the perfect body, legitimated by her obstetrician. A counter discourse is offered in the same article citing research from a medical expert, warning of the potential risks that vanity may have for the health of the baby. In the same article other sources are drawn from to add extra veracity to the story.

Longhurst and Johnston’s (1998) concept of Embodied Geography is especially relevant here, with regard to the manner in which women’s bodies are variously located within different (public / private) spheres in which their discursively constructed corporeality is negotiated. Longhurst and Johnston (1998) illustrate pregnant women and women bodybuilders to illustrate their point as these women differ in their relationship to public locations on the basis on their different embodiments. Utilising Kristeva’s (1982) concept of abjection, to explain how pregnant bodies are represented, Longhurst and Johnston explain that pregnant bodies are codified as non-sexual, disabled, incapacitated and ugly and therefore best kept within the private sphere away from the public gaze. Bodybuilders on the other hand are constituted as sexy, their taut slim bodies (provided these don’t invert as overly masculine) are coveted to come under the public gaze.

Lupton (1994) proffers that in a consumerist culture; obsession with the body has become embodied as narcissistic. She contends that narcissism has emerge from a contemporaneous “commodity culture” in which the body has become “packaged” in order to maximise its value in the market place (p. 36). Pregnant bodies have the potential to disturb this uneasy balance between self-image and self control. Kent (2000) dismisses the desire to be slim as buckling under the pressures of vanity; rather she sees it as a response to the dominance of a phallogentric culture that gives primacy to the autonomous individual (p. 205). Accordingly, the quest for the perfect body is more to do with exercising control and the desire for freedom than it is about nervousness around body image (Lupton, 1994).

7. 8. 2. Media and the medicalization of childbirth.

Earlier Parson's (2002) story stood out as a potent unveiling of a growing tendency, within the genre of satire, to view a 'natural' birth as a frightening experience and caesarean section as the panacea of a pain-free birth. The regular occurrence of caesarean as a liberating force has the ability to legitimise this mode of birth and in so doing galvanise the medicalisation (and in the context of the current study, surgicalisation) of childbirth once and for all. In the context of the current study, women's birthing bodies are the object of an obstetrical gaze that has rendered vaginal birth as problematic, which caesarean can fix.

More sinister is the incitement of fear, linking a vaginal birth with a defective body. Such was the case when an incantation, appeared in the Sunday Star Times, hailing women into the choice of a caesarean (Laws, 2004). Under the pretence of satire, Laws lures women to abandon vaginal birth for their own good. Waves of paternalism echo between the lines of his text. The obsequious tone of the text at once glorifies and objectifies women. In the following excerpt, women are being both lauded for their role in the survival of the species and objectified as some form of lottery prize.

Women are genetically programmed to forget the pain of childbirth. Apparently this is because Nature wants them to have more. And because if they had the slightest perception of what they had been through, then no man would get close, let alone lucky. Mind you, there has to be some compensation. If birthing were left to men, human kind would expire within a century (Laws, 2004, p. C9).

Behind this facade of satire is a thinly veiled biological essentialism that defines women both in terms of their ability to keep the human race going and in terms of men's desires. This rhetorical strategy is used both to instil a sense of women's place in society and a foreboding around what happens to women's bodies when they reproduce, as is evident in the following text.

Any woman who has laboured is little short of heroic in my book. The distended belly, the incontinence, the veins...dear lord, the clothes. And that's all before the waters burst and the Spanish Inquisition arrives – its intent being to torment and rearrange a woman's nether regions. Which it does.

Little wonder then that such a brutal barbarism has provoked a counter-revolution. From women themselves. And little wonder that the caesarean is suddenly in vogue with one in four Kiwi kids now being delivered via the scalpel rather than the cervix (Laws, 2004, C9).

Women's reproducing bodies are denigrated and positioned in relation to men's desires for not only for the perfect body. Here women's bodies have failed to live up to the male norm. Natural childbirth is positioned as unbecoming, brutal and barbaric. Giving birth has become disembodied, reduced to detached 'bits' such as the scalpel. Women who signal a desire to circumvent this repugnant state are positioned as resistance fighters leading the charge to liberate all women. In line with Laws' ideology is the belief that pregnant bodies are a no-go zone (*sic*) an 'emplacement' in which pregnant bodies are coded as non-sexual and ugly and kept from the public gaze (Longhurst & Johnston, 1998). Longhurst and Johnston's (1998) concept of 'embodied geography' has utility here to explain the different spaces for women's labouring bodies. Laws' construction of women's (ugly) labouring bodies would see these best emplaced in the private spaces of the clean, controlled environment of an operating theatre, away from public view, in contrast to the vocal, messy and capricious space of the birthing room. He uses dubious statistics to strengthen his case and a series of dichotomies that pitch natural birth against caesarean, midwives against doctors, defining each on what the other is not. Little room is left for women to decide. Those who express concern are positioned on the basis of being 'PC' and treated with contempt, midwives especially.

And where's the choice in maternity care? There was a turf war between midwives, GPs and specialists. Well the midwives have won that – essentially because they are cheaper. Not better but cheaper. They now appear to be going around mopping up the last resistance (Laws, 2004, p. C9).

Under the guise of liberalism, Laws' so called common-sense approach stealthily conceals the complex and contradictory nature of caesarean, in the absence of clinical indications. The undermining of midwives has the potential to persuade some women to demand a caesarean. A possible impact of Laws' sensationalism is to undermine women's confidence in their bodies to give birth naturally. Toward the end of Laws' spoof he positions himself as a feminist and summons his readers to ironically respect women's autonomy.

Me? I'm a feminist. Give women what they want. And if a male can make sure they get to see their babies arrival and the rugby test on the same day – that seems sane to me (p. C9).

Here the expropriation of feminist discourse juxtaposed to the Kiwi bloke vernacular, double as discursive strategies. The effect of representing caesarean as a deliverance from the chore of childbirth is to conceal a latent nexus of power relations, serving the interests not necessarily of those Laws purports to represent. His positioning himself as a quasi comic in the text veils a gender bias that is guarded behind a mask of libertarianism. For Laws' the 'second wave' of the medicalisation of birth has arrived.

7. 9. Conclusion.

How caesarean is spoken about in professional and popular culture has the potential to shape desired ideals for what it means to be a childbearing woman in the current moment. Out of the compilation of the talk of women, midwives, obstetricians and the media, emerge the discourse of convenience and desire. These discourses are interrelated in a mutuality that has reformulated the meaning of choice and control in childbirth within the broader parameters of the discourse of consumerism. The discursive construction of the choice of caesarean as an optional extra has materialised from a multiplicity of meanings that merge into an ensemble of conflicting expectations on how babies are to be born. Amid the cache of mutable 'truths,' is a reminder that there is no one universal 'truth,' that serves to account for women's choice of caesarean for no obvious clinical justification.

Childbirth has come to settle at the intersection of the 'natural' and the 'cyborg'. Each has its own signification of the enactment of control around childbirth. For some women the meaning of empowerment lies in the exhilaration of confronting their corporeality as in the case of natural birth. The embodiment of pregnancy and childbirth for these women represents the quintessential expression of a complete and fulfilled sense of self. For other women, the essence of motherhood no longer holds centrality in their lives. Empowerment for these women may lie in shaking off their biological providence, choosing instead to circumvent the uncertainty of giving birth naturally. Importantly, well educated women are choosing this major intervention for

themselves. It is the appreciation of these diverse realities, complexities and contradictions that confront the discursive practices of childbirth today. Here convenience and desire form a loosely woven tapestry to reveal a fragmented and shifting terrain upon which decisions are to be made. What is most profound in the informants' talk and texts of both popular and professional culture, is how vaginal birth is represented as dangerous, an abyss from which there is no escape and a threat to women's embodied sexuality. Increasingly the encroachment of reproductive technologies into the domain of childbirth has meant some women have come to lose confidence in their body's ability to perform. The medicalisation of women's bodies has heralded in a need to normalise women's reproducing bodies in relation to men's desires for the perfect body. Desire and convenience are not alone in shaping women's choice of birth mode, but overlap within a wider mosaic of discourses not the least of which is fear and risk, the focus of Chapter Eight.

Chapter 8. Discourse of Risk and Fear.

8. 1. Introduction.

Woven throughout this thesis is the construction of childbearing women as self-governing individuals, able to determine their options in the (re)productive market. This premise is reinforced in particular in Chapters Six and Seven, where the discourse of autonomy along with the discourse of convenience and desire, were identified from the talk and texts of women, professionals and popular culture, as influencing women's choice of caesarean as an alternative birth option. Both have reconfigured the meaning of choice in the discursive practice of childbirth. Chapter Six, was testimony to autonomy (re)surfacing as an immutable reality within the wider discourse of liberal humanism, its agitation into medical discourse coiling back on itself as a form of control. In Chapter Seven, the discourse of convenience and desire, overlap in a blended mutuality that enabled a different enactment of control around childbirth. As the topic has been played out in both professional and popular culture, 'choice' in childbirth has come to reflect women's discursively constructed and fragile subjectivity. The fragile nature of subjectivity, is integral to Chapter Eight in women's, midwives' and the obstetrician's talk, from which the discourse of fear and risk are identified. Fear of childbirth materialised as a fear of pain, loss of control and fear of the outcome. A follow on effect of this fear has been the imaginations of risk associated with vaginal birth. These fears then spill over into media discourse to reformulate commonsense truths about childbirth.

In Chapter Eight I argue that through the omnipresence of fear and risk, there is a capricious space in which exists the possibility for the simultaneous abnormalisation of normal (vaginal) birth, and normalisation of abnormal (caesarean) birth, for low risk childbearing women. For the purposes of this study, these discourses embody two sides of the same coin, in so far as the invocation of one is the invocation of the other. Themes to emerge in and through these prevalent discourses are probed alongside (dis)enabling evidence. Pertinent too are the conditions of possibility that have constituted fear and risk as a profound and poignant force for constructing choice in childbirth.

8. 2. A culture of fear.

Fear and risk have become ubiquitous features of contemporaneous Western society. Furedi (2002) argues we have become a culture of fear that is incessantly preoccupied with risk (p. xii). This obsession with safety, he sees is more to do with a compulsive fear than to do with scientific thinking (Furedi, 2002, p. 12). Safety, which a non-clinical caesarean section has come to symbolise, resonates as an “empty signifier” (Laclau, 1994) that has come to represent a plurality of meanings to fill an uncertainty void. For this reason, the increasing regularity of caesarean has the potential to normalise this mode of birth, juxtaposing a normal vaginal birth, as a riskier option. At this particular historical moment, women’s choices have come to rest in a bio-political space occupied by what Davis-Floyd (2001) and Shaw (2002) refer to as “cyborg” and “natural body” subjects. In this space, fear and risk intersect to position healthy childbearing women somewhere between health and pathology.

8. 2. 1. Fear of vaginal birth.

Many writers align the rise in request for caesareans with a fear of giving birth vaginally (Bewley & Cockburn, 2004; McFarlin, 2004; Hofberg & Brockington, 2000; Ryding, 1993; Hildingsson, Radesstad, Ruertson & Waldenstrom, 2002). The extent that fear of childbirth is disabling is classified in the psychiatric literature as tokophobia¹ and defined as “an unreasoning dread of childbirth” (Hofberg & Brockington, 2000, p. 83). When it occurs in nulliparous women it is referred to as primary tokophobia. Secondary tokophobia may occur as a result of a previous traumatic experience (Hofberg & Ward, 2003). In the current study, knowledge sharing was seen by women as a means of overcoming fear of giving birth vaginally. One woman tells of her endeavours to help her sister overcome her fear of vaginal birth.

... I read loads of books when I was pregnant and that all convinced me that a vaginal delivery was by far the best thing for

¹ The etymology of toco- is childbirth. (See Harris, P., Nagy, S., & Vardaxis, N. (2006). (Editors-in-Chief). Mosby’s dictionary of medicine, nursing & health professions. Australian & New Zealand edition. Sydney: Mosby / Elsevier).

the baby. I've given her a few books to read and I think the more information she has, the more the fear will diminish because she'd know what's going to happen and how a huge proportion of women have entirely wonderful deliveries (WFG2, p. 7).

The text highlights how women's relationships with other women, as part of a wider network of relationships outside of maternity care providers, plays a significant part in the constitution of women's choice in childbirth. Shared knowledge and experience are strategies perceived to enable informed decision-making. Equally fears can spring from birth narratives that have an apocalyptic impact as is evident in Tom's depiction.

The other issue is one of "myth", these are stories that patients would imbibe from friends, relatives, and aunts. It's a bit of human nature, the more morbid the story or the more frightening the story the greater the audience, and the greater the receptivity of that story. So, nobody would talk about a happy birth experience, it's always how they know of somebody's daughter who had a bad experience and the baby delivered in a poor condition. So, it's the fear that patients encounter, having heard these stories (Tom, p. 2).

Myths and stories have the potential to kindle morbid fascination with frightening accounts of childbirth that disempowers women's confidence in their bodies to give birth.

Davis-Floyd (2001) suggests the trust eventuating in technology, appears to be predicated on its ability to control uncertainty. In her discussion around the "technological imperative" (p. S10), she suggests that the more proficient we are in using technology to better nature, the greater our fear of those natural processes that are beyond our control. In an earlier publication, in citing Richards (1993), Davis-Floyd (1994b) contends birth, death and sexuality are three natural processes that cannot be controlled and so are feared in Western society. All are encoded within childbirth. In this sense a caesarean guarantees control over natural birth and appeases the fear of its uncertainty. It follows then, that control has become synonymous with safety. Yet for Davis-Floyd (2001) the representation that technology is an improvement on nature, is illusionary. "These procedures keep fear at bay by giving both practitioners and birthing women the illusion of safety: They appear to minimize risk while in fact they often generate more problems than they solve" (p. 10).

Concern over fears around vaginal birth has prompted some obstetricians to question colleagues who desire to control this physiological process for healthy childbearing women (Bewley & Cockburn, 2002b; Klien, 2005). While obstetricians' fears surrounding childbirth are widely known, it has only recently come to the surface in the medical discourse (Klien, 2005; Wax, Cartin, Pineete & Blackstone, 2004). In their American survey, exploring the preferences for birth mode among practising O & Gs, Wax et al. (2004) reported "Fear of childbirth" as an "acceptable indication" for their own, womens' and / or their partner's choice of caesarean (p. 205). These fears largely centre on the potential for pelvic floor disorders and loss of sexual functioning. Klein rejects this endorsement of fear of childbirth, drawing attention to a Scottish study, he claims Wax et al. ignored, in which all female O & Gs, who had a previous vaginal birth would choose that birth mode in subsequent pregnancies. Where a previous vaginal birth has resulted in a traumatic experience fear of vaginal birth is a plausible reality.

8. 2. 2. Previous traumatic experience:

In the current study, a history of a previous traumatic experience was uncontested as a 'relative' indication for a subsequent planned caesarean. Previous traumatic experience was a reality considered to have both a material and symbolic impact on the health of a woman and her baby and has been found in the wider literature to be an important factor behind maternal requests in subsequent pregnancies (Hofberg & Brockington, 2000; Melender, 2002). One woman related a poignant story of personal loss.

My first child died neo-natally so I've always known that if I wanted a caesarean I could have one and that it's there as an option.

The second baby was lost at thirty-three weeks and my younger sister lost hers at thirty-nine weeks. My older sister I think was thirty, my younger sister and myself decided to opt for caesarean purely because, really the fear. There was no indication to say that it might go wrong, but you feel as if you want to choose to have a caesarean (WFG2, p.4-5).

Another woman who had a previous traumatic experience preferred to leave her options open by going to a specialist for her subsequent pregnancies. She had confidence in the specialist who she perceived was willing to support her decisions and thus enable a sense of control over their birth in subsequent pregnancies. Zadoroznyj's (1999) study is pertinent here in that for many women the experience of childbirth represents a 'critical reflexive moment' in their lives with important implications for having greater control in subsequent births. This repositioning of the self as a consequence of experience opens up a range of possibilities for determining future encounters with maternity care providers.

While evidence suggests that many women will respond to counselling and proceed to a vaginal birth (Ryding, 1993; Sjorgren & Thomassen, 1997) the experience of a previous negative experience has implications for subsequent infertility (Gottral & Waldenstrom, 2002). Importantly a previous emergency caesarean and instrumental vaginal birth are key elements implicated in a negative experience (Hofberg & Ward, 2003; Ryding, Wijma & Wijma, 1997). Moreover Hofberg and Ward have identified a 'vicious cycle' in that a morbid fear of childbirth has been implicated behind emergency caesareans and instrumental births. It is for this reason women's fears need to be taken seriously if a vicious cycle is to be avoided.

Women who undergo caesarean for genuine reasons also need to be taken seriously. One woman in WFG1 recounts her deprecation with her previous emergency caesarean.

...I had a medical caesarean, I had pre-eclampsia, and sort of trying to resist having a caesarean and ended up getting induced and um went into foetal distress, we ended up having a caesarean and when I was in the ward recovering afterwards I had several nurses ask me if I had an elective caesar, yeah and some of the comments, they didn't feel very positive towards me (WFG1, p. 2-3).

Another woman in WFG1 had a friend who faced a similar experience. The effect of the censure was to evoke silence, blame and a sense of marginalisation upon an already fragile subjectivity. Fear of vaginal birth in the absence of a previous

traumatic experience was perceived to be linked to the fear of pain and fear of losing control.

8. 2. 3. Fear of pain:

Juxtaposed to a previous traumatic experience, is a debilitating fear of pain associated with vaginal birth and emerged from one member of the group as she related the story of her sister who went into premature labour after having been denied a caesarean (WFG2, p. 5). This is consistent with the findings of Hofberg and Brockington (2000) who found an increased morbid outcome for those women who were declined a request for an elective caesarean. A caesarean was also seen as a way of getting around the fear of pain and anxiety associated with giving birth and was discernible in both WFG1 and WFG2.

...I think if a woman had an extreme phobia or something about giving birth vaginally, to my mind that would be a clinically indicated reason for her choice of a caesarean; if she's going to be that stressed about it, it's highly unlikely it's going to be a particularly good experience for her or the baby (WFG1, p.13).

*People can have just as much of a fear can't they, even if they haven't had a bad experience and they still have a lot of fear of pain, or just the worry if it's[the birth] going to be okay and they want to actually choose to control it.
(WFG2, p. 6).*

There was an overall sense that if the fear of giving birth vaginally is so stressful, that it has psychological implications for a woman and her baby, then it is considered a valid reason to have a caesarean. Ryding (1993) asserts there was a case to be made for a caesarean for those women who continued to have a debilitating fear of childbirth following counselling.

How childbirth is represented within the context of women's lives, will shape a woman's embodied experience of giving birth. Fear of giving birth has the potential to threaten an autonomous sense of self. As an object of interest in psychiatric discourse, tokophobia has implications for standardising strategies for dealing with everyday

anxieties around childbirth. Kitzinger (1998) however cautions against the medicalisation of women's normal fears about giving birth. Then again, for women who have a strong sense of control over life events, representations of women's faulty body, as portrayed in medical discourse has the potential to set women up to fail against the imperative of natural birth (Sbisa, 1996). Sbisa maintains that when the forces of nature are pitched against the forces of obstetrics, a woman's fear of abandoning herself is intensified. This only serves to reinforce the need to control how her baby is to be born.

8. 2. 4. Fear of losing control.

In Chapter Six it was revealed that having control over one's childbirth experience was the prerogative of middle class women, a privilege sanctioned through popular media (Parson, 2002). In Parson's article "*When push comes to shove*" fear of loss of control is the overriding concern. Here middle class women were singled out as wanting to be in control of life events. The article signalled a turn from the moral indignation directed at celebrities, to middle class women as feisty liberated women. In her text, the fragile and contradictory nature of the subject emerges from the imaginings of a vaginal birth. Fear of loss of control is constructed as the enemy of middle class women.

Middle class women of my generation are used to being in charge of every aspect of our lives and, faced with the most frightening experience of those very controlled lives, it is hardly surprising that an increasing number of us exert what power we can and opt for a caesarean (Parson, 2002, p. B8).

The provocative tone of the text has already produced its effect that is the construction of caesarean section as a birth mode for today's self-governing women. This subject position is given legitimisation through the institution of the media through popular discourse.

In Davis-Floyd's (1994a) study, professional women tended to view the mind as separate from the body. Thus biological processes, such as pregnancy and giving birth, were seen as 'out-of-control,' disrupting their ideals of a self-governing self (p. 1130). In the women's talk of the current study, while preferences for control in childbirth

differed across the group, fear of losing control was considered to influence why women opt for caesareans.

Fear and control are big reasons. It's losing control...(WFG2, p.15).

Of interest was a distinction between control over time and control over the birth process. The control a woman has over birth when she chooses a caesarean was interpreted as tentative.

But the control you have with a caesarean is only time. That's all. You don't really have any control over the rest of the process (WFG2, p.15).

Another member, who had had a previous history of an emergency caesarean, surfaced a different meaning of control over birth through a planned caesarean. Implied here is that the actual birth of the baby is only one part of a process. Preference for control in childbirth emerged as varied in women's talk. For one woman, the preference was to go to a specialist, while she contemplated her choices. Trust in her obstetrician took precedence over desire for control over her birth experience.

(WFGm1) I'm a very trusting person of doctors in hospitals and clinics. I would just put that trust in the professionals to look after the birth of my child, rather than perhaps myself feel responsible for it

(WFGm2) So you would give up responsibility for your own birth?

(WFGm1) Yes. [] I'm not pregnant so it's hard to say.

(WFGm2) What about trusting your midwife to guide you through the process and then you feel like you've got some input as well, rather than giving it all away to people who do things to you?

*(WFGm1) I think it's about fear of the unknown
(WFG2, p. 15-16).*

In the continuing interaction, WFGm1's fear of the unknown stemmed from conversations with friends about their (complicated) experiences with childbirth. The obstetrician is positioned as an agent, whom she trusted to negotiate her childbirth on her behalf, someone to guide her through her fear of the unknown. WFGm2

encourages WFGm1 to trust her midwife to guide her. The assumption is that if WFG2m1 trusted her midwife to take her through the process she would retain some control in childbirth. The interaction illustrates the different perceptions of maternity care providers and their diametrical position in relation to who has control in childbirth.

8. 2. 5. Fear of outcome.

The women in the focus groups drew on a vast range of experiences to inform their knowledge of childbearing. Their sources include first hand awareness of childbearing or through family friend, relatives, women's networks and the media. How childbirth is represented through these channels shaped the manner in which birth outcomes are perceived. Fear of the unknown may serve therefore as a powerful incentive for choosing a caesarean. Tom proffers that fear has a major bearing on women requesting a caesarean.

I think that it is the fear of women, or people in general, of the possibility of things going wrong during labour. So, that is the one issue. The second one is the issue of pelvic floor dysfunction. [talks about research]. We [researchers] know that vaginal deliveries are associated with a high incidence of urinary and faecal incontinence, as compared to women who have not had a vaginal delivery (Tom, p. 2)

As identified in Chapter Six fears surrounding pelvic floor dysfunction come through Tom's text. The embodiment of fear has both a material and symbolic impact on the health of women and their babies and as discussed earlier, positions fear as a 'relative' indication for a caesarean. However, Bewley & Cockburn (2004) caution practitioners to look beyond a request for caesarean, as fear of vaginal birth does not necessarily signal a desire for caesarean.

8. 2. 6. 1. Fear of outcome and assisted conception.

Fear of the outcome was particularly intensified for women who had undergone assisted conception. In the women's talk, pregnancies conceived through assisted

reproductive technologies (ARTs) were perceived to be behind an increase in caesarean rates.

There's another group mentioned in the 'Treasures article'; it was women or couples who had had fertility treatment in order to conceive. A lot of those were saying that they opted for a caesarean, even though there was no clinical reason, simply because of it being so difficult for them to conceive and they had so many concerns about maintaining the pregnancy, and that there's - to them, they just weren't willing to take the risk of vaginal delivery. So that's another group as well and I wonder if, because there is an increasing number of people using fertility treatment, whether that's contributing to the numbers as well (WFG 1, p12).

With increasing numbers of couples using fertility services it is perceived that there will be a corresponding increase in the demand for caesarean. A caesarean represents a means to an (positive) end for parents. By implication a vaginal birth is seen as risky. Parents' expectations for a perfect baby have been made possible through technology and its immutable promise of certainty.

The impact assisted conception has on caesarean section rates, is evident in the literature (Thompson, Shanbhag, Templeton & Bhattacharya, 2005; Wang, Sullivan, Black, Dean, Bryant & Chapman, 2005). Wang et al. undertook a retrospective study of infants conceived through ART between 1996 and 2000. They confirmed a higher rate of caesareans (47.1%) associated with ART when compared to the general population of childbearing women (25.4%).

The association of ART and caesarean also emerged in midwives' talk. Where women's faulty biology is represented as the inability to conceive without the aid of technology, the resultant anxiety is transmitted to an inability to give birth naturally. In the midwives' talk women who have undergone in vitro fertilisation (IVF) are positioned as desperate subjects.

(MFGm1) And again that happens [] with the IVF [] they've already had failed IVF cycles or they get a pregnancy, they miscarry, they want this baby and they don't want any risk.

(M FGM2) Yeah, it's the risk, isn't it? (MFGDHB, p. 18).

For a growing number of women undergoing ARTs, the choice of an elective caesarean is a foregone conclusion. This technological solution is reflective of how the medicalisation of childlessness has evolved discursively over the last four decades. In tracing the historical roots of infertility, Whitford and Gonzalez (1995) found that prior to this time, infertility had not materialised as an object of medical discourse. Childless couples were merely integrated into the extended family structure. The emergence of infertility within medical discourse was enabled against a pronatalist backdrop, advances in endocrinology, fertility enhancing drugs, and internal surveillance of pelvic organs. Whitford and Gonzalez proffer these conditions were also accompanied by wider societal transformations, such as the changing status of women in the workforce and concomitant delay in childbearing, alongside the limited availability of babies for adoption.

Becker and Nachtigall's (1994) analysis of infertility within a framework of risk conceive medical risk-taking as a form of elite risk-taking, as opposed to social risk-taking. They conceive that therapy, regardless of risk, means that risk becomes normalised. Women then willingly prepare themselves for the risks associated with technological conceptions in order to have a 'take home' baby (Becker & Nachtigall). Becker and Nachtigall suggest infertility is best situated as a social construction so as to avoid the potential for women to become victimised, positioned as desperate and scorned for not attaining society's norm of motherhood. This socially constructed gender expectation of motherhood as the natural and inevitable path for women is powerfully reinforced in popular culture (Kent, 2000; Williams & Fahy, 2004).

8. 2. 6. 2. Assisted conception and the precious baby.

Within the discourse of risk, babies conceived by ART are positioned as precious, in need of specialist care, as one midwife highlighted eloquently.

There is the notion of the precious baby, there certainly is the notion that the baby is very, very precious and that the only way to care for them is to give them specialist care and that somehow or other equals safety. They should birth in hospital for safety and they really ought to have a doctor present (MFGSE, p.21).

Specialist care is deemed safe care. The onus is on the woman to be a ‘good’ mother by avoiding risk (Kent, 2000; Lupton, 1999). An interesting paradox is apparent in that the technology that secured a pregnancy may not fulfil the same for future pregnancies. Evidence from Jolly, Walker and Bhandra (1999) and Mollinson, Porter, Campbell and Bhattacharya (2005) show an association between caesarean and subsequent (in)fertility. Putting aside future pregnancies, evidence of the risk of ARTs to babies is beginning to surface in the paediatric and obstetric literature (Green, 2004; Wang et al., 2005). In Wang et al.’s (2005) study, when compared with their national Australian cohorts, babies conceived to women who had undergone assisted conception were at greater risk for preterm birth (PTB) and low birth weight (LBW). These findings are also supported by Thompson, Shanbhag, Templeton and Bhattacharya’s (2005).

8. 2. 6. 3. Power / Resistance.

The positioning of babies from ART, as precious in relation to babies conceived by other means, suggests relations of power enmeshed in this field of play. For Foucault (1978) wherever there is power there is also resistance (p. 95). Rather than seeing power and freedom as mutually exclusive, Foucault (2003) conceived them to be co-productive and ubiquitous. He articulates its productive capabilities as;

...a set of actions or possible actions; it incites, it induces, it seduces, it makes easier or more difficult; it releases or contrives, makes more probable or less; in the extreme, it constrains or forbids absolutely, but it is always a way of acting upon one or more acting subjects by virtue of their acting or being capable of action (p. 138).

Implied here is a “field of opportunities” (Foucault, 2003, p. 138) in which all manner of means are available to a subject when power is acted out. To the extent that power is acted out is epitomised in the midwives’ talk that follows. MFGSEM1 recounts the story of a woman’s desire to have a normal birth, after a successful conception. It portrays an uneasy terrain some women have to negotiate to resist being positioned as a risky subject in obstetric discourse.

(MFGm1) They had to spend an enormous amount of energy justifying that it was okay to have a home birth, or a normal birth. They were strong people, but they had to do a lot of work

(MFGm2) And had to be strong?

(MFGm1) And they did have a simplistic normal birth, but it was like, they were constantly having to tell people that it was okay to do that.

(MFGm3) It is just society, here again we're hearing from our colleagues that this is a precious baby from IVF.

(MFGm1) Yes, it's not like they're all precious?

(MFGm3) Exactly, what baby isn't precious?

(MFGSE, p. 23).

Under the medical gaze, a home birth would be regarded as 'precariously normal' (Armstrong, 1995) and in relation to ART, a forbidden prospect. Nevertheless the woman in the story was able to act upon her desire through resisting a technological imperative. While the woman was acted upon by disciplinary practice she was also 'capable of action' as Foucault attests.

Sawicki (1991), a Foucauldian feminist, sees as plausible the part women have played in defining current practices "for better or worse" (p. 80). Sawicki discounts the view, held by many radical feminists, that new reproductive technologies are a symbol of men's triumph over women's reproductive bodies. Rather, she sees a wider social field encumbered with a complex network of power relations, not necessarily emanating from a hierarchical foundation. For Sawicki (1991) the historical pathway of 'women's procreative bodies' has been one of struggle and resistance from a multiplicity of contestable sites of which childbirth is one such site. Monopoly over childbirth has encompassed interplay between 'natural' childbirth and obstetric ideologies, both sometimes co-opting each other's rhetoric (Arney & Neil, 1982; Sawicki). Sawicki claims the application of Foucault's disciplinary model of power, to the broader social field, has potential to open up a wider range of opportunities for women within a range of subject positions available. One such subject position has its signification in cybernetics. Feminist anthropologists, Davis-Floyd (2001) and Shaw (2002), suggest that the materialisation of our interdependence with technology is our

transformation as cyborg subjects, a subjectivity in which the boundaries of our cybernetic and organic components have become ostensibly hazy. It is in reproduction that this embodiment of technology arguably has its highest expression.

8. 2. 7. Fear of litigation.

Fear of outcome has not only constituted women as risky subjectivities in and through the discourse of risk, but also through practitioners' fear of litigation. A perceived fear of litigation is implicated as a factor behind the constitution of choice of a caesarean in the absence of clinical justification. The potential for litigation was epitomised in the following conversation and foreshadows an ominous turn for clinicians to practise defensively in the future.

...like we're saying already with breech, they're covering themselves, the next thing we're saying is the twins, that that'll probably be happening. And then with the women themselves, you've only got to say, well my baby's less intelligent at 7, and that was probably because I had a vaginal birth. Because some research will come out in years to come that says that having a vaginal birth is downright dangerous to your baby, and a risk to your baby's intelligence (MFGDHB(p. 18).

Skolbekken (1995) attributes, in part that the current resurgence of risk has to do with a vested interest in containing malpractice claims through risk management. While the threat of these claims overseas is very real, in Aotearoa New Zealand, practitioners are protected through a no fault personal insurance scheme administered by the Accident Compensation Corporation (n.d.). This cover precludes the prospect of litigation in cases of malpractice. Tom contends that there are no statistics on neonatal morbidity and litigation in this country to provide insight into the impact of the threat of litigation on practice.

...its very difficult to comment, saying what degree of litigation may be responsible for a physician to deliver by caesarean section. Yet, in the UK and USA and Canada that is a concern and obstetricians would prefer doing an elective caesarean section than a vaginal delivery because of the possibility of litigation. But I cannot comment in New Zealand but I personally do not believe that is something that influences my decision (Tom, p. 10).

Cotzias, Paterson-Brown and Fisk's (2000) study exploring obstetricians' attitudes toward maternal request for caesarean (Chapter Two) have shown that fear of litigation is a key factor shaping the defensive practice of obstetricians in the UK. Fear of litigation has been substantiated by Symons (2003) and Kirkham and Stapleton (2004) as a commonly cited reason for caesarean. A common belief lies in the notion that any action is better than none. However Fernandes (2004), a forensic pathologist and obstetrician in the USA, warns that acting pre-emptively cannot always be taken-for-granted.

Soon enough I expect that a lawyer will find grounds to launch litigation for the complications encountered by a patient when the procedure had no scientifically supportable justification. The legal justification for the law suit will undoubtedly be that the patient truly did not appreciate the risks and that we as a medical profession did not clearly identify the risks. Keep in mind ANY complication of an unnecessary surgical procedure is unnecessary (2004, p. 4).

Coney (2001) in her feature article in the *Sunday Times* newspaper, is unsympathetic to doctors fear of litigation. This is evident in her response to the prediction that by the year 2010 around 50% of childbearing women would choose a caesarean as a matter of choice.

To get birthing women into hospital (and squeeze out home birth with midwives) doctors have promised women perfect births and perfect babies. But if you play God you get blamed for obstetric disasters. Some C-sections represent defensive medicine. Doctors can get blamed for not doing enough, but not doing too much [*sic*]. But Wagner points out that the growing C-section rate has not led to a drop in litigation (2001, C6).

Coney (2001) backs up fear of outcome, the need for a perfect baby and litigation as factors behind the trend for this choice of birth mode. She cites Wagner (2001) to strengthen her case. Wagner questions the morality of defensive obstetrics and refutes its appropriation in childbirth. "During the years that defensive obstetrics increased there has been no slow down in litigation" (p. 86). Allied to the fear of litigation is the fear of the potential for adverse outcomes.

8. 3. Risk.

Furedi (2002) simply explains risk as “the probability of damage, injury, illness, death or other misfortune associated with a particular hazard” (p. 17). He asserts, as a concept, risk is open to infinite interpretations, fraught with ambiguity and discursively constituted within particular socio-cultural and political contexts, founded upon mainstream thinking, at a particular period in time. Inherent within these multiple meanings of risk, is the distinction between what is actual and what is possible that suggests a tension between present and future temporalities. Furedi (2002) argues that relations between these temporalities (recall Parker, 1997) are contingent upon how secure society is with itself in the present. A propensity to focus on “adverse outcomes” is foundational to a fear of the future, consequential to a preoccupation with uncertainty in the present (p. 18). The constitution of risk then, is influenced by how society perceives its ability to control its future. Within the context of childbirth, in some quarters, a preoccupation with the uncertainty surrounding a vaginal birth today, has led to a fear of childbirth per se, the effect of which is a focus on the potential for “adverse outcomes” and to attempt to avoid these where possible.

8.3.1. The Historical Context of Risk.

Following Ewald (1991), Lupton (1999) chronicles the historical and erratic pathway that risk has embarked upon, from the middle ages through modernity to postmodernity. During the Middle Ages risk was attributed largely to forces outside the individual’s control. Predicated on the Enlightenment, modernity emerged to embrace notions of an ordered world underpinned by natural laws in which knowledge was conceived of as objective, progressive through time, was measurable and amenable to prediction (Lupton, 1999). As suggested elsewhere in this thesis, the notion of a linear temporality, assumes an endpoint that will culminate in a final truth. A truth about risk has accordingly transformed over time, from a notion of providence to one of control and predictability (Lupton, 1999).

Toward the end of the twentieth century, understandings of risk came to rest alongside uncertainty, focussing on the potentiality of harm (Lupton, 1999). Lupton proffers “...‘risk’ is often used to denote a phenomenon that has the potential to deliver substantial harm, whether or not the probability of this harm eventuating is estimable”

(Lupton, 1999, p. 9). Statistical developments enabled a surveillance of the population and the early detection of the populace outside the parameters of a statistical norm (Lupton, 1999). Probability estimates allowed the extent to which an outcome can be predicted from a hypothetical relationship between variables (risk factors) (Armstrong, 1995; Lupton, 1999; Skolbekken, 1995). Researchers were able to make inferences about the population to within a specified level of significance (Hicks, 1996). Thus began the codification and prediction of risk through estimations of its eventuality (Armstrong; Lupton). In the present study, it is on the basis of these statistical manipulations that women are informed as to their prospects for achieving a natural birth as is evident from Tom's text.

...we always tell them that at any stage of natural labour there's always a 25, 22-27% chance, in this hospital at least, of a caesarean section. That's the average rate across New Zealand and in most Western countries as well (Tom, p.1-2).

Lupton (1999) questions a realist position of risk, in that it assumes a rational individual, able to assess and evaluate risk, and configure a cost-benefit analysis. Further incongruence manifests as attempts to reconcile subjective meanings within a realist framework as though these meanings were an objective and neutral truth (Lupton, 1999). Moreover she maintains, individualising risk assessment obscures the socio-cultural and political context through which risk is mediated. More controversial, is a strong constructionist stance that contests the notion of objective risk.

8. 3. 2. Risk in a Post-modern World.

Conceptions of risk in postmodernity, view it as a product of discourse, historically constituted, within a particular socio-political context (Lupton, 1999). Drawing on Foucault's notions of governmentality, Lupton (1999, p. 95) explains that what counts as risk is contingent upon a nexus of power- knowledge relations and institutional practices. It is in this context that risk is (re)produced, and subsequently normalised as an entity. As an entity it is protected from scrutiny and given legitimacy through the "discourses, strategies, practices and institutions" that establish 'truths' about risk (Lupton, 1999, p. 85-86). Accordingly, risk as such, has no meaning outside the socio-

cultural context within which it was generated. Its contingent nature renders knowledge about risk as invariably fluid and likely to change with time and place (Lupton, 1999). Presently, risk has come to settle in a space occupied by surveillance medicine (Armstrong, 1995). Illness once occupied by the individual body now sits outside, in what Armstrong (1995) calls the “extracorporeal space” (p. 395). Armstrong implicates lifestyle as an extracorporeal space within surveillance medicines. In this sense lifestyle represents a potential risk factor for future illness. “The risk factor has no fixed or necessary relationship with future illness; it simply opens up space for possibility” (Armstrong, 1995, p. 401).

8. 3. 3. Precarious normality.

Within surveillance medicine the tenuous relationship between risk factors and future illness has transformed pathology into “...a point of perpetual becoming” (Armstrong, 1995, p. 402). Furthermore the weakened boundaries between health and illness render normality as “precarious”. Within the context of obstetric discourse, it can be argued that by blurring the boundaries between health and pathology, vaginal birth is positioned as what Armstrong calls “precarious normality” (p. 403). This precarious positioning is evident in the following interaction from MFGDHB with regard to a shifting threshold for evaluating normality within childbirth.

(MFGm1) I think the threshold has gone down, hasn't it?

(MFGm2) C-sections. That's the next thing. It's already out there in the UK.

(MFGm3) Once that of course gets out there and is distributed it influences the whole culture (MFGDHB, p.7).

Embedded within the midwives' talk, is an uneasy presage of the normalisation of caesarean section, partly driven by disciplinary practices from overseas and concern for the ripple effect once the discourse of risk has been fully unleashed.

8. 3. 4. Risk Epidemic.

Armstrong's (1995) exposé about surveillance medicine, has opened up the possibility for what Skolbekken (1995) refers to as risk epidemic mediated through the discourse of epidemiology and one that coincidentally parallels a worldwide epidemic of caesarean (Flamm, 2000; Savage, 2002). Skolbekken searched MEDLINE databases between 1967 and 1991, and observed a steady increase in 'risk articles' with acceleration in publications between 1987 and 1991. Obstetrics and Gynaecology journals reflected a more rapid increase than generalist medicine, second only to Epidemiology. Skolbekken (1995) also observed a wide variation in obstetric practices between two diametrically opposed forms; the Netherlands and United States of America (USA). At one extreme of the continuum was the USA, where there is a concerted approach to medicalise all childbearing women as high risk in need of hospitalisation. At the other extreme is the Netherlands, in which the locus of the birth is largely in the home, with Norway in between. Skolbekken's analysis, along with that of Bailit, Love, and Mercer (2004), expose the fluid and contradictory nature of risk and generates the question as to whose interests are being served in the social construction of risk. Both Skolbekken and Lupton (1999) warn there is nothing neutral about risk.

8. 3. 5. Risk and convenience.

Wide variations in caesarean rates underlying obstetric practice in Brazil signal the possibility of commercial interests being served, as is alluded to in the current study, by Tom.

In countries like Brazil, in the private sector, the C-section rate is in excess of 90%. One has to consider, is this driven by medical indications or is it commercially driven? Which means, do surgeons get a higher fee for surgical deliveries as opposed to vaginal deliveries? I'm not sure. In the public sector, and I think universally, the figure for caesarean sections is around 25-30% (Tom, p. 5).

Tom hints at obstetrician incentives shaping women's choice for caesarean in countries with high caesarean rates such as Brazil. There, caesareans have become a cultural expectation and normal practice (Belizan, Athabe, Barros & Alexander, 1999) with a CSR to be around 70%, (Potter, Berquo, Perpepetuo et al., 2001). These writers corroborate Tom's hunch. Other factors that are thought to come into play include an allegiance to birth technologies by women of socio-economic power. Another feature is a perception among poor women that the quality of care for normal birthing in the public system is lacking and therefore caesarean is deemed the better choice for poor women in that country (Behague, Victora & Barros, 2002). Moreover in Brazil, a substantial discrepancy between preferences and birth outcomes, among women utilizing private hospitals, indicate increased rates may not necessarily reflect a woman's desire for this birth mode (Potter, Berquo, Perpepetuo et al., 2001). Potter et al's (2001) findings contradict previous views that infer women are driving the trend. These researchers attribute their findings to beliefs about the safety and comfort of caesarean, a misconception between women's acceptance of reasons for a caesarean and their actual preferences, as well as obstetrician convenience (Potter et al., 2001). While Potter et al. (2001) acknowledge that they have no evidence to support their interpretation, the findings are in accord with other researchers (Hopkins, 2000).

Never the less the Brazilian context highlights how through regularity of events those events quickly become established as norms. Further, notions of fear are reinforced through screening programmes which form the basis of risk scoring (Downe, 1996). Downe has cautioned of implications that can befall women whose scores lie outside the margins of a particular set of statistical norms, in that they become the justification for prophylactic intervention.

8. 3. 4. Risk and the prophylactic paradox.

The 'prophylactic' positioning of caesarean has been embraced in some medical texts as a means of improving on nature (Steer, 1998). Steer appropriates evolutionary discourse and socio-biology to endorse his ideology, alleging a struggle between the 'need to think and the need to run' (p. 1053) has resulted in Homo sapiens selecting for cranial enlargement and a narrow pelvis. This tactical argument which constructs

caesarean as a solution to evolutionary pressures, met with considerable resistance within the literature (Kitzinger, 1999; Wagner, 2000; Upadhyay & Buist, 1999). Kitzinger argues that Steer's hypothesis is an avenue for promoting the widespread use of caesarean. Wagner can find no evidence to support Steer's thesis. Upadhyay and Buist (1999) sceptically conclude that a considerable amount of evolution will need to take place before caesarean can be touted as the panacea of safety for women and their babies.

Skolbekken (1995) points to an array of paradoxes inherent within how statements on risk are conveyed and perceived. For example one paradox highlighted by Skolbekken is an inconsistency between statements that show how life expectancy in the western world has reached an all time high, amid perceptions of increasing risks to health. Likewise an American study by Bailit, Love and Mercer (2004) exposed a similar paradox when they examined characteristics in the population of childbearing women to assess whether these had changed over time. Despite increases in the caesarean rates, women's risk profile for caesarean had decreased. Ironically this nebulous interpretation of risk is evident when women, considered as low risk, have higher rates of caesarean section than women who are considered to be high risk (Bailit, Love, Mercer, 2004; DeClercq, Menacker, & MacDorman, 2005; Nuttall, 1999).

Robertson (2001) and Carabine (2002) have shown how discourses are productive, in that they coexist with other wider discourses to bring about particular effects. These effects can often be contradictory, such as educated women, choosing risky options, such as caesarean (as with any major abdominal surgery) depicts how these meanings of choice, become a site of contest and challenge. This assertion has support in a study by Johanson, El-Timini, Rigby, Young and Jones (2000) who found knowledge of risk factors of a caesarean has little bearing on decision-making. For these writers, professional nulliparous women, while cognisant of the risks of caesarean, preferred a caesarean birth guided by the perception that it was 'easier, less painful and more convenient' than a vaginal birth.

The embodiment of risk as conceived by Robertson (2001), is the epitome of the embodiment of neo-liberal ideology of the free and autonomous individual, responsible for the choices they make (p. 302). The onus is on the individual to make the ‘right’ choice that will minimise risk. Lupton (1999, p. 99) refers to this state of affairs as ‘neo prudentialism’ in that it is underpinned by neo-liberalist ideals of self responsibility for risk aversion, while at the same time removing the state’s responsibility for the welfare of its citizens. In extending this self-governance to Foucault’s ideas around the ‘clinical gaze’ Williams and Bendelow (1998c) imply that these contemporary notions of risk, hail in ‘a new form of surveillance’ (p. 71) and at its core the creation a risky subject.

8. 3. 6. Risky subjects.

With positioning childbirth to be precariously normal, as inferred from Armstrong (1995), is a corresponding construction of childbearing women as risky subjects in the discourse of obstetrics. Ogden (1995) has shown how shifts in self identity correspond to conceptions about health risks. She observed throughout the 20th Century, identity has switched from one shaped by external events, to one mediated through interaction with the environment to the current conception of an efficacious self. This latter conception coincides with Lupton’s neo-prudential self, in that its focus is on self-control and risk avoidance. Ogden believes that “In the late 20th Century the individual has become at risk from his or herself” (p. 413). The following scenario from MFGSE reflects the constitution of a risky subject in and through the rhetoric of risk. Depicted is a midwife’s frustration at what she perceives is a needless journey, for a woman from out of her region, on the bases of her age.

[I said] Why are you making your decision to go to Wellington? She said well I have to go to a specialist. I said, why do you have to go to a specialist and she said, because I’m 37. I said why does that mean you have to go to a specialist? Because I’m older and my consultant said I’m older, my family have said I’m older and I have to go to a specialist.

I said well, there you go. She told me who she was going to and I said, what date is your Caesarean. I thought how sad. There is this woman who absolutely knows nothing. The information that has been given to her is that she’s 37, she’s got to go to Wellington and she’s got to go to a specialist. You just know where that’s going (FGMWSE, p.22).

The woman is positioned in the text as a 'risky' subject being acted upon by both enabling and constraining activities of obstetric discourse and the wider social field. Caesarean is positioned as an inevitable path, under the gaze of a particular specialist. The effect is the constitution of a fragmented and fragile subjectivity whose age has been inscribed on her (docile) body through the discourse of risk and fear. Caesarean has become a contestable prescription for maternal age. Despite a plethora of research articles and commentaries on the topic, evidence regarding risk, related to maternal age, appear conflicting (Albers, Lydon-Rochelle & Krulewitch, 1995; Barley, Aylin, Bottle & Jarman, 2006; Bell, Campbell, Graham, Penny, Ryan & Hall, 2005; Bewley, Davies & Braude, 2006; Carolan, 2002; Gibert, Nesbitt & Danielson, 1999; Cunningham & Leveno, 1995; Marwick & Lynn, 2001; Smit, Scherjon & Treffers, 1997; Windridge & Berryman, 1999). A perusal through the Cochrane Database of Systematic Reviews (2005) conveyed little in the way of evidence to suggest nulliparous women over the age of 35 years are placed necessarily as high risk.

One substantial study by Albers, Lydon-Rochelle and Krulewitch (1995) explored the association between maternal age and risk factors (actual and potential) to determine their predictability of labour complications in primigravida women at full term. These researchers found that maternal age, epidural anaesthesia and the receipt of adequate prenatal care were risk factors for caesarean in healthy primigravida women. The primary caesarean rate increased 2.5 fold in women who were 30 years and older and women who had a caesarean were more likely to be positioned as socially advantaged in society. Women of lower socio-economic positioning were at the lowest risk for surgical birth yet supposedly at higher risk of co-morbidities. The increase rates of caesarean, among primigravida women, could not be put down to antenatal, intrapartum or postpartum complications. Albers et al's (1995) findings not only raise questions about maternal age and caesarean, but also raise fundamental questions around how social positioning has implications for health outcomes, particularly for healthy, well screened, socially advantaged women. Another study in the Netherlands (Smit, Scherjon & Trellers, 1997) found older healthy nulliparous women, were at no greater risk than their younger counterparts, if at the first

antenatal visit the midwife selected women who had no underlying pathology necessitating secondary care in hospital.

In this light, it could be argued that at the intersection of the discourse of obstetrics and surveillance medicine, women have no other choice than to be positioned by, as well as position themselves in, the discourse of risk (Lupton, 1999). Indeed in the context of Aotearoa New Zealand, Payne (2002) found that the majority of women of thirty five years and beyond, were unperturbed by their positioning in medical discourse as at risk. In reading Payne, this quiescence can be attributed to women actively subjugating themselves to medical discourse, for the sake of their baby's and their own health. Lupton (1999) infers an antithetical position would be irresponsible. She aptly conveys this tenuous position as follows:

Many of the discourses that surround the pregnant women suggest that it is her responsibility to ensure the health of her foetus, and that if she were to ignore expert advice she is culpable should she and her baby miscarry or be born with a defect. The pregnant women therefore is positioned in a web of surveillance, monitoring, measurement and expert advice that requires constant work on her part: seeking out knowledge about risks to her foetus, acting according to that knowledge. Yet the discourses of risk that surround her are generally embraced willingly, because the woman herself wants to maximise the health of her foetus, to achieve the 'perfect child' (p. 89 – 90).

The effect here is that women are caught between technologies of power and the technologies of self (Powers, 2003). By individualising risk and attributing risk to lifestyle choices, victims are responsible for adverse events and wider structural factors that impact on health, can remain silenced (Howden-Chapman, 2005; Lupton, 1999; White, 2002).

8.4. Protecting Normal Birth.

The transfer of Armstrong's (1995) concept of 'precarious normality' to vaginal birth, highlights the historically specific and fluid nature of knowledge around risk and childbirth. Also signalled, is the surreptitious manner in which caesarean is

increasingly represented as the paragon of safe practice. For example a breech presentation was up until relatively recently, considered a variation of normal birth (Wagner, 2001) and instructions for managing breech births are still included in midwifery texts under the coding of malpresentation requiring medical assistance (Downe, 1996; Coates, 2003). In Aotearoa New Zealand it is codified in the notice pursuant to under section 88 of the New Zealand Public Health and Disability Act (2002) as malpresentation, level of referral 2 which states that a LMC “must recommend” to the woman that “ a consultation with a specialist is warranted” (Ministry of Health, 2002, pp. 31-34).

Following the publication of the Term Breech Trial (TBT) mentioned elsewhere (Hannah, Hannah, Hewson et al., 2000) a planned caesarean was recommended for all women presenting with a breech baby at term. Resistance to the trend is evident in the MFGDHB talk and exemplifies how the threshold of normal is receding.

(MFGm1) But that's what happened with breech, you've only got to get one thing going wrong...

(MFGm2) One study that's shown that you can have better outcomes if you deliver with breech with less brain injury, you've only got to get one that people pick up and run with, and the same I think is happening with this twin thing. There's one or two studies that have shown...

(MFGm3) Small studies!

(MFGm1) Yes, but it's been picked up, isn't it? It's been picked up and run with.

(MFGm1) And they've been sued.

(MwFGm2) And that's what's happening in the UK with the twin thing, so, and probably in the States, so you'll see it happening, probably gradually, over here in the next few years.

(MwFGm3) I don't think it has to.

(MFGm1) No it shouldn't.

(MwFGm3) No it doesn't have to. There can be local guidelines that say that a vaginal birth should be attempted.

(MFGm1) ...this year we've had numerous sets of twins vaginally and women have done well.

(MwFGm2) Just watch out because of what happened with the breech thing.

(MFGDHB, p.7-8).

The lengthy excerpt signals an inevitability of other variations of normal being treated along similar lines to breech presentations based on overseas trends. Its sombre tone is befitting when it is recalled that since the TBT there has been a push to generalise its findings for all women presenting with cephalic presentations, regardless of risk. The disenchanted tenor above, is a reflection of disenchantment in the wider field of play within childbirth. Albers (2005) attests to the downplaying, even disregard, for research findings that show the necessary conditions to enable healthy women to accomplish safe and effective normal birth. All too common in U.S. hospital care is the “over treatment of normal childbirth” (Albers, 2005, p. 670).

A similar resistance with regard to protecting normal birth in the face of increasing medicalisation surfaced in MFGSE talk.

(MFGm1) I would hope that midwifery as a profession would become very political and strong and loud. That's what I would hope. We need to be doing it now.

(MFGm2) There are protecting normal birth conferences all over the world. This whole movement internationally, led by midwives, about what's happening here and let's get together and see what's happening (MFGSE, p. 17).

The protective tone of the text affirms the positioning of midwives as guardians of normal birth that also emerged in women's talk. The sense of urgency echoes a concern about the decline in normal birth, published in the media (Dominion Post, 2003; Ministry of Health 1999) stating that normal birth was no longer the usual way of giving birth in the United Kingdom.

In endorsing an international midwifery call for better utilisation of low interventionist approaches for supporting women during birth, van Wagner, Lemay and Stonier (2004) are critical of the indifference toward available evidence that corroborates low interventionist approaches for supporting women in childbirth, in favour of the gratuitous use of obstetric interventions. These writers point out that vaginal birth is

not “an option” and call for greater respect by clinicians for the complexity of this physiological process.

...that vaginal birth is clearly the safest birth for most women and babies, and that caesarean surgery on demand will have disastrous social and financial consequences for health internationally. CAM advocates safe, sensitive care within a health system that maximises women’s ability to have a normal physiologic labour and birth (2004, retrieved, 30.11.04).

Van Wagner et al. (2004) speak on behalf of the of the Canadian Association of Midwives (CAM) in alliance with the Society of Obstetricians and Gynaecologists of Canada (SOGC). They also remind their readers of the socio-cultural context within which childbirth is embedded, that extends beyond the narrow confines of medicine. Be that as it may, maintaining childbirth as a socio-cultural event is a significant challenge for midwives’ partnership with women.

The following text reflects the contested space between a midwife and a woman in negotiating her desire for a ‘normal’ (vaginal) birth. In the story the woman is to undergo a planned induction, because of her ‘type one’ diabetes. It emphasises the tremendous sense of accomplishment for the midwife when the woman, having had a pregnancy deemed to be fraught with problems, has a vaginal birth.

...she wanted everything absolutely normal, but as the pregnancy progressed and she was talked to and she realised that she wasn’t going to have a normal birth, at that stage she said well why can’t I just choose to have a caesarean section, because with the diabetic induction they’re going to put drips in both my arms, I’m going to be constantly monitored, I’m going to be lying on the bed. I’ll probably have a long labour and then have a caesarean section, why can’t I just choose it from the beginning? But we talked her through and she in fact had the best diabetic induction I’ve ever seen. She had the baby delivered by about midday, one o’clock (MFGSE, p. 7).

While the desire to keep birth normal is inherent throughout the transcript, the above narrative conveys the tremendous challenge the midwife and women faced in their endeavours to achieve a vaginal birth. Not only do they have an ethical responsibility to uphold each women’s right to free and informed choice, they also have a responsibility to ensure that no action or inaction, on their part, places women at risk

(New Zealand College of Midwives, 2005, p. 10). The subtext of the storyline portrays a birthing woman resisting attempts to be subdued by the medical gaze. The effect of this surveillance is a sense of powerlessness at an imagined eventuality of a caesarean. The woman's birthing body is reconstituted as a 'docile' body at the boundary of risk, in and through the disciplinary practices of midwifery and obstetrics. She is positioned in the text as both an active and passive negotiator in the space between a natural and a technocratic birth (Davis-Floyd, 2001). Her fragile, thwarted and then triumphant subjectivity, has implications for destabilising her goals for birth.

8. 5. (Dis)enabling the evidence.

The momentum gained in the decade to date for caesarean to be constituted as an alternative birth mode, has taken place with little regard to establishing the long term effectiveness of the procedure for normal healthy populations of childbearing women. Its increasing regularity is an indication of how practices are predicated on the availability of technology and become habituated (Kaczorowski, Levitt, Hanvery, Avard, & Chance, 1998). Through routine utilisation, procedures become normalised and secured within the 'safety of the norm' (Berg, 1988).

Whose evidence counts? (Stewart, 2001) is a problematical question in poststructuralist thought. Sackett, Rosenburg, Gray, Haynes and Richardson (1996) describe evidence based practice as "The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (p. 71). While evidence can manifest as something concrete, to convey the aftermath of an event, it is commonly based upon facts that bear out a given event (Cluett, 2005). This privileging of the facts has manifested in a hierarchy of evidence that privileges quantitative methodologies over qualitative methodologies.

The pinnacle of quantification is deemed to be the Randomised Control Trial [RCT] (Akobeng, 2006; Aslam, 2002). This avenue of exactitude has been discussed within the context of the Term Breech Trial (TBT). The ripple effect from a campaign for an RCT is evident in Tom's talk as he contemplates how a non-clinically indicated caesarean section has developed as an alternative to a normal vaginal birth.

Unfortunately, there will not be a randomised term vaginal cephalic delivery trial, like the breech delivery trial, because I don't think it would be ethical to randomise patients. And I don't think patients would want to participate in such a trial (Tom, p. 5).

Here an RCT represents the gold standard of evidence, through which the 'problem' of maternal requests for caesarean can be settled. Tom is cognizant that such a trial is contentious because of the ethical issues surrounding randomisation. His view is in accord with FIGO (1999) and NICE (2003) that see no ethical justification for a caesarean in the absence of clinical indication. Critics of the Term Cephalic Trial [TCT] argue against it on the basis of its (f)utility (Kingdom, Baker & Lavender, 2006; Klien, 2004b; Buckley, 2005; Burchardt, 2005). Burchardt (2005) contends that the "RCT has taken on the aura of not only the gold standard, but the only standard" (2005, p. 1) of evidence.

Paradoxically, Sackett et al's (1996) definition of evidence-based practice gives primacy to the individual, a notion that is tricky under the tenets of quantitative research. Greenhalgh (1999) points out that it is the client's (qualitative) narrative through which clinical practice is informed. Indeed Greenhalgh warns of the tendency to reify the population's story, as in the case of surveillance medicine, over the individual's narrative (p. 2). Stewart (2001) who explored health professionals' perceptions of EBP in maternity care, found the manner in which evidence is used, can be filtered through the researcher's / practitioner's ideology. Moreover, definitions of the evidence varied widely and there was difficulty in implementing evidence in practice when the subsequent care was not commensurate with the prevailing culture of the maternity setting. Stewart purports that evidence is used either to support practice or is said to be flawed, if it was not in accord with a practitioner's liking. She also attests that while the evidence in its own right may be useful, rhetoric around EBP has the potential to be co-opted as a manipulative strategy for maintaining dominant cultural norms and professional control.

That a practice can override the evidence defies the tenets of evidence-based practice, yet the gap between implementing clinical practice based on effective evidence is

widely recognised in the literature (Langer & Villar, 2002). Likewise Goer (2003) infers an unsuspecting smokescreen operating at an editorial level within some peer-reviewed journals. Where research articles display the hallmark of a journal's criteria for publishing, any failings may (un)intentionally escape scrutiny. She warns, "once the misinformation is widely disseminated, a well-crafted rebuttal has little effect" (Goer, p. 124). A cautionary tale lies at the core of her commentary in that the findings may eventually find their way into policy decisions. In reading Goer it would appear that truth making has as much to do with public relations as with purity of publication. The displacement of a normal vaginal birth with the normalisation of caesarean, is both paradoxical in the face of EBP and antithetical to its ideals (Johanson & Newburn, 2001).

8. 6. Fear and risk in popular discourse.

As has been conveyed throughout this thesis, in popular culture there has been an upsurge of interest about caesarean on demand (Coney, 2001; Fitzsimons, 2004; Gallop, 2006; Healy, 2005; Marsh, 2004; McCurdy, 2001; Parson, 2002; Patterson, 2003; Song, 2004; Vanderberg, 2002) since the topic surfaced in the British press under the headline of "Too Posh To Push" (*Daily Telegraph*, 2001). Many are underpinned by fear and risk, often varied and contradictory. Banner headlines such as 'Too Posh to Push' (*Daily Mail*, 2001; Song, 2004) "C-section birth risks need to be known" (Coney, 2001) 'When Push Comes to Shove' (Parson, 2002) capture the attention of their readers and show how headlines are metaphorically appropriated to invoke different meanings around childbirth. The initial article served as a warning to women contemplating a caesarean, for no clinical reason. The warning emanated from a delegate at the Royal College of Nursing's annual conference and was in response to caesarean rates reaching "epidemic proportions". The catastrophic image of the trend was endorsed with statistics to depict a caesarean as a risky business compared to a vaginal birth.

"Women who give birth by caesarean section run a 90 per cent risk of complications," she [the nurse] says. "Giving birth by caesarean section is also four times more likely to lead to

potentially fatal problems than delivering a baby naturally”
(Daily Telegraph, The Dominion Post Saturday, June 9th, 2001).

This representation of caesarean section, as a dangerous procedure, positions women who choose a caesarean for no particular reason as irresponsible risk takers. Vaginal birth is positioned as natural and safe in comparison to caesarean. The article was followed in the same year by Sandra Coney’s (2001) article “C-section birth risks need to be known” which appeared in a national weekly newspaper with a wide audience throughout Aotearoa New Zealand. Coney also alerts to the risks of caesarean and called for women to have accurate information about the realities of the operation. She is candid about the role doctors have in driving the trend.

The entry into the idiom of popular discourse of the slogan ‘Too Posh to Push,’ from its metaphorical inception in 2001 was rapid, aided and abetted sometimes through catastrophic accounts of fear. In Parson’s (2002) article, earlier in the chapter, a caesarean for no reason is spoken of as a form of deliverance, liberating women from fear of childbirth. The article was accompanied by a photo of a disembodied pregnant abdomen with a caption that read *Labour Pain: The thought of giving birth is the ultimate nightmare for some women*. Parson’s (2002) use of metaphor reinforces her apocalyptic stance.

But faced with the brutal forces of life and death, the house of cards we like to call our inner confidence collapses quicker than you can say Enron. It turns out that our self-promotion has been as misplaced as much of corporate America’s. The truth is not that we are too posh to push but that we are too scared (Parson, 2002, p. B8).

Rather than proffer an informed debate, Parson’s (2002) satirical genre, creates an affront of fear and provocation. The reverberating slogan of ‘too posh to push’ is less strident in Parson’s appropriation; it merely reveals the strength of one rhetorical device, among others, for making meaning. The fragile and contradictory self is invoked when women are faced with the uncontrollability of giving birth. Parson’s (2002) allegorical use of the demise of Enron serves to epitomise and strengthen the fragility of the subject through evocative imagery. It is when the subject strays from the ideal birth plan and cannot sustain her sense of unity that she becomes scared. At this juncture, the

fragile and contradictory nature of the self is revealed and confronted. In defiance of the discourse of liberal humanism, childbearing women are decentred as unified, autonomous, rational, individuals. A spoof, be that as it may, the article is compelling in evoking fear in the hearts and minds of its readers, around the prospect of normal birth.

Time Magazine (Song, 2004) used ‘too posh to push’ some two years on as a headline to an article subtitled, “As more pregnant women schedule C-section, doctors warn that the procedure is not risk free.” The article charades as a cautionary tale for women contemplating the option of caesarean for no clinical reason. After some whimsical banter sensationalising celebrities, positioned as being “too posh to push”, Song transforms her text into a judicious warning of the dangers of a caesarean.

While C-sections are safer than ever – thanks to improvements in anaesthetics, antibiotics and operating techniques over the past few decades – they still introduce real risks. In 1% to 2% of cases, C-sections lead to infection, damage to other organs during surgery or severe bleeding in the mother. They also endanger the baby if the infant’s gestational age has been miscalculated and the child is removed from the womb too soon. Risks to the mother increase with successive C-section, and the procedure isn’t recommended for women who plan to have more than two children (2004, p. 2).

Here Song (2004) highlights some of the risks of caesarean filtered through a soothing tenor. While her message has the support of an expert in Foetal Maternal Medicine, this is neutralised at the end of the article with an account involving the ‘chair’ of a department of obstetrics and gynaecology, promoting caesarean.

When her first child was due last year, she scheduled her own C-section. Warner had spent the past five years surgically reconstructing pelvic-floor muscles and repairing leaky bladders in women who had experienced difficult natural deliveries. [] “I wouldn’t think twice about having another C-section” (2004, p. 3).

Song draws on the discourse of fear surrounding the potential for pelvic dysfunction as a consequence of vaginal birth. Clearly her texts make available a range of positions for women to adopt within the discourses of fear and risk. Absent from her text is a sense of how women who have had a caesarean are expected to cope with the recovery from major surgery, together with the demands of caring for a new baby. It is at this juncture

that Fitzsimons (2004) provides a candid insight into the recovery from a caesarean in an article that appeared in *The Guardian*, a daily newspaper, widely circulated throughout the United Kingdom. The article, again under the banner of “*Too Posh To Push?*” leads in with an introduction, “ Reports that Caesareans are an easy option are rubbish, says **Sheila Fitzsimons** (*sic*) – who has the scars to prove it.” Fitzsimons’ commentary represents a resistance to an article that appeared in the *Daily Mail* the previous day entitled, “*The demise of natural childbirth*” signifying caesarean as a soft option.

Quite clearly, those who suggest that caesareans are an easy option haven’t had their belly sliced with a knife. I have. Twice. And it hurt (Fitzsimons, 2004, p. 1).

After a description of the events during her labour, no stone is left unturned in her quest to shed light on her experience, as can be glimpsed in the following excerpt:

I was led back to the ward in seventh heaven. I’d fallen in love. That was the easy bit. Unfortunately I couldn’t pick my daughter up. I couldn’t see her in the cot. I couldn’t sit up. I had to wear horrible tights. I wasn’t even allowed to eat or drink. I did manage to breastfeed by rolling on my side and having the baby in my bed with me. It was agony.

Some one once told me that having a caesarean was like having your head stapled to your knees. It was far worse. Try to imagine instead someone cutting you open, pouring on vinegar and then sticking you back together with Sellotape that you feel will come undone at any point. Get the picture? (Fitzsimons, 2004, p. 1).

Fitzsimons’ graphic account, from her experiential knowledge, is guaranteed to inflame fear about the realities of a caesarean. At once her fragile subjectivity is laid bare, only to be resurrected and repositioned as a soothsayer, cautioning her audience about the dangers of romanticising caesarean.

The capricious and sometimes apocalyptic spin that typifies some media accounts of childbirth, conjure up fear surrounding childbirth. Klein (2004a) blames frightening imagery in the media for inducing women’s fears of childbirth and implicates the practice of caesarean, in the absence of clinical indications, as a defensive response to women’s unexplored fears. These fears he asserts, largely concern pain, lack of

support and pelvic dysfunction as a prelude to future sexual (dys)functioning. For Tom, similar fears are also invoked by media stories that materialise around pelvic dysfunction.

The other bit of media coverage was to do with pelvic floor dysfunction in women who have had caesarean sections versus woman who have vaginal deliveries. And the third one, especially here in New Zealand in recent times is the adverse outcomes which have hit the front pages of newspapers (Tom, p. 1).

From these it is discerned that popular culture utilises three discursive strategies to bring about its effect. Through summoning celebrity iconography, ideal identities are carved through the invocation of desirable positions. Juxtaposing vaginal birth with an imperfect interior, invokes a sexual panic with an elective caesarean as a means for circumventing the potential for later sexual (dys)function. Moreover, banner headlines in newspaper publications such as *Are Midwives Delivering* (McLoughlan, 2005) *Deaths Prompt Call for Review of Maternity Care* (McDonald, 2005) and *War for the Womb* (Editor, Dominion Post, 2005) depict maternity care as a war zone of competing interests. The effect is to evoke fears as to the safety of a normal vaginal birth.

In the professional literature, many attempts have been made to review the evidence on the risks and benefits of an elective caesarean in an endeavour to promote informed decision making (Bewley & Cockburn, 2002b; Minkoff & Chervenak, 2003; National Institute for Clinical Excellence [NICE] 2004; Penna & Arulkmaan, 2003; Kirkman, 2004). Yet despite these efforts, the debate continues with no sign of any reconciliation on the matter.

8. 7. Conclusion.

The discursive ways in which the choice of a non-clinically indicated caesarean is talked about, illustrates a complex and contradictory maze along which women are required to negotiate toward a safe and satisfying birth experience. An analysis of the discourses of professional and popular culture suggest that childbirth has come to settle at the intersection of the natural and the cyborg informed through the discourse of fear and risk. These couplings are positioned in this study as two sides of the same

coin, each reinforcing the other; each enabling and constraining choice through defensive practice. The manner in which these discourses (inter)act, invokes images of the fragile nature of normal birth, perched precariously at the frontier of a battle to claim caesarean as an alternative birth option. This relatively new frontier exposes a landscape of contention and contradiction, in which the gap between evidence and practice widens as it is filtered through the practitioner's ideological stance. It is this backdrop that sculpts the choice of caesarean for women straddling the void of uncertainty.

Notions of fear of the future as an effect of the current preoccupation with the uncertainty of the present, has its most patent expression in childbirth. For women straddling the void of the uncertainty that surrounds vaginal birth, caesarean is seen as the means for attenuating the fear of the unknown. The construction of risk as an object of obstetric discourse has come about through the effect of power-knowledge in so far as this disciplinary practice has claimed the authority to define what counts as risk. For women the embodiment of a risky self is further intensified through surveillance technologies especially in the case of assisted conceptions and older birthing women. The discourse of fear and risk has opened a *Pandora's box* inside which vaginal birth is destined to become abnormal and caesarean increasingly normal. Taking stock of the multiple readings of the topic and the implications of the thesis is the direction and purpose of the next and final Chapter.

Chapter 9. Discussion.

9.1. Introduction.

The study explored with the research informants, the discourses that shape women's choice for caesarean in the absence of clinical indications. Informing the study were the views of women, midwives and an obstetrician who provided valuable insights from their tacit, theoretical and experiential knowledge in the field of childbirth. From their talk, the discourses that constitute the choice of caesarean as a birth option were identified as autonomy, convenience and desire, fear and risk. These discourses were set against a backdrop of more prevalent mainstream discourses, such as neo-libertarian and popular discourse and have opened up a range of possibilities for understanding this new object of obstetric interest.

This thesis has used a poststructuralist lens to unpack the ways caesarean is talked about and represented in the literature. In the process I have traced a volatile moment in the history of childbirth, in which an explosion of discourses sculpts out women's choice of birth mode. The meaning women give to childbirth is informed discursively through a multiplicity of discourses alongside social and institutional practices. These filter through a socio-political milieu, in the shape of talk, texts and iconography in popular culture, birth stories, professional encounters with midwives and obstetricians, conversations, antenatal education classes, government and legal policy. Within this discursive landscape, a plurality of perspectives competes for dominance and eventual truth around choice in childbirth. Chapter Nine concludes the journey this thesis has taken. The chapter contemplates Foucault's importance to the study, the discourses to emerge, along with the implications of the study for women and maternity care provision. The limitations of the research are identified, as are the implications for further research.

9.2. Through the theoretical looking glass.

In this study I have drawn on the theoretical ideas of poststructuralism to unravel the fluidity and the fragility of the debates surrounding caesarean, as a choice of birth mode, in the absence of clinical indications, within the context of subjectivity and discourse-power-knowledge. The French philosopher, Michel Foucault provides the theoretical lens through which analysis is framed. For Foucault (1972; 2002) subjectivity is an effect of discourse. This is a departure from the reasoned self-governing individual of liberal humanism, from whom, it is assumed, rational choices emerge. Foucault contends discourses are bodies of knowledge, inherent within disciplinary practices that enable and constrain that which is possible. As such, the possibility of truth has an inextricable link to power since knowledge is the outcome of power and power is important for sanctioning what can be true (Carabine, 2000; McHoul & Grace, 1998). My chosen methodology, framed within a post-structuralist lens, provides for a plurality of truths. In the current study one truth about caesarean, as a choice of birth mode, has surfaced as coveted, contestable, mutable, constitutive and contradictory. In analysing discourse, Foucault's (2002) interest lay in the relationship between the status of "who is speaking"? (p. 55) including their qualification to speak, the "institutional sites" (p. 56) that give discourse its legitimacy and the positions the subject occupies while speaking.

Language, a permutation of discourse, far from being an indolent reflection of society functions productively to form the objects of which it speaks (Foucault, 1989, p. 54). These objects are located in an historical and socio-political context and so it was of interest for Foucault to trace conditions of the past that made possible objects of the present (Carabine, 2000; Weedon, 1997; McHoul & Grace, 1998). Searching for contradictions, how subjects are positioned and the effects of language are also central to his analysis. In undertaking a Foucauldian discourse analysis, I have documented the ways in which textual representations of childbirth and discursive practices can constitute women's choice of birth mode.

The conditions that have made caesarean as a birth option possible, have come through the technological events of modernity and juxtapose with postmodernity's temporality of presentness, to culminate in a quick-fix ethos. At the forefront of this

event has been the insidious medicalisation of life events that has undermined confidence in women's bodies to perform normal physiological functions. In the process, normal birth has become positioned precariously at the intersection of the natural and the cyborg (Davis-Floyd, 2001; Shaw, 2003). For some women the meaning of (dis)empowerment lies in confronting their corporeality with the intent of constructing an existential sense of self. For others the essence of motherhood may have become decentred. For these women the meaning of (dis)empowerment may lie in shaking off their biological providence in order to control life events or to circumvent uncertainty. It is an appreciation of these diverse realities that is at the heart of midwifery's project – being with women.

9.3. The discourses.

Chapter Five provided a platform from which the research was unveiled. Drawing from the ideas of the preceding chapters it offered a prelude into the emerging surfaces that made possible the present reconfiguration of the choice of caesarean, as an object of obstetrical discourse. What unfolded was a complex array of tactics that exemplified how discourse-power-knowledge is inextricably linked to the production of truth. This new configuration of caesarean had filtered through a visage of beguilement, resulting in a pathologising paradox in which endeavours to abnormalise the normal normalizes the abnormal. These discursive strategies were played out on a number of podiums, ranging from championing women's autonomy, professing caesarean as the obstetrician's choice, invoking fears around vaginal birth and appropriating the media for the transposition of medical knowledge into common knowledge, in the interests of popular appeal. Following on from Chapter Five, the talk of women, midwives and an obstetrician, in Chapters Six, Seven and Eight, sculptured choice out of the discourses of autonomy, convenience and desire, fear and risk, to provide insights into what is being said about this birth mode from a wider field of play.

In Chapter Six the discourse of autonomy, came to light as a means through which women's choice for a caesarean is constituted. Highlighted were different meanings around autonomy and its appropriation as a discursive strategy for control in

childbirth. Thus (de)constructing autonomy exposed a fragile and dubious character, that assumes a (mostly) rational, reasoned and seemingly stable self. Unmasking the power relations beneath the surface of autonomy, affirms how the rhetoric of choice in childbirth has commodified the concept and appropriated it to serve the interests of dominant groups in this field of play (Kitzinger, 2001). While on the surface autonomy has an allure of affirmation of rationality and competence, beneath lies a potential to position women and their babies in an adversarial space. Autonomy's selective, privileged yet tenuous status has become reified as an immutable truth. Furthermore, in interpreting Powers (2003), the coalescence of autonomy within a matrix of other mainstream discourses, liberal humanism, neo-liberalism and human sciences, illustrates how discourses can intensify their effects. One such effect is to lure in women's 'docile' bodies for their (re)productive utilisation. Moreover, the privileged status of autonomy highlights an inverse care law, operating behind its façade. The exposure of this anomaly is evident when low risk women of higher socio-economic position have the highest caesarean rates suggesting women's choice for a caesarean for this social group takes primacy over the risks of major abdominal surgery. Little attention is given to respecting choice for a vaginal birth for low risk women.

In Chapter Seven, a self-governing self intersects with the discourse of convenience and desire, to imagine subjectivity orientated to the present. Trust in technology is predicated on its ability to control life events. The desire for control over time and events also emerged as grounds for justifying the choice of a caesarean. In a convenience culture, the temporal expediency of caesarean satisfies the containment of bodily deeds. The convenience of scheduling birth around particular dates has a certain appeal for some women. Convenience and desire are (dis)enabled by a particular discourse through which subject positions are channelled. For some women stepping outside the discourse of motherhood has meant new pressures have come into view and so the convenience of an elective caesarean is an efficacious concession that guarantees (re)productivity. For women who remain within the institution of motherhood, technology provides possibilities for scheduling events around the needs of other family members. These shifting notions of control in the context of childbirth are testimony to how meanings are contextualised, contingent upon a particular socio-

cultural-historical context. They also serve to disable universal notions that have potential to fix a truth about women's desire for control in childbirth.

In postmodernism, time is of the essence and with it comes the promise of imminence. For some childbearing women, choosing a caesarean may indicate a self orientated to the present (Parker, 1997) and it is this sense of imminence that has precedence over the future, including future pregnancies. Thus convenience is intertwined with desire, in that imminence and efficacy have come to represent a desire to contain the self and its (em)bodied activities in the present moment. I argued that the manner in which these discourses (inter)act, invokes images that depict the fragility of normal birth as it is perched precariously at the frontier of a technological explosion and sexual panic. Moreover representations for the perfect bodily interior, portrayed in the media, fuel this panic. What is most acute in some informants' talk and in some texts of popular and professional culture, is how vaginal birth is represented as dangerous, an abysmal threat to women's embodied sexuality. Increasingly the encroachment of reproductive technologies into the domain of childbirth, has meant that discourses about women's fragile corporeality have weakened their confidence in their body's ability to perform. While autonomy, convenience and desire may overlap in the constitution of women's choice of birth mode, their interconnection is part of a wider mosaic of discourses not the least of which is fear and risk.

In Chapter Eight the discourse of fear and risk manifests in a self, orientated toward avoiding uncertainty. Fear of childbirth is a powerful force implicated behind women's reasons for choosing a caesarean in the absence of clinical indications. Fear manifested as fear of pain, previous traumatic experience, loss of control and fear of outcome. These fears have been sanctioned in professional and popular discourse with the effect of increased anxiety around vaginal birth. The flow-on effect of fear is the amplification of risk. Fear and risk are envisaged in this study as embodying two sides of the same coin, each invoking the other. It is in this abyss that caesarean has come to represent safety. The effect is to approach childbirth with vigilance. Fear and risk have become omnipresent and disabling discourses, as contemporary society becomes increasingly preoccupied with safety and litigation. This propensity beckons in the prophylactic use of an elective caesarean as a risk management strategy. The effect of such quality control is to position well women on an echelon with pathology. The

pathologising of women in this way has the potential to convert a population of healthy childbearing women into patients (Taylor, 1979). Despite the resistance from within and outside obstetric discourse, the 21st century hails a prophylactic caesarean as a form of control.

The construction of risk, in the field of play of childbirth, epitomises risk as a product of power-knowledge, in that the discipline of obstetrics has claimed the authority to define what counts as risk. Within this field of play, risk has become individualised. Against a backdrop of neo-liberalism, the onus lies with the individual to make wise decisions so as to minimise risk (Lupton, 1999; Powers, 2003; Robertson, 2001). Inducements, such as a pain free birth and control over events have an added appeal and serve to reinforce compliance (Williams & Fahy, 2002). And so the embodiment of a risky subjectivity, making ‘right’ choices in childbirth, is consummated through the discourse of fear and risk. Lupton’s (1999) notion of a neo-prudential self comes to mind, cajoled into a false sense of empowerment in the interests of the state (see also Grace, 1991; Powers, 2003; Surtees, 2004). The (dis)ease between neo-liberalist and social democratic ideals, surfaces a tension between health status and social inequalities, whereby healthy low risk women are rendered more susceptible to costly interventions, compared with women represented as being at greater risk of complications.

9.4. The media.

In the current study the consensus was that the media has a powerful influence on the choice of non-clinically indicated caesarean, and serves to hasten the trend by drawing on the experience of celebrities to bolster news stories. The various ways in which the choice of a non-clinically indicated caesarean is talked about in popular culture, has the potential to romanticise and normalise this mode of birth. Media imagery moulds desired identities and subject positions which childbearing women can opt to adopt. The apocalyptic spin, typified in some popular media publications, invokes a fear around vaginal birth. As unabated accounts, media discourse lacks refutation and so has the potential to take on an authoritative truth. Rhetorical devices are utilised for maximum impact and in the process the media conspires in its own exploitation to

serve an eclectic of interests. It is in this space that the medicalisation of childbirth receives its highest legitimisation.

9. 5. Implications of the study.

Unpacking the ways in which the topic is represented in professional and popular culture has been complex and challenging. The plurality of meanings coalesces in an ensemble of conflicting expectations around childbirth, to reflect the diversity of 'truths'. Such heterogeneity highlights the contentious and contradictory nature of the topic and is a salient reminder that there is no one universal 'truth' that serves to account for women's choice for a caesarean with no clinical justification.

An appreciation of women's diverse realities, confronts the discursive practices of childbirth today. The repositioning of the self as a consequence of experience opens up a range of possibilities for determining future encounters with maternity care providers. If caesarean rates in Aotearoa New Zealand are to reduce, heeding women's concerns about previous experience and addressing these concerns appropriately with women will do much to stave off the propensity for these fears manifesting as indications for caesarean in subsequent pregnancies. Furthermore better support and resource allocation toward strategies for protecting, promoting and improving opportunities for normal birth, at an institutional level, must be awarded greater primacy in the space (pre)occupied by primary health discourse. The study is of interest to mainstream maternity policy makers in that if autonomy is to be championed in the discourses of childbirth, then the active promotion of the choice of homebirth would convey an earnest respect for a woman's right to self-determination and signals a serious intent to ensure equipoise in decision-making.

The momentum that the choice of caesarean has gained in the decade to date, has taken place with little regard to establishing the long term effectiveness of the procedure on normal healthy populations of childbearing women. As technology is a highly competitive, capital intensive enterprise, of which an ensemble of invested interests awaits satisfaction, the risks of an intervention are often underplayed. In the quest for better and bigger, a shadow is cast over the reputation of evidence-based

practice and as reproductive technologies proliferate, women's experiential knowledge of their bodies becomes increasingly redundant. Normalising ideas about fear and risk quickly establish as a fixed truth, setting in motion a prophylactic paradox whereby healthy low risk women are summoned to undergo a rigorous preventative workout of peri-operative interventions, to ward off complications, from a prophylactic procedure, that is of itself risky. These findings will provide the impetus for better dissemination of accurate information for women and their support persons, with regard to the realities this major operation will have on future childbearing decisions.

9. 5. 1. Resource implications.

While it cannot be assumed that caesarean is the sole prerogative of middle class women, this social positioning in relation to the choice of caesarean, reflects the privileging of choice along consumptive lines. As has been argued in this thesis, it is ironic that resources available to women of low obstetrical risk, has rendered them more susceptible to interventions. It is for this reason that caesarean represents an awkward moment in the allocation of public health resources as low risk consumers are enticed into exercising their freedom of choice for caesarean. The issue has opened up possibilities for (re)examining this new ethical frontier within the context of the consuming subject. To all intents and purposes there lies the potential for opening up fresh possibilities for contemplating how consumerism can coexist in society, alongside justice and fairness for the health of all its citizens.

While maternal requests for caesarean, as a matter of choice, have not yet made their mark on health economics, in the Aotearoa New Zealand context, their potential demand in a consumerist society needs to be taken into account as an important variable in future health economic evaluations (Petrou, Henderson & Glazere, 2001). The cost differential between a caesarean and a vaginal birth has been well documented in the literature and shows unequivocally a vaginal birth as more cost effective (NICE, 2004; Petrou, et al). In Aotearoa New Zealand the cost of an uncomplicated caesarean overall is NZ\$2,696.00 when compared with an uncomplicated vaginal birth at NZ\$870.00 (Oben, 2006). Important are the intangible costs such as loss of productivity and the impact the operation has upon other family

members. Lessons to be learned from the UK, are that if the caesarean rate were to increase by 1% it has been estimated that it would increase the cost of caesarean by 2.2 million pounds for the NHS (NICE, 2004).

The legacy of the neo-liberalist health reforms of the 90s forms a backdrop against which a demand for 'high tech' private enterprises can be kindled. The current quiescence cannot be taken-for-granted in a shifting historical, socio-political climate, in which institutional reforms may once again deregulate the market to give the consumer (customer) what they want. History attests to an egalitarian paradox where the unintended consequences of upholding women's right to pain relief in labour, ushered in the medicalisation of childbirth during the early part of last century. The democratising of the choice for a caesarean, in the absence of any clinical justification, will inevitably lead to the completion of a second wave of the medicalisation of childbirth. Whether caesarean, as an alternative birth mode, can be explained as a libertarian imperative, an embodiment of lifestyle, the satiation of desire, the attenuation of fear or the avoidance of risk, one unintended consequence of this consumer choice will, for certain, be an impact upon maternity resources.

9. 5. 3. Implications for women.

A caesarean for no clinical reason is a major public health issue at both an individual and population level. At an individual level, women are expected to cope with the recovery from major abdominal surgery and the demands of family and a new baby. Furthermore, with the normalisation of caesarean, lies a potential for marginalising women who choose a vaginal birth. At the level of the population, healthy women are positioned in the sick role. The end result of an increase of the primary caesarean rate is a less healthy population of childbearing women in the future.

Moreover the social positioning of middle class women in relation to the choice of a caesarean regardless of need is a salutary reminder of the relationship between social inequalities and health status (Dew & Kirkman, 2002; Howden-Chapman, 2005; Maternity Alliance, 2000). Specifically, inequalities have a direct bearing on maternal and infant mortality (WHO, 1998; Peckman & Carlsen, 2005; Fowler, 2002; Fransen,

2002) as well as access to elective surgery (McLeod, Dew, Morgan, et al, 2004). Consequently, an elective caesarean as a choice of birth mode has exposed an injustice within society where those least in need, receive a disproportionate allocation of the health resources.

9. 5. 4. Implications for Practice.

The construction of caesarean as an alternative birth mode is the latest exploitation in the field of obstetrics. Its unidirectional propulsion into the 21st century stands in defiance of evidence-based practice. Importantly, in the light of unconvincing evidence, the issue has been afforded a disproportionate amount of time, energy, cost and word space, as each side jousts for territory in the contentious terrain of childbirth. The victor will have profound repercussions for the future of childbirthing practices. What is often obfuscated in the debate is a will to make vaginal birth better. Addressing factors such as ‘doing no harm’ in childbirth, the equitable distribution of health resources, protecting and nurturing normal vaginal birth, respecting women’s knowledge as well as their birthing bodies, building women’s confidence in their bodies to enable them to make valid choices as to how their babies will be born, all have bearing on the health of women and maternity services in the future. Suffice to say the trend for caesarean as an alternative option, will have new meaning for midwifery and obstetric practice.

9. 5. 4. 1. Implications for midwifery.

Despite a growing body of knowledge that supports the provision of community based, midwifery care, for women of low obstetric risk (NICE, 2004; Tracy & Tracy, 2003), this effective resource is often under-valued in medical discourse (Albers, 2005). And while a midwifery model of community based care is a key focus of maternity service provision in Aotearoa New Zealand, the capricious nature of health as a market commodity, is a reminder of the fragile nature of this form of care. This has particular salience in a climate of escalating costs, against a background of private interests and an erratic socio-political context. The propensity for women to take up the option of a primary elective caesarean, signals an increase in referrals to specialist

obstetric services for midwife LMCs, along with the need for hyper-vigilance in caring for women during pregnancy, around birth and the post partum period in both current and future childbearing occasions. Incentives for surveillance are compelling given the evidence to emerge, in Chapter Two, linking caesarean to anomalies of placentation which has potential devastating consequences for women and their babies, aside from the potential, for respiratory problems in neonates.

With increasing costs of health in the public sector and the need for cost containment within DHBs (Barnett & Barnett, 2005) allied to the increasing surgicalisation of childbirth, midwives are faced with having their scope of practice discursively (re)constituted. Here lies the potential for (re)positioning of midwives to incorporate aspects of surgical nursing into their practice. In this new form of organisation an uneasy dynamic comes into play, as the separation of midwifery education from nursing, was premised on the basis that for the majority of women, pregnancy and childbirth are normal physiological processes. Inevitably with increasing numbers of caesareans, comes pressure for greater skill mix in caring for women who are recovering from this major abdominal operation. Research in the UK (Baxter, 2007) has shown marked improvement in women's satisfaction with their care, where initiatives to (re)introduce registered nurses into postnatal wards to provide post-operative care for women following caesarean, have been implemented. However, in Aotearoa New Zealand, the memory of the hard won battle for independence remains indelibly etched in the hearts and minds of the profession. And so, an ominous ambience accompanies the possible (re)positioning of midwives to include aspects of surgical nursing or alternatively, the (re)incorporation of nurses into the postnatal care of birthing women. Discussion around the topic of maternity assistants, sporadically surfaces for debate in midwifery forums as to its feasibility, with little resolve (Campbell, N., personal communication, February 8, 2007). Notwithstanding this are the challenges facing midwifery education programmes particularly for students' clinical experience, in the care of women, as it applies to the normal childbirth modules of the syllabus. With fewer normal births on the horizon (Ministry of Health, 1999) greater clinical experience in caring for women undergoing surgical interventions, in tertiary care institutions, will be necessary should the trend maintain the momentum it has gained in other cultural contexts.

The volatile nature of the topic places a tremendous challenge on midwives in keeping birth normal and has significance for public health. It is at this juncture that Tudor Hart's (1971; 2001) "inverse care law," as discussed in Chapter Six, has relevance for the disproportionate utilisation of health resources, in that cycles of disadvantage have implications for future generations (Howden-Chapman, 2005; Peckman & Carlsen, 2005). For midwives there is an ethical duty to support the health of families for generations, through their commitment to protecting the practice of normal birth. As primary health care practitioners, midwives are strategically placed to support the health of current generations and beyond, by keeping birth normal (Foureur, 2005). It is therefore an imperative, from the findings of the current study, that midwives have an integral role in the planning of future maternity services within the context of public health. A broader focus on public health will enable midwives to identify how socio-economic position and social structures are linked to health outcomes for women and babies (Fowler, 2002; Chapple, 2007). Actively addressing inequalities in maternity care is an important sphere of activity for current and future midwifery practice. It has been well documented in the literature that inequalities in health are unfair (Woodward & Kawachi, 2000) and while these may be impossible to eradicate, they are avoidable (Reid, Robinson & Jones, 2000; Woodward & Kawachi, 2000). Salient here is Chapple's appeal to midwives to take up the gauntlet of inequalities. Reducing the impact of inequalities in maternity care is an imperative and not, as she puts it "...an optional extra" (Chapple, 2007, p. iv).

9. 5. 4. 2. Implications for Obstetrical practice.

An increase in the primary caesarean rate, also has new meaning for obstetric practice. Accommodating women's desires for a caesarean in the absence of need, paves the way for an increased loading on specialist services. Increased referrals to obstetric specialists, in current pregnancies, will mean greater intrapartum surveillance with repeat caesareans.

The key question pertinent to this thesis is: whose interests are being served by offering this major operation as an alternative birth mode? There is little disputing that when clinically indicated, caesarean serves the interests of women and their babies.

One contradiction to emerge is the disproportionate and unprovoked attention in the literature that the championing of women's choice for this birth mode, has received. Intriguing has been a preoccupation in obstetrical discourse with "maternal request" for caesarean as a new indication for a caesarean, based on dubious evidence. More curious has been efforts from a high profile U. S. Government institution, the National Institute of Health (NIH), in its "state-of-the-science statements" (2006, p. 1) that continue to reinforce 'maternal request' as a fixed (indication) truth, against a hail of resistance, from both within and outside the disciplinary practice of obstetrics (Young, 2006). The NHI has become a system for differentiating and categorising how maternal request for caesarean is analysed and specified in obstetric discourse. In Foucauldian terms the NHI is the 'grid of specification' through which 'maternal request' for caesarean is incorporated into clinical practice (see Powers, 2001a), the increasing regularity of which will normalise this birth option.

Childbirth Connections (2006), formerly known as Maternity Centre Association, a not-for-profit organisation, supporting informed decision-making in childbirth, refer to the NHI's attempt as a "misplaced focus" (p. 9/10). The label "maternal request," is viewed with some suspicion (Childbirth Connection, 2006; Young, 2006) in that it detracts from socio-political and economic elements behind increased caesarean rates. It is for this reason the category "no indicated risk" as proposed by DeClercq, Menacker and MacDorman (2005) is a preferable label as it unambiguously explicates the reason for the operation and thus disables the default tendency of "maternal request," as indicated by Gamble and Creedy (2001). Addressing the anomalies behind the label of 'maternal request' and appropriating the term "no indicated risk" is an important project both for obstetrics and policy analysts, in the interests of reliable and valid statistics.

If the prediction offered by Bleker (2001) ripples across global boundaries, the future of obstetrics and gynaecology (O & G) is on the edge of a historical shift with significant implications for maternity services. Changing attitudes, new configurations of maternity care, preference for specialists over trainees, the dissemination of information via the 'net, herald a new order of sub-specialities, education and practice. Bleker points out that these new changes make way for the increasing numbers of women entering the discipline. This, put beside new lifestyle demands, signals the

initial signs of 'daylight' obstetrics, already mooted elsewhere in this thesis. Significant is a concern about a loss of knowledge and skills around vaginal birth, as younger members of the profession become exposed to the regularity of caesarean as a birth option (DeMott, 2000).

9.6. Limitations of the study.

The strength of the study lies with the rich source of data provided by the women, midwives and the obstetrician who took part. Their views are corroborated by a profusion of international literature to bolster the study's findings. Be that as it may, the choice of caesarean is located in a cultural context at a particular moment in time. As such it would have been pleasing to hear a wide range of views from a diverse group of women. The limitations of the study were reflected in an over representation of European women. Absent from the study were the voices of women who identified as Maori, Pacific peoples women and Asian women. It is assumed that the topic had limited appeal for Maori and Pacific Peoples women, given that these women had the lowest rates of elective caesarean overall at the time of recruitment. Asian women had the highest elective caesarean rates in the region (Capital & Coast District Health Board, 2002). These trends have continued to the present time (Fisher, Hawley, Hardwick & Plunkett, 2005). The limitations may also reflect the problems associated with accessing women serendipitously through advertisements in local newspapers. Of particular relevance is what are the views and characteristics of women who chose not to respond to the advertisements? For better or worse, there is no perfect method of recruitment, as access to women from a central data base would have implications for privacy.

Another limitation was the absence of women who had personal experience of choosing a caesarean, in the absence of clinical indications, as opposed to positioning this group of women as 'other' in the talk and texts of participants. One danger is to stereotype or homogenise these 'others' in their absent presence (McLeod & Nola, 1998; Riggins, 1997, p. 4). Riggins cautions that the voice of the dominant group can become the embodied 'truth' despite its status as an incomplete representation of the 'others' reality. Greater representation from obstetricians would also have added

value to the study in view of the divergent nature of debate within the obstetrical literature.

9.7. Implications for future research.

The epistemological agenda of poststructuralism, where the self has been (re)positioned as in process, often fluctuating, fragmented even contradictory, has valuable currency for midwifery research and practice. I propose that a poststructuralist epistemological project is consistent with midwifery philosophy, in honouring the diversity of women and enabling a dynamic and flexible approach to care. Poststructuralism acknowledges the complexities and contradictions of a flexible self in relation to bodies of knowledge, social and institutional practices and subject positions.

Further research using a range of methodologies is needed to include women who have actually chosen a caesarean as a birth mode to elicit a more in-depth knowledge of their own tacit understandings of their experiences. Additional qualitative studies can provide a useful pool of rich data for future qualitative meta-synthesis (Zimmer, 2006). This is particularly timely in light of pleas for the incorporation of qualitative research into systematic reviews. While its applicability for poststructuralism may have some unforeseen epistemological foibles, a fusion of findings around a particular topic has potential for further generation of a midwifery body of knowledge (Zimmer, 2006). Having said this, from a poststructuralist perspective, the problematic of a fixed truth comes to mind, when contemplating research that has as its end point, the pursuit of theory development or meta-narratives of women's experiences. Further, research using quantitative methods would complement this research and build on existing research (Bulger, Howden-Chapman & Stone, 1998) pertaining to the frequency of caesarean in the absence of clinical indications in Aotearoa New Zealand. Including population based studies, designed to gain insights into the long term impact of caesarean on healthy low risk women, has applicability to a wider population of childbearing women and complement more in-depth studies of the experience for women.

9.8. Conclusion.

The thesis has brought to light a volatile moment in the history of childbirth, in which an explosion of discourses sculpts women's choice for a caesarean in the absence of clinical need. The conditions of possibility for this historical moment are manifold, but most salient has been the construction of caesarean as an alternative birth option under the mantle of the all encompassing ubiquitous, incontrovertible, unassailable and invincible discourse of autonomy. The rhetoric of autonomy has appeal in mainstream discourse. It has ushered in the convenience of scheduling life events, the satiation of desires, the promise of instant gratification and the freedom to avoid adverse events. In so doing, an ensemble of expectations around childbirth have surfaced.

In this precarious moment, new meanings joust with the old, on a shifting terrain awash with rhetoric that co-opts, competes, and contradicts, to bring about a cache of mutable truths. It is against this convoluted landscape that women's choice in childbirth is constituted. Through its regularity in professional and popular publications, it has attained a gratuitous legitimacy beyond its truth value, in which the medicalisation of normal bodily functions is meted out for control. The moment has exposed a paradox of pathologisation in which medicine endeavours to reclaim birth on a number of platforms. It is at this contentious site that the choice for caesarean, as an alternative birth option, can best be explained as an illusion; at worst a delusion.

Awareness of the various ways in which the choice of a caesarean section is represented and how different discourses converge to constitute subjectivity, opens up a range of possibilities for understanding the complex and contradictory nature of caesarean as a birth option. Furthermore the deconstruction of choice within the context of discourse-power-knowledge, unleashes avenues for power-resistance and opportunities for midwives to contemplate the discursive positioning of women through the competing discourses of childbirth.

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Appendix 1. Ethics approval changes to protocol.

Wellington Ethics Committee

Room 425, Fourth Floor
Community & Support Services
Wellington Hospital
Private Bag 7902
Wellington South
Phone (04) 385 5999 ext. 5185
Fax (04) 385 5840
Email: claire.l@wec.org.nz

17 October 2002

Wellington Ethics Committee Ref No: 02/07/070

Jeanie Douche
35 Upper Watt Street
Wadestown
Wellington

Dear Jeanie

02/07/070 - Doctoral Study: - Non clinically indicated caesarean sections: Discourses constituting choice in childbirth

Thank you for your letters of 24 and 25 of September 2002 addressing the points raised in our letter to you of 16 July 2002 and requesting approval for a co-facilitator to assist you with focus groups. We have no additional ethical issues related to this request. Accordingly, the above study has been given ethical approval by the Wellington Ethics Committee

Accreditation

This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Progress Reports

The study is approved until February 2005. The Committee will review the approved application annually. A progress report is required for this study in October 2003. You will be sent a form requesting this information prior to the review date. Please note that failure to complete and return this form may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Amendments

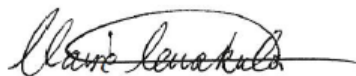
All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

General

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Please note a new version of the application form (EA0502) is now available either by email from the Administrator or from the Health Research Council website, www.hrc.govt.nz. Form EA0699 will not be accepted after 31 December 2002.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Claire Lavakula', with a long horizontal flourish extending to the right.

Claire Lavakula
Co-Administrator

Wellington Ethics Committee

22 December 2003

Wellington Ethics Committee Ref No: 02/07/070
Please quote this reference number in all correspondence relating to this study

C/- Ministry of Health
P O Box 5013
10th Floor, 180 Molesworth Str
Wellington, Phone: 496 2405
Email: claire_lavakula@moh.g

Jeanie Douche
35 Upper Watt Street
Wadestown
Wellington

Dear Jeanie


**02/07/070 - Doctoral Study: - Non clinically indicated caesarean sections:
Discourses constituting choice in childbirth**

Thank you for your letter of 14 November 2003 requesting ethics committee approval for a technological assistance confidentiality agreement as a variation to your original research protocol.

As this document raises no ethical issues, ethical approval is granted by the Chairperson under delegated authority from the Wellington Ethics Committee.

Thank you for bringing this form before the Committee for approval. We continue to wish you well with your research.

Yours sincerely


Claire Lavakula
Co-Administrator

Massey University, Campus Human Ethics Committee: Palmerston North (HEC: PN)
Old Main Building, Turitea Fax: 64 6 350 5622 <http://www.massey.ac.nz/~muhec>
Professor Sylvia V Rumball, Chair Secretary
Telephone: 64 6 350 5249 Telephone: 64 6 350 5799 extn 7773
Email: S.V.Rumball@massey.ac.nz Email:



Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099

1 April 2003

Ms Jeanie Douche
Health Sciences
WELLINGTON

Dear Jeanie

**Re: HEC: PN Protocol – 02/15
Non-clinically indicated caesarean sections: Discourses that constitute
choice in childbirth**

Thank you for your letter dated 14 March 2003 outlining changes you wish to make to the above protocol.

The changes were approved and noted.

Any departure from the approved protocol will require the researcher to return this project to the Massey University Campus Human Ethics Committee: Palmerston North for further consideration and approval.

Yours sincerely

A handwritten signature in black ink, appearing to read "S. Rumball".

Professor Sylvia V Rumball, Chair
Massey University Campus Human Ethics Committee: Palmerston North

cc Associate Professor Cheryl A Benn
Professor Jenny Carryer
Health Sciences
TURITEA PN351

Massey University Human Ethics Committee
Accredited by the Health Research Council

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

Appendix 2. Advertisement recruiting women into study.

(Newspaper)



A division of INL Publishing Ltd

ADVERT PROOF

To: Annamaree Rae
 Attn: Annamaree Rae
 Ad Number: 2HR204300
 Fax Reference: 42002
 Scale: 180%/Rot. 90° CCW
 Date/Time Sent: Tue, 18 Feb 2003 3:57 PM

PLEASE CHECK	ADDRESS <input type="checkbox"/>	PHONE NO <input type="checkbox"/>	PRICES <input type="checkbox"/>
	CONTENT <input type="checkbox"/>	ARTWORK <input type="checkbox"/>	LAYOUT <input type="checkbox"/>
	Approved by _____	Date _____	Signed _____

Birth Choices Study: Wellington Region

My name is Jeanie Douché and I am a midwife, currently undertaking doctoral study at Massey University. I am interested in exploring with women of childbearing age, the discussions around the choice for a caesarean section, where there are no clinical reasons.

I would like to invite you to take part in the above research project. If you are interested in taking part or wish to know more about the research, please provide your contact details below and post this form back to me; c/o:

The School of Health Sciences, Massey University,
 Private Box 756, Wellington.

Or contact me; (04) 801-2794 ext 6752 Email: j.douche@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, Palmerston North, Protocol 02/15 and the Wellington Ethics Committee, Protocol 02/07.070.

 Please send me an information package about the research. "*Birth Choices study: Wellington Region*".

Name _____ Phone _____

Address _____

2HR204300-rs

Advertisement recruiting women into study.
(Parents centre)

**An Invitation to take part in
Midwifery research.**

Title: Birth Choices Study: Wellington Region.

My name is Jeanie Douché and I am a midwife, currently undertaking doctoral study at Massey University. I am interested in exploring with women of childbearing age, the factors that may influence the choice for a caesarean section, where there are no clinical indications and would like to invite you to take part in the above research project.

If you are interested in taking part or wish to know more about the research, then please tick the appropriate box below and post this form back to me c/o The School of Health Sciences, Massey University, Private Box, 756, Wellington or contact me on the following:

Phone: (04) 8012794 x 6752 (Work).

Email: J.Douche@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, Palmerston North, Protocol 02/15 and the Wellington Ethics Committee, Protocol 02/07.070.

If you are interested in the research entitled '*Birth Choices Study: Wellington Region*' please tick the box () below.

() Please send me an information package about the research.

Name _____

Phone _____

Advertisement recruiting Midwives and O & Gs into the study.

*An Invitation to take part in midwifery
research.*

Title: Birth Choices Study: Wellington Region.

My name is Jeanie Douché and I am a midwife, currently undertaking doctoral study at Massey University. I wish to explore various discourses around women's choice of caesarean section in the absence of clinical indications, with health care professionals who provide maternity care in the Wellington region.

If you are interested in taking part or wish to know more about the research, then please tick the appropriate box below and post this form back to me c/o The School of Health Sciences, Massey University, Private Box, 756, Wellington or contact me on the following:

Phone: (04) 8012794 x 6752 (Work).

Email: J.Douche@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, Palmerston North, Protocol 02/15 and the Wellington Ethics Committee, Protocol 02/07.070.

If you are interested in the research entitled '*Birth Choices Study: Wellington Region*' please tick the box () below.

() Please send me an information package about the research.

Name _____ Phone _____

Address _____

Appendix 3. Information sheet (composite) for participants.

(Adapted specific for women midwives and obstetrician participants).

Research Title: *Non-Clinically Indicated Caesareans: Discourses that constitute choice in childbirth.*

Information sheet for potential participants.

Thank you for responding to my invitation to participate in my research. The following information is designed to provide you with some important details about the research, that you will need to know, before you decide to take part in the study.

Researchers and Supervisors profile:

My name is Jeanie Douché, and I am a midwife lecturer at Massey University, currently undertaking a Doctoral Thesis, through the School of Health Sciences at Massey University, Private Box 756, Wellington. Phone (04) 801 2794 ext 6752. E-mail J.Douche@massey.ac.nz

My supervisor for this research is Cheryl Benn, Associate Professor, School of Health Sciences, Massey University, Turitea Campus, Private Bag 11 222, Palmerston North. Phone (06) 350 5799 ext 2543. E-mail C.A.Benn@massey.ac.nz

My second supervisor for this research is Jenny Carryer, Professor of Nursing, School of Health Sciences, Massey University, Turitea Campus, Private Bag 11 222, Palmerston North. Phone (06) 350 5799 ext 7719. E-mail J.B.Carryer@massey.ac.nz

What is the nature of the study?

For my thesis I am interested in exploring the various factors that influence women's choice of a caesarean section, when there are no clinical indications, with a group of women and health care professionals.

What is involved?

The research involves the exploration by women and health care professionals of the discussion around caesarean section, in the absence of clinical indications, as a birth option. If you choose to take part in this research, you will be invited to participate in a focus group session with other women (*midwives*) / (*an interview*) to consider the

topic. Should there be a need for ongoing discussion, then further (focus groups (*interviews*)) will be arranged as agreed upon by the group. The group session may take up to one and a half hours of your time, there will be no risks to you as a participant. The focus group (*interview*) session will be recorded on a dictating machine, in order to capture fully the nature of the conversations. The interviews will be held at a jointly agreed upon time and place. A co-facilitator will be in attendance to ensure the smooth running of the focus groups and a contribution will be made toward the travel costs of participants attending these.

How will confidentiality and anonymity be assured?

The interviews will be transcribed into words, by an authorised transcriber, who will sign a confidentiality agreement, with regard to the privacy of the information. The co-facilitator attending the focus group sessions will also be required to sign a confidentiality agreement. The only other people to view the data will be my supervisors and myself. Your wish to remain anonymous will be respected, however due to the nature of working in groups, it is not possible to guarantee absolute anonymity or confidentiality, as there is always the risk of disclosure outside the group. To minimise this potential, members of the groups will be asked to sign a group confidentiality agreement. Information obtained from the conversations will be treated in confidence by the researcher. In the event where data are used with individual accounts, a fictitious name will be used in the presentation of the study's findings. Anonymity around place names will also be kept in these accounts.

What will happen to the data when it is obtained?

The recordings of the interviews from the focus group sessions will be transcribed, word for word, and analysed for themes. Participants will be given the opportunity to view these transcripts if they wish. Should you wish to make any comment on these, you will need to return them back to researcher within a time period of 15 days. On completion of the feedback, the findings will be written up in a doctoral thesis.

How secure will the data be?

Information from the focus groups, in the form of hard copy, will be stored in a locked filing cabinet in the researcher's office. Audio recordings will be kept separately from hard copies of the transcripts and field notes, originating from the sessions. Digital data will be transferred to a data voice file, on the researcher's hard drive on her computer, in a separate file from the transcript file, for further protection. These will be kept for 10 years from the time of collection and destroyed as negotiated with the group.

How will the information from the study be used?

The information obtained from the study will be used for publication in a Doctoral thesis, academic and professional journals such as the New Zealand College of Midwives Journal. Dissemination at international and national conferences is also likely. It too will be accessible to health care professional and service providers, seeking to examine the provision of maternity care in the light of staff development and health resources.

What are your rights?

As a participant you have the right to:

- decline to participate in the research;
- refuse to answer any particular questions;
- withdraw from the study at any time but that your comments, made during the focus group sessions, are unable to be removed from the audio recordings or transcripts of the group's discussion.
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name, or individual identifying information, will not be used unless you give permission to the researcher to do so.
- be given access to a summary of the findings of the study when it is concluded.

Please feel free to contact either my supervisors or me if you have any questions or concerns about the research process. This project has been reviewed and approved by the Wellington Ethics Committee, Protocol 02/07.070 Massey University Human Ethics Committee, Palmerston North, Protocol 02/15. If you have any concerns about the conduct of this research, please contact Professor Sylvia Rumball Chairperson of the Massey University Regional Human Ethics Committee, Palmerston North, Telephone, 06 3505249, or email S.V.Rumball@massey.ac.nz

What do I do now?

If, after reading the information sheet you still wish to take part in the research, please sign the consent form enclosed sheet and return: Jeanie Douché, Senior Lecturer, School of Health Sciences, Massey University, Private Box 756, Wellington. Phone contact, 801 2794 extension 6752.

Appendix 4. Consent form

Research Title: *Non-Clinically Indicated Caesareans: Discourses that constitute choice in childbirth.*

Consent Form:

I have read the information sheet and have had details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I may withdraw from the study at anytime but that my comments made during the focus group session are unable to be removed from the audio recordings and transcripts of the group's discussion.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. (The information will be used only for this research, presentations and publication arising from this research project).

I understand that by taking part in the study I have agreed to have the interviews audio recorded and to the presence of the focus group co-facilitator.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed:
Name:
Date:

Appendix 5. Interview guides

Interview / Topic Guide: Women

1. *What is your experience of a non-clinical caesarean section?*

2. *It has been predicted in a professional forum and published in the media that by the year 2010 around half of all women will elect to have a caesarean section. In what ways do you think that discussion in the media will influence women's choice for a non-clinically indicated caesarean section as birth option?*

3. *In what ways do you think this possible trend will impact on the future of women's birth experiences?*

4. *Would you (or in the case of previous experience, did you) have any difficulty in making a decision to have a caesarean section in the absence of clinical indications?*

5. *What do you see as the implications for the maternity care staffing and health spending if the trend were to become a reality?*

6. *For women who choose to have a caesarean section in the absence of clinical indications what sort of information do you think should be available for women before consenting to the operation. ?*

7. *All things being considered, if you were to imagine yourself as having your first baby, you were 39-41 weeks pregnant with no complications and the baby's head had gone down well into the pelvis, what would your preference be between a vaginal birth and a caesarean section?*

Many thanks for taking part in this focus group.

Interview / Topic Guide: Maternity practitioners

1. *In your experience how common do you think the practice of women requesting a c-section, for no clinical indications, is in New Zealand and overseas.*
2. *Have you personally had a client request one?*
3. *What is your opinion regarding the validity of a non-clinically indicated elective c-section, as a choice of birth mode and how would you feel about facilitating a woman's request for one?*
4. *It has been predicted that by the year 2010 around half of all women will elect to have a caesarean section. How real do you think this prediction is and how do you think it will impact on the future of obstetrical practice?*
5. *What are your thoughts around a non-clinically indicated c-section, as a valid birth alternative.*
6. *Can you comment on the type of information do you consider women will need about the risks / benefits in order to make an informed decision?*
7. *What do you see as implications for public health resources if the trend for women's request for a c-section as a birth option should become normalised?*
8. *All things being considered, if you were to imagine yourself / your partner / relative / friend, as a primigravida, at term, with an uncomplicated pregnancy, vertex presentation, and head engaged, what would your preference be between a vaginal birth and a caesarean section?*

Many thanks for taking part in this interview.

Appendix 6. Focus group confidentiality agreement

Research Title: *Non-Clinically Indicated Caesareans: Discourses that constitute choice in childbirth.*

Focus group Co-facilitator's Confidentiality Agreement.

I agree that information shared in the focus group sessions will be treated in confidence. I therefore undertake not to disclose, at any time, the identity of any fellow participants nor anything that I have heard during formal or informal parts of the session.

Focus group co-facilitator.

Signed:

Date

Appendix 7. Transcriber Confidentiality agreement

**Research Title: Non-clinically indicated Caesarean Sections:
Discourses that Constitute choice in childbirth.**

Transcriber Confidentiality agreement:

This is to state that in the process of transcribing information supplied to _____ (*transcribing service*), informants confidentiality will be maintained and that the information will be stored in a secure manner during the stages of transcription.

No data will be retained by _____ (*transcribing service*) on hard copy or disc following the successful completion and transfer of the data file on to the researchers hard disc.

Signed _____

Date _____

Signed _____

Date _____

Appendix 8. Focus group co-facilitator's confidentiality agreement

Research Title: *Non-Clinically Indicated Caesareans: Discourses that constitute choice in childbirth.*

Focus group Co-facilitator's Confidentiality Agreement.

I agree that information shared in the focus group sessions will be treated in confidence. I therefore undertake not to disclose, at any time, the identity of any fellow participants nor anything that I have heard during formal or informal parts of the session.

Focus group co-facilitator.

Signed:

Date

Appendix 9. Technological assistance confidentiality agreement

TECHNOLOGICAL ASSISTANCE CONFIDENTIALITY AGREEMENT.

I(Full Name – printed) agree to keep confidential all information to which I have access during the course of providing assistance to Jeanie Douché with her project “Non-Clinically indicated cesarean section: Discourses Constituting Choice in Childbirth”

No copies of any of the data will be made by me from the files on the researchers hard disc.

Signed

Date

Full Name - printed
