THE CURSE OF EVE:
A GENEALOGICAL ANALYSIS
OF THE DISCURSIVE PRACTICE OF CONTEMPORARY CHILDBIRTH.

By

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In my journey along this road less traveled, I have not been alone. It has been made with the support of many people. Without their encouragement it would have not have been such a rewarding experience.

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CHAPTER ONE

Crisis in Contemporary Childbirth

The purpose of this study was to engage in critical reflection on the evolution of contemporary childbirth practice by means of genealogical analysis and deconstructive critique. With this strategy the historical and sociological elements that determine birth practices in today's society were examined. This thesis explored the legacy of 18th. century traditions that have shaped 20th. century medical ideology as it relates to childbirth. By providing a postmodern interpretation of contemporary birth practice, this research will contribute to an alternative version of the apparent crisis that exists between providers and recipients of care. There appears to be a dilemma in current maternal/ child services, as more women seek to to regain control of their own birth experience and to be more involved in the decision making process. Areas of conflict have emerged between medical priorities and women's preferences (Lewis, 1990). These areas appear as themes which have been identified as some of the more contentious issues in contemporary childbirth. As such, the themes are woven in various forms throughout this study. They are discussed in numerous contexts which are reiterated in the course of the analysis .

If, as we are led to understand by the literature, there are problems with contemporary childbirth practice, this praxis-oriented research provides the necessary insight into those hidden power structures that control birth in

today's society. Since long before the turn of the century, opposition to changes in control of childbirth has come from the institutions whose very existence depends on protection of the status quo. Women's voices have been raised in protest before, but perhaps now is the time for them to be heard. This thesis aims to contribute to the emancipatory knowledge required for transformation of contemporary childbirth practice.

Historical overview.

The nature of the relationship between providers and recipients of childbirth practices centres on control of childbirth and pain control in childbirth and can be more clearly understood from a historical perspective. There has been much debate about the biblical references to childbirth, for example "in sorrow shalt thou bring forth . . ." (Genesis, 3: 16). For most women in the eighteenth century bringing forth children " in sorrow" had an uncanny ring of truth. Fear of death and debility were based on the reality of childbirth and as Leavitt (1983) explains, their search for safer and less painful childbirth led them away from traditional birth practices. The availability of analgesia placed the physician in a position to control the practice of childbirth. Women had been led to believe that obstetrics offered the best hope for a successful outcome. After two hundred years, many women are still searching for a solution to their dilemma, control of pain and/or control of birth. This thesis explores the historical, political, economic and social mechanisms which, to this point in time, have prevented childbearing women from realizing their goal.

Global Perspective.

Although references to Britain and the United States have been presented in the majority of situations in this study, it may be misleading. Challenges to the medical model of childbirth are being seen in countries in many parts of the industrialised world. Rapidly expanding technology, in the form of routine electronic monitoring in labour was thought to have been related to the two to threefold increase in caesarean section rates. According to Wagner (1994) the uncritical acceptance of medical intervention in childbirth came to an end as clinical and social epidemiologists were able to demonstrate the extent of iatrogenic problems. In a number of Western European countries, women were demanding to have more control of their birth experiences and for more humane birth practices (Wagner, 1994). Canadian childbirth history is unique as it is the only western industrialised country that has had no legally recognized midwives. Unlike their European counterparts, Canadian physicians did not train with midwives. For the Northern communities, British trained midwives were hired. As O'Neil and Kaufert (1988) have pointed out, when mandatory evacuation for childbirth was introduced for Northern women, midwives were no longer needed and communities suffered as a result.

Research in Australia and New Zealand into the legitimacy of claims that hospitals were the safest place to give birth have refuted this claim, stating that normal babies "fared worse in large hospitals"(Lumley, 1988).

Although the relative saftey of home birth and birth in smaller hospitals remains a contentious issue in Australia, a very thorough analysis of the perinatal data has shown very small perinatal mortality rates in smaller hospitals. This has been attributed to careful selection and appropriate referral. Dr Judith Lumley (1990) was instrumental in reviewing birthing services in Victoria, Australia, with a view to providing women with greater freedom in deciding what childbirth services were most appropriate for them. It is interesting to note that between 1988 and 1990, planned home births accounted for 0.5% of the national total as the medical model remains the dominant model in that country. A viable alternative for Australian women seeking alternate childbirth experiences is Homebirth Australia, a national consumer's organization. With a grant from the National Health and Medical Research Council, a detailed report was compiled in response to the lack of perinatal data on planned home births. These results have been made available to assist childbearing women and health professionals in their choice of birth setting. Based on the data that were collected, a total of 6,421 women chose an alternative to the medical model.

Kitzinger, (1991) has noted that in Spain as in other European countries, the history of childbirth has followed similar lines. Midwifery training followed the medical model of birth, equivalent to the British system. Childbirth in Spain comes under the auspices of the National Institute of Health and is heavily influenced by modern obstetrical practice. In the 1970's, a group of women, supported by a few doctors and midwives

formed an association called Nacer en Casa or Birth at Home. The reason given for this radical departure was a profund belief that birth was not an illness but an physiolgical and personal experience (Kitzinger,1991). This brief description of the state of childbirth practice in some industrialized countries around the world reflects the assumptions that contemporary childbirth practices are in a state of crisis. The tensions that appear to exist between recipients and providers of childbirth services can be categorised in Kuhnian terms as a paradigm shift. This is described by Lather (1991) as the result of exploration of alternative knowledge and by "the inability of the dominant paradigm to explain empirical anomalies" (p.106).

Interpretation of Risk.

An empirical anomaly would adequately describe the issues of risk and responsibility that have been at the centre of the childbirth debate since midwives were replaced by medical men. Risk and relative risk are terms used by epidemiologists and refer to the probability that a health related event will occur, usually in the context of an unfavourable outcome (Last, 1988). The model of risk assessment described by Tew (1990) refers to the risk scoring system used in the U.K. but it resembles those used in most modern obstetrical units. Predicted antenatal risk status is calculated by combining biological and social characteristics such as age, number of births and socio-economic status with a medical and obstetrical history. Risk assessment also includes a labour prediction score. These are criteria that are imposed by obstetricians and their significance for mortality rates is of immense

importance to the profession (Kaufert,1988). The assessment of risk and the response to risk is just a part of a "medical number game" and as Kaufert maintains the resulting perinatal mortality rates are merely artifacts, construed to support prevailing medical assumptions..

Personal experience can also colour perceptions of risk. The concept of learned helplessness although no longer considered a plausible model, has been applied to childbirth. Janis et al. (1978) have postulated theories that link high levels of maternal anxiety to learned helplessness. Levy and McGee (1975) have suported Janis' theory and found their hypothesis confirmed. Intense psychological stress reactions to childbirth resulted in an unfavourable childbirth experience. As Wagner (1994) states, the mere fact that a woman has been deemed to be "high risk"affects the way she perceives herself and her baby and affects the way in which she approaches childbirth. This focus on the probable negative outcome produces reliance on the technocratic model and what Wagner calls "a self-perpetuating spiral of increasing risks". Ideal care has come to be synonmous with all that high technology can provide. Although of undoubted benefit for the identification of high risk status in pregnacy, the risk approach can result in too many people being categorized as at risk with the potential for unnecessary intervention (Caldeyro-Barcia, 1985). Abuses of statistical interpretation of risk have also resulted in unfavourable and unsubstantiated implications that alternatives to the medical model of childbirth are unsafe.

Prepared Childbirth.

The role that prepared childbirth has played and continues to play will also be challenged within this critical inquiry. Predominance of the medical model of birth has become a source of concern to some observers of contemporary childbirth practice. An cursory examination of the different approaches to prenatal education reveals a disparity of philosophies. Romalis (1990) has pointed out that these different perspectives highlight the conflict between primary prevention advocates and proponents of the medical model. Advocates of natural childbirth contend that institutionalized prepared childbirth is the means of socialization into the medical model. According to Gilkison (1991) institutions that offer antenatal education have a vested interest in the product. She maintains that there is " a high degree of control" over what should be taught, by whom and for whom, all of which is aimed at " shaping a woman's behavior to accommodate the requirements of the institution." This view is supported by Rothman (1981) who argues that the prepared childbirth movement is one in which patients are socialized to accept the medical model. Attendance is therefore encouraged by their doctor, secure in the knowledge that cooperation with the system would be instilled in his patient. Hospital antenal classes are considered by Tews to provide "an unrivalled opportunity for putting across obstetrical propoganda from authoritative sources to the target population . . ." (1995, p. 94).

Contemporary birth practices are reflected in institutionalized prenatal education . This system of preparation for childbirth or prenatal education in

the industrialized world traditionally implies a homogeneous system of providing relevant information for the promotion of a healthy pregnancy to women and their families. Judging by the proliferation of the natural childbirth movement, growing numbers of women are opting out of the technocratic prescription for childbirth. From this, it would seem that the present institutionalized system of childbirth education is at variance with the needs of many childbearing women. Any changes in the discursive practice of childbirth would need to address disparities in the current situation.

Applying Lather's concept of emancipatory knowledge to childbirth education, for example, presents some exciting possibilities for future praxis oriented research. Collaborative and interactive dialogue between the providers and the recipients of birth practices would go a long way towards establishing greater understanding of some of the more contentious issues.

Whether the promises inherent in institutional prenatal education can be fulfilled in the context of today's " managed" childbirth will be questions for participants in future research. Arising from praxis oriented, empowering or participatory research, a transformation of the present model of childbirth education could be developed, one which would facilitate the generation of emancipatory knowledge. Such an approach would be more likely to reflect the realities, beliefs and expectations of childbearing women and their families. Although as Romalis states, a more politicized childbirth education movement has begun to emerge in the last decade as a greater

challenge to the medical model, this group is not considered to be a legitimate part of the accepted childbirth system. Their philosophy of childbirth is in direct contrast to the use of childbirth education as the means to condition women into compliance within the technocratic medical model. A rational approach is required to deal with the "divide and conquer" philosophy of governments faced with diminished health care budgets. Praxis oriented research into the dynamics that exist between recipients and providers of discursive practice of childbirth will provide the means to do just that.

Politics and Childbirth.

This study takes the form of critical inquiry into the discursive practice of childbirth, and it is important to recognize how history has shaped the politics of childbirth. Deconstruction of our present system reveals that the political climate of the eighteenth century is not far removed from twentieth century politics. Those in power still determine what knowledge is legitimate. In the transition of childbirth from women centred to the medical domain, politics determined that women in the eighteenth century were denied access to knowledge. Only male physicians were privileged. Now history repeats itself in the contemporary opposition to legalized midwifery in many parts of the world. In the context of critical inquiry, it is relevant to the politics of childbirth to question why and how the medical achievements have occurred within the last century. Briefly, nineteenth century women were convinced that childbirth had become safer and more comfortable as asepsis and pain

relief became available. In increasing numbers they chose to give birth in hospital. In addition, as Wertz & Wertz (1979) explain, hospitalization for delivery provided "a brief respite from domestic responsibilities" and was welcomed by many women in the industrialized world. Contemporary society has also changed in the last century and many women are now becoming aware of a new version of " childbirth politics " as well as the politics of health care funding (Romalis, 1985). The politics of health care have always been problematic. Now that health care demands have become big business for multinational companies, the stakes are considerably higher. Challenges to the dominant medical model are not tolerated. Through critical inquiry, the legitimacy of the dominant model and the political process that has constructed it will be examined. Contemporary childbirth is not only governed by the political agenda, but the institutionalized scientific knowledge of childbirth is now supported by big business, pharmacology and technology. By tracing the historical and social origins of this discursive practice, it will become apparent why some contemporary childbirth practices are so entrenched. The question is not merely why but how did this happen? Genealogical analysis and deconstruction will provide the necessary illumination.

Technocratic Model

There may be misconceptions as to the way in which the mechanisms for the production of the technocratic model have developed. These will be clarified as the the historical elements emerge through genealogical analysis.

Some of the elements that will provide a framework from which to proceed are as follows:

1. The mechanization of childbirth which refers to the introduction of the obstetrical forcep for delivery of the baby.
2. Asepsis and Pain Relief.
3. Hospitalization/ institutionalization.
4. The demise of the midwife.
5. Differentiation between doctors and midwives in terms of education reflected in text books and terminology for childbirth.
6. The medicalization of childbirth through use of pharmacological agents.
7. Intervention through routine artificial rupture of membranes and episiotomy.
8. The introduction of electronic monitoring of foetal well-being and other related technology

While not intended to be all inclusive, these are some of the more significant elements which will be considered in the transformation of childbirth practice from its holistic form into the present technocratic practice. Other seemingly unrelated factors such as world wars, industrial, and technological advances also will be considered for their impact on birth practices. Effects of political, economic, sociological and psychological change in contemporary society will be included in the analysis for possible influence on the discursive practice of childbirth practice.

Traditional vs Technocratic.

In spite of the technological advances in twentieth century obstetrical institutions, there appears to be an increasing discrepancy between the expectations of many mothers and the expectations of their obstetricians. For many advocates of the natural childbirth movement, women giving birth in today's obstetrical institutions with the medically prescribed routines for birth have become alienated from their own bodies (Romalis, 1985). Although the popular press has given a great deal of attention to the changes in contemporary childbirth practice, not all the coverage has been complementary. The result has been what Romalis (1985) has called " a new consciousness about childbirth". In spite of the apparently high profile of contemporary childbirth practice in the popular press, there appears to be a lack of critical academic inquiry into the persistence of medical hegemony. This also applies to the continued but covert opposition to midwifery in North America.

Historically, childbirth had been the concern of women, but in the late seventeenth century in America, it was considered by doctors to be an enterprise that could be shared with midwives (Wertz & Wertz, 1986). The transition from a shared practice to medical control of birth progressed in different countries, at different rates and for different reasons. This complete reversal can be summed up as a question of choice. As Wertz & Wertz (1986) point out, late eighteenth century women were convinced that, in the absence of a viable alternative, the medical model was their only choice, essential for

a healthy and safe birth. With the growth of the natural childbirth movement in the last fifty years, many women have become more aware of the fact that they do have choices.

Paradoxically as the opposition to medicated, active management of childbirth grows, so does the opposition to a viable alternative to high risk care. Schwarz (1990) describes the policy of active management or engineering of birth as a means of preventing potential pathology. Congruence between lay and professional perspective appears to be lacking. However from the proliferation of hospital based alternate birthing centres, it can be seen that the consumer demand for change is being heard. What form the changes will take will depend on the economic rationality that drives government policy and the degree to which the domains of medical power and knowledge are threatened. A good example is the move towards legalization of midwifery across Canada which can be seen not only as consumer driven but as government response to dwindling health care budgets. That this movement has received considerable medical opposition is noteworthy, once again reflecting the concerns of the dominant power system that exists.

Just as prevention oriented consumers of obstetrical services are seeking alternatives to the management of childbirth, with equal enthusiasm obstetricians are embracing new technologies with which to perfect the engineering of childbirth (Schwarz, 1990). There appears to be a serious divergence of philosophies, of perceptions and of goals between providers

and recipients of services for childbirth. Critical inquiry, with its emphasis on " fundamental contradictions" (Lather, 1991) will provide illumination for this tangled web, leading to a more egalitarian system.

Such a radical departure from the present atmosphere of confrontation between competing groups will require commitment to praxis that is both transformative and interpretive. The preliminary stage requires deconstruction of what is now accepted as discursive practice in childbirth.

Critical reflection on the present institutionalized form of childbirth education can only take place through an increased awareness of the mechanisms of power/ knowledge. This form of analysis highlights the ways in which contemporary society reflects the historical accidents that have shaped the major institutions that govern many aspects of our lives. As reflected in the literature, tensions do exist within the sphere of contemporary childbirth practice between proponents of the technocratic model of childbirth and those who would favour emphasis on a more natural process for childbirth. This tension is reflected in political and social arenas by task forces on legalization of midwifery and by a proliferation of hospital based birthing centres in response to consumer demands.

Central Constructs

The central constructs or concepts that provide a framework for this thesis are identified as follows. The first is genealogical analysis or what has also been termed Foucault analysis. This form of analysis has been chosen for its compatability with critical inquiry. The descriptive language of genealogy

provides the means for critical reflection on the ancestry of the discursive practice of contemporary childbirth. By engaging genealogical analysis, a critical historical reflection on the hierarchical and patriarchal structure of the discipline of medicine will illustrate the pervasive way in which contemporary childbirth practices have been determined by political and social structures and by economic ideology.

Deconstruction of the elements identified by the Foucauldian analysis provides an added dimension to the critical inquiry into birth practices. This postmodern mechanism attempts to break away from traditional ideology by identifying the key dichotomies. The definition of one excludes the other and subverts priviledged positions (Fox, 1994).

Another central concept is that of the discursive practice of contemporary obstetrics. Foucault (1970) has described discursive practice as the means by which transformation takes place (quoted in Arney & Neil, 1982). A post-modern interpretation of discursive practice in childbirth would examine the underlying power structures and the paradigms that provide legitimacy to the medical domination of childbirth. Reformulation of medical dominance over childbirth, according to Arney & Neil (1982) has come about as a result of the challenges of natural childbirth to the medical control of pain in childbirth. Childbirth had been categorised as one dimensional, " a physiological process delimited in time", a mechanistic dimension (1982). Childbirth practice evolved into a two dimensional experience with the medical recognition of the psychological experiential component. That ,

according to Arney & Neill (1982), is where the challenge of natural childbirth becomes a serious threat to medical dominance of birth.

In order to understand how the discursive practice of childbirth has been transformed, a critical reflection of the current social, political and economic climate will be undertaken. Such a process will provide an opportunity for recognition of alternative discourse and subsequently transformative praxis. Integration of theory and practice in childbirth that was inclusive and equally representative of women and of midwives, could then become incorporated into contemporary childbirth education.

Foucauldian Analysis.

The degree to which contemporary childbirth practice is congruent with the expectations of childbearing women will be explored within the framework of Foucault's epistemology. This analysis aims to illuminate the dynamics that exist between the contemporary discursive practice of childbirth and its historical roots. Foucault, quoted in Cherryholmes (1988), defines discursive practice 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 enuciative function" (1972, p.117).

From a Foucauldian perspective, in addition to the historical component, the social construction of the origins of power and knowledge also warrants close scrutiny. The social construction of discourse on childbirth has resulted in its medicalization. Freund & McGuire" (1991) point

out that medical knowledge although apparently empirically precise is considerably influenced by "social factors in their production, transmission and development " (p.206). They support the connection between the contemporary medical paradigm and the historical changes that have taken place as a result of the social construction of scientific knowledge. Access to knowledge is also culturally defined and as Freund & McGuire have stated, "social distribution of knowledge reflects and shapes social distinctions of power and prestige"(p. 206). They go on to elaborate on the extent to which medical knowledge has been used to redefine illness and disease, noting that the factors contributing to "discovery" of disease categories could not really be considered purely objective and scientific.

Political, economic, social factors and value judgments are involved in the process. An excellent example of this process is medicalization of childbirth which reflects the power of the medical paradigm to define birth as an illness. Once categorized, scientifically, and medically, childbirth requires the expertise that society has come to expect from those privileged with specialized knowledge. The success of Western medical practice is assured. Through genealogical analysis, Foucault makes it possible to ask of history not only what took place but how the discourse acquires its power. Genealogical analysis is able to demonstrate quite succinctly the ways in which culture, social power and social structure continue to determine the dominant views of society which appear to be as tenacious as they are insidious.

Purpose of the Study.

The purpose of this study was to investigate the phenomenon of what Foucault had described as the "techniques" of power/ knowledge " as it relates to the discourse of contemporary birth practice. By deconstructing the predominant ideology, this thesis contributes to further critical inquiry. What has been achieved by this study is a greater understanding of the social, political and economic forces that determine the way in which childbirth is viewed in society today. It is hoped that the results of this research will provide the stimulus for other researchers to engage in praxis oriented research that has an emancipatory agenda.

This thesis explored what Foucault described as "the strategies, the networks, the mechanisms" (1988, p.104) that have provided legitimization for the medical model of contemporary childbirth. In doing so, it sought to provide a rationale for change in the discursive practice of childbirth. Also of major importance was the examination of the way in which the predominant discourse proliferates and is perpetuated through most forms of institutionalized childbirth education. Integration of a strategy that would facilitate praxis with regard to the status quo in childbirth education, will enable women to have a more positive childbirth experience. This strategy provides a practical guide toward modifying and transforming the present practices with regard to such things as choice, decision-making and empowerment. The psycho-social ramifications of improved perceptions of

the childbirth experience would benefit the whole family, providing the necessary foundations for a healthy, cohesive unit, which supposedly is to be the cornerstone of twentieth century society

Objectives of the Study.

The objectives of this study were threefold. Primarily, it was to identify the socially constructed and historically embedded elements that have produced the discursive practice of contemporary childbirth. Once these elements or historical accidents were identified, the second objective was to examine the evolution of medical ideology and its relationship to contemporary childbirth. In that context, several questions were posed. For example, how has an authoritative knowledge of childbirth been generated and by whom? Foucault (1978) maintained that although the question of who exercises power in today's society is a fundamental one, it cannot be resolved without answers to a final question. That question was concerned with how and why the discourse has become institutionalized. Addressing that question was the final goal of this thesis. Definitive answers to these questions were beyond the scope of this thesis. Nevertheless, genealogical analysis and deconstruction of the medical model of birth practices provided valuable insight into the content and function of medical ideology and its role in the discursive practice of contemporary childbirth.

The intention of this thesis was to explore the historical origins of the predominant or discursive practice of childbirth. Through genealogical analysis, the reciprocal influences of the social construction of gender and the

hegemony of patriarchal ideology, power and knowledge were examined within the context of childbirth practice. The way in which a genealogical analysis provides an historically based critique is to identify a "discontinuous series of elements that have contributed to its evolution. In this thesis, an analysis of childbirth practice has resulted from "a meaningful concatenation of components" (Noujain, 1993, p.159) from the turn of the century to contemporary technologically oriented society.

The goal of this heterodoxy (or different view) was to provide an alternative pedagogy for childbirth. This allowed for praxis that was focused on the discursive practice related to childbirth that empowers rather than subordinates childbearing women. This alternative discourse would be brought about through encompassing reform in childbirth education in its present institutionalized form.

Theoretical Implications

The theoretical implications of this thesis are to be found within the paradigm of critical theory and focus on ideological illusions and assumptions about knowledge production and power. Within this paradigm, a basic tenet is that our assumptions about knowledge and power in our society are taken for granted. In challenging these assumptions, this thesis contributes to the existing body of knowledge about contemporary birth practices by deconstructing the ideology that provides legitimacy to the medical model of childbirth. Although there has been a great deal in the literature on history and childbirth, this postmodern study sought to expose

an alternate and equally legitimate discourse on birth practices. This has been achieved by deconstructing the historical and social structures and challenging the authority of that discourse to speak for all women on childbirth issues. Discursive practices are enforced by power structures and, provide support for "a hierarchy in which theoretical knowledge is superior to practical knowledge" Cherryholmes (1988, p. 89).

Subjective and empirical knowledge is devalued in our society and theoretical, scientifically based epistemology is presented as the " truth". Such knowledge, according to Habermas (1979) is informed by interests, ideology and power. Critical discourse has the mechanism to question whose interests are being served by contemporary birth practices and to focus on the ways in which power and ideology distort the discursive practice. As Cherryholmes points out, critical discourse must be "symetrical and undominated"(1988, p. 89). With regard to contemporary birth practice, consensus between recipients and providers of services would be the ultimate goal. These conditions, according to Cherryholmes, are necessary conditions for emancipation from past practice. The review of literature documented the ways in which medical ideology has served to legitimize the subordination of women in birth practices.

The literature also supported the theoretical implications of this thesis which used critical discourse to uncover the ideological illusions on which childbirth practice is premised. Fundamental contradictions were examined within the context of critical inquiry. Critical reflection on the status quo of

childbirth preparation will pave the way for an emancipatory approach. By means of a systematic analysis that is both historical and sociological, this thesis has provided an alternative view to the institutionalized medical model of childbirth practice. Encouragement of this perspective is crucial for the development of an alternative methodology, one that has explored the potential of an empowering pedagogy for childbirth, and provide a catalyst for change. By providing new lenses with which to view contemporary discursive birth practices, this thesis has contributed to the existing body of knowledge on that subject.

While the research about women's experiences in childbirth has produced a wide range of studies, it still appears difficult to determine consistently and with any accuracy how childbearing women feel about the biomedical model of birth. Studies in the United Kingdom have shown lower socio-economic groups, single mothers and ethnic groups to be underrepresented (Jacoby & Cartwright, 1985). Considered to be cost effective and efficient, surveys appear to make up the majority of research on experiences and recommendations of childbearing women. Other studies, using in depth interviews of women from different socio-economic groups have been done by Oakley (1980) and Kitzinger (1990), showing distinct variations in attitudes and expectations about birth. In spite of methodological problems with much of the research produced to date, several issues have been consistently identified. Some common themes include issues such as, insufficent choice and control of their birth experience, lack of

continuity of care and absence of understanding by staff (Jacoby & Cartwright, 1985). These issues appear to be representative of symptoms of the problems with the system, but without sufficient recognition of the "epidemiology"(determinants and distribution) of the "disease."

Rationale

As with an appraisal of any kind , critical reflection of the status quo must be undertaken before any meaningful praxis can take place. There appears to be a paucity of academic inquiry into the discursive practice of contemporary childbirth, in spite of dissension among many consumers. On a global scale, economic rationality has forced governments to review health care policies and their budgets. The medical model of childbirth is a very costly machine to run, but to use the Canadian example, any attempts to diversify the present system have failed. Economics has been the reason given for its apparent failure. Conflicting ideologies are caught in a power struggle as women seek to have more control over their birth experiences. It is a timely undertaking to reflect on the underlying ideology that controls the discursive practice of childbirth.

Genealogical analysis will provide the means for critical reflection of the medical ideology that determines contemporary childbirth practices. Ideology is understood to refer to the belief systems defined by a legitimate authority, constructed and presented to society as indisputable fact. In their discussion of the epistemology of critical theory, Campbell & Bunting state that "ideology is what prevents agents in society from correctly perceiving

their true situation and real interests"(1991, p. 4). These authors emphasize the emancipatory aspect of critical reflection, which according to Campbell & Bunting, produces a kind of knowledge inherently productive of enlightenment and emancipation (1991). In essence, the reasoning behind this study is that the current ferment over health budgets makes it imperative that policies that determine the future of chidbirth practices serve the needs of women not institutions. Government policy should be determined by praxis orientated research such as this.

Praxis.

As emancipatory oriented research, this thesis has been directed towards a "praxis of the present" (Gramsci quoted in Lather,1991, p.50). This concept describes the development of increased awareness of particular groups to their actions and situations. This term would seem to be an appropriate description of the natural childbirth movement in North America. Although this movement has been in existence for about forty years, within the last twenty years it has become more widespread. The increasing struggle between providers and recipients of obstetrical services has been well documented by Romalis (1981) and many others, and illustrates the way in which birth has become a consumer issue. The need for praxis oriented research becomes more apparent as the conflict between medical hierarchies and consumer advocacy groups becomes more polarized.

As Giddens (1979) suggests, the task of a critical social science is to explore the intersection between choice and constraint and to centre on questions of power (quoted in Lather,1991). The structures that have produced the contemporary crisis in birth practices have strong social, political, economic and historical roots. Strong measures are required to transform structural inequalities in society. Accordingly, the call has gone out to social science researchers to discover not only what changes are desirable in our social world, but how can meaningful change be brought about? Praxis oriented research, involving not only critical reflection but self reflection offers much to recommend it, in order to achieve these goals.

The foundation of praxis, Friere's (1973) concept of reflection and action, is the preparatory stage of critical reflection. A systematic and thorough critique of contemporary childbirth practice by means of genealogical analysis will provide that crucial first stage of critical reflection on the discursive practice of the dominant model of childbirth education would determine the legitimacy of the power/knowledge that determines contemporary childbirth practice. Lather (1991) argues for a similarly emancipatory approach to research and expresses a strong commitment to "research as praxis". She maintains that as such, research as praxis within the context of empirical research in the human sciences has an extremely important role to play . As she points out, the postpositive period in the social sciences is "marked by much methodological and epistemological ferment". Recognizing that no research is neutral, Lather maintains that it is crucial to

develop an emancipatory approach to research . This in turn implies what Lather calls "a transformative agenda.

From a postmodern perspective, this has serious implications for conventional methodology. Lather (1991) also expresses the view that an emancipatory social science would contribute to a greater understanding of not only what she calls "the maldistribution of power and resources" but will be instrumental in bringing about changes in that maldistribution.The merit of its application to an analysis of discursive childbirth practice is self evident. In Lather's view, the goal of research oriented praxis is to contribute to the creation of a more equal world. Research with "a transformative agenda"as described by Lather is aimed at the development of a more egalitarian approach to generate knowledge. Recognizing that knowledge is socially constructed, based on value judgments and embedded in particular historical and geographical contexts, Lather expresses the view that the postpositivist researcher seeks emancipatory knowledge which " increases awareness of the contradictions distorted or hidden by everyday understandings and in doing so, directs attention to possibilities for social transformations...."(1991, p.53) . To paraphrase Lather, empirical research of this nature encourages self reflection on the contradictions in our personal and professional lives and paves the way for praxis oriented research (1991, p.56).

Summary.

An introduction to the topic and an outline of the way in which this study proceeded has been provided in this chapter. Subsequent chapters progress as follows. In Chapter Two, a review of relevant literature contribute to additional background for this topic. The literature also illustrates several issues that are central to the discursive practice of contemporary childbirth. The themes identified in the literature review will be reiterated through out the study. Chapter Three presents an explanation of the specific theoretical orientation, method and methodology that were used for this thesis. Detailed descriptions of deconstructivist and genealogical analysis of childbirth are provided in Chapters Four and Five. Deconstruction serves as a form of triangulation for the study. In Chapter Six, the final chapter a summary of the study is presented and the implications of the research discussed. Suggestions are provided in the final chapter for ways to implement the findings into contemporary childbirth education.

CHAPTER TWO.

Review of Literature:

Through a review of literature, issues that are pertinent to contemporary childbirth practice have been reiterated. Moving from the broad historical, social and political context to a focus on specific themes, the literature review has emphasized those issues considered to have most impact on the discursive practice of contemporary childbirth. Social and political control of childbirth are addressed in the review of literature. Discourse on the related issues of the ethical and moral ramifications of childbearing women's right to personal choice and control also have been included. The literature review has explored the role of contemporary childbirth education in the proliferation of the dominant ideology. In addition, an investigation of available literature has helped to illustrate some of the dilemmas that confront those with alternative views on childbirth. The ways in which these dilemmas impact upon discursive practice of contemporary childbirth have been examined. An essential issue in the discursive practice of childbirth is the power/knowledge dichotomy which has been explored from the perspective of critical scholars such as Foucault (1980a, 1980b) Cherryholmes (1988) and Lather (1991).

Role of Childbirth Education.

Sociologists and anthropologists have joined the ranks of health professionals and lay movements in challenging the role of childbirth education in Western society . Kitzinger (1990) presents a disquietening but convincing viewpoint which emphasizes the need to "reconstruct the meaning of birth". In Britain in 1956, a group known as the Natural Childbirth Association was formed, whose aim was to educate women to become "prepared" for "natural" childbirth. This eventually evolved into the more politically correct National Childbirth Trust. Using the example of the early years of the childbirth movement in Britain, Kitzinger (1990) shows how in preparing women for childbirth, educators were encouraging compliance at all costs in their clients. She points out that the National Childbirth Trust supported medical paternalism and the view that women did not know what was in their best interests. The goal of early prepared childbirth, according to Kitzinger (1990) was to "reinforce a compliant feminine image of the pregnant and labouring woman".

With regard to childbirth, the issues of control, choice and communication are of paramount importance, especially when comparing the early forms of childbirth preparation to the modern childbirth movement. The previous Lamaze and Grantley Dick Read methods promoted the concept of woman's control over her body. This can be contrasted with most contemporary childbirth education models that

proclaim control over external forces to be the issue, supporting strong belief in the power of doctors to control pain (Kitzinger, 1990).

The rhetoric of "choice" has also undergone some drastic changes. One wonders at the speed with which the pendulum swings. The passage of a mere fifty years has resulted in pronounced differences in the fundamental principles of childbirth. Kitzinger (1990) shows clearly that in the beginning stages of National Childbirth system, educators went to great lengths to uphold the status of the professionals. Promoting a woman's right to make decisions regarding her birth would have been at odds with this stance and would have resulted in sanctions from the professionals they sought to accommodate. According to Kitzinger (1990) a different story has come about since obstetrics has become increasingly interventionist. She goes on to state that the National Childbirth Trust now champions choice and control in childbirth. With the rise in a whole range of interventions since the 1970's, in particular medical induction of labour, the National Childbirth Trust has begun to challenge the golden rule of "doctor knows best".

Communication has also undergone radical metamorphosis. Strong emphasis of co-operation with the medical profession, in the early days of the National Childbirth Trust, was reflected in the classes that promised " a better quality patient, more compliant , less hysterical" Kitzinger (1990, p. 106). The National Childbirth Trust. campaign for more humane treatment of women was effective in reinforcing medical paternalism, female weakness and vulnerability. Women's resistance to medical control was reduced to simply

a matter of lack of communication, either the woman's inability to understand or the doctor's inability to explain (Kitzinger (1990). The new model of communication has been adapted to include assertiveness, but problems are once again at an individual level. Inequality, class, race or gender are never included as part of the problem which Kitzinger (1990) points out is probably a feature of the white middle class bias, among educators.

North American counterparts in childbirth education have come under similar criticism and the same issues of control, choice and communication have been and still are, contentious issues. The North American model of childbirth education has come under fire for being "particularly suited to Judeo-Christian families, who accept traditional gender roles"(Romalis, 1985). The natural childbirth movement, according to Romalis, encourages dependence of women on men as well as the domination of the medical practitioner. In a similar vein to their British colleagues, North American childbirth education classes urge women to consider the doctor as the ultimate authority. Through prepared childbirth classes also called parenthood education, women are socialized to accept the medical model of childbirth (Rothman, 1981). In this way, the medical definition of birth and pregnancy and its associated technology is disseminated very effectively.

The concept of "natural childbirth" as Mitford (1992) points out, is a very slippery one and can be interpreted in many ways. For the purpose of

this study, natural childbirth refers to the opposite of medical childbirth, with particular emphasis on an egalitarian relationship between a woman and her caregivers, professional and otherwise. Romalis (1985) points out that a new consciousness has developed towards childbirth. Books, popular magazines and newspaper articles have appeared geared towards the childbearing woman as consumer. To many mothers, the term "natural childbirth" implies a greater emphasis on choice and control and a woman's right to make decisions about episiotomy, pain relief and other matters.

To physicians, trained to view birth as a potentially dangerous medical event, natural childbirth is a contradiction in terms. According to Mitford (1992), it was in response to the medicalization of childbirth in the United States that the natural childbirth movement was born. Ironically, prepared childbirth as it is now called, became merely an echo of the medical model. What was to have been a revolution in childbirth practice has become a reformation. The ability to be "awake and aware" in childbirth, with epidural anaesthesia, has become the gold standard (Mitford, 1992, p. 79).

Davis-Floyd (1991) looks at birth from an anthropologist's point of view, and proposes that the hospital is a primary socialising agent for mainstream beliefs in our society. With regard to birth, Davis-Floyd maintains that many obstetrical procedures have become "rituals, responses to a technological society's fear of the natural processes . . . ". This view is supported by Gilkison (1991) who points out that the facility that provides antenatal classes exercises political, social and institutional control over what

is taught and who teaches. She maintains that prepared childbirth can be considered as the means to shape a woman's behaviour to accommodate the requirements of the institution.

Control & Choice; Is there a case for medical paternalism?

By invoking the views of such celebrated minds as Immanuel Kant and John Stewart Mill, an interesting perspective on medical paternalism has been presented by Komrad (1983). He maintains that, as illness represents a state of diminished autonomy, the doctor-patient relationship " necessarily and justifiably involves a degree of medical paternalism". The twentieth century has seen the domain of medicine enlarge considerably and this transition according to Zola (1986) has been" an insidious and undramatic phenomenon accomplished by medicalization of daily living". Not suprisingly, childbirth has entered into this sphere. In their discussion of the social construction of illness, Freund and McGuire (1991) demonstrate how childbirth has become re-defined within scientific paradigms. As a result of medicalization, what was non-pathological, in the case of childbirth has been brought into the medical domain (Freund and McGuire, 1991).

Once childbirth is defined as an illness, to engage the reasoning of Mill and Kant proposed by Komrad (1983), such "physical incapacity" becomes reason enough for "attenuation of autonomy". In this way, paternalism is considered to be not merely justified but a doctor's obligation to protect patients for their own good (Komrad, 1983). In twentieth century childbirth practice, this philosophy is not likely to be compatible with the views of

natural childbirth advocates. In the present climate of advocacy for womens' rights, and with the growth of obstetrical technology, the role of childbirth education requires critical reappraisal, in order to address the competing ideologies and apparent contradictions inherent in the way in which contemporary childbirth services are delivered.

Medical Ideology / Technology.

An examination of the foundations of medical ideology will highlight some of the areas of conflict between the advocates of the medical model and those of natural childbirth. Fox points out that " medicine has in the modern period become very heavily technologised losing some of its previous art or craft" (1994, p. 147). Freund & McGuire (1991) in describing the biomedical model that has evolved, maintain that medical training is disease oriented, with emphasis on acquisition of technical and diagnostic skills.

Armstrong (1983), and Arney and Bergen (1983) share the Foucaldian perspective on medical technology with Fox (1994). Fox states that "technology which medicine has developed in this century . . . has been used to identify disease and construct normality" (1994, p. 147). Freund & McGuire (1991) also continue in this vein by suggesting that the training and the socialization of medical staff actively discourages and devalues interest in what is normal. What doctors learn among other things, is that "real" medicine is about pathologies, not patients (Freund & McGuire, 1991). This opinion is shared by Scully (1994) who points out that childbirth is viewed by physicians as a medical problem rather than a natural process. Although it is

changing, Scully (1994) maintains the predominance of white, male physicians has created a climate of infantilization, racism and sexism in childbirth. These legacies of the Victorian Age effect the relationship between childbearing women and the professionals entrusted with their care. The term " vaginal politics" coined by Frankfort (1972) describes the frustration that many women experience within existing healthier systems. Her book describes the way in which women are consistently denied access to information that would enable them to make informed decisions regarding their treatment. According to Freund & McGuire (1991), in spite of the assurances of the objectivity, neutrality and scientific basis of biomedicine, medical ideology is influenced by social stratification at a personal and public level. Social class and gender, strongly associated with specific views about health and illness, affect the knowledge produced and disseminated by medical practitioners. In this way, Freund and McGuire (1991) propose that medical ideology provides legitimacy and reinforcement of professional practice. Using the specialization of obstetrics as an example of legitimacy through medical ideology, Freund & McGuire (1991) present the view that medicalization of childbirth was promoted when women's reproduction was brought under the professional "canopy definition of illness".

Dilemma of Doulas and Midwives

Social construction of medical expertise, brought about by the sexual politics of late nineteenth century, achieved its aim of excluding women from all aspects of medicine. In North America particularly, midwives were

barred from legitimate practice. Their European counterparts had a more protracted demise. How this has come about and the ramifications for contemporary childbearing women is of importance to this study. Through professional dominance, modern medical practice has been incredibly successful in what Schwartz (1990) has termed "engineered childbirth". The transformation of midwifery and childbirth into the science and technology of obstetrics has been chronicled by historians such as, Oakley (1980, 1984), anthropologists, Davis -Floyd, (1991) and social scientists,Tews,(1990) , and Scully (1994). By declaring abnormality in childbirth to be any deviation from a proscribed statistical norm, the scientific approach of obstetrics was presented as the only safe option for childbearing women (Schwartz, 1990).

Active management of labour, the brainchild of O'Driscol (1980), was presented as the solution to prevent pathological deviations from the norm. This practice effectively excluded midwives from childbirth. Having excluded women from the education that would allow them to gain entrance to legitimate practice, the demise of the midwife was complete with the acceptance by childbearing women of hospital confinement as the optimum choice for birth. The once autonomous midwife has been relegated to the role of " subcontractor" of engineered childbirth, in a "supportive role, providing professional companionship and a caring attitude" (Schwarz, 1990, p. 58).

Schwarz (1990) illustrates how text books used in the training of pupil midwives and medical students have undergone substantial alterations in the last fifty years, reflecting the transformation of childbirth into a scientific

endeavour. The midwife of the fifties has been replaced by a nineties version, a nurse-midwife proficient in high technology management of labour. In response to the assembly line climate in large obstetrical units, many mothers have sought the services of a doula or companion in labour, someone who will rub her back and provide emotional support. A climate of economic rationality, resulting in drastic cuts in health care have placed obstetrical nurses in an untenable position. Too busy attending to monitors and graphs to provide those personal touches, the close relationship that a midwife had with a woman through labour is now provided by a doula. As the numbers of nurses entering training dwindles and midwives struggle for legalization and legitimacy, paradoxically training for doulas has become very popular, though more so in North America than in Europe. Another expression of women's disenchantment of the medical model of childbirth provided by health care institutions is the homebirth movement. As Romalis (1985) describes the situation, proponents of the medical model see the homebirth movement as a radical political statement. She maintains that it demonstrates very clearly the polarity between those who believe that birth is a natural woman centred process and those who would define it as a high risk situation requiring medical management.

Power/Knowledge Dichotomy

Foucault provides illumination of the "epidemiology" of the crisis in contemporary childbirth. His postmodern conceptualization of the power/

knowledge relationship supplies the essential critical insight (Cheryholmes, 1994). With regard to modern medical practice, Fox (1994) describes the mechanism by which power is acquired. He maintains that the basis of the hegemony of medical discourse is knowledge, accomplished by what Foucault describes as "the gaze of power". The primary principle of panopticism is the exercise of power through the relationship between the observer and the observed. This panoptic gaze is a mechanism that entails surveillance on many levels. Fox explains that medical power has come about through its ability to achieve knowledge and expertise obtained with surveillance of society at both micro-political and macro-political levels. According to Fox (1984), this knowledge is achieved at the expense of those who must be subjected to the power of the "gaze". Further interpretations by Fox (1984), of Foucault's concept of the gaze as the technology of power, relates to the way in which observation and medical classification of individuals can be made. Both the observer and the observed are aware of what constitutes deviations from the norm which has been defined by those with expertise. Using the metaphor of the panopticon, Foucault has demonstrated the insidious, covert nature of the source of the disciplinary power. Duncan, (1994) points out that the very nature of panopticism renders the social and politcal forces of patriarchy invisible and therefore, difficult to overcome.

Cherryholmes (1988) also discusses the way in which power operates, both visibly and invisibly. The expectations and desires of society are shaped by the exercise of power. Power is visible at the formal, public level, through

criteria that society acknowledges. At the individual level, power operates invisibly through individual's adaptation to the expectations and desires of society. Through this mechanism, the effects of power remain invisible (Cherryholmes, 1988).

For Foucault (Kritzman, 1988), the relationship between power and knowledge or power and truth is a complex one. His position is that the strategies of power produce knowledge . According to Foucault (Kritzman, 1988), the domain of knowledge, that of truth and freedom and the domain of power can not be considered separate entities. He maintains that the development of human sciences produced yet another mechanism for the exercise of power. Science and the production of scientific truth has become "institutionalized as power through a university system with its own constricting apparatus of laboratories and experiments" (Kritzman, 1988, pp.106-107). Foucault (Fox, 1994) points to the political production of truth and knowledge and the foundations of discourse and discursive practice. He states that because truth is discursive and discourse is historically situated, truth cannot be spoken in the absence of power. Truth, according to Foucault,

> is produced only by virtue of multiple forms of constraint . . . each society has its own "general politics" . .. which determine the types of discourse which it accepts and makes function as true.... also the mechanisms and instances which enable one to tell the difference between true and false statements . . . the

> means by which each is sanctioned . . .the techniques and procedures accorded value in the acquisition of truth . . the status of those who are charged with saying what counts as true (1980, p.131).

This insight by Foucault of the interconnectiveness between truth (knowledge) and power is fundamental to this study. His emphasis on the political production of knowledge and the asymmetries of power have ramifications for the discursive practice of contemporary childbirth. Following Foucault's line of reasoning, discursive practices are controlled by those who produce knowledge. The challenge for transformation of arbitrarily produced discourse, therefore, lies in exposure of its genealogy.

CHAPTER THREE.

Methodology.

Critical postmodern research, according to Slaughter (1989) requires researchers to construct their perception of the world anew, not just in random ways but in a manner that undermines what appears natural, that opens to question what appears obvious (Denzin & Lincoln,1994. p.154.)

This thesis is framed within an interpretive paradigm described by Bateson, (1972) quoted in Denzin & Lincoln (1994, p.13.), wherein the researcher is bound within "a net" of epistemological, ontological and methodological premises. As such this particular form of research is guided by a set of beliefs and feelings about the world. The choice of suitable methodologies for interpretation of the complex web of social, political and historical influences of contemporary childbirth practice has been, to say the least, problematic. Critical research of this kind lies somewhere between critical theory and postmodernism. To acquire insight into the historical accidents that have led to institutionalization of asymmetrical relations of power and privilege, considerable reflexivity is required.

Of singular importance is the extent to which ideological assumptions have determined the perpetuation of medical domination of childbirth . In order to provide the most pervasive and thorough understanding of the phenomenon in question, a strategy of multiple methodologies has been selected. Using critical theory as the overall framework, such tools as genealogical analysis and deconstructionism are employed. The use of

multiple methodologies provides what has been termed a bricolage (Denzin & Lincoln,1994) and can serve as a form of triangulation, an alternative approach to validation. This technique reflects an attempt to secure an in-depth understanding of the phenomenon in question. Denzin & Lincoln have observed that the complexities of women's experiences are sufficiently great to warrant multiple approaches via qualitative research (1994). Issues surrounding childbirth practice warrant no less.

The term "bricolage" is understood to describe

> a complex, dense, collage-like creation that represents the researcher's images, understandings and interpretations of the world or phenomenon under analysis. It has also been interpreted as . . .a pieced-together, close-knit set of practices . . .an interpretive paradigm (Denzin & Lincoln, 1994).

Bricolage is also reflexive and interpretive.The bricoleur, as described by Levi-Strauss (1966), assembles different pieces of a story, creating solutions to problems, and weaving new meaning into the political and social landscape.

Genealogical analysis is yet another facet of the multiple methodologies employed in this particular research. The term genealogical analysis has been attributed to the philosopher Frederiche Nietsche, utilized when he wrote "The Genealogy of Morals". Genealogical analysis is a form of deciphering, an historical deconstruction of a given phenomena. This strategy

will highlight discrepancies between the discourse that exists between various groups of recipients and providers within the sphere of childbirth.

Deconstructivist inquiry rooted in the work of Nietzsche, also involves close scrutiny of text to determine whether there are actual contradictions of meaning. By means of deconstructive analysis, it will be demonstrated that concepts and ideology, the political and social "truths" surrounding childbirth, have been historically legitimized .

In order to contextualise the research to be undertaken, it is necessary to declare what Lather (1991) refers to as intense personal engagement with the issues. Kirby & McKenna, have also said that by stating personal assumptions about the topic another important dimension is added to the data. In this way, what they term "conceptual baggage"(1989, p.32) becomes an integral part of the research process. The paucity of research on the experiences of women found by Kirby & McKenna (1989 led to the formulation of several key points for their research perspective. The first is that the concept of Self is " absolutely necessary and integral to the research and should not be discounted from it"(1989, p. 20). Another key point, according to Kirby & McKenna, is that theoretical examination must be strongly rooted in the very experience that it claims to explain (1989, p. 20).

As defined by Harding (1987), methodology is a theory and an analysis of the way in which research does or should proceed. The theoretical perspective that seems to provide the most appropriate framework for this thesis is critical theory. The inherent characteristics of critical theory provide

important avenues by which to demonstrate the inconsistencies and lack of coherence between the medical model of childbirth and the marginalised midwifery model. These characteristics have been discussed by many authors and those relevant to this thesis will be discussed here. These have been adapted from post-modern critical theory research related to workers and are summarized by Denzin & Lincoln (1994), as follows.

Critical theory is:

- A focus on the lived experiences of marginalised groups.
- A relevance to those who have been marginalised by the hierarchical discourse of mainstream science, with its cult of the expert.
- A legitimization of practical knowledge usually excluded by the scientific authority.
- A validation of perspective/knowledge other than that of the scientific expert.
- Empowerment of marginalised groups arising from recognition of their ability to contribute to research into a more egalitarian practice.
- Democratization of the scientific process, whereby the existing hierarchy would be exchanged for a collaborative model.
- A critique of the ideology that supports endemic technical rationality.

A challenge to the assumptions upon which the cult of the expert has been based

A central theme of the thesis which can be found in both the method and the methodology is the supposedly unseen power/ knowledge imbalances. The production and legitimization of the power/knowledge that determines contemporary institutionalized childbirth education has been examined within the context of the critical theory model. Reality and knowledge are constructed and contextual, another facet of critical theory, (Campbell & Bunting, 1991) which is a key issue in this thesis. This research proposed to demonstrate how in childbirth, as in many other areas of social reality, "knowledge is used to maintain oppressive relations" (Kirby & McKenna, 1989.) Critical reflection on the historical connections that determine the discursive practice of childbirth today will provide a fundamentally emancipatory impetus to reformulation of current childbirth education. In addition, critical reflection and deconstruction of the hierarchical binarisms will result in reorganization of the relevant discursive practice at the workplace and /or institution.

The Method.

Although in discussion with Cherryholmes, author of " Power & Criticism" , genealogical analysis could be considered to be both method and methodology, for the purpose of this study, its primary application has been as method. Fox (1994) has described genealogy as an analytic strategy which documents the ways in which a practice has been described discursively. In his use of the genealogical method, Armstrong (1990) describes it as a means to map out a problem. In applying this strategy to the discursive practice of

childbirth, it is hoped that the systems of meanings, or metanarratives related to that body of knowledge have been deconstructed. Foucault has applied this system of analysis to the practice of psychiatry to demonstrate the linking of power to knowledge and to demonstrate the coercive character of knowledge that has been claimed to be legitimate. In adapting this method to an analysis of childbirth practice, a similar construction of cultural, social and political metanarratives has been demonstrated. This reflexive and critical perspective provides insight into what Cherryholmes describes as "the ambiguities within the history of discourses in order to discover the ways in which power operates"(1988, p. 162). As the originator of the philosophical use of genealogy, the works of Frederich Nietzsche have continued to be interpreted and reinterpreted. Allison (1994) describes Nietsche's genealogy as

> a critical method describing the means to examine all forms of political and technological control and domination, all forms of contemporary knowledge and power. He sees that the aim of genealogy is to decipher the ways in which power and knowledge have become legitimized. Allison goes on to describe the genealogical critique of values is one which consists in relating any given value to the ordinary direction of volition, of unveiling the long lineage that issues from this primordial orientation, and in unravelling the remote thread of encounters that have since frozen into values (1994, p. 12).

It is the primordial orientation of knowledge and power in childbirth that is the issue in this study. Analysis of that phenomena, by means of the genealogical method resulted in the unraveling of those threads that have become so tightly woven and exist in the form of contemporary childbirth practice.

In his discussion of Foucault's interpretation of genealogical analysis, Noujain (1987) describes the genealogical method as one that can demonstrate "how some aspects of our society descend from past practices or institutions that today may appear objectionable". He goes on to point out that social agencies, institutions, hospitals and universities play a pervasive part in shaping our lives. He contends that this is reflected in what he calls the "architecture" of such institutions by regulations, rules and timetables and by the sciences that inform them. The way in which medical control over childbirth has succeeded to overcome every challenge to its authority will emerge through application of this method as each thread of history is unraveled and contemporary discursive practice deconstructed.

Research Focus of the Study.

The research focus of the study is an historically based critique of institutionalized childbirth. This has been achieved by deconstructing those historical elements that have linked together to emerge as a legitimate and powerful institution in the form of medicine in contemporary society. Foucault has outlined a method for critical historical analysis that is intended to reveal inherent ambiguity and contradictions in present practices. An

interpretation of Foucault's use of genealogy has been provided by Noujain (1993). A contemporary French philosopher, Noujain has used a schematic form to illustrate Foucault's system of tracing the progression of historical elements or accidents. The focus of this research was to show how today's practices descend from questionable authority. Today's society performs in ways that can be traced to knowledge produced by power.

Research Methods/ Theoretical Framework.

Critical inquiry, genealogical analysis and deconstruction provided the theoretical framework for this study. Although this may present a departure from the well trodden paths of qualitative research, this postmodern approach provided the necessary perspective to illustrate the way in which the weaving of historical accidents has determined the contemporary discursive practice of childbirth. Genealogical analysis as interpreted by Foucault, has been described by Noujain as an historically based critique on the way in which aspects of society have descended from past practices or institutions. Genealogical analysis as a means to examine the discursive practice of contemporary childbirth came from discussions with Dr. Cleo Cherryholmes. He proposed that genealogical analysis can be considered both theory and methodology.

At this juncture, it is important to clarify the specific meaning of the terms method and methodology and the way in which they are utilized in this study. Controversies abound on the misappropriation of these terms (Bunting & Campbell, 1991). As researchers in many different disciplines

continue to strive to find new ways in which to identify and interpret their data, the need to have concise definitions of these terms will prevail. Though there are undoubtably many others, the definition of method that is described by Harding states that method should be considered as " a technique or way of proceeding to gather evidence"(quoted in Bunting & Campbell, 1991, p. 3). The technique can take several forms, such as observation, listening to or questioning informants, examining records (e.g. historical documents, existing texts or medical records).The latter technique in the form of genealogical analysis provided the means to gather the information required for this study. As such a method does not provide a philosophical stance or theoretical assumptions.These are provided by the methodology or the underlying theory that guides the research.

Methodology, on the other hand, as defined by Harding (1987) is understood to mean the theory and analysis of how the research should proceed. The choice of methodology would be guided by the purpose of the inquiry. The epistemology or theory of knowledge that drives the methodology in this study will be critical theory. Critical theory has as one of its major tenets the assumption that social conditions are not interpreted as natural and constant but are created by specific historical situations (Stevens,1989). In this way it can be seen how Foucault's genealogical analysis complements the methodology.

Limitations.

Identification of personal bias and ideology is a particularly important limitation in this thesis because of the researcher's personal and professional involvement with the research topic. It is necessary to continually direct attention to the researcher's biases because as Janesick explains in the Handbook of Qualitative Research (1994), our biases help to identify the research questions and provide a conceptual framework. Lather (1990, p. 20) points out that the "postmodern tenet of being inscribed in that which we struggle against" creates a serious challenge to the impartiality of serious research. A woman, a midwife, and a mother, would undeniably experience what Lather describes as " intense personal engagement with the issues." However, to borrow terminology from the discipline of Anthropology, a novice using a microscope for the first time to observe material is not able to decipher and differentiate between significant and insignificant data. Conversely, personal experience provides very different, sharper lenses, to use the same analogy, with which to make critical observations. As stated by Kirby and McKenna (1989) " Self is absolutely necessary, integral to the research and should not be discounted from it." Another advantage of familiarity with the subject matter is the use of language.The language of the discursive practice of childbirth is a familiar one for a researcher with childbirth experience, both personal and professional. It is one that requires no translation. As quoted in Cherryholmes (1988, p.116), Foucault asserts that

we know neither the origins nor the authors of our discourses. He speaks of the anonymous exercise of power.

Language is also used to define the boundaries between those who are part of the dominant professions and those who are not. According to Hudson (1978) "the use of professional language also reinforces the hierarchy of knowledge in which theoretical and conceptual knowledge, grounded in formal training carries more weight than practical or experiential knowledge." Through experience in the field, the researcher is very aware of the way in which professional language can be used in the anonymous exercise of power over childbirth.

The application of genealogical analysis to childbirth practice has demonstrated "the political processes and institutions by which truth" is produced" (Foucault quoted in Cherryholmes, (1988). A Foucauldian perspective, using interpretive analytics has illuminated the forces of history and the forces of power on what we say and do. It also provides insight into the way in which words are linked to things and theory to practice (Cherryholmes, 1994). As the review of literature demonstrated, the predominant ideology of professional discourse on birth that we have inherited, continues to proliferate unquestioned and basically unchanged.

There is much to suggest in the literature that contemporary childbirth practice is in need of a departure from the constraints of the technocratic model. In order to be credible, challenges to the current practices must be undertaken within an academic paradigm, empirically not emotionally

driven. Critical and interpretive paradigms provide, the means to develop an understanding of the controlling social, political and economic structures. The "intense personal engagement with the issues "referred to earlier in this chapter provides the researcher with insight into the contradictions inherent in the ideology. This experiential component provides the necessary reflexive quality to this study. Reflexivity is understood to mean that the researcher is part and parcel of the setting, context and culture that is represented Thompson, (1987). The contentious issue of construct validity has been addressed in part by determining the historical significance of whose voices were silent and whose voices were heard in the establishment of childbirth as a powerful professional domain.

To be aware of personal bias is an important task for anyone engaging in research of any kind. No knowledge is value free. On the subject of values, Lather (1986) goes further, and quoting Harding (1986) makes a point of differentiating between values that are coercive and those that are participatory values. Lather maintains that rather than being seen in a negative light, the researcher's values permeate the inquiry and serve to reduce the distortions in our cultural understanding. Lather (1986, p. 64) sees an advocacy approach to inquiry as based on " enabling prejudices" and feels that this has much to offer postpositive research. With a greater understanding of how knowledge production and legitimization are historically situated, " scholarship that makes its biases part of its argument" becomes a strong contender for legitimacy. However an intimate knowledge

of the lived experiences of childbearing women may prove to be an advantage in this case.

Clearly, the researcher's arbitrary choice of where the genealogical analysis should originate could be considered problematic. Also the limiting of the elements to those that have been selected as significant could be debated. One of the major constraints of this study are to be found in its reliance on historical documents. However, historical records appear to be relatively consistent, but must be understood to be inherently biased. Again the questions "who speaks and whose voice is not heard" are applicable. It would not be difficult to reach a consensus among medical professionals on the radical changes that have taken place in the care of childbearing women whether over the last five centuries or the last fifty years. What could be considered contentious is the emphasis provided by genealogical analysis on the effects of power on human dignity within the sphere of childbirth.

Assumptions.

One of the primary assumptions that determines the direction of this research is that all is not tranquil or congenial within the realms of contemporary childbirth. This is a strong personal assumption on the part of the researcher which has come about as a result of long term involvement with and close proximity to providers and recipients of contemporary birth practices. This experience was gained while working within the predominant model of care, in both primary and tertiary care settings. Of relevance to this study is what has been termed "conceptual baggage"(Kirby and McKenna

1989). This recording of the experience and reflections of the researcher provides accountability. The need to be aware of the interaction between the researcher and the research is seen as an important first step in the whole process. Kirby & Mckenna (1989) maintain that this process enables personal assumptions of the researcher about the topic to form an integral part of the study. In this particular study, there is a very strong commitment on the part of the researcher to reflect on the tensions that exist between "social childbirth and scientific childbirth" (Leavitt, 1983). This conflict, inherent in birth practices has been simmering since the nineteenth century. As Leavitt(1983) explains , by the middle of the twentieth century the medical model had succeeded in dominating childbirth in the industrialized world. Protagonists for woman centred birth practices are becoming louder in their opposition to the medical model, but lack academic support for their claims.

This leads to another personal assumption which is that women want to contribute to changes in the institutionalized scientific practice of childbirth which has usurped its legitimacy. This thesis contributed to the necessary first step of critical reflection on the status quo. By providing the opportunity for the multiple voices of childbearing women to be heard, this thesis provided the academic support for change in the existing model of childbirth practice. The importance of identifying personal involvement, values, beliefs and experience as they relate to the study is emphasized by Kirby and McKenna (1989). They go on to point out that by stating clearly what personal assumptions have provided direction and impetus for the

research should be very clear to all who read it. This staking a claim, as it were, on a specific territory helps to contextualise the researcher firmly within the the topic. The personal assumptions of the researcher clearly favour a more balanced model of childbirth practice. Based on personal observations of the discursive practice of childbirth, the existing system is heavily influenced by the technocratic model. There is much literature to support this view.

"Conceptual Baggage."

The term " conceptual baggage" referred to by Kirby & McKenna (1989) is a process by which the personal assumptions of the researcher become an integral part of the thesis. Research of a qualitative nature poses questions. The questions that are posed by this study are presented with real situations in mind, and with a strong personal sense of wanting to understand the how's and why's of birth practices in today's complex social settings. Motivation to pursue this topic comes from the researcher's experience (as a midwife) of the tensions that exist between the medical model of birth and those who advocate less intervention. There is no doubt that this experience will guide the research. To uncover the hidden structures that have determined today's birth practices, specific methodology has been chosen. This also reflects the personal bias of the researcher. Kirby & McKenna (1989) emphasize that different methodologies carry with them specific underlying assumptions which will shape the way in which information is gathered and the kind of knowledge that is created as a result. This research will

undoubtedly be influenced by experiential knowledge of the historical and sociological origins of contemporary birth practices. This study will engage in a critical inquiry into what Kirby & McKenna (1989) have called "the political nature of knowledge creation" as it relates to the formulation of contemporary childbirth practice.

Analysis through Genealogy/ Evaluation and Judgment.

The subjects for analysis of this Foucaudian method/ methodology are the complex systems of meanings that evolve "from macrosocial practices to micropractices" (Cherryholmes, 1988.) This all-encompassing description provides an appropriate way to characterize issues surrounding the history of childbirth. Analysis of the discourse of childbirth presents a challenge that is met by the application of postmodern critical theory.The ability of the researcher to demonstrate the contradictions that exist in the discusive practice of contemporary childbirth will undoubtedly be questioned. How is this interpretation to be evaluated and by what criteria? As Denzin & Lincoln (1994, p. 11) indicate, within the postmodern approach, such concepts as validity, reliability and generalizability require re-evaluation. The question of validity of research findings is one that requires special attention in research situated within critical discourse. According to Cronbach (1987) "validity is concerned with making sense of a situation" It organises and categorises experiences. To elaborate, Cronbach (1980) maintains that "the job of validation is not to support an interpretation, but to find out what might be wrong with it. To call for value-free standards of validity is a contradiction in

terms, a nostalgic longing for a world that never was." (Cronbach, 1980, p. 103-105).

On the subject of construct validity as it relates to critical discourse, Foucault is quite clear in his opposition. Neither the authors or the origins of our discourse are known to us according to Foucault (1980). From this perspective construct validity is seen as being intimately connected with the power-knowledge relationship and therefore politically and socially produced. The critical paradigm deals with the issue of evaluation, by taking the same three questions used by the scientific method and reformulating them. They are usually refered to as the ontological, epistemological and methodological questions. Lincoln (1990) maintains that these three questions are fundamental for the evaluation of knowledge. The qualitative paradigm proposes alternative solutions to the conventional questions relating to validity, objectivity and generalizability.

Ontology is no longer viewed as one dimension, but as a relativist ontology, consisting of multiple socially constructed realities (Lincoln, 1990). The epistemological question is dealt with by asserting that knowledge production is a subjective and interactive process. On the subject of methodology, this paradigm has adopted a hermaneutic perspective, one that emphasizes a free-flowing form of analysis. This is achieved by a dynamic state of iteration, analysis, critique, reitration and reanalysis (Lincoln,1990). In this paradigm, trustworthiness replaces the conventional criteria of validity, reliability and objectivity with credibility, transferability, dependability and

confirmability. Inquiry of this nature is also required to meet the criteria for authenticity. These criteria are felt by Lincoln to be an intrinsic part of this paradigm because of the importance of dealing with such things as power imbalances (1990).

Deconstruction, as a form of postmodern criticism provides is yet another way to explore and analyse the ways in which power and knowledge are socially constructed, politically mediated and professionally legitimated in childbirth. It can also function as triangulation. Deconstruction provides the means by which contradictions, what is valued, what is not, within discursive practice can be exposed (Cherryholmes, 1988). According to Lather (1991) the process of deconstruction entails three stages: 1. Identification of binary oppositions, that is the oppositions that structure the argument. 2. Reversal or displacement of the negative or dependant term and location of it in a positive position. 3. Creation of a more fluid and less coercive conceptualization of the term. Through such a strategy, a heightened awareness of the realities in discursive practice will be achieved. Lather describes this process of deconstruction as facilitating understanding of "the oppressive role of ostensibly liberatory forms of discourse"(1991).

Definition of Terms.

Much of the terminology used in this thesis is based on a postmodern interpretation. To avoid misunderstanding of meaning, a brief glossary is provided.

Briccolage. An oblique collage of juxtapositions that moves back and forth from positions that remain skeptical of one another. (quoted in Lather, 1991, p. 10).

Criticism. From a Foucauldian perspective, criticism is the means by which to uncover the ambiguities within the history of discourses in order to discover the ways in which power operates. This power is reflected in discourses, institutions and social practices. (Cherryholmes, p162. 1988).

Deconstruction. A form of poststructual criticism, terminology derived from Jacques Derrida which analyses texts in such a way as to provide a continual displacement of binary oppositions and reversal of valorized structural assumptions. (Cherryholmes, 1988; Hlynka& Belland, 1991; and Lather, 1991). It has also been described as a mode of interpretation and by Fox, (1994) as a strategy by which to explore the authority of a particular claim to truth or knowledge.

Discourse. A term that refers to what is spoken, written or enacted. It is considered to be an organization of practices in order to " supply a coherent claim to a position or perspective. In postmodern terms, it is used to indicate the association between knowledge and power (Fox, 1994). According to Lather, in a Foucauldian sense, discourse is "a conceptual grid with its own exclusions and erasures, its own rules and decisions, limits and inner logic, parameters and blind alleys. A discourse is that which is beneath the writer's awareness in terms of rules governing the formation and transformation of

ideas into a dispersal of the historical agent, the knowing subject" (Lather, 1991,p.166).

Discursive practice. A body of anonymous 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 (Foucault, 1972.)

Genealogy. An analytic strategy which documents the ways in which a practice has been described discursively. Unlike a standard history, no effort is made to discover a rational progression of understanding of the practice, or to 'explain' why different perspectives were dominant at different times. Instead discontinuities between discourses are highlighted (Fox, 1994).

Metanarrative . An overarching discourse or position which organizes other positions. Class and gender have been used in structuralist social theory to explain the organization of societies in terms of economics or patriarchy. Postmodernism is suspicious of any efforts to connect events or attributes within such frameworks of 'explanation', seeing metanarratives as fabrications rather than representations of social reality (Fox, 1994).

Postmodern. A response across the disciplines to the contemporary crisis of representation; a profound uncertainty about what constitutes an adequate depiction of social "reality" (Lather, 1991, p. 21.) Put another way or in Lyotards words "an incredulity towards metanarratives" (1984.)

Practice. The integration of values and interests into an ideology that forms a set of rules that determine how activities will be performed on a

regular basis. These rules are based on beliefs and interpretations which purport to be true or valid. (this definition paraphrases Cherryholmes, 1988. p.4.) and although referring to educational practice can be applied as readily to childbirth practice and is discussed at length in subsequent chapters.

Praxis. Associated with Friere, praxis is thoughtful reflection and action that occurs simultaneously. Praxis is the integration of knowing and doing. (Kirby & McKenna, 1989, p. 34).

Reflexivity. Analysis which interrogates the process by which interpretation has been fabricated (Fox, 1994).

CHAPTER FOUR:

Genealogical Analysis

Chapter Three has presented a brief discussion of genealogical analysis, appropriation by other authors and pertinence to an historically and sociologically based critique of the discursive practice of contemporary childbirth. For those not familiar with this particular technique, it is important to clarify what is entailed when engaging this particular strategy. At this stage, a detailed description of the various components that are required for a genealogical analysis will be provided.

There are many interpretations of the genealogical writings of the philosophers Neitzsche and Foucault , but for the purpose of this thesis Noujain's (1987) explanation of the similarities and the differences in their perspective has been selected as being the most succinct. In his interpretation of Foucault's practice of genealogy, Noujain (1987) specifies several distinct components which make up this "recurrent dialogue with history ". The aims of a genealogical analysis, according to Noujain (1987) are as follows: the tracing of the origin or lineage of an element , the identification of individual elements and their successors and predecessors, the marking of the emergence of a new element at the intersection of a series of elements.

Elements

An element, described by Noujain (1987) is " any identifiable entity. " That is to say, any distinct object, an event such as a war or a revolution, an

institution, any situation or person could be described as an element. When these elements are linked together in some significant way, described by Noujain as "a meaningful concatenation of components", they provide a genealogical explanation of a particular historical period (1987). An important characteristic of genealogical interpretations of history that Noujain has identified is the fact that history appears as a discontinuous series of elements, with a hiatus or gap between the element and its antecedent and successor(1987). Primarily, according to Noujain (1987), the task of the genealogist is to describe or narrate the predisposing or preceding elements that resulted in the emergence of the changed element.

Provenance

Although defined as "place of origin" or "proof of authenticity " (dictionary reference), in genealogical terms, provenance becomes a somewhat complicated term. Genealogy sets out to establish the lineage of an object or element, or what Noujain (1987) has also described as the origin of an element. He discusses at length, Neitzsche's opposition to "a rationalist quest to find the metaphysical essence of an object". Presenting genealogical analysis as being opposed to a search for the source or genesis of an object, both Foucault and Neitzche are in agreement (Noujain,1987) . There cannot be a pure *ursprung* (Neitzche's term for unspecified origins). They prefer instead to focus on the establishment of the lineage of an element. There is not a single point where it springs into existence, but it evolves into an entity , the result of many threads that have intersected and

become woven together to form one . Through *provenance* (Foucault) or *herkfunft* (Neitzsche) "the object of genealogy..... has been constructed piece by piece on the basis of forms foreign to itself" As Noujain (1987) explains, paraphrasing Foucault, in order to establish the provenance of an object, the genealogist is required to trace all those foreign forms. The task of the genealogist is also "to discover all the subtle, particular and sub-individual marks which are a network, intertwined within the object and difficult to unravel." What will be found underneath the apparently "unified appearance of a concept is the multiplicity of events through which it was formed" (Noujain, 1987, p.166).

Emergence

The marking of the emergence of an element from its predecessors is of considerable importance to the genealogist. Foucault describes this process as the opposition of two or more adversarial elements or "forces foreign to each other" competing for the same space (Noujain, 1987). The mechanism by which one element is subordinated by the other is closely tied to power, knowledge and related discourse. Who exercises power and how does this happen, are questions posed by Foucault regarding the strategies of power in society today (Kritzman, 1988). The elements that will emerge from our historical past as valorized and legitimate are determined by those with power and knowledge. The production of knowledge, through deployment of professional power, that has determined the course of the discursive practice of contemporary childbirth has been discussed by Arney (1982),

Oakley (1986), Leavitt (1984) and numerous others and will provide valuable insight for this study.

Historical Placement of the Genealogical Analysis

In view of the fact that much has been written about power, knowledge and the discursive practice of childbirth, it is important to position this study. Arney (1982) points out that the particular social location of the person who is writing about history plays an important part in the selection of the period to be analyzed. Reiterating what Arney (1982) has said, the particular "social location of the researcher" results in the selection of the kind of history and the period of time chosen for analysis. Through a profoundly personal engagement with contemporary childbirth practice, the direction of this research has been informed by the experiences of the researcher.

Historical research can be problematic as Lynaugh &Reverby (1986) have indicated because the very nature of history requires a search for the "best" explanation for human events. History is contextual. According to Lynaugh & Reverby, common problems with historically based research can be found in adherence to several myths. They are summarized as follows. Most historical research seeks a single truth, when in fact "history is distilled through a researcher's concept of reality and explanations of chosen evidence"(1986). History has been considered to be an accurate record of important events and people in the past. In reality, what has been recorded has been a matter of choice on the part of predominantly male historians. As a result many events concerning women were considered "irrelevant and

unimportant"(1986). Power and knowledge are once again deployed to silence those who would speak for themselves. The history of childbirth is no exception. Critical inquiry into the writing of history has provided new sources of evidence and new insight into many women's issues. A crucial point made by these authors relates to the genealogical analysis undertaken here. Lynaugh &Reverby (1986) maintain that an historical analysis allows us to get away from "the narrow concepts of winners and losers". They go on to state that history also " provides the tools to examine the full range of human existence and to assess the constraints under which decisions were made"(1986, p.). This is precisely the focus of this examination of the discursive practice of childbirth.

Three quite disparate histories of obstetrics have been outlined by Arney (1982). The first history is an interpretation of the past by those who practice within the profession of obstetrics. Eccles (1982) has observed that the history of obstetrics has tended to concentrate on great men and their discoveries. The focus has been on the scientific nature of knowledge, although as Arney (1982) points out, faith was placed in scientific advances years before science had a significant impact on obstetric practice. The image of expertise through science was an illusion because "systematic application of tested principles did not characterize obstetrics until well into the twentieth century"Tew (1993). However as Arney points out, the profession "emphasizes the notion that there is a direct link between knowledge and practice" (1982).

The second history that Arney describes, takes a radically different view of the same period. From the perspective of feminist scholarship, the history of obstetrics needed to be rewritten, this time with the contributions of midwives and childbearing women. In their exploration of the end of the gynocentric period, Ehrenreich & English (1978) describe the way in which "even the quintessential feminine activity of healing was transformed into a commodity." Defined as a commodity, childbirth became a much contested enterprise leading to the demise of the midwife (1978, p.11). When the obstetrical archives were examined from the perspective of critical scholarship, it became apparent that midwives were considered a problem, "a social, political and economic impediment" to the development of obstetrics as a profession. To deal with this problem, a political solution was implemented (Arney 1982). The British medical solution was control through education and registration (Donnison, 1978). The final solution for the midwife problem in America was to outlaw them. The American medical profession would settle for no less (Ehrenreich & English, 1978).

It is the third history which has been identified by Arney (1982) as a social history that provides direction for this thesis. This alternative view "seeks to lay bare the nature of professional power, how it was acquired by obstetrics and how it has been retained through its reformulation" (Arney , 1982). According to Arney (1982), the profession and its critics focus on the role of technological development in the expansion of obstetrics. Instead, Arney's third history looks at the social history of medical control of

childbirth, the social organization of obstetrics and the discontinuity in social development of the profession. The discontinuity that he has identified will be incorporated in this genealogy which will revolve around elements and origins, antecedents and successors of what Arney has described as "the deployment of power which determined what path obstetrics took". With that concept in mind, this analysis will trace the antecedents of hospitalization for childbirth, and the emergence of what was to become the medicalized model of childbirth.

Having established social criticism as the characteristic of history that will provide direction for the analysis, the next task for the genealogist is to determine the time period to be examined. Here a balance must be struck between Neitzche/Foucault objections to origins of a positivist nature and the practical limitations of a thesis. In his chronicles of obstetrical history, Cianfrani (1960) provides details of the development of the profession for several centuries. He identifies periods where little or no progress was made but also pinponts the turn of the twentieth century as the beginning of the "greatest advances" in obstetrics. This thesis will focus on that period when obstetrics became a recognized profession. Though as Arney (1982) points out, this was achieved by gaining control of the medical marketplace by undermining all its competitors, especially the midwife. It is for this reason that the turn of the century has been arbitrarily chosen as an appropriate time in history to analyze. This period also represents a time of radical departure from traditional women- centred childbirth practices to contemporary

childbirth practice under the jurisdiction of medicine. In approximately ninety years, centuries of tradition have been transformed. Social childbirth became scientific childbirth (Leavitt, 1986). What Arney (1982) has described as "serendipity, political maneuvering, shifting alliances and keen rhetoric" have brought about a dramatic re-interpretation of what was once defined as childbirth. It is the task of the genealogist to trace those sometimes obscure social, economic and political influences that brought about this dramatic metamorphosis.

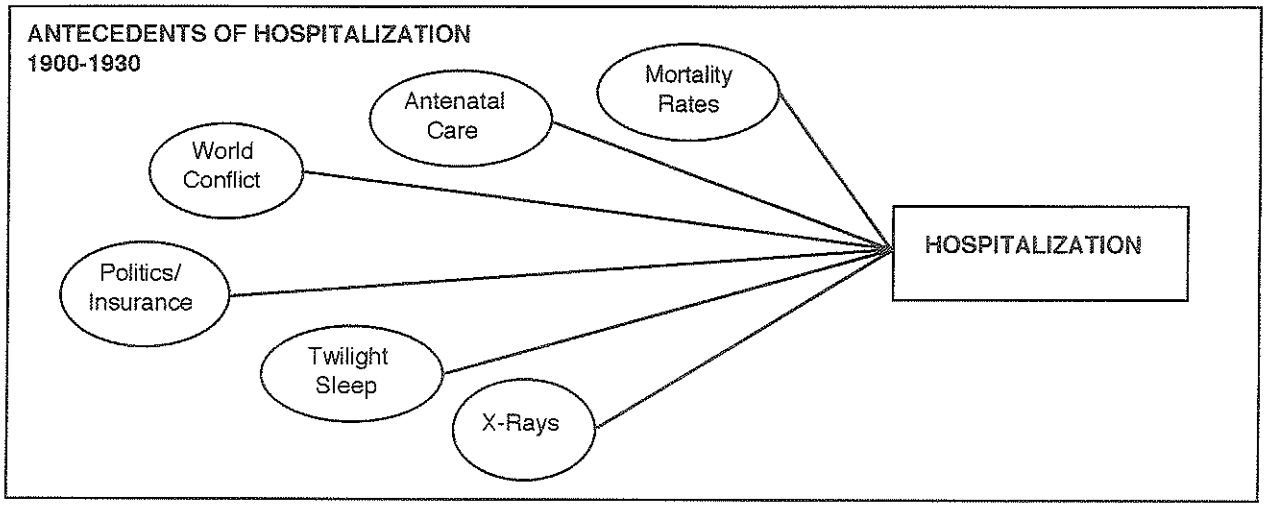

Figure 1. Antecedents of Hospitalization

Hospitalization

In the spirit of Neitzsche, before discussing those events that took place in the early nineteen hundreds, it is necessary to look to those antecedents that occurred prior to the turn of the century which influenced

the evolution of childbirth practices. Oakley (1986), Leap & Hunter (1993) and others have noted that in the eighteenth and nineteenth century medical discourse, pregnancy was considered a natural state. Arney (1982) observed that for most of recorded history, " women having babies were attended by women". How it came to be that childbirth became a pathological state from which women were to be saved by medical intervention in so short a time is a remarkable phenomenon. Oakley (1984) points to the time when the health of mothers and babies became the concern of the state. A shortage of conscripts for the army became linked to maternal health. Serendipity indeed.

World Conflict.

From the annals of British history, the Boer War (1899-1902) was one event that appears to be quite unrelated to childbirth, but it was the catalyst for far reaching change in perceptions of childbirth. At that time, the deplorable lack of healthy young men conscripted to fight for their country was a national disgrace (Lewis, 1980). This state of affairs was attributed to poor feeding in infancy and childhood as a result of maternal ignorance (Oakley, 1986). Maternal health, deplorable economic and social conditions did not enter into the calculations of the politicians at this point. Of more concern to the Empire builders of the 1900's was infant mortality and the declining birth rate, which were translated into deterioration of the race and impediments to colonizing the world (Oakley,1986).

The Challenge for Traditional Midwifery.

Rather than being an accomplishment, the introduction of the Midwives Act in Britain (Arney ,1982; Oakley, 1986; Leavitt, 1983; Leap and Hunter, 1993; & Donnison, 1977) placed midwives in a " uniquely disadvantaged position". These authors emphasize the paradox of the once autonomous midwife, transformed into a subordinate group, regulated by medicine by becoming a registered and legitimate body. While not as restrictive as in North American where the trained midwife had all but disappeared, the British Midwives Act, through strict management of the education and licencing of midwives, represented a victory to medical men. They would now be in a position to "occupy a more manly and dignified position" relieved of the drudgery of attending to the poor by registered midwives (Donnison, 1977). Rural general practitioners in particular, expressed hostility towards the newly certified midwives whom they considered "an outrage against the medical practitioner" (Donnison, 1977). They sought support from government and their obstetrician colleagues to maintain constant scrutiny over midwives' practice (Arney, 1982). By means of the Central Midwives Board, an all male, medical body, stringent provisions were made to restrict the practice of trained midwives. More specifically, the medical monopoly over the use of anaesthesia was the deciding factor in the fate of the midwife (Leavitt, 1986).

In addition to exclusion from education as a result of the Carnegie Foundation's Flexner report, science and technology in the form of anaesthesia had spelled the demise of the American midwife (Leavitt, 1983).

The power of science was invoked to "entrench pregnancy firmly in the pathological realm" (Arney, 1982). This was because as Donegan (1978) explains, early 20th. century American medical men" faced a formidable obstacle to continued dominance in obstetrics". That obstacle was the midwife and the solution was political not scientific. As was the case with British nurses, Susan Reverby (1987) , discussing the dilemma of the American nurse, illustrates how powerful medical ideology brought about "the institutionalized subordination" of the nursing profession. Preoccupied with their own struggles for autonomy, British and American nurses distanced themselves from the midwives problems (Donnison, 1977). Rehabilitating the practice of midwifery, according to Donnison, was to prove too great a challenge. Energies were directed instead to upgrading the nursing profession (1977).

Political Discrepancies.

In Britain, in the early nineteen hundreds, health was becoming a public matter and environmental problems, overcrowded urban slums and smoke pollution were all considered in the context of infant mortality. Women's employment out of the home was considered another factor responsible for high rates of infant mortality. Oakley (1986) maintains that labeling working mothers as irresponsible was a backlash against the suffragette movement, gaining momentum at the time. Maternal health finally received some recognition in the National Insurance Act in 1911, which stipulated that low income men should receive a maternity

allowance, payable at childbirth. It was later distributed directly to the mothers themselves. Government initiated milk distribution, classes in infant care, "housewifery" and motherhood followed shortly afterwards. This practice, according to Oakley (1986) represented a systematic investment in the monitoring of maternal behaviour, a technique that was to be perfected over the next fifty years (1986). The midwife was a central figure in the "provision of antenatal care, skilled assistance with confinement and postnatal care" in the maternal and child welfare scheme of the early twentieth century (1986).

Motherhood, Mortality and Medicine.

Attention was eventually brought to maternal mortality, in the context of the First World War. Mothers were dying , in the prime of life "rearing children for the nation" (Oakley, 1986). Puerperal fever, haemorrhage, toxaemia and chloroform anaesthetics have been identified as the major causes of death for women in early twentieth century (Beinart, 1990). These factors were associated with urban women, medical intervention and hospitals (Tews, 1995). Given the birth experiences they had, it is not suprising that all women, rural, urban, lower, middle and upper classes, feared childbirth. Many influential factors combined to convince women, on both sides of the Atlantic, that the hospital was a solution to their problems (Lewis, 1990). For example, the Women's Guild maintained that most working class homes did not provide a suitable environment for childbirth (Graham, 1985). Evidence to the contrary showed that country women, although poor, were well fed and fared better in childbirth than more affluent

urban women (Tew, 1995). Another supposed benefit was the ten day hospital stay recommended by doctors which was to provide a much needed rest for postpartum women. Ironically, poorer women who could not afford to rest, were less likely to die from phlebitis. What was considered to be the best of medical care for childbirth produced the highest rates of maternal mortality (Arney, 1982; Oakley, 1984; Leavitt, 1990; & Tew, 1995).

The deciding factor of hospital births for American women was the advent of "Twilight Sleep". Its wholesale acceptance in America was in response to women's demands for painless childbirth, who had been convinced by the medical profession that there was a medical solution.As a result of the expertise required in the administration of the scopolamine/ morphine mixture, Leavitt (1986) explains how the new specialty of obstetrics was upgraded and expanded. With childbirth firmly situated in hospitals, the midwife was effectively eliminated, powerless against the combined forces of the women's movement, government and obstetrics (1986).

Tools of the Trade.

The recognition of different blood groups and the introduction of X-ray measurement of the pelvis were two notable scientific discoveries in the first decade that had an impact on childbirth. Oakley (1980) has observed that in the early 1920's, overzealous practitioners, dazzled by the ability to accurately diagnose pregnancy and measure the pelvis, ignored the warnings coming from the laboratories. Routine antenatal X-rays were recommended. Nearly thirty years would pass before measures were taken to reduce the amount of

radiation used on mothers and their unborn babies through routine antenatal X-ray.

Amid considerable public outrage at "avoidable" maternal deaths, the connection between maternal mortality rates and lack of antenatal care was beginning to be made. Antenatal clinics were set up on both sides of the Atlantic with such encouraging results as lower pre-term delivery rates, higher birth weights and lower neonatal mortality rates. In addition to providing mothers- to- be with rest, good food, and healthy surroundings, antenatal care was thought to be the solution to maternal mortality (Tew, 1995). This was not the case. Antenatal care did not reduce the rate at which mothers died in childbirth, and as Oakley (1984) points out, mothers were understandably skeptical about the claims that attending antenatal clinics would be their salvation. Poor attendance resulted in women themselves being identified as to blame for mortality rates, which diverted responsibility from the government and the medical profession.

Evidence presented by Tew (1995) shows that in the early nineteen hundreds, puerperal sepsis continued to be the greatest single cause of death. Obstetrical interventions, incompetently performed were multiplying as a result of increased surveillance through antenatal care. Both in the United states and the United Kingdom, infection rates were higher in hospital than at home for which the much maligned midwife was inevitably blamed (Tew, 1995).

Out of the Home and Out of the Picture for Midwives.

The move from home births to institutionalized delivery was not so simply made in Britain as it had been in America. On the British scene, midwives, general practitioners and consultant obstetricians were involved in staking a claim in the management of childbirth (Peretz,1990). The solution to this dilemma was thought to be what was called the National Maternity Service, established throughout Britain in the early 1930's. Domiciliary midwives were "the backbone" of the service, supported by general practitioners. For mothers and babies at risk, hospital care was available under the care of a specialist (Peretz, 1990) . The system could have survived on both sides of the Atlantic with better provision of analgesia in domiciliary practice. As more women chose to have their babies in a hospital, with the promise of pain relief, obstetricians assumed control of childbirth by controlling pain-relief measures, relegating the midwife and the general practitioner to a subordinate and eventually unnecessary position(Beinart, 1990). What seemed such a promising system could not survive the proliferation of science and technology engaged to deal with the "problems" of childbirth. In Britain, by the middle of the nineteenth century, the percentage of hospital deliveries was double those delivered at home.

The New Boys on the Block.

When the British College of Obstetricians & Gynaecologists was formed, it illustrated the irony of women choosing the hospital for birth.

With the introduction of the National Health Service, the status of obstetrics was assured with recognition of hospitalization for childbirth. The result was an expansion of obstetrical beds which led to greater numbers of obstetricians. Once the competing ideologies were silenced so the circle was complete. Obstetrically educated, hospital oriented nurses replaced traditionally trained midwives in America as improved transportation provided yet another boost for a smooth transition for childbirth in hospital (Arney,1982).

Saved by Sulphonamides: Pharmacology, Mothers and Mortality;

In the nineteen thirties, streptococcus had been identified as the agent responsible for puerperal sepsis. Despite rigorous attention to hygiene, which included pubic shaving and enemas, sepsis following childbirth continued to take its toll. It was ironic that those women who were in the lowest social class and were the least likely to receive medical attention in childbirth had the lowest rates of maternal mortality from puerperal fever (Tew, 1995). Although attributed to her, it was certainly not the midwife who was responsible for these rates (Donnison, 1977). With the introduction of sulfonamides in 1935, there was a sustained decline in the numbers of women who died in childbirth (Oakley, 1986). There is no indication that the practice of obstetrical intervention decreased. In spite of recommendations from medical associations in America and Britain, it was quite the contrary. Tew (1995) describes how eminent obstetricians cautioned against "over-enthusiastic intervention undertaken on insufficient indications" but the rewards were too great. Birth was defined as a pathological process by Dr.

Joseph DeLee in the early 1920's, who proposed that birth required prophylactic forceps delivery and routine episiotomy under anaesthesia to decrease the inherent danger of childbirth to mother and child (Leavitt, 1986). Almost eighty years later, his prescription of scientific, systematic intervention for managed childbirth remains the gold standard for obstetrics in most institutions.

Rescued by the Red Cross; A Halt to Deaths from Haemorrhage in Childbirth.

Just as the Boer War and World War One had brought about important changes for women, World War Two was to provide yet another important development which was to affect childbearing women. Records for the 1920's and thirty's show that almost as many women died as a result of haemorrhage in childbirth as sepsis (Tew, 1995). In the years leading up to the war, there was a new understanding of rhesus blood groups. As well as haemoglobin levels and blood volume in pregnancy, there were significant developments which decreased the risks of obstetrical intervention (Oakley, 1986). But until the outbreak of World War Two, blood transfusion was not without risk as the technology was not sufficiently advanced. In order to meet military needs, improved techniques for blood transfusion were developed. As a result, maternal mortality rates continued their downward trend. (Tew, 1995). The serendipity of sulfonamides and blood transfusions, enabled mothers to survive childbirth in greater numbers than ever before. The damage inflicted by surgical intervention could now be negated.

A Breath of Country Air: Solution to Maternal Mortality .

Yet another serendipitous affect of World War Two was to cast serious doubts on the benefits of medically managed, hospitalized childbirth in Britain. During the war years, thousands of pregnant women were evacuated to the country. Tew (1995) has produced mortality statistics to show that a shortage of medical staff and equipment produced surprising results. Reductions in maternal mortality were dramatic. Less obstetrical intervention had a positive effect on mothers and their babies. Although quick to take credit for the dramatic reduction in mortality rates, attributing it to improved training for obstetricians, it was simply coincidental (Tews, 1995).

For a more plausible explanation, from childhood a whole generation of women had benefited from dietary supplements, extra milk and vitamins. Pelvic deformities due to rickets which had been the legacy of poor urban environments were now a thing of the past (Eccles, 1982). Anaemia, also related to deficiencies in diet was understood in the context of pregnancy. Epidemiologist, Professor Tom McKeown (1965) in his analysis of declining mortality rates emphasizes the social component of health, higher standards of living and healthier environments. Sanitary engineers had reduced the prevalence of the bacteria and adequate diets resulted in reduced susceptibility to disease. The population as a whole became more healthy, but women in particular were healthier in childbirth. This observation led McKeown (1965) to conclusions that had been made by some obstetricians thirty years before,

which was that healthy pregnant women needed less intervention. In his investigations of maternal mortality since the 1930's, Mckeown (1965) maintained that two fifths of the maternal deaths were potentially avoidable. Referring to the situation up until 1927, he goes on to state that "the introduction of institutional confinement had an adverse effect on mortality" (p.28.) Regardless of what the statistics had to say, in the late nineteen thirties there was "a remarkable widening of the indications for intervention during labour and a great increase in the number of operative deliveries"(Holland quoted in Tew, 1995). On the other side of the Atlantic, hospitalization for childbirth was progressing at a greater rate and by the nineteen fifties, most births occurred in hospitals, a fifty percent increase in approximately twenty years (Leavitt, 1986).

There is a perplexing question that remains to be answered. In the light of birth rates and mortality rates that were falling, healthier mothers and babies, how did the rate of hospitalized births increase so dramatically? As the war years had shown, there were viable alternatives to pregnancy as pathology and technology as routine. It is interesting to uncover the obstacles to those alternatives through genealogical analysis. By analyzing what Tew(1994) describes as "the diverse strands of a complicated tapestry", it will be possible to explore the way that medicalization of childbirth came into being.

To summarize this section on hospitalization for childbirth, it is clear from the records that the antecedents to hospitalization for childbirth are not

what they seem. Arney's (1982) classification of three histories of obstetrics is useful here. The medical profession's interpretation of the history of hospitalization would focus on the need to intervene to save mother and baby from the dangers of childbirth. In the second history of obstetrics, their critics would focus on the detrimental effect on women. By contrast the social history of hospitalization for childbirth would focus on the deployment of power which has determined the direction of the discursive practice.

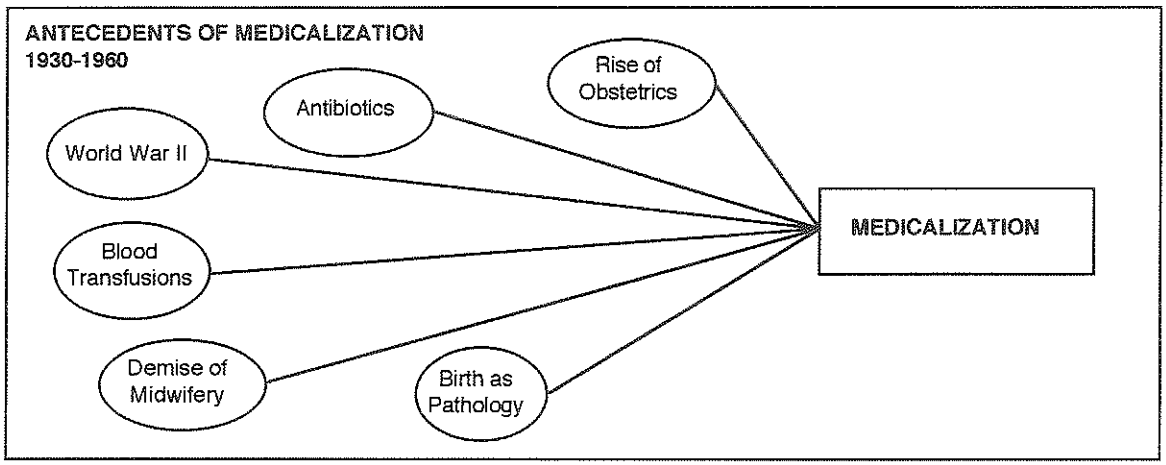

Figure 2 Antecedents of Medicalization

Medicalization

Although its role in society is debated by social scientists, medicalization of daily living has been a recognizable phenomena for some time. Up until the turn of the century, Illich (1979) maintains that medicine attempted to enhance what occurred naturally. Since mid century, the domain of medicine has tried "to engineer the dreams of reason"(Illich, 1979.

p. 47.). This is particularly true of such normal occurences as childbirth and menopause.

Birth as Pathology.

Having effectively discredited the midwife and the general practitioner, all that remained was for women to be convinced of the inherent dangers of childbirth and that obstetricians would remove those dangers. Once childbirth was defined as a medical problem, the move to hospitalization was an obvious consequence. Freund and McGuire (1991) demonstrate how ideology has influenced the medical practice of Western industrialized societies, providing legitimacy to medical control. Childbirth was inexorably moving toward medicalization, once reproduction was defined as pathological. Conrad and Schneider (1980b) outline the three stages of the process by which medicalization has occurred in the twentieth century. These can be readily applied to childbirth.

Semantics.

The first level on which medicalization occurs is the conceptual level. Medical terminology is engendered to define or describe a problem or situation. Schwarz (1990) describes the role of obsterical textbooks and the changes in philosophy, language and semantics that has occurred in the last four decades that have transformed childbirth practice. The emphasis that changed from woman to patient, from active to passive participant is reflected in textbooks. Obstetricians of the "calibre" of Professor (Sir) Dugald Baird who epitomizes Arney's first category of historians, encouraged all

obstetricians to aspire to the "attainment of efficient physiological reproduction"(Schwarz, 1990). Terms like "active management" proposed by O'Driscoll in his text, were to provide Joseph DeLee's prescription for childbirth in the 1920's with a whole new look.

Government and the Gatekeepers.

The second level of medicalization, suggested by Conrad and Schneider (1980b) is accomplished at the institutional level. The power of the physician as gatekeeper can be seen in perpetual debates on the legalization of midwifery, and place of birth. Any threats to medical autonomy are not tolerated. The supportive relationship between multi-national pharmaceutical companies and the medical profession could also be seen as an example of the way in which medicalization operates (Kaufert and McKinlay,1990). The medical-industrial complex has a powerful role to play in determining the direction of health care (Relman, 1986). Government and medicine also combine forces to control drug manufacture, regulation and distribution (Zola, 1972). In many cases, this is to the detriment of holistic alternatives. Health insurance is yet another example of the influence of medicine at the institutional level, particularly in America where the system of insurance based, fee-for-service medicine prevails (Stacey, 1990). Freund and McGuire(1991), in the context of the "technological imperative", provide another illustration of institutional medicalization as the way in which health insurance gives priority to medical treatment that involves high technology (p. 255).

The Enigma of the Expert.

The interactional level is the third level at which medicalization occurs, according to Conrad and Schneider (1980b). In this dimension, health related situations are treated as medical problems. With regard to childbirth, it first became necessary to "blur the demarcation between normal and abnormal births"(Arney, 1982). He maintains that the future of obstetrics was determined by this ideological change and dated back to the days when barber surgeons took over from midwives. Competing ideologies regarding normal childbirth have separated mothers, midwives and obstetricians since the days of burning midwives as witches and the rise of barber-surgeons (Ehrenreich & English,1973). For childbirth to come under the jurisdiction of medicine, a reconceptualization of the whole birth process was required. The scientific view of the body provided the basis for what Arney (1982) refers to as "the rhetoric and practical strategies" that were used so effectively in the first 350 years of obstetrics that they have continued to be resources for the advancement of twentieth century obstetrics.

The Mystification of Medical Myth.

As Zola has pointed out , the use of medical rhetoric to advance a cause operates as an agent of social control. Medical involvement in all aspects of our daily life are presumed beneficial. The prestige of any programme or prescription is "immensely enhanced.... when it is expressed in the idiom of medical science"(Zola, 1972).

This observation is particularly relevant in the context of hospitalization and medicalization of childbirth but most notably with regard to induction of labour. The cumulative effects of hospitalization and medicalization can be seen in the proliferation of technology required for widespread adoption of the practice of elective induction. The antecedents of the emergence of technology as an identifiable element are not always obvious. To use genealogical terminology, technology came into being as a result of inheriting components from different elements that had preceded it. Control of birth was at the heart of the matter according to Arney and Neill (1982) What was required was control of the patient and of labour. For the patient, control of pain was the crux of the matter. Obstetrics rose to the challenge. Technology provided the solution.

Potent Medicine.

Early attempts to induce labour had been fraught with danger. In addition to ergot, a rye fungus, an incredible array of solutions and objects were inserted into the uteri of pregnant women with disastrous results (Arney, 1982). In the nineteen forties, use of pituitary extract was becoming more advanced and by 1955 oxytocin was synthesized and its use quickly adopted for induction of labour. Tested on animals, and in laboratories, synthesized artificial pituitary extract was endorsed in the popular texts of Williams and DeLee as the solution for the problem of post-maturity (Arney, 1982). Various routes of administration were tried, and according to Oakley (1990) included nasal, intramuscular and the transbuccal route. Of these, the

intravenous method was deemed to be the most effective. In the early sixties, documented by Oakley (1986), machines were developed for the titration method of delivering controlled amounts of oxytocinon. Scully (1994) discusses the way in which elective induction of labour has become the corner-stone of modern obstetric practice. Convenience for both the obstetrician and the mother have been presented as persuasive arguments in favour of induction in the absence of medical indications. Arney (1982) claims this was "cloaked in the rhetoric of medical-surgical propriety" and notes how the terminology to describe the risks of induction were described in gradually less alarming phrases. The hazards of elective induction seemed a small price to pay for birth on demand. To reiterate Zola, expressed in the idiom of medical science, the practice of elective induction was enhanced.

Control of Pain: The Crux of Childbirth Practice.

Elective induction was only part of the pharmacological approach to obstetrical control of childbirth. It led the way for more effective ways to deal with the pain of labour. General anaesthesia and the amnesia of twilight sleep were replaced by a widespread acceptance of local anaesthesia as the method of choice (Arney and Neill (1982).

Trouble in Paradise?

By the end of the decade, opposition to this trend toward elective induction were beginning to be heard. Not only was the women's movement becoming vocal on this issue, but individuals with credibility among obstetricians like Caldero-Barcia have been outspoken about increased

obstetrical interference (Scully, 1990). Regardless of the opposition and by a somewhat circuitous route, the medicalization of childbirth had been accomplished, a clearly defined element in the discursive practice of childbirth.

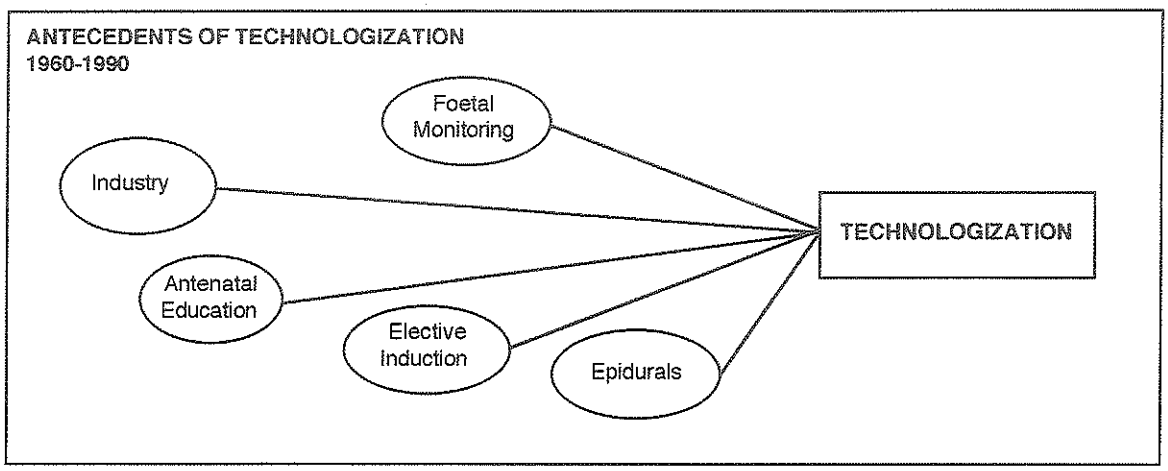

Figure 3 Antecedents of Technologization

Technologization

Science and Technology

As with the emergence of the elements of hospitalization and medicalization, there are many influences on the antecedents of technology in contemporary childbirth. Freund and McGuire (1991) present a very convincing reason for the proliferation of reproductive technology in the form of the technological imperative. They state that in most Western societies there is a fundamental drive to use whatever technology is available. If we have the technological ability then we must use it. From technological capability comes standard practice as the technology becomes routinized. This concept also implies that action is preferable to inaction (p. 255). One of

several ramifications of perinatal technology is that there is a tendency toward what Wagner (1990) describes as a "cascading effect" with the application of one technology leading to another. That reproductive technology is big business, is hardly suprising.

The Role of Industry: Problem or Solution.

Reproductive technology is viewed very differently by those who adhere to the medical model of birth contrasted with beliefs held by the supporters of the social model (Wagner, 1990). An essential principle of the social model with regard to technology is that it should do no harm, one of the ancient tenets of medicine. The question asked by a social and historical analysis of childbirth is how could the discursive practice become so removed from the ethical implications of proliferating technology? One wonders whether the role of technology is compatible with the basic premise of medicine, that is to do no harm.

Ramifications of the "Rational" Position for Birth.

A fundamental change in practice is related to the birthing position. It can be demonstrated that the position for birth is an antecedent that has contributed to profound changes in the discursive practice of childbirth. Technology as "an identifiable element" has been constructed from a vast array of diverse antecedents. Hospitalization for birth, obstetrical training for midwives and elective induction have all contributed to acceptance of " the modern obstetrical position" (Arney,1984). Women "brought to bed" for their labours were denied the benefits of physiological positions, descent and

spontaneous rotation of the presenting part. Labour, thus impeded, required assistance for delivery. As Tew (1990) states, the unnatural posture that was imposed on childbearing women, contributed to the complications of labour, situations that required medical technology. Obstetrical intervention and birth position are highly correlated with the proliferation of technology. For example, better control for monitoring the foetal heart have been used as justification for the recumbent position for birth. Concern for aseptic technique is another explanation described by Arney (1982). The problems for delivery personnel associated with moving an anaesthetized woman were also alleviated with the lithotomy position. The most commendable feature of the recumbent position was of course that it made management of labour with obstetrical intervention easier to accomplish (Arney, 1982). Unfortunately, as research by Calderyo- Barcia showed, labour was less efficient in this position than the lateral position, usually resulting in medication (oxytocics) to augment the process. Though supported by sophisticated data, these findings certainly did not result in a change in practice. Clinical practice represents investments of time and energy, financial and professional investment. None of these can be discarded, not even in the light of "scientific" research.

Episiotomy and the recumbent position are also unfavorably linked. Tew, (1990) and Donnison (1977) point out that the move to hospitalization was analogous with increases in forcep deliveries, which resulted in episitomies. The practice of episiotomy became the treatment of choice for

obstetric management of birth, claiming to minimize damage and reduce risk of future problems. Though these claims were eventually refuted by randomized trials undertaken by midwives, as many as 90% of childbearing women were to experience the increased discomfort of routine episiotomy before the practice was objectively evaluated. Evaluation, in the form of research by midwives is attributed with a decline in the practice in the early eighties (Sleep, 1991; Chalmers & Richards, 1977). It was noted by Tew (1994) that further reduction could be achieved "if other interventive and restrictive intranatal practices" were also reduced. Obstetricians and the lithotomy position do not compare well with midwives as birth attendants and the lateral position. The literature serves to demonstrate that birth position is clearly an antecedent to the technological imperative that dominates contemporary childbirth practice.

The Quest for the "Ideal Labour Pattern".

In the form of Bishop's Score and Friedman's partogram, science and technology once again were called on to engineer childbirth (Schwarz,1990). The Bishop score, an analytical device, indicates the relationship between the condition of the pregnant cervix and the likelihood of a successful (elective) induction (Oakley, 1986, Arney, 1982). Based on the findings, supposedly the decision for elective induction is made. However, the obstetrician can either disregard the findings or simply not include a Bishop Score in his assessment. In this way, the elective induction can proceed, unimpeded by awkward contraindications.

Schwarz (1990) explains how Friedman's partogram, statistical analysis of two parameters of labour, was used to determine the average normal progress of childbirth. Though he did acknowledge that there were "many variables" to be considered, Friedman extrapolated an "ideal" labour pattern with statistically determined limits to normal progress in labour. Continuing the discussion, Arney and Bergen (1984) point out that once an "optimal birthing trajectory" was established, close monitoring would determine whether or not labour was progressing "on the curve". For any deviation from the ideal, remedial action would be swift, medication to stimulate the errant uterus and bring the mother back on the track of "virtuous parturition". The result of this practice, as Arney (1984) illustrates was that" induction rates skyrocketed" in the late sixties and early seventies. The practice of acceleration of labour increased to epidemic proportions. With "perfection" of administration pumps, syntocinon was (.. and still is) delivered in electronically controlled amounts, and scientifically prescribed increments, following the recommended " one size fits all" philosophy.

Two related antecedents of tecnologization of birth that are connected with birth position and the practice of elective inductions are electronic monitoring and epidural anaesthetics, important adjuncts to the management of labour. Although introduced earlier, technological advances in the eighties such as telemetry and continuous infusion epidurals were improved and became part of "the tools of the trade". Although childbearing women have a vested interest in reproductive technology in seeking safer,

less painful childbirth, the larger stakeholders, namely medicine, pharmacology and health related multinational businesses are clearly in control.

Safety and Surveillance: A Case of Cause and Effect?

To guard against iatrogenic foetal distress related to induction of labour with syntocinon, close surveillance of mother and baby was required (Tew, 1990; Oakley, 1984; Arney, 1982). For this purpose new and improved electronic monitors have been designed, and driven by accelerating medical technology, have changed the face of childbirth. It would appear from the literature that more intense observation is likely to result in more intervention (Tew, 1990).

To Bury Caesareans or to Praise Them?

Advances in technology resulted in greatly improved techniques in medical, surgical, nursing and anaesthesia. As a result, there was increased confidence in the ultimate operative intervention in childbirth, caesarean section. Sophisticated antibiotics and improved knowledge of transfusion techniques greatly increased the safety of the procedure (Tew, 1994, p.165.). It is interesting to note the differences between the caesarean rates in the U.K and in the U. S. A. In the eighties, Tew (1994) notes that the rates in Britain were almost half those of their American counterparts. Arney (1982) makes a connection between increased surveillance with foetal monitoring and increased caesarean rates, but notes that regardless of the controversy that

revolves around foetal monitors, the fundamental issue is one of control of childbirth. Technology provides the means to assure the continued "sovereingnty of the profession of obstetrics" (p. 123).

State of the Art Anaesthesia.

Epidural anaesthesia is a technological innovation that was partly in response to consumer demands. In the past, the pursuit of pain relief in labour has led women to take such desperate measures as opium and ether, at great risk to both mother and baby. Beinart (1990) makes the careful distinction between pain relief for normal labour (analgesia) which is contrasted with pain relief (anaesthesia) for painful intervention. Since anaesthesia emerged as the solution to the problem of pain in labour, medical power has hinged on its ability to deliver safe and effective pain control to women in childbirth (Arney & Neill,1982; Leavitt, 1983). From this perspective, medicalization, hospitalization and technology can be seen as extensions of that power. Many mothers endorsed the move to hospital for delivery because it would provide control of pain. They were content to exchange control of birth for control of pain (Lewis, 1990). Obstetricians also endorsed the move because a hospital environment made interventions so easy (Leavitt, 1983). Technology was to provide the ultimate solution for all the stakeholders in the form of epidural anaesthesia.

Pain in childbirth had always been a problem for obstetricians, as it interfered with the management of the birth process, as described in texts (Arney & Neill, 1982). Epidural anaesthesia seemed to be the remedy for the

"ingrained fears and expectations" in childbirth of twentieth century mothers (Tew,1995). Without the painful interventions that are accepted as an inevitable part of childbirth and legitimized through hospitalization, medicalization and technology, women could find the control of birth they once lost. A greater understanding of the physiological role of pain in childbirth should not require women to forego all the benefits that they have strived so hard to achieve.

Who Controls Whom? A Case of the Tail Wagging the Dog?

Antecedents of widespread use of epidural anaesthesia can also be found in the multinational companies who manufacture and promote the pharmaceutical products and related technology. Relman (1986) has pointed out that the health care industry is very lucrative and expanding rapidly. The ramifications of this powerful business also can be seen in the development and proliferation of "high-risk" and intensive care units. Oakley (1994) points out that the interests of the multinational companies coincide with those who promote obsterical management of childbirth (p.25). This brings them into conflict with those who would see a focus on a more normal, physiological approach to birth. Another group who benefited from obstetrical management of labour are the anaesthetists who are as Oakley notes, are essential members of the obstetric team.

Assumptions of improved outcomes resulting from obstetrical intervention are the corner stone of medical practice in industrialised countries, but statistics do not bear out this claim (Romalis, 1985). Distrust of

technology, suspicion of the claims of causing reductions in mortality rates has resulted in evaluation of birth technology by epidemiologists and social scientists. Rather than attributing the decrease to medical technology, the data points to social causes that have improved the health of women and their babies (Wagner, 1990).

As Giddens (1989) has said, the complexities of reproductive technology presents many dilemmas. He goes on to stress that the importance of the social problems associated with increased intervention in the reproductive process is only beginning to be recognized.

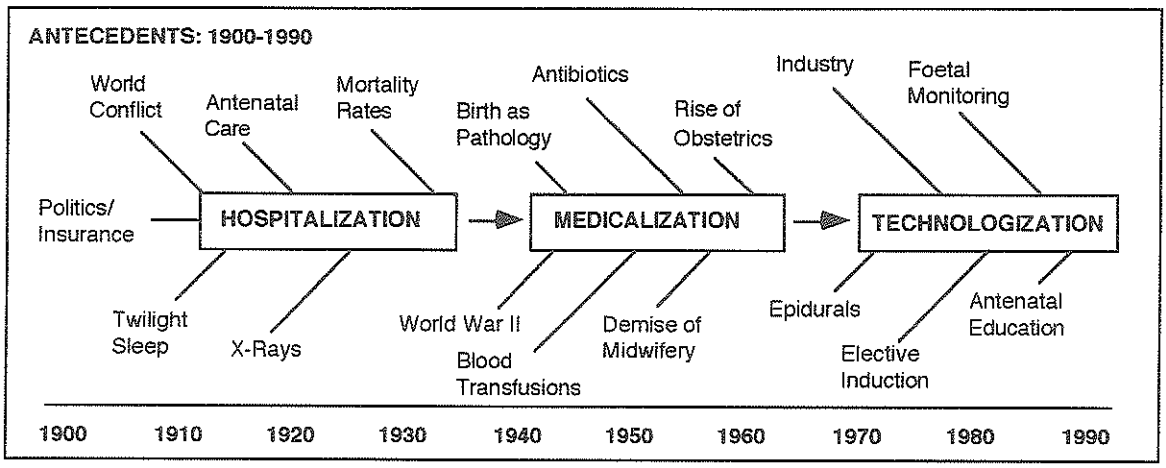

Figure 4 Antecedents 1900-1990

Summary.

If not already apparent, this adaptation of genealogical analysis is not intended to be a precise chronological account of history. Giddens (1987). views on knowledge, power and history provide clarity for this predominantly sociological analysis. He states that sociological analysis can provide the necessary sobriety to challenge the apparent inevitability of

history. In this way, "sociological analysis can play an emancipatory role in human society". Rather than resembling a law of nature, as Giddens elucidates, our knowledge of history is always tentative and incomplete. Acknowledging the shortcomings of a historical analysis need not detract from the important contribution that can be made from a historical, sociological perspective that a genealogical analysis of the discursive practice of childbirth can make.

CHAPTER FIVE.

Deconstruction.

Deconstruction, in the words of Robert Scholes, is " a *pharmakon* , a healing medicine and a dangerous drug, depending on the amount of it that we imbibe and what other agents we mix with it "(1990, p.6). To reiterate the description provided by Nicholas Fox, deconstruction is a strategy which provides the ideal mechanism... "to explore the authority by which a statement or claim to truth or knowledge has been made"(Fox, 1992). The preceding genealogical analysis has challenged the assumptions that have been made about the authority of the medical ideology that determines contemporary childbirth practice. The very nature of discursive practice of birth in today's society has been subjected to a poststructural criticism.

The scientific model based on assumptions of superiority to all other models has excluded all other claims to knowledge of birth. Deconstruction will provide the framework to examine the rationality of this claim. Questions must be asked concerning the power/ knowledge dichotomy which provides the foundation for the medical model. Deconstructive discourse on birth practice will help provide some of the answers by interrogating the values that are placed on the medical control of childbirth. Through deconstruction, the discursive practice can be subjected to further analysis to determine whether the authority to claim absolute power over

knowledge of birth is legitimate. The origin and meaning of medical discourse that has determined contemporary medical ideology will be given closer scrutiny by means of reduction to binary oppositions. Just as values, knowledge and power are constructed by social realities, so can they be deconstructed to reveal new meaning.

A deconstructivist approach allows what Lather (1991) describes as a "blind-spot" to be illuminated, divested of contradictions. A deconstructivist approach also seeks to challenge unequal distribution of power. In order to deconstruct power and authority, Lather suggests an exploration of the way that it was constituted, tracing its effects (1991). Authority in the form of power and knowledge suppresses communication. To deconstruct the discursive practice of childbirth is to ask questions and "to probe the many reasons for silence" (1991) . A critical interrogation of the history of childbirth has revealed that women were not authorized to speak on their own behalf. This "other" knowledge was not compatible with the dominant medical paradigm. Authoritative knowledge has been generated through socially constructed mechanisms and maintained by political and institutional power. As Scholes points out, mere inversion of the hierarchy is not sufficient. It also not feasible. A deconstructive critique of the power and knowledge that determines the direction of birth practices will reveal contradictions inherent in the institutions that perpetuate the contradictions, giving recognition to those outside the dominant model of childbirth.

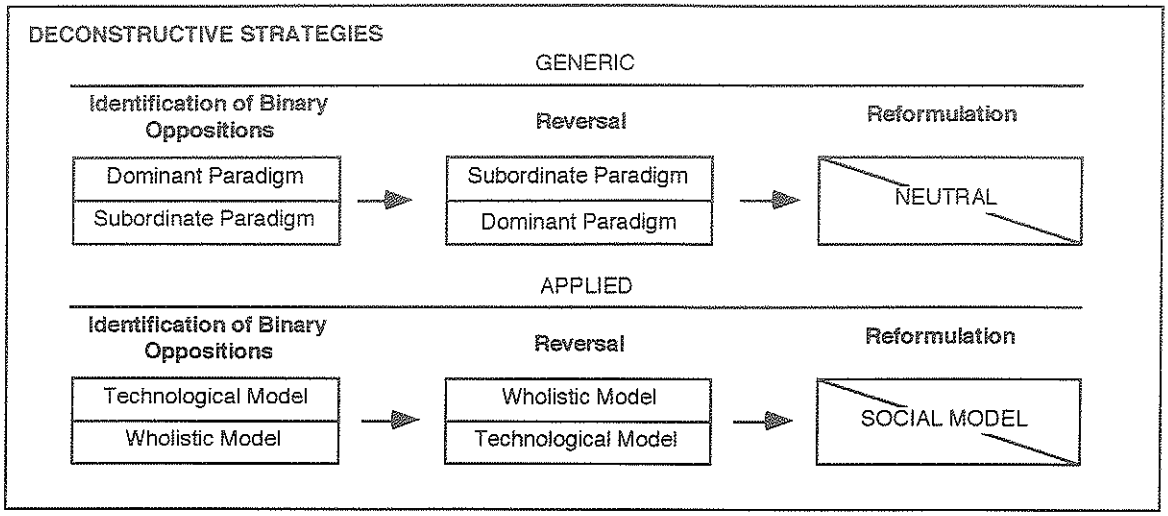

Figure 5 Deconstructive Strategies

The Process.

The process by which deconstruction takes place has been referred to in previous chapters but to provide a brief overview it can be separated into several stages, which for simplicity's sake are 1. identification of the binary oppositions; 2. reversal or displacement; 3. continual displacement and revision of meaning. The goal of deconstruction, summarized by Lather (1992) is to create a more fluid and less coercive conceptualization of terms ....as a safeguard against dogmatism (p.13). Skepticism of traditionally held beliefs is the corner stone of deconstruction. Attributed to Derrida, this strategy hinges on inversion and reversal, and of displacement and "dislocation of the hierarchical structure" (Lather, 1991 p. 82). The history of childbirth, medical discourse and texts have made substantive claims, but as Cherryholmes (1988) explains, deconstructive analysis illuminates the ambiguity of the discourse. In the case of contemporary childbirth,

deconstruction of the discursive practice will serve that purpose . Similarly, genealogical analysis of childbirth practice has shown there are many examples of rhetoric and logic converging, both contradictory and ambiguous (Cherryholmes, 1988. p. 39). Displacement of ideological values, by breaking them down into smaller binary oppositions will provide clarification.

These strategies of displacement require several stages which have been referred to in earlier chapters. Before reversal or inversion of traditional meanings can take place, what Foucault (1979) has called the "localization of power" must be determined. In order to engage in deconstruction of the discursive practice of childbirth, the first step is to identify the binary oppositions. The preceding genealogical analysis identified the antecedents, and the important elements from which contemporary practice evolved. These antecedents and elements can also be described as examples of "localization of power" and will serve as binaries in the deconstruction process. The next stage in deconstruction is to determine how or why one binary holds more value than its opposite and if the position is reversed, whether its value (or devaluation) is logical and rational. This is a dynamic process which should result in a more egalitarian relationship between binaries when contrasted with the opposition and dominance of its original form. An understanding of whose interests are served by the maintenance of the dominant discourse will be provided by this deconstructive critique of the discursive practice of contemporary childbirth.

Binaries.

The following have been selected as the binaries that form the discursive practice of childbirth that will undergo deconstruction. The arbitrary selection of the binaries could be a contentious issue if viewed from the perspective of orthodox methodology. The concept of connoisseurship as proposed by Eisner (1985) has been invoked to contend that the experience of the researcher provides that necessary ingredient which allows the perception of "complex and subtle" aspects of childbirth to be perceived in ways that may not be always apparent to the casual observer (Belland, 1991). The elements that have been selected as binaries have been identified as important to the genealogical analysis of contemporary childbirth practice. Deconstruction as analysis of those elements and antecedents is to serve as a form of clarification or validation of the findings of the genealogical analysis.

The Antecedents of Hospitalization.

Science & Technology/ Nature.

The distinction between scince and nature has been made for hundreds of years and the supremacy of one over the other has only been questioned in relatively recent history. The technocratic model, as Davis-Floyd (1992) so clearly explains, dominates society because of the "hierarchical social context that "super-values" them and the individuals that control them". This super-value status is at the expense of any other competing ideology. When compared with science/ technology, mere nature is found wanting. Is this

logical? Given the suppression of alternative views, it probably is logical that society values science and technology more than nature. The question of whether it is rational or not becomes problematic under the close scrutiny of deconstruction. Interrogation of the discourse becomes crucial. Whose voice is heard in this "debate"? What remains unspoken? Why? When it becomes apparent that the voice of political power speaks loudest in support of science and technology, its authority becomes questionable. To refer again to Davis-Floyd (1992), this paradigm has become so embedded in society, augmented by its "core cultural rituals" that the dominant value of science and technology becomes unassailable in contemporary society.

Doctor/ Patient Relationships.

Much has been written about the doctor/ patient relationship. Armstrong (1983) maintains that the increased hegemony of medicine has created subjectivity in patients. In pregnancy in particular, the asymmetry of power between a woman and her doctor could be beneficial for the doctor but compromising for the client or patient. Factors such as locale have an important bearing on the relationship. As Tew (1990) and Leavitt (1986) have pointed out, when childbirth was conducted in the woman's own home, the relationship tended to be more egalitarian . Compliance with treatment is a key factor in this relationship and as Danzinger (1986) has outlined, it is considered the doctor's prerogative to define what is relevant, what is therapeutic and conversely what is not. Deviations from the medical model are seen as challenges to legitimate authority. Natural childbirth, requires

expertise of a different kind and from this perspective would be labeled as "unscientific" and therefore discredited. Expertise, defined by the medical model, is used as power to maintain the asymmetrical relationship between a doctor and his client. Expertise viewed from such divergent positions calls into question the legitimacy of the structural asymmetry of the doctor patient relationship (1986). Deconstruction of the doctor/patient relationship would reverse/displace the dependent status of patient, providing a more egalitarian situation.

Homebirth/Hospital Birth.

As the genealogical analysis has shown, scientific knowledge was called upon to discredit the home as a place for birth. At a time when puerperal sepsis was rampant among mothers delivered in hospital, it is ironic that birth at home was branded as unsafe and unclean and institutional birth became the optimum for mothers and their babies. (Oakley, 1984, Tew, 1990). Homebirth represented a challenge to the dominant paradigm, so that the power of scientific knowledge had to be invoked to persuade mothers that hospitals were unsafe. Most women in industrialized countries have been socialized into believing that their bodies are defective machines, dependent on medical expertise for safe delivery of their babies (Davis-Floyd, 1992). So effective has the socialization process become that even women who accidentally deliver their babies at home are sanctioned. Davis-Floyd provides examples of the rituals of hospitalized birth that these women were required to experience after uncomplicated home births. For twentieth century

women, the issue of wholistic versus technocratic is a complex one. As Freund and McGuire (1991) have stated, "the medical profession has successfully asserted primacy in defining deviance." (p.152). In that way it has become a primary moral authority in modern sciences. Women involved in home birth movements in contemporary society are seen as "socially and politically subversive" as were their Medieval counterparts by those with a vested interest in preserving the hegemony of the medical model (Davis - Floyd,1992, p.196). From the perspective of the technocratic model, home birth has been defined as deviant in Western society.

The Antecedents of Medicalization.

Obstetrician/ Midwife.

Early midwives were unable to withstand the pressure from church and state as childbirth came under the auspices of medicine (Ehrenereich & English, 1976). But as Freund & McGuire (1991) point out , professional autonomy is the key to the subjugation of one group for the benefit of another. Control of licensing, access to facilities and legitimacy of claims for insurance form just a small part of the barrier to professional autonomy for those who would be modern midwives (p.224).

Deconstructing these roles, in the light of genealogical analysis provides the basis for questioning the legitimate supremacy of the obstetrician in the domain of childbirth. The very nature of their training, with its emphasis on pathology and technology puts obstetricians at a disadvantage

and serves as an impediment to their care of the normal pregnant woman. Tew (1990) has used statistical data convincingly to demonstrate that obstetrical intervention is highly correlated with an excess of mortality for hospital births. Although the statistics can be skewed by proponents of midwives and obstetricians alike, Davis-Floyd has found that close scrutiny of data obtained on midwife-attended home births provides favorable comparisons. Analysis of length of labour, complications, neonatal outcome and procedures utilized, showed that midwife directed home births were safer. A study from Holland in 1986 even goes so far as to say that the midwife is the most effective guardian of childbirth (Tew, 1990). This sentiment is not shared by all women, some of whom feel very strongly that they alone are the guardians of their childbirth experience.

Intervention/ Natural childbirth.

Complications of pregnancy and risk factors are concepts that women in Western society have come to associate with pregnancy though socialization that occurs during prenatal visits and antenatal classes. Invariably as Davis-Floyd (1992) explains, hospital based classes tend to reinforce the technocratic model. Seemingly innocuous interventions, such as artificial rupture of membranes (A.R.M.) are usually justified on the basis of being in the mother's best interest. Research has shown, that far from being innocuous, A.R. M can indeed be problematic, resulting in a cascading effect of interventions. Space does not permit a detailed discussion of informed consent as it relates to A.R.M. and elective induction as it would provide

enough material for a thesis topic in itself. In order for mothers to make informed decisions about their birth experiences, they would need to receive information that was less biased towards interventions such as A.R. M. Unfortunately as Davis-Floyd (1992), tells us, " a basic tenet of the technocratic model is that some degree of intervention is necessary with all births" (p.57). Iatrogenic complications such as infections and the subsequent need for augmentation of labour with its attendant need for greater analgesia have become accepted practice (Tew, 1990, p.32). By engaging a deconstructive critique of this practice, the dependent, negative or opposite term is elevated to the position of choice and the accepted routine of intervention then relegated to the subjugated position. The benefits of intact membranes have been well documented by Caldeyro-Barcia (1975) and others but the technocratic model has used its claim of legitimacy to disregard such alternative but equally authoritative knowledge.

Technocratic Pain Control/ Wholistic Means of Coping with Pain.

In deconstructing pain in childbirth, Davis-Floyd's (1992) terminology to differentiate between two paradigms of childbirth is used. As shown in previous chapters and the genealogical analysis, control of pain in childbirth has always been at the crux of the control of childbirth itself. Fruend & McGuire (1991) maintain that individual responses to pain, or what they term "pain expression" (p. 164), is very clearly influenced by sociocultural factors and psychological as well as the biophysical aspect. These are complex factors indeed and within the realm of childbirth are of paramount importance.

Within the technocratic model, as outlined by Davis-Floyd, the pain of labour is a problem to be dealt with by an increasingly more sophisticated pharmacology. For example, institutionalized childbirth education has had an important role to play in the socialization of women, by encouraging use of anaesthesia. (Gilkison, 1991). By contrast , according to Davis -Floyd, iatrogenic pain is to be expected, accepted. Within the wholistic model, in true deconstructive form, the opposite is the case. The pain of labour is seen as purposeful and positive. Labouring women can be supported, encouraged to be in control of their pain, as part of a normal physiological experience. According to Arms (1994) emotional support is considered the best pain relief.

The Antecedents of Technologization.

Elective induction/ Spontaneous Labour.

With the advent of machines to deliver accurate doses of oxytocin in the sixties and seventies, acceleration of labour became more efficient. Extensive clinical use of the drug was undertaken, in spite of the lack of knowledge of the function of this hormone in human labour. De Geest et al. (1985) have shown that much of what we know of the role of oxytocin in labour has been obtained from animal research. Another confounding issue related to the use of oxytocin in acceleration of human labour was that accurate analysis of uterine activity in human subjects was hampered by ethics. Considerable research also has called into question the early data that provided the basis for the widespread practice of elective induction. Brindley & Sokol (1983), Seitchic, Holden, & Castillo, (1986), Kruse(1986), and Curtis &

Safransky (1988), all write in support of the use of radioimmunoassay techniques which have produced data that demonstrates that the dosages recommended by most hospitals are excessive. Tew (1990) and Wagner (1994) have maintained that there is no factual evidence to support the claim that medical interventions have made childbirth safer. Health care has been defined in industrialized society by powerful interest groups and as Freund and McGuire have stated, any attempt to set a broader agenda for health care would most certainly be contested (p. 260).

Multinational business interests in the insurance industry, technology and pharmacology have contributed to health care expenditures that continue to escalate to enormous percentages of the gross national product. Governments everywhere struggle to maintain health care systems (p.290). Deconstructiion of contemporary childbirth practice requires a reversal of the valorized and accepted practice and an examination of the dependent or discredited practice for its merits. This exercise allows the "unsafe" practice of the wholistic model to be measured against the same gold standard as the medical model for safer childbirth. Considerable evidence is to be found to support the view that for certain specific situations obstetrical interventions are beneficial but as Tew contends, successful reproduction depends primarily on healthy parents. Childbirth without direct intervention of physical science has been shown to be the optimum. The benefits of natural birth extend beyond those of mothers and babies to socioeconomic benefits for society as a whole.

Surveillance Technologies of Birth/ Faith and Trust in Women's Bodies for Birth.

From pre-natal screening to electronic foetal monitoring in labour, pregnant women experience a wide range of surveillance technologies. It is not the purpose of this thesis at this point to debate the merit or lack of surveillance in pregnancy, rather it is to discuss the overall effect of being under a proscribed medical gaze. A deconstructive critique of the surveillance of childbirth demands that positive values are to be reversed and displaced and those values that were previously viewed negatively measured by the same criteria.

Principles of Panopticism.

Foucault's interest in the principles of panopticism inherent in the medical gaze resulted in his view that these relationships between observed and observer produced "an institutionalized disciplinary power" (Foucault, 1979). When this observation is applied to the discursive practice of contemporary childbirth, several interesting concepts emerge. In addition to surveillance from external disciplinary forces, Foucault's panopticism has an element that he describes as self surveillance.

This is particularly relevant when discussing women's perceptions of their body in childbirth and the constitution of their role in childbirth.The role of institutionalized childbirth education in this socialization process has been discussed in previous chapters. Protagonists of the technocratic model

would no doubt be in favour of close observation of women in all stages of their pregnancy, ever vigilant protection against the inevitable pathological sequellae of conception. The wholistic model of childbirth categorized by Davis-Floyd (1992, pp.160-162) as female centred, which places great importance on the experiential and emotional knowledge of childbearing women, would be more likely to interpret such surveillance negatively. The medical preoccupation with surveillance of the pregnant woman implicitly questions the ability of the woman's body to function effectively in childbirth. Surveillance of the pregnant female merely reinforces the basic tenets of the technocratic model of birth which according to Davis -Floyd (1992), are based on the mechanistic view of the female body as being "an abnormal, unpredictable and inherently defective machine"(p.53).

Regional Anaesthesia/ Wholistic Techniques for Pain Control.

The role that technology has played in control of the pain of childbirth has been identified in the preceding pages. The task of this deconstructive critique is to expose the what Lather (1991) has called the contingencies of our knowledge. Establishing how obstetrical anaesthesia has become so firmly entrenched as the optimal choice for pain control in childbirth will provide a framework for the strategies of displacement to be applied. In discussing the role of technology in control of pain in childbirth during the last thirty years, assumptions have been made that the improvements in maternal and infant mortality and morbidity have been related to advances in technology (Wagner 1994; Leavitt 1986; Tew 1990; Oakley 1984; Arney & Neill 1982).

The period from 1960 to 1990 will be the focus of this deconstructive critique as it represents the period of the greatest technological change. In that time period there was a dramatic difference in women's birth experiences with local anaesthesia compared with the previous practice of general anaesthesia for childbirth. These technical changes coincided with a departure from the concept of uni dimensional (physiological) childbirth to one which was two dimensional and included the psychological dimension of birth (Arney & Neill, 1982). The demands of childbearing women were legitimized by the natural childbirth movement and according to Arney and Neill (1982) forced obstetricians to find new ways of dealing with pain of birth. No longer satisfied with medically induced amnesia which robbed them of the experience of childbirth, women were becoming aware of the importance of the psychological aspect of pain in childbirth (Arney & Neill, 1982; Leavitt, 1983; Davis-Floyd, 1992).

Assessments of the efficacy, safety and cost effectiveness of birth technology is usually carried out by the manufactures of the product and the medical professionals most involved in their use (Wagner, 1994). He goes on to discuss how little public accountability is required of private sector , particularly in the realm of research and development that is publically funded.

What does reversal of the binaries produce? In the past, very little time and money has been spent in the analysis of the efficacy, safety and cost-effectiveness of holistic measures for pain management in childbirth. Much

has been written in the scientific genre abut the deleterious effects of pain and fear on the progress of labour. Less time and space has been spent to demonstrate how a woman's heightened sense of well being can lessen the perception of pain in labour (Arms, 1994).

A conducive environment as promoted by Michel Odent (1991), massage, warm baths and ambulation at will, all promote the production of beta-endorphins. Wagner (1994) points out that this endogenous substance has an effect similar to that of morphine, relieving pain and promoting a feeling of well being as well as being thought to have beneficial effects on the baby. The positive effects of social support in the form of doulas (labour support) usually have been denigrated by medicine. However in a recent randomized controlled trial of four hundred women (Kennell, 1988) in a large midwestern U.S. hospital , dramatic results were related to the presence of doulas. Compared with the control group, dramatic reductions were seen in the epidural and Caesarean rates. Social support in childbirth has also been shown to shorten labour, resulting in less intervention and significantly less medication. Decreased anxiety and depression and improved breastfeeding are also added benefits associated with the use of social support (Klaus, Kennell, Berkowitz, & Klaus, 1992) The choice of a support person throughout birth is an example of simple and cost effective measures.

Resistance to this alternative knowledge is strong and given the economic rationality that pervades contemporary childbirth practices, it is hardly suprising. Providing women with viable alternatives requires an

honest unbiased scientific appraisal of all the physiological and psychological elements connected to pregnancy and birth. Medical control of the domain of childbirth however is far more complex than reviewing the issue of informed consent. To quote Lather (1991), "deconstruction foregrounds the lack of innocence in any discourse by looking at the textual staging of knowledge". Scientific knowledge produced by and for the medical model is highly valued in Western industrialized society. The dependent or negatively placed binary, in the form of women's knowledge of their bodies, of intuition or internal knowledge is culturally devalued. Women who seek confirmation or affirmation of their natural knowledge are confronted with the power of the biomedical model (Davis-Floyd,1992).

Routine monitoring of birth / non-invasive observation of birth.

The importance of this component of contemporary childbirth practice has been identified in previous sections of this thesis. In order to engage in deconstructive critique, the binary oppositions must be defined. The opposite practice to the accepted routine of electronic monitoring is rarely presented as a viable alternative to technology. This is in spite of the support of intermittent auscultation in labour which is the result of considerable research . Though randomized trials have shown the efficacy of not using electronic monitoring for normal labour, the continued use of oxytocics as an intervention provide justification for the technology (MacDonald, Grant, Sheridan-Pereira, Boylan & Chalmers, 1985). The power of the medical or technocratic model is demonstrated in the omnipresent practice of routine

electronic monitoring of childbirth. Wagner (1994) also cites the influence of the economic interests of the manufactures of the technology. Disturbances to the natural birth process in the form of elective intervention compromise the foetus which in turn is reflected in the responses that the monitor records. A prime example of a self fulfilling prophecy as monitoring has been correlated with increased rates of intervention (Tew, 1990; Wagner,1994). The purpose of routine monitoring is to observe any deviations in the normal fetal heart rate. This observation again inscribes a pregnant woman's body as having the potential for pathological responses to childbirth.

As discussed earlier, Foucault's principles of panopticism can be readily applied to many aspects of childbirth. Electronic monitoring of women in labour also reinforces the defective machine metaphor, which as Freund and McGuire observe is one of the oldest Western images incorporated in the biomedical model. It is important to remember that the economic and political climate of Western society has been a strong influence on contemporary childbirth practice. Fruend and McGuire (1991) also caution us to remember that these medical realities are socially produced. The assumptions of the technocratic model have concrete implications for the discursive practice of birth in industrialized countries today.

Reversal/ Displacement of the Discursive Practice of Contemporary Childbirth Practice:

To summarize, this chapter of deconstruction of the antecedents and elements of contemporary childbirth practice has provided an alternative

view of many of the accepted techniques used in modern obstetrical institutions. In a deconstructive critique of the two oppositional paradigms , the object is not to deteriorate to a mere argument regarding the merits of one model of childbirth practice versus another. The goal of deconstruction according to Lather (1991) is not dialectical resolution. In the case of the contemporary discursive practice of childbirth, it is important to appreciate that both models have merits. Throughout history women have made choices about the quality of their birth experiences. For example, home birth versus hospital birth and medicated versus unmedicated but as the literature has shown, they have made these choices with limited and biased information.

For women, there are many influences on decision-making process (Janis, 1977) For example, the use of expertise in the doctor-patient relationship and the asymmetrical power relationship of male doctor to female patient , discussed in an earlier segment of this thesis. Socialization through prenatal education which was also referred to in the preceding chapters contributes to the decision making process. The definition of risk and the use of guilt to obtain a patient's consent for a procedure are all contributing factors to the birth choices that women must make. Risks are exaggerated by proponents of both paradigms. Studies have shown that there is a tendency to play up the risks of the rejected alternative while discounting the risks of the chosen alternative (McClain, 1983). In a similar vein, methodological flaws in recent research findings that compare midwife-

attended home births and physician-attended hospital births resulted in the conclusion that midwife-attended home births are not necessarily associated with greater risk than their hospital counterparts (Johnson,1991).

Oppositional Paradigm.

It is ironic that there is a great deal of rhetoric on the subject of choices available for women in childbirth at a time when intervention rates and use of technology belie that reality. What is wrong with this picture? The dominant paradigm continues to exert its influence and alternative knowledge continues to be devalued. The iatrogenic and psychosocial risks of hospital births are minimized and those who would chose otherwise are publicly censured (Davis-Floyd,1992). Deconstructive critique according to Lather (1991) requires both the dominant and the negatively valued term to be displaced with a neutral term which transcends the binary logic. When this principle is applied to contemporary childbirth practice neither hospital or home birth are seen as the dominant paradigm. From the debates that abound in the popular press as well as in journals and text on the subject of childbirth, it would seem that the time has come for a paradigm shift in the Kuhnian tradition. Those who adhere to the technocratic model of birth have been taught not to question the dominant paradigm and why should they? The effect of medical power structures has been to construct knowledge that supports the medical ideology.

What has been described in terms of the oppositional paradigm is the wholistic model (Davis-Floyd, 1992) Campbell and McFarlane (1990) have

commented on the fact that advocates of this paradigm became a more cohesive group in the mid 1970's. This was seen as a backlash against the widespread use of elective induction and as a result the Association of Radical Midwives came into being. In their search for the optimum birth experience, it is possible that the consumer is likely to precipitate the emergence of a new paradigm, one that combines the best of the wholistic and the technocratic models. The proliferation of alternate birthing centres within the confines of obstetrical institutions has not provided the solution many women were seeking as they found that technocratic practices were merely wrapped in pretty covers.

Throughout history, women have had contributions to make as childbirth evolved from home to hospital. Today's mothers are more informed than their seventeenth century predecessors but feel it should not be necessary to sacrifice all the benefits of modern medicine in order to structure their childbirth experience within a traditional female context. Given an honest appraisal of the available options, women should be able to choose without retribution either a hospital birth with alternative techniques for pain control, and support of a doula or home birth with the blessing of medical and political institutions and the back-up up of the latest technology should it be required. No longer a passive recipient but as an active participant, many women are actively seeking control of the childbirth experience.

Within the new paradigm and in answer to the critical questions regarding the legitimacy of the discourse, all the participants should be authorized to speak and none are excluded. All knowledge is valorized and no utterances penalized. There will undoubtedly be critics of the new paradigm who would debate potential compromise to the safety of mothers and babies. Questions about lack of personal responsibility are not relevant in light of lack of political responsibility to address severe socio-economic problems found to be much more injurious to maternal child health. One wonders how the high rate of expenditure on technological advancements is justified and who other than multinational companies benefits from such expenditure? Many socio economic factors would be addressed by monies spent on effective birth control, improved prenatal nutrition and reproductive education.

Reformulation.

What of the role of education within an egalitarian paradigm? Changes to childbirth education alone would hardly be sufficient. In order for a new paradigm to emerge as a viable alternative to the present system, childbirth and the health of mothers and their babies must become a priority. The principles of health promotion and health education although not traditionally employed to deal with childbirth could provide some useful strategies. Kolbe (1988) indicates that there are three definitions of health promotion. The first definition that he proposes has an emphasis on medical treatment. From the literature it would seem that this complete reliance on

the medical model has not aways served women well. The second definition of health promotion described by Kolbe emphasizes social reform. The 1986 Ottawa Charter reflects the shift in focus to the community and individual level. Achieving Health For All (Epp, 1986) spells out the importance of strengthening community participation and development of personal skills. The creation of environments conducive to community involvement in health issues that go beyond clinical care is an important part of this definition of health education and has ramifications for childbirth education. The third definition of health promotion that Kolbe has outlined is centred on health behaviours. This also has implications for a new paradigm for childbirth education. Barriers to change (personal, social or institutional) can be identified within the context of health education.

Fostering health beliefs that would empower women to take more responsibility for their reproductive health would have far reaching effects. At a very early age, young people, boys and girls can learn to respect their bodies. Healthy coping strategies, empowerment and assertiveness are all behaviours that can be applicable to childbirth. Life style and health behaviours as Bruhn (1988) notes are learned "during the process of growth and development, through parental and peer modeling". As he points out, information is also acquired through mass media. Because health behaviours and life-style are so closely interrelated, Bruhn maintains that as changes occur during our lives, we modify our health behaviours to accommodate the

change. (1988, p.72). From childhood, we have learned about our bodies and our health in a medicalized context.

Medicalization of so many aspects of our lives has been the result of socialization that has gradually occurred. Women's dependence on the medical model with its inherent pharmacology and technology has been learned by exposure to the dominant paradigm from infancy. The importance of childbirth in our society cannot be diminished. As Wagner (1994) maintains, strategies which affect it positively may alter societies overall health beliefs and behaviours.

The unhealthy aspects of medical control of health have been described quite eloquently by Ivan Illich (1979) and his classification of levels of iatrogenesis are of relevance to this study of the discursive practice of childbirth. They will be outlined as follows. The first level is clinical iatrogenesis. This relates to damage caused by ".... undesirable side effects of mistaken or contra-indicated technical contacts with the medical system.....whether the intention was to alleviate suffering or with intent to exploit ". This also includes attempts to avoid litigation or prosecution, considered by Illich to be as harmful as any other damage. Social iatrogenesis is considered by Illich to be the second level of pathogenic medicine and refers to medicalization or what Illich maintains is expropriation of health.

According to Illich, the third level of iatrogenesis that the health professions dispense is cultural iatrogenesis. It is at this level that pathological medicine is at it's most pernicious, according to Illich, destroying

the potential of people to deal with health related problems in a personal and autonomous way. This "ultimate evil of medical progress" produces a paralyzing effect on healthy responses to normal biological events such as birth and death. According to Illich, health management is designed on the engineering model in which health is acquired "as if it were a commodity" (1979).The self reinforcing loop that he describes as the means by which iatrogenesis proliferates has been illustrated with the genealogical analysis of contemporary birth practices.

Although Illich maintains that iatrogenesis has become "medically irreversible", he provides a glimmer of hope to those health professionals who seek a more egalitarian approach to health care. Although he believes iatrogenesis has reached epidemic proportions, he makes assurances that a reversal of the status quo can be accomplished. The remedy that he proposes comes from within the individual and focuses on "a recovery of the will to self care among the laity". To foster this nebulous quality in contemporary society, Illich calls on legal, political and institutional bodies to recognize and impose limits on the medical monopoly that now exists.

This is not a new concept but its revival should be a timely one. The focus on the "recovery of the will to self care" that Illich has proposed is reflected in the WHO report on health promotion and childbirth which was prepared in 1986. The recommendations are for the adoption of strategies that promote autonomy and authority in the childbearing woman, in her family and their community, rather than the professional community and the state.

Within the WHO report, there are a series of fundamental principles of health promotion which converge on the concept of a social model of childbirth. This convergence of alternative paradigms recognizes birth as a healthy life event. Recognizing this radical departure from the medical model has unlimited ramifications.

The Social Model.

A social model of childbirth places positive emphasis on personal experience. In addition, the social model adheres to support of individual and community resources. Commitment to the priority of childbirth should be reflected in the provision of necessary funding by government and is a necessary adjunct to the success of any health promotion strategies. The cost effectiveness of primary care are also an important aspect of these recommendations. As key players in the provision of primary care, utilization of midwives throughout pregnancy would also ensure continuity of care in a community setting. This reflects the philosophy on primary care set out in the Alma Ata agreement in 1978. Emphasis on prevention rather than intervention is also an important principle in the social model proposed by WHO. The option to choose the most appropriate setting for birth is an important departure from the present system. A stated principle of this model is that regardless of which setting a woman and her birth attendant may choose, all the necessary diagnostic, consultative, emergency and other services should be provided (Wagner, 1994).

These fundamental principles set out by the WHO report on health promotion and birth are closely aligned with the recommendations of this thesis. Assumptions of dissent among the participants in contemporary childbirth practice which prompted the genealogical analysis of the discursive practice have been born out by the literature. Dixon (1988) in his study of obstetric interventions, comments on the vested interests of a variety of health care groups in maintaining that healthy maternal- child outcomes are to the credit of obstetrical expertise and technology. Using the fairytale of the Emperor's Clothes as an analogy, he suggests that the emperor's new clothes have been found to be threadbare.

This is consistent with the conclusions that have been reached by genealogical analysis and deconstructive critique of contemporary childbirth practice. By adapting the critical questions of Foucault and Derrida and applying them to the discursive practice of birth practices, disquietening observations have emerged. In answer to the question "who is authorized to speak" it is clear that women have not been authorized to speak of their personal views of childbirth. To ask what discourse is rewarded and what is penalized in our society is to realize that alternative paradigms have been excluded and utterances questioning the legitimacy of the dominant paradigm have been penalized. The social and political arrangements, the power structures in industrialized society have moral and legal means to reward those who support the medical model and to punish those who do not.

Summary.

The present system of maternal-child care which functions within the technocratic model is reinforced by all the social and political systems that provide the framework for Western society. Every facet of this framework influences the discursive practice of birth. Governments, through funding and organization of services support medicalization of birth . The role of education at all levels is to disseminate knowledge, among other things perpetuating the belief that without medical intervention birth is too dangerous. An important factor in the pervasive nature of belief in the medical model is the power of multinational companies who produce the technology and pharmacology. The most powerful protagonists of the technocratic model are undeniably to be found in the medical profession and in the specialty of obstetrics in particular. For almost a hundred years, so history tells us, the medical model has withstood many of the challenges to their supremacy. Perhaps the very mechanisms which created the powerful system reflected in today's medical institutions will be the means of the eventual transformation (Freund &McGuire, 1991).

The legal system, insurance companies and multinational technology and pharmaceutical manufacturers have all contributed and had their share of the profits of the technological model of birth. "Hoisted by their own petard," in tough economic times, the medical profession could have priced themselves out of the market. Governments everywhere are seeking ways to reduce health care costs without compromise to the health of the people. The

social model of childbirth has the potential to become a viable alternative, providing cost effective and efficient care within a traditional female context but with all the benefits that the last one hundred years have brought.

With regards to power and knowledge, this thesis has explored the ways in which medical power and knowledge have become the only legitimate authorities on childbirth. In terms of the discursive practice of contemporary birth, power and scientific knowledge have determined the supremacy of the dominant paradigm. Rather than observing that the emperors new clothes are threadbare, genealogical analysis and deconstructive technique have revealed that the emperor has no clothes.

CHAPTER SIX

Conclusions.

Through the method and analysis, claims that the legitimacy of the technological model of childbirth were not valid were confirmed. Alternative views have been silenced by political and economic power. The analysis of the discursive practice has revealed that women's experience of childbirth has been excluded.

The primary objectives of this thesis have been to identify the socially constructed and historically embedded elements of contemporary childbirth practice. This has been accomplished by genealogical analysis. In addition, the thesis has maintained that the power/knowledge nexus is fundamental to contemporary childbirth practice. The invisible networks, strategies and mechanisms that have served to provide legitimacy for the dominant model of childbirth have also been interpreted using deconstruction strategies. These "techniques of power and knowledge" described by Foucault (1988) have been subjected to a decidedly postmodern interpretation which has been provided by a system of genealogical analysis and deconstructive critique. What Lather (1991) has described as a "collage of juxtapositions" or briccolage has been used to provide critical reflection on the discursive practice of contemporary childbirth.

The conclusions drawn from this thesis support those of many authors who propose a radical paradigm shift from the medical model to a more

egalitarian model of childbirth practice. This study has provided the necessary critical reflection on the mechanisms that maintain the status quo. As such it has completed the first stage, the prerequisite for transformative praxis. If future research is required to further justify a radical paradigm shift, the groundwork has been laid for a continuation of praxis-oriented research. Suggestions for future studies could include collaborative and interactive research into the priorities of childbearing women.

Development of an Adjunct to Postmodern Methodology.

The combination of genealogical analysis and deconstructive critique has been developed into a very useful strategy in the course of this study. As an analytical mechanism, this alliance of genealogy with deconstruction has facilitated a new level of analysis. The antecedents and elements identified in the genealogical analysis serve as binaries for the deconstructive critique. As an adjunct to postmodern research, this methodology could be employed in the analysis of other contemporary institutional discourses. Diverse disciplines, such as education, law or medicine, seeking to examine the origins of their present discursive practice could benefit from this critical inquiry. These contemporary institutions are all governed by inherent power structures that determine the dominant ideology. Practical applications could include examinations of legal practice , medical or teaching practice, for example, and many other areas of human endeavour.

Transformative Praxis.

The present climate of economic rationality with regard to health care in Western industrialized countries is not conducive to some of the more radical changes reflected in the proposed social model of childbirth. For example, collusion between government and the medical profession have resulted in a stalemate on the legalization of midwifery and training of midwives in many parts of the industrialized world. Tough economic times are cited as the problem. In contrast, the multinational technology industry produces more equipment for intervention in childbirth. As costs spiral, hospital personnel are reduced to cope with shrinking health care budgets. In spite of these formidable barriers, in the short term, there are many ways in which health promotion and health education can pave the way towards making childbirth a priority in the future.

The basic strategies that are employed in health promotion such as coalition building and networking can be applied to childbirth. In this way policies can be developed that promote public interest in childbirth as a healthy life event and resources can be directed to the community level. Community organization, based on the principle of "starting where the people are" has been shown to be effective (Minkler & Cox,1980, Minkler, 1991). This could be adapted for childbirth education. Also related to empowerment, the Friere method of creating critical consciousness and dealing with the underlying problems at a community level is also applicable to childbirth education.

The media has been used in many health promotion issues such as drug and alcohol abuse and drinking and driving. Promoting an accurate view of healthy childbirth and depicting normal alternatives to medicalization would be similar to the goals aspired to by other health promotion programmes. Education of the public in healthy childbirth should be at different levels. Childbearing women would require the most comprehensive education programme but school children and the general public would also benefit from varying degrees of information designed to promote childbirth as a normal life event. The key is to establish childbirth as a health promotion priority.

The pitfalls of enabling and empowerment in health education have been well documented (Grace,1991). Although strategies that promote enabling of informed choice and empowerment for self responsibility are fundamental to the success of the social model of childbirth, it is important to guard against the influence of "medically based discourse" in childbirth education. The rhetoric quite often disguises an ideology of "benevolent management." For this reason, the emphasis on non-professional community members should be the focus as recipients and providers of childbirth education for women. The role of the health educator is primarily that of a facilitator.

In many industrialized countries, there are barriers to a woman's choice of birth attendant and place of birth. There are ways to make these alternatives safe and effective but the political will is not there. Swayed by

business and medical interests, and fear of litigation, government will maintain the status quo. Until such time as women are able to have access to all the information that they require in order to make an informed choice about their childbirth experience, this inequality will persist. This thesis has shown that a collaborative model of childbirth is required to replace the existing hierarchy. It has also traced the elements that have transformed childbirth since the turn of the century.

Genealogical analysis has shown how childbirth has evolved into a medical problem in less than a hundred years. A reversal of the status quo is something that Illich (1979) assures us is possible. While not seeking a return to the turn of the century, there are many childbearing women who would support a new paradigm. It is clear from the literature that the needs of childbearing women in Western industrialized countries are not met by physician directed childbirth. They seek to be equally involved in the decision making process. To fully understand that childbirth is a natural life event, childbirth education that supports that paradigm is crucial. Health education with childbirth as a priority can provide the catalyst for change. This study has provided the initial reflexive framework required for transformative praxis for contemporary childbirth.

REFERENCES.

Allison, D. B. (Ed.). (1994). The New Nietzsche. Contemporary Styles of Interpretation. Cambridge, Massachusetts: MIT Press.

American Psychological Association, Council of Editors. (1994). Publication Manual of the American Psychological Association (4th ed.). Washington, D.C: Author.

Arney, W.R. (1982). Power and the Profession of Obstetrics. Chicago: University of Chicago Press.

Arney, W.R., & Neill, J. (1982). ' The location of pain in childbirth, natural childbirth and the transformation of obstetrics', Sociology of Health and Illness, 4, 1-24.

Arms, S. (1994). Immaculate Deception Two: A Fresh Look at Childbirth. Celestial Arts., Berkley, California.

Armstrong, D. (1990). ' Use of the genealogical method in the exploration of chronic illness: a research note', Social Science and Medicine, 30, 1225-7.

Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. Journal of Abnormal Psychology. Vol. 87, No. 1.

Barnett, B., & Parker, G. (1986). Possible determinates, correlates and consequences of high level anxiety in primiparous mothers. Psychological Medicine. Vol. 16, 177-185.

Bastian, H., & Lancaster, P. A. L. (1992). Home Births In Australia 1988-1990. (AIHW National Perinatal Statistics Unit. ISSN 1034-7178)

Brindley, B. A., & Sokol, R. J. (1983). Induction and augmentation of labor: basis and methods for current practice. Obstetrical and gynecological Survey. Vol. 43. No. 12.

Bruhn, J. (1988). 'Life-Style and Health Behavior' in D. Gochman (ed.) Health Behavior: emerging research perspectives. New York. Plenum Press. pp.71- 86.

Campbell, J. C., & Bunting, S. (1991). Voices and Paradigms: Perspectives on critical and feminist theory in nursing. Advanced Nursing Science. Vol. 3, (3): 1-15. Aspen Publishers.

Caldeyro-Barcia, R. (1984). 'Purposes of Prenatal Care', presented at the Consensus Congress on Appropriate Technology for Prenatal Care, World Health Organization, Washington, DC.

Conrad, P., & Kern, R. (1986). Racism and Sexism in Medical Care. Sociology of Health and Illness: Critical Perspectives. Second edition. New York: St. Martin's Press.

Conrad, P., & Schneider, J.W. (1986). Professionalization, Monopoly and the Structure of Medical Practice. Sociology of Health and Illness: Critical Perspectives. Second edition. New York: St. Martin's Press.

Conrad, P., & Schneider, J. W. (1986). Creating. and maintaining the dominance of medicare. In P. Conrad (2nd. ed.) Sociology of Health and Illness. New York: St. Martin's Press.

Coser, L. A. (1977). Masters of Sociological Thought: Ideas in Historical and Social Context. Second edition. New York: Harcourt Brace Jovanovich, Inc. (pp..226-227).

Cherryholmes, C. H. (1988). Power and Criticism: Poststructural investigations in education. New York: Teachers College Press.

Cronbach, L. (1987). Construct Validity after Thirty years. In Linn, R. L. (Ed.), Intelligence: Measurement, Theory, and Public Policy. Urbana: University of illinois Press.

Cronbach, L. (1980). Validity on parole: Can we go straight? New Directions for Testing and Measurement, 5, pp. 99-108.

Curtis, P., & Safransky, N. (1988). Rethinking oxytocin protocols in the augmentation of labor. Birth. Vol . 15: 4.

Daly, M. (1978) Gyn/Ecology: The Metaethics of Radical Feminism. Boston: Beacon Press. (p.226).

Davis-Floyd, R. E. (1992). Birth as an American Rite of Passage. Berkley: University of California Press.

De Geest, K., Thiery, M., Piron-Possuyt, G., Vanden Driessche, R., (1985) Plasma oxytocin in human pregnancy and parturition. Journal of Perinatal Medicine. 13. 3

Denzin, N. K., & Lincoln Y. S. (1994). Editors. Handbook of Qualitative Research. Thousand Oaks, California: Sage Publications.

Dixon, T., (1988). The Emperor Clothes. Canadian Family Physicician. Vol 34, (pp. 1827-1828).

Donegan, J.B. (1978). Women and Men Midwives: Medicine, Morality and Misogyny in Early America. Westport, Conn.: Greenview Press.

Donnison, J. (1977). Midwives and Medical Men. A History of Inter-Professional Rivalries and Women's Rights. London: Heinemann.

Duncan, Margaret Carlisle. (1994) The Politics of Women's Body Images and Practices: Foucault, the Panopticon and Shape magazine. Journal of Sport and Social Issues. February. Sage Publications.

Eccles, A. (1982). Obstetrics and Gynaecology in Tudor and Stuart England. Canberra: Croom Helm.

Ehrenreich, B. & English, D. (1973). Witches, Midwives and Nurses. Old Westbury, New York: The Feminist Press.

Ehrenreich, B., & English, D. (1979). For Her Own Good: 150 Years of the Experts Advice to Women. London: Pluto.

Epp, L. (1986). Achieving Health for All: A framework for health promotion in Canada. Toronto: Health and Welfare, Canada.

Final Report of the Ministerial Review of Birthing Services in Victoria. (1990). Having a baby in Victoria. Health Department , Victoria: Author.

Freund, P.E.S. & McGuire, M.B. (1991). Health, Illness, and the Social Body. New Jersey: Prentice Hall, Inc., Englewood Cliffs.

Friere, P. (1970). Pedagogy of the Oppressed. New York: Continuum Publishers.

Fox, N. J. (1994). Postmodernism, Sociology and Health. Toronto: University of Toronto Press.

Foucault, M. (1979) Dicipline and Punishment. New York: Vintage Books

Foucault, M. (1978). The History of Sexuality. Volume 1: An Introduction. New York: Vintage Books.

Foucault, M. (1988). Politics, Philosophy, Culture: Interviews and other writings of Michel Foucault, 1977-1984. New York: Routledge, Chapman & Hall, Inc.

Garcia, J., Kilpatrick, R. & Richards, M. eds. (1990). The Politics of Maternity Care. Services for Childbearing Women in Twentieth Century Britain. Oxford: Clarendon Press.

Giddens, A. (1987). Sociology: A brief but critical introduction. London: Harcourt Brace Jovanovich, Inc.

Giddens, A. (1989). Sociology. Cambridge: Polity Press.

Grace, V. M. (1991). "The Marketing of Empowerment and the Construction of the Health Consumer: A Critique of Health Promotion". International Journal of Health Services, Volume 21, Number 2, (pp. 329-343).

Griffiths, A Phillip. (1987). Contemporary French Philosophy. Royal Institute of Philosophy Series. Cambridge: Cambridge University Press.

Harding, S. (1987). Introduction. Is there a feminist model? In S.Harding. (Ed.) Feminism & Methodology. Bloomington, Indiana: University Press.

Haug, Marie R. Power (1986). Authority and Health Behavior. in D. S. Gochman (Ed). Health Behavior: Emerging Research Perspectives. New York: Plenum Press.

Hudson, K. (1978). The Jargon of the Professions. London; McMillan. in The Game Planners, Mackintosh & Whitson, 1990. Montreal: McGill- Queens University Press. (pp.108-111).

Hylnka, D., & Belland, J. C. (Eds.). (1991). Paradigms Regained: The Uses of Illuminative, Semiotic and Post-Modern Criticisms as Modes of Inquiry in Educational Technology. New Jersey: Educational Technology Publications, Inc., Englewood Cliffs.

Illich, I. (1979). Limits to Medicine: Medical Nemisis: The expropriation of health. London. Pelican Books.

Jacoby, A., & Cartwright, A. (1985). 'Finding out about the Views and Experiences of Maternity-Service Users'In J.Garcia, Kilpatrick R. & Richards, M. The Politics of Maternity Care: Services for childbearing women in 20th. century Britain. Oxford: Oxford University Press.

Janis, I. L. (1984). The Patient as Decision Maker. In W.D. Gentry (Ed.), Handbook of Behavioral Medicine. New York: Guildford Press.

Kaufert, P.A. (1988) Inuit and Obstetricians: Analysis of a Dialogue on Risks in Childbirth. Presented at the Wenner-Gren Foundation for Anthropological Research, International Conference, Lisbon, Portugal.

Kennell, J. (1988). Medical intervention: The effect of social support during labor. Pediatric Research. Vol. 23, (p. 211).

Kirby, S., & McKenna, K. (1989). Experience, Research, Social Change. Methods from the Margins. Toronto: Garamond Press.

Kitzman, L.D. (1988) Michel Foucault: Politics, philosophy and culture. Interviews and other writings of Michel Foucault, 1977-1984. New York: Routledge, Chapman and Hall, Inc.

Kitzinger, J. (1990). 'Strategies of the Early Childbirth Movement: A Case-Study of the National Childbirth Trust', in J. Garcia, R. Kilpatrick and M. Richards (eds.) The Politics of Maternity Care: Services for Childbearing Women in Twentieth Century Britain. Oxford: Clarendon Press.

Kitzinger, S. (1991) The Midwife Challenge. Pandora Press, Hammersmith, London: HarperCollins Publishers.

Klaus, M., Kennell, J., Berkowitz, G., & Klaus, B. (1992). MaternAl assistance and support in labor: Father, nurse, midwife or doula? Clinical Consultations in Obsetrics and Gynacology, Vol. 4. No. 4. (pp. 211-217).

Kolbe, L.J. (1988). The application of health behavior research: Health education and health promotion. in D. Gochman, (Ed.), Health Behavior: Emerging Research Perspectives, pp. 381-395.1988, New York:

Komrad, M. S. (1983). A defence of medical paternalism: maximizing patients' autonomy. Journal of Medical Ethics. Vol. 9.

Kruse, J. (1986). Oxytocin: Pharmacology and climnical application. The Journal of Family Practice. Vol. 5. pp. 473-479.

Last, J. M. (1988). A Dictionary of Epidemiology. Toronto. Oxford University Press.

Lather, P.A. (1990). Getting Smart: feminist research and pedagogy with/in the postmodern. New York: Routledge,Chapman and Hall. Inc.

Leap, N., & Hunter, H. (1993). A Midwife's Tale: An oral history from handywoman to professional midwife. London: Scarlett Press.

Leavitt, J.W., (1980) Birthing and Anaesthesia:The Debate over Twilight Sleep. Signs 6 (1, Autumn):(pp.147-64).

Leavitt, J.W., (1983) "Science" enters the Birthing Room: Obstetrics in America since the Eighteenth Century. Journal of American History. Vol. 70. No. 2(September) (pp. 281-304.)

Leavitt, J.W., (1986.) Brought to Bed: Childbearing in America, 1750-1950. New York: Oxford University Press.

Levy, J., & McGee, R. K. (1975). Childbirth as Crisis: A Test of Janis's Theory of Communication and Stress Resolution. Journal of Personality and Social Psychology. Vol. 31, No. ! 171-179.

Lewin E., & Olesen V. (1985). Women, Health and Healing: Toward a new perspective. New York: Tavistock Publications.

LeBaron, S., Reyher, J., & Stack, J. M. (1985). Paternalistic vs Egalitarian physician styles: the treatment of patients in crisis. The Journal of Family Practice. Vol. 21, No. 1.

Lincoln, Y. S. (1990). Fourth Generation Evaluation; The Paradigm Revolution and Health Promotion. Canadian Journal of Public Health, March-April, 1992. Supplement 1.

Lumley, J. and Astbury J., (1980) Birth Rites, Birth Rights: Childbirth Alternatives for Australian Parents. Victoria, Australia: Sphere Books.

Lynaugh, J., & Reverby, S. (1986). Thoughts on the Nature of History. Nursing Research. January/ February 1987 Volume 36. Number 1.

MacDonald, D. Grant, A., Sheridan-Pereira, M., Boylan, P., & Chalmers, I. (1985). The Dublin randomized trial intrapartum fetal heart rate monitoring. American Journal of Obstetrics and Gynacology, Vol,. 152, (pp. 524-539).

McKeown, T. (1965). Medicine in Modern Society. London: George Allen and Unwin.

McKinlay, J.B., & McKinlay, S.M. (1977). " Medical Measures and the Decline of Mortality." in Sociology of Health and Illness: Critical Perspectives. Second Edition. Conrad & Kern (eds.) St. Martin's Press. New York.

Mill, J. Stewart. (1974). On Liberty. Gertrude Himmelfarb (ed.), London: Penguin Books.

Minkler, M. (1983). "Theory into Action: Health Education in a Honduras Refugee Camp" Paper presented at the 111th. annual meeting of the American Public Health Association, Dallas.

Minkler, M., and Cox, K. (1980). "Creating Critical Consciousness in Health: Applications of Friere's Philsophy and Methods to the Health Care Setting". International Journal of Health Services, 10, 311-322.

Mitford, J. (1992). The American Way of Birth. New York: Penguin Books.

Noujain, E. G. (1993). History as Genealogy: An exploration of Foucault's Approach to History. In Contemporary French Philosophers. Griffiths, A. Phillips, Eds. Cambridge, London: Cambridge University Press.

Oakley, A. (1980). Women Confined: Towards a Sociology of Childbirth, Oxford: Martin Robinson.

Oakley, A. (1984). The Captured Womb: A history of the medical care of pregnant women. Cambridge, Massachusetts: Basil Blackwell, Inc.

Odent, M., (1991). Planned home birth in industrialized countries. WHO Regional Office for Europe. Copenhagen.

O'Driscoll, K., & Meager D. (1980). Active Management of Labour. Philidelphia: W.B. Saunders Company Ltd.

O'Neil, J. and Kaufert, P.A., Brown, P., Voisey, E., Moffatt, M.M., Postl, B., Brown, B., and Binns, B. (1987) Inuit Concerns about obstetric policy in the Keewatin Region, N.W.T. Paper prepared for presentation at the 7th international congress on circumpolar health, June 8-12. Unea, Sweden.

Raps, C. S., Petersen, C., Jonas, M. & Seligman, M. E. P. (1982). Patient behavior in hospitals : Helplessness, reactance, or both? Journal of Personality and Social Psychology. Vol. 42, No. 6, (pp.1036-1041) .

Reverby, S. M. (1987). Ordered to Care: the Dilemma of American Nursing, 1850-1945. (Cambridge History of Medicine) Cambridge, London: Cambridge University Press.

Reynolds, J. L. (1988). Anxiety and childbirth. Canadian Family Physician. Vol. 34. Sept. (pp.1831-32).

Romalis, S. (1981). Struggles between providers and recipients: The case of birth practices. in Childbirth: Alternatives to Medical Control. Austin, Texas: University of Texas Press.

Rothman, B. K. (1981) Awake and Aware, or False Consciousness? The Cooption of Childbirth Reform in America'.In S. Romalis (Ed.) Childbirth: Alternatives to Medical Control. Austin, Texas: University of Texas.

Sartorius, R. (1983.) Paternalism. Minneapolis: University of Minnesota Press.

Schaeffer, M. H. (1989). Environmental stress and individual decision-making : Implications for the patient. Patient Education and Counselling, 13, (pp.221-235).

Schain, W. S. (1980.) Patient's rights in decision making. American Cancer Society. Vol 46. No. 4.

Scholes, R., (1991) Textual Power: Literary Theory and the Teaching of English. London: Yale University Press.

Schwartz, E. (1990) The Engineering of Childbirth. In J. Garcia, R. Kilpatrick, & M. Richards, (Eds.) The Politics of Maternity Care: Services for childbearing women in 20th. century Britain. New York: Oxford University Press.

Scully, D. (1994). Men Who Control Women's Health: The Miseducation of Obstetrician-Gynaecologists. New York, N.Y.: Teachers College Press.

Seitchic, J., Holden, A., & Castillo, M. (1986). Spontaneous rupture of the membranes, functional dystocia, oxytocin treatment, and the route of delivery. American Journal of Obstetricts and Gynecology, Vol. 156. No. 1. (pp. 125-130).

Sleep, J. (1991) 'Perineal care: a series of randomized trials. In Midwives Research and Childbirth, Vol.2. (eds S. Robinson and A. Thompson), London, Chapman and Hall. (pp.199-251).

Sleep, J., Roberts, J., and Chalmers, I. (1989) The second stage of labour. In M. Enkin, M. Kierse and I. Chalmers (Eds.) A Guide to Effective Care in Pregnancy and Childbirth. Oxford: Oxford University Press, (p.231).

Stephens, P. (1989). A critical social reconceptualization of environment in nursing: Implications for methodology. Advances In Nursing Science, 11(4), (pp. 56-68) .

Tew, M. (1995). Safer Childbirth? A critical history of maternity care. London: Chapman and Hall.

Thompson, J. L. (1987). Critical Scholarship: The critique of domination in nursing. Advanced Nursing Science. Vol. 10.(1) 27-38. Aspen Publishers, Inc.

Thorpe, J. and Bowes, W. (1989). Episiotomy: can its routine use be defended? American Journal of Obstetrics and Gynaecology, 160. (pp.1027 -30).

Trandel-Korenchuk, D. M. (1987). Disclosure practices of certified nurse midwives relative to methods of childbirth pain management. Journal of Nurse-Midwifery. Vol. 32, No.3.

Wagner, M. (1990). Appropriate technology for birth. New Zealand College of Midwives Journal, 3, Nov. (pp.10-11, 14-15.)

Wagner, M. (1994). Pursuing the Birth Machine: The search for appropriate birth technology. Camperdown. N.S.W.: ACE Graphics.

Weaver, J. and Garret, S. (1978). " Sexism and racism in the American health care industry: A comparative analysis". International Journal of Health Services 8, 4: (pp.677-703).

Weiss, G. B. (1985). Paternalism modernised. Journal of Medical Ethics. Vol. 11.

Wertz, R.W. and Wertz, D. C. (1979). Lying In: A History of Childbirth in America. New York: Schocken Books.

Wohlreich, M.M. (1986.) Psychiatric aspects of high-risk pregnancy. Psychiatric Clinics of North America. Vol. 10, No. 1.

Wortman, C. B. & Dintzer, L. (1978). Is attributional analysis of the learned helplessness phenomenon viable?: A critique of the Abramson-Seligman-Teasdale reformulation. Journal of Abnormal Psychology. Vol. 87, No. 1.

Zola, I. K. (1972). Medicine as an Institution of Social Control. Sociological Review 20. November: (pp.487- 504). also in Sociology of Health

and Illness: Critical Perspectives. Conrad & Kern (Eds.) Second edition. (pp.379-390).