A qualitative study of the experience of pregnancy and childbirth in the north east of England

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ABSTRACT

This thesis is an ethnography of two socio/economically differentiated groups of pregnant women living in the Co. Durham. It follows these women through the latter part of their pregnancies and until after the birth of their babies, exploring how they talked about their experiences of being pregnant and giving birth.

This thesis starts from the pretext that the physical condition, and how it is handled, is socially constructed and explores how the women, from the two groups, talked differently about their experiences. This thesis argues that the socio/economic differences between the two groups had important implications upon how the women perceived and talked about their condition and their ante-natal health seeking behaviour.

The ethnography illustrates however that there was a common theme used by both groups of women when talking about being pregnant and giving birth, the theme I have chosen to call the medical/pathological model. In this thesis I have explored why this particular theme might be so attractive to all the women concerned.

Finally this thesis considers the *ad hoc* way the women used the various cultural themes in their talk about their experiences, taking a small step back from the content of the talk to look at how the women used the content in practice.

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CHAPTER ONE

Introduction

1.1. INTRODUCTION:

This thesis looks at how two groups of women, from different socio/economic groups, living in the north east of England, talked about and made sense of their experiences of pregnancy and childbirth. It examines the various themes the women drew upon in conversations about this topic, how these themes were used and offers some analysis about their use.

I will be looking at the way these women talked about and dealt with pregnancy and childbirth from a classical medical anthropological starting point: it has been suggested by medical anthropologists that health, illness and the behaviour which surrounds them can only be understood if they are regarded as culturally specific, and the interpretation of any human physical condition therefore should not be considered to be a universal 'fact'. Kleinmann suggests 'health care systems, are, like other cultural systems symbolic systems built out of meanings, values, behavioural norms and the like' *{Kleinmann 1986:31}* I will be using such an approach as the fundamental premise from which to explore my field work material.

In this chapter, by way of an introduction to my ethnography, I will first look at various questions raised by my data, then go on to my methods and the ideas and issues which lay behind them - offering an illustration of how my material developed. And finally I will examine my material within the light of some ongoing theoretical discussions, outlining the approaches which I have found helpful for understanding my data.

1.2. IDENTIFYING THE PROBLEMS

I first became interested in pregnancy and childbirth through my own experience of it. I was stunned by the fact that, despite my diligent preparation for the event of labour and delivery throughout my pregnancy, including a rigorous daily exercise routine, detailed reading, arrangement for an independent midwife and attendance at individualised ante natal-classes, I was unable to exercise any autonomy over the actual event. When it came to it, I felt unprepared, uninformed and unsupported and as a result underwent a complete decision reversal which involved depending upon and totally submitting to a pathological/medical interpretation of childbirth. {Which I had, incidentally, indulgently challenged throughout my pregnancy}.

Pregnancy and childbirth were events which I found to be particularly emotive. They became the centre of my life and indeed have not much receded from this position since - hence this thesis! As my ethnography unfolded, I became aware that my kind of experience was a central theme in the material I was collecting. That is, for all of the women who helped in my research, the pathological/medical interpretation of pregnancy and childbirth was an overarching theme which remained present despite varying ideological convictions. This theme was used in a diverse and elastic manner, it was greatly influenced by socio/economic status and constantly reshaped over time, but it was a common cultural concept for all the women to whom I spoke.

However, although all the women involved in my research had a sense of the unpredictable nature of childbirth, the way they reacted to this uncertainty was by no means uniform. Many of the women I spoke to had the same impelling need, as I did, to manipulate their experience, and went about this in various ways ante-nataly. However this was not at all the case for others who were much more laid back about the whole thing, expressing, in some cases, that they felt preparation was futile.

Thus, I had a two fold problem. On the one hand I had to explain the similarities shared by all the women to whom I spoke, while on the other I had to explain the differences between the two groups of women. What was it that explained

these differences in behaviour and ways of thinking about childbirth? They all lived in the North East of England, but did not form one homogeneous cultural group; factors such as educational background and socio/economic status appeared to have a great effect upon the way they approached and talked about pregnancy and childbirth.

Another important element soon became apparent, the women's ideas about childbirth were by no means static. As with my experience, all the women, no matter how prepared they were had some degree of elasticity in their ideas about their pregnancy and birth experiences. Not only then did my data present a wide range of explanatory models of pregnancy and childbirth, with divergent behaviours associated with them, but the models used by the women also constantly reshaped and while certain themes remained constant, how these were used and expressed moved around *{cf Garfinkel 1967}*.

The issues raised by my data therefore were threefold:

1. The women I spoke to could not be said to share the same 'folk model' Footnote 1. Although they shared the same geographical living area i.e. the north east of England. The picture was more complicated than that.

2. The ideas that these women had about childbirth changed over time depending on their experiences. Indeed, they reshaped during the course of an interview on many occasions. The women appeared to pick out the issues they wanted to take on board and disregard anything which did not fit into their ideas about birth at **that point in time**.

3. Despite the differences between the women and the apparent shifting in how they talked about their experiences, there was an all-important similarity - the consistent importance of the pathological/medical model of explanation in some shape or form.

I will explore these three issues in this thesis, first by introducing the women in my ethnography, giving examples of the kind of stories they told me and the themes which were important to them. Then, by taking a closer look at the pathological/medical explanation of childbirth, I will illustrate how some of the

literature surrounding this topic has offered a challenge to the pathological/medical rationales suggesting therefore that this explanatory model may not be as 'scientific' or homogeneous as it may seem. This will offer an explanation as to how the women were able to use such an explanatory model in the same `ad hoc` way they used other ideas and notions to describe their experiences.

I will then go on to explore why the pathological/medical explanation might be attractive to the women, and finally will examine the flux which took place in the way the women used their various cultural themes in their talk about their experiences of pregnancy and childbirth.

1.3. METHODS:

The Approach:

In order to illustrate the idea that childbirth, like any other physical human conditions, is culturally constructed *{cf. Coreil 1990, Dunn 1988, Kleinman 1986}* I opted for a qualitative approach in my methods. The richness of cultural contextualisation which is, I would like to suggest, the trade mark of social anthropology can only be achieved through ongoing, qualitative research techniques.

My personal justifications for such an approach were two fold: firstly I wanted a methodological approach which allowed me to look at motivations, a priority which has been argued should always be at the forefront of any analysis of human behaviour if we are to draw conclusions from the data, claiming an understanding about what is actually going on *{Briggs 1977 & Rosaldo 1980}*.

Secondly my opting for qualitative data collection rested upon the importance of process in social interaction, by using these methods I hoped to get away from the tendency of describing people as if they were statically suspended in a cultural system which is beyond their manipulation. Quantitative data can have perhaps the unintentional consequence of presenting reality as a concrete, typological entity, and in so doing fails to encapsulate vital contradictions and dynamism which are vital to our social existence.*{Geertz 1973, Cicourel 1964, Rowse 1988, Pope 1993}*

(Although my failure to conduct quantitative social survey type research did cause hold ups with the medical ethics committees.)

However, due to my subject matter, the anthropological **participant observation** *{cf Bruyn 1966, Kuper 1989, Malinoswski 1966, Spradley 1980}* approach was of some what limited value to me. Apart from in specific and relatively short interactions, pregnant women do not tend to form a coherent community in which an observer can join in as a participant.

As an alternative to the participant observation approach, I designed two semi structured interview plans: one for ante-natal and the other for post-natal experience and I used these as conversation prompters. (See appendix I} These informal conversations were conducted in the homes of the participants where I hoped to be able to adopt the role of visitor and thereby put the women at ease as much as possible. Along with these interviews which lasted anything from 45 minutes to 2 hours, I followed several of the women through their experiences of pregnancy by joining them on ante-natal visits to the surgery and hospital, I also participated in various ante natal-classes which included those run at the hospital, surgery and those run by the NCT {National Childbirth Trust}, and was lucky enough to be present during the labour and delivery of some of the women.

During the months of May, June and August 1994, I conducted twenty semi-structured interviews with eleven women in total, which I tape recorded and then transcribed {which took ten times as long as the actual interviews themselves!}. I also met several of the women and accompanied them on their various ante-natal visits, as well as observed births of women from both the samples.

This research method enabled me to get an idea of what things these women considered important in their experience of pregnancy and their plans for birth. I managed to get a clear picture of how these women talked about their hopes, encouraging them to explore with me why they had made various decisions about their ante-natal and natal care and how these had developed over time. In the discussions we

had after the birth we talked about how the physical sensation itself measured up to their expectations and what were the things they had considered to be important during the actual labour and how these governed their decision making.

Much of the material in this thesis is based upon a direct transcription of recordings made during those interviews. To make the material more 'reader friendly' I have cut out sections of the speech which may make the understanding of it more difficult. Expressions such as 'er', 'erm', 'you know what I mean?' and any unnecessary repetition, stumbling or stuttering have therefore been excluded from this account. Where I have done this editing is marked by two stops. And of course all names have been changed. Where I thought personal details may identify the individuals concerned I have made minor alterations to the primary data. However the women largely speak for themselves.

The Sample:

My original research proposal suggested a twofold sample should be selected both small in number, one coming from the south of England consisting of a second-generation immigrant group of women, and the other from the north east of England consisting of a non-mobile, group of caucasian women. I was hoping that such a diverse sample would open up opportunities to look at the cultural heterogeneity highlighting the diverse and often some what `ad hoc` way people make sense of their experiences of social life.

However, unfortunately, despite meeting up with the midwifery team working in a suitable area in the south of England and gaining their approval, I was never able to submit my proposal to the relevant ethics committee because I never got past the obstetrical consultant of the unit. It was not a case of his rejecting my proposal. Rather, he simply didn't bother to reply despite my several letters and phone calls. On a final attempt at liaison with him his secretary informed me he was never very good at paper work, he had a big pile of letters on his desk and my letters were among them. (Incidentally, I have still to receive a response from him, a year later, so she wasn't exaggerating!)

In the meantime progress was being made with my North Eastern sample. I received permission from all the relevant doctors and had met up with various members of the midwifery team and devised a strategy of approach with them. Subsequently, I submitted my proposal to the local ethics committee{See appendix II}. However this stage (like all the other stages) took longer than expected and involved correspondence to and fro. The ethics committee's main concern, apart from the paper work (such as the importance of using a SDHA *South Durham Health Authority* consent form, which I have never seen) was 'There is a general concern over the involvement of a small number of patients and the outcome of the study needs to be better defined.'

My letter of return illustrated the advantages of qualitative research techniques and stressed if such quality was to be achieved, I must limit my numbers to a manageable sample and keep my objectives relatively open. This thankfully satisfied their needs and I received ethics committee clearance by the end of February.

It was at this stage that I eventually abandoned my southern sample and rethought my methods. It just so happened that during the summer holidays previously, my daughter and I had gone on a day`s outing to a farm with a friend and her children. During this outing we had bumped into another friend of hers who had just finished a NCT training to become an ante natal instructor. I was interested in this since I was at this stage pulling together initial ideas for my research proposal. Having enjoyed a pleasant day at the farm I promptly forgot about the incident until I found myself in a position of having access to a sample of women through the NHS who met only one set of criterion. I needed another group sharing different socio/economic and cultural backgrounds and then I suddenly thought of the NCT. My friend kindly got in touch with the local group and they distributed a letter of introduction from me to the latest ante natal-class.

The same letter of introduction was distributed to both groups {See appendix III}. This included a consent form. Some responses came very promptly but

it took until May for me to have a sufficiently balanced number of responses from each target group to begin conducting my field work. Unfortunately a couple of women who responded earler had already had their babies by the time I contacted them and in these cases, I was only able to conduct the post-natal interviews. I was lucky enough to receive the same number of responses from each group: five from each, a total of ten in all. (I later gained another NCT woman, making the total up to eleven)

The two groups were very different apart from the divergent ways I contacted them. The NHS group was selected with a specific criteria in mind in an attempt to get a particular group of women. These were:

1. Women who were native to the area, having local family connections {preferably matrilineally} which stretched back at least three generations.
2 Women having their first babies.
3. Women who were due to give birth within the following four months: preferably some in their second trimester and some in their third.
4. Women sharing relatively low socio/economic status.

While the NCT target group was much smaller my sample had to be more opportunist, therefore the criteria that describes this group was more coincidental.

1. Women with geographically mobile pasts either originating from other areas or having lived in other areas for much of their lives.
2. Women interested in the NCT as a source of advice on childbirth.
3. Women sharing relatively high socio/economic status.
4. Women who were due to give birth within the next three months.

Due to these differences there were several unavoidable factors which did not match in the two samples. For example the mean NCT group age was older for two reasons: firstly, the women in this group tended to start having families later in life than the NHS group and secondly two out of the six NCT women I spoke to were not first time mothers. This age difference may have had important implications for whom the women relied on for advice during pregnancy. Footnote 2.

(See appendix IV for some methodological and ethical problems.)

1.4. THESIS STRUCTURE - THEORETICAL DISCUSSIONS :

My material has three very important elements to it which have shaped the way I have chosen to theoretically organise this thesis.

a. On the one hand all the women in my sample shared key themes in common within the way they spoke about their experience of pregnancy and childbirth and these shared ways of talking helped shape the way they dealt with their condition both ante-nataly and nataly. However despite this consistent element there were two other vital factors:

b. Firstly there were very important differences between the two groups.

c. And secondly when talking about their experiences, whether using the common or divergent themes, there was always an `ad hoc` element.

In an attempt to cover the various problems posed by my data I therefore used a combination of theoretical perspectives to form an analytical framework which could successfully be applied to all of those problems. The thesis is as a consequence divided into three sections.

1.4.1. SECTION 1. OF THE THESIS.

Section 1. consists of chapters two & three which are an introduction to all the women with whom I spoke. These chapters include much ethnographic material, allowing the women to tell their own stories about their experiences of pregnancy and childbirth. The theoretical emphasis which lies behind this section of my thesis comes from a medical anthropological approach, looking at 'health care systems' in terms of systems symbolically built out of meanings, values, behavioural norms, etc. *{Kleinman 1991:31}*. By presenting the women talking directly about their experiences, I have explored the culturally prescribed norms and values which lay behind their health-seeking behaviour during pregnancy and childbirth.

While pregnancy and childbirth can not be construed as an illness as such I feel it legitimate to adopt this medical anthropological approach for two reasons:

Firstly both pregnancy and child-birth involve massive physical change which suspends the 'normal' physical condition. This was pointed out by most of the women in my research.

And secondly the entire procedure, in our culture at least, comes under the medical/pathological model of interpretation which presents childbirth within the frame work of a physical illness. *{Brackbill 1984, Hahn 1987}* 'For many American women [and I suggest British women], the folklore and traditions surrounding pregnancy and birth, which gave childbirth meaning as a social event involving women and babies, have been replaced by the medical discourse of ultrasound, foetal monitoring, and other aspects of contemporary perinatal care.' *{Michaelson 1988:11}* (For ethnographic details see footnote 3.}

For my purposes then those medical anthropological theories concerning people's interpretation of illness is transferable to the analysis of childbirth. The approach is a useful starting point for looking at the metaphors used by the women when they talked about their experiences. It will also allow me to demonstrate the cultural differentiation between the two groups of women *{cf. Young 1982}* I spoke to, a consistently crucial aspect to my ethnography.

1.4.3. SECTION 2 OF THE THESIS.

Section 2 also consists of two chapters both of which compliment one another and attempt to theoretically tackle the problem of the consistent prevalence of the medical/pathological model in my material. Chapter Four is an examination of the medicalisation of reproduction in our culture, placing it within it's socio/political perspectives, addressing therefore issues such as the presentation of authoritative knowledge and professionalism.

Within this analysis I have chosen to interweave various theoretical approaches. When looking behind the pathological/medical model I found a historical approach backed up by a cross cultural perspective, a quantifiable perspective, and a feminist and professionalisation critique very fruitful. I hope that such an analysis will enable the reader to resist the trap of assuming that medicine, since it is a science that we all rely on, is an absolute truth. After all, as Levi-Strauss eloquently observes

'Every civilisation tends to overestimate the objective orientation of it's thought and this tendency is never absent.' *{Levi-Strauss 1976}*

Chapter Five follows directly on from the conclusions drawn from Chapter Four. Lomas cautions that 'Behaviour in hospitals is not always as rational and scientific as it would seem. Much that occurs in obstetrics is heavily ritualised.' *{Lomas 1978:174}* . She goes on to explain 'We do not regard the practices surrounding childbirth in our society as ceremonial or ritualistic, but may the ritual be hidden from us only because we are so hypnotised by the apparently rational assumptions behind them that we do not even begin to seek a further explanation.' *{ibid. P177}*

In this chapter I look at the medical/pathological model in my material in terms of self propagating ritualistic behaviour having therefore both cultural and social implications.

1.4.4. SECTION 3. OF THE THESIS.

In the final section I address the remaining three edged problem raised both by my data and by the short comings of all the other theories used in sections 1. and 2.

1. The inflexibility of models.

When talking about explanatory models in the way proposed by Kleinmann, and many ritual theorists, there is the unfortunate consequence of describing those models as if they were something static, a concrete entity over which the individual as such had no control. My ethnography suggests that this perspective is too limited. The women talked very much in a flow, using mediums which constantly changed. The reasons for this movement were multi-variable, but included the way they perceived me, reactions they had from various medical staff, information they had considered relevant from various sources - pregnancy books, classes, friends, family - the mood they happened to be in and the physical sensations they were experiencing and their experiences as they moved through pregnancy and childbirth.

2. The use of metaphors not models.

I can not suggest that there is a typical pathological/medical model. Rather, all the women in this ethnography used more of a medical/pathological *metaphor* when describing their experiences, whether they were portraying themselves as the type of person who would challenge and reject the authority held by the medical profession or as person who supported it. My evidence suggests then that the flat, explanatory model theory is too limited in its approach. The women I spoke to were much more active in the construction of the themes they used to talk about their experiences. They drew from their existing cultural settings, but they never used the themes as unmovable models. I therefore found the *metaphor* concept as used by Lakoff *{Lakoff 1980}* to be a useful theoretical addition to the classical medical anthropological approach.

3. Pluralistic value systems:

I also found that I could not argue that all the women, nor indeed their advisors, adhered wholly to the medical model of interpretation; indeed one of the crucial paradoxical issues of pregnancy and childbirth, which can cause much distress, is a sense of contradiction between the notion of pregnancy as a representation of full health and pregnancy which is treated as a pathological condition *{Balaska 1987, Gaskin 1990}*. Many of the women appeared to be a bit bewildered by the pull from these two camps. (For ethnographic examples see footnote 4.)

In Chapter Six therefore I look at the crucial movement, or elasticity and process, which underlay the way the women spoke about themselves as pregnant women and the way they talked about the interactions they experienced in connection with their pregnancies and childbirths. This chapter is dominated by a theoretical sensitivity to the ongoing process involved, analysing explanatory models in terms of elastic metaphors which are pieced together in an *`ad hoc`* *{cf. Garfinkel 1967 & Watson 1991}*, dynamic way.

And finally Chapter Seven is a summary and conclusion to the thesis which will review all the material with possible policy implications.

FOOTNOTES FOR CHAPTER 1.

Footnote 1. By folk model I refer to a set of culturally prescribed norms and values which an individual uses to make sense of their physical being.

Footnote 2: Several of the NCT women talked about it being such a long time since their mothers had had their children, offering this as a reason for not relying on them as a reliable source of information. Some of the differences between the ways these two groups of women talked about their experiences of pregnancy and childbirth may therefore have been particle rather than cultural in origin.

Footnote 3: Ethnographic examples of the 'altered state' involved during pregnancy.

E.g.-A:

> ' I'm quite a fit person normally .. I was .. going to carry on being fit, I was .. not going to succumb to the pregnancy .. I was just going to carry on as normal. Just because I thought .. "I'm usually healthy anyway."
>
> 'But I didn't I felt awful. I now realise when I think back .. how I felt, that friends I'd seen .. go through with children pregnancies and you sort of managed and I think actually that having seen them go through it that they were probably feeling not as good as I had the impression that they were feeling ...'

E.g.-B.

> 'then I started to get the sickness part, I wasn't actually sick once. It must have about fifteen weeks I think me mind was more occupied with other things before that. .. I was getting a little bit queasy at about twelve weeks but it was never really, really bad. But it was here when I could be sick all the time but I .. never actually was sick but I don't know which is worse. Once we got over that stage it wasn't too bad actually till I started to get really big and uncomfortable. I may be's had two or three good weeks where I could do what I wanted to working in the house get things ready...'
>
> 'I must admit I never enjoyed being pregnant. No. It might sound an awful thing to say but it was like a big inconvenience. .. You hear some women who bloom, you know they've never been fitter. It wasn't like that with me at all. Because a lot of the time I was tired and restless, I used to come in from work and go to sleep virtually. .. I always felt tired. Couldn't get out of bed on a morning it was. Na I didn't enjoy it!

E.g.-C.

> 'and they talk about self image: .. for both men and women a pregnant body is extremely sensuous. a pregnant woman is beautiful in her own way. Well that says it like you should feel it and actually I didn't feel, I feel completely desexed actually and you know I hate having this.
>
> 'I feel like a huge egg. .. my self image, cause I'm used to being sort of quite slim and active and now I feel like .. this huge egg on these wobbly legs .. And although I don't hate myself I don't particularly like the condition.
>
> 'I'm sure that's not most women's experience actually because you get .. kind of saggy and baggy and you feel tired .. you might look all right and actually
>
> "my god I don't feel like that I feel absolutely dreadful .. Why don't I feel kind of blooming and blossoming?"
>
> and .. you might feel like a lesser person.'

And even if the physical changes do not become a particular issue for the pregnant woman the mental readjustment to the condition can demand a massive reconception of self which can often be very disturbing:

E.g.-D.

> 'the first time I went to see a lady doctor I thought that might be a good idea, I was very .. shocked about all this in the first place .. actually I used to go to the doctors and end up in tears it was just a frightening thought....
>
> 'the maternity nurses there have done most of the caring actually, the first time I went into the hospital there was floods of tears and they rushed me off into a cubical and they gave me a cup of tea and said "It's all right it happens from time to time." It was just going into that room with all these big pregnant women there I sort of it's a bit of a shock.'

Examples of the way all the women used the pathological/medical model in talking about their experiences of pregnancy and childbirth. Even when women talked about hating hospitals, injections or doctors all but one still expressed a belief that childbirth should be done in hospital and thought that medical ante natal visits no matter how unsatisfactory were not to be missed.

E.g.-a. Talking about ante natal visits one woman said:

> 'Reassurance really .. Obviously .. first and foremost to make sure .. maternal and foetal well being. But on top of that .. which I think is part of the midwife's job .. I think that's the thing Jenny actually does, was .. the reassurance part of that not everybody' you don't get from everybody.....
>
> 'I did get, .. for the last two weeks of the pregnancy she was sort of a quiet baby, doing a lot in the evening and I was quite anxious. The last probably .. for about a month .. If baby was all right and things. I didn't do a movement chart, just .. made a mental note of it and went up to the hospital on one occasion to have her monitored .. and really looked forward to the **ante natal visits in some ways it was like a fix,** you could go and make sure things were OK.'

When describing a stay in hospital during her pregnancy this woman said

> 'Yes I saw the consultant he was very good in the hospital he came every single morning ... He came to see everyone ..
>
> **'I couldn't get many .. reasons. I suppose really he couldn't give me many reasons because he didn't know why it had occurred.**
>
> 'He wouldn't volunteer any information, the registrar was better who just happened to be a woman!'

This example shows that although this woman was aware that the medical model offered her no definite answers and that while one medical staff member would provide her with one kind of response another might react completely differently, she still never entertained the idea of questioning their authority over her condition as a pregnant woman. Despite their performances and her perception of the faults in their delivery of care she continued to trust their expertise. She never questioned the legitimacy of the medicalisation of pregnancy and childbirth.

E.g.- b. Talking about where to have her baby this woman told me:

> 'I never asked, they never even asked me anyway. I just, when I went me first appointment, I just got booked into hospital. That was it really you know.

'I wouldn't have wanted it at home in case of complications. Everything is there, the hospital and .. but .. at the start I would have liked one at home. Cause you see I always said I would because I don't like hospitals. I hate them.! I've never been to hospital.

'But in the end I thought, why me mum as well, if there were any complications and what not you are there and all the stuffs there so it's easiest.'

Despite her prejudice against the medical setting of the hospital environment this example shows how irresistible the medical explanation of childbirth as a pathological process can be.

E.g.- c. Talking about the same topic of hospitalised births ante-nataly this woman said:

'But .. things .. like that. The birth at home having it at home, water birth and what positions you can have. A home birth no and not squatting neither.

'I fancy being in hospital and just lying down on me back. Just looks more natural, looks more normal, what you see more of I think. I don't know anybody else that's gone and had a baby any other way. It's just what people do I think.'

Footnote 4. Ethnographic examples of pluralistic value system:

E.g.- a.

'what about those in the Third World and that, where they don't go into hospital where they get looked after as well I can't imagine. Then they going back to work half an hour later .. but that's the way people live over there. I wouldn't like to say, I don't think it was dangerous but these days it must be all medical technology I mean just me mum talking about .. monitors and the scans and things.

"Oh we didn't have them when I had you,"

'you know monitors for heart beats and contractions but now they can detect all these if you've got troubles like. .. if it's not right .. they give you an emergency section. I don't know me mum never had any problems not like me.'

Here you can see this woman was very aware that in her mother`s time and in other countries birth is and was much less medicalised. She struggled to fit her own experience of a highly managed birth into the idea of birth being a more 'natural' event.

E.g.- b.

'I don't think I like the hospital cattle market really. .. I find that very difficult to be herded because it does take away some sort of self and it takes away the sense that your pregnancy is important at all or even natural at all. Hospital procedures they're intrusive and they are really not worth doing. .. they are more trouble than they are worth, just leave well alone. I don't think anything attracts me to a hospital birth actually.

'I think my GP. stressed the risk factors, not in a frightening way. She was very reasonable about it but having pointed them out they, .. they certainly grew in my husbands mind. And then I spoke to one of the consultants, and he was of the opinion of

"yes wouldn't it be lovely if we could do this but I can't guarantee that things are going to go well. If I could, brilliant."

'And he is such an intelligent and sensible bloke I thought

"well fair enough."

'The NCT are much more pro home birth. Yes if I hadn't been informed about this post patrum haemorrhage I probably would have gone along with the NCT idea and had a home birth. They say

"yes it is a risk but statistically it's, it's .."

'but Simon's mind was made up anyway because any risk is too big.'

SECTION ONE

The Ethnography

In this section of my thesis I will present selected bits of my ethnographic data as it was given to me. This section will largely be made up of direct transcripts from the interviews I conducted with the eleven women. I will draw from both the ante-natal and post-natal data collected, my emphasis being the types of themes the women used in talking about their experience of pregnancy and childbirth.

I will be taking up the ideas proposed by Dunn, assuming that there is 'this network of interrelationships among beliefs and practices associated with health and illness' or in this case pregnancy and childbirth. The diagrame below illustrates the complex interweave between some of the various influences which helped to shape the way the women talked about their experiences.

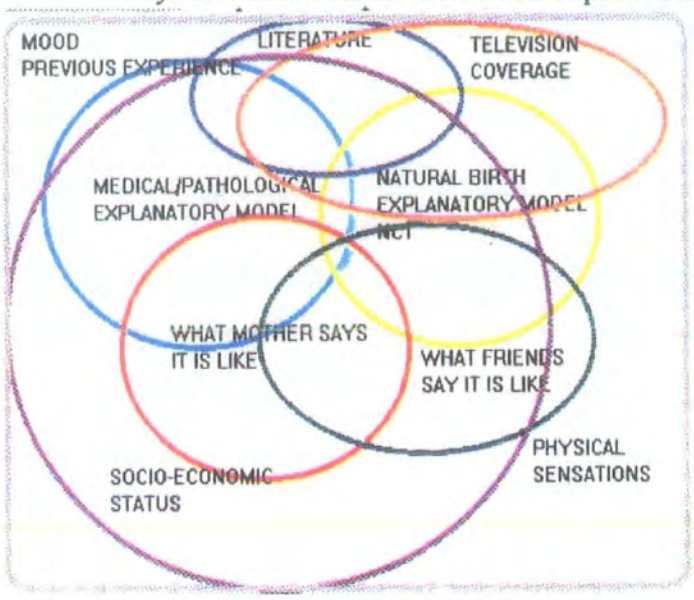

Fig. 1. The interelated web of types of influences shaping how the women talked about their experiences of pregnancy and childbirth.

However my data cannot be fully explained by such a two dimensional perspective for two fundamental reasons: Firstly there was a great deal of diversity

between the two groups of women I spoke to suggesting that although all the women shared the same cultural setting - that is the social `package` which goes with living in the north east of England - the themes they picked up to use in their conversations varied on several counts. Secondly the way the women used these themes was very flexible allowing for a degree of elasticity and for a variety of concepts to be used simultaneously despite their differing contents.

Although my main thrust in this section will be to show the type of explanatory models the women used in describing their experiences of pregnancy and childbirth the two issues, mentioned above, will also become apparent as the data speaks for itself. In response to the first issue, that is the diversity between the two groups of women I spoke to, I have divided this section into two chapters. The first, Chapter Two, will focus upon the women to whom I gained access via the NHS, while the following chapter, chapter three, will look at the women I gained access to through the NCT.

And the second issue while touched on in this section will not be directly addressed here. I felt the foundation of the types of cultural themes used should be laid before I ventured into a discussion on the elasticity and movement within that cultural setting. These issues will therefore be looked at in detail in Section Four and will not be directly discussed in this section.

CHAPTER TWO:

The NHS women.

2.1. INTRODUCTION:

This chapter is based on the five women whom I contacted through an NHS maternity unit situated in a small market town in South Durham. The women all shared similar backgrounds, coming from traditionally 'working class' families. They had all been educated in the local state schools and all had their family roots in the vicinity - within a radius of ten miles. Each woman had a very unique experience of pregnancy and childbirth. However there were certain patterns in the way they talked which occurred again and again during the interviews I conducted with this group.

In this chapter I will allow the 'NHS women' to tell their own tales. I will pick out what I considered to be the most striking parts of the conversations I had with them and use these to demonstrate the type of culturally prescribed resources this group of women used to talk about their experiences.

For the sake of organisation I have tried to structure the two chapters in this section along similar lines. But as the themes these women used in their conversations varied in several crucial areas this has only been possible to a limited extent.

2.2. LOCAL SOCIAL NETWORKS:

Robin Andrews, is a twenty-eight year old clerical worker in local offices. Her accounts were typical of several of the women I spoke to in this group and were littered with referrals to other people's views and experiences. Almost every point she made was justified with personal knowledge of an experience had by somebody she knew, or an opinion held by somebody else. Her conversation was structured around consistent referrals to her social support network.

> 'Yer but it wasn't the midwife I was supposed to see, I was really disappointed about that. .. I was supposed to see Sis. Bird and my next door neighbour said "Oh she's lovely you know...."
> 'I thought I would enjoy being pregnant but I haven't. Me mam said she'd enjoyed being pregnant with all of us and I mean she had four of us. I've had a really bad time, only got over me morning sickness about six to eight weeks ago and me mam kept saying

"Oh there's nothing wrong with yous," and I'm thinking "I'm not, I can't cope with it. I don't want to be pregnant .. I can't stand it....."

'That's it I don't want an epidural .. That really frightened us and then like Carl at work goes "Oh my wife had one of them she is fine" .. But that's still enough to put you off. That's definitely out of the question.....

'Me next door neighbour, she had two and she's told us a lot. Two little boys. She talks .. to us about it more than me mum. Yer a lot more. Well she enjoyed it, dead quickly you know. I hope I had one of them. So she had just had pethidine, yer that's right. They were very quick, her second one especially. If she has another one she has to camp on the door step.... I would trust Lucy's advice the most.....

'Me mam says she wouldn't go. She doesn't think .. it's right that anybody should be there. She doesn't think anybody should see you in that state. Well why not?....

'Childbirth can be a dangerous thing. I mean me mam had me sister at home, like her second one, and she was supposed to have me at home but at the last minute she had to get in cause of complications. So then she was supposed to have me brother at home and then complications there so she got taken in so it's just not worth it.....

'Perhaps they'll give us more information when I start going to the ante natal classes. Well I don't know whether I want to go to them because some people feel .. it's worth it goin when others say oh it was a waste of time. .. Lucy enjoyed them but then she knows a lot of people so, but I mean I don't know a lot of people.....{She never went to these classes in the end}

'I'm dreadin feeding on demand. I think I would argue with them in the hospital over it. I mean me mam says I wasn't fed when I wanted to be fed....

These examples show that during this conversation which took place before Robin had her baby, she drew on other people's views and experiences in telling her own story. Whether or not she agrees with these is irrelevant she simply uses them as a means of expressing her point. She can therefore use a story from her mother to support her case in one instance and criticises a different anecdote from her mother to prove her point in another. Although Robin says that she trusts one person's advice above all others, in telling her story she supports and rejects aspects of all the information received from her various social network sources.

This way of talking about pregnancy and childbirth was typical for this group of women.

For example Alex Manly is a twenty four year old leisure attendant.

'I had no expectations really just what me mates .. tells ya .. The only thing what worried me was when I was pregnant and peoples were saying to's me when they kick ya it really hurts. And all that .. I was aware and I was thinking
"Is there something wrong there" .. the only things what worried me...

'Me mam cause she's there I keep asking her everything. And the labour side it used to worry me, what me mam said her labour was like. I used to think
"Hey I hope it doesn't happen to me..."

'Me friends they told us their labours, what they went through, had gas and air. One of me friends Sarah she had a great labour it was sort of like in and out sort of thing .. she said it was nothing. And then someone else says, like Tracy she said oh it's painful she hated everything about the pregnancy, the labour and everything and I'm thinking
"Oh right great." ... It still didn't frighten me I was just hoping it would be all right, I was hoping for an easy labour....

'They say once your waters break it's practically over but it wasn't with me. I was later . It didn't break gush straight away, it was just a trickle all the time. It was just friends you know just people like who've had like their waters break and that's it. Lots of me friends told us stuff.....

'I would have been lost without me mam. I always am so. If I was worried I used to get on the phone
"What's this?" You know type of thing....

'I mean everybody at work all the lasses from where I work a couple of them like Jane she says hers was nothing, another one said hers was sort of like horrible you know they tell you everything.....

'I wouldn't know, it's what I've heard. I haven't been there. A few people have told me different stories. .. they didn't like being induced .. it's supposed to hurt when you get induced....

While Alex has a very different style of narrative than Robin both women constantly refer to stories or opinions they have heard from other people to illustrate their own case. When this group talk about their ideas and expectations they

typically refer back to various personal network sources and the phrase "I believe" is noticeably absent when compared to the NCT sample of women. {see sec. 3.7.}

Susan Ratcliffe a seventeen year old woman offers another example illustrating the importance of local social networks when talking about pregnacy and childbirth. Her story was laced with referrals to other people's experiences or views which she knew about.

'I take more notice of me mother, me mam .. says

"oh I did it this way which I found was better" she said "because I did one way with one and one way with the other and I found that way better." So bottle feeding, I didn't fancy breast feeding.

(Me) 'Why?'

'Da na it just seems easier in the bottle. But me gran she breast fed and she was saying that was better but me mam said

"No don't listen man, just you use the bottle." So I take more notice of me mam.

(Me) 'Have you spoken to your midwife much?'

'No not really, don't need to. See I'm all right about everything. .. whey there's a lot .. round here .. of younguns on the town, thats having kids. Thirteen years old and stuff like that well spoke to them and they say just take it as it comes. That's it so.....

(Me) 'Have you got any expectations about the birth?'

'Yer it's going to hurt. That's about it. I don't know really because labour can go on for quite a while can't it? I haven't never thought about it. ..'Me mam said she can't remember much, it's a pain that you forget she said she can't remember. People try to describe it but she said "I'm not going to bother trying to describe it because it 's something you can't describe."

'There again you've got me aunti she .. me mum's she's .. put a lot of weight on now she .. was dead skinny and things like that, dead little and I always thought that smaller people who are little have more trouble but then she's got a sister that's big and all that and she had to be cut and all sorts she had a lot of trouble. Been told that little boys though cause more trouble, but me mam doesn't know that cause she had five little girls.....

'I don't really want one of them epidurals. My aunti had an epidural with her son and she says she can't feel the lower half of her stomach. It took all the feeling away and things like that she says it's not very comfortable. And then she had gas and air with her second one and she says gas and air is the best with what she has experienced any way so I think I'll just go for that

'I've only started to think about what I want during the labour during these last couple of weeks anyway. I ask people I knew, the majority of peoples I know have had gas and air

anyway and they seemed all right so. Then again it mays not suit me that pain relief. I don't really know.

2.3. MEDICAL/PATHOLOGICAL MODEL

As with all the women I spoke to the medical/pathological interpretation of pregnancy and childbirth was very important in the ways the NHS women spoke about their experiences. However they used this model in quite a distinct manner - the medical/pathological was assumed to be safe. Since it was regularly used, its justification was never considered to be an issue. What official policy may or may not have been regarding pregnancy and childbirth was rarely considered to be worth comment. Medical knowledge was somehow considered out of these women's jurisdiction, it simply was the way it was and their own ideas and opinions stemmed from how friends and family had coped. While the medical message in various forms was adopted, the formation of that message from the medical institutions was virtually ignored. Even if the women had had bad experiences, or knew of friends who had unpleasant memories of ante natal or natal-care, this was rarely seen as evidence with which to challenge the medical/pathological interpretation of pregnancy and childbirth.

Rosy Carr, for example, a thirty-two year old sales assistant, told her tale in the form of a horror story but although she shows irritation at decisions made by medical staff she never follows this through to an open challenge of the pathological/medical model. She maintains the attitude that 'they' are the professionals and they know what they are doing, almost as if her experiences are not big enough to challenge the expertise of the professionals.

'And then like by half past eight, came in checked us round, 10 cm dilated. So they said they would leave us half an hour then check ya. They asked if I wanted to open me bowels, I said no no. And it was like that checked every hour for three hours and there was nothing and then they just said at the end when Mr Shaw came in that he examined me and said there's no way you are going to deliver, we are going to have to do a section and I just cried me eyes out. I'd gone through all that and then I had to go through a section which to me, because they said he was breech, I could have had in the first place. I thought to meself

"They could have saved me that because I'd said at the beginning I can't remember which midwife it was if I'd known I was going to have a planned section would I want to try a little labour first? I said no straight away. I said "No if I know I am going to have .. a section I'd rather come in and have a section and get it over with." And as it happened I had completely the opposite. I had to go through it and still have a section.

'But then again they had done an x-ray and the x-ray had said yes you are broad enough to deliver breach. I mean I saw the x-ray with Mr Floods and he had pointed out to us so I sort of believed him ... But then people have said before. I had a friend who had hers by section, she had the same. She had the x-ray and they told her that she was big enough to deliver breach and she ended up having a section. Why I think if you're breach and if you go back over records the amount of people who actually do deliver breach and you get the majority haven't I don't think they should let you try cause it's a long traumatic experience'

However during the same interview when talking about modern techniques of childbirth Rosy argued

'Oh I think it was good because if that wasn't there you could like go on for a week. .. if I wasn't induced like how long would I have had to wait? I mean I could have gone full term and then gone over me time but like say years ago if you had blood pressure did they have all these things to find out? .. would they just leave you? Would you be poorly? Is that how things happened? You don't know these things .. I'm all for epidural, I think it's a good thing because I'm soft with pain to start with and I said all along I wanted an epidural because I'd heard people who had gas and air and I didn't fancy that.

'I don't think there are so many risks these days because they've got so much going for them. If there's something wrong that's it. Well there was a girl in our room she came in for just a routine monitoring and she went in the monitor and the heart beat wasn't normal and she had a section the same day and she wasn't due for another three weeks. Well to me if she hadn't come in for the monitoring that baby may not have survived, it's the same with the blood pressure thing.'

Alex Manly who had previously stated that she did not wish to be cut told me in a post-natal interview:

'They had to cut me with him being so big .. they weren't going to cut .. she said towards the end they had to because he was so big. Cause I had heard people say the cut and the stitches are painful so I thought I'll make sure I'll ask and I did.

(Me): 'What would have happened if they hadn't cut you?'

'I probably would have split, I don't know. I wouldn't really like to say. It might have been all right, it might not. When they said they were going to cut me I thought "Oh God!" .. And then I says "Do you have to?"

She says "Why we will have to yes." I thought well they're the midwives they know what they are doing. I should just let them get on with it. As long as it didn't hurt me I wasn't bothered.'

2.4. RESISTANCE TO THE MEDICAL/PATHOLOGICAL MODEL

The above does not prove that these women accepted whatever they were told by medical professionals, obeying the authoritative message given out every time without resistance. On the contrary this group of women resisted medical staff opinions but their resistance was subtly different from that of the NCT group {see sec.3.5}.

The resistance and protests in the NHS group were made in a much less obvious way. The NHS women were not in the business of standing up and being counted for a cause of resistance. That was not their priority. Rather they protested in a very individual way, with no desire to form a pressure group or make an ideological statement. And very importantly the image used of the medical profession during these protests was not a homogeneous group image. The notion of all the medical staff being the same was abandoned and replaced by the concept of everyone being an individual. These reactions were aimed therefore not at the medical profession as a whole but at particular individuals to whom the women were objecting.

For example Tracy Cuthbert a twenty seven year old nurse who voices full support of medicalised childbirth on the one hand, tells of her resistance to one midwife who happened to irritate her during her labour:

> 'And then this other girl came and took over, she was ever so posh [I cringe!] and she was ever so sort of refined and she just, oh I don't know ..I didn't like her and I was getting annoyed but I was still .. in control, enough .. not to shout at her cause I thought "Patronising cow don't you tell me that, don't you tell me that." And every time this lass was leaving the room I was saying to Mark "Patronising cow who is she telling me that's what I should do. I bloody well will do that." But as soon as she comes back in I would like, you know what I mean. Oh it was awful and I kept saying even then "Just take it out and operate just pull it out. Get it out. That's what I want."
>
> She was saying "You don't want that Tracy, that's not what you want Tracy no."
>
> And I'm saying "Oh but it is."
>
> " No!"
>
> And I'm saying "It is!"
>
> "No! You don't want the pain afterwards."
>
> I was thinking "Silly cow" I was getting really annoyed with her.'

In the same vein Robin, someone who also voices her support for medicalised birth as a general concept, fought her own personal battle with a midwife she didn't like.

'They were all really really nice apart from the first midwife in the morning, I didn't like her cause she was horrid. She reminded me of Jo Fergurson off the telly off 'Prisoner Cell Block H' and I didn't like her at all. She was abrupt, it was unbelievable. "Yer well what have they sent you down here for?"

"I've had a show and I was a bit worried about it cause there was more blood than I thought."

"Oh don't be silly girl"

And I thought "Oh I don't like you." That was it, it just totally knocked me off. I didn't even want to talk to her when she asked us questions. No, I just ignored her I just didn't answer her questions. There wasn't a lot she could do really . she kept trying and I thought "No I'm not even going to talk to ya." It was one word answers and that was it. She was trying to be nice, I think she realised that she had hooked us and she was trying to be nice but by then it was too late.'

And Susan's struggle against the advice given to her by her midwife during labour actually involved a physical battle.

'I was like out and I woke up and I wanted to go to the toilet and she says "You can't go to the toilet."

And I said "I need to go to the toilet" and they wouldn't let us go to the toilet. And so I started getting mad, I was trying to get off the table. She says "If you get off the table you would have gone into labour {Would have delivered} and just had your baby on the floor"

And Mark was saying "No no you can't get off the table." And it was just all the panic and that. And I was saying "Let me out." I must have been pushing a long time and she goes "Right, lie on your back." That's when it was she goes there's the baby's head and she said "The baby's coming." She saying "Put your bum on the table." And I was just .. "your baby is coming"

And I was just "Oh it's coming."

'I was hollering, me legs and me bum were off the table and they were saying "Get down!" and trying to put me legs down. They told us I was in labour and I just didn't believe them "No I'm not in labour I want to go to the toilet" and they said I was trying. Eeh I really swore some and all I don't usually swear much .. They're saying "No she's coming"

And I'm saying "No I need to go to the toilet." It's an awful feeling that but it's like I say if she had told us it was like that, I would have known I was in labour. It was Mark cause Mark was pinning me down .. he'd got hold of me arms like that. I hate that, that being tied down .. and I heard I told him to get out. And the midwife said "Oh they always said that." I kept telling him to get out. It was awful, he said nothing.'

There appeared to be two ways of looking at the medical professions involved in childbirth in these cases and these seem to cut across each other. That is

provided the women talked about the medical profession as a faceless scientific service which always acted in the interests of both mother and baby, they told of how they were satisfied with the attention they had received indeed they frequently mention enjoying medical attention. The professionals in this case were beyond reproach.

But such a view by no means meant that these women would not protest at an individual if and when they felt it was appropriate. When a medical staff member, whether it was a midwife or obstertrician, was seen as an individual the women felt they had the right to resist and protests their decisions or advice. The two images sit happily side by side within the context of the account being told and the conviction of one did not weaken the strength of other.

2.5. HEALTH SERVICE AS A SOURCE OF INFORMATION

Although the women in this category all told their stories with frequent referrals to personal social networks as sources of information, guidance and support, when asked directly whether they managed to get much information from the health officials the answer was usually "Yes" particularly when talking about midwives.

Tracy:

> 'you talk to your midwife more, you ask them questions more. They are your source of information. I really got upset when they .. said to us this baby is really big and you are going to have come for a scan. I think it was just the way they mumbled and said "Oh it's too big." I was thinking "Oh what do they mean by that how big is big?" And this is after I got back in the car you see. It was too late to ask questions. I'd been a bit stunned. I'd thought "God!" So I got back in the car and I thought all these questions and sat at home for a couple of days and in the end I thought "This is stupid I'm a nurse here. Fancy not going and asking." So I went up and asked her I just said "Can I come up?" and sat and had a chat and really that is the role they should be used as. But whether other people would use them or not but they're there for it. And when you're feeling sick and your sickness is finishing and you're getting tired and you're getting funny aches and pains and things. As soon as they mention "Well that's nothing to worry about, that's because of this." Well that's finished with isn't it? You put that to the back of your mind. Like an information centre really, reassurance and they are always on the other end of the phone.'

Here Tracy is using the homogeneous group image to describe the midwife and her role in caring for pregnant women. She is portraying herself as an assertive customer who is confident in taking up the services offered to her by this group of experts. However this homogeneous image wavers a little when she talks

about her feelings about doctors and she therefore slips into descriptions which identify individuals rather than the group as a whole. When describing her consultant for example, she does not talk in terms of being able to talk to him. Rather she refers to the skills and knowledge he has as an individual.

'I think you would talk to a midwife more, if you had female doctors it might be a little bit different. But I like the consultant, he was really helpful. He was relaxed and you could put your sort of faith in him. .. You think "Oh yeah he knows what he's talking about." .. the others were all right really .. I saw Mr Grant mostly. Well one of the junior doctors was a lady doctor and she was really nice and .. it was nicer to have a lady doctor when they were doing all these awful things to you.'

Rosy told me how she also was an assertive type of woman who had the confidence to use the medical profession as a major source of information:

'Yes. I'm the type that will ask you see. I'll not sit back and just let them talk about me or when they've finished their little conversation I'll ask them my questions that I want to know so I make sure I find out. I wouldn't say that I was armed with questions but if there was anything I thought I should know that they talked about me I would ask. Because I mean there is a few things that was obvious that are medical, that I don't understand. I'd ask the midwife what were they on about there, you know and if she could she would tell me.'

Although the majority of the women in this sample suggested that they used the medical profession as a reliable source of information and guidance it was not the case for all the women all the time. Robin said:

'Whereas Dr Perry I don't think I could have talked back to him. I would have just like laid there and listened. I wouldn't have asked anything. I wouldn't have said anything. It made us feel nervous because I wanted to ask things but I just felt as if I couldn't. I'd never met him before, I mean he was nice enough they all were but you just pick somebody that you really really like and that is so.'

And Susan described her community midwife as unapproachable:

'Whey no. Sometimes she can make comments just to make you laugh and that but otherwise na. No, why you just get leaflets, I've never been told nothing. Why you've got to tell them. They ask you if you've got anything wrong and if you've got any questions but apart from that no. No I've had none. I either ask me mam or I go from the book see what's that. [by the book she refers to the free Health Education Authority booklet she received from her community midwife.]

'She never really, she never really talked like that though not really .. she like just said

"Read these leaflets and go by what these leaflets say." That's all she's really said. Never really had a chance to sit down and talk to her. .. don't need to. See I'm all right about everything.'

2.6. LAISSEZ-FAIRE/UNPREDICTABILITY

By using local social networks as a major source of practical guidance and support these women formed opinions which were based upon a varied and complex interweave of impressions. There was an overall theme of unpredictability. Because they had heard many accounts of pregnancy and childbirth there was a tendency to adopt a laissez-faire attitude - "What will happen will happen there is nothing I can do about it anyway."

Alex explained why she never thought ante-natal classes were of any importance:

'I didn't go to any ante natal classes though, I just didn't want to go. .. why I thought it would come naturally and it did. Ah yes everybody told me different like it was a different story every time, just wait and did it meself.....

'I just went in and expected what came. I just did what my body tells us to do.'

And Susan described ante-natal classes in a similar way:

'They have them classes as well. She is trying to get me to go to those .. me midwife. I say nought. People got different methods, that's the trouble, one saying one, one saying the other. .. when it comes along I'll just find out for meself.....

'Me mam she said you can't desribe it any more because all of them are different. She said even with her fifth one she was a bit on the nervous side. You still don't know what is going to happen. Eeeh a little bit it worries us. The midwife said all the people that go to these breathing things as well, well they don't really use them when they go in there anyway. So she really doesn't think they're sort of any .. use anyway.

'I never thought all them classes and that would be any use. I really don't think they do all that breathing exercises and I think you just you just get on with it. I think everything goes out of your head.'

Since childbirth was so unpredictable and everybody they knew had experienced it differently preparation classes were seen as futile, a waste of time because there was no format for how the experience was going to affect you personally. Therefore when talking about preparation for birth Robin told me:

'No there's nothing you can do because you just don't know what is going to happen. I mean I didn't know that was going to happen. There's nothing can prepare you for them saying to ya "Sorry but we are going to have to take you down for a section." No way.

'And I wasn't expecting to have an epidural so I could never have prepared for it could I? I went for that at the last moment. It just went clean out the window everything. Well it was probably right because Allison me friend she'd had two epidurals and she said it was the best thing since sliced bread and it was because I didn't feel a thing.'

2.7. CHILD-CENTRED EXPERIENCES

This laissez-faire attitude was an over-riding indication of the way these women viewed their experiences. The NHS women talked about their pregnancies in a some what baby-centred fashion. The end product was not the birth but the baby itself. The birth was an unpleasant part of the process of pregnancy and was not particularly an event in itself.

When asked about expectations of pregnancy Susan replied:

'Oh yer I've always wondered what it would be like. I just used to imagine ourselves "Oh what would it be like pushing a pram about" .. you see all your mates. Like me best friend she had a baby it's about a year now. And ya think "Ahhhh must be brilliant, must be brilliant" and she used to put on an act on for yer"Yerr it's dead good!" and that.
Then she used to go "Shaaa I can't go out anywhere. I've got to find a baby sitter." But on the other side it looks fun.'

Later when talking about birth coverage on the television she said:

'I watched that, there was a programme on called 'Baby Monthly', I watched 'Special Babies'. Just when they are going through the labour and I think "Oh my God! Oh no!"
Then you all get broody and can't wait and things like that. I thought 'Baby Monthly' was good. It was where I think it was four people and the babies were about four months old. They showed you the sleepless nights and things like that. Then they started trying all these different methods and .. there was one woman where the baby was older. She was trying to find a child minder and the baby was a couple of months old and she couldn't find one and that was hard work. They had this other woman, .. she .. kept getting up in the middle of the night and she kept switching the camera on. "It's twenty five past two and I think I will kill myself." That sort of thing. Then you try putting her in a dark room, go into the kitchen and scream at the wall and after she did that the baby went to sleep...'

When talking about her pregnancy experiences Rosy said:

'Well it wasn't very nice I must admit. But once we got over that I started to think about the pregnancy. Maybe's about Christmas time, after Christmas I started to buy things and look at things for the baby. 'Cause before that I just wasn't really interested in being pregnant.'

Although the questions I asked Rosy were aimed specifically at her experience of the pregnancy and childbirth her responses, centred directly on the baby itself. For Rosy thinking about being pregnant meant visualising the baby - the birth and preparation for it were not her priorities.

2.8. CONCLUSION:

All the above examples, I think, carry an implicit but ever-present flavour which characterises the way this group of women talked about their pregnancy and childbirth experiences. That is they all talked in very personal individual terms. The sources of practical guidance and support came from existing, local social networks based upon established, personal relationships. The way they reacted to medical staff again was done on a very individual level.

They rarely spoke in terms of *big answers* - believing in a fixed ideology one way or the other. There was a certain tone of humility in the way they told their stories, what was to be was to be and they had little control over that sort of inevitable destiny. They all seemed to have an irresistible desire to have their experiences culturally manipulated in a medical/pathological way and they were content to hand over the responsibility for this manipulation to the professionals who were in the know. This was done even when the women talked about not respecting or obeying medical staff and their advice, since this type of resistance was always done on a very individualistic basis and therefore did not threaten the women's trust in the medical profession as such.

Having explored the way this half of my sample talked about their experiences I will go on to compare this with the data I collected from my other sample of NCT women.

CHAPTER THREE

The NCT Group

3.1. INTRODUCTION

This group of women came from roughly the same geographical area as those I have introduced in my last chapter. However, I met them through a different source of contact. All these women attended NCT ante-natal classes for which they had to pay and had to arrange a long time in advance. The NCT has a closed number system, that is these classes only admit a limited number of people after which applicants are turned away. It was through these classes that I contacted them. Footnote 1.

In this chapter I will follow the same format as the last in that I have chosen various themes which cropped up again and again and therefore seemed to be important to this particular group of women. I will allow the women themselves to tell their own stories using straight transcripts, which were taken from recordings of the interviews, and I will be examining these against the ideas already stressed by the NHS group in the previous chapter.

In the final part of this chapter I will compare the ways two groups of women talked about their experiences of pregnancy and childbirth, looking at the similarities and exploring how certain patterns immerged in both groups of women despite the differences between the two.

3.2. NCT CLASSES:

All of this group of women considered, at some time during their experience, that NCT ante-natal classes were invaluable to them. The reasons for this appear to be two fold: Firstly the NCT was recognised as having a very specific message and this message was said to allow for an **informed choice** and Secondly the

classes offered a support group, an instant sense of community or `we're all in the same boat` type of atmosphere which appeared to be important to all the women.

Sarah Button a thirty-eight year old nurse talked about the NCT message suggesting that it is too dogmatic although she still found going to the classes invaluable:

> 'I .. think the NCT does a good job but sometimes I think they over do it. Particularly on the .. natural part of childbirth.
>
> 'It was actually anti hospital really. I didn't dare say I was a nurse. It was this blanket theory that .. all obstetricians and all midwives were .. didn't make it your own personal experience.
>
> 'It was good by giving us the facts really. .. respond to being told what to do in hospital. .. ask why people want to do what they do to you. Question yer that's it they give you confidence to question. It certainly .. Alex definitely. I put down that I didn't want my membranes ruptured and at 8 cm without asking the midwife attacked me with an amic hook to sort of. Without asking you see, I was so gone on the pethidine that I thought "Oh well if she wants to do it." I was just gone! But it was Alex who said "We don't want that, we don't want that done." .. so then I came to my senses and she said "Well what do you think?" and I said "Well I'm not really coping very well with the pain. If you rupture my membranes I'm, it's going to make it worse." And she said "Well that's all that's holding you up" and I thought "Bloody hell I've gone" I went in at half past five and was four cm and at quarter to eleven I was fully dilated so I .. I thought "Well I've hardly been slow progress up to now and to rupture membranes is not going to help, it's going to make me go bananas basically." So she respected that but it would have been very easy to lapse into it. It certainly makes you more assertive the classes.'

Here Sarah talks about a narrowness in the message propagated by the NCT classes. However she feels that this strong approach to preparation for childbirth helped her and her husband carry out their birth plan. It was very important to Sarah and Alex to work out how the birth experience was going to go before the event in terms of artificial rupturing of the membranes and Sarah suggests that by attending the NCT classes they were able to resist the decision made by the midwife and therefore stick to their previously negotiated plan. Sarah went on to talk about the other important aspect of NCT classes, the social support:

> 'I made quite a few friends through the NCT .. I think you're more like minded .. in the NCT group and I think that you can make .. because you are like minded, closer friends and more friends.'

Alison Dawson a thirty year old also expressed the importance of having a support group of like minded people which the NCT classes provided for her.

> 'With the NCT people go with fairly similar points of view. Usually educated, middle class and not asking when can I have drugs! Will an epidural cut out all sensation? Can I be knocked out completely? But I think there's more range allowed in the NCT, they're more accepting of things that are different. One poor girl said she had every drug that was going. You know
>
> "I thought I'd be fine, when we got oh no! give me the pethidine now!" and it worked with her and it was great. You know everybody was just glad that she had had this little girl and that she was happy with that.
>
> 'The NCT are much more pro home birth.... And a certain lady is doing that'

Alison described the NCT group as being a strong force with an ability to offer unified support. While she believed its approach was flexible the way she told the story about the 'girl' was somehow apologetic, as if that was okay but not particularly desirable, therefore suggesting the same `natural birthing` message implied by Sarah. It is interesting to note that when Alison mentioned one woman having a home confinement she was referred to as a 'lady' and not a 'girl'.

Alison later expanded on the importance of the NCT classes for her, saying:

> 'My ideas have been reinforced in the NCT classes. It all made sense. There were good reasons for the pains you would experience. And so long as you do that then that's fine. I would say you need to know about it. The NCT groups are very very supportive and I think the other thing that you feel is that they think I can cope with things. They know I'm a human being you are all right you know .. which I don't think the NHS has time or the resources to give you. NCT is social and supportive and informative as well.'

Alison showed clearly that she went to the NCT seeking confirmation of her ideas about childbirth. She knew she would find in these classes a group of people able to reflect the issues she held as important. Group recognition and support were very important elements in attending the NCT classes.

Footnote 2.

Cathy Brooke who is thirty years old and works in publishing also described the NCT classes using similar ideas as those above. She said

'One of the most interesting and beneficial things I've got out of these NCT classes is .. reassurance .. Because .. although I've seen women give birth. I heard loads of experiences of giving birth and .. I know the sort of physiological changes that you go through .. the teacher is actually very good at allaying some of your fears...

'And that's done a lot to allay my anxiety to how I will cope with the pain.

'I've read .. the NCT book .. and I thought what a good book. .. it's not at all patronising and it isn't prescriptive. And I thought .. this is extremely sensible, it's written for grown ups. And I thought well if that's written for grown ups .. the chances are the classes will be for sort of like older women as well.'

While Cathy was not so interested in group support in the same way as Alison, it was important for her to be reassured. She went to the classes carrying ideas about childbirth with her and was relieved when the teacher encouraged these ideas and added to them. In other words she felt respected.

These examples illustrate the type of things these women got out of their NCT classes. Almost in direct opposition to the laissez-faire attitude of the NHS group these women went out of their way to formulate their convictions on how childbirth should go. They wanted to be at the centre of the cultural manipulation of the experience and felt that they should be suitably armed to do that. The NCT ante-natal classes provided the ammunition.

3.3. UNPREDICTABILITY

Set against this was the polar realisation of the unpredictability of childbirth and these diametically opposite elements appeared `juxtaposed`, in the stories these women told me. Unlike the NHS group the acceptance of the idea that childbirth is ultimately uncontrollable did not lead to a 'what will be will be attitude'. On the contrary loss of control to unpredictability was if anything to be guarded against, but just in case this failed there was always a back up policy of flexibility on some issues. The issues that were chosen seemed to be arbitrary but this flexibility was hoped to soak up any unpredictable element not accounted for in ante-natal planning.

Thus although Cathy was adamant about some issues regarding the plan of her forthcoming birth she told me:

'I haven't got a written birth plan but I've got .. I've got in my head about the way I would like things to go. .. it's been there for a quite a long time so it's not one .. and also I think that again you have to be flexible. So although it's in my head it's not sort of written, it's not carved in tablets of stone. And also Adrian is aware .. we've discussed it and he's aware what I want and what I don't want .. I mean I don't actually think this will happen but suppose the midwife started doing all the, I mean I don't think for a moment she would do this, but if she starts doing this cheer leading you know push! push! push! push! .. he'll tell her to shut up .. he'll tell her to shut up in no uncertain terms '

This clearly shows the paradox that Cathy and the other NCT women were struggling with. However this potential contradiction did not seem to pose any threat to their ante-natal preparation and therefore did not challenge the beliefs they held about how childbirth should be carried out. They would do their best and at all times endeavour to remain at the centre of control over their experiences and that was enough. The NCT ante natal classes helped them to do that.

Alison told me :

'In my first stage which I hope to do at home, I will be moving around probably. .. and concentrating. .. it's .. painful but it's not unpleasant. And you feel quite clever and quite "I'm doing this." So yes I should imagine I will just tootle about really.

'I would feel guilty if I did it with drugs because of the dopey effects on the kid. And I don't really want to be spaced out so that I don't know what is going on. I had a friend who tried to get her husband into bed, she was so out of it they had to say "No dear you're having a baby." So yes I would rather be in control and not lose too much dignity...

'The only thing is then is that I don't want to be induced. I wouldn't like to say "Yes I would definitely do this or that." Just to be left alone. For me .. it's more important to be given my own space'

On the one hand Alison wanted to be open-ended about her plans for childbirth but on the other she had some very prescriptive ideas.

Trisha Peal a thirty three year old Graphic Designer stated:

'And a girl actually in the NCT who seemed to be fit and healthy had quite a long labour. So I'm I don't necessarily think that people who are fit .. have a harder time. Particularly I realised that recently .. the way there are so many possibilities about what can happen. Nobody can predict your birth so it doesn't matter what anyone tells you about it, it could be

wrong. You don't have to listen to anybody you know. You can just take it your own way. I think what I want to do is get my mind round it. Feel as much in control as I can feel and .. not be frightened.

'By realising what's happening to me when it begins to happen .. timing contractions and sitting down and relaxing and being aware of it not trying to ignore it. Doing things that I have been advised to do.'

It appeared tp be the very unpredictable nature of childbirth, which for Trisha, would enable her to take the control she desired. This she hopes will be achieved by following various advice procedures.

3.4. THE MEDICAL/PATHOLOGICAL MODEL:

All the women in this group accepted the medical/pathological model of pregnancy and childbirth if not consistently then intermittently during their experiences.

Helen Baker a thirty two year old Chartered Accountant told me:

'Well I think the more natural the better. Women were designed to have babies. All over the world women are having babies and having them fairly easily. It's just this developed western society that has brought more and more intervention. Particularly when you hear in America the Caesarean rate is everso high and it's because the doctors are frightened of being sued in case anything goes wrong, so just in case they do a caesarean. So my idea is if you stay as natural as possible you always put the safety of the baby and yourself first. So .. in stages, as little as possible I mean pain relief. There again if I could manage with nothing I would and then there's the TNS machine and then gas and air and then get on to the drugs if necessary. Having said that I wouldn't have a home birth because I would like to be there where there is the equipment necessary. Then if it did happen that I did need that back up then everything I needed would be right there.'

Despite a strong belief in 'natural' childbirth and a conviction that this is somehow in opposition to the cultural manipulation of childbirth carried out in the hospital setting in our country, Helen still found the medical/pathological interpretation of childbirth irresistible; but she managed to place both her convictions side by side without any difficulty.

Gabby Mason a thirty two year old Physio Therapist told me about her on going struggles with her Consultant at the hospital. She said:

'I then went to the hospital to the post graduate centre and I photocopied various articles which have been very helpful actually in speaking to my consultant. A lot of my sources of information are therefore quite technical. .. and come about through my own studies. In compiling the plan where I thought ideas might be contentious I referenced them .. so that if he was interested, and I didn't think for one moment he would be, he could actually see that I wasn't making this up and that it wasn't anecdotal .. that I had sound reasons for offering this as the case. So I very much wanted to present a research-based birth plan because I felt that was arguing in my favour, which he couldn't really if he was a thinking obstetrician wanting to keep up to date and to indicate .. agreement with the Winterton report and 'Changing childbirth' {Footnote 3}. He couldn't really argue against it'

Although Gabby is telling a story about resisting the medical/pathological model of childbirth in that she is describing a confrontation she had with her Consultant, the ammunition she is using against him comes directly from the medical/pathological model. She is playing him at his own game.

This is the case for several of the other women I spoke to and indeed for the information given out by the NCT. Rather than challenging the medical/pathological model these women wish to have informed choice. This informed condition means knowing and using in your favour the medical/pathological interpretation of childbirth, both groups the NCT women and the hospital staff are therefore moving in the same direction with the underlying assumption that childbirth is ultimately a potentially pathological process.

3.5. RESISTANCE TO THE MEDICAL/PATHOLOGICAL MODEL.

The women went to the NCT classes to be informed. They did not want to experience childbirth in the darkness of ignorance. They were not happy to hand over responsibility to the medical professionals, although they did not reject this entirely. Instead they wanted and expected to be part of the authoritative knowledge which surrounds childbirth in our country. Doctors and midwives were not going to have the monopoly on decision-making. The NCT group wanted to be included. They resisted the medical/pathological model therefore not just on the personal level like the NHS group but as a homogeneous authoritative group of professionals.

Gabby told me:

'The NCT are wanting to ensure that women are informed and what ever decision they make that's fine with them as long as it's been an informed decision....I sense a much more working together and an informing and an empowering.'

The NCT provide women with the medical/pathological knowledge necessary for informed choice. The women wanted to be empowered against the medical profession so that they did not passively submit to medical decision without understanding the rationale and intricacies behind these decisions.

Trisha explained:

'I want to know what my options are. I feel that I know now and that's where the NCT has come in'

And Cathy argued:

'Well I see the NCT like .. a lobbying group for what women want and I see the NCT is a vocal and sometimes extremely unpopular group of people who are .. lobbying for change. I think I mean even .. policy change and thinking ....

'I think that women are actually very bad at challenging the status quo because we are not taught to do it and you get labelled as a trouble maker. And you get labelled as someone who is gobby and .. that's not the case you are simply trying to find out in order to .. assimilate some kind of view point and that's where the NCT helps.....

'They do take quite a .. strict line.. And I think probably quite a lot of that comes from the teacher. .. But .. they do inform you so that you can make a sensible choice and I'm quite used to being told the absolute worst scenario and absorbing all that information and then thinking my way through it. But I think some of the women .. go back more terrified than when they came in. .. I like to know all the facts so that I can assimilate them and then make my own decision'

Although this empowerment is an underlying theme with all the NCT women to whom I spoke the degree to which they take up this challenge as a crusade to improve their own childbirth experience and childbirth of the future is variable. While some see it as their duty to promote the empowered woman cause others are not so adamant. Trisha told me:

' I heard .. in the NCT classes .. somebody had the experience where they said

"Oh! You've written Oh! you've been to the NCT Oh you've written this well we won't give you any pethidine then if you don't want it!" Said it like that, which I think is a bit petty

really. Extremely petty really and I wouldn't write across the top of my birth plan that I have been to the NCT. Cause it doesn't stand for natural childbirth you know.'

Trisha seems to be aware of the crusade associated with NCT membership but resents being labelled too firmly as one of the cause.

3.6. HEALTH SERVICE AS A SOURCE OF INFORMATION:

How the Health Service was used and whether the information given out was considered to be useful or forthcoming depended largely on one crucial factor: whether or not the women felt supported by their Health Service workers. This presented an interesting dichotomy which cut across the information given by midwives and doctors.

Gabby tells of her experences with the Health Service thus:

'Before we embarked on this pregnancy I went to see the midwife at the surgery for a kind of pre-conceptual visit because I wanted to find out what her views on home confinement were and had she not been in agreement then I would have registered elsewhere. .. but she was, she was very, very positive about it. I found her very useful and helpful on that visit but she's been on long term sick leave for practically all of my pregnancy....

'Going along to the surgery the first thing they do is one of the receptionists does the weighing and the urinalysis which I find difficult because.. I see that as part of a midwife's role and I'm very worried about the eroding of the role of the midwife. I see that any delegation of her function really is watering down and diluting and how can midwives as professionals really expect to see their cause furthered while allowing these little erosions locally....

'the midwife then does your blood pressure and I find initially that I had to ask for the information. What is my blood pressure? How is it doing? I didn't find them keen to volunteer....

'I found the information .. conflicting from the midwives. .. dietary information. I intend to breast feed and I was asking .. what kind of diet will I need to maintain good milk supply and their advice was more the eat lots of chocolate, move on to butter and drink full fat milk. .. where as I made an appointment to see the dietitian and the advice she gave was totally different. And that disturbed me that professional midwives weren't actually giving relevant information.'

Gabby was disappointed not to get the midwife whom she had arranged to see. This midwife, she felt, had been very supportive and the standins were just not as reliable. By visiting the dietitian Gabby put herself in the centre of the debate about

breast-feeding advice, pushing her opinion justifiably so she believed into the authoritative knowledge offered by the professionals. She was not prepared to accept their advice and was confident that she knew better.

A similar scenario arose with the consultant:

'I find every visit with the consultant to be confrontational .. and really as far as I'm concerned a waste of time. .. I go to the clinic, I sit there .. They .. would have insisted on weighing me. .. I query the research behind weighing in pregnancy and what they are trying to achieve. .. blood pressure is taken, well that's OK. I don't have a problem with blood pressure so I know that that's something that needs to be.... He doesn't tell me anything I don't already know basically. I can see that my stomach is growing, he never listens into the baby and we always have .. discussions about method of management. So I always find the hospital visits really quite traumatic.'

However later on during her actual labour Gabby found the advice of an attending obstetrician very reassuring.

'I think it's fairer to say that I felt that I relied on the obstetrician because she was ..the .. continuous link bearing in mind there was a shift change over...It was her the obstetrician that I really felt that I relied on totally... .. she was there all the time. She'd been involved in all the decisions, right from the ante natal clinic and the decision to induce labour and .. she read my birth plan and she knew what I was after and I felt that she was on my wave .. length and that I was on her wave length and that we understood each other.'

The interesting difference between these examples and those cited in the previous chapter is that the patterns seem to be reversed. In Chapter Two I showed examples of the NHS women putting up resistance to the medical advice offered to them and argued that this resistance was done very much on a personal basis. With the NCT group however rejection of Health Service advice rested upon the medical profession as a whole. Health professionals were seen as a homogeneous group, they were rejected as a whole, as an institution which treated people like a 'cattle market'. It was only when the staff members were seen as individuals outside of this encompassing group, who were on the same side as the women, that the women decided to trust them and the advice they gave.

When talking about the NHS generally Alison said:

'I don't think I like joining the ante natal cattle market really. I think I find that very difficult, to be herded because it does take away some sort of self and it takes away the sense that your

pregnancy is important at all. You know it's just one process, millions of people under a routine. I mean the examinations they're intrusive and they are really not worth doing. .. They are more trouble than they are worth.

"Just leave well alone. I've had enough of being squashed endlessly, pummelled." I don't think anything attracts me to a hospital birth.'

But when she told me about her individual midwife whom she knew as a person the story was quite different:

'The midwife I'm supposed to be under is lovely. I really liked her and felt I could rely on the things she told me. But she had an operation on her knee so I've only seen her twice. In practice continuity of care is never going to happen, but it would be nice. But because of that I think I don't rely on the midwife at all. They are a hassle factor. If you did build up a relationship it would make the whole process less anxiety ridden.'

Cathy sums it up when she compared the personal home service she had managed to get with the impersonal usual NHS service available to most women:

'The priorities of the medical profession have been I think to make life as easy as possible for themselves. .. and to .. herd you all in like cattle, make sure you all have the babes properly and then herd you out again. You know the other side and actually bugger what you feel or what you would experience.....

'I think continuity of care is very important. I also think it's very important to get on with your midwife and it's vital and Mary has been very, very good. She .. comes round and has a cup of tea, tells you about her family for about half an hour and then says "Oh well I suppose we'd better get on with it." Do you know what I mean? She's incredibly efficient but she sort of disguises her efficiency in a very informal way. She was a brilliant source of information. She always brought something with her...

'People {at the NCT classes} have been asking me "What kind of ante natal care have you had?" Well I've said "Oh she comes round on Saturday morning, we have a cup of tea." And they find out they didn't have to wait three hours in line to have a grim examination and be told .. that they were going to the loo every two minutes or what ever. The midwife would say "Oh well that's going to get a lot worse." Grim fatalism and .. I think the comparison between the kind of care I've been getting and my expectations and .. their expectation and the care that they've received is actually quite big and getting bigger all the time and they can see this gap opening up.'

3.7. THE TYPE OF PERSON:

As Alison has already said the NCT classes do appear to attract a certain type of person. In my sample this certainly seemed to be the case. All the

women I spoke to in this group came either from professional families, with parents' occupations ranging from teachers and university lecturers to army officers and surveyors. In the minority of cases where family connections were not of this type, the women themselves and their partners were in this white collar category of employment.

They were women who were not afraid to have an opinion and were used to that opinion being heard. The NCT classes provided them with the opportunity to strengthen and verify their opinions giving them the support they wanted to make a stand against any medical practices they may have seen as unnecessary. As Gabby said, it allowed them to feel empowered.

I was frequently told that the women already had ideas about childbirth before they attended the classes and these were reinforced and justified by the NCT message.

Helen said:

'The main idea is that I will be in hospital for as short as time as possible. .. secondly is that if at all possible I would like Janice there to deliver and nobody else. The third one is .. in the stage of pain relief, I would like to keep it at as lowa level as possible. I will start with the TNS machine if that's not, then I will go onto the gas and air and if that's not working I would consider to go on to pethidine. I think it's just something in me, it's the way I do everything. I don't like medication. I don't take medication unless I'm really ill. The birth plan remains consistent. I knew from fairly early on and from all I had read and all the ante natal classes and things I went to just confirmed that was still what I wanted to do.

'I'm quite a believer in mother's instinct as well. That I think .. your own body, .. particularly having gone to classes and read the literature, you know what to expect within certain bounds and if it went beyond that.'

What came first was Helen's beliefs and the classes etc. simply confirmed and filled in these beliefs.

Cathy told me in a similar vein:

'Well the thought .. behind having a home birth I suppose are two fold. One is that I have .. a fundamental belief that pregnant women are not ill. Therefore hospital is possibly the worst place for them....I'm not ill, I'm not suffering from sort of heart complaints. It probably comes from the fact that .. I can be really suffering and I won't take two paracetomol .. and I think that there's an awful lot of hypochondria actually in the world. And also there is this

kind of thought that .. all pregnant women would go into hospital and .. it's very interventionist when .. you're pregnant.....

'Because it's a perfectly natural process .. people get pregnant every day. People have babies every day. So why is it treated .. as an illness. So there's that also I hate being ill. I absolutely hate it. I hate sort of succumbing to illness. Also the other thing is that .. I wanted .. complete control or as much control over this as I can possibly get, mainly because .. I don't like losing control over something which I consider to be mine....

'And .. and I'm somebody that's used to having a high degree of control anyway .. and I think that .. will help me cope much better mentally with the pain.....

'Yet my ideas have developed quite a lot since I went to the NCT classes. Again it's this thing about more information. Cause although you .. do get a lot of information from this book{NCT book} it's one thing to read it and it's another thing to have somebody tell you about it. The two things have to go .. hand in hand .. otherwise you know it can becomes a bit academic really...

'they've been very .. useful. They are good I mean I think they are good but that's probably because they are in some sense preaching to the converted if you see what I mean. .. I've had these thoughts before hand and although they were kind of half formed they reinforced what I thought rather than presented things that were fresh, which is part of the reason I didn't go to the NHS classes.'

3.8. THE SIMILARITIES:

The irony of my data is that, despite the diversity between the ways these two groups of women see themselves and tell their stories, there are some interesting similarities in their experiences. For example all the women, bar one {perhaps significantly from the NCT group} gave birth in the conventional position, that is for a vaginal delivery they all adopted the semi reclining position. There is extensive evidence to suggest that this position reduces the pelvic outlet and works physiologically against the pull of the muscle contractions *{eg Caldeyro 1960, caldeyro 1979, Flynn 1978, Gardosi, 1989, Lui 1974, Mitie 1974, Scott & Kerr, Stewart 1981, Russell 1969}*. However all the women relied ultimately on the advice given to them by their medical attendants.

For example although two of the NCT women questioned this position when it came to pushing they both complied to the will of their attendants and adopted it.

Trisha said:

'That was something which I did try to question at the time but then I trusted her with what she was saying. .. I was .. I think they had one leg each actually. I think they had hold of one leg each and .. so I was off on my bum with my legs sort of up in the air .. And I was thinking surely this is going down to come up .. and I tried, .. she let me . I said I wanted her to turn me over and I was sort of leaned over the back of the bed on my knees but I didn't feel stable, .. I didn't feel comfortable at all like that. I felt quite insecure and I was quite happy to turn back round and be back in, I wasn't lying down I was sort of .. semi reclined, but .. the midwife wanted me like that I think. .. but .. I didn't question it we just got on with it. .. I was a bit surprised because you read in the books people used to give birth lying flat really .. and that's when it's more sort of pushing down to come up. .. I think I .. did say to her "Is this a good position, is this right? Am I not working hard against the bed?".. but she said "No this is right you're doing really well." sort of thing. I seem to remember thinking "Oh well she seems to know what she is talking about"....

'he was saying (Trisha's husband) "Feel the head!" .. and he wanted me to take my hand off the bed but I was pushing myself off the bed to take the pressure off where I didn't want it. I was using my arms and I didn't dare let go which was a shame I didn't particularly want to feel it but I would have liked to have seen it.'

Trisha was clinging on to the bed to make herself feel stable and lifting her body weight off her sacrum {thereby increasing her pelvic outlet}. She was not particularly at ease in the semi reclining position her midwife had advised.

Sarah unfortunately was not so satisfied with her experience which again concluded with her adopting the position she was advised to adopt by her midwife.

'I wanted to adopt different positions for whatever I felt like at the time....I remember me sort of hanging over the back of the bed which was comfortable.....I think part of .. me was thinking "No it's too quick!" so this is when I thought I was going to have my bowels open and .. Adrian went to get a bed pan and I could hear her saying "Oh she probably wants to push" and I was thinking "No I don't want to push." Then of course she came in and I wanted to push. And I think that was the most disappointing thing was pushing in the semi-upright position. .. sort of sitting I just wasn't comfortable. I just really felt like I wasn't pushing at all well. And she would not let me get into another position. I was so angry.

(Me) Did you ask her why she wouldn't let move into another position?

'I didn't ask there, I don't think, there wasn't a reason .. because we had had this conversation when she wanted to rupture my membranes:

"Are you worried about the baby's condition? Is this why you wanted to rupture my membranes?". No she wasn't worried at all about her condition. .. So I don't know I never asked why she was just "No! No! No! No!" I had been so comfortable slopped over the side of the bed I think I wanted to be on the floor .. so you can move your bum about .. I just felt that I could have moved me bottom about and dealt with the pain .....

I was so cross with her .. in the end that I .. actually said "Is there anybody else in labour ward?" she said "No" and I said "Good!" and I just screamed just because I was so cross'

All the women delivered their babies within the hospital setting using at least one form of medical intervention. Footnote 4. The way both groups of women responded to the medical staff within the hospital setting during their actual labour and delivery was again very similar.

For example both Alex, (NHS), and Gabby, (NCT), had an ambulance to take them to hospital. Alex explained as follows:

'Any way so at first when I went in they wanted me to lay down the ambulance people when they came they said to us like "You can go out on a stretcher." I says "No I'll walk out."

'But when I got to the hospital I had to go on a stretcher otherwise they get wrong because of infection and anything thing else that can happen. Which was really for my safety that's the way they saw it so I wasn't going to complain either. They was the midwives I .. did as I was told. So basically I trusted their advice.'

Whereas for a very similar event Cathy has a very different story:

'It was just amazing and of course when I went out it was really light .. it was as light as it is now and the ambulance men came and I was still .. having contractions about every two minutes but they weren't lasting very long at all. .. the ambulance men tried to .. carry me down in the wheel chair. I barked at them! I said "Get rid of that wheel chair." I said "I am going to walk out of this house on my own two feet." .. anyway the midwife said "Oh just let her." So I walked down the stairs, walked out of the kitchen, walked into the ambulance.'

Although the two accounts tell very different stories the two women actually behaved similarly. They both declined the offer of being carried into the ambulance from their home but Cathy interpreted what she did as a direct resistance to the medical/pathological interpretation of childbirth, almost as if she were making some kind of political statement.

There was not a uniform behaviour pattern but on the day, there was little distinction in the various reactions of the two groups of women in the face of the authority of the medical/pathological interpretation of pregnancy and childbirth. The capacity to trust and rely upon the professionals as knowers manifested itself as a need in all the women.

Tracy, an NHS woman, told me:

'This sister come in and said "I think you should go on the bed" and I'm saying "No I'm not going on the bed." And she saying "Tracy on the bed!" And as soon as she'd said that you see. that's what I'd needed .. somebody to say "No messing on the bed now!" And I got up on the bed and I had to.'

She took on the sick role and handed full responsibility over to her medical attendant.

Gabby an NCT woman told me of a similar incident in her experience:

'I was thinking "Right this is over to them. This is their you know their area. I've done what I can do I can't influence her position and I should be guided by them and if they said it takes theatre it's supposed to be theatre, then theatre it would be. And if it takes a Caesarean then it takes a Caesarean." I had the confidence in them and I can remember it said "Do what ever it takes you to do" and I genuinely meant that. It wasn't .. I'm abdicating all responsibility, it's a case of .. I can't do any more it's over to you now.'

And a transcript of a part of her labour goes as follows:

Dr: 1. 'Can you let your legs drop otherwise you will get cramp. I'm sure you know the ropes but sometimes you have to be reminded.'

Gabby: 'I'm a mother now'

Dr: 1. 'You're a first timer all over again'

Dr: 2. 'All right a little bit cold'

Gabby screamed

Dr. 1. : 'Breathe away.'

Dr: 2. 'Do you feel my hand?'

Gabby: 'Yes!'

Dr: 2 'OK'

Gabby screams

Dr. 1.: 'Nice big breaths. Gabby breathe away.'

Gabby screams louder.

Midwife: 'Right Gabby you're doing really well. Good girl. There.'

Gabby:' Stop please stop, please stop!!!'

Dr. 1.: 'He can't stop at the minute Gabby. He needs to find out what's going on in there.'

Gabby screamed.

Dr. 2.: 'But it's all right, don't worry, everything is under control. I've delivered thousands like this.'

Although these two groups of women tell their stories in very different ways and actually prepared for their births very differently the differences between their actual experiences were not in many cases as large as one might have expected.

3.9. SUMMARY AND CONCLUSION:

The NCT group of women were made up of particular types of people. They all had quite firm beliefs about how pregnancy and childbirth should go. They all had a need to feel in control of their experience and to have more information. They went to the NCT classes to meet these needs and found there, group support and reinforcement of their particular beliefs about childbirth. One of the most fundamental themes that all the women shared in one form or another was that childbirth was 'natural', and they felt more equipped to guard this belief when armed with the resources offered to them by the NCT classes.

My ethnography had a very specific pattern to it: there appeared to be two important factors which cut across one another. If we are to get at the causal web behind the way these women made sense of their pregnancy and childbirth experiences and the health seeking behaviour which was associated with it both of these factors need to be explored.

Firstly the two groups of women used different themes during their conversations and therefore talked about their experiences in quite distinct ways.

Secondly however, despite the apparent cultural heterogeneity between the women I spoke to there were a surprising number of similarities in their health-seeking behaviour during pregnany and the actual delivery of their babies. When it came to it all the women fundamentally trusted the medical/pathological interpretation of gestation, labour and delivery and it was this trust that had a dramatic affect upon the way they talked about their experiences.

FOOTNOTES FOR CHAPTER THREE

Footnote 1. Out of the five NHS women only one attended any ante-natal classes.

Footnote 2. When I went as a passive observer to an NCT class I became very aware of the instantaneous creation of a cohesive group. To start with the room was totally rearranged giving the impression of specially created space, a space which tried to reflect the special views of the group that inhabited it. This procedure took quite a while and involved clearing away all the chairs in the room and collecting dozens of bean bags and cushions from a cupboard which was down the corridor and up a spiral flight of stairs and scattering them all over the floor. During the class every one lounged upon these cushions and at the end of the session the procedure was reversed.

Personally I found the semi reclined on the floor position rather awkward and can only assume that this discomfort would have been increased if I was heavily pregnant. Ironically enough when I went to the NHS class run at the hospital exactly the opposite approach was adopted - everybody was seated in chairs and when there was not enough to go round only the men were considered fit and agile enough to sit on the floor on cushions.

Footnote 3. 'Changing Childbirth' was the 1993 White Paper which reported on maternity services in the UK and how they should be modified to meet consumer needs.

Footnote 4. The caesarean rate was considerably different for the two groups. The NHS group rate was three times that of the NCT. group.

SECTION TWO

In this section I am going to focus upon the consistent theme which runs through all the accounts I heard: that is the medical/pathological interpretation of pregnancy and childbirth. Despite the differences between the two groups of women involved in my research - both socio/economic differences and more culturally based differences in terms of how they reacted to their pregnancies - both groups found the medical/pathological interpretation of this life event irresistible. In this section therefore I will be looking in detail at this interpretation and I hope thereby to offer an explanation for this apparent consistency between the two groups of women.

In the next chapter, Chapter Four, I will look at some of the literature which offers a challenge to the medical/pathological interpretation of pregnancy and childbirth. Stylistically speaking this chapter is going to involve a slight digression in approach. I will be applying secondary material to aid explanation of a particular incident which happened while I was collecting my ethnography, and I will not therefore be using the women's accounts of their experiences to illustrate my case. Chapter Four will be structured around this one particular incident and its analysis will largely be made up of material from secondary sources. By using this method I hope to be able to take a look behind the pathological/medical interpretation which was accepted by all the women I spoke to.

The following chapter in this section will follow directly on from the conclusions drawn from Chapter Four. Chapter five will therefore have a starting point which ignores the rationality offered with the medical/pathological interpretation of childbirth. In this chapter I will use the anthropological approaches used to explain ritualised behaviour and will apply these to the experiences described to me by the women of their pregnancies and childbirths. Chapter five therefore will offer an alternative explanation as to why all the women in my sample found the pathological/medical interpretation so irresistible.

CHAPTER FOUR

A Closer look at the Medical/Pathological Model

4.1. INTRODUCTION

Despite the divergent ways the two groups of women talked about their experience of pregnancy and childbirth and the different approaches they took to ante-natal preparation, both groups subscribed {in some shape or form} to the medical/pathological interpretation of the event.

I realised the need for this chapter after I had sat through a very traumatic delivery {See Sec. 4.2.} and found myself in bed that night trying to justify all the procedures I had observed using a 'scientific' rationale. I wanted all the apparent suffering I had witnessed to be logically justifiable, I was seeking 'facts' to make the event fit more easily in my mind. I wanted it to be a `black and white` case. All this mental turmoil came after I had spent three months reading around the subject, which included coming across literature which offered a direct challenge to the pathological/medical interpretation of pregnancy and childbirth. This chapter then will consist of a review of some of that material and will therefore offer a closer look at the medical/pathological model.

From the literature examined I have chosen four basic theoretical approaches which I hope will help elucidate the issues lying behind the pathological/medical management of pregnancy and childbirth:
In the section 4.3. of this chapter I will use a historical approach - looking at the professions and institutions which surround childbirth in our country and how they developed. This approach will use a Foucaultian style method of analysis.

To supplement this line and in order to give a fuller account, I will go on in section 4.5.1. to use a traditional anthropological cross cultural approach. I hope therefore to fill in some of the gaps left by the historical approach.
This will be followed by sections 4.5.2 & 4.5.3. in which I will use a quantitative approach and finally in sections 4.6. & 4.6.1. I will be looking at the power relations in the professions. All these approaches can successfully be used together, I feel, to get behind the medical/pathological interpretation of pregnancy and childbirth.

4.2. THE DELIVERY

We had been in the delivery suite for over ten hours. The labour had been induced originally with the artificial rupturing of the membranes and then after an hour a syntocinon drip was put up. This meant that Gabby also had to be strapped up to a monitor as a precaution to assess the baby's heart rate and Gabby's uterine contractions.

Despite the inconveniences of the drip and the monitor Gabby had been able to move off and on the bed at will. She coped realy well with the pain of the contractions, closing her eyes tight and swaying her body too and fro each time the pain overcame her. Towards the end of this period she also clung onto the gas and air and said she found it afforded her a lot of relief. She was smiling gently in-between her contractions, looking realy well, rosy-cheeked and contented despite her obvious pain; she was delighted with her performance feeling very much in control of the whole experience. It was going well but it felt like a long ordeal. The midwives were calming and supportive. They kept bringing in steaming pots of tea for me and Gabby's husband but poor Gabby had only cold water to drink, much to her distress.

However as time passed things began to change dramatically. From a laid-back labour the event turned into what looked like to me to be a pathological nightmare. Gabby had an epidural sited which instantly made her less mobile. She lost feeling in one leg altogether. However she was thankful for the pain relief and was no longer able to judge when a contraction was coming. Her humour changed and she

became more passive, submitting to a sense of overwhelming relief. But it wasn't over yet!

Midwives suddenly seemed to take a back seat and the room filled with green clad specialists. Gabby's legs were put in stirrups and covered with sterile shields, after which an obstetrician's arm disappeared up her vaginal opening. Unfortunately although the epidural blocked out the sensation of the contractions Gabby's vaginal nerves were apparently still fully functional. The obstetrician was very sympathetic to Gabby's distress and conducted his examination as quickly as possible. He called for the anaesthetist to try to increase the cover of the epidural. We all waited and many jokes were passed round; the atmosphere was filled with excited nerves. The internal examination was resumed and Gabby screamed into the gas and air mask.

There was a time limit set and the seconds ticked away quickly. A stronger anaesthetic was put down the epidural catheter and Gabby's blood pressure suddenly dropped. The blood drained out from her face and she went a grey colour. She called out for a bowl and was violently sick after which she fell back on the bed limply gasping 'Do what ever you have to do. I know you have got to get this baby out somehow.'

Consent forms were signed and Gabby was wheeled off to theatre for a caesarean section.

This account is very personal, it is how the experience felt to me as a passive observer. Gabby and her husband, who was also present, remember it quite differently. But the reason I put this here is because to me it felt like I had witnessed a woman being physically tortured during one of the most vulnerable moments in her life: when she was exhausted from labour and fully dilated. I wanted there to be a medical reason for these practices.

This chapter will endeavour to explore some of the literature which looks behind the medical/pathological interpretation which justifies Gabby's, and many others, birthing experience.

4.3. USING A FOUCAULT STYLE ANALYSIS

> Foucault located contemporary reality withn its historical social construction. He refused to accept any discipline, institution or indeed cognitive concept as rationally objective, arguing that everything is embedded in its historic origins. For him there was a very specific role for social science:
> 'It seems to me, that the real political task in a society such as ours is to criticise the working as institutions which appear to be both neutral and independent, to criticise them in such a manner that the political violence which had always exercised itself obscurely through them will be unmasked' *{Foucault 1974:171}*.

Although Foucault did not apply this perspective directly to obstetrics I have found his approach on the rise of bio-power *{cf. Foucault 1975 & Foucault 1982}*, dividing practice: objectification and scientific classification *{cf. Foucault 1982}* - where the individual becomes the object of study to which a designated knowledge, in this case obstetrics and all the professionals and institutions which go with it, and therefore power could be focused - a very useful tool in looking at the fundamental assumptions lying behind the disciplines and technologies associated with pregnancy and childbirth in my ethnography.

I therefore intend to use this model in this chapter to shed light on the development of modern birthing practices, and the things that happened to Gabby, examining how power has been exercised in the development and acceptance of this behaviour in the institution of the maternity hospital and in the professions and disciplines associated with the hospital.

A Foucaultian style analysis would advocate a refocussing of my attention away from any debate as to whether or not Gabby could have delivered her

baby with or without the medical intervention to which she was submitted, since such a debate would depend upon assumptions of human physical capabilities, which itself rests upon the science of medicine *{cf. Foucault 1974}*. Instead a Foucaultian perspective would advocate that I look towards the way human birth has been *objectified {Foucault 1982}* through the history of the rise of the institutions, technologies, knowledge and power relations which now surround pregnancy and childbirth in our country. I will go through some of the issues raised in Gabby's experience to assess what such an approach can offer.

1. The induction: Induction was carried out despite substantial evidence suggesting that induction procedures have not improved morbidity or mortality rates in either mothers or infants *{e.g. Cartwright 1979}*. Induction is based upon the notion of an optimal gestation time of forty weeks. Looking at the history of this concept it appears to have arisen directly out of the rise of the disciplines of obstetrics and midwifery. The metaphor of the germinating seed with an elastic duration time *{Gelis 1991:61}* was abandoned as the physiology of childbirth became an object of study and therefore, according to a Foucaultian-style analysis, control. *{cf. Foucault 1982}*

The optimal gestation time is part of the medicalised, or *objectified {cf. Foucault 1975}*, way of interpreting pregnancy and childbirth {and part of the rise of bio-power in general *cf. Foucault 1975*}and by presenting this, and a whole package of other definitions, as medical 'facts' and part of the authoritative knowledge system, the discipline of obstetrics - associative institutions, professionals and technologies - came to be seen as indispensable.

Once interventionist procedures such as induction have been initiated a labouring woman is restricted to the spatial limits of the maternity labour ward and, as was the case with Gabby, must be strapped onto a monitor under close professional supervision. (Here again evidence has suggested that the use of monitors may not have improved infant or maternal mortality or morbidity but rather some have suggested that it increases maternal morbidity since it is associated with an increased caesarean

section rate. e.g. Backbill 1984, Chard 1977, & Prentice 1987). To use the words of a midwife in another birth I observed:

"Once you go down the road of induction you have to go all the way down. You can't stop you have to deliver that baby no matter how."

Spatial confinement such as this, according to Foucault, forges a 'docile body that may be subjected, used, transformed and improved.' *{Foucault 1975:221}*

Using a Foucaultian model of analysis and applying it to pregnancy and childbirth, it may be argued that as human birth became the subject matter of the obstetrical institution it became *marginalised* and therefore controllable: it became encased within their 'science' in which practices such as induction could be legitimised. Prior to the 1700s birth was not differentiated from other social and economic activities of life. It was incorporated into the normal cycle of existence. It took place within the domestic unit and was managed by unspecialised women friends and neighbours who acquired their skills by experience and informal apprenticeships *{Oakley 197:P25}*. It was never a focus of any discipline or institution. Through the historic rise of *bio-power*, with its *dividing practices*, its new *technologies* and *knowledge/power* systems, of which induction is part, the medicalisation of childbirth was legitimised and therefore accepted.

2. The pain relief: Secondly, the same style of analysis can be applied to the painkillers that were administered to Gabby. The interaction surrounding the administration of the pain relief, as indeed all the interactions mentioned in the account, rested upon the unquestioned legitimisation of the professionals' status in relation to the woman. By the social and spatial segregation of birth in the hospitalised setting, it could be argued, that Gabby found herself in a similar position of subordination as the *marginalised vagabonds* described by Foucault *{Rabinow 1984:11}* since these were the very same processes Foucault identified as being used to control and dominate the *marginalised.*

3. The operation: Thirdly, if Gabby's decision to hand over the responsibility of her body to the anaesthetist and the surgeon is seen in terms of the Foucault's rise of *bio-power*, it could be argued that the medical profession has achieved ultimate control

over their *subject* - the pregnant woman. Gabby consented to having her body totally paralysed by one professional, so that another, the obstetrician, would be able to carry out the principles of his discipline upon her. This could be interpreted as a manifestation of the individual becoming the *object* of study upon which the designated *knowledge*, and therefore power is focussed *{cf. Foucault 1977}*.

Short of offering her life, Gabby could not have demonstrated her *subjectification* more explicitly, and short of killing her the professionals could not have more explicitly demonstrated their successful domination. Foucault looked into similar types of scientific classification where 'modes of inquiry ... try to give themselves the status of sciences' *{Foucault 1982:208}* and identified potential dangers in the rise of rationalisation. Through looking at the history of scientific rationality, he asks how and around what concepts it is formed, how it has been used and where it developed.

4. The attire: The professionals used very specific types of clothing when their intervention stepped up. Foucault talked about a process he called *self-formation* when describing those involved in dominating *subjectified* individuals *{Foucault 1980 II}*. I believe this concept could be used to take a closer look at what happened during Gabby's birth experience. The scrubbing up and putting on of the 'greens' could be interpreted as an illustration of professional *self-formation* in which the health carers are positively active.

According to Foucault this process involves 'operations on {the professionals} own bodies, on their own souls, on their thoughts, on their conduct' *{Foucault 1980 II}*. By successfully achieving self-formation, the professionals are able to present their knowledge as authoritative, which provides them with the unlimited power of definition. It was the consultant's diagnosis of Gabby's condition, not her own understanding of her physical experiences, which directed her action, and of course the action she chose reiterated the power of the authoritative figure since it depended upon technology monopolised by the medical professions.

If we turn away from the issues presented by the medical/pathological interpretation of pregnancy and childbirth when looking at Gabby's experience and instead take a historical glance at the rise and legitimisation of this interpretation itself, a very different picture emerges. New issues become important: the rise of the institution and the authoritative knowledge which flourishes within that institution provide new explanations which challenge the interpretation offered by the medical/pathological model accepted by Gabby and all the other women in my research.

4.4. COMPLEMENTARY STYLES OF ANALYSIS

Having applied the unmasking objective proposed by Foucault to the hospitalised birthing practices carried out during Gabby's birthing experience, I will now go on to supplement his approach with some complementary styles of analysis. This is appropriate, I feel, because it contributes towards a more complete picture of the medical/pathological interpretation of childbirth.

Although a Foucaultian type perspective offers an interesting insight into the obstetrical professions and institutions it overlooks two fundamental issues which are pertinent to my discussion here. Firstly in being a social constructionist, Foucault denies the existence of a universal bodily form and this has importance implications for my subject of pregnancy and childbirth. Secondly his theories never tie down power as such, which again considering the power relations between Gabby and her attendants is also a vital issue. The rest of this chapter, will attempt to fill in those voids by supplementing the Foucaultian style analysis with cross-cultural, quantitative and more sociological analytical methods which consider power ownership in relation to gender relations and professionalisation techniques.

All these approaches will be used in conjunction to *unmask* the obstetrical *institutions which appear to be both neutral and independent* and will combine to offer a closer look at the medical/pathological interpretation of pregnancy and childbirth.

4.4.1. CROSS CULTURAL COMPARISON.

'Cross-cultural materials break through the crust of habituation in a way of viewing human beings' *{Mead 1967:143}* In the same way that Foucault manages to demystify our own society by locating it within its historic construction, many anthropologists have argued that cross cultural comparisons can be similarly utilised. Foucault argued that the body itself was a social construction *{cf. Shilling 1993}* rooted in historic patterns discussed in Sec.4.3. but a *biosocial {Jordan 1980}* cross-cultural approach suggests there is in fact a universal biological entity - the body - which actually exists. They thereby stress the importance of how this flesh object is embedded within a culturally specific social matrix. *{Bernstein 1982, Engleman 1977, Evaneshoko 1982, Faust 1988, Freedman Lawrence 1950, Ford 1945, Jarcho 1934, Jordan 1980, Konner & Shotal 1987, Rajadham 1965, Sargent 1989 etc.}*

Through the examination of childbirth in other cultures anthropologists have concluded that 'The act of giving birth to a child is never simply a physiological act but rather a performance defined by and enacted within a cultural context.' *{Michaelson 1988:1}* Evidence from cross cultural material then raises doubts on the extent to which the body is simply a social construction which has direct implications upon two important issues in Gabby's experience: pain, and delivery position.

Pain:

Gabby used painkillers on the advice of those medical advisers surrounding her during her labour. Thus far a Foucaultian style of analysis would be sufficient. However such an approach ignores Gabby's physical condition and the pain she was experiencing. By using cross-cultural comparisons, the degree of social construction of pain and the format that construction takes can be established. Morse demonstrated that Fijian women behaved stoically, labouring silently while the Fiji-Indian women were more restless calling out frequently in response to the pain. Although these reactions illustrate how the two groups perceived their pain differently, both groups did describe childbirth as painful, it was simply how they expressed this pain which was different *{Morse & Park 1988}*. This, I would like to suggest was also the case in Gabby's childbirth experiences: thus the picture is clearly a mixture between a biological entity, the pain of childbirth, and how it is culturally handled.

For Gabby the unavoidable pain factor may have governed many of her decisions and this element cannot be ignored. It seemed that while she felt in control of her pain threshold she was able to congratulate herself. However when she handed over the responsibility for her pain to the professionals her enthusiasm for her own performance evaporated. It is only by considering the body, and the pain experienced in the body, as a real entity that this process can be fully appreciated.

Delivery position:

Bernstein describes childbearing in Japan as follows: 'The position of birth was .... squatting ..... on the floor.... The expectant mother was careful not to face north, the direction from which evil came.' *{Berstein 1982}*, while Engelman points out that 'In the last stages of ordinary labour, those positions which I have classified as inclined are most frequently resorted to..... usually the patient has a support of some kind within reach, a rope, a stake, or an assistant' *{Engelman 1977}*. According to Hart, South-east Asian birth customs include 'The expectant woman sit(ting) on the mat, leaning against the pillows or trunk in a reclining position ..... A rope may be suspended from a rafter for the woman to clutch.' *{Hart et al 1965};* and Sargent states that in the Barida 'A woman who fusses or cries in childbirth dishonours her family and is lower than an ant..... If she feels the urge to push, she should kneel, sitting on her heels.' *{Sargent 1982}*. 'Squatting and holding on to the wall is the best position for giving birth. I stand behind the woman and I massage her until the baby comes out.' is part of an account given by a midwife from Thailand about the birthing position used there *{Vincent-Priya 1991}*.

These examples reveal much cultural diversity but there appears however to be one consistency - the delivery position is never horizontal it involves an upright or semi-upright position with the pelvic outlet unpressurised in every case. Ford asserts 'The women usually assumes a sitting position, less commonly she either kneels or squats.' *{Ford 1945:58}* The implication of this trend is that birth is physiologically most efficiently concluded through an upright posture. Such a conclusion implies the idea that the body is to some extent a universal entity. In this

methodological approach the evidence has preceded the conclusion, the pattern is deduced from the cross-cultural data and it suggests an optimal position for the biological process of delivery. Cross-cultural comparisons not only uncover the possibility of a universal body but show the degree to which in 'Western industrial societies obstetrical services that are often thought of as planned and rational contain many forms of behaviour which are habitual, traditional and so assumed as to preclude their evaluation.' *{Richardson 1967:IX}*

By ignoring, as Foucault proposes, the possibility of the body being a physical entity, the extreme pain and optimal delivery position of childbirth is never appreciated. The significance of the *'political violence'* committed by the *'subjectification'* of pregnant women, by enforcing the dorsal position, is therefore completely missed. During a most crucial period and when a time limit was set Gabby's legs were put up in stirrups and all her weight was pressed down upon her sacrum, the expanding part of the pelvis, the epidural she had earlier similarly took away her chance to be in an upright posture. The real implications of this I would like to suggest can not be appreciated using a Foucaultian style analysis alone.

In accepting the premise that the body does exist as a biological entity, but is made sense of through social construction, we can use physiological explanations to understand possible universal patterns and therefore appreciate the full implications of enforcing the dorsal position. Certain principles of physics can be applied to explain childbirth, and the quantitative research that has been carried out to substantiate and validate these universal rules can also be taken into consideration in the analysis of childbirth.

4.4.2. USE OF QUANTITATIVE DATA:

Using this third methodological technique I will look again at the delivery position as well as two other issues involved in Gabby's delivery - the use of C-section for delivery and the encouragement of a passive patient.

Delivery position:

'In the majority of the cases studied, it was found that, when the patient changes from the dorsal position to the side position, the intensity of the uterine contractions increases ' *{Caldeyro 1960}* 'It was shown that the cross-sectional surface area of the birth canal may increase by as much as 30% when a woman changes from lying down on her back to the squatting position.'*{Russell 1969}* 'Lying supine, the weight of the contracting uterus reduces the placental blood flow by compressing the large artery of the heart and the large veins leading to the heart' *{Caldeyro-Bricia 1979}* In 1977 a study in Birmingham Maternity Hospital compared a group of women who walked about during labour with a 'matched' group that lay down horizontally, the results showed that the duration of labour was significantly shorter, the need for analgesics far less and the incidence of foetal heart abnormalities markedly smaller in the ambulant group.*{Flynn et al 1978}* 'In the recumbent group, 22 out of 39 women spontaneously expressed the wish to be upright when they reached the bearing down phase ..... many mothers commented that once positioned onto the cushion, pushing seemed to be much easier and that they felt more involved and more in control physically..... We were impressed by the readiness with which women in first labour accepted this unorthodox birth posture despite having no specific ante-natal preparation.' *{Gardosi 1989}* 'The dorsal recumbent position in the second stage of labour may give rise to foetal acidesis.... in the upright position the sagital diameter of the pelvic outlet is increased .... gravity will aid the downward pressure of the expulsive efforts ..... The pressure of the uterus on the vena cava will also be reduced' *{Stewart et al 1981:1298}*

I have included this selection of the empirical evidence on the issue to illustrate the magnitude of the material available, yet despite the consistent publication of literature suggesting that an upright position may contribute towards a successful delivery, all the women in my ethnography bar one gave birth putting all their weight upon their sacrum bone while in a semi reclining position. This included Gabby for the final and most crucial stages of her labour.

Caesarian sections:

In the end Gabby was advised to have a Caesarian-section-C-section , I would briefly like to examine this phenomenon against some quantitative data in order to show the depth of analysis that can be achieved by supplementing my previous approaches with this style of analysis.

The justifications behind performing the C-section on Gabby were two fold:

Firstly and perhaps foremost, the labour had gone on a long time and Gabby and her infant were at risk. The operation then had to be carried out because she was physically incapable of delivering the child herself without medical intervention.

Secondly because Gabby had been unable to cope with the discomfort of internal examination it was assumed she would be unable to comply to acceptable forceps behaviour i.e. she protested against the pain inflicted upon her by calling out and writhing.

However some of the quantitative-style literature offers a challenge to this cause-effect equation and I will therefore therefore three other potentially causal variables:

For this discussion I will talk about the body as a physical entity and will therefore analyse the justifications offered for the operation using the same rationale constructed by the medical profession.

1. In an investigation done in Oxford on induced labours Richards found that the instrument delivery rate was 32.5% compared to 19% in non-induced women and concluded 'membership in the induced group itself appears to carry an added risk of an operative delivery.' *{Inch 1984:47}* If these results are applied to Gabby's experience the cause and effect equation could be reorganised to read: induced labour - need for C-section. Thus the medical intervention, of the induction, (justified by the discipline of obstetrics), created the need for the surgery, thereby increasing dependency upon the discipline and its management powers over birth and also the institution and technologies within which the discipline has autonomous control.

2. C-section rates across England and over time are not consistent. When these are compared to the 'at risk' elements in the population there does not appear to be a consistent relationship, i.e. those groups of women who are considered to be most at risk do not have the highest C-section rate. There is, however, a direct relationship between C-section rates and whether or not the location is a teaching institution: teaching hospitals consistently have a higher rate of surgical deliveries than non-teaching; *{Cartwright 1979}* Particular obstetricians appear to have preferences about performing such operations, noticeably older obstetricians perform C-sections more frequently *{Scully 1980}*. It could well be therefore that in Gabby's case it just so happened that the obstetrician on duty had a tendency to perceive a need to perform C-sections, or that the operation was carried out because the hospital is a teaching hospital.

3. Food and drink, other than water, were withheld from Gabby as a precaution against inhalation of vomit when and if a general anaesthetic was administered. This is despite the evidence to suggest that those women who have been recorded to have died from this condition were in fact starved prior to their anaesthetic *{Inch 1984}*. Some of the literature suggests that this is an unwise procedure -'A sudden demand for energy as occurs in labour rapidly depletes her own stores of glycogen she has to start using her fat stores as a form of energy. This is rather an inefficient process, however, and there are by-products in addition to the release of energy. These by-products called ketones ..... causing alterations and the blood chemistry and weakening of the muscle cells. The uterus then contracts less effectively and labour slows down' *{Inch 1984:33}*. So now our causal equation might read: all refreshment withheld for duration of labour - C.-section.

4. Maternal exhaustion - this issue lies behind the effect side of the equation and also carries some interesting presumptions. Brackbill argues that in the US 'physicians do not try to rationalise caesarean surgery in terms of physical benefits for mothers. There are no benefits for mothers.' *{Backbill 1984:25}* There is substantial evidence to suggest C-section is potentially dangerous to the infant *{Chard 1977, Brackbill 1984, Inch 1984, etc.}* plus of course the obvious post-operative morbidity caused to the

mother. Footnote (Deaths associated with C.-sections accounted for 27 out of the total of 36 deaths. *{Chard 1977:43}* [I do not argue that there is definitely a cause-effect relationship here, but the possibility should not be dismissed by those performing the operations].

Like the cross-cultural data, this quantitative material suggests that there is a universal physiology involved in childbirth which in turn implies the existence of a biological body, a fact which Foucault consistently denies. These approaches can then, I would like suggest, be used in conjunction with a Foucaultian style analysis since they illustrate that the social construction of Gabby's {and indeed all the pregnancy and childbirth experiences in my data} childbirth experience was not only historically rooted but that it also transcended and implanted itself over and above the universal entity of the body.

4.5.3. THE PASSIVE PATIENT:

My final point in this section is that of the well behaved patient. I have included this issue in this quantitative section even though the approach digresses from the rest of section 4.5.2. Rather than using an analysis of figures this point will be argued using a review of literature.

In an analysis of some of the literature read by a large number of training obstetricians, Rothman suggests these professionals are actively encouraged to seek the passive patient. For example the American Society of Psychoprophylaxis in Obstetrics in 1960 stated 'In all cases the woman should be encouraged to respect her own doctor's word as final..... He is responsible for her physical well-being and that of her baby. She is responsible for controlling herself and her behaviour.' *{Rothman:167}* Obstetricians, suggests Rothman, are not trained to care for the woman as a holistic individual. Rather they should accept DeLee's definition of childbirth as a dangerous pathological process *{Ibid:151}*, 'thereby focusing away from the woman depersonalising her into a passive biological organ on which he/she can practice his/her professional skills -saving lives'.*{Scully 1980:236}* The way Gabby's pleas for her internal examination to stop were ignored implies that the obstetrician's concerns were

more crucial than those of Gabby's {See Sec.3.8.}. In this way power becomes knowledge and knowledge becomes power. Footnote 1

Thus by taking a look at the institution of the training hospital and examining the literature and teaching techniques utilised there, Foucault's process of *self-formation {Foucault 1980 II}* can be seen in the making. Neither Rothman nor Scully use a historic methodological approach,+ rather they rely on large-scale social surveys and broad literature sweeps within the profession they are investigating. In so doing they *unmask* the self propagating aspects of the discipline and institution. An analysis of contemporary practices within the institutions which define knowledge and therefore power provides a window onto the construction of the disciplines in the here and now.

The problem of explaining Gabby's (and many others like her - several in fact in my research) experience of childbirth stands at this point as follows; why did obstetrical practices such as induction, dorsal positioning, epidural pain relief and C-section techniques develop and become legitimised as part of the science of medicine if some research suggests that these practices may be detrimental to the physiology of spontaneous childbirth? We have a historic explanation including the identification of such processes as *dividing practices*, *subjectification*, *objectification* and *self-formation* but whose interests did these historic changes serve? Who was the driving force behind these changes in the management of pregnancy and childbirth in our country?

4.5. WHOSE POWER IS IT ANY WAY?

Where does power come from? Foucault never attempts to answer this question instead he assumes its presence as the starting point to his analysis. Power exists as if in limbo, hovering over history awaiting to be exercised by individuals in social discourse. Why some manage to access full autonomy over authoritative knowledge and exercise power more effectively than others is never explained. Why all the women in my sample adhered to expert knowledge and therefore the authority of the medical professionals is never explicitly addressed. Foucault talks about the driving

forces behind historic change without identifying the drivers. People become almost passive to the forces of changes around them. He dispossesses them, excluding himself of course, from the powers of reflection and self determination.

Self-Formation:

Self-formation, according to Foucault, involves a certain amount of purposeful manipulation, this implies that certain groups of people are conscious of the power they wield and see that it is in their interests to maintain that position. Power then becomes a form of capital and as such becomes socially more tangible. It may therefore be useful to supplement the Foucaultian question of 'How has power functioned?' with 'Whose interests have been served in the power relations which surround the medical/pathological discipline and institutions which have featured so highly throughout my ethnographic data.?'

In answering this question I hope to show how the complement of theoretical approaches, which I am advocating, can offer the apparatus for finally demystifying the seeming *neutral* and *independent* scientific rational which lay behind the obstetrical procedures carried out on Gabby during the delivery of her baby. I will explore two areas of discussion in answer to this question:

4.5.1. A FEMINIST CRITIQUE OF THE MEDICAL PROFESSION:

Some feminists have looked at the development of the medical profession within pregnancy and childbirth with the premise that one of the most important patterns within the profession is the overwhelming sexual division of labour - men hold the position of authority, women are placed subordinate to that authority.

Oakley describes the rise of the male dominated, surgical technology, which now surrounds childbirth as a means of restricting the autonomy of both the female midwives and the pregnant women, and suggests this is an illustration of the generalised pattern where occupational options for women became narrowed down with the ideal of domesticity becoming prominent. *{Oakley 1979}* Similarly Tew argues that 'exemplifying their 'inferior sex' stereotype midwives recognised the

limitations of their skills and waited to be rescued by obstetricians .... The obstetricians' victory for their occupation implied also victory for their philosophy, victory for the medical management of procreation, which directly affects everyone.' *{Tew 1990:21}*

Some feminists therefore argue that the sexual division of labour within the medical profession acts as an example for the order of reality thereby providing a model of how gender relations should be. Resistance to this definition of reality, they suggest, was reinterpreted under the patriarchal medicalisation of society as illness. 'During the nineteenth and early twentieth century the physician's technique for handling female assertiveness of sexuality was to label it illness or insanity, the resource for which ranged from rest to incarceration to surgery..... female sexuality is still considered somewhat problematic, and physicians continue to feel a need for medical domination over women patients. One way to handle this problem is by depersonalising the woman into a nonsexual being.' *{Romalis 1981:84}*

Scully shows how residents in maternity hospitals prefer a 'well-behaved' woman, one who 'had been taught to respect and submit to the authority of experts..... In short, the residents preferred happy, obedient, respectful and thankful patients' *{Scully 1980:91}* Tew suggests that doctors intimidate women into passive submission by exaggerating the dangers of confinement, rebuking those who are unwilling to comply with their interpretation of childbirth, condemning them as 'selfish and irresponsible' *{Tew 1990:14}*

Women's physiological inadequacies in childbirth, it is argued, were a direct reflection of women's legitimated subordination, they were inadequate, unable to function healthily without direct dependence upon their superiors - men. Romalis argues: 'The historical emergence of the male expert with his affirmation in the economic and political spheres was accompanied by the discounting and decline of female expertise. The result is our contemporary legacy of male institutional domination over female concerns of childbirth and childbearing' *{Romalis 1981:4}*

By ignoring such issues, some feminists would argue that Foucault's style of analysis fails to fully elucidate the nature of gender relations and as such fails to appreciate an important aspect of the criticism of the working of the maternity hospital institution which appears to be both *neutral* and *independent.* He is consequently unable fully 'to criticise them in such a manner that political violence (between men and women) which has always exercised itself obscurely through them will be unmasked' *{Foucault 1974:171}*

The feminists I have mentioned therefore offer another layer of meaning: they use arguments that fit neatly into Foucault's concepts. However within these they identify those responsible for the developments of history. There is no room for chance in their accounts; history is directed by men at the expense of women and the professions which surround childbirth in our society are an illustration of this manipulation. Gabby's experiences could therefore be explained in terms of gender relations. The use of obstetrical procedures such as the dorsal position, the type of pain relief, and the operative delivery can all be interpreted as evidence of male domination in a patriarchal society. (Footnote 2)

4.5.2. PROFESSIONALISATION:

This additional element in the discussion of power relations is presented here not as an alternative to the feminist writers mentioned above but rather as another dimension to it. (Foot note 3) By strengthening the term Foucault applies to power, from 'exercise' to 'manipulate', the issue of a possible consciousness in power relations can be more explicitly addressed. Parry & Parry define professionalism as 'a strategy for controlling an occupation in which colleagues set up a system of self-government' *{Parry & Parry 1976}* The occupation is controlled primarily in the interests of its members and this is achieved by:

1. Restriction of entry - ensuring a high demand for the services offered by that profession.
2. Self regulation of behavioural control of the profession's members
3. Maintenance of a monopoly over their field which is supported by law.
4. Popularisation of their knowledge as both the legitimate and authoritative.

1. Restriction of entry: Carver describes the North American obstetrical profession as coming from 'as a rule,.... comfortable, traditional middle-class families. Their fathers were the providers, often professionals, and their mothers were housewives..... Their families expected them to be successful ..... They were the delight of their teachers, the pride of their schools and their parents' *{Carver 1981 :127}* According to Carver therefore the obstetrical profession tends to limit its members to the upper middle classes and in doing so, provides this section of society with a vehicle for maintaining their exclusive position as well as ensuring the status of the professional members themselves.

In Gabby's case therefore it could be argued that it was vital that she accepted the medical/pathological interpretation of pregnancy and childbirth unquestioningly, since it is such unconditional subordination which allows for the exclusive survival of the profession. Without it the restricted entry may be put under scrutiny, and the practice of procedures rendering the professionals skills and therefore position indispensable, would no longer be maintainable.

2. Self regulation: 'Of all the professions, medicine has been among the most successful in achieving autonomy and establishing the freedom to work without regulation from outside its own community. Consumers have a very small voice in policies that regulate the terms of health care delivery and only physicians control the content of medical work and education of recruits.'*{Scully 1980:12}* Although this is said to be gradually changing, Scully shows that the medical profession holds autonomy not only over the calibre and number of recruits but also acts as its own standard regulator. As such it stands without reproach. The 'doctor knows best' syndrome is never challenged.

While marching behind the `banner of science` some critics have suggested that the obstetric profession has been obliged to develop its techniques in defiance of the scientific evidence produced, suggesting a high degree of unaccountable self-regulation *{Tew 1990:293}* There are many examples of this to be found in the literature *{Bowes W. et al 1970, Brazelton, T. 1961, Campbell 1984,*

Chalmers 1977, Caldeyro-Barcia 1979, Fields 1968, Flynn 1978, Hoult 1977, Johnson 1971, Maclerian & Carrie 1977, Mitie 1974, Liston et al 1974, Potter et al 1971, Prentice 1987, Rosenblatt 1966, Rosenblatt 1986, Russell 1969, Standley et al 1974, Stewart et al 1981} This issue of self-regulation reinforces the whole idea of the professionals using obstetrical techniques, such as those in Gabby's case, in order to maintain their position of privilege.

3. Maintenance of monopoly: The history of the professionalisation of obstetrics is closely related to the struggles fought by midwives. It became a battle over jurisdiction, a battle which was largely won by the obstetricians and the victory of which was maintained through legislation. *{Donnison 1977}* The obstetrical profession achieved exclusive rights over childbirth in our society not simply in terms of physical manipulation but also in respect of how childbirth can be legitimately interpreted *{Romalis 1981}*. Home births are now rare, if not positively discouraged, and midwives have been reduced to the supportive role *{Tew 1990, Turner 1993, Gaskin 1990, Scully 1980}*.

4. Authoritative knowledge: The successful operation of the above three professionalisation techniques hinge upon an all-embracing component, the legitimisation process. It would be useless constructing an exclusive body unless that body was perceived to be the seat of authoritative knowledge, and thereby holding a valid claim over its privileged and prestigious position. Once established as such the profession possesses a self-maintaining system in that the pedestal it monopolises creates the illusion of superiority, legitimising both its position and its interpretation of reality. It is argued that only through the active practice of those in the profession can this knowledge become authoritative and hence lead to the development of obstetrical procedures such as those experienced by Gabby. *{cf. Turner 1993}*

Such interpretations of obstetrical practice as the feminist and professionalisation explanations can be criticised for suggesting the scenario of a conscious conspiracy, where the obstetrical disciplines and institutions are wilfully created. Bloch criticises such conclusions, illustrating their absurdity: 'It..... involve(s)

ideologies being created as a plot by cynical rulers who deliberately invent subtle and totally convincing mystifying devices for the domination of others..... This view ... implies a pseudo-history, a just so story of an absolute beginning, when the thinker, unbound by society or the necessities of life or for that matter any previous intellectual preconceptions, worked out the whole thing' *{Bloch 1986:6-8}*

Foucault, however, while conceding that some people may and do exercise power over others, allows all individuals to be victims of their own history. No one group of people is responsible for manipulating historic change. Power is anonymous, simply facilitating historic change without being owned. He does not deny the exploitative nature of the power/knowledge relations but manages to offer a description of their development without pinpointing a villain, without allocating responsibility and as such manages to capture a more feasible explanation of the complex relations.

Although his definition of power liberates him from this trap in social theory, the other side of the coin is that it also results in many important issues being overlooked. In the case of the medical/pathological interpretation of pregnancy and childbirth, a Foucaultian-style analysis ignores the important role of the benefactors. It fails to unmask the gender and class relations, and as such, important aspects in the political violence of the obstetrical institution remain unrevealed. Put together however these approaches contribute towards the *unmasking* objective. No one approach can claim to tell the whole story; one offers solutions where the other falsifies itself and as such they can stand to complement each other, in a rather academically-perverse contradiction.

By using a Foucaultian style analysis as a backdrop to present centred analysis, the themes people use to talk about their experiences can be placed into perspective. Authoritative medical/pathological knowledge then simply becomes one of the many choices available to the participants in childbirth. My evidence suggests that this particular interpretation holds precedence over the others on offer, despite differences in socio/economic status or cultural expectations. However if this

acceptance does not depend upon a scientific justification, as some of the literature claims, then why do all the women adopt it?

4.6. CONCLUSION:

By using a four-pointed theoretical line of analysis, I have been able to take a closer look at the pathological/medical interpretation of pregnancy and childbirth, which remained very important to all the women I spoke to during this research. In this chapter, I have used some literature which presents a challenge to this interpretation and uncovers many cultural assumptions which lie behind it. The evidence suggests that there is justification in treating the pathological/medical rationale as a Kleinmanian explanitory model. The 'scientific' rationale behind such practices as those experienced by Gabby, therefore, almost become irrelevant and the fluctuating and sometimes inconsistent way in which the women produced this model of interpretation, during their conversations about their pregnancies and childbirths, suggests that an absolute scientific proof is neither expected nor looked for.

FOOTNOTES FOR CHAPTER FOUR:

Footnote 1 In Foucault's emphasis on the historic development of this process of self-formation, subjectification and the rise of bio-power leads to the tendency for the individual involved in the discourse to become lost. The subtleties of the procedures by which these processes are achieved can therefore be overlooked.

Footnote 2. Ironically one of her attending doctors - indeed the one that told Gabby that the examination she was protesting about could not stop despite her discomfort - was herself a woman!

Foot note 3: The discussion of the ownership of power/knowledge within the obstetric 'profession' centres around two points: Firstly, and perhaps most importantly, it is the obstetrics who hold ultimate power over birth manipulation in our society. It is their interpretation of the events which holds the authority, and by strength of that authority, it is their model of understanding which is popularly accepted. {For ease in discussion I will assume in this section that the obstetrical profession as a united whole offers a singular explanation of childbirth. The heterogeneity of their explanations will be examined in due course.} Thus Rothman shows how the midwifery model of interpretation is no match for that offered by the obstetrical profession 'Midwives in hospitals are frequently required to place their clients on delivery tables, and even strap them into stirrups, whatever the midwife's own judgement of the best position for birth.'*{Rothman 1981: 160}*

Secondly in the literature surrounding the 'professionals' the issue of financial reward is paramount.*{Barber 1963, Mills 1951, Parry & Parry 1976 etc.}* When the pay of midwives is compared to that of obstetricians, it can be clearly seen that the latter profession is the most successful at protecting their own interests. It is they, therefore, that hold the power/knowledge at their disposal. (These two vital issues highlight again the importance and centrality of a feminist critique since the majority of obstetricians are men.)

CHAPTER FIVE

Pregnancy and Childbirth as Ritual.

5.1. INTRODUCTION:

In this chapter I will look at the possibilities of analysing the management of pregnancy and childbirth and the language used to describe them in our country in terms of ritualised behaviour. I will using this perspective to explore the prevalence of the medical/pathological interpretation in the talk all the women produced for me about their experiences.

I will be suggesting therefore that, if we look at the cultural manipulation of pregnancy and childbirth, and the way in which the women I described in their conversations in terms of ritual, then we might approach an explanation as to why the cultural diversity between the two groups of women disappeared when they all opted to trust and submit to the medical/pathological interpretation of pregnancy and childbirth. I will be picking out useful examples from both groups since the point here is not the differences between the two but the similarities. (Footnote 1)

5.2. WHY HUMANS HAVE RITUAL:

Malinowski's pioneering work can, I believe, be a useful tool in the analysis of the way these women talked about their birth. He points out that there is a tangible limit to which any amount of technical manipulation can control the natural environment. 'in spite of all his forethought and beyond all his efforts [mankind finds] there are agencies and forces which one year bestow unwanted and unearned benefits ....and another year again the same agencies bring ill luck and bad chance..... To control these influences and these only he employs magic.' *{Malinowski 1954 :29}*

Malinowski's use of the term magic here may, I suggest, be replaced with ritualised behaviour. Thus it can be argued, using such a model, that it may be the

fear of the uncontrollable nature of gestation and delivery {or unpredictability see sec. 2.6. & 3.3.} which motivates us to surround childbirth in medical/pathological rituals. Participating in and observing such rituals offers the individual a sense of homogeneous belief which placates the inevitable feeling of powerlessness in the face of 'nature' *{cf ibid. P67}* Thus each culture encases the physiological process of pregnancy and birth with in a series of ritual manipulations in order to address this sense of lack of control.

Several of the women I spoke suggested that the unpredictable nature of childbirth and the fear of being out of control are both very important elements in how it feels to give birth.

For example Sarah directly attributes increased hospitalised management of childbirth to an unpredictability factor:

> 'On the whole I think that women particularly in second, third and fourth pregnancies .. who have never had problems before and had no problems in pregnancy, have no associated medical condition.. I .. think there that is very little risk at all. And .. they say that first babies are very risky but I think it's just an unknown quantity. I mean lots of people say to me "Well .. you advocate home delivery how, why don't you have one?" You know and this sort of thing. But you just don't know I think that you are an unknown quantity.'

Alison fitted the predictable criterion proposed by Sarah in that she had had previous uncomplicated pregnancies and births, but she was persuaded against a home birth in favour of a hospitalised one on the same issue of unpredictability.

> 'The GP stressed the risk factors {of a home birth} not in a frightening way. She was reasonable about it having pointed them out they .. certainly grew in my husband's mind. And then I spoke to one of the consultants and he was of the opinion "Yes wouldn't it be lovely if we could do this but I can't guarantee that things are going to go well. If I could brilliant." And he is such an intelligent and sensible bloke I thought "Ooh well fair enough."' {She had a perfectly normal birth but in the hospital setting which in the end she was thankful for because she hadn't put her other children through the ordeal.}

And Robin told me:

'Well there's nothing you can do really, is there? It's not up to you like. So I'm totally glad that I didn't have a home birth definitely. I mean me friend was right things do go wrong and there's proof of it. Cause like we were all talking about it what we were going to do. "Am I going to have it in hospital? Am I going to have it at home?" She said "Oh I advise you to have it at hospital too many things can go wrong."' For Robin her experience bore testament to this statement, since she ended up having to have a C-section.

Gabby summed up the idea saying:

'I felt fairly sure from what I had seen going on in hospital that doctors tend to get twitchy about childbirth anyway .. and that the more risk factors you introduce the more twitchy they get.'

This data suggests therefore that the element of unpredictability is crucial to suggesting why these women thought their births should be culturally manipulated. Because there were no certainties they felt more comfortable giving birth under the supervision of an expert. And the answering of this need is frequently apparent in the way the medical staff talk to the women during their ante-natal and natal care.

For example, when I accompanied Trisha on an ante-natal visit to her midwife and she produced a list of questions to ask her, the midwife made a point of being enthusiastic about the list giving the impression that nothing fazed her. And after all the queries were answered she raised her eyebrows and said 'Oh, how boring!' suggesting that she had coped with much worse and that everything was under control.

During Alex's labour the consultant told her 'But it's all fine you've got nothing to worry about. We often get this sort of thing.' Afterwards she told me that she had been told that the procedure they had performed on her to deliver her baby had been extremely intricate and the consultant had never done it before.

Sarah told me:

'I think a midwife's role is also to encourage .. so if it's a frightening experience I think you need somebody who's seen it before .. she's delivered any number of babyies in a night .. for

them you're doing OK. This is quite normal "Fine .. this is what you can expect next" sort of touch.'

And Tracy stressed:

'She said "Oh I think I made a mistake you're only one or two cm dilated!" I couldn't believe it .. the pain at that point it made me freak and I just lost control. I just panicked for the rest of the day really. Totally panicked it was just major, major pain. I could have coped having this sister. She was a .. an .. old school nurse you know what I mean. She would have .. taken control. She needed to be firm and that's what I needed, someone to say "Now come here!".'

What is needed is someone who is prepared to take control, someone who will not be put off no matter what the circumstances and who is there to tell the labouring woman that they the professionals are able to handle all the necessary procedures of the birth management, regardless of whether they actually are or not. The trick is, it seems, is to appear to be capable of anything. The unpredictable nature of childbirth then creates the need for such an approach. It is the uncontrolable factor which leaves us dependent upon wanting to believe it can be controlled.

5.3. BIRTH AS A RITE OF PASSAGE:

Davis-Floyd's interesting analysis of American childbirth takes up the idea of childbirth being ritualised. She defines ritual as a patterned, repetitive and symbolic behaviour enacting a cultural belief of value *{Davis-Floyd 1990:275}* and using this definition she applies van Gennep's classical rites of passage model, allocating the various stages of hospitalised birth to his three consecutive rites.

1. Separation: Within the first category she includes the ritual behaviour of the woman being depersonalised with the adornment with a hospital gown, and ID bracelet and the, not only unnecessary, but potentially deleterious act of shaving off her pubic hair. These rituals, argues Davis-Floyd, 'symbolically de-personalizes the lower portion of her (the labouring woman's) body, returning it to a conceptual state of childishness.' *{Davis-Floyd 1990:279}*

2. The transition rite she argues is marked by rituals which concentrates on sending one basic set of messages which are repeated over and over again in different forms thus stabilising the individuals under stress, 'giving them a conceptual handle-hold to keep from falling apart or losing it' *{ibid. p279}*. Uniformed and repetitive obstetrical

ritual therefore provides the conceptual courage enabling the participants to face the unpredictable physiology of childbirth *{ibid. P280}*.

3. Reintegration: The final stage of course is the woman leaving the hospital with her baby, no longer as an expectant mother but as a new mother therefore filling a new social category.

According to van Gennep rites of passage rituals enable individuals to transcend social categories, moving from one designated, cognitively constructed group to another while protecting those individuals from the intrinsic dangers associated with this passage.

> 'Transition from group to group and from one social situation to the next are looked on as implicit in the very fact of existence, so that a man's {or in this case woman's} life comes to be made up of a succession of stages with similar ends and beginnings: birth, social puberty, marriage, fatherhood, advancement into a higher class, occupational speculation and death. For every one of those events there are ceremonies whose essential purpose is to enable the individual to pass from one defined position to another which is equally well defined.' *{van Gennep 1960:3}*

5.4. THE PROFANE AND THE SACRED

There are several exciting issues raised in this theory which do seem to bear some credence in the light of the data I have collected. Van Gennep argues, as does the medical profession, that the movement from one social category into another, such as pregnant woman to mother, is inherently dangerous, while Leach's discussion on the division of time into sacred and profane can be used to add a further interesting perspective. Profane time according to Leach is dominated by normal everyday activities which take place in the normal living and working environment. Sacred time however is special, it is a time for ritualised behaviour - a protected time which does not leak into normal everyday activities. *{Leach 1961}* The carrying out of van Gennep's dangerous rites of passage then would be restricted to the sacred and would therefore be safe.

The idea of getting away from normality in order to give birth was a frequent theme used by the women. The reasons they needed this special space were varied. Some wanted to be away from their other normal ties:

Helen said:

'I'm glad I had him in hospital .. I wouldn't have liked Esmee [the older child] to have seen me and get upset .. Not know what was going on .. otherwise she would have had to be dragged out the house and locked out of the house for ages.'

And Alison:

'I mean certainly if any of the children were around the blood and mess would have been very distressing for them. I didn't particularly want that kind of mess either you know your own bed isn't as protected as their bed and it was all fine in hospital.'

Whereas others just thought it simply should not be done in the home:

Tracy said:

'Well you don't give birth now every day do ya? I mean it's not like pegging out the washing or sommmat .. It's something special and you should go out of your home to do it. That's what I think anyway.'

And Trisha said:

'I actually like the hospital environment and I felt it was like a special event. It was a special visit. I went into hospital to have a baby .. whereas every day is the same at home, sort of thing.'

The mess associated with childbirth was also seen better coped with in the hospital setting: (Foot note 2)

Alex said:

'I couldn't believe how much came out. Oh no I wouldn't like that sort of thing in doors I don't' think.'

Childbirth then was seen as a special event, an event encased in unpredictable dangers and discomforts. Because of these it was best coped with in a special place equipped to deal with all eventualities, where protecting rituals might be practised successfully. The separation was made by leaving the home environment and

being admitted into hospital and this act involved various procedures which appeared to change the pregnant woman from a fully autonomous person to a labouring mother with reduced responsibility. {Footnote 3.}

Trisha described the process:

> 'I think it was just like they said when you get there you ring the bell and they will come out to collect you. And there was nobody else around and you felt like they were waiting for us .. it was exciting .. so I went into the room which later on then had my name on the door which was quite funny .. I wanted to be in the gown, I didn't want to wear my night-dress or anything 'cause it was going to be fairly sweaty and I knew I would get extremely sweaty .. It just looked well used but that didn't bother me. But .. she asked me for my notes and things and she said "Get yourself changed into the gown and get yourself comfy on the bed and I'll come back." And she gave me an internal and they put me on the monitor they said it would only be for a short while to test the contractions.'

Trisha didn't have an ID bracelet or have her hair shaved but she went through a similar type of procedure to become a hospital patient. She removed her own clothes and therefore possibly her outside or profane identity and she had her name put on the door stating this was her rightful place. She now belonged to the special or sacred time in this special place and she submitted her body to medical equipment and techniques with the internal and monitoring. (Footnote 4.) This description is typical of those I was told about by most of the women - the separation is thus accomplished.

5.5. TRANSITION

My data would suggest that there are two important elements to this part of the rite. Firstly the physiology of the birth itself creates an altered state of consciousness which transformed the women *{cf Odent 1984}*. Crucial in this is the experience of pain, when in the full throes of childbirth, the cultural differences between the two groups of women appear to decrease in a sense then they become de-cultured *{Scarry 1987}*. Secondly the symbolic messages the women experienced during this period. Victor Turner, who writes on ritualised behaviour, argues that symbolic messages encourage the internalisation of a specific set of cultural norms *{Turner 1967}*. Therefore it can be argued that by fusing the transforming process of childbirth with medical/pathological ideological presumptions, childbirth itself ensures that the new mother becomes re-integrated into the medical/pathological appreciating

value system {see sec.5.5.2.}, 'Through hospital procedures, obstetrician deconstructs birth, then reverses, inverts and reconstructs it as a technological process.'*{Michaelson 1988:171}*

5.5.1. THE PAIN.

Sarah describes it as:

'They were very intense my contractions. A very intense sensation .. it was like a trance yes. Well aware, but sort of drunk .. And I think the other thing is the contractions are so, so intense or for me they were so intense that I couldn't think of anything else except for coping with that. Even in between times .. when you are supposedly normal the thought that "How am I going to cope with the next one?" It distracted you from being able to sort of think of things that didn't actually seem pertinent to that actual moment in your labour. I can remember .. at ten o'clock they said "Would you like to have a shower now we've done the examination" And .. she said "You're eight cm" .. at ten o'clock .. I remember looking at the clock, well now I do, and I said "Is that ten o'clock in the morning?" Because we had gone in in the evening and because I didn't think I would go from four cm to eight cm so quickly. .. I thought I must have been labouring all night.'

The intensity of the pain and the inward focusing needed to deal with it altered Sarah's conception of time. She became suspended in timelessness, in her altered state of consciousness.

And Alison told me:

'I think during the thing you are .. so involved with what's actually going on .. your mind never gets past the birth .. It doesn't go onto future things etc. I think it's just .. so involved with what's going on and concentrating on the job in hand that .. everything is just not important any more. No you are aware enough .. I think it is just a highly concentrated state. It's a little bit other worldly because you're aware of things but sometimes you just can't be bothered to react to them. They don't have any significance so to that extent it's a bit trance-like. Because you're not sociable because if they ask you a question you're concentrating on a contraction or what ever .. there is no need to reply .. but I think that's all probably to the good it's what we are designed to do.'

And Trisha told of a similar experience where her capacity for choice appeared to have shut down under the intensity of her labour experience:

'I mean I didn't have any pain killing injection .. so in fact I went just with the TNS from .. getting to the hospital at six o'clock until about half past two .. and then I was on gas and air after she'd broken the waters she said then "Your contractions will come much quicker." So then I was on the gas and air. I think I probably used three times my quota of gas and air .. but I thought it was good. .. it never occurred to me to have anything else. .. Even when we got to the real pushing stage I just thought "This is just my job now I have to do this." And that was it you know. I never thought to ask for anything else, it never occurred to me at all. People said to me afterwards "Ahhh you're brave!" And I thought "Or perhaps I'm stupid I didn't think about it."'

This evidence suggests that there is another element to the Malinowskian unpredictability factor which drives us to culturally manipulate birth in the way that we do, and that is the sheer pain which is involved. It is not surprising that when a woman experiences a level of pain which causes her to lose her capacity to think, or to conceive of the passage of time, she falls into a state of dependency upon those people around her, particularly when those people offer a consistent cultural theme which is easy to identify. Similarly the trauma of watching someone in so much distress has the tendency to make people feel helpless and to combat this feeling ritualised practices can provide concrete and positive action.

The distress caused to an observer can be appreciated in the way the women talked about their partners' experience of the labour.

Tracy told me:

'He knew that I didn't want anybody in this room .. I said "I don't want every body in there like. I'm not having anybody in." I think in the end he was just panicking so much he was just letting everybody through the door.'

Sarah described a similar need for her partner to hand over the manipulation of the birth to the professionals:

'The fact that I suddenly went from the contractions being five minutes apart and sort of being able to cope by .. walking around, very loudly and singing. The fact that I became obsessive basically and I had to be on all fours and on a particular piece of carpet every time a contraction came and I thought "I'm getting out of hand here." And I think the other thing I was aware was that Alistair was finding it .. upsetting .. He felt the responsibility until then he wanted to hand it over to somebody else.'

And Alison said:

'I was aware that .. she said [the NCT instructor] that it isn't that important to go into hospital .. if you don't feel like you are in labour .. because .. the likelihood is that they will induce you .. put you up to a drip if nothing else happens. So that's why I was very very anti phoning the hospital at all and when I did she said [the hospital midwife] "Oh well we will give you so many hours from when your waters went then we will put you up to a drip." So I was upset when I heard that. .. I didn't want him to go in [her husband] but he has a nurse who works with him and she said "Well you really should go in." And it was only the NCT that made me realise that you didn't have to go in if you don't feel like it .. Well it was sort of .. a compromise Simon was desperate that I should go in and phoned me back four times in twenty minutes and said that you really ought to get in and I thought well when he comes back he can phone them and say "Well she's not having contractions what so you suggest?" .. then.'

These examples illustrate just how nerve-racking it can be to be involved in a labour as an observer. There appears to be an urge to try to control the event in some way and when the observer is a lay person this involves making sure the labouring woman is in the safe hands of the cultural manipulation offered by the hospital and it's staff.

5.5.2. SYMBOLIC MESSAGES.

These surround the pregnant woman as soon as she goes into labour and passes through her separation rite. They are manifest in the equipment in the labour suite, the clothes the attendants wear, and the way the staff talk to the women. For example all the women were told that as soon as their waters had broken they were to come to hospital and many were not permitted to be mobile after this point (Footnote 5.) The symbolic message was that the medical interpretation is absolute and must be obeyed. Now that the woman had entered her rites of passage the pathological/medical interpretation must be submitted to.

Alex described her labour in hospital:

'I couldn't walk around I had to lie there because of the waters breaking, 'case the cord came down or infection or sommait. I was just laid on the bed on me back. I was sick of being laid down towards the end, you know. It would have been nice if I was in labour that long to be able to walk around.'

And Rosie told a similar tale:

'When they actually induced me on the Thursday morning it was about half past ten. It was the pecerine jelly that they give you. .. they put me on the monitor for about an hour to make sure. (Footnote 4.) I couldn't get out of bed so that it could get a good hold and there was about three of us on the same day that had it in the same room actually. And all day we kept saying "Do you feel anything?" "No." And one of the girls she started getting pains and what she thought were contractions which wasn't in the end. .. I started to feel not in pain, uncomfortable but not in pain by the time visiting came round on the night me mam and Phil came in and I said I felt different but I can't explain how different. I felt heavy .. I wanted to just pick up and just carry around put me arms underneath the bump .. and me back was aching. .. When they went home on the night I said "If I don't see you before I'll see you tomorrow." And I says "I don't think I will see you before. I don't think it's working." They went home like about quarter to nine and like as the night wore on I still wasn't getting pain. I was like chewed and uncomfortable. .. I went to bed about half past eleven and I had a sleeping tablet and pain killers. I had an iron tablet. I must have gone straight to sleep and I woke up I think it was about five past twelve and I can't explain how I felt it wasn't pain. It was like a bubble and then it just sort of felt like I wet meself but I couldn't stop it so I just sort of rang the bell I says "I think me waters have broken." The nurse comes down and the nurse that was on that night was actually really nice .. she stuck her head in the door and said "What's the matter have we got a water fall?" I says "Yeah I think so." She came down and she moved all the pillows around "Don't move" .. And she says "Oh yeah definitely your soaking wet down there." Then it was like action. They went and go for the trolley because you're not allowed to walk or anything once your waters have broken, they put me on the trolley. They don't like you to walk, you can't even sit they put you on the trolley. You're just laid there on one spot. Like if you're laid in one spot like I was to me you're just focusing upon what is going on like. If you're doing anything else you can maybes stick it to the back of your mind when the pain does come you can do whatever it is you've got to do. There's that clock you know in front of you. I mean I had twelve and a half hours lying there just watching that clock.'

Rosie's experience is filled with the repetition of the medical/pathological message. She is separated within the hospital setting, her labour is brought on artificially with the help of medical technology, before retiring she accepts a tablet cocktail, and as soon as labour started she was no longer permitted her mobile freedom. In these cases the symbolic message was the same: 'You are now to take on the passive sick role because we, the medical professionals, are in charge and

with our superior knowledge we know what is best for you.' For Rosie, some of this felt almost like a sentence. However for others the symbolic messages were invaluable props.

Alison explained:

> 'I just had the gas and air for fifteen minutes I managed with that. .. I wanted something else to .. concentrate on I think really. I think it was just getting beyond my my coping .. mechanisms. "Oh I'll have the gas and air." And I think someone asked for it for me. I don't know how he knew. I don't remember, I don't remember saying anything but I definitely wanted it when it was there. Simon certainly helped me then .. I mean I tend not to talk at all. But you're not really aware that you're not talking because you are talking in your head if you see what I mean.'

Alison's mind was so inwardly focused that she became unaware of whether she was speaking or not. But despite this intense trance-like state she felt her own physical and psychological resources run out and she was relieved to find the safety net of the medical technology there at hand. She was able to rely on and accept the medical/pathological symbolic message.

This type of account was quite common in the stories the women told me about their experiences. For example Helen explained:

> 'I think really I could have just coped on the TNS machine but it was just nice to have that whiff of gas and air just at the end. I don't know why I just felt I needed that little bit extra help. I think it was reassurance really.... It was me who asked then she just brought I had the mask and I think I probably only had three sort of puffs on it. I think it just helped me push you know .. it was a prop it helped me focus things somehow.'

5.6. YOU DON'T KNOW UNTIL YOU'VE BEEN THERE:

The excruciating pain and the feeling of bewilderment, confusion, vulnerability and simultaneous strength and weakness is, according to most the women I spoke to, indescribable. It is something that cannot be removed from the event itself or, put another way, it is something which belongs to the sacred and cannot be transferred to the profane. Therefore no matter how prepared the women may have been, when it came to it there was an element of surprise.

Sarah told me:

'I didn't want to talk about the labour and delivery because I felt I knew it .. from the text books .. But then I don't think anybody can explain those sensations to you anyway..... And I think that I .. can now .. identify with those women's feelings. It's because they were out of control so hearing about it is very different. Even though you could observe what happens to that person, how they react externally. You don't know what's going on up there about how they are feeling about themselves.'

And although Susan said to me ante-natally:

'People try to describe it but she said [her mother] "I'm not going to bother trying to describe it because it is something you can't really describe." Closest she said she could get is constipation. "You're constipated and you really try" But that's the closest she can get.'

Post-natally she complained:

'I wish they'd told us like "If you feel like going to the toilet that's what labour's like."..... All I felt like was that I needed the toilet like I was constipated that's all I felt.'

So even when the women felt prepared for the experiences many felt these were not what they had expected. It could be argued that any amount of preparation in normal time, which is structurally separated from the sacred intensity of the birth itself, cannot be carried over. (Footnote 6.)

5.7. REINTEGRATION

Some of the women described the period of 'Now off you go, you're on your own' as quite traumatic whether it was the first stage of the process of moving from the labour suite to the post-natal ward or from the hospital to home. Having submitted to the medical/pathological interpretation with all its technological magic, reassurance and support in some cases the women found themselves feeling a bit stranded when their cultural prop was no longer there.

Alison said:

'The midwife she offered just the presence of somebody who obviously knew what they were doing. .. And that if there were anything that were arising she would know what to do .. she would be in complete control. She was just a lovely calm person. You felt she had a wealth of experience and expertise nothing was going to faze this lady. you could throw anything out..... She was incredibly calm, very relaxed "Oh this is going great." Just very positive and

very calm. I mean she didn't even move quickly. .. And you could hear the chaos going on outside and she was just going "Oh this isn't very nice for you." .. It was very nice actually I couldn't have chosen a better midwife. .. I think the only thing that is a shame is that .. in the short space of time you build up this relationship with the midwife. You rely on her and think she's absolutely wonderful and you're shipped off really before you come out of your involvement in the birth and you're on the ward with new people and new nursing practices and they are not people that you've built a relationship with. .. I'm just trying to remember why .. I was quite sad when she went .. She took me to the ward and then said "Good-bye" .. "Come back! I'd rather you saw me through the next twenty four hours really."'

And Trisha told me:

'I came out and they said to me in the hospital "You you're midwife will probably ring you tonight .. because you're a first time mother and breast feeding .. or she should ring" I think they said "to let you know that she's coming tomorrow and that she is there all night if you need her." Well she never rang and four in the morning I was pacing round the bedroom going beep to that midwife {pretending to use the hospital beeping button} .. because I was so cross that she never rang you see and I needed the support on the first night..... I was at home now having to do all this nursing .. having had all that care in hospital now I was having to do myself all that. That was a bit of a shock to me.'

And Tracy, who had a C-section, makes a very interesting observation on this issue:

'Well, I still have this thing, where you .. haven't really given birth because you haven't pushed it out it's a peculiar thing. You think of course I've made this baby, it is part of me but then you think it's a bit strange because you haven't really. Well .. it was a bit awful that I didn't actually have her. You know what I mean, it's still in a bit of limbo at the moment.'

Tracy almost seems to have missed out on her reintegration process because she never felt the full transition. Because she wasn't able to follow the procedure all the way through, she was left feeling in limbo.

An uncomfortable reintegration was not the experience for all the women. Several of them were really keen to return to normal and felt restrained in the hospital setting.

Alex explained:

'I've never been in hospital before .. I was pleased to come out. I was ready to come home the first and second day. The first day why I couldn't walk .. I said to the midwife "How long do

you have to stay in?" Because I'd heard you've got to be in four days. And she said "It's flexible now but I advise you to stay up to six hours." Well I couldn't move after six hours anyway. I came out on the third day and I wouldn't have come out if they'd said to me "Stay another day or so." I would have stayed. But I really didn't want to. I would have done. It was fine so I came home I didn't see the point of being there when some one else could have the bed. That's how I saw it .. so I prefer to be at home...he wanted me home because he was missing us you know. He wanted us to be home on the Tuesday like. He was chuffed to bits we were coming out on the Wednesday.'

And Rosie told me:

'I was dying to get out I was tired of it. I suppose you miss your home comforts and I know when you are in hospital you've got the babies and the midwives are always there if you need them .. if there is something goes wrong there is someone right there. So when you walk out of the hospital you think "I'm on me own" Sort of frightening experience. But .. as well a couple of them, two or three of them that I wasn't stuck on at all. So for me I was desperate to get out of hospital I'd just had enough of it I wanted to go home.'

5.8. CONCLUSION

There is much evidence in the stories that all the women told me to suggest that it is fruitful to analyse the cultural manipulation of childbirth in our country, and the way women talk about these, as ritual or as a rites of passage. This approach helps explain three crucial issues:

1. Why many of the current obstetrical practices appear to survive, despite evidence suggesting they may be detrimental to the physiological process of childbirth.
2. Why the cultural gap between the ways the two groups of women told their stories lessened in the light of the event itself.
3. Why all the women I spoke to found the medical/pathological interpretation of childbirth irresistible.

The important function of ritual, according to Turner and Malinowski is to internalise specific norms and values in the participants. Turner argues that through the process of ritual, norms and values become saturated with emotion and as a consequence are accepted and internalised by the members of that society *{Turner 1967:80}*. The ritualisation of childbirth then could be said to have a circular motion in

that it that it recreates the dependency upon the symbolic message which it creates. Those leaving a hospital-managed birth are convinced of the value of hospitalised procedures and so the system is self-propagated.

However, while this type of analysis may answer some of the questions raised in the previous chapter it tends to give the impression that the participants in ritual adhere to concrete cultural norms. This is not what my data suggests. All the women adhered to the medical/pathological model of interpretation of childbirth and looking at it as a ritual helps explain this. However just as important are the varied and changing ways in which they adopted the many messages given out by the medical profession {see appendix IV & secl. ?}. The women picked and chose various medical/pathological themes they wanted to take on board and used these to describe their experiences, but their choices did not remain constant: Ideas were dropped and adopted depending on the context in which they arose.

This conclusion in itself raises questions about several of the claims made by anthropologists working with ritual theory. If, as the perspective as I have used it indicates, ritual serves to internalise cultural norms within the participant's world views *{cf Turner 1967, Malinowski 1954, Davis- Floyd 1988, 1990}* - through various techniques such as repetition, emotional infusion, specialisation etc.- then how is it that all the women I spoke to used the medical/pathological interpretation with such elasticity and relativity? It cannot be denied that they did all feel the need to adhere to this interpretation of pregnancy and childbirth. However, the way they used it always remained flexible and changed over time, suggesting therefore that the cultural norms and values behind the ritual message were not blankly internalised but rather were used in the same way as any other resource in the conversations about their experiences.

Just because these women underwent various pregnancy and childbirth medical/pathological rituals did not mean they were stamped for life with a static model of interpretation of these events. It may have helped reconfirm the importance of this particular model of interpretation in their minds, but the way they drew upon

this way of looking at pregnancy and childbirth in their conversations always displayed an `ad hoc` component - changing according to the demands of the on-going situation in which they were communicating and responding. These as yet unexplained problems in the way in which all the women spoke about their experiences of pregnancy and childbirth will be the focus in my next chapter.

FOOTNOTES FOR CHAPTER FIVE:

Foot note 1: I feel I should point out at this stage that this approach is somewhat contentious since while when I suggested labour might be described as some kind of trance state the majority of women agreed, they did not like the suggestion that the cultural manipulation they underwent during their pregnancies and births and the way they reacted to these might be described as ritualised behaviour. For example Helen said:

> 'No, no I don't think it's ritual. It's just another stage. No I wouldn't have said so. OK. I was very noisy probably. Well Jeremy said I'm very noisy erm but that's not special, it's not a ritual or anything. I would do that anyway. I'm quite noisy, say I play hockey and on the hockey field I'm noisy, I'm verbal where as he isn't. He's completely quiet and self contained. I think to a large extent he finds it embarrassing that I am noisy but tough he's not going through it. But that you know that's my character anyway, so I don't think I am doing anything different to what I would do in other circumstances spending a lot of energy on other things.'

While I do not intend to reject such sentiment I do not feel that their rejection of such a suggestion totally disregards it's uses. Ritual is a value loaded statement suggesting a certain blindness or ignorance and perhaps that was why it was dismissed by some of the women in my sample. In this analysis I am not suggesting that any of the women acted out of either of these, rather I am exploring ritual as a way to explain the irresistible nature of the pathological/medical interpretation of pregnancy and childbirth to which I myself fully submit!

Footnote 2 Cf M. Douglas 1980.

Footnote 3. All the women I spoke to gave birth in hospital and were advised to do so. This is despite evidence indicating that this setting is no safer and could indeed add more risks eg cf. Albermann 1977, 1984, Bowes 1970, Brazelton 1961, Caldeyro 1979, Inch 1984, Hall 1984, Hoult 1977, Johnson 1971, Klosterman 1987, Liston 1974, Mehl 1987, Potter 1971, Rosenblatt 1981

Footnote 4. This is a routine procedure which all the women underwent despite evidence questioning it's usefulness in obstetrical management: cf Brackbill 1984, Inch 1984, Prentice 1987, etc

Footnote 5. Despite cross cultural and quantitative evidence which questions such a practice See sec. 4.4.1. & 4.4.2.

Footnote 6. In order to get a real idea of what these women were telling me about their experiences then my own experience of the sacred in this context could be said to offer me an invaluable insight. *{cf Rosaldo 1983}*

I have never experienced a time when I felt so open to suggestion. My mind was totally preoccupied and it took all my energies to concentrate on getting through the next contraction. The force of the arrival of several green clad specialists cannot be underestimated. Any kind of resistance was out of the question. They promised me an end to my ordeal and I was in no position

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I have never experienced a time when I felt so open to suggestion. My mind was totally preoccupied and it took all my energies to concentrate on getting through the next contraction. The force of the arrival of several green clad specialists cannot be underestimated. Any kind of resistance was out of the question. They promised me an end to my ordeal and I was in no position not to believe them. Any hopes wishes or aspirations were tossed into the wind as I stared thankfully into the eyes of the consultant. He had the technology to help me, he diagnosed me unfit to deliver alone and offered me a solution and I desperately clung onto this solution this symbolic message. Having had this experience I can associate with the idea that you cannot anticipate how you will feel during your labour and delivery and it would seem that Malinowski and van Gennep offer a very feasible the explanation for the specialness of the occasion.

CHAPTER SIX

From model to metaphor.

6.1. INTRODUCTION:

In this thesis I have looked at the ways two groups of women talked about their experiences of pregnancy and childbirth and have shown the different and similar cultural resources they adopted to tell their stories. In this chapter I will be focusing upon a consistent trait which appeared throughout all my data. Laced into the ways the women described themselves and their experiences to me was a constant `ad hoc` type flexibility.

There appear to be two important aspects which are useful in describing this phenomenon. Firstly the women picked and chose themes, to which they had access, to make various points in their conversations. However the themes they chose were frequently reshaped depending on the context of what they were saying. They did not so much use models, as stretchy metaphors. *{cf. Lakoff 1987}*

Secondly, because of this constant picking and choosing, the ideas the women had on pregnancy and childbirth developed over time. Priorities changed and impressions were constantly built upon. Each woman then moved about within her cultural setting, which itself was mobile, and within this movement each woman had an ultimately unique experience. As Hunt et al argue the way women look at health is a 'dynamic interactive process where tentative notions of what is the matter, stemming from prior history and experience, are built upon, elaborated, discarded and so on, as this construct is continually exposed to the exigencies of every day life.' *{Hunt et al 1989}*

In this chapter, I will be looking at some examples which illustrate the dynamic elements in the way these women spoke about their experiences. I will be moving my focus away from the themes themselves towards the way the women actually used these themes. I will be moving from model to metaphor.

6.2. RELATIVE REMEMBERING.

Pertinent to this discussion is how the women perceived me and what they thought I wanted to hear. As their ideas on this formulated, so the accounts they told me altered. This complex, story-telling procedure, based upon personal drive to present self in a particular way with on-going empathetic guaging of the receiver of that image - trying to work out what it might be that I as a social anthropologist might be interested in - constantly reshaped as the conversations progressed. Therefore a recollection of an incident could be attributed a very different and relative emotional charge provided that charge, fitted into the overall picture the story-teller was wanting to portray.

For example Alison recalled her birthing experience telling of an incident where she cried out to the midwife to stay in the room with her:

> 'Simon was there and that was that was what was important and remained what was important .. near the end when I thought I was about ready but the midwife hadn't said anything and she was going to leave the room .. it then became very important to me that she didn't .. I managed to sort of gasp out "Don't go." In the middle of a contraction and she said "Alright." Because I knew it was getting to the stage that he was going to be born and I didn't want him to be born when there was nobody there. But Simon he was my emotional support and I had to keep hold of him.'

This picture suggests Alison depended upon her husband for her emotional support and the midwife's presence was needed for more practical matters. However later on in the interview Alison recalled:

> 'Just .. as I thought he was ready to come was a moment of panic and I thought well will he come out you know, will everything work and I think that was the point when I didn't want the midwife to go I needed her with me, I needed to rely on her.'

This description of the same incident suggests somewhat different motivations behind the action. Here Alison appears to describe herself as emotionally unsupported in a moment of irrational panic where she needed the midwife for reassurance, her presence for practical purposes is not a consideration.

6.3. MEANINGS AND ELASTIC TERMINOLOGY

I will use the examples of 'labour', 'natural' and 'non-intervention' which were frequently bandied about, to illustrate the point that terminology used did not

mean the same thing to every woman and what they meant by those three terms was greatly affected by their unique experiences. All three terms of course relate directly to the medical/pathological interpretation and therefore illustrate the relative and elastic way this interpretation was called upon in conversation about pregnancy and childbirth.

Robin described her experience of a fifteen hour labour:

'My first thought "Why have they left us in labour all this time?" Because it was fifteen hours by then wasn't it. Then they decided to take us down "Why didn't they x-ray my pelvis in the first place?" All sorts goes through your head. I'm annoyed they didn't x-ray me pelvis when I remember Mr Grant saying "You might have to have a caesarean because of your road accident." Oh I'm really annoyed about that. One of them things they are always saying "Well they try to give every body a normal birth." But I think "Yer but why that long?" You know "Why did they us do fifteen hours worth of labour?" .. I could have been down on there and back up on the ward by then if they'd thought about it. No if they had got someone to give us an internal before they did. I mean they left it so long'

Robin's ordeal was long and quite traumatic. It included being attached to a drip of syntocinon which caused her considerable discomfort and having an epidural catheter sited and continually topped up. These procedures of course had the associative monitoring - she was continually strapped to a foetal heart monitor and contraction monitor and was having regular blood pressure checks etc. All are normal procedures for this kind of medical intervention and as Robin says lasted fifteen hours. At the end of that time an internal examination suggested that the application of the baby's head was poor and her cervix was only three cm dilated. As far as Robin was concerned however regardless of these findings she had been in full labour since her waters broke.

Susan on the other hand had almost the opposite experience, she opened up and delivered very quickly. Like Robin her waters broke at the beginning of her birthing experience but she did not consider this to be the start of labour.

'They broke me waters, and that to full labour was about ... they took me down at about 4 o'clock and I was sat for about half an hour and they broke me waters and after that it was about 6 o'clock. 6 to quarter to 8 and she'd come. I woke up it didn't even seem as long as that. It seemed really really fast. Labour can be quite exhausting with people who go a long time. It was like "You're in labour push!"

" I don't want to push!" What are you making me push for ?'

In Susan's story then labour means a relatively late stage in the birthing experience. It actually starts at the second stage when the cervix has fully dilated and the baby's head is descending. Despite the fact that both Robin and Susan went to the same hospital, were actually attended by the same staff, and share similar backgrounds these two women made sense of the word 'labour' through their very unique experiences and since these differed immensely so did their use of this term in their story telling.

Similarly the term 'natural' was by no means statically and universally understood as one thing. Rather it was used by the women to illustrate their stories and therefore depended upon the events which they were describing and how they wanted me to hear their story about those events.

Alex said:

'No, I by people say "It comes natural to ya, when you're in labour" And it did come natural to me but I mean you do need help as well from the midwives. They did help me.'

This explanation of how Alex coped with labour suggests that a natural birth can be assisted by medical staff. Although the midwives helped her she was still able to do it naturally. In fact the help she refers to included having a syntocinon drip put up, having two injections of pethidine and having an episiotomy. However despite this level of medical intervention Alex was able to say that labour came naturally to her.

Whereas Tracy acknowledged:

'I'm not really into natural birth stuff to be quite honest... 'I'm a firm believer that if people take the time to invent these pain killers then you should take them, like that doesn't bother me. I just think that's how babies are born in hospital with all the things that are in hospital. You go to hospital to have a baby .. That's what you do .. there would never be a question. .. That's what you do you go into hospital to have a baby!'

The implication here in what Tracy is saying is that the physical act of giving birth in hospital cannot be considered natural. A natural birth therefore for Tracy was never an option. Birth is medicalised and not natural, the two are mutually exclusive.

Just by taking these two expressions 'natural' and 'labour' it can be seen that the women made sense of and used such terms in contextually specific circumstances. How one woman used the term depended upon her previous experience and on what story she was telling at the time. Models of understanding then were never static; they constantly moved depending upon these variables.

'Non-intervention' was another theme which was important to many of the women I spoke to from both samples and indeed is a central issue in the NCT message.

For example Cathy explains:

> 'All pregnant women would go into hospital .. it's very interventionist when you're pregnant. People keep monitoring you this and that and the other. .. I've heard horrific stories like every time you go for an ante natal appointment you have to have an internal examination. You have to have this, that and the other done. You .. go along and you say "Well I've got a bit of back ache" and suddenly before you know it you're receiving big straps around your back and things like that. Where as I think that if you feel all right you should be just left to get on with it because it's a perfectly natural process. .. People get pregnant every day, people have babies every day so why is it treated as an illness?'

But exactly what is a non-interventionist pregnancy and birth? From all the women who attended the NCT classes, it was clear that they picked up the non interventionist ideas in a very `ad hoc` way. There appeared to be no consistent model. They used these ideas depending upon the point they wished to make.

For Sarah the issue of the cord was very important.

> 'I didn't want syntonetrine for the afterbirth given so that she would get any. That wasn't really the reason, the reason I didn't want to have it while she was still attached so that the blood was correct. .. I wanted the cord clamped and then the syntonetrine given .. so that she didn't get any. There's a theory .. there is more chance of jaundice because the placenta going down pushes into the baby and .. baby's got more red blood cells to break down.'

However Helen who also went to NCT classes described her birth and told me:

> 'the midwife was sort of behind me and Janice said

"Don't collapse down Helen you'll squash the baby." And then I think I sort of sat up a bit more had a look at him and .. Janice clamped the cord cut him off. Letting the cord stop pulsating that wasn't something, I just hadn't thought about the cord. She gave the injection for the placenta but I didn't notice that happening or anything. She didn't ask if I wanted the drug well there again Janice knows me and we talked about these things she knew I was quite happy. I said "Have I had the injection?" She said "Yes" and that was it. The cord was not important to me at all.'

And Trisha fell directly in-between these two views of the level of intervention that should be taken with the baby's cord.

'I thought "I want my baby's blood to go into my baby if it's going to help her." I was just determined that she was going to get the last drop and that was fine with her.{The midwife} It took a little time to wait till it stopped pulsating I remember her saying "I'm just waiting for the cord to stop pulsating" .. that was another thing I had wondered "Do I want this injection?" .. that seemed a bit artificial to me and .. but as I understood it you can be hanging around quite a while for your placenta to come otherwise and I thought "No I can see the logic of getting this seen to and get everything out now" and so I was happy to go along with the injection.

The same observation can be made for several other 'interventionist' procedures. For example induction was abhorred by some as being unnatural and threatening lack of control, while others who still wanted a natural or a minimum interventionist birth welcomed it.

Alison explained:

'I definitely don't want to be induced, if that can be avoided at all costs really. It isn't natural and is fairly unpleasant more like having an illness really. Every pregnancy and every birth is unique. Every body is different. I couldn't tell when forty weeks would be up. I was on a three week cycle when I got pregnant. Basically I think they come when they are cooked. Because he has been engaged they kept telling me you'll be early. The due date is a bit of a shame really.'

Whereas Gabby, who also told me having minimum intervention was important, since she wanted a natural delivery over which she had control, said she would welcome being induced:

'It couldn't happen soon enough. I would be happy to be induced partly because I feel the weight of the baby which is uncomfortable and there's a sense .. "I've been pregnant long enough and I want to get on with the business of finding out what it will be like."'

And for Alex the issue of induction was beyond comment because she hadn't experienced it personally when she gave birth:

'I've heard it hurts as well so. I wouldn't know it's what I've heard. I haven't been there. A few people have told me different stories .. they didn't like being induced .. it's supposed to hurt when you get induced. You just hear different stories.'

But later she told me:

'They did put the drip in us to make the contractions moving faster because they had stopped to go faster.'

The drip she refers to is one of the most technical forms of induction.

The apparent flexibility of the way the women took up various issues applied to most of the themes the women used to describe their experiences. All the women heard the things they wanted to hear and disregarded issues they considered unimportant *{cf. Last 1981}*. They did not passively accept concrete cultural models but they renegotiated themes which they found appealing and adopted or dropped these themes depending on the context in which they were talking.

6.4. DROPPING AND TAKING UP

During the course of the conversations I had with the women they obviously had several points they wanted to express. The women told their stories about their pregnancy and births using various illustrations. The way they used these indicated that the point was not so much the medium they were using but the contextual point they were expressing with that medium.

For example Sarah told me:

'I think information is all important really I mean for instance .. when I was pushing her out .. that .. thing where you .. get that awful sensation where it's burning, it's really painful and the temptation is there not to push at all. And and I thought "Thank goodness I know to keep pushing here and not to hold myself back." And I thought that information is really important to tell to tell people. .. I think I found it .. a frightening enough experience

knowing what I know, so for people that don't go to classes or who haven't talked about it or read anything about what it is about must be absolutely thrown.'

The premise she is using then is that women should be well informed if they are hoping to deal with the experience of childbirth. However later in the same interview she told me:

'Books and things .. I think they're some very good ones around aren't there? But again they can be contradictory as well can't they and I think you can almost do too much reading around the subject. .. I used to find out when I went to the classes there were girls that had every book, got so confused that they were actually getting more anxious as a result of that.'

When Robin was talking about her experience of labour she initially stated:

'The advice they give us was good. I think it was the same all the way down the line. They all said the same thing and explained every thing to us. They were dead nice.'

The point she was making is that she felt well looked after and had no complaints to make about the staff. However she went on to say:

'the medical student, she .. relaxed us totally when she kept going over and looking at the baby's heart beat compared to the contractions. That was the only part that I got annoyed about because nobody else had noticed that, she was the only one who had noticed that and in the end that was the reason for them giving us the other internal.'

This suggests that the concerns of the medical staff were not in fact the same and she found some members of staff more trustworthy than others.

Alison explained to me that she found the NHS ante natal-classes unhelpful because she was already well informed:

'The ante natal classes weren't any good, may be because I knew too much anyway. They were aimed at such a broad spectrum of people. I'm not saying they weren't good for some people just no good for me.'

She went on later in the interview to describe herself as someone who was not at all informed and therefore made a decision she regretted:

'I can't understand why we did what we did then. I was tired and sick of being pregnant. I didn't trust my body particularly. Some house doctor I'd never seen him and he said he would do that so he did. I didn't even know what an induction was, which was really naive I suppose.'

These examples illustrate the flexible way the women used various mediums. Depending on what point they wished to make they took up and dropped various themes in an *ad hoc* way *{cf Garfinkel 1967}* to provide their stories with suitable illustrations.

6.5. THE GIVING AND RECEIVING

This dynamism does not only apply to the way the messages were received and used by the women. It also applied to the way various people gave out information about pregnancy and childbirth. The interesting point here is that due to the conflicting or even contradictory advice given to them, the women felt compelled to pick and choose their own themes just as they would in any other situation. There was frequently no need for consistency, that was almost irrelevant.

Susan told me:

'I've just got leaflets and that's it. One about it's called 'Pregnancy Book' then you get just .. leaflets about breast feeding and .. injections and things you get. .. I've read .. that big pregnancy book it's good. You get a good one at the hospital like .. You get like this big folder, big blue folder .. parental craft and all that in it really good. Ya get more at the hospital than the surgery. They have them classes as well, she's trying to get me to go to those, them classes just talk about breast feeding and I say

"Na." Cause people got different methods that's the trouble. One's saying one thing, one saying the other. You sort of like when it comes along I'll just find out for meself. Why different leaflets, leaflets saying different things.'

Susan is suggesting that she had been given conflicting advice from various official sources and yet she still found the information useful.

During an observation of a birth I noticed two doctors giving Rosie very different advice. However she took no notice of this and opted confidently for one version which fitted in best with her own idea of herself.

Dr A. 'No I'm not worried about the trace the trace is fine we'll just leave it all for now and see how things get on shall we?'

Dr A. 'We have to make a decision and this will have an affect not only on your delivery today but on future pregnancies and deliveries because once you've had one caesarean.

You see the baby's head is not even in the pelvis yet and the top of your pelvis the bones stick inwards a little and that's why the baby isn't coming out. So we need to get him out don't we? And the heart rate keeps dipping.'

Dr B. 'We are giving you this Caesarean not because your pelvis is too small. Just because you are having a caesarean now doesn't mean you will have to have one in subsequent pregnancies if you have another baby. It's not you, it's not because you are too narrow for the baby's head. We are worried about the heart beat you see. Do you understand?'

Rosie opted for the first explanation:

'There's nothing can prepare you for them saying

"Sorry but we're going to have to take you down for a section" when you are expecting to have a normal birth. No way frightened the life out of us. I thought

"What have I done wrong" .. that was my first thought. "What have I done wrong? Why didn't they x-ray me pelvis in the first place?" All sorts goes through your head.'

By accepting the first explanation Rosie was able to get away from her 'what have I done wrong?' anxiety and answer the question satisfactorily herself. She simply dismissed the second explanation as irrelevant and never mentioned it again.

During a NCT ante-natal class I observed the instructor also using sliding metaphors. It was important for the teacher to instil confidence in her group by portraying herself as a person who is as well informed as the medical profession about pregnancy and childbirth. This stance put her under a great deal of pressure to be not only a knower, but a knower of facts the women wouldn't normally be told by NHS staff. For this reason many 'facts' appeared to be stretched into a particular direction for example:

1. Pethidine was dismissed as largely ineffective, although several in the group spoke of having had it before and finding it very effective.
2. Epidurals were said to result in back ache lasting anything up to year. Again this was accepted by the group although I spoke to women afterwards who said that that was far from what they had heard from people who had had epidurals.
3. Entenox was said not to cross the placenta at all.
4. And massage was described as 'something that will really work.' although none of the women I spoke to used this technique as a form of pain relief during contractions.

In each of these cases, the people using the metaphors had particular objectives in mind and therefore stretched their mediums to convey those meanings appropriately. There were certain themes that particular people were likely to use when talking within particular situations but these could never be described as models since such a phrase implies a concrete entity of some kind and this was never how information was given out.

6.6. METAPHORS IN LABOUR.

While all the women and their advisers and attendants seemed happy to use sliding metaphors during normal interaction, on occasions come a problems arose during actual labour. Because of the pure physical sensation of labour and the extreme vulnerability felt by the women at this time, some needed to cling onto something that was not going to move. They needed a firm prop and in some cases an elastic metaphor wouldn't do. This dilemma lead the women to make decisions that they subsequently regretted.

The way Cathy talks about her experience makes a very interesting point of fact:

> 'I realise now what I was feeling at about twelve o'clock, one o'clock in the morning was the urge to push .. But because I was very confused, because I wasn't actually sure what this was meant to feel like and because I had eaten a big meal .. I felt like I wanted to go to the toilet and empty my bowels and I thought "That's what is going to happen" and I thought "I can't push" because I was .. doubly confused because the NCT teacher specifically told us that when you are 10cm dilated the contractions don't hurt. And I thought the pain of the contractions would stop, so I was waiting for the contractions to stop hurting which of course they didn't... Well I wasn't pushing hard enough because that's the other thing which was conflicting advice. I mean I understand that some women can just sort of breath their babies out but not me I have to push like mad. I didn't push very hard, I understand why they call it labour. .. there was none of this breathing out, I had to push like mad it was the most painful thing... I was clinging on the advice about the feelings I should be experiencing which was wrong .. so of course .. by three o'clock .. they said
> "Oh look you are going to have to have some help" and I remember feeling very disappointed.'

Due to the extreme demands of the experience of labour Cathy focused upon a particular message she had heard during an NCT ante natal class. She tried to

use it not as a metaphor but as as a concrete entity. She was unable to let her interpretations move because she needed them as a prop and consequently felt very let down since her prop had failed her.

6.7. DECISION CHANGES:

No matter how clear the women were prior to the birth on how the birth and delivery would be, every woman to whom I spoke changed her mind over at least one issue. The pressure behind the changes were generally two fold. Firstly, the actual physical sensations involved in labour and the emotional distress associated with that and secondly, advice given from various sources but particularly the medical staff in attendance.

Tracy explained:

'She also showed us .. like monitor thing for the baby, but if it's inside you know if the baby is in distress then they are going to attach it to the head. And I mean we were disgusted at this thing, how cruel and fancy putting that on a baby's head. Cause I know Martin had said "They wouldn't put that on my baby's head!"'

And later she told me:

'There's no dignity in it anyway you just don't care. My baby ended up having two of those monitors on her head. It doesn't really hurt. If you need it you need it..... It was just like all of a sudden the world just stopped and this major pain came and I thought I was going to die. I said

"Oh my God!" You see I was in this total pain. I never had a break from pain that was the problem never ever. And what was making it worse was instead of her face facing my spine, I can't remember what you call it now, her back was against my spine so it was pressing my spine..... As I say any body could have come into the room and done anything, I couldn't have given a nick what they doing.'

Tracy made several decisions she had not expected to make due to the sheer ordeal of the labour. She did not enter labour with a fixed model. Instead she abandoned several ideas and adopted new unexpected ones in an ongoing manipulation of making sense of her experience.

Sarah told me:

'I expected to be much calmer than I was, far more in control. I expected to be able to do my breathing .. I expected to be able to walk around, get into what ever position I wanted to.

Whatever felt comfortable. Get into the bath, I didn't gain as much relief as I had hoped that would..... There was a girl in our group who was determined to do it without any .. other form of pain relief except for the TNS. That was my intention but I thought it was just horrendous. I thought

"God I've got to have the pethidine!"... I was very surprised about how I was .. I thought I would be worried about foetal distress and that sort of thing but no not at all. .. I was just getting on with the contractions and the next contraction ..... I hadn't expected it to be so frightening about labour really. .. I think it's because you're not in control, things are happening to your body.'

Sarah found herself abandoning several of her previously-held expectations in the face of labour and as a result the decisions she made during this stressful time were very different from those she had anticipated. {Also see Sec.5.5.1}

It is not only the physical sensation which motivated decision alterations. The women I spoke to all constantly built upon their perception of how pregnancy and childbirth should be managed, and their ideas changed depending on information they received and decided to incorperate into their perception of the events.

Although ante natally Helen explained to me:

'I wanted to have the domino scheme but they don't do that, what they are offering me is something very very similar where by I go in as late as possible. .. I hate going into hospital.... The idea is to stay as natural as possible... I'm going to be at home. .. I know that that works .. you can go into hospital in the last couple of hours deliver and be out again. I don't think the first stage is dangerous.'

She describes the actual event quite differently:

'From a week before me due date I was thinking

"Any night now. It's all going to start happening." I was really sort of half lay awake at night waiting for the pains to come and it didn't so it was a real surprise I still wonder now how long it would have actually taken had I been left alone totally. .. I went to see the consultant on the Wednesday .. and he was due to be born on the Saturday before that so he was about four days overdue by then. He said he usually leaves his ladies a week to ten days. At that stage I was so hot and bothered I said "The earlier the better" and he said "Oh I'll do it on Monday night." He didn't like to do it any earlier than a week really and that fell on the weekend so the earliest he would do was the Monday. So I said "Fine."'

After being induced with prostine on the Monday night which involved going into hospital before any sign of spontaneous labour Helen went on to explain:

> 'Well he said that he could leave me longer to see if the pessary would start working or give me another one or that .. they could try breaking me waters and that could start things off. And I said "Yes break me waters." I wanted to start and get things going. I think I just wanted to get on with it and I didn't object to having my waters broken. I think that's probably more natural than sticking drugs in you. I don't like drugs. I don't like the idea of drugs at all if I can help it. It's .. just something you know that's just helping nature along rather than pumping yourself.'

What is particularly interesting about this decision change is that Helen manages to maintain her original fundamental belief of having a 'natural' birth despite a decision reversal which involved having her birth medically managed. She had an artificial hormone inserted into her body and her membranes ruptured but she was able to describe these procedures as 'helping nature along'. However, although Helen was able to fit her changed decision into her original ideas about childbirth, the example shows that Helen abandoned her ideas about labouring her first stage at home because of the notion of a forty week gestation period and because of advice she received from her consultant.

The examples I have used thus far to illustrate the case of decision movement have tended to come under one of the categories or the other. That is they have been motivated either by physical sensation or developing advice. Of course these divisions are artificial and all three examples are in fact probably to some degree a combination of the two. My last illustration however explicitly falls in-between these two categories.

Ante-natally Robin told me:

> 'The only thing that I've read that really worried us is about epidural at H-------l hospital. There's five women that I've read suing the hospital because they're paralysed from the waist down. "That's it I don't want an epidural" That really frightens us. So I definitely don't want the epidural. That is one thing. Apart from that I'm not bothered.'

But after the birth she explained:

> 'I wasn't expecting to have the epidural. I went for that at the last moment. It just went clean out the window everything. Well it was probably right because Alison me friend she'd had

two epidurals and she said it was the best thing since sliced bread and it was I didn't feel a thing..... I tried but no way I couldn't. I felt awful creaking the bed about because there's like other people in the ward so to keep out of the way I sat in the day room. Tried to read a book impossible. How people say they sat and read when they were going through that pain I don't know but I just couldn't. I remember needing to walk about all the time, back ache mainly, it was there all the time it ached. One of the midwives I'd been talking to at about four in the morning this was said that the epidural was good. And she told us "How many people in five million get paralysed?"..... So when the midwife "Have you thought of pain relief?"
"Yes I'll have the epidural" and that was it. It was "I'll have the epidural" and I thought "Robin you didn't want the epidural when you first started off."'

Robin's decision then to have the epidural seems to have rested upon having a very disturbed night in the first throws of labour and a conversation she had during that time with a midwife. However having made that new decision Robin was able to take up previous advice she had had from a friend which she had previously ignored and this in turn helped support her decision.

6.8. CONCLUSION:

While it is useful to talk in terms of models in order to analyse the cultural context in which people make sense of their lives and physical experiences I do not feel such an approach can be offered as an adequate explanation in itself. The situation in my data is far more complex and warrants further explanation.

In this chapter I have looked at the ways the women used the various cultural themes about pregnancy and childbirth on offer during their conversations with me about their experiences. It can be seen that the rich soup of ideas around the topic from which the women drew was used in a very `ad hoc` and movable manner. Because of these dynamic elements I would not say that the women used cultural models to interpret their experience instead they used sliding metaphors in an ongoing process of assemblage.

CHAPTER SEVEN

Summary and Conclusion

7.1. INTRODUCTION

At the beginning of this ethnography I identified a set of issues, which I became aware of during my field work with two groups of pregnant women living in the north east of England. These were:

1. Despite a sampling technique which ensured a wide socio-economic diversity, the pathological/medical interpretation of pregnancy and childbirth was a consistent theme, frequently drawn upon by all the women to whom I spoke.

2. However the two groups of women involved in my research reacted, ante-natally, to their condition of pregnancy in quite different ways and these differences tended to co-incide with the socio-economic differences between the two groups.

3. Within these general patterns there was a great deal of movement and ongoing assemblage. Ideas about pregnancy and childbirth were used as sliding metaphors. Themes were picked up and dropped in conversation depending upon multiple variables; such as: interactive experiences with other women, health professionals etc. *{cf. Hunt 1989}*, the self image the women were trying to create in relation to their accounts of their experiences *{cf. Goffman 1978}*, empathetic incorporation of my reaction to their accounts during the interviews *{cf. Carrithers 1992}*, physical sensations connected to the condition *{cf. Odent 1984}*, emotional state etc. at the time of interview.

In this final chapter I hope to draw all these aspects of my findings together, assessing how my ethnographic material and the problems it raises may best be interpreted and the policy implications of that interpretation.

7.2 THE DIFFERENCES.

The two groups of women to whom I spoke were different in two fundamental ways: Firstly I gained access to them via different routes: one group was contacted through the NHS and was picked (using set socio-economic criteria) and the other through the local NCT classes. And secondly the NHS group were all local women, who had attended State schools in the area and had traditionally 'working class' family backgrounds, while the NCT group were all migrants into the area, had varied educational backgrounds (which included both State and private schooling, as well as in several cases a university education) and had 'middle class' family backgrounds.

These fundamental differences between the two groups of women appeared to carry significant implications in the way they chose to talk about their experiences of pregnancy and childbirth. The NHS group generally had less comment to make about their experiences.{see Appen. IV.} They accepted the medical interaction in which they participated ante-natally, natally and post-natally as inevitable and although they put up objections to individual health professionals on a personal basis in some instances, they generally accepted the authority of the medical/pathological interpretation as legitimate. {see sec 2.3.}

Out of all the women in this group, only one felt the need to prepare for the birth by attending ante-natal classes. Their way of looking at pregnancy and childbirth tended to render such preparation futile, since it was the health professionals' responsibility to take care of any problems which might arise and all the women had confidence in their ability to do so. Generally the attitude was: 'What will come will come and there is not much I can do about it.' {see sec. 2.6.} It did not fall into their jurisdiction as such.

However, while the medical profession was left to deal with any uncontrollable medical problems related to their pregnancies or birthing experiences they were not relied upon very much as a source of support. Local networking with friends and family, predominantly female, largely filled this role, and it was advice from

these sources which offered these women most of their practical support. {see sec. 2.2.}

The NCT group on the other hand generally had much more to say about their experiences of pregnancy and childbirth and about the medical interactions in which they participated, associated with their condition. In talking about the health professionals, this group of women tended to feel a need to offer a challenge to the medical/pathological interpretation, the expression 'educated decision' was frequently bandied about {see sec. 3.4. & 3.6.} and this group was not prepared to accept the opinion of the professionals unless they personally thought it was justified.

The NCT classes were seen as a way of gaining access to the necessary information they felt they needed to make the educated choices concerning their pregnancies and birthing experiences {see sec. 3.5.}. These women armed themselves with information gained from the ante-natal classes, various books and literature as well as information supplied by NHS health professionals. They thus felt more equipped to deal with the unpredictable aspects of pregnancy and childbirth. {see sec. 3.3.}

The theoretical and therefore policy implications of these findings suggests that demographic history and socio-economic status carry with them significant cultural differences which can not be underestimated when considering pregnant women's health-seeking behaviours. To talk in terms of 'patient's models' as a single, concrete entity, as implied by Kleinman, is therefore too limited, since even my sample taken from a white, ethnically homogeneous group living in a twenty-mile radius area of the north east of England showed a high degree of cultural heterogeneity.

7.3. THE SIMILARITIES.

Despite the differences in the ways the two groups of women talked about their pregnancies and childbirths, there was an overwhelming similarity: the ultimate acceptance of the pathological/medical. Regardless of the divergent ways the

two groups of women talked about their experiences of pregnancy and expectations of childbirth at the end of the day they all subscribed to the medical/pathological model of interpretation.

To explore this aspect of my ethnographic data, I took a two-pronged approach. Firstly I took a closer look at this model of interpretation, testing its legitimacy against a selection of secondary literature. I used a historic approach {see sec. 4.3.}, a cross cultural approach {see sec. 4.5.1.}, a quantitative approach {see sec. 4.5.2.}, and a more sociological approach using a feminist critique and professionalisation theory {see sec. 4.6.} Thereby I was able to conclude that it does not seem to be the impeccable 'scientific' performance of medical practices related to pregnancy and childbirth which made the medical/pathological interpretation so irresistible to all the women I spoke to.

This led me to test another theoretical approach: the anthropological theories surrounding ritual. I found that the perspectives outlined by Malinowski {see sec. 5.2.}, van Gennep, Davis-Floyd {see sec. 5.3, 5.4.,5.5., 5.7.} and V. Turner were able to address the issue of: 'Why all the women in my sample, despite any previous convictions, ended up accepting the medical/pathological model?' By using such theories I was also able to incorporate the all important issue of the actual physical sensation of childbirth, or more specifically the pain involved, into my discussion {see sec. 5.5.1.}. Such theoretical approaches were therefore invaluable when dealing with this crucial element in my data.

A question which can be raised from the conclusions drawn from my analysis in Chapter 5. is - 'How fruitful is ant-natal preparation?' Both groups of women relied upon the medical/pathological interpretation of childbirth but it was the NHS group who had fully anticipated this turn of events. By making little attempt at being involved in the autonomy over their birthing experiences they had not put up any hurdles which might get in the way of their accepting the health officials' interpretation of events.

The NCT group on the other hand wanted 'informed choice' and needed to feel in control of their experiences. And in many cases these women were faced with having to abandon hopes of personal autonomy when they surrendered to the medical/pathological interpretation of their experiences. They tended therefore to have more difficulty in justifying where they delivered their baby, what position they were going to deliver their baby in , what pain relief they needed etc.

While my ethnography suggests that the NCT provides a vital service to the women who chose to attend their classes and who needed to feel informed in order to approach childbirth with confidence, my data does not imply that these women were necessarily given an advantage by attending these classes. Indeed it could be argued that their experiences of childbirth may have been made more traumatic by the struggles they had to endure when submitting to the medical/pathological interpretation of events and thereby giving up their personal autonomy over the events.

An important question in assessing whether a woman who has attended NCT, or indeed NHS, run ante-natal classes is at an advantage may be 'How does the knowledge that a woman has attended NCT classes affect the way health officials react to her?' Certainly from observations made during the labours of both an NHS and an NCT women the two women were approached in a very different manner, by both the midwives and the doctors. However the institutions and staff involved in these interactions were different and I did not conduct interviews with the staff in question to ascertain their views upon the women they were attending. It is an important issue which my ethnography simply brushes against but which perhaps could be fruitfully explored in further research.

7.4. THE ASSEMBLAGES

Despite the overall patterns I found in my data, an important aspect of the way all the women spoke about their experiences of pregnancy and childbirth, regardless of the themes they chose to use, was the flow in the way they used these themes. Every point they made was used relatively. These women could not be said to

be using models as such, rather they used metaphors which constantly moved along a sliding scale {cf. 6.1., 6.2.,6.3.}.

While ideas such as patient's model theory and ritual theory were useful in explaining some aspects of my data they could not be used alone - they simply left too many holes by being too static in nature. All the women used and picked out various cultural themes, but these were utilised in interaction and therefore were manipulated according to that interaction. The women did not regurgitate cultural models, but used a variety of metaphors in a colourful and conscious manner, sometimes building on and sometimes ignoring various aspects of these stretchable metaphorical interpretations.

Some ritual theory suggests that, as a form of cultural apparatus ritual functions to internalise and reinforce concrete cultural norms. While I do not deny that ritualised behaviour, such as that discussed in Chapter five, may help to popularise the pathological/medical interpretation of pregnancy and childbirth, it cannot be said to alter the women's perspective permanently. Each woman took with her, into the medical interaction surrounding her pregnancy and childbirth, a unique and constantly reforming set of ideas and values. The ritual experience was placed upon such a foundation and can be and was therefore manipulated in a diverse manner. Gabby, for example, was able to undergo a full medicalised childbirth with the delivery of her first child, with all the ritual behaviour which goes with it, and yet still opted for NCT classes, hoping for a more 'natural' childbirth with her second.

Due to the various aspects raised by my ethnographic data I found using a mixture of theoretical approaches to be most fruitful. No single approach appeared, to me, to solve all the problems raised. I needed a more flexible theoretical framework which would allow me to utilise the insights offered by various theoretical perspectives not frequently seen together, each offering useful ground in explaining my ethnography.

Figure 2 The theoretical combination.

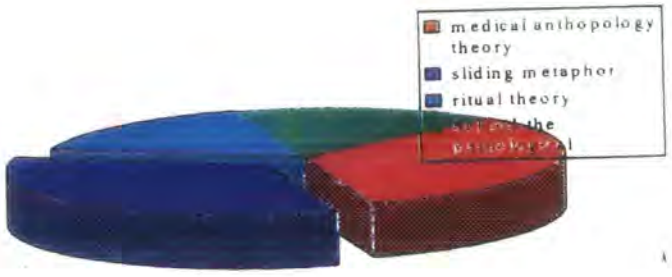

Figure 2. illustrates the combination of theoretical approaches which I used to analyse my field work. The whole circle represents the ethnography in its entirety and the divided sections illustrate the various aspects of my ethnography and the theoretical approaches I used to look at them.

The red section refers to Chapter Two and Three where I took a medical anthropological approach, with a cultural heterogeneity sensitivity, to look at the way the women talked about their experiences. The two green shades stand together and refer to Chapter Four and Five where I took a closer look at the medical/pathological interpretation of pregnancy and child birth and explored it in terms of ritualised behaviour. And finally the blue section represents my discussion in chapter six about the flexible way all the women used metaphor to describe their experiences.

7.5. POLICY IMPLICATIONS

During my field work I was told of a proposal for an NCT teacher to be employed by the NHS to deliver a series of ante-natal classes in a hospital which serves a traditionally 'working class' area. In the light of my data such a policy would seem to be inappropriate. It is based on the assumption that the cultural messages which so

appealed to the 'NCT type' of person - i.e. a woman who is likely to have a relatively high socio-economic status etc. {see sec. 3.7.}- should be impressed upon a group of women who come from a quite different socio-economic and, importantly, cultural background.

Indeed the evidence from my ethnography helps explain why, in many cases, the resource of the standard, NHS-run classes is not taken up. The whole notion of preparation for childbirth, and taking responsibility for your own pregnancy and childbirth is likely to appeal more to a certain section of our society. In other cases such messages would only ever seem irrelevant. {see sec. 2.6.} The key to policy making, not only in terms of ante-natal classes but also more generally, is thus flexibility. Groups such as the NCT offer an invaluable service to those who wish to attend them and therefore fill an important cultural need with a particular group of women. However, to assume that such classes will be universally useful falls into the trap of assuming that pregnant women form a culturally homogeneous unit. {See sec. 1.2., 1.4., 7.2.}

A more flexible approach not only allows for cultural heterogeneity but also addresses the other important factor highlighted by my data, the elasticity in the way all the women used various themes during their discussions about their experiences of pregnancy and childbirth. {see chap. 6}

Finally my ethnography appears to suggest one other important policy implication, which does appear, in my material at least, to be universally applicable. {see chap. 5} All the women despite any socio-economic differences between them, despite any cultural heterogeneity, and despite any sense of elasticity, needed to feel confident in those medical professionals responsible for managing their pregnancies and childbirths. They wanted the reassurance of an expert who knew exactly what they were doing and more importantly had everything under control. In the cases I have explored it seems feasible to argue that such impressions were maintained through the construction of a variety of ritualised medical practices (the empirical evidence

justifying the clinical 'effectiveness' of these practices becomes irrelevant: see chap. 4) and I would like to suggest this appears to be a successful formula.

7.6. NHS VERSES NCT?

The priority of being able to make 'an informed choice' was high with all the NCT women to whom I spoke and being part of this movement was seen as a step towards that objective. The standard information given out by health professionals was not to be accepted blankly. Being part of the NCT, according to several of these women, provided the means to question the authority of the medical/pathological interpretation of childbirth {see sec. 3.2}

How much of a challenge the NCT organisation presents to NHS pregnancy and childbirth practices is somewhat unclear {see sec. 3.4}. For example the NCT literature presents a good deal of research results which tend to begin from the starting point that medicalised childbirth is necessary: the Winter 1994 magazine publishes results from a survey on foetal scalp monitoring without mentioning any of the arguments against the practice of monitoring itself, it simply examines technicalities, assuming the practice is legitimate. {see sec. chap. 5, footnote 4} The NCT 'informed choice' then could be said to be rooted in a medical/pathological interpretation of childbirth. {see sec. 3.4.}

Over the past twenty years or so childbirth practices in the NHS have changed: a more 'natural' birth policy is now acclaimed to be a high priority within the service. It could be argued that pressure groups such as the NCT have affected these changes. However it could otherwise be argued that both organisations have mutually co-operative ideological systems which help maintain one another. If the NCT does not in fact challenge NHS practices which present a medical/pathological interpretation of pregnancy and childbirth, then the toleration of this organisation by the medical professions and institutions, and its encouragement by limited policy change with-in the NHS, can be interpreted as two self-interested organisations protecting their own priorities by mutual and profitable exchange.

As my data has illustrated, even those women who saw themselves as offering a challenge to the medical/pathological interpretation of childbirth, by rejecting many medical rituals, they found themselves depending upon those rituals both as a safety net devise {see sec. 5.5.2.} and as a focus against which to pitch. They all picked different elements of the pathological/medical interpretation against which to make their objection {see sec. 6.3.} but in their protest they had a common cause and it was this cause which crystallised the message of the NCT movement and their affiliation to it.

The relationship between the NHS with its medical/pathological emphasis and organisations such as the NCT may therefore not be as clear as it seems. My ethnography suggests that the idea of these organisations and their philosophies as representing opposite sides of the fence is too limiting. The ideological messages are more intertwined and offer a range of cultural themes which are drawn upon by those people involved in pregnancy and childbirth in a colourful, ongoing, interactive process.

CONCLUSION

In this thesis I have demonstrated how two groups of women, living in the north east of England, but coming from divergent socio/economic backgrounds, talked about their experiences of being pregnant and giving birth. The material I have presented raised three basic issues and I needed a combination of theoretical approaches in order to analysis these issues.

Firstly socio/economic status had significant implications upon how the women talked about their experiences and expectations. There was to some extent a cultural division between the two groups of women.

Secondly despite this cultural diversity both groups of women used the pathological/medical interpretation of pregnancy and childbirth.

Thirdly when talking about their experiences the women used various cultural themes in a very flexible way, their conversations always had a strong sense of flux and process.

FURTHER RESEARCH

This research brushed upon a continuum of further issues which I was unable to explore but which could be fruitfully looked at in future. For example how medical staff saw the different types of women and whether this affected the care they delivered to them during the ante-natal and natal period. How the women's experiences affected their partners' interpretation of pregnancy and childbirth and what effect the partners involvement has upon the events and how they are talked about? What are the long term affects of a birthing experience and how do they affect post-natal practices?

The answers to these questions would build upon the issues discussed in this thesis and would therefore be useful in continuing to build a fuller picture of how people make sense of and talk about pregnancy and childbirth in our country.

The numbers I used in this piece of research were by necessity small - eleven women in total. I feel that the level of opportunistic results would be improved if further research was to be conducted using a similar methodological approach with increased numbers in the sample. This ethnography then acts as a pilot study for a more substantial project in the future.

APPENDIX I

ANTE-NATAL /POST-NATAL INTERVIEW PLANS.

Census questions:

1. Age.

2. Marital status.

3. Number of children.

4. Employment details:
Of yourself, of your husband, of your father.

5. Educational details.

6. House details.

7. Name of: midwife, consultant, and GP.

Experience of pregnancy:

1. Have you been to the ante-natal classes. Why did you decide to go, what were they like?

2. How many times have you seen your midwife and doctor/obstetrician?

3. In what setting have you seen your midwife and doctors?

4. What were you told by your midwife and doctor, what did they explain as important, does this coincide with the things that have been important to you during your pregnancy?

5. Have you experienced any continuity of care? Do you feel that this is important and if so why?

6. Did you have any expectations on what pregnancy would be like? If so where did the ideas come from and have you found the real thing much different from what you expected?

Expectations for the birth:

1. How do you feel about your birth and where have you got your expectations from?

2. Have you heard of 'active birthing' If so where from? And what do you think?

3. Do you consider childbirth to be a private thing? If so how would you like to see your privacy protected?

4. What do you feel about a medicalised birth? Would you prefer to deliver unaided by pharmaceuticals? If so why - is birth natural?

5. What do you consider to be the attractions of a hospital birth? Do you feel that childbirth involves risks? If so what are they?

7. Can you describe how you expect to behave during your labour? Why do you think you might behave like that? Do you expect it to be a frightening experience? If so why?

8. What needs are you expecting the hospital staff to meet?

9. How does it feel if your expectations do not match the information you have been offered by other people?

Information gaining:

1. Where have you found you have accessed most helpful information about your pregnancy and childbirth?
a. chatting with friends and mother
b. ante-natal classes
c. speaking to doctors
d. speaking to midwives
e. other sources i.e. books, films etc.

2. Have you read anything on childbirth in the popular press? If so how has it affected your ideas about your labour? e.g. water birth coverage.

Birth plan:

1. Have you devised a birth plan? Has this altered at all during your pregnancy? If so why?

2. Where are you booked for the delivery? Why have you made that choice?

3. What do you feel about the concept of emotional support during labour? Who will you look to if you need such support?

4. When devising your birth plan what were the considerations you made? Do you emotional needs demand as much consideration as you medical needs?

5. How do you feel about the length of stay away from home? What would be your ideal and why?

POST-NATAL INTERVIEW PLAN

1. Whose advice did you find most useful?
From those who attended you during your labour and delivery did you trust the information you were given ? If so why?, and from any sources you used before your labour.
Did you find you remembered much information generally? If so what and from what source? Why do you think these issues became important to you at that time?

2. When it came to it did you feel well prepared? What preparation do you think was most useful? Was there a point where you felt your preparation was not enough?

3. Were you anxious about any aspect of the birth? {Post patrum haemorrhage} If so where did these worries stem from and how did you cope with them? In hindsight do you wish you had had your baby at home?

4. Did you feel you could rely on your midwife/ obstetrician? What did they offer you? Did you feel well supported? If so by whom. If not why?

5. Did you communicate through your husband to make your needs known? How did he support you? Were there times when you felt irritated with each other?

6. Did you trust your body?

7. Did you at any point disagree with the staff over any decisions you were about to make? If so what sources of information were you relying upon? Did you feel confident in your challenge? What was the result?

8. Did you receive any painkillers? If so, why and what? Did you have internals? What guided your decision?

9. How did you feel before you went into labour?

10. At what point did you go into labour? Why then? Can you describe to me the pain? Were you mobile? Did you stop becoming so at one point? If so why? What happened when your waters broke? What were you advised?

11. Have you had reason to feel guilty about any aspect of your labour and delivery?

12. Who was present during the labour and delivery? Why were they present? Did you find that obtrusive?

13. Did you take in a birth plan? Did you follow it? How did the birth compare to your expectations?

APPENDIX II

PROTOCOL OF RESEARCH PROJECT:

AIMS AND OBJECTIVES:

This research proposal comes under the discipline umbrella of 'Medical Anthropology' and as such starts from the premise that the experience of health and disease {and in this case pregnancy and childbirth} is far from universally consistent. Indeed an individuals interpretation of their physical condition, and consequently their reactive behaviour to that condition, is tied up within a complex weave of ideological, social, economic and demographic variables. Thus medical anthropological research can offer health professionals crucial insight into specific cause, course and treatment of ill health and as a consequence may provide vital material about how best to offer medical services to that community.

The research proposal I have designed focuses upon this basic concept but also incorporates the issue of process. Much of the material to date on women's understanding of their experience of pregnancy and childbirth tends to overlook the fact that interpretations are not static but rather are an ongoing negotiation involving the interactions of various models of belief. I aim therefore hoping to collect qualitative data, by both passive observation and in-depth interviews, which will illustrate the processes involved in the decision making procedure of ante-natal and natal care and therefore establish the motivations behind why a woman for example might decide to have her delivery within the domestic setting, and perhaps most importantly why women undergo decision reversals either during their pregnancy or labour.

SAMPLING TECHNIQUE:

Access to my sample will be through both the local Durham NCT group and the Bishop Auckland community midwife team. There are particular cultural and socio-economic variables which I wish to address and having already discussed my objectives with C. Vasey, head of midwifery at Bishop Auckland Hospital, we decided that our best and least intrusive approach would be for the community midwives to select a small number of women based upon my criterion and approach them individually, thereby distributing the consent letter provided by myself. [copy included]

This NHS sample will come from a white working class population with long term family residence in the area [a minimum of three generations] whereas the NCT sample will come from a white middle class and geographically more mobile population. Since the research will be qualitative the number will be limited to ten women and within that I hope to incorporate both a diverse socio-economic and age variable.

A series of in-depth interviews will be supplemented by observation of interaction during ante-natal and natal behaviour [subject to the women's consent] and I will need to cross-reference the women's understanding of the situation with information from the professionals responsible for her care in order to get a balanced analysis of the dynamics involved in the construction of meaning. and therefore the motivations surrounding decision making.

TIMETABLE:

Since this research is based upon the ongoing process of the understanding of pregnancy and childbirth it will be vital for me to follow women throughout an extended period of their pregnancy thus enabling me to examine the dynamic formulation of beliefs which surround what is considered to be an acceptable birth. For example do ante-natal classes affect how women anticipate their delivery experience, similarly does exposure to N.C.T. or the Active Birth Centre's publications actually make any impact upon how women eventually handle their labours?

APPENDIX III

LETTER OF INTRODUCTION AND CONSENT FORM:

My name is Mandie Simpson and I am a Social Science research student based at the University of Durham. My area of interest is in women's experience of pregnancy and childbirth. I am therefore approaching you in the hopes that you would be willing to talk to me about how you feel about your own experiences and what factors have contributed towards the decisions you have made about your health care during this period of your life.

As you will know simply from browsing through the 'Pregnancy' section of any book shop there appear to be many different approaches to pregnancy and birth in our country, for example some women opt for a 'Natural' childbirth at home while others may prefer to have Caesarean Sections in hospital. What I am hoping to look at is why women make such differing decisions, what is it that attracts some women to the idea of one type of birth plan while other women go for virtually the opposite?

This research aims to get an appreciation of what pregnancy and child birth actually feels like, hopefully seeing it through your eyes and understanding your experience as you interpret it. I am therefore taking only a small sample of women {of which I hope you will be part!} so that I can follow through their pregnancy in detail. This will involve a series of interviews, to be arranged at your convenience, and observations during ante-natal and natal care procedures.

The results of this research will be submitted to the Local Health Authority with obvious policy making implications: in understanding how you feel I hope to be able to act as a kind of bridge of communication between women experiencing pregnancy and childbirth and those responsible for its care.

If you are interested in helping me with this piece of research could you please fill out the form enclosed and forward it on to me in the stamped addressed envelope also enclosed.

Your cooperation is greatly appreciated and I hope I will be meeting you in the not too distant future.

Thank you!

Mandie Simpson. BA

NAME :- - - - - - - - - - -

ADDRESS : - - - - - - - - - -
- - - - - - - -
- - - - - - - -
- - - - - - -

TEL. NUMBER:- - - - - - - - -

I - - - {Name} am interested in participating in the research project to be carried out by Mandie Simpson on 'The experience of childbirth.' and give her permission therefore to contact me at the above address and telephone number.

Signed:

APPENDIX IV

SOME METHODOLOGICAL ISSUES

The bulk of my ethnography consists of an array of accounts told both ante-nataly and post-nataly by a diverse sample of eleven women- five from the NHS and six from the NCT. In speaking to them I was able to follow the hopes, wishes, motivations and expectations these eleven women held about their pregnancy and childbirth experiences. I listened to the way they described their experiences during the latter parts of their pregnancies observing how what they told me developed over time, what social pressures appeared to affect the way they talked about their experiences and what motivated the decisions the individual women made. This approach proved very fruitful but obviously was not without it's shortcomings:

Problem one:

Firstly in this very process of story telling the women I spoke to were in the business of presenting themselves as particular types of people. They constructed narratives about themselves, *{cf. Goffman 1969}* This desire appeared to me to be more obvious in the NCT group, although I found evidence for this process in both samples

E.g.
When answering a question about sources of information one woman responded.

> 'I've got leaflet upon leaflet and all sorts of booklets from the midwife and from the hospital and that we've picked up ourselves. That's why I've heard of the NCT cause there is bits of the NCT material been given to me I think, although I'm not really into natural birth stuff to be quite honest, I am really very much a hospital person I .. wouldn't want to be sitting at home or anything like that.'

It seemed important for this woman to show me that she had reviewed her options and made a calculated choice by pointing out that she had consciously rejected the NCT stance. However when she later produced her pregnancy literature I failed to find any NCT material amongst it although she assured me that was all the stuff she had.

What I was hearing then was not necessarily an account of what was happening, although of course that was an important element in the accounts, rather I was getting the impression of a person which was specifically created by the woman who was in the process of painting a particular picture of herself. I was never able to see the events through her eyes as it were but only able to see the accounts in the way she chose to reveal them to me.

Problem two:

Despite following a consistent semi-structured interview plan some interviews were twice as long as others and while there was variation within each group the NCT interviews generally lasted longer than the NHS ones. It was almost as if the type of questions I was asking were more interesting or somehow more pertinent to the NCT group when they left the NHS women wondering why on earth I was interested in that and frequently by the end of such an interview I left feeling the same!

For example to the question 'How do you think you will cope with the pain of childbirth?' asked in the ante-natal interview one NHS woman replied:

> 'I've no idea no. I've never really thought about that... Da na, **that's a funny question,** you just deal with it.
> 'I don't know what I will do, kill him for a start.
> 'Na I .. I think its like what me mam said its a pain that you can't describe so it's pain that's nice in a way but it's painful. Eh she says .. what's going to happen at the end .. there's something at the end you're nackered but there's that relief. She says after that you don't remember it anyway.'

In response to the same question an NCT woman responded:

> 'Yer **now that I have got expectations about** although I'm willing to accept these may completely go out the window because I've heard so much about other peoples labour experience to know, and I'm sort of wise enough to know that what you start off thinking you would like you, could do a complete U turn. Because of all kinds of things. .. largely because, I suspect, because of the pain. You know you may think

"Oh I want a completely drug free labour" and then, you know, two hours into it you are absolutely screaming blue murder
"Please just give me as many drugs as you can lay your hands on!".. also people who have said "Right I want an epidural from the first contraction" have gone through it with gas and air.
'So my expectations are I suppose .. one of change.
'I mean change in thought process. How I would like it to go which I don't know whether it will or not .. the contractions start in what ever way, waters breaking, they start waters break or what ever.
'If I can keep moving about, not round the entire house, just kind of upstairs and .. I'm hoping my .. anxiety level, well I know it won't be anywhere near as high as if it was in hospital. For two reasons: one because I have a antipathy towards hospitals but the other reason is in a hospital you are kind of sterile, light surroundings, surrounded by strangers where as in a house you are in your own house you can have in who you like. Its comforting and there's nothing like .. when you're feeling a bit grumpy and sad, pathetic, to actually have your own bed to .. flop onto .. it's like it's like being a child again and to be looked after and stuff like that.
'So that's how I would hope it would go .. and then I'm prepared for a hideously long labour I'm told.....

The response continued in the same vein, going into issues such as a detailed description of her worse fears of a hospitalised, medicalised birth, description of the ideas she got about positions and where she got them from, reassurances she got from other members of the NCT group etc. Suffice it to say that this woman gave a far more detailed not to mention longer response than did the first woman.

Such discrepancies in response between the two types of women is an important issue which lurks behind my research methods. As a post graduate from Durham my genre of speech and idea formulation is bound to coincide more with the NCT group than the NHS group. As this illustration indicates the same question which motivated an intricate and detailed reply from the NCT woman in some cases was considered to be almost futile by the NHS woman and no matter how hard I tried to repitch my questions I failed to stimulate the same enthusiasm. Indeed in transcribing the conversations I noticed that my own accent altered dramatically depending on who I was interviewing but there still remained a tendency for my NHS interviews to be on the whole shorter than my NCT ones.

Although therefore I went armed with the same semi structured interview plan to all my interviews the evidence would suggest that I was perceived as a very different person by one group than I was by the other. Although I made every effort to make my material cross comparable, purely by virtue of the fact I chose to look at two different cultural groups as such I created one type of interaction with one group and a very different one with the other. My methodology rested upon the way these women told stories about themselves, and this projection of self very much depended upon how they perceived me, their sense of empathy. *{cf. Carrithers 1992}*

I do not feel that these differences render some of my data more valuable than the rest on the contrary this discrepancy tells a story in itself - that is that several of the women in one of samples felt confident to indulge in elaborate discourse with the empathetic assumption that I as their audience would appreciate their stories while several of the women in the other sample simply shied away from, or didn't possess, such descriptions.

Problem three:

While in the business of presenting themselves in a particular kind of way all the women tended to use concepts which, when placed side by side out of the context of the actual flow of the conversation, could appear to be contradictory. However this element was never considered to be important. It really didn't matter provided the account itself reached it's desired conclusion. *{cf. Garfinkel 1967}* By watching out for this ad hoc nature in the way these women described their experiences to me, I instantly rendered myself one step removed from the actual interaction, I looked at the discourse out of context and in so doing removed myself from the frame of action. *{cf. Goffman 1975}* For a start I translated the spoken word via transcription into written text, putting then into black and white something that was only ever produced to be heard in that specific interaction which I contributed towards creating.

Problem four:

This indiscretion raises obvious ethical problems since although I tried to outline to all the women what I was hoping to do with the material, in being interested in their stories about themselves and how they told them, I somehow created a conversant context which I was later largely going to disregard in my analysis. Many of my reflections and observations on the material have come during subsequent examination of my transcripts done at leisure away from the mental demands of the

interaction. This gives me the strange sensation of somehow 'cheating'. If I were relying on field notes from a participant observation methodological approach this issue would not be so obvious since my notes would consist of reflections I had had there and then during the interaction itself. I would still be involved in the interaction.

However the obvious advantage I had having taped all my interviews was that I had direct access to exactly what was actually said and not what I thought was said, and as already stated I was able to ponder over the conversations analysing them in detail. I am very grateful to all the women that helped me in my research for allowing me that privilege!

Having explored how I collected my data and the thoughts and aspirations around my methodological approach I will introduce the theoretical themes I will be using in this thesis to explore my ethnography. The remainder of this chapter therefore will be looking at some of the literature and approaches which might be used in the analysis of my ethnography therefore locating it within medical anthropology.

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