CREATING AMBIGUITY, CREATING SOCIAL CHANGE

BY

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Abstract

Current government policy in Victoria, as elsewhere, is seeking to change the provision of maternity care from an obstetric-led system to a flatter, more collaborative system that brings midwives to the front line as primary carers, at least in the public sector.

However, dominant medical discourses continue to exert a sedimentary effect on contesting claims from midwives that deny the high-risk nature of the majority of births and which valorise the competence of the female body. Although there have been modifications in maternity arrangements (and the incumbent government is currently considering more), medical discourses continue to legitimate obstetric power via legal and professional structures, fortify the obstetric ‘habitus’, infect mainstream popular consciousness and undermine autonomous midwifery practice. Drawing from research material gleaned from in-depth interviews with nine obstetricians and thirty midwives conducted in 2004 and 2005, I argue that alternative discourses may strategically undermine obstetric dominance. Specifically, reversing stereotypes; inverting the binary opposition and privileging the subordinate term (or substituting the negative for positive); and defamiliarizing what is perceived to be fixed and given, all play on the ambiguities of representation and present social activists (midwives, childbirth educators and women) with valuable opportunities to challenge fundamentalist medical orthodoxies.

Key words: Discourse; representation; maternity; social change
Introduction

This paper will argue that representations of birth are important in both preserving a system of medical dominance and in subverting it. This paper draws upon interviews I conducted in 2004-5 with nine obstetricians and thirty midwives practising in a large regional maternity unit in Victoria. The study was approved by hospital and university ethics committees. This material is reported in italics. My purpose in this study as a researcher long engaged with asymmetrical power relations in the birthplace was to gauge the possibilities of a genuinely collaborative care regime emerging that could overturn a deeply sedimented (Butler 1993) maternity system characterised by what Degeling et al’s (1998, 2000) study termed a medical-led hierarchy. All participants in this study were presented with similar core semi-structured questions covering: mutual points of conflict and co-operation; the nature of professional relations between midwifery and obstetrics; their respective visions of ideal professional practice; the differences between private and public sector practice (for obstetricians); preference for model of care (for midwives); their respective views of birth; who should be in charge, the positive and negative attributes of their occupations; and their views on the practical possibility of instituting collaborative models of care.

An interventionist medical discourse

Interviews with obstetricians revealed differing views about birth and the body from midwives. All obstetricians, bar perhaps one, expressed admiration for the skills of
midwives in supporting women and a few actually agreed that it was better to wait before intervening. However, Dr No 2 insisted that Caesareans ensured a healthy baby and a healthy mother:

… the idea of 10-15% Caesarean delivery rate and trusting your own body that 85-90% will get there naturally in the modern setting, not even with the legal aspects, is not possible to achieve again even though it was probably about 11% when I trained. But what has disappeared has been the difficult forceps, the baby that is really flat at birth, the woman who has terrible tears, the babies that are traumatised by the whole thing. I totally agree with the midwife that there is a cascade of intervention but … compared to a traumatic vaginal delivery it is often a far more gentle option for mother and baby .. I would never want to see us go back to the days when we had 11% or 12% or even 15%.

The departure point, therefore, was generally the degree to which one waited. Dr 1 (a particularly inclusive obstetrician) agreed with midwives that, ‘women will eventually deliver vaginally if you leave them alone’. However, obstetricians were burdened with ‘litigation and more charged with, not only having the birth, but having a vaginal birth, … a good outcome, a baby who is in very good condition, a mother who has not got perineal damage through prolonged second stage and bladder and bowel problems in the longer term [as well as] a positive experience of the birth [that is] in being heard and being listened to. However, as she emphasised, obstetricians were ‘not prepared to sacrifice a baby or a baby’s good start in life for a process’
A discourse of hierarchy

Degeling et al (1998; 2000) confirm the pronounced hierarchy within the health system. The question is where does it come from? Dr No 3 defines birth by ‘its [inherent] unpredictability’: the body is such a precarious and unreliable entity it eschews a ‘waiting to see’, holistic (typically midwifery) approach to birth. It legitimates interventions and authorises obstetricians to correct the ‘garbage’ contained on the internet:

_I always try and involve the patients as much as they want to be involved or can be involved. [but because of] its unpredictability I guess we are really looking at what are realistic options … you like to have them feeling as if they are part of that decision making. So a lot of the time discussion is actually informing. . . [and] negating the garbage which is sometimes given off the internet or unfortunately through antenatal classes, well meaning but inaccurate and wrong . . . (Dr No 3)._

Like bringing consumers in to feel as if ‘they are part of that decision-making’, No 6 explained that most of the obstetricians had agreed ‘_probably because of workforce issues_’ to move towards a collaborative framework with midwives. The general feeling was that professional boundaries had moved to invite greater midwifery independence. For Dr 2., however, ‘rule by a committee’ was nonsense; when it came to the crunch the obstetrician had to take charge:
….. we need each other and to be knocking heads or see us go further apart [is futile].

But the difficulty is that somebody needs to be ultimately responsible …. You need to have one person, the boss is the wrong word, but one person who has ultimate responsibility.

For their part, many midwives denied that obstetricians supported a more egalitarian arrangement. One midwife (No 26) overheard a conversation between two obstetricians where one said to the other ‘Just wait till they hang themselves’.

Collaboration was just a shibboleth, she said:

… sure it’s easy to be nice and easy to get on with and collaborative [but] when the chips are down you see what things are really like. So I don’t think things are really changed if you want to talk about collaboration.

For most midwives, such as Mid No 25, the discretionary power of doctors to assign risk status to women particularly at the booking-in and 41 week reviews undermined the woman, compromised midwifery collaboration and sustained medical dominance:

Doctors remain in control .. because all women have a booking-in visit at Pregnancy Care Clinic and … all women have a 41 week visit to talk about induction and to book it. The doctors book the induction so there is no impediment to birth being medicalised. There is not the level of continuity to allow the midwives to present an alternative case to the woman. Not all midwives share the same philosophy so the woman is often left very exposed to a one-sided view of the pros of induction. If she is
feeling tired and fed up she is particularly vulnerable to the suggestion by the doctor to accept induction.

For many midwives, therefore, the new changes had not resulted in a relationship of equality but one of hierarchy. This is not a new revelation but it is worth considering what strategies may be put in place to effect sustained social change towards genuine collaboration.

Undermining the agent

Activists need to consider the ubiquity of casual and routine but negative discourses that undermine the competence and confidence of the mother. In cases of objectification, the birth, the baby and the mother are turned into the role of the ‘other’ – the uninformed, the uneducated and the naïve – as objects to be assessed and managed by the expert. Further, as Midwife No 25 testified, some doctors discouraged women from asserting their own choices by using frightening and threatening language:

…. often what happens is that the woman who has a Caeasarean section before and wants a vaginal birth [the next time] goes down to the doctor and the doctor gives her the ‘dead baby talk’, the ‘ruptured uterus talk’. You know, one in 200 uterus’ will rupture.
Individualising incompetence and infantalising women

Mid Glg 22) related a practical example of the difference in clinical management where obstetricians normatively assumed individual pathology while midwives were prepared to wait and see:

...we had a woman, it was her third baby, she ruptured her membranes and it has been 16 hours. They wanted to start giving her antibiotics already and send her upstairs to sit here overnight. We said, but she’s having a normal pregnancy, her baby was moving, she was meeting all the criteria, we had done a CTG and everything was fine but they still wanted to put a drip in her and give her antibiotics and make her stay. We said, but why? Where is your reasoning for that? It’s normal and it is still normal until it is past the 24 hour period then it becomes abnormal if she hasn’t gone into labour.

For Mid (No 4) the obstetric orientation towards birth as pathology was driven by their role as crisis care managers who evaded the real causes of pathology - the social and contextual issues:

We are used to more holistic, how everyone is feeling/mothering sort of view. Their [midwifery] knowledge base is huge. I think they are much more into let’s fix what the problems are and move on. Whereas a lot of the medical problems might be to do with social issues, what’s happening at home sort of thing and not getting to the bottom of that won’t actually fix the problems.
The medical body-as-pathology view of birth was inevitable, Midwife (No 4) explained because: *They* [the obstetricians] *didn’t see the beautiful water birth at 1 o’clock this morning because we didn’t need them. They don’t see the normal. It would make me anti too if I spent my day being called in for the real emergencies where we need them. They don’t come and sit in the corner with the hands crossed and watch a beautiful home birth.*

Further, Mid No 12 complained that medical staff typically announce to the woman that they will break her waters rather than negotiate with her about her plans for the birth or just assume that women will want pain relief. Typically, the doctor might say: *Hi my name is X this is what we are going to do and the options for pain relief are such and such and you can have whatever your want, whereas the midwife would never approach a birth like that, talking about pain relief.*

Such assumptions, midwives complained, undermined their work in staving off intervention and destroyed the confidence of women.

Critical discourse analysis

If language is a key to unravelling the complex mechanisms that sustain medical dominance, it is also a key to undermining them and creating a different reality. Critical Discourse Analysis (Fairclough 1989, 1992, 1995; 2000; Teun Van Dijk 1984, 1991, 1998; Wodak 1989, 1997) begins with the premise that knowledge is created through social interaction. Meaning comes not from the thing itself being
described (language as reflective) or by the meaning given to the thing by the speaker (language as intentional) (Hall 1997). Meaning is created during conversation; from the way that people use words (or other signs or codes) to create meaning (a social constructionist theory) of language) in the give-and-take between different speakers (Bakhtin 1981). Further, meaning is never fixed because people bring different meanings to the world depending on their own lived experience which also implies that meanings change over time and from culture to culture. Meaning is therefore slippery; it is never fixed (Hall 1997; Derrida 1981). Language as a form of social action thus disputes the structuralist approach to language that words have fixed meanings across all social contexts.

Foucault (and Nietzsche) (Fuller 2007b) were interested not just in language but how language was mobilised in sets of statements or discourses to rule in and rule out what is and what is not possible to do and say. The medical discourse certainly circumscribes material and social realities, for example, by prescribing the body as faulty; assuming that it will always fail at some stage and by proposing that women add nothing of consequence to the clinical encounter. Such discourses not only control women rendering them frightened of birth and questioning the competence of their own bodies, they self-authorise the power of the medical profession and constantly reaffirm their indispensable presence at birth. For example, midwives have reported that some obstetricians intervene even when labour is progressing well and even when the baby’s head is visibly crowning. From a Foucauldian perspective, the medical discourse produced the subject position of the pregnant woman as imminently on the cusp of incompetence and failure.
The possibility of agency

Foucault was less concerned with establishing the origins of claims and more interested in the internal juxtaposition of discourses that produced ‘the true’ (Dean 1994: 32) and the relationship between knowledge and power that ordered the regulation of bodies, self-government and the formation of the self. Nevertheless, he conceded that resistance to the power-knowledge nexus and the emergence of the disciplinary society was possible. The ‘micro-capillaries of power’ foreshadows a radical rejection of dominant discourses of the disciplinary society and governmentality although precisely which mechanisms might be at work were never broached. McNay (2001) resurrected the possibility of female agency by deploying strategically the critical thought of Butler and Bourdieu taking some concepts from each to plug the gaps in the other; that is, using Butler’s work to fix Bourdieu’s failure to theorise the habitus as gendered and using Bourdieu’s and Ricoeur’s work to fix Butler’s overly determinist account of subjectivity in the concept of ‘sedimentation’. However, it remains to be demonstrated how agents actually negotiate dominant discourses in constructing their own responses.

In this respect a recent study of how contemporary class-privileged women constructed breastfeeding choices reveals both the pull of powerful discourses but also the relativising influence of contextual factors. For example, in responding to ‘stratified, highly consumerist, and deeply invested in bodily discipline, medicalized and bio-medicalized discourses, and a regime of experts’ (Avishai 2007:149), some class-privileged women responded by constructing breastfeeding as a body-
management project while others rejected the emphasis on embodied breast-feeding altogether if it jeopardised their commitment to the ‘success-oriented world of paid work’. The implication of this study is that women’s actions are conditioned within a specific social, cultural, political and historical context, as McNay (2002) also recognised in her concept, ‘situated subjectivity’. The women in the Avishai study were disciplined by dominance discourses, but not captured by them.

The politics of representation: the production of subversive discourses

The negotiation of medical discourses is more difficult for women, however, because of the context of birth – the perceived monopoly of obstetrics on safety and quality and women’s own position of vulnerability, especially during labour. Further, midwives are often expressly forbidden to encourage women to reject obstetric advice or to ‘just say no’. In any case, ‘just saying no’ is reportedly difficult for most people because it is typically regarded as rude or hostile (Kitzinger and Frith 1999) and such advice falsely assumes that women in hard labour maintain a rational capacity to interrogate information. Birth plans have been posed as a possible solution, but they are unreliable (Deering et al 2007). One solution is to choose a caseload model of care but insufficient numbers of midwives and hospitals have yet to put these into place. Another more subversive strategy is to assist women to question the medical model in early pregnancy: a strategy that brings the role of the independent childbirth educator to centre stage. Such tactics need to directly challenge the central premises of the objectivist medical model, that is, that the ‘truth’ lies in expert knowledge; that the
body is essentially faulty; that the body is a set of muscular and chemical impulses, and that, finally, all bodies are the same (Rothfield 1995).

Creating ambiguity: creating social change

In his research on reversing racial stereotypes Hall (1997) provides guidelines to subversive strategising that could be useful in changing the dominant discourse(s) of childbirth. Most childbirth educators knowingly undertake the first two strategies. The first is to reverse the dominant stereotype that birth is always risky, that only the medical specialist has legitimate knowledge and that context is irrelevant to the progress of labour. For example, many antenatal educators (who are usually midwives) advise women to delay admission to hospital because the unfamiliar environment often inhibits strong labour contractions. They also often convey the idea that midwifery care is either equivalent or superior to obstetric management bar exceptional high-risk cases thus subtly undermining obstetric dominance.

Hall’s second strategy for undermining dominant representations (1997:272) is to construct ‘a positive identification with what has been abjected’, thereby inverting the binary opposition and privileging the subordinate term. Again, midwifery educators typically show enervating films of women in birth and they also substitute negative discourses about pain with positive discourses that depict pain in childbirth as signifying the gradual realisation of successful delivery.

However, Hall’s third counter-strategy is less understood: it tries to ‘contest [the dominant regime] from within’ by struggling with representation, that is, by working with the unstable character of meaning. Since meaning can never be fixed, the strategy grasps the quintessential element of the dominant regime and works on it to make it strange, ‘.. to defamiliarise it, and so make explicit what is often hidden …’
(Hall 1997:274). Harkening back to a typical discourse expressed by Obstetrician No 3 above, we can see that the baseline medical interpretation of the birthing body is its ‘unpredictability’. Defamiliarising what is accepted as a given, as fixed in meaning, would involve embracing (rather than denying) the medical assumption that birth is unpredictable, that no-one really knows what will happen, that every birth is different and that bodily signs are not definitive signifiers. Rather, they may be interpreted differently by different professionals trained in different interpretive philosophies. By valorising uncertainty, ambiguity and difference, but then giving it a different meaning, is to subvert the dominant discourse which authorises intervention ‘in case something goes wrong’. This strategy has the roll-on effect of exhorting both obstetricians and women to trust the birthing body and thereby resist the Enlightenment edict that conflates the body with nature and by denying that the role of science is to control both.

Conclusion

I argue in this paper that highlighting the practical ambiguities in reading the body in labour offers social activist midwives, childbirth educators and women the opportunity to undermine entrenched obstetric dominance performed on a daily basis via discourses that undermine holistic care and women’s confidence. Bodily signs can be re-interpreted, not as signals to intervene ‘before something goes wrong’, but as ordinary differences being played out according to ‘situated subjectivities’.

References

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