The Politics of Maternity

Rosemary Mander and
Jo Murphy-Lawless

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The evidence surrounding the skills and approaches to support good birth has grown exponentially over the last two decades, but so too have the obstacles facing women and midwives who strive to achieve good birth.

This new book critically explores the complex issues surrounding contemporary childbirth practices in a climate which is ever more medicalised amidst greater insecurity at broad social and political levels. The authors offer a rigorous, and thought-provoking, analysis of current clinical, managerial and policy-making environments, and how they have prevented sustaining the kind of progress we need. *The Politics of Maternity* explores the most hopeful developments such as the abundant evidence for one-to-one care for women, and sets these accounts against the background of changes in health service organisation and provision that block these approaches from becoming an everyday occurrence for women giving birth. The book sets out the case for renewed attention to the politics of childbirth and what this politics must entail if we are to give birth back to women.

Designed to help professionals cope with the transition from education to the reality of the system within which they learn and practise, this inspiring book will help to assist them to function and care effectively in a changing health care environment.

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1 Introduction

Homage and legacy

I learned about maternity politics and its significance from a number of midwives whose politicking reached the level of an art form. These midwives honed their political skills in clinical, managerial, policy-making, educational and academic arenas; they manoeuvred and manipulated situations and people with a deft sleight of hand invisible to anyone not looking out for it. Since that initiation, I have come to appreciate others' political dexterity in wider arenas. As well as learning from such experts, there is another source which I am proud to acknowledge. In some ways, this book represents a form of homage to a classic volume, which is familiar to and loved by generations of readers. Because of the dynamism of the subject area, few books on maternity or childbearing politics achieve the status of 'classics'. The book which has indubitably achieved this status is the one edited by Jo Garcia and her colleagues, published in 1990 (see also Chapter 6). Its multidisciplinary scholarship brought a new depth and breadth of academic work to maternity politics. Its continuing use, not to mention its regular disappearance from library shelves, testifies to its ongoing importance and relevance in the rapidly-changing world of maternity scholarship. The legacy of this book, 'The Politics of Maternity Care: Services for Childbearing Women in Twentieth-Century Britain', is apparent in many publications, in addition to virtually every thesis and dissertation, on maternity or midwifery topics. This legacy clearly makes the book by Jo Garcia and her colleagues a hard act to follow.

With this legacy in mind I set out to produce a new book on the politics of maternity. While not an edited book like its eminent predecessor, the present volume seeks to emulate the academic standard set in 1990. There are also other differences. In this book I aim to develop a definition of politics which is relevant to women in addition to the multiplicity of disciplines who practise in maternity, with their even more various agendas. Because 'The Politics of Maternity Care' was an edited volume, developing and applying such a definition would have been difficult. This may have had the effect of making more subtle, or possibly diluting, the focus on politics. Any such effect, however, was more than compensated by the breadth, variety and academic scholarship of the contributed chapters.

While Jo Garcia and her colleagues' book continues to be used and useful, I recognise that the relevance of some of the material has decreased with the passage of time. This is largely due, again, to the dynamic nature of maternity care. It is also necessary to consider whether the changing context of maternity care has reduced the relevance of 'The Politics of Maternity Care'. In order to contextualise the maternity environment, it may be helpful at the outset to reflect on the changes which the maternity services have encountered since Jo Garcia and her colleagues published their ground-breaking book.

Significant developments in the maternity services since 1990

In the decades since 'The Politics of Maternity Care' was published, changes have occurred on all fronts but, for the sake of convenience, I address changes in policy and practice.

Policy developments affecting maternity services

The nature of the National Health Service (NHS) as a 'political football' became most evident during the Thatcher era (UK Prime Minister 1979–90). Partly due to her government's attempts at reorganisation and partly due to longstanding under-funding, the NHS Review was undertaken in 1988. The outcome was the government White Paper *Working for Patients* (1989), which introduced an internal market in health care; this constituted a system of contracting for services between purchasers and providers. This system came into operation in April 1991, making Health Authorities and general practitioners (GPs) responsible for assessing population needs and purchasing services from hospitals and other units of service. At the time of writing, this system has largely been dismantled, but changes in funding and providers are in the forefront of plans by the present coalition government.

Changes in NHS funding are nowhere more apparent since the mid-1990s than in Public Private Partnership (PPP) and Private Finance Initiative (PFI) contracting arrangements (see also Chapter 6). These private sector bodies, in the form of partnerships or consortia, have been used to provide capital investment for both hospital and community developments. A typical PFI project will be owned by a company set up specially to run the scheme and will comprise a consortium of a building firm, bank and facilities management company. While possibly structured differently, PFI projects usually feature four key elements: Design, Finance, Build and Operate. The key difference between PFI and conventional ways of providing public/health services is that the public sector does not actually *own* the asset, ie the property. The health authority effectively leases the property, making an annual payment, like a mortgage, to the private company who provides the building and services. This arrangement continues for the duration of the contract (25–30 years), which may be extended more or less indefinitely through renegotiation. PFI is now used for a large majority of capital schemes, such as hospital building projects (Liebe and Pollock 2009).

Since 1999, the much sought-after political devolution within the United Kingdom has, effectively, given rise to four different NHSs (Connolly et al 2010). Although devolution has, to date, had limited impact in Northern Ireland, people who use the health services in Scotland and Wales are well aware of their relatively privileged position. While there are a number of policy differences, the impact to date on maternity services is more difficult to assess. There are certainly proud reports of exciting developments in the devolved nations (Kirkman and Ferguson 2007; Reid 2011a). It is appropriate to question, though, whether devolution stimulated the development or just the report of the development.

A progressive policy which should have affected the childbearing woman is the increasing focus on client/consumer input into decisions at all levels of health care. This increasing focus is reflected in the document 'Patient Focus Public Involvement' (SEHD 2001). Publications like this seek to operationalise the principle of 'Nothing About Us Without Us', adopted by disability activists in the late twentieth century. The achievement of such lofty ideals, however, requires a change in the culture of health care. This would be facilitated by investment in communication systems, genuine consumer/client information and involvement and universal responsiveness among health care personnel. At the time of writing, it remains to be seen whether sufficient priority is accorded to client input to achieve such an outcome.

The political significance of the inequities and inequalities of the health care system were demonstrated most forcefully, not to say notoriously, by the Black Report (DHSS 1980). Although rates of, for example, life expectancy and infant mortality appear to have improved since 1990, the gap between the most and the least affluent has not; in fact that gap is actually increasing (Mackenbach 2011).

The policy developments envisaged by the Winterton Report (1992) and 'Changing Childbirth' (1993), and their equivalents in the three devolved UK countries, brought seemingly infinite promise for the childbearing woman and her midwifery attendants. Such promise was encapsulated in the cliché 'woman-centred care' (Reid 2011b: 190). By default, though, obstetric and other medical practitioners in the maternity area would be variably affected. These effects, together with the financial implications of such momentous changes, proved insurmountable for managers and policy makers (Rothwell 1996), leaving women's and midwives' aspirations for control, choice and continuity yet to be realised.

Developments affecting practice in maternity

The usual perception of a lack of newly qualified midwives to maintain the workforce had begun to change by 1990; this led to recognition of the difficulty of newly qualified midwives finding employment (Mander 1987). This finding was supported by Penny Curtis and her colleagues, who investigated the midwifery workforce in England (Curtis 2006). These researchers identified the 38.26 per cent of midwives with effective registrations who do not practise, but gave scant

attention to the woefully deficient establishments. Thus, the connection failed to be made between perceptions of shortage in clinical areas and budgetary priorities.

The chapter in 'The Politics of Maternity Care' by Rona Campbell and Alison Macfarlane on place of birth was written in the long shadow of the Peel Report, when the homebirth rate was at an all-time low. Since then, perhaps in association with policy developments mentioned already, but also influenced by women's activism, the number of out-of-hospital births has generally risen. As I discuss in Chapter 8, the fledgling midwife-led facilities in freestanding and alongside settings face many challenges (Hatem et al 2008) and the homebirth rate has increased only patchily.

The rise in some areas of the homebirth rate may be linked to enthusiasm for independent midwifery services. Such enthusiasm, however, was not shared by members of the Royal College of Midwives (RCM); when invited in 1993 to ballot on supporting their independent co-professionals, the members voted to withdraw their indemnity insurance (Warren 1994). Since then the statutory regulatory body and the European Union have further threatened independent midwifery (HPC 2009) by requiring exorbitantly-priced professional indemnity insurance as a requirement for practice (see Chapter 7).

The increasing escalation, between 1994 and 2004, of the long-term rise in caesareans has carried serious implications for midwives, childbearing women and maternity services (Mander 2007). The recent levelling off of the caesarean rate in some countries suggests that medical personnel have finally recognised the iatrogenic nature of what they have for too long regarded as the ultimate rescue operation.

The publication of the twin volumes of 'Effective Care in Pregnancy and Childbirth' in 1989 by Iain Chalmers and his co-editors sounded a clarion call to their obstetrician colleagues to put their practice on to a research-based footing. Little did they foresee the Pandora's box of evidence-based practice (EBP) which would be opened on an unwitting world of health care. Not unconnected to the intrusion of EBP is the increasingly litigation-oriented and defensive practice which is currently required of a range of practitioners.

Another innovation which has influenced practice since 'The Politics of Maternity Care' was published is the Baby Friendly Hospital Initiative, launched in 1991. Altruistically, this project's prime focus is on the establishment of breast feeding by preventing interventions which interfere with the physiological initiation of lactation. The extent to which the benefits to babies outweigh the tyranny for mothers and staff is, however, difficult to assess (Mander 2008a).

As well as the possibility of midwives returning to their roots in the form of facilitating breast feeding, a similarly 'radical' approach has emerged through what may be known in this commodified climate as a 'unique selling point' (USP). The concept of 'normality', originally allocated to midwives by medical practitioners for whom such humdrum practice held little lucrative incentive (Donnison 1988), has been grasped avidly. The fact that the concept is poorly defined and equally poorly understood has proved no deterrent. In Scotland,

government policy has supported this development in the form of 'Keeping Childbirth Natural and Dynamic' (KCND 2009).

An aspect of maternity attracting less attention is the changing pattern of maternal mortality. While the number of maternal deaths in developed countries such as the United Kingdom is nearing the irreducible minimum, their causes have changed markedly. No longer are the obstetric accidents, such as haemorrhage, major factors. Increasingly significant are the problems of women with complex needs, including lack of basic maternity and psychosocial care. Thus, the medical contribution to the prevention of deaths of women, who for various reasons are alienated from the health care system, is becoming less and less relevant.

A changing picture

This brief overview of some of the developments in maternity care since 'The Politics of Maternity Care' was published has shown that political issues are becoming more, rather than less, significant. Equally, these issues are likely to affect an ever wider range of personnel. These developments demonstrate all too clearly the need for a new book to assist practitioners and others negotiating labyrinthine maternity politics.

Terms and meanings

Jo Garcia and her colleagues gave little attention to the *nature* of politics. Although the contributed chapters in their book addressed issues which were implicitly political, politics was rarely mentioned as such. The exception to this observation is found, perhaps unsurprisingly, rounding off Robert Kilpatrick's interview with Wendy Savage (1990: 340). In this interview Savage's thoughts on the meaning of maternity politics become abundantly clear as a combination of party, medical and gender issues.

Before encountering the complexities of the political maelstrom of maternity care, though, exploring the breadth and limitations of the nature of politics will make this encounter more manageable. My exploration provides, as well as food for thought, an indication of this book's orientation.

Politics

Widely used, with little thought to its meaning beyond negative complexity, politics is a term which deserves to be teased apart.

A definition, which has long been a favourite, comes from my well-thumbed dictionary and emphasises politics' interpersonal and organisational aspects:

> astutely contriving, manoeuvring or intriguing.
>
> (Macdonald 1977: 1036)

This definition is wide enough to permit an approach sufficiently eclectic to include a number of aspects relevant to clinicians and practitioners. It has been pointed out to me by an anonymous reviewer, though, that this definition neglects crucial aspects of politics, such as power and control. So I undertook a search for a more inclusive definition, which produced helpful additions:

(a) 'the activities involved in getting and using power in public life, and being able to influence decisions that affect a country or a society'

This definition constitutes 'Party Politics' which, while possibly connected to maternity politics, are subtly different. Party Politics are generally more predictable, with a rigidity of philosophy and infrastructure not found in other forms of politics.

(b) 'a person's political views or beliefs'

This definition is similarly linked to Party Politics, so is equally limited in its relevance to maternity.

(c) 'a system of political beliefs; a state of political affairs'

Apart from the possible Party Political dimension, this definition implies a major degree of homogeneity among midwives. While certain shared aspirations and a few commonalities of practice may apply to midwives, this definition is too tightly constraining. This is because midwifery is too closely linked to the cultural environment within which it happens for many global similarities to be identifiable.

(d) 'matters concerned with getting or using power within a particular group or organisation'.

(OALD 2011)

This definition is usefully broader, although Jo Murphy-Lawless opts for a subtly different one (Chapter 6). It succeeds in focusing on the crucial concept of power, while at the same time narrowing the scope to only specified groups of actors or other participants. This definition is clearly a useful adjunct to my original definition; it does, however, beg the question of the meaning of power, which lies at its heart.

Power

In his crucial contribution to the literature on Power, Steven Lukes (2005) draws on the context of Party Political issues in the United States. His original work was undertaken in the middle of the twentieth century and certain aspects of his writing show this, originating from a different generation and less than applicable to the present context. This criticism, however, does not impair the underlying importance of his ideas for a wide range of other fields and times. He argues that power is not the demonstration of absolute authority, as is sometimes assumed but that, given the right conditions, even the relatively disempowered may position themselves to exert power. This power differs qualitatively from that to which they have been subordinated, but this difference makes the exercise

no less effective. Lukes' writing on the politics of power serves to operationalise the work of others whose ideas were approximately contemporary. Michel Foucault (1982) and Arthur Berndtson (1970) focus on power as underlying actions bringing change which, in turn, is characterised by novelty and its continuation. The effectiveness of such change is likely to be facilitated or impeded by factors such as consensus or opposition.

Control

As with many terms, control may mean all things to all people. But it has been particularly constrained by ideas about perceptions of societal acceptability in the form of self-control and of the source of control, that is, internality or externality (Rotter 1966; Bandura 1977). The distinction between power and control lies not only in the suitability of the words themselves. As found in a qualitative research project, knowledge is a fundamental factor which is a common requirement for both (Namey and Drapkin Lyerly 2010). These researchers, who examined the concept from the individual's point of view, also identified the crucial role of self-determination, which appears to correspond closely to traditional views of autonomy, as it is perceived as encompassing authority, decision-making and agency.

Practising politics

Whereas the forms of politics outlined here may be too subtle to be subject to scrutiny, the means by which politics are put into practice have attracted attention. The first consideration is how, if politics concerns getting or using power, that power is obtained and manipulated.

Power and practice

As mentioned already, the existence of a power balance or imbalance is not the absolute and negative phenomenon often perceived. Power may be regarded as being more relative, determined by a wide range of factors, of which the various participants may be more or less aware. As well as the existence of this relative (im)balance of power, its exercise is also influenced by the situation in which the actors find themselves. That is, a certain environment may facilitate the display of power by one participant, but under different circumstances another participant may be more competent.

The analysis by Marsden Wagner of the empowerment and disempowerment of different actors in the maternity scenario (Wagner 2007: 35) provides valuable insights into the creation and operation of power differentials. He argues that individuals become powerful not only because of, but sometimes despite, their own efforts. For such power to become established, as Edmund Burke is alleged to have observed ominously (Burke 1909), it is necessary for other

participants to remain passive, that is, to *not* oppose this assumption of power. Wagner continues by suggesting that such an assumption of power may begin benignly, even altruistically. But such individuals may develop tunnel vision and become blinkered so that, in the absence of any opposition, their conviction of their own rightness and that they have the only answer passes and escalates unchallenged. These increasingly powerful individuals are then positioned to redefine the situation or territory to their own advantage. This effectively disempowers any potential opposition because the powerful individuals are able to present themselves as the solution, albeit to a problem which may not have existed before they created it. The next step in this process is for the powerful individuals to relocate the, now redefined, problem to a place where there is least threat to their sole authority over the outcomes. To achieve this, a certain 'massaging' of information may be necessary. A high level of communication skills and resources are a prerequisite for the dissemination of these fraudulent ideas among the recipient groups and others who are being disempowered. In the unlikely event of any opposition being articulated, small concessions may be offered as a sop to those venturing to display such temerity. Wagner correctly identifies these latter stages of the development of power as the establishment of continuing power through control of the situation. He goes on to suggest that a number of strategies may be employed to ensure that control is established and maintained.

Establishing control

In his supremely relevant analysis, Marsden Wagner indicates that a number of long-term interventions may be applied to consolidate a power base by assuming control of certain aspects (Wagner 2007: 36). This control may initially be through involvement in the education of the disempowered group to further weaken them and to increase the authority of the powerful. A subsequent method of ensuring control is by additionally limiting the activities of the weaker group. This may, first, be achieved by undermining their confidence in their own ability, particularly regarding opposing the powerful. Secondly, control is further strengthened through recourse to other powerful groups, such as legislators, who enact laws to limit the activities of the less powerful group. Control over financial resources may be similarly effective, making the disempowered group relatively impoverished and low status, hence reducing its attraction to new members. Fiscal control over the less powerful group also prevents that group from studying their own situation in order to improve their lot through increasing knowledge. Finally, the powerful group's ultimate control is assured and made unassailable by it making itself autonomously self-regulating. Whereas this powerful group may make inroads into other groups' statutory regulatory systems and influence them, its own position becomes impregnable. In this way questions about the behaviour of members of the elite powerful group are addressed internally. Lack of transparency ensures the continuation of such control.

Without needing to mention the potential for the all-too-familiar corollary in health care, Wagner astutely concludes:

> This is absolute power indeed.
>
> (Wagner 2007: 37)

Theory

Having briefly defined some practical aspects of politics, it may be helpful to consider whether and to what extent our understanding may be enhanced by the theoretical literature. In order to do this, I give attention to three crucially important phenomena which I have not mentioned thus far.

Hegemony

Originating with the ancient Greek concept of military alliances between one nation state, or hegemon, and another, the twentieth-century Marxist philosopher Antonio Gramsci applied the idea of hegemony to indirect control of and by different sections of society. Since then the term has been broadened to include cultural and occupational aspects of human life. A useful and very relevant definition was coined by feminist author Nancy Fraser, focusing on the power of certain groups to fashion a society's 'common sense' (Fraser 1989). By this, she meant those facets of everyday life which are too well and widely understood to be worth mentioning. The facets to which Fraser was referring include the power to:

1 create authoritative definitions of social situations and social needs;
2 determine the universe of legitimate disagreement;
3 shape the political agenda.

Thus, the role of certain dominant groups, including social, occupational or special interest groups, becomes clear. The resulting restriction of the environment in which negotiations and discussions about a particular issue begin and end is known as cultural hegemony. The aim of certain groups is to establish mastery, a word which I use deliberately, within this environment. Thus, these groups, agencies or institutions persuade others of their unique ability to define issues and concerns in which they already have a well-recognised interest.

It is apparent that hegemony is qualitatively different from power. The distinction is found in the *level* of the exercise of mastery. Whereas power is exerted at a practical, interpersonal or interorganisational level, hegemony operates at a higher theoretical level by constraining definitions of issues and the thought processes leading to those definitions.

Decision-making

While decision-making has attracted considerable attention, this may have done little to clarify such a complex area. The lack of clarity applies, particularly, to

assumptions of the homogeneity of this process. All too often the focus is solely on one level, such as clinical or interpersonal decisions (Jefford et al 2010), and other levels are disregarded. Individuals' input into local organisational, as well as national, policy decisions probably deserve at least as much attention. Appropriate decision-making is intended to ensure that services are responsive to the needs of consumers; it ensures the functional autonomy of the practitioner and increases the woman's control over her experience of childbearing. At the same time, the decisions made by the three major groups (childbearing women, health care providers and policy makers/managers) are likely to impinge on or to influence each other's decisions. Although a number of governmental departments (eg SEHD 2001; DoH 2010a), have endorsed the need for greater and more effective consumer participation, the observation that the public 'role in decision-making remains under-developed' (Callaghan and Wistow 2006: 583) still applies. While the public role continues to be limited, certain occupational groups appear to fare little better (Raynor et al 2005).

Oppression

Just as the concept of power is crucial to political activity, oppression as a converse notion also needs to be recognised and, thus, will manifest itself repeatedly throughout this book. The complexity of oppression has been widely studied, not least by feminist scholars such as Patricia Hill Collins, who has developed others' ideas of intersectionality (Hill Collins 2000). Rather than oppression being a simplistic one-way cause and effect phenomenon, Collins represents it as an interlocking system of oppressive activities. Age, (dis)ability, socioeconomic class, race, gender, sexual orientation and faith are examples of factors which are interwoven to create a web of oppression, which Collins entitles the 'Matrix of domination'. Collins' work has focused mainly on the problems of oppression which African-American women face, making her ideas particularly relevant to the present context.

A brief history of hegemony and power in maternity

The history of power in maternity care reflects to a large extent the place of women in the various cultures and societies. This is partly because it is only recently that, in some countries, men have been permitted to become midwives on a comparable basis with women. There are similarities with women's history generally, including the limited sources, due to history usually having been written by men (Barclay 2008; Cheung 2009).

Power imbalances are demonstrated as far back as the 'handy woman' and the Scottish 'howdie' (Leap and Hunter 1993; Reid 2011b). These women shared an untrained background with the colonial midwife (Jackson and Mander 1995), and her ousting by her formally-educated successor. In the United Kingdom, power relations between the untrained midwife and the usurper were complicated by the perception of threat among 'general practitioners' (GPs) at the arrival of the educated midwife (Reid 2011b).

Feelings of threat among GPs were aggravated by their limited specialist knowledge, even compared to their untrained midwife counterparts. Thus, their ability to establish a practice and a livelihood depended on their creating some competitive advantage over lower-paid occupations, such as midwives and homeopaths (Fahy 2007; Dupree 2011).

While not necessarily benefiting GPs, the prestigious nature of medicine escalated in the nineteenth century, with associated increases in power and financial benefits (Watchorn 1978). This power facilitated the medical control of midwifery through the introduction of legislative midwifery regulation during the opening decades of the twentieth century (Donnison 1988; Reid 2011b; see page 58 and page 141). Such statutory control served to medicalise and further limit midwifery practice into and beyond the late twentieth century (Mein-Smith 1986).

In the United Kingdom, nineteenth-century nurse leaders sought a united front to strive for the common goal of registration. Because midwives considered their need more pressing, they spurned nurses' advances and some, such as Mrs Bedford-Fenwick, reacted by strenuously opposing midwifery legislation (Robinson 1990). A similar rebuff by midwives was encountered by nurses in the 1970s when new legislation, to implement the Briggs Report (Committee on Nursing 1972), was planned. The Royal College of Midwives (RCM) supported the planned legislation (RCM 1986), but the then statutory bodies, the Central Midwives Boards, anticipated that the control of midwifery by medical practitioners would simply be supplanted with nursing control. To further complicate matters, the Association of Radical Midwives (ARM), was formed in response to the threat to the midwife's role. The result of midwives' resistance was that the legislation fervently desired by nurses, eventually enacted as the Nurses, Midwives and Health Visitors Act (1979), was significantly delayed. That midwives are still blamed for this delay and that it continues to rankle is clear from the Nursing and Midwifery Council (NMC) website:

> This was due to the need to take account of … lack of consensus within the professions [especially from midwives].
>
> (NMC 2010a)

Moving into the present day, the balance of power between medical practitioners erupts only occasionally in the literature. The problematical relationship with midwives, however, as evidenced by the NMC quotation, continues to constitute a running sore for our nursing cousins (Mander 2008b).

The purpose of and rationale for this book

This book is necessary because all midwives currently being educated and beginning to practise need, as stated by Eugene Declercq as long ago as 1994, to be politically aware and active (Declercq 1994: 236). This is partly to ensure that they are able to function effectively as midwives in clinical settings. But at organisational

and national levels midwives also need to negotiate cultural and health care systems whose 'changes' impact profoundly on the midwife, her role and function. It is no longer sufficient for midwives and other health personnel to provide safe and effective care for the mother and child. Such an orientation has long since ceased to be adequate, and the need for political astuteness among student and new midwives and other health care personnel has been demonstrated (Savage 1990). This magnificent midwife has been described by Robbie Davis-Floyd as the post-modern midwife, bringing a range of beneficial traditional skills as well as knowing 'the limitations and strengths of the biomedical system' and 'how to subvert the medical system' to ensure that care is woman-centred (Davis-Floyd 2005: 33). For these reasons this book facilitates an awareness of and an ability to manipulate appropriate political strategies.

Many difficulties faced by health care personnel, including student and newly qualified midwives, derive from the mismatch between the ideals which brought them into health care and the reality of the modernist health system within which they learn and practise. This system features hegemonic power being held by certain disciplines to the disadvantage of other occupational groups. The new arrivals on to the maternity stage have needs which are sufficiently important to be addressed openly. This is because students, newly qualified midwives, and others, tend to assume that what they experience is unique. This sad assumption results in feelings of isolation and disengagement, possibly leading to the loss of idealistic practitioners from the profession (Mander et al 2009 and 2010). This book demonstrates the commonality of these systematic challenges as well as remedial strategies. In this way, more constructive approaches to these challenges will be available and may be employed to benefit and retain these new entrants.

Throughout this book I endeavour to present an objective yet balanced portrayal of the phenomena under scrutiny. Such objectivity has, in the past, been criticised as being too condemning of some occupational groups, such as medical practitioners. If this is how my writing is perceived, it is unfortunate. While probably not intentional, such condemnation should be viewed in the context of our obstetric colleagues' sole *raison d'être* being to intervene in what is ordinarily a physiological process. In view of the possibility of iatrogenesis, some censure is excusable.

My focus in writing this book is as far as possible on the individual, whether she be a childbearing women or a midwife. For this reason, I attempt to make the discussion more personal and relevant by using the singular, rather than grouping women and midwives into homogenous masses.

This book and its organisation

The chapters begin with the individuals involved in maternity care, by considering interpersonal issues. Moving on to a larger canvas, occupational or professional groups and the relationships between them are addressed. Because of the significance of the issues for the global majority of childbearing women and their attendants, as well as for more economically advantaged countries, third world

matters are explored in Chapter 4. The next chapter scrutinises the differing philosophical approaches to maternity care and their impact for childbearing women. In Chapter 6 Jo Murphy-Lawless contemplates the politics of policy-making in state health systems. Chapters 7 and 8 provide case studies of the deleterious and beneficial effects of political activity, respectively, with a view to the reader being able to learn from others' experiences. The final chapter draws together the major themes emerging in this book, together with some relevant reflection on my own personal experiences of being a midwife, both as a practitioner and as an academic.

2 Interpersonal politics

The extent to which health care in general and maternity care in particular are accessible to the total population varies hugely between different health systems, states, regimes and times. As well as variations in accessibility, the *experience* of those who succeed in accessing health care is similarly variable. A range of phenomena is likely to affect the client's experience, including features of the client, provider and service.

In this chapter, I examine some features of the client group which are associated with differences in their experience of maternity care. This examination focuses on a number of differently powerful client groups who may be particularly disadvantaged, or possibly advantaged, in their experiences of maternity care.

What's in a name?

I have so far avoided using precise terms for those accessing maternity services. The names or titles which we allot to those whom we attend constitute a veritable minefield. The words carry messages extending far beyond simply the fact that this person is accessing a particular service and many reflect the imbalance of power between the provider and the recipient of care. In her well-reasoned argument against 'patient' being used in maternity as long ago as 1986, Ann Thomson reminded readers, that the World Health Organisation (WHO) had defined patienthood in terms of being 'helpless, incapable of understanding and sometimes non-compliant' (WHO 1985). Referring to childbearing women as patients, who are passive and unable to act responsibly, let alone make decisions, is widely thought to be a thing of the past. Such terminology is no anachronism, as I found when I recently tapped 'maternity patient' into a search engine and 42,000 results appeared. Thomson recommended the phrase 'childbearing woman', and that 'patient' should only be used when 'they really do occupy the sick role' (Thomson 1986: 163). Thus, my comfortable position doesn't last; I must bite the bullet, relinquish my seat on the fence and come down on the side of 'the childbearing woman'.

There is no shortage of alternatives to the 'p-word'; contenders include consumer, client, service-user and customer to name but four. A concept which has attracted considerable attention, though, is 'partner' as in 'partnership' (page 105 and 175). As with motherhood and apple pie, it is difficult to argue against

this concept, but it deserves to be unpacked beyond obvious feel-good superficialities. The term was first applied to midwifery practice in the heady days of the early 1990s, when maternity care in New Zealand was seeking to free itself from the shackles of medical and nursing domination. Partnership emerged as a politically acceptable rallying point for childbirth activists and midwives, who were persuaded that 'Midwifery is the partnership between the woman and the midwife' (Guilliland and Pairman 1994). This message is still articulated loud and clear (Pairman 2006; Gray 2010). Many questions have been asked about the precise meaning of partnership and how such an equally balanced ideal is possible in the real world of midwifery practice (Skinner 1999; Fleming 2000; Mander 2011a). As New Zealand midwifery approaches maturity, these questions have yet to be answered, perhaps by encouraging more flexible interpretations or perhaps by a more egalitarian relationship between the professional organisation and its membership. Until that time the term 'partnership' will probably continue to be applied to a relationship to which it is less than well-fitted.

Asking the service-user

In order to ascertain what title or label the users of health care prefer, the not unpredictable step of asking them has proved popular, particularly in mental health (Deber et al 2005). Canadian researchers suggest that service-users favour the comfortable familiarity of 'patient'. Tracing the roots of alternatives, eg consumer, to their largely commercial origins, Raisa Deber and her colleagues suggest that such terminology is increasingly relevant to health care. Based on a survey of 1,037 people attending community facilities, such as orthopaedics and oncology, they conclude that 'patient' is moderately preferred; but the implication of the imbalance of power which it carries is firmly rejected.

In maternity Mrs N Batra and Richard Lilford undertook a survey to identify a term which would provide childbearing women with an acceptable alternative to the 'patient' label (Batra and Lilford 1996). But they met with limited success. While 'client' and 'consumer' were unpopular with childbearing women, these obstetricians found that 'mother to be' and 'pregnant woman' were the least unacceptable. More recently, Dominic Byrne and his colleagues (Byrne et al 2000) investigated women's preferences by asking those attending a hospital antenatal clinic to complete a brief questionnaire, and 72.7 per cent (446/613) responded. The term 'patient' was selected by 39 per cent of the respondents as their first choice from a list of possibilities. 'Commercial descriptions' (Byrne et al 2000: 1235) such as 'client' and 'consumer' were preferred by women earlier in pregnancy. Although not mentioned by the authors, this preference probably reflects these women's limited exposure to medical culture.

Systematic effects

Just as Deber and her Canadian colleagues conclude the relevance of 'consumer', Peter Scourfield discusses how 'commercial' labels for the service-user are