Deceptive promises: women’s understandings of technology in maternity care

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A Thesis Submitted in Fulfilment for the Degree of Doctor of Philosophy in Midwifery

Written under the supervision of Dr Jo Murphy-Lawless

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DECLARATION

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Dedication

Marcinowi
(To Marcin)

In memory of Philomena Canning (1959 -2019)
our most courageous midwife, our tireless advocate for women
Summary

Deceptive promises: women’s understandings of technology in maternity care.

Background

The biomedical approach of obstetrics, relying on intensive use of technologies, has been championed as the most relevant approach to women’s needs in childbirth, and to problems faced by maternity care systems worldwide. Despite the attempts to humanise care and produce evidence to encourage the appropriate use of birth technologies, most changes within this existing paradigm have been superficial or unsuccessful. As a result the rates of technological intervention into birth process, such as caesarean section, induction of labour, fetal monitoring and epidural analgesia, and “active” management of labour, have been increasing sharply. This has also been the case for the Irish maternity services. Astonishingly, women’s conceptualisations of technology in such profoundly technologised maternity services have been relatively unexplored in the literature and their voices have been marginalised or disregarded in public debates and health policy.

Aim

To explore women’s conceptualisations of technology in the context of highly technologised maternity services in Ireland in order to reimagine our understanding of technology and its effects in maternity care.

Methodology

This study used feminist poststructuralism as its theoretical framework and employed Foucauldian discourse analysis as its methodological stance. Women’s understandings were generated using photo-elicitation interviews with photographs of hospital environments and of women being cared for within those environments. My analysis is based on twenty-one individual and three group interviews, with twenty-nine participants overall. Women from across social and cultural backgrounds who experienced different types of care within the Irish maternity services participated. The accounts of two men were also included. While I employed feminist poststructuralism
to theorise the ambivalence and conflicts in women’s understanding and emphasise their marginalised knowledges, discourse analysis allowed me to capture the powerful discourses which shape women’s conceptualisations, and to grasp how they assemble their understanding of technology from available discursive resources.

Results

The findings of this study reveal the ambiguity and conflicts in women’s understanding of technology in maternity care, and the discrepancies between their voices and the discourse of technocratic biomedicine. The capabilities of technology used within the current obstetric model for maternity services offer women a limited notion of care, yet such care is often considered clinically faultless. Instead, women insist on the humane rather than technological imperatives as essential in ensuring care which is genuinely enabling and facilitative of their needs. Women’s voices challenge the persuasive strategies of biomedicine and expose its promises as deceptive, giving only the appearance of comprehensive maternity care.

Conclusion

Women’s voices suggest an urgent need to shift the model towards the midwifery approach to ensure appropriate use of technology in maternity care and appropriate maternity services.
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Introduction

Background

“a basic pattern of highly-technological intervention remains: most hospitals now require at least periodic electronic monitoring of all labouring women; analgesics, Pitocin epidurals, and episiotomies are widely applied; and one woman in five is delivered by Caesarean section. Thus, although some medical procedures drop away, the use of the most powerful signifiers of the woman’s dependence on science and technology intensifies.” (Davis-Floyd 2004: 75)

A growing tendency to use medical technologies in Western societies in the second part of the twentieth century has essentially transformed the way maternity care is conceptualised. Currently, even in the low-resource countries where birth technologies are not easily accessible to the majority of women, technocratic biomedicine relying on intensive use of these technologies has been favoured as a first-line approach for dealing with the challenges in the provision of maternity services (Ohaja 2015, Ohaja and Murphy-Lawless 2017). The prevalent consensus in the public debates is that high-tech maternity care represents the most sensible approach to deal with the “risks” of childbirth, and while some difficulties with it must be acknowledged, they can be rectified with even more intense technological management. Despite the attempts to keep the use of birth technology in check (e.g. Wagner, M. 1994) and attempts to humanise care which resulted in superficial rather than substantial changes (Davis-Floyd 2004, Wagner 2001), the procedures that most acutely signify technologisation of maternity care, listed in the excerpt above, are on the rise.

Ireland is no exception to those trends and technological intervention into the birth process has remained remarkably high in the Irish maternity care with consistent increase year by year (HSE CPOG 2016, HSE NWIHP and CPOG 2018). The figures for 2017 indicate a caesarean section rate of 32.1% (34.2% in nulliparous women), instrumental births standing at 14.9% (28.9% in nulliparous women) and induction of labour at 31.3% (39.3% in nulliparous women), with great variation across maternity
units nationally\(^1\). Additionally, 40.2% of women are accessing epidural anaesthesia (ibid.).

It is difficult to obtain any comprehensive, consistent national statistics on the use of electronic fetal monitoring (EFM), despite its well established link with increasing rates of instrumental and caesarean section births without corresponding improvement in outcomes (Alfirevic et al. 2017). A national survey examining EFM use in 2002 (Devane, Lalor, et al. 2007) reported its use on admission by 21 out 22 hospitals on all women, eight out of 22 units reporting its routine use in labour on women with healthy pregnancies and no risk factors. Even the most recent Irish research on the effects, as well as perceptions of EFM, does not contain detailed national data on its prevalence in Irish maternity hospitals (Smith et al. 2019, Smith et al. 2012, 2017). This suggests that the practice of EFM is not systematically “monitored” in Ireland. The studies merely conclude that it is “widespread in clinical practice” (Alfirevic et al. 2017), although Smith et al. (2019) report the rates for their sample of women with no complications\(^2\), where continuous EFM is used in labour, resulting from its use on admission, stand at 86%. The rates following the low-tech practice of intermittent auscultation on admission, while significantly lower, are still high at 72% (ibid.: 5). The most current detailed statistics available are for 2014, but include only a handful of hospitals. The three Dublin maternity units, accounting for more or less half of all births annually in Ireland, when their data is combined have a rate of external continuous EFM at 73.9% (81.3% for nulliparous women), University Hospital in Galway reports 68.1% (80.8%), and Cavan General Hospital has its overall rate at 89.6%. EFM on admission is reported by Galway and Cavan at 93.3 and 100% respectively\(^3\). This demonstrates near universal reliance on EFM and suggests widespread and unquestioned acceptance of its utility which extends to nearly all births. Despite this, the Irish Health Service Executive (HSE) “does not intend” to include metrics on its use in Maternity Patient Safety Statements published

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\(^1\) The statistics illustrating this variation can be accessed through HSE Maternity Patient Safety Statements at [https://www.hse.ie/eng/services/list/3/maternity/mpss/](https://www.hse.ie/eng/services/list/3/maternity/mpss/), the data for 2016 and 2017 individual hospitals collated at [http://www.bump2babe.ie/](http://www.bump2babe.ie/)

\(^2\) These statistics are based on a sample of “low-risk” women with a long list of stringent exclusions (Smith et al. 2019: 2), some critiqued as a clear indicator of risk (e.g. post-term pregnancy). If not for those exclusions the overall rate for all women in hospitals where this study was conducted would be even higher.

monthly since March 2016 (Dáil Eireann 2017: PQ No. 571). Ironically, it is this unmonitored monitoring of women’s labours which is the most prevalent technology on Irish maternity wards.

In this research I understand technologisation both qualitatively, as the extent to which technology and technological approaches pervade maternity care practice, and quantitatively, as the extent to which the actual technological means of monitoring and managing birth are used. The former understanding of technologisation is central to this dissertation and thus is present throughout my work. The statistics of technological intervention presented above represent the latter understanding, exemplifying the frequency of technological procedures in Irish maternity hospitals, and are helpful for comparisons with systems in other countries.

As I outline in detail in Chapter 2, I understand technology as complex, high-tech resources used within our maternity services and as practices which rely on those resources but I also consider technology as an underlying philosophy or paradigm of thinking about childbirth and the provision of maternity services. Further, throughout the thesis, I refer to similar dual understandings of midwifery. Thus midwifery can be also considered as being about certain “resources” and about practices relying on midwifery skills and bodies of knowledge, as well as an underlying philosophy or a paradigm for providing maternity services. The latter understanding refers to midwifery as an example of a social model in the provision of maternity services (Wagner, M. 1994; Walsh and Newburn 2002a, b) which offers an alternative to the current technocratic model underwritten by biomedicine. Throughout this research and in my analysis I consider the social model for maternity care, or the midwifery model (Rothman 1991) synonymous with it, as an alternative approach to technocratic biomedicine when it comes to maternity services and birth technologies. I agree with Rothman that by choosing the latter terminology we acknowledge the crucial work of midwives in propagating, disseminating and sustaining this approach (ibid.: 24-25). This is despite the fact that this model can be and is also practiced by other health professionals than midwives (Renfrew et al. 2014), that inter-professional cooperation in this model is crucial, and that it is the “beliefs, values, and ideas... about women, babies, and birth” of a particular care provider that matter in its provision (ibid.: 48).
Discussing midwifery and technology as paradigms for maternity services cuts across professional divisions as they are understood as a set of assumptions about appropriate maternity services. Thus any health professional can practice within any paradigm as long as they respond to those assumptions. Further, they can practice a different model during the same day at work though this is dependent on both environment and constraints stemming from often hierarchised institutional contexts which allow or hinder certain practices on the day\(^4\). This example helps to emphasise the continuum that can exist between the technocratic/biomedical and midwifery/social models (Walsh and Newburn 2002b), which I have separated for analytic purposes and for the clarity of my argument. Nonetheless the overriding reality on a day to day basis is that a sharp dichotomy does exist between the role of midwifery and the role of technology in our maternity services.

The midwifery/social model or paradigm for maternity services focuses in large measure on the work that can be undertaken at the level of primary care and prevention, and on building and maintaining health and wellbeing of women, their babies and their families. It is characterised by a comprehensive view of women’s needs in childbirth as individual, emotional and social in nature. This distinguishes it from the often apparent reductionism of the technocratic/biomedical model. The midwifery/social model sees women’s reproductive processes as healthy and normal rather than in the first instance dangerous and risky, and aims to facilitate women in their capacity to give birth over a privileging of intervention. In this model relationships and social support between women and their health care providers are central unlike in the technocratic/biomedical model where imperatives of technological management and clinical performance can take precedence when planning and delivering maternity services (Davis-Floyd 2001, Downe and McCourt 2008, Rothman 1991, Sandall et al. 2016, Walsh and Newburn 2002a, b).

Similarly to midwifery, I understand obstetrics relying on high-tech resources and skills, as both a practice and an example of a technocratic/biomedical model for maternity

\(^4\) I would like to acknowledge Margaret Dunlea for drawing my attention to this and offering a vivid description of how an individual practitioner can actually practice midwifery and biomedical model on the same day.
care. As Walsh and Newburn (2000a) observe obstetrics as a practice has an “optional” but crucial place in the midwifery/social model (ibid.: 479), with obstetricians and other specialist professions being referred to in case of “medical care for complications” being necessary (Renfrew et al. 2019: 224).

This research

Women’s overall conceptualisation of technology in maternity care, which is an aim of this study, has been relatively unexplored in the literature considering such profound technologisation of maternity services in Ireland, and internationally. There are important insights into women’s understanding of technology which are scattered across the literature and this research is particularly indebted to the work of three American authors, Robbie Davis-Floyd (2004), Barbara Katz Rothman (1991), and Emily Martin (1991), and the British sociologist Ann Oakley (Oakley 1980). Those scholars have offered a feminist analyses of women’s accounts of pregnancy and birth, and explored socio-cultural and deeply ideological contexts, including the dominant biomedical paradigm, which shape them. While their work did not focus specifically on technology, it included essential theorising of its role in maternity care.

While some studies looked at women’s experience of birth technology in general, they did not address the systemic and highly politicised contexts for its use (e.g. Kornelsen 2005, Williams and Umberson 1999). Usually, women’s overall experiences of care were scrutinised (e.g. Halldórsdóttir and Karlsdóttir 1996a, Johnson et al. 2007, Lundgren 2005, Reed et al. 2016, Simkin 1991) or their attitudes to particular birth technologies, such as fetal monitoring, epidural anaesthesia, induction and caesarean section (e.g. Crawford et al. 2017, Henderson and Redshaw 2013, Jepsen and Keller 2014, Ryding et al. 2000). Moreover, those existing studies relied predominantly on a pre-agreed or implicit notion of technology, rather than aiming to tease out women’s own understandings. Also, I have not come across studies exploring explicitly women’s perception of appropriate technology use in maternity care and this is one of the gaps my study attempts to address.

When it comes to Ireland, there has been some recent work undertaken examining women’s experiences in the context of highly medicalised maternity services (Fawsitt et
However, we have no research in Ireland exploring the intricacies of birth technology based on women’s understandings, which would aim to unpack and theorise its socio-cultural and political dimensions. This is another gap this research aims to address through examining how women understand technology in maternity care in the context of Irish extensively technologised maternity services.

By turning to women’s voices as a missing source of knowledge about technology in maternity services, I aimed to find novel conceptual tools for our understanding of technology. To meet this aim, I was drawn to feminist poststructuralism for its emphasis on marginalised voices and examination of the arrangements of social power, as the voices of women have been peripheral in the debate about our maternity services. Feminist poststructuralism conceives ways in which powerful conceptualisations, such as the dominant view of technology in maternity care, can be gradually dismantled. It also insists on multiplicity and ambivalence in our understanding as “productive” and helpful for change, and this was crucial in my analysis. I adopted Foucauldian discourse analysis to help me recognise how the dominant discourses operate in women’s accounts and how women can craft their understanding by reworking those discourses. I hoped that such epistemological and methodological frameworks would make an important contribution to a greater complexity in our debates on technology in maternity care, beyond professional and official discourses.

The key finding of this study is that women’s voices challenge the seeming consensus about appropriate maternity care as intensely technological, a consensus which perpetuates virtually undivided dominance of the biomedical model. Women’s understandings of technology and its promises in maternity care are ambiguous, and the current focus on technology and high-tech expertise gives rise to women’s essential needs being addressed in an incidental rather than systematic manner. What women need rather than more technology, which is advocated in current high-tech obstetric-led maternity services, is care which focuses on their individual needs, and is humane, as much as it is technologically and clinically impeccable.
Outline of the thesis

Chapter 1 looks at maternity care policy and is an overview of the historical trajectory from the late 1940s which led to the technologisation of Irish maternity services. It examines the political and institutional contexts which continue to facilitate technologisation of care provision.

Chapter 2 examines the notion of technology and arrives at its definition for this research. I understand technology in maternity care as both technological resources operating within institutional context of maternity hospitals as well as a technocratic paradigm of thinking about maternity care provision. In this chapter I also explore socio-cultural contexts for understanding technology in our society. These include modernity, late modernity, and modern science, the belief in technological solutions to problems in our society, and “scientific” risk management.

Chapter 3 outlines the theoretical/methodological model for my understanding of production of knowledge in research about birth and technology and for interpretation of women’s voices. This research adopts a feminist poststructuralist epistemology and a methodological approach of Foucauldian discourse analysis. I offer justification for choosing such a framework and discuss concepts which are crucial in feminist poststructuralism and discourse analysis.

Chapter 4 is an account of the method. It outlines how this research was designed and conducted, and discusses the issues of ethics, reflexivity and rigour. I recount the challenges of my fieldwork and describe the photo-elicitation interviews as well as justify the selection of particular photographs which I inserted into my interview schedule. These photographs of hospital environments and of women labouring within those environments served to facilitate women’s understanding and increase the relevance of the research topic for them.

Chapters 5 to 7 focus on women’s accounts of technology in maternity care and present the findings of my study. Chapter 5 outlines the understanding of technology emerging from women’s accounts. It discusses the ambiguities and disunities in women’s perception of what technology can and cannot achieve. Chapter 6 turns to “subjugated
knowledges” and practices in maternity care which focus on humane aspects of care. These emerge as genuinely enabling and empowering for women but are discounted when care is framed by technological imperatives. Chapter 7 demonstrates how women negotiate and challenge persuasive strategies of technocratic biomedicine in their accounts. It outlines what constitutes appropriate technology use and appropriate maternity services for women.

Chapter 8 brings together the social, political, and theoretical contexts for our use of technology in maternity care and juxtaposes them with women’s understandings of technology. It demonstrates the disparity between women’s voices and the dominant discourse of official documents, policies and public debates around birth technology.

Chapter 9 brings the thesis to a conclusion and focuses on the contribution and implications of this study for further research as well as further action to be undertaken to ensure appropriate technology use in maternity services.
Chapter 1

Technologised maternity services in Ireland: how have they evolved and how do they continue to be sustained?

1.0 Introduction: the argument, the structure of the chapter and a note on midwifery.

In this chapter I argue that the way maternity services have developed in Ireland contributed to the dominance of the high-tech medical model of maternity care and to systematically rising rates of technological intervention. It can be argued that the presence of technology on such a scale in Irish maternity care is part of the more universal trend towards increased use of technology in maternity care and development of high-tech modes of management of birth internationally. However, it has been reinforced by the combination of local political and institutional contexts crucial to comprehensively understand the role of technology in Irish maternity care system (Murphy-Lawless 2011a: 449). These include women’s subordinated position in the extremely conservative patriarchal society which emerged in post-Famine years (Murphy-Lawless 2011a), the powerful alliance of the medical profession and the Catholic Church (Ferriter 2005, Wren 2003) and resulting marginalisation of midwifery in the system (Murphy-Lawless 2011b). This has been exacerbated further by the demographic factor of a continuing high birth rate compared to the rest of Europe (HSE and Health Pricing Office 2016) and persistent lack of investment in maternity services even during the economic boom which resulted in excessive pressures on hospitals in providing care (Burke 2009, Dáil Éireann 2018, O’Regan 2007, 2015).

The chapter is divided into two parts. In the first part (section 1.1), I focus on how policies around maternity services historically facilitated the technologised model of birthing in Ireland. In the second part (section 1.2) I examine the evidence concerning different aspects of the model of maternity care provision: the setting of care, the leading care provider and the effects of private provision of care. I argue that in Irish maternity services it is developments deemed by research to increase technologisation that have been endowed with continued support.
In the first part of this chapter I argue that even though Ireland has made very small steps towards more appropriate technology use in maternity care since the 1990s, this shift has occurred within a number of constraints. In 1999, a Domino and home birth scheme was initiated in the National Maternity Hospital and in the early 2000s, two pilot midwifery-led units in Drogheda and Cavan with midwifery-led care were introduced. Since then, several additional developments have been put in place: three additional Domino schemes, community midwifery clinics in two Dublin hospitals for antenatal care, and provision of waterbirth. However, all the above developments have been limited geographically and by restrictive access criteria based on medical understanding of woman’s “risk profile” (Murphy-Lawless 2011b). Moreover, the shift had occurred in a maternity system which has been underfunded, understaffed, overcrowded with problems exacerbated by the cuts imposed on health care services during the crisis in 2008 (Burke 2009, Kennedy 2012). This shift had occurred alongside the legislation undermining midwifery as an independent and fully-fledged profession and a continuing emphasis on hospital maternity services as the first-line approach to care. As a result only very small numbers of women have benefited annually from the shift towards midwifery care (Department of Health 2016).

In the second part I examine the following political and institutional contexts which illuminate current technologisation of maternity care in Ireland: the strong role of the medical profession, whose dominance has been underwritten by the subsequent health legislation and policies (formal and unwritten), adherence to the medical model in health care provision, with reliance on hospital-based services and an accompanying underdevelopment of primary and community-based services, and the existence of a two-tier system of health care, with substantial minority of women receiving their care within private practice provided by consultants (Burke 2009, Kennedy 2002, Murphy-Lawless 2011a).

This chapter discusses midwifery and its role in the system amidst a widespread confusion about the role and the scope of midwifery (Kennedy et al. 2018, Renfrew et al. 2019) and thus I would like to clarify what I understand by midwifery and midwifery-

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5 For a list of available options see: http://aimsireland.ie/where-will-i-have-my-baby-where-to-get-advice/ Accessed 22 October 2018
led care before I begin my analysis. For Renfrew *et al.* (2019) midwifery is a “knowledgeable, skilled, and compassionate care across the continuum from pregnancy to birth and beyond” (ibid.: 397). However, what is most crucial for me is that midwifery is about focusing on normality and maintaining the skills of “optimising normal biological, psychological, social and cultural processes” for women, their children and their families (Renfrew *et al.* 2014: 1132). It is about respecting women’s individual circumstances and preferences and tailoring care to them, and about supporting women in their capabilities to birth their babies (Kennedy *et al.* 2018). It is about forming trusting relationships between women and their midwives and about continuity across care continuum (Renfrew *et al.* 2019). Within midwifery approach all of the above are considered as essential for quality care as well as ensuring improved clinical outcomes.

In the introduction I have discussed midwifery as a model and as resources and practice. This chapter concentrates more on the latter understanding of midwifery, as it focuses on the role of midwives, their skills and their knowledge in the maternity services. It also discusses the role of midwifery-led care as mitigating against technologised care and inappropriate use of technological intervention even within maternity services with technocratic biomedicine as the dominant framework.

I understand midwifery-led care as a care led by the distinctive values of midwifery, where “midwives are in partnership with the woman” and are the lead clinical decision-makers primarily responsible for women’s care and “ensuring provision of maternity services” (Devane *et al.* 2007: 98). Midwifery-led care is also characterised by striving to provide care for women in the community and within home-like and not medicalised environments, whenever this is possible.

Therefore for midwifery-led care to be a lived reality, it is not sufficient for the care to be primarily *delivered* by midwives, as is predominantly the case within our obstetric-led services. Rather, the values and conditions I have just laid out above must be evident. Also, for midwifery-led care to become a genuine option for women, midwives have to be supported systemically to practice within the midwifery ethos and to use midwifery skills. I would also argue that obstetric-led care is not necessarily about being
actually *delivered* by obstetricians. It can be delivered by midwives who practice within the values of obstetric medicine.

We have the evidence that if models of care relying on midwifery were widely applied “fewer women and newborns would require referral and treatment services for serious complications” (Kennedy *et al.* 2018: 224) which rely on resources of the high-tech obstetrics. We also have the evidence that midwifery care “saves lives, reduces preterm birth, promotes health and well-being, and improves sustainability” of maternity care provision (Renfrew *et al.* 2019: 397). Moreover, the benefits of care provided by midwives within “effective continuity midwifery models” extend to both healthy women and those who have complications (Sandall, Coxon *et al.* 2016: 7).

1.1 Historical background for institutionalisation of high-tech maternity care in Ireland

1.1.1 Maternity and Infant Care Scheme and the role of the medical profession

Irish maternity care services operate on the basis of the legislation dating back to the early 1950s. The 1953 Health Act legislated for the Maternity and Infant Care Scheme (MICS) as providing a framework for provision of what was then free, means-tested maternity care. The MICS was a result of allied opposition of the Catholic church hierarchy and the medical profession and the defeat of the original Mother and Child scheme, which was an attempt by the Irish government to introduce free, state-provided medical care for mothers and children (Barrington 1987, Burke 2009, Ferriter 2005, Wren 2003). It prepared the ground for a doctor-led, hospital-based, two-tier health care system in the Republic of Ireland. The Scheme established GPs as the first points of contact for providing care and the primary care givers for pregnant women, alongside the hospital doctors, undermining in this way the position of midwives as a primary profession providing maternity care for women. In the long run the Scheme hindered the development of non-hospital based services and comprehensive midwifery in Ireland. Although the scheme guaranteed women below a certain income limit a choice of a doctor or a midwife without a fee for ante-natal care, delivery in hospital or maternity home required additional fees. This created the distinction between women who could and could not pay and supported the institutional and political logic that a midwife attending home deliveries provides substandard care which
is “the poor woman’s option and thus worth less cultural capital” (Kennedy 2012). As a result domiciliary births sharply decreased by the early 1960s to reach less than 1% by 1974 (Kennedy 2002: 85). Although free hospital care under MICS was extended to all women in the 1991 Health (Amendment) Act (House of the Oireachtas 1991) it was by then far too late to reverse the general public’s belief in doctor-led hospital care as superior within the system where essentially no alternative existed.⁶

1.1.2 Towards full hospitalisation of maternity care

1.1.2.1 The 1970s health legislation

Throughout the 1960s the proportion of domiciliary births in Ireland was rapidly decreasing. In the late 1950s the rate was approximately 30%, and it decreased to 4% in the 1960s to reach 0.4% by the end of the 1970s (Kennedy 2002), making the hospitalisation of birth virtually complete. More than 99% have been giving birth in hospital ever since (National Perinatal Epidemiology Centre 2016, O’Connor 1995). The pace of hospitalisation in Ireland was much faster than in neighbouring system in United Kingdom, where in the 1960s 40% of births still occurred outside hospital, 15% in the 1970s, and 96% of hospital birth has been achieved only in the 1990s (Macfarlane and Mugford 2000: 523).

The impending hospitalisation was reinforced by two health policy documents, the 1970 Health Act and the 1976 Discussion Document on Development of Hospital Maternity Services. The emphasis placed on provision of health care within hospital settings was embodied in Section 62 of the Health Act 1970. Although this section required health boards to provide “appropriate medical, surgical and midwifery services”, this obligation was considered to be “fully complied with by providing those services within the confines of a hospital” (House of the Oireachtas 1970). It ensured that settings other than hospital need not to be developed for birth.

⁶ From a national survey of women’s health needs which was based on the representative sample of the Irish population (Wiley and Merriman 1996), we know that by the late 1990s, 35.5% of all women chose private maternity care, the proportion of lower professional and upper professional classes at 48.6 and 65.5% respectively (ibid. 110).
Taking the hospitalisation even further, the 1976 Discussion Document on Development of Hospital Maternity Services outlined the plan for the provision of maternity care within “consultant-staffed obstetric/neonatal unit” to all women on the basis of “the welfare of the infant” which was to be ensured by the availability of neonatal and paediatric services (Comhairle na n-Ospideal 1976). To this end, already existing small units, i.e. those catering for less than expected minimum 1,500 to 2,000 births per year, were considered inadequate to deal with maternity patients and due to close as “not viable” and “below standards required for the practice of modern obstetrics” (ibid.).

What is telling in the 1976 document is the complete invisibility of women and midwives which clearly demonstrates the presumptions of policy-makers of the time. Women are barely mentioned within the document permeated with concerns about the safety of the infant which is to be ensured by high-tech expertise within the medical unit. It could be argued that the “welfare of the infant” was indeed a primary concern for the obstetric profession’s training needs. Neither midwifery nor midwives are mentioned, and the only staff ratios that are discussed are those of medical professions, not even the ‘nurses’, as midwives were then regularly called. The rationales guiding the document were those of the “obstetric belief”, that hospital birth under consultant equates with optimal maternity care to ensure low mortality rates for babies (Murphy-Lawless 1998: 203-204). This contrasts with Tew’s (1998) analysis of birth statistics which demonstrates that perinatal mortality would have fallen more rapidly without the large scale hospitalisation of childbirth as a result of improvements in living conditions and in the overall health of the population.

The 1970s legislation provided the ultimate framework for the dominance of centralised consultant-led maternity services. Although, as McIntosh (2013) observes, reasons for hospitalisation of childbirth are complex, and include women’s demand for pain relief and doctors’ beliefs about safety and risk, “the growing power of the acute hospital sector in managing health care” (ibid.: 417) has been the truly significant development. This power contributed to Ireland ending up with an over-reliance on hospital-based services. A substantial part of health care has been provided within the hospitals ever since, with a lack of sufficient community and primary care settings (Burke 2009). Presently, this has been even more evident in our maternity services where most
women deliver their babies in centralised hospital units (HSE NWIHP and CPOG 2018; Department of Health 2016). Accordingly, hospitalisation of services provided the context for a technology-intensive practice and the rate of medical interventions in childbirth has been continuously increasing since the 1970s (Brick and Layte 2011, Kennedy 2002). This progressing hospitalisation has been compounded by increasing birth rate and an underfunded overcrowded system designed for a much smaller number of births than it has been forced to accommodate (Kennedy 2002). Such context has provided a fertile ground for the development of the Active Management of Labour (AML) discussed in the section below.

1.1.2.2 The introduction of Active Management of Labour

The Active Management of Labour (AML) approach was formulated and put into practice by the master of National Maternity Hospital in Dublin Kieran O'Driscoll in 1963 (Perkins 2004). As a “care package” AML consisted of strict criteria for diagnosis and monitoring of labour and routine intervention if predefined time frames were not achieved. This involved routine rupture of membranes on admission and routine use of oxytocin when progress was considered too slow. In 1972, the restriction on the length of labour in National Maternity Hospital was formally introduced, with women required to deliver their babies within a 12 hour time frame (O’Driscoll et al. 1993), a policy still in operation in the National Maternity Hospital together with other elements of the AML. The 1970 Health Act and the 1976 Discussion Document through supporting full hospitalisation and consultant-led services facilitated institutionalisation of AML and its technologised, assembly-line philosophy of care.

It is noteworthy however, that the clinical elements of AML were accompanied by a non-clinical one: the provision of one-to-one support of a woman by a student midwife throughout labour (O’Driscoll et al. 2003). This element has been argued as perhaps the only truly effective one in achieving the clinical outcomes AML has continued to claim, such as for example, the reduction in caesarean section rate (Brown et al. 2008, Thornton and Lilford 1994).

1.1.2.2.1 Efficient and cost-effective organisation or scientific project?
“high-intensity birth intervention shaped by developments in economics and the economic organisation of medicine” (Perkins 2004: 137).

AML with its focus on rational management, efficiency and productivity promised an improvement in the functioning of hospitals as institutions, allowing for more “efficient deployment of nursing staff” (O’Driscoll 1972) and a better management of hospital resources (Murphy-Lawless 2011a). Increased productivity, ensured by the smoother handling of “throughput”, and its economic benefits were amongst rationales for introducing AML. However, AML was as much a response to practical demands of Irish hospitals working over their capacity to manage the scarce resources as it was a result of the biomedical worldview and its attempt to control the process of birth. It offered a response to the issue of maintaining “modern” control of childbirth and making it a “scientific project”, focused on yielding certain clinical benefits such as reducing the occurrence of caesarean section, “prolonged” labour, cephalo-pelvic disproportion and trauma to the foetus (O’Driscoll 1972). As a “modernisation project” (Gray 2000) it aimed to eliminate uncertainty involved in birth and to ensure its predictability. Maternity hospital, according to AML’s architects, was to become “a modern intensive care delivery unit” (O’Driscoll 1972), aimed at systematically controlling the pace and length of each woman’s labour throughout its duration. Routine “correction” of this pace, attributed to the sole factor of inefficient uterine activity, had become the core characteristic of AML.

Although AML was “more managerially than technologically induced” (Perkins 2004: 143), it would not have been possible without the technological advances in oxytocin isolation, dosage and administration. These advances made the oxytocin use safer and more controllable. The possibilities offered by oxytocin fitted well with the 1960s’ increased interest in making birth management “scientific” (McIntosh 2012), i.e. devising systematised protocols, with precise criteria for success and failure, and reliance on objective clinical signs to prescribe the course of action to be undertaken. At the core of the AML was the use of oxytocin, a technology which allowed to accelerate the birth process. As a result this process was reduced to a problem of “uterine efficiency” to be systematically monitored and corrected as necessary.
1.1.2.2.2 Professional power and women’s role

AML helped to reinforce obstetric consultants in their position of authority in birth. It strengthened obstetric profession’s wide-ranging power through providing it with “its own” new technology of birth management (McIntosh 2012). The AML approach emphasised clearly defined roles for each health profession and for women. It discarded the “watchful waiting” approach characteristic to midwifery and replaced it with an “active” approach of consultant-led care with routine involvement of consultant obstetricians in the care of “perfectly normal women” (O’Driscoll et al. 2003). Due to “centralising management in the consultants office” (Perkins 2004: 144), the central role and responsibility of consultants was reiterated although they were those already in position of power within the system. Midwives’ role was minimalised and they were expected to follow highly prescriptive protocols concerned strongly with monitoring of clinical signs. Their continuous support for women was defined as strict “emotional” management aimed at maintaining their composure and ability to cooperate with staff rather than listening and responding to their individual needs. Despite the claims that the “true purpose” of AML was to “enhance the experience of childbirth for mothers” (O’Driscoll 1994: 1015) as well as decrease both emotional and physiological trauma, the disadvantages for women and the advantages for the hospital and obstetric doctors have not been adequately acknowledged (Sakala 1993a: 1185). Within AML protocols, as more recent editions of AML manual demonstrate (e.g. O’Driscoll et al. 2003), women continue to be seen as merely recipients of treatment designed to assist them in achieving a predefined norm in birthing. They are not considered active participants in their own births and thus their real (not projected) needs end up at the very bottom of the hierarchy (McIntosh 2012), and clinical measurements and monitoring may override women’s self-diagnosis and knowledge in labour.

Despite the promises of improving women’s experience of birth, AML have consolidated the determinants of technologisation of maternity care, such as routine monitoring of progress and use of oxytocic drugs and other interventions to achieve the clinically desired pace of progress. However, besides the original AML “package”, any prescriptive protocol-based approach to maternity care can be considered an “active management” in its essence (Winter and Duff 2009) as it allows for highly interventionist regimes.
where routine technology use is justified and where standardised, uniform approaches are encouraged for all women at the expense of accommodating their individual needs in childbirth.

1.1.3 Reluctance to shift the model towards midwifery-led care

The ground for opening a debate about the shift away from high-tech, high intervention models of care had been prepared in the 1980s and 1990s. Increasing concerns about the effects of technologisation in maternity care on women, their families and the wider society had been voiced by authors such as Ann Oakley, Marsden Wagner, Barbara Katz Rothman and Robbie Davis-Floyd. In Ireland, the constraints of underfunded maternity services, overstretched by the unprecedented number of births in the economic downturn in the 1980s, brought these effects into sharp focus. This was accompanied by accumulating evidence critiquing the harmful effects of technologised approaches to childbirth, summarised concisely in the first edition of “Effective Care in Pregnancy and Childbirth” by Iain Chalmers, Murray Enkin and Marc J. N. C. Keirse (1989). Equipped with this evidence, the Irish birth rights movement gathered momentum during the 1990s. In 1996 the “Mother and Child 2000” national conference was held with a view to lending support for women-centred care and challenging policies committed to consultant-led care as the model suitable for all women (Devane, Murphy-Lawless, et al. 2007: 95). It demanded the publication of the review of existing models of care under MICS which was conducted in 1994. Disappointingly for conference organisers, when this review was finally published (Department of Health 1997), it disregarded the accumulating evidence for midwifery-led care and restated the existing combined model of care as functioning well. The subsequent Condon report (2000) reiterated the existing institutional framework for the medical model of care and echoed the 1976 Comhairle n’Ospideal document in seeing maternity hospitals as places when consultants’ skills are to be maintained and hence further centralisation of care provision in large hospitals was justified (Devane, Murphy-Lawless, et al. 2007: 96). Moreover, the Condon report disregarded frameworks for policy change towards less technologised maternity care already sketched out in the neighbouring system in UK (Department of Health (UK) 1993, House of Commons Health Committee 1992), as well as ignored mounting evidence of their safety (e.g. Campbell and MacFarlane 1987,
1994). The Condon report was rejected locally by the then North Eastern Health Board and the new review committee, known as the Kinder Group, was appointed with a much broader aim and involving a broader spectrum of stakeholders, including women as service users (Devane, Murphy-Lawless, et al. 2007: 97).

1.1.3.1 Kinder report: “a critical break” with the medical model

It was the Kinder report (2001) which for the first time shifted the debate about Ireland’s maternity services towards considering midwifery-led models of care. It demanded “far reaching” rearrangements in provision of maternity care and at last the need for more evidence-based care was acknowledged. The Kinder report is considered a “critical break” (Devane, Murphy-Lawless, et al. 2007) with the supremacy of the hospital-based obstetric model, as it proposed pilot midwifery-led units to be established in Cavan and Drogheda, with more such units to follow in Monaghan, Dundalk and Navan. It also recommended expanding community midwifery from these units, and included home deliveries within its remit. Since the Kinder report less technologised midwifery-led options of care have never left the debate even though the overall shift in the system has proven to be limited. The postulates of the Kinder report were subsequently reiterated in the KPMG report, an independent review of maternity services in the greater Dublin area, where Ireland’s reliance on hospital based services and underdevelopment of primary and community care were identified as “out of step with current best practice” (KPMG 2008: 9).

1.1.3.2 Contradictory tendencies

Overall, late 1990s and early 2000s were marked by two contradictory tendencies. On the one hand the need to introduce midwifery-led care had been finally recognised not only by academics and activists but increasingly by official policy documents (e.g. Government of Ireland 1998) and reports assessing the quality of maternity services (e.g. Kinder 2001 and KPMG 2008). In line with this shift, community midwifery schemes were established in some maternity hospitals and with the two midwifery-led units operating, a direct entry midwifery study programme was rolled out in 2006. On the other hand the lack of commitment by subsequent governments to actually make midwifery-led care universally accessible in Ireland continues (Murphy-Lawless 2011a:...
Although there has been a critical shift in the discourses, ensuring the actual provision has been slow and reluctant. Also, even when services are provided they are targeted for closure to “direct” the resources towards more acute hospital care. Consequently, midwifery-led care remains marginal and as the medical model continues to be a “standard” form of care the rates of technological intervention into the birth process increase further at a rapid pace. Such unsupportive contexts for midwifery-led care have been exacerbated by the onset of the economic crisis in 2008. The resulting cutbacks in health services and a staff recruitment embargo resulted in making the existing resource and staff shortages in maternity care even more severe (Burke 2009, Murphy-Lawless 2011a). This has played a part, among other factors, in a number of adverse events in maternity services between 2008 and 2018 such as, for example, a number of high-profile maternal deaths, with overrepresentation of non-Irish women amongst them (HIQA 2013, Murphy-Lawless 2013), and a series of perinatal deaths in the Midland Regional Hospital in Portlaoise (Department of Health 2014, HIQA 2015). Those events, together with issues such as the scans misdiagnosis scandal (Murphy-Lawless 2011b), suggest an overburdened, fragmented system of care which is not sustainable and where the critical lack of resources and staff, as in the case of Portlaoise hospital, can foster a reliance on technology which makes “medical misadventures” for women and their infants even more likely.

When resources become scarce within the system which usually relies on high availability of complex resources, such a system becomes unsafe. The widening disparity between technocratic philosophy of practice and the lack of access to resources that are at the core of such systems, contribute to resources being used in a provisional, erratic way. In other words, within a maternity system which is relying on complex expertise and infrastructure, those very resources may be used to address the pressures on the system rather than for addressing clinical need.

1.1.3.3 The National Maternity Strategy and the 2010s: another critical break?

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The culmination of contradictory tendencies discussed above was the long awaited National Maternity Strategy (Department of Health 2016) and its Implementation Plan (HSE NWIHP 2017). The Strategy was prompted by the increased number of high-profile cases of maternal deaths and “adverse events” in Irish maternity services mentioned above, particularly the investigation following Savita Halappanavar’s death which had development of the national maternity strategy as its recommendation (HIQA 2013).

Yet again, as numerous preceding documents, the Strategy and its implementation sustain the combined model of care outlined in MICS. While making significant concessions to less technologised settings in the form of a proposed extension of midwife-led birthing units, they maintain their geographical and ideological subordination to the institution of a high-tech hospital and its high-tech expertise. The Strategy adopts the risk approach and an “overriding safety principle” as the overlaying approach which results in risk-based models of care which are embedded in biomedicine and not in paradigms of well-being and supporting normality in birth (Downe and McCourt 2008). What the Strategy proposes is a reiteration of what has already been recognised in various reports preceding it (e.g. Kinder 2001, KPMG 2008, HIQA 2013). This is why it is difficult to view it as the critical break with the medical model or as the actual “fundamental overhaul of services” that the Strategy itself claims to propose (Department of Health 2016: 5) and which has been suggested in the publicity surrounding its launch in 20168. In this, the Strategy mirrors similar developments in the UK Changing Childbirth report of 1993 which:

“gave only an illusion of change and improvements. The implementation of midwifery-led units, with their highly structured criteria of ‘risk’, or the provision on the NHS of birthing balls, pools or complementary therapies suggested that women’s demands and choices were central... At the same time, however, beliefs about risk were tightly drawn, and intervention rates... continued to climb” (McIntosh 2012: 144)

The National Maternity Strategy and its implementation plan demonstrate that every change in the system of maternity care in Ireland continues to be contained within the obstetric authority and biomedical understanding of birth. As a result, its potential to

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de-technologise maternity care is significantly limited. The notion of midwifery as an autonomous profession\(^9\), as well as acknowledgment of its crucial expertise in supporting normal birth is absent in the Strategy. While it presents different options of care, including hospital adjacent midwife-led care, it is at the discretion of the medical profession and its notions of risk and safety, to dictate conditions of access to such type of care for women. The scope for a different model of care is also limited due to the choice of the co-located birthing centres (termed “alongside birth centres” in the Strategy) over free-standing ones located in community, despite the evidence of the excellent outcomes of the latter and their further reduction of technological intervention rates when comparing with co-located facilities for healthy women (Hollowell et al. 2011). Despite that, the belief of obstetric medicine prevails, that the further away from hospital women give birth, the less control can be exercised over the outcome and thus the more risk must be involved. Moreover, even co-located birthing centres in the Strategy and the implementation eventually are considered expendable, and can be reduced to a “designated space” in the hospital whenever the size and activity of a given hospital does not “justify” them (Department of Health 2016: 6-7). This raises a question: is the Strategy about a genuine shift towards providing less technologised options in Irish maternity services or is it actually about managing their chronic overcrowding?

1.2 Characteristics of the Irish model of maternity care contributing to overuse of technology

Based on the political and institutional contexts outlined above, I will tease out the characteristics of the current dominant model of care in Ireland which contribute to inappropriate use of technology in childbirth. I will juxtapose these characteristics against the backdrop of what is considered good practice according to the knowledge

\(^9\) Midwives in the Strategy are considered solely as members of a “multidisciplinary team” (Department of Health 2016: 3) rather as a standalone profession. Curiously, the same issue, i.e. the appearance of being supportive of major change, has been identified in the Changing Childbirth report (Department of Health (UK) 1993) by McIntosh (2012). This speaks volumes about the parallel obstacles in both maternity systems in dismantling obstetric authority.
we currently have from research evidence\textsuperscript{10} and accounts of “birth models that work” (Davis-Floyd et al. 2009).

My argument is divided into three following sections, and in each of them I consider one aspect of the Irish maternity care which strongly prohibits the more appropriate use of technology. The first section is focused on the hospital-based services and a consideration of the large centralised maternity unit as the most suitable setting for birth. The second section focuses on consultant-led services and the assumption that these provide the best model of care for all women. As a result of this assumption, it is consultant obstetricians who are considered the ultimate authority when it comes to maternity services. I acknowledge, that it is not possible to fully distinguish between the effects of the birthing environment and of the particular health professional leading a woman’s care. There may be an overlap in the care of individual women of those two aspects, for example, when professionals supporting normality in childbirth work within contexts focused on pathology and likewise, when highly prescriptive practices find their way into out-of-hospital settings. However, by separating the setting and the practitioner, I aim to emphasise that both are important in appropriate use of technology in maternity care. The third section points to the significance of private obstetric practice within the Irish system which is reinforcing further the first two aspects.

1.2.1 Birth setting and the use of technology

1.2.1.1 Hospital as a maternity care setting

The hospital had started to emerge as an institution for the provision of maternity care in the UK and Ireland in the mid-eighteenth century. This was justified by the medical profession on the grounds of lower mortality for women and their infants and had provided a necessary social context for technologisation (Tew 1998). This justification

\textsuperscript{10} I use the term “evidence” in a more general sense than it is used within the philosophy of evidence-based medicine where it is not only strongly focused on clinical outcomes measured by randomised controlled trails but is considered an authoritative element of clinical practice. Such a narrow understanding of evidence may override the experience and skills of individual practitioners as well as women’s knowledge. In this way I would like to acknowledge that knowledges which may be considered as the evidence should reach beyond the clinical factors and quantitative methodologies.
has been holding on so far despite lack of evidence justifying it for healthy women (Wagner, M. 1994). Irish as well as international evidence demonstrates that the prevalence of the hospital-based care and lack of access to settings alternative to hospital inadvertently contributes to higher use of technology in maternity care (Begley et al. 2009, Hollowell et al. 2011, Davis-Floyd 2004, Hodnett et al. 2012, Wagner 2001). Extensive hospitalisation of childbirth has been repeatedly quoted as a crucial factor in high intervention rates in the West (Oakley 1980; Wagner, M. 1994; Walsh 2008).

The introduction of obstetric surveillance and intervention technologies on a wide scale would not have been possible without the context of the hospital. Thus, introduction of technologies and hospitalisation reinforce each other. This is why understanding the omnipresence of technology in our thinking about maternity care would not be complete without acknowledging the significance of near complete hospitalisation of childbirth in Ireland (Kennedy 2002). The trend in Ireland since the 1970s has been towards providing maternity services within large hospital units (Kennedy 2002; Begley et al. 2009). This is reflected not only in disregarding birthing in the community, such as provision for homebirth services and birthing centres, but also in the reluctance to introduce co-located midwifery-led units. As O’Connor observes, the Irish maternity service “was designed to meet the needs of consultants, who needed very high patient caseloads to maintain their skills, and to train future consultants”, rather than women (O’Connor 2001), and as a consequence it is centralised in large tertiary hospitals, and even small hospital units are not considered viable.

Hospitals evolved as institutions within which high-tech expertise and resources are located and utilised. Therefore, being cared for within the hospital environment inadvertently encourages more interventionist approaches to care. Hospital-based maternity services being tailored to complex and emergency cases, tend to use more technology on its healthy users since it is already incorporated into practice. Also, the underlying philosophy is of routine surveillance and active treatment, with a view of impending pathology. It is more difficult in such settings to support normality in birth than within primary care and community settings. This has been the reason for the systematic critique of medicalisation and hospitalisation since the 1970s, aiming both at the healthcare system in general (Illich 1976, McKeown 1976) as well as maternity care.
specifically (Chalmers and Richards 1977). The hospital environment has been deemed too hierarchical and constrained by institutional rules, making it difficult to promote personalised approach to the needs of individuals within it (Davis-Floyd et al. 2009). Within such environments not only the interests of women and their infants may be overridden by the institutional ones. It is also the practice of professions working within the hospital which becomes subjected to pressures towards compliance with institutional paradigm.

Also, apart from being medical institutions, hospitals are predominantly economic and organisational endeavours where crucial objectives are those of productivity, uninterrupted work and cost-effectiveness (Perkins 2004, Walsh 2006b). This can be achieved by routinisation and standardisation of work which contribute to the wide scale regimes of unnecessary technological intervention such as AML, as I have outlined in the section 1.1.2.2.

1.2.1.2 Advantages of non-hospital settings for birth

Hospitals have never been proven to be the safest place for women with healthy pregnancies but despite that the policy of supporting full hospitalisation of birth as well as favouring large units over the small ones was supported by often uncritical national departments of health (Wagner, M. 1994). Enkin et al. (2000) concluded that restricting women in the choice of place of birth cannot be justified in favour of any birth setting. However, internationally there have been difficulties within medical models of care with endorsing places of birth which would serve as an alternative to hospital care, as well as validating the independent practice of those assisting women outside maternity hospitals. Despite the evidence of the safety and cost-effectiveness of non-hospital birth settings, they are often a contentious issue and their existence is "fragile", i.e. it is difficult to sustain them within a technocratic framework favouring the conventional hospital environments.

All available reviews and studies report decreased reliance on technology within non-hospital settings such as alongside (co-located) midwifery units, freestanding midwifery units and when birth takes place at home. The results of the Birthplace cohort study in UK (Hollowell et al. 2011) demonstrated lower intervention rates such as fewer
intrapartum caesarean section, instrumental delivery and episiotomy, and greater chance of having “normal birth” for women planning to give birth in all of those settings when compared with women who planned to give birth in hospital obstetric units. Similarly, the most recent Cochrane review on “alternative settings”\(^{11}\) (Hodnett \textit{et al}. 2012) for birth had confirmed lower intervention rates and higher incidence of spontaneous vaginal birth for women birthing within them and identified “no apparent risks to mother or baby”. The same conclusions were reached by the authors of the MidU study (Begley \textit{et al}. 2009) conducted in our two midwifery-led units in Cavan and Drogheda. The comparison of care within those units and within the respective hospitals they are affiliated with between 2004 and 2007, had confirmed lower use of technological intervention (including augmentation of birth and the use of CTG during labour), decreased need for epidurals, as well as more appropriate use of antenatal screening technologies such as CTG, ultrasound scanning and biophysical profile.

1.2.1.3 Low-tech “extreme”: domiciliary births

Planned domiciliary births offer a further decrease in the use of technology in birth over hospital settings and also compared with midwifery-led units (Hollowell \textit{et al}. 2011), yet across the Western world they are even more contentious than midwifery units (Wagner, M. 1994). Homebirths have been repeatedly demonstrated by the research as leading to similar outcomes and lower intervention (Johnson and Daviss 2005, de Jonge \textit{et al}. 2009, Olsen and Clausen 2012). This has recently come to be reflected in the official guidelines for the provision of maternity care in the UK which state that “both multiparous and nulliparous women… may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit)” (NICE 2014: section 1.1.2). Those guidelines followed from the Birthplace cohort study (Hollowell \textit{et al}. 2011) quoted above which found decreased intervention as well as excellent perinatal outcomes for homebirth for women who had already given birth. Although it indicated

\(^{11}\) “Alternative settings” in this review are understood as a variety of settings which are unlike “conventional” hospital rooms which are similar to other hospital rooms for sick patients. “Alternative” settings aim to support normal labour and birth and include home-like bedrooms within maternity hospitals and home-like units adjacent to hospital wards, and more recently, “ambient” and Snoezelen rooms within hospitals where the bed is not a central feature or is absent altogether. Those recent additions “contain a variety of sensory stimuli and furnishings designed to promote feelings of calmness, control and freedom of movement.” (Hodnett \textit{et al}. 2012: 2-3)

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that for the women giving birth for the first time, adverse perinatal outcomes (including both deaths as well as birth injuries) were slightly more frequent, these were still extremely rare. However, all evidence and guidelines refer to women deemed at “low-risk” of complications, the level of risk being defined within the biomedical framework, and thus making such low-tech approaches dependent on the medical profession for access. Perhaps a case study of outcomes of the Albany Midwifery Practice best demonstrates the intricacies of provision of low-tech as well as homebirth services for women (Homer et al. 2017). This is because this practice has been catering for women of all “risks” within a local population of high socio-economic disadvantage. Despite this, Albany’s outcomes were excellent which indicates that high-tech models of care can be replaced by less technologised ones within out-of-hospital settings. However, this requires building a strong commitment to a philosophy of care supporting normal birth and being responsive to the needs of the local community of women through a flexible and holistic service. This brings my argument to the importance of midwives as leading practitioners in appropriate use of birth technology which I will turn to now.

1.2.2 Leading care provider and the use of technology

1.2.2.1 Midwifery-led models of care versus obstetric-led care

“It is the ideology of the practitioner, not of the society, that has the greatest effect on an individual birth” (Hodnett 2002, see: Davis-Floyd et al. 2009: 451)

There are many similarities in the argument concerning the role of the leading care professional and the role of birth setting when it comes to technology use in maternity care. Available evidence indicates that where midwives are the leading carers for the majority of pregnant women or the prevailing philosophy is the one on one midwifery model, the use of technological intervention decreases even if subsequently some women will be transferred to doctor led, more medical levels of care (Davis-Floyd et al. 2009; Sandall, Soltani et al. 2016). Also, in older studies, midwifery-led continuity models of care have been demonstrated to lower caesarean section rate (Hodnett 2002; Gagnon et al. 2007) while the newer ones indicate a lower rate of instrumental births (Sandall, Soltani et al. 2016). These results are certainly aided by the ethos of midwifery to support wellbeing and normality in childbirth and thus by the emphasis placed on
social and emotional factors in birth, along with the medical ones (NMBI 2015, RCM 2004, Clews 2013). It is also due to midwives’ training which, although often accomplished within a biomedical approach, also includes the use of low-tech non-interventionist techniques along with the high-tech ones. This requires midwives to balance between the two. Moreover, even within high-tech maternity care units midwives are expected to support women as much as “treat” them medically. This allows midwives to maintain certain skills necessary to attend to a wide range of women’s needs apart from the clinical.

Obstetricians, on the contrary, are trained within a biomedical approach which is pathology-oriented and technology-intense. Consequently, the use of technology is an important part of their practice and in case of complicated pregnancies and women who are not well there would be a good reason for it. Yet research demonstrates that even when their skills are used during straightforward births, doctors are still more likely to intervene and use technology, perhaps in accordance with their training and the resulting view on birth as pathological, when comparing with midwives. Analyses of available maternity care statistics in United Kingdom (Tew 1998) and the United States (Perkins 2004) both demonstrated that when caring for women with healthy pregnancies, midwives had lower intervention rates than doctors and obstetricians practicing within similar settings. Accordingly, Enkin et al. (2001) list both “routinely involving doctors” and “routinely involving obstetricians in the care of all women” as forms of maternity care which are “unlikely to be beneficial” (ibid., p. 48).

1.2.2.2 Low-tech maternity care providers

Midwife-led continuity models of care12 have been repeatedly demonstrated to offer care with less intervention compared with obstetric-led care: less pain relief needed as well as less use of medication overall (Sandall, Soltani et al. 2016; Begley et al. 2009). Additionally, the most recent systematic review reported not only women having greater satisfaction with their care but also better outcomes for babies, such as fewer

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12 These models are characterised by either “continuity of care” or “continuity of carer” (Walsh 2008). The former involves “a stated commitment to a shared philosophy of care”, the latter “the actual provision of care by the same caregiver or small group of caregivers”. What is the most important in this section, however, is that midwives are the lead care providers.
preterm births and “less early neonatal death” and “less all fetal loss” (Sandall, Soltani et al. 2016). Also, the already mentioned MidU study observed fewer expensive screening technologies being used (e.g. scans, CTG and biophysical profile) when midwives lead the care (Begley et al. 2009), thus there is a merit to calling a midwifery approach “low-tech” and non-interventionist. Authors describing “birth models that work” (Davis-Floyd et al. 2009) unanimously agree that midwives are essential to birth models which are appropriate for women’s needs and sustainable for the society. Such models have to be based on the philosophy and practice of the midwifery model, which to be truly women-centred must consider women’s reproductive processes as healthy and normal. Ultimately, however, these may be adopted by any practitioner (Walsh 2008; Davis-Floyd et al. 2009).

1.2.2.3 Low status of midwifery: limited re-emergence as a separate profession

In the 1950 Nurses Act, Irish midwifery was not considered separate to nursing. Accordingly, care provided by midwives as leading professionals was bypassed as the advantageous option by the Maternity and Infant Care Scheme in 1954. The Scheme ensured the protection of the medical hegemony over women’s health in pregnancy and childbirth (Lee 1989, in: Murphy-Lawless 2011a) and there was no genuine challenge to this until the 1990s. As a result, the position of midwives within the Irish system has been poor and as they have been considered as equal to “obstetric nurses” or obstetric assistants for many decades. This has been enunciated in the philosophy of Active Management of Labour and its subsequent manuals (O’Driscoll et al. 1993; O’Driscoll et al. 2003). The challenge to recognise midwifery as separate profession, as well as to provide separate training and midwifery-led options of care, had been first spelled out by the 1998 Commission on Nursing. It is only in the 2011 Nurses and Midwives Act that the Nurses Board was changed into Nursing and Midwifery Board of Ireland to acknowledge their separate status to some extent (House of the Oireachtas 2011).

1.2.2.4 Lack of autonomy

Independent midwifery practice continues to be limited and interfered with by the legislation, which especially impacts on home birth provision and out-of-hospital access.
to midwives. It is not discussed at all in the National Maternity Strategy which considers midwifery solely as a profession operating as an outreach service from the hospitals. In 2007 the indemnity insurance for midwives practicing independently was withdrawn and currently it is provided by the HSE under a stringent Memorandum of Understanding (MOU), which although drafted as a temporary solution, have become permanently tied to the administration of the 2011 Nurses and Midwives Act (House of the Oireachtas 2011). This is despite the MOU being non-evidence-based and "driven by Irish obstetric imperatives" and "risk management" rather than understanding of what genuine midwifery involves (Murphy-Lawless 2012). Also, the 2011 legislation forbids independent midwives, called Self-Employed Community Midwives (SECMs) since its introduction, from practising without insurance, and they face imprisonment or enormous fines if they find themselves outside the MOU (House of the Oireachtas 2011). This is not paralleled in the regulation of practice of any other medical profession (Murphy-Lawless 2011b). Finally, the MOU requires new midwives to complete three years of hospital training after graduating without requiring them to practice in the community or in a midwifery-led unit even if that is what they intend to do when they graduate (Murphy-Lawless 2011a). Such requirement actively discourages the maintenance of new midwives' vital skills to practice outside medical settings and undermines their confidence to provide less technologised care. The above obstacles leave Irish midwives working within an environment that does not cultivate midwifery expertise or facilitate low-tech practice.

The low status of midwifery and the resulting underdevelopment and underuse of autonomously practised midwifery in the Irish maternity care system have been contributing to a high reliance on this highly-interventionist, technology-intensive system. The midwifery-led options were not available for decades within the system and once cautiously introduced, have not been available universally, the access being restricted by their limited number, geographical location, or the ascribed "risk status" 

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13 Although in 2006 the first direct entry midwifery degrees were introduced, due to the low proportion of midwife-led out-of-hospital practice in the system, apprenticeship for midwifery students is available almost entirely within an obstetric-led context.

14 The example of this is the lack of use of the intermittent auscultation rather than CTG by midwives in hospitals due to the lack of institutional support and guidelines for intermittent auscultation which contributes to undermining midwives confidence to rely on this low-tech method (Hill 2016).
of a woman. Presently, midwife-led care options within the Irish maternity care system include care within already mentioned midwifery-led units in Cavan and Drogheda and hospital Domino schemes, as well as homebirth services provided by 16 independent and 4 private midwives\textsuperscript{15}. Available statistics combining all the above services indicate that midwives are the lead professionals in approximately 4.5\% of births (Department of Health 2016, National Perinatal Epidemiology Centre 2016). This does not include midwives’ antenatal clinics in hospitals as these are officially within a consultant-led system even when designated as midwifery clinics. However, while not leading the care as autonomous professionals, midwives are the ones caring for the majority of women in Irish hospitals (Murphy-Lawless 2011a: 450). This makes Irish maternity care consultant-led often in name only and, to a great extent, one that is actually midwife-delivered.

1.2.3 Private practice and the use of technology

“the dominance of doctors as the pre-eminent voice of authority on childbirth (...) is still evident in the public-private split in the maternity services (...) women choose private antenatal care with a consultant obstetrician as the ‘best’ form of care, believing that the obstetrician is the expert” (Murphy-Lawless 2011a: 447)

1.2.3.1 More intervention without better outcomes

Apart from the more frequent use of technology within hospital settings and in consultant-led care, it is also in private practice that technological intervention increases. Although researchers mention Canada as an exception, in Latin America, Europe, China, Australia and United States women who are choosing private care have been reported to experience higher rates of obstetric interventions than public patients of comparable “risk status” (Dahlen et al. 2012, Kozhimannil et al. 2013, Lutomski et al. 2014). The same trends have been demonstrated to be true for Irish maternity care. In an analysis of outcomes in one Irish urban hospital between 2008 and 2011 women who

\textsuperscript{15} Numbers of Ireland’s independent midwives, or SECMs, fluctuate between 15 and 20 and vary year by year. The current number is 16, down from 22 in 2017. The remaining 4 homebirth midwives work with the company Private Midwives Ireland. See: Homebirth Ireland website http://homebirthireland.com/how-to-organsie-a-home-birth-in-ireland/home-birth-providers/. Accessed 3rd November 2018.
were private patients were more likely to undergo scheduled caesarean section (34.4% vs 22.5%) and instrumental delivery (20.1% vs 16.5%) and those differences were neither justified by their “risk profile” nor by better outcomes as a result of such technology intense practice (Murphy and Fahey 2013). If anything, women in private practice appeared to be overall healthier than public patients. Another study, examining all births nationally between 2005 and 2010 confirmed the finding of higher intervention rates in private practice (Lutomski et al. 2014). For women who booked for private care the intervention rates were as follow: caesarean section 17.8% (vs 9.8% for public patients), instrumental delivery 18.1% (vs 14.9%), induction 32.5% (vs 26%), episiotomy 29.5% (vs 20.9%), epidural 64.1% (vs 50.4%). This demonstrates that private practice may contribute to the more interventionist care and in this way encourages more technology use.

Lutomski et al. (2014) argue that differences may not be exclusively due to the private package of care. They may be exacerbated by the fact that consultant obstetricians known for more interventionist style of practice (mentioned in a previous section) play a more central role in the care of private patients. While this may be a contributing factor to an already complex issue, both public and private care in Ireland is predominantly obstetrician-led, which would warrant that the differences may be due to private care indeed.

1.2.3.2 Public-private split: a history

Ireland is unparalleled in its public and private split and restricted access to primary maternity care. Compared to other European countries, the Irish system is “unique to have large quantities of private healthcare carried out in our public hospitals and that the vast majority of this private care is publicly funded” (Burke 2009: 112)\(^\text{16}\). The co-existence of private and public maternity care in Ireland has been called “extraordinary” (Barrington 1987) and the existence of this split in primary care “unusual” in Western

\(^{16}\) It has been proposed recently in the Sláintecare Report (House of the Oirechtais 2017) and in the Sláintecare Implementation Strategy (Government of Ireland 2018) that Ireland shifts its health care provision to a universal healthcare model. This involves the phased removal of private practice from public hospitals and the development of a single-tier public system (ibid.). However, whether Irish health care will actually move towards a universal model, and the extent of change when it comes to provision of private practice in the system, remains to be seen.
Currently, approximately one-third of women, a substantial minority, choose private maternity care (Lutomski et al. 2014) and the private medical insurance market plays an important role in “emphasising hospital-based, obstetric-led services” (Kennedy 2012: 381).

Private health care, rather than provision of universally accessible primary care, has been consistently supported by the Irish state. While this development was unplanned, it was nonetheless incentivised which led to institutionalising for-profit care into the public maternity care services (Burke 2009). The two-tier system that we currently have originates as far back as the instituting of the Maternity and Infant Care Scheme, discussed above in section 1.1.1, which safeguarded the private fees and the incomes within the doctors’ private practice (Ferriter 2005). Since then the government has “consistently reinforced the dual nature of public and private provision in public hospitals in Ireland” (Burke 2009: 112). As a result private hospital-based maternity care had become deeply entrenched and normalised within the public system. The Irish state continues to allow consultants to receive both salaries for public practice and fees for private patients, and in this way supports private practice. At the same time, even within private practice, most hands-on work for women is performed by “state salaried midwives” who are paid immeasurably less and “unpaid midwifery students” (Murphy-Lawless 2011a: 450).

Nonetheless the strong position of the senior cadre of consultant obstetricians had resulted in their ability to have a decisive voice in shaping maternity care and aided in conceptualising private obstetric-led practice as if it was the best choice for women. This ensured the continuing power of the medical model and its practitioners’ philosophy of care (Murphy-Lawless 2011a: 447). Also, the health care “market” was opened to private providers in the 1990s in order to deal with insufficiencies of the public system (Burke 2009) which further pushed healthcare system into dependence on private care and due to the nature of private care provision, into a more interventionist model of care.

As mentioned earlier, private care in Ireland is almost exclusively obstetric-led. Private packages come with a guarantee of having an obstetrician attending the delivery of the
baby\textsuperscript{17} and thus giving women the impression that having a medical doctor at the birth of their child may be somehow more crucial to good outcome. There is no option to combine midwifery-led care with being a private patient in the hospital if transfer of care is necessary in pregnancy, or for the post-natal period. This may dissuade women with private insurance who would like the benefit of having midwifery-led care and private accommodation. Midwife-led private care options have been only introduced in 2014\textsuperscript{18} but as this is a new service provided outside HSE jurisdiction no data as to the number of women using them is available. However, judging from the overall uptake of midwifery-led options and homebirth in Ireland, the number of women using it must be minuscule. This illustrates the role of private insurance in encouraging women’s choice of private consultant-led maternity care. This is also supported by the case study of the Australian system quoted by Devane, Murphy-Lawless and Begley (2007, after Shorten and Shorten 2004) where introduction of incentives to increase private health insurance coverage has resulted in a surge in intervention and operative birth rates in private hospitals.

1.2.3.3 “Competitive edge”

According to Perkins (2004) business-like models of organisation in obstetrics and pathological mechanistic paradigms of birth co-evolved and reinforced each other. The business model meant that treatments were introduced according to their potential to increase professional competitiveness, perceived efficiency and potential for increasing good outcomes, rather than real need for women and babies as well as evidence-based practice. Technological management of birth has provided obstetricians practicing privately with a competitive edge in the system and still contributes to seeing consultant-led private care as the desired model of care. This may inadvertently lead to higher use of technology to “actively manage” birth. Perkins argues that offering high-tech treatments to its private patients has been a market strategy to increase competitiveness and “scientific respectability” of obstetrics as a profession (Perkins

\textsuperscript{17} http://rotundaprivate.ie/maternity-options/ and http://www.coombe.ie/index.php?nodeld=84
Accessed 15\textsuperscript{th} March 2017

\textsuperscript{18} Private Midwives are “a division of UK Birth Centres” and offer a wider range of care options than those available in Ireland due to relying on less restrictive insurance policies in UK: https://www.privatemidwives.com/ Accessed on 15\textsuperscript{th} March 2017
2004: 134). In turn, this has contributed to “reconceptualising pathology in terms of the new technology” and applying this new technology to pathology reinvented in such way (ibid. 136). This might be one of the reasons why private care, being embedded in the market-driven business model, is well known to be more technology intense, it needs to gain some edge over what is free and accessible to all. As a result, while such an economic model expands, normality in childbirth decreases (Begley and Devane 2003).

1.2.3.4 “Demand” and unmet need

There is a paucity of research exploring the actual reasons for which women choose private maternity care (Fawsitt et al. 2017). However, as Kennedy observes the demand for private care may be driven by demand for private accommodation as much as for the high-tech obstetric care (Kennedy 2010: 149). Additionally, Fawsitt et al. (2017) reported that women are paying for private care not to fall victim to an under-resourced system and to ensure continuity of care which is not guaranteed as part of being a public patient. The latter reason is important in the context of the Irish system where genuine continuity of care is offered only to private patients in hospitals and women under the care of independent midwives. The majority, public patients with consultant-led care, are cared for by the “medical team” of registrars and senior officers rather than consultant obstetricians. Perkins (2004) also lists the privacy of single postnatal rooms and convenience of prompt antenatal appointments provided within private practice as “justifying” the price. However, fees for Private Midwives and obstetric-led packages in Ireland can actually be similar especially when purchasing a full package\(^\text{19}\). This demonstrates that the context for private care is perhaps not the need for high-tech expertise as such but the lack of investment in maternity care paired up with the development of extensive, widely available obstetric-led private hospital service. Also, while women may genuinely seek more high-tech methods offered by private practice (Fox and Worts 1999; Davis-Floyd 2004), this “demand” can also be questioned in the face of evidence of the “what is must be best” effect (Porter and Macintyre 1984, van Teijlingen et al. 2003) or the “status-quo bias” (Fawsitt et al. 2017) when it comes to

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women’s preferences for care. Consequently, women may often “choose what is offered as ‘good maternity care’ to them” (Perkins 2004: 44). Finally, within the neoliberal context, commodification and privatisation are seen as inevitable and equated with widening choice (Daellenbach and Edwards 2011: 222). Such “choice” however, within maternity care, becomes an “individualised responsibility” of a woman, and is made on terms defined by the obstetric profession providing the extra paid-for service.

1.2.3.5 Business or safety?

Perkins (2004) notes that high-cost and high-complexity interventions have been used to a greater extent on private patients in the past (Perkins 2004: 45). The emergence of obstetric private practice was a response to increasing numbers of women being able to pay for services rather than having an increased safety as its goal. As a result care had begun to be “tailored” to women’s socio-economic status, with a corresponding hierarchy of staff that were to care for them, of staff’s level of training and experience as well as different technological and surgical procedures used depending on individual women’s position within this hierarchy (Perkins 2004: 44). This is still apparent in the marketing of semi-private and private maternity care in Ireland as distinct from public care in Irish hospitals. The Rotunda hospital obstetrician and previous master Sam Coulter-Smith claims that private maternity patients are paying the “insurance” to be cared for by a “more experienced person than a standard hospital registrar” (quoted in Madden 2011). However, as during birth most of the care in Irish hospitals is performed by midwives, it is with more surveillance in pregnancy (i.e. more tests, frequent checking, and more complex equipment), more active management of birth and offering greater access to high-tech treatments that private practitioners have been justifying their payment.

1.3 Conclusion

Maternity care models which work best go against the “technocultural grain” (Davis-Floyd et al. 2009: 15). They rely on the midwifery approach which puts women and their needs in the centre of care and supports women in their ability to give birth, minimising technological intervention as a result (Rothman 1991). Technocratic maternity care
carries a huge potential to inflict harm on women and their babies but also on healthcare systems and people working within them, its negative impact extending across society (Davis-Floyd et al. 2009, Edwards et al. 2018). Yet it is this system that has flourished in Ireland.

This chapter demonstrates multiple enablers of technologisation operating in Irish maternity services: the lack of commitment to strong midwifery and unwillingness to afford it a fundamental role in the system as well as the reluctance to dislodge existing configurations of power which allow obstetric rather than midwifery or social imperatives to prevail in shaping maternity care and which protect vested interests of the medical profession. This has contributed to normalisation of highly interventionist hospital care provided by obstetric consultants as “standard” care for all women in Ireland, despite this “standard” being at odds with evidence and best practice. The most recent developments in Irish policy, such as the National Maternity Strategy (Department of Health 2016) and its Implementation Plan (HSE NWIHP 2017), demonstrate that maternity care is still very much framed within the medical model and its “risk management” strategies. This may continue to curtail the development of less technologised, more appropriate maternity care.

However, apart from the above historical and institutional contexts, there is more than health system barriers, policies and politics that is required to make sense of such an extensive technologisation of Irish maternity services. In Chapter 2, I explore what else may be at stake when we see technology as the touchstone of modern healthcare provision but also, when we see it as an all-encompassing remedy to the difficulties of our society in general, and in particular, its “risk aversion”. Thus in the next chapter I turn to much broader and equally challenging socio-cultural contexts of science, technology and risk and their ramifications in modern and late-modern society.
Chapter 2

Conceptualising technology: modernity, late modernity and the technical fix

2.0 Introduction

“[technology] is more than the sum of its parts” (Rothman 2000)

The first part of this chapter examines the concept of technology and the contexts for its appearance as a term in general use. It aims to arrive at a definition of technology for the purpose of this thesis. I focus on what is termed “modern”, “high”, “advanced” or “scientific” technology. My aim is to move beyond technology as isolated and separate machines and devices and use the term more comprehensively to take in the range of complex relationships amongst social, cultural, political and economic factors that interact to make technology what it is. By focusing on technology in its scientific, modern incarnation I intend to emphasise after MacKenzie and Wajcman (1999) that “before the latter part of the nineteenth century the contribution of activities we would now think of as science to what we would call technology was often marginal” (ibid.: 7). Thus, within my argument I explore technology as a concept fundamental to complex systems operating within the institutions of modern society, one of these systems being the provision maternity care in our society.

There are two aspects of this term that I discern in this project. One is focused on technology as a set of resources of a complex system, and the institutional context within which such system operates. The other considers technology as a paradigm of thinking. They are not discrete but I separate them analytically to emphasise that technology is not only concretised through objects and procedures but has become a way of thinking on how things can be done, in society and within maternity care.

The second part of the chapter outlines the socio-cultural contexts for our understanding of technology and its function in our late modern society. I begin with looking at the modern project and its endeavour to achieve progress and improvement of a human society. Next, I explore the conviction that problems in our society (and, by extension, in our maternity care) are essentially technological and their solutions can be reduced to their technical aspects, epitomised in a “technical fix” philosophy and the
“technological imperative”. Subsequently, I discuss the authority of science in modern societies as having the status of an absolute “truth” (Foucault 1980b), a superior form of knowledge and a provider of the best “fixes” for our predicaments. This, together with a conceptualisation of technology as the principal application of modern science, results in the technological appearing to represent the fundamental laws of science, and thus technology is considered as inevitably, purely scientific. Finally, I argue that it is the risk discourse with its predominantly scientific legitimation, and the conceptualisation of technology as the most certain way of dealing with risk in childbirth which is crucially responsible for our political difficulty with attempting the de-technologisation of maternity care.

2.1. Conceptualising technology

2.1.1. Universalistic understanding of technology

The most basic impulse for the development of technology seems to be the realisation that something can be done in a different way than the usual. This prompts humans to search for practical ways to act upon and interact with the world in a new way rather than accept things as they are. Technology in such a broad sense is an activity aimed at “getting leverage” over the physical world (Kirkpatrick 2008: 17). In this sense technology is the opposition to the “natural”, spontaneous processes we otherwise experience and contains the refusal to let things simply happen the way they do, and thus from its very beginning is a human-devised reality. Understood in this way technology reflects an essentially human need to alter and act on surrounding environments, its development traced back to the very first prehistoric tools and techniques (Diamond 1997). Within such a conceptualisation almost anything human-made can be conceptualised as technology and this is echoed in prehistoric and anthropological research where technology is “a purposeful production and use of tools and methods for manipulating and controlling the world” (Kingery 2001: 123). Such use of the term “technology” is of course possible only retrospectively and it does not allow us to consider technology as distinctively modern. Moreover, if almost anything human-devised is conceptualised as technology it is difficult to discern what is different about modern, scientific technology comparing with techniques and phenomena deemed low-
tech or non-technological. However, what I find helpful in the universalistic understanding of technology is that it sees technology as essentially a social practice. Technology is not only a reworking of the physical world to adapt it to human needs but becomes an expression of a given society and its culture (Kirkpatrick 2008). In contrast, once the term appeared in the modern period, its associations have been focused around technical aspects.

2.1.1.1 Midwifery technology?

If such universalistic understanding is applied to technologies used for birthing, there is a whole body of knowledge about birthing process predating modern technologies. Marsden Wagner, in a similar vein to Kirkpatrick, argues that technologies have always existed and uses the term “technology” with regards to techniques such as the use of herbs and bodily techniques developed over centuries to assist women in childbirth (Wagner, M. 1994). Within such an understanding, midwifery knowledge as well as knowledge of healers and handywomen, aimed at “getting leverage” over the physiological processes in birthing, can claim its own technologies. Such an application of the concept of technology allows Wagner to argue that modern high-tech medicine is not the only approach and does not have the monopoly to devise technologies for childbirth and that there are non-medical techniques to assist women in childbirth such as, for example, different positions and techniques for supporting the body in a complex labour and protecting the woman and her baby from harm.

Within such a broad definition however, I would not be able to separate medical technologies used in biomedical maternity care from “midwifery technology” (Newnham et al. 2016) or traditional techniques which developed over the centuries. I believe this separation is essential for us to begin to understand the grip of technology as a modern concept within biomedicine on our imagination.

2.1.2. Technology as a modern concept: emergence of mass scale technical systems

Contrary to the view of technology as universalistic is the argument where technology has been considered a distinctly modern phenomenon (Marx 2010, Misa et al. 2003). Firstly, apart from sporadic and now obsolete uses, the term was still not in use well into
the nineteenth century. Secondly, the term emerged as a response to ideological and material changes accompanying modernisation and industrialisation.

The Oxford English Dictionary provides a list of definitions reflecting the changes that technology as a term has undergone historically. According to this list the term “technology” appeared in the seventeenth century with three uses: as (1) “treatise on a practical art or craft” and (2) “technical language or nomenclature” to the most remote (3) “the systematic treatment of grammar”. Tracing the historical development of the concept Leo Marx identifies the vocabulary which was in use during the Industrial Revolution to depict what we would now call "technology". This had included "practical", “industrial” or “mechanical arts”; “inventions”; “machinery” and “mechanism” (Marx 2010: 563). According to Marx, the new ideological developments such as the ideal of technical and social progress, and changes in the material character of production with the increasing elaboration of industrial machinery used on a mass scale created a need for a new word. The emergence of complex mechanical and industrial systems caused profound changes in the nature of “mechanical arts” and prepared the context for the appearance of “technology” as we know it (Misa et al. 2003). These "arts" had become complex systems of technical elements and this shift resulted in profound changes in their societal function (Misa et al. 2003: 11). As a result, separate "inventions" and "machines", and the individual "tools" that were not part of the mass scale system ceased to convey the essence of what the industrial era was about. The existing vocabulary could no longer sufficiently address this conceptual void.

In my research I concur with the view of technology as a modern phenomenon and I consider an impulse to apply technology to birth as modern, resting on the cultural milieu of modernity and industrialisation. It is within this framework that a high-tech

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20 All those uses had been supplanted by the nineteenth century "modern" definitions of technology.
21 This shift can be illustrated by an example of weaving. In the first part of nineteenth century, domestic production consisting of small workshops of skilled workers operating hand-powered looms had been increasingly replaced by a factory system of production, a complex technical system involving a highly mechanised production process on a mass scale (for an exemplary description of this process and the social complexities involved, see Mason 2008). As a consequence of large scale standardisation of production individual workers had less control on the pace of their work, materials used and quality of their produce (Pacey 1983).
hospital system rather than a community or a “domestic” one could become regarded
as a desirable maternity care development.

2.1.3. Sociological definition of technology for this research

The latest\textsuperscript{22} definitions of technology in the Oxford English Dictionary (OED 2007) are
convergent with the common understanding of technology for members of our society
at present. At the same time, this dictionary does not yet list the very recent and
perhaps most ubiquitous understanding where technology is synonymous with digital
communication technology and its devices. According to the definitions in OED which
are still in use technology is considered as (italics mine):

\begin{itemize}
  \item[(4a)] “the \textit{branch of knowledge} dealing with the mechanical arts and applied sciences;
  the study of this”
  \item[(4b)] “the \textit{application of such knowledge for practical purposes}, esp. in industry,
  manufacturing, etc.; the sphere of activity concerned with this; the mechanical arts and
  applied sciences collectively. Freq. with modifying word, as alternative technology (...)
  information technology, space technology”
  \item[(4c)] “the \textit{product of such application}; technological knowledge or know-how; a
  technological process, method, or technique. Also: machinery, equipment, etc.,
  developed from the practical application of scientific and technical knowledge”
  \item[(5)] “a particular practical or industrial art; a branch of the mechanical arts or applied
  sciences; a \textit{technological discipline}”
\end{itemize}

The above definitions reflect the now primary association of technology with technical
and scientific knowledge and their practical application, as well as the outcomes of such
applications in the form of devices and machines, but also knowledge and procedures
that result from such application. The last definition seems to be a recollection of the
earlier term: "mechanical arts". The definitions supplied by Merriam-Webster’s
Collegiate Dictionary (2016) hardly differ and enumerate different meanings of
technology as "the practical application of knowledge especially in a particular area" and

\textsuperscript{22} By "latest" I mean definitions that are common in use today even though they emerged over the span
of the Industrial Revolution (1750-1850).
"capability given by the practical application of knowledge", as well as "a manner of accomplishing a task especially using technical processes, methods, or knowledge" and "the specialised aspects of a particular field of endeavor".

Although such uses of the term date back to the late eighteenth and early nineteenth centuries, this is what would be still recognised as technology today and what we can find in the public discourse. We can see how as industrialisation progressed the term had been expanding in the nineteenth century writing on “mechanical arts” (OED 2007). However, apart from the academic arena it has never really extended beyond the technical aspects of technology and that is precisely where the boundaries of technology are drawn in its everyday use. The impulses which are social, cultural, political or economic are not part of technology in those definitions whereas these aspects are strongly emphasised by authors concerned with the social studies of technology (Bijker et al. 1987, MacKenzie and Wajcman 1999). Within this scholarship “the definition of technology itself must incorporate the social arrangements within which it emerges and becomes embedded” (Williams and Edge 1996: 875) and it is impossible to conceptualise technology and society as separate (MacKenzie and Wajcman 1999). Further, the position of focusing solely on technical aspects of technology has been criticised as concealing the fact that technology is made by humans and suffused with human values (Burnett et al. 2009) and involves cultural values and ideologies, as well as ethical, political and economic concerns (Pacey 1983).

2.1.3.1 Technology as resources of a complex social system

In agreement with these positions, I move beyond “technical aspects of technology” in my understanding (Pacey 1983: 4-5). Standing aside from a restricted meaning of technology as an equipment and knowledge and or method of “making things work”,

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23 Perhaps this is also why definitions including the social dimension of technology have never made it to OED. The reason for this omission may also lay in technology as a concept becoming complex and also suffusing all areas of social life in late-modern society. This may account for the reluctance of a "public" source such as the OED to consider the most recent developments of the term with such broad boundaries.
my primary focus is on technology as inseparable from the social-cultural context as well as institutions within which it is designed and used.

Marsden Wagner defines technology in the health domain as “an association of methods, techniques and equipment which, together with people using them, can contribute significantly to solving a health problem” (Wagner, M. 1994: 5). While this definition allows him to include any human-devised techniques of assistance in birth as technologies it does not include the socio-cultural and the institutional context of the hospital as part of technology. Wagner’s concept and the title of his book, The Birth Machine, corresponds at least in part to my understanding of technology: "a wide array of medical interventions, often of a technical nature, used before, during and following birth" (Wagner, M. 1994: 8). However, although Wagner’s work does explore these aspects of technology in depth, for the purpose of this research I needed a more comprehensive definition, which would explicitly address the problem of cultural, social and political values, a more purely sociological understanding (Wagner was a perinatologist). What has not been addressed in Wagner’s definition is addressed in sociologist Ann Oakley’s (1993a) definition of medical technology as “the set of technologies, drugs, equipment and procedures used by health-care professionals in delivering medical care to individuals and the systems within which such are delivered” (ibid.: 172, emphasis mine). Similarly to Oakley, I consider technology in maternity care a complex socio-technical system integrating artefacts (such as drugs and equipment), knowledge and expertise, as well as procedures and protocols employed by health professionals working within this system, and including the social context of the institution within which technology operates (which is predominantly the maternity hospital24).

This is my first understanding of technology as diverse resources operating within a particular social context and forming a coherent system.

24 Misa et al. (2003: 3) consider hospitals as "second order technological systems" because they integrate pharmacological, expert-professional, organisational, hygiene management, digital-computerised, surveillance, clinical and surgical technologies.
2.1.3.2 Technology as a paradigm of thinking

Apart from understanding technology as a diverse set of resources belonging to a complex socio-technical system, there is a second aspect of understanding technology that I would like to explore and uncover. Within this second understanding, technology is regarded as *a paradigm of thinking*, a conceptual model underlain by biomedicine which allows us to think about maternity care and the very process of childbirth in technological terms. This observation follows the work of other researchers such as Barbara Katz Rothman (2000), Robbie Davis-Floyd (2001, 2004) and Marsden Wagner (1994, 2001). The essence of this paradigm lies not in the use of resources such as equipment and high-tech medical expertise although their presence in the birthing room is perhaps the most palpable manifestation of this paradigm. It is the understanding of technology as an underlying philosophy which justifies extension of the technological criteria to the aspects of birthing which are not technological but individual, emotional, cultural or social.

Technology as a paradigm of thinking allows certain aspects of maternity to be more essential than others: the objective quantifiable responses to maternity “problems”, standardised and ensuring predictable outcomes – in both these instances, efficiency and rational management function as central values. These influence what we have come to understand as “care” at the very fundamental level.

Technology as a paradigm resembles Ellul’s “technique” which refers to both material, concrete products of technology such as machines and equipment but more importantly it encompasses technological phenomenon in the most general sense as "the reality of the technological" (Ellul in: Shaw 2014). For Ellul's technique is "the totality of methods rationally arrived at and having absolute efficiency (for a given stage of development) in every field of human activity" (Ellul 1964: xxv, italic in the original). For Ellul, Western

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25 Although technique in Ellul's work was translated as technology, he preferred the term technique. Technology as a concept, for him, echoed its older use as a "discourse on mechanical arts" (see: OED 2007), the study of technological procedures, a teaching on discourse on them (Lovekin 1991). It is the technique that points out to "the technological phenomenon, the reality of the technological" for Ellul (Ellul quoted in: Shaw 2014: 34). For the purpose of clarity, I am using the term "technique" when referring to Ellul's concept or to invoke technology as paradigm.
civilisation is characterised by such "technological intention" towards efficiency, and it is this quest, rather than its material end products in the form of machines that is problematic: "technique has become a form of intention. To control technique would therefore require an intention that could go beyond it, to another level of objectivity, which is clearly a more formidable task than redesigning artefact" (Lovekin 1991: 83). Technique is characterised by rationality and artificiality. Through the former it eliminates anything spontaneous and personal and is typified by "systematisation, division of labour, creation of standards, production of norms" (Ellul 1964: 79). The latter means that technique creates a world where "the technical milieu absorbs the natural" and subordinates it to its imperatives (Ellul 1964: 79) and consequently also contributes to non-technical human activity gradually becoming technical activity.

Although this determinist view of technique as autonomous and impacting the society and the actions of its members from the outside has been criticised (Bijker et al. 1987, MacKenzie and Wajcman 1999)26, I still find Ellul's description of technique helpful in grasping the difference between conceptualisation of technology as a system of interconnected components and their institutional context, and technology as an overarching principle, the "technological rationality" that is governing this system.

2.1.3.2.1 Technocratic paradigm: “technique” in maternity care

In this sense technology can be understood as the “ideology” of maternity care system as much as one of the ideologies of our late modern society and its institutions. Barbara Katz Rothman, a sociologist writing on maternity care and motherhood, offers similar understanding of the technological paradigm. Rothman (2000) considers technology as a way of thinking as well, not only as machinery and know-how intertwined in a complex system. Technology becomes “ideology of technological society” which allows us to think about our world in “mechanical, industrial terms” (ibid. 2000: 28).

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26 Feenberg considers Ellulian understanding of technique as preventing the conceptualisation of technology being susceptible to human influence and excluding people's participation in its design and implementation, and is a political construction that should be challenged (Feenberg 1999). In contrast, Merton concedes that people, far from being unknowingly moulded by technology, choose to accept the technological path and everything that comes with it because it fits with the values of modern society (Shaw 2014)
Alan Barnard and Margaret Sandelowski (2001) have also drawn on Ellul’s understanding of technique in order to separate technology and technique in the context of nursing practice. They have argued that the former could be used for better purpose once the "technological paradigm" in the form of technique is reformed. Their interpretation of technique involves "the formation of systems comprised of human, organisational, political, and economic structures, which are aimed at the absolute efficiency of methods and means in every field of human endeavour" (Barnard and Sandelowski 2001: 372). For them it is not technology but technique that should be challenged as contributing to the technologisation of thinking about maternity care. It is technique that does not allow the inclusion of the personal, individual and emotional as well as the social and cultural in the conceptualisation of important considerations in maternity care. However, as Oakley (1993a) argues "technology is never neutral - a thing considered in and for itself" (ibid.: 172) and is always an expression of certain social arrangements. Similarly Langdon Winner (Winner 1999) argues that certain technological artefacts have politics deeply embedded in their design and embody specific forms of power and authority (Winner 1999: 28). Thus, while Barnard and Sandelowski’s argument does draw attention to the necessity to challenge technique as responsible for technologisation of care, rather than shifting focus from technology to technique (or technology as paradigm) we have to pay equal attention to both. We still have to be conscious of what are the reasons for technologies taking the shape they do (Wajcman 1991).

I agree with Bernard and Sandelowski that even humane aspects of maternity care can become a technique when ordered and categorised into rigid protocols with little room for spontaneous, flexible practice dependent on situation and the individual woman’s needs (Barnard and Sandelowski 2001: 372). This can happen within the context of the institution which purports to operate on purely clinical objectives obliterating the social contexts of birthing and mothering27. Perhaps the opposite could also be possible, that what we consider technological could be prevented from becoming a technique through

27 For example, according to two women in my interviews (Shauna and Tara), maternity hospitals should be about preparing women for mothering their children well (e.g. demonstrating how to care for the baby but also supporting women in practical aspects of motherhood), as much as about clinical aspects of birthing. However, within the biomedical framework the importance of the former is diminished.
its humane, appropriate uses, respectful to women's needs and not privileging technical knowledge over theirs (Wagner 2001).

Perhaps the most comprehensive description of the technological paradigm in maternity care is authored by Robbie Davis-Floyd (2001, 2004). Within this paradigm, birth is considered as a mechanical process and thus appropriate maternity care can and should be scientific and objective. Consequently, it should be based on a technical knowledge of birth "mechanics", and on facts and measurements, rather than relationships, caring and empathy, and reverence for women's embodied, experiential knowledge of their bodies as in a midwifery approach, which she terms “the holistic model” (Davis-Floyd 2004: 160-161). A standardising and separating approach is considered applicable to maternity care, a source of blanket policies. The same protocols may be used for all women within (or outside) certain criteria, the care divided by the medical departments and specialties working in the hospital with disregard for the relevance of protocols (or indeed a need for such a rigid approach) for individual women (Perkins 2004). As Downe and McCourt (2008) argue this paradigm is governed by simplistic cause-effect conceptualisations of the birth process and short-term measures, with clinically defined parameters overstepping what is not clinical. This paradigm is also characterised by linear thinking (Downe and McCourt 2008), hence the importance of time-frames and progress charts where similar progress is expected from women whose births are placed in the same category by the system. 28 The technical and technological are valued over the human and social aspects, as well as over what Davis-Floyd (2004) terms the "sufficiency of nature" (ibid. 160), all seen as essential in the midwifery approach.

A pathological focus of the technological paradigm in maternity care reduces the definition of a good outcome to an absence of pathology (Downe and McCourt 2008: 11). As a result, as Downe and McCourt point out, such a paradigm is neither supporting or maintaining normality nor prompting exploration of what contributes to wellbeing.

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28 The issue of time and timeframes in childbirth and midwifery practice has been examined in detail in McCourt (2009).
For Davis-Floyd (2004), such an immense focus on pathology results in the belief that all births require to be managed and all benefit from intervention.

Childbearing and maternity care can be considered technological whenever the overarching approach to it is some sort of “active management” and within hierarchical, strictly regulated and highly specialised environments where protocols and norms are devised to determine scenarios for the individual women when they deviate from what is expected of them. As Arnold Pacey (1983) observed, the essence of early industrial production was the organisation of work and the regulating, controlling and standardising possibilities it offered rather than elaborate machinery which had yet to develop. In this light, the actual use of high-tech machinery is not necessary for us to be able to call a woman’s birth technological. It is the modernist, rationalising intent which makes it technological and the consequent expectation that her birth is efficient, predictable and scientific.

2.2. Socio-cultural context for the technocratic paradigm and the current use of technology

“the discourses and practices of biomedicine and technology are played out on a complex cultural ground” (Rapp 1999: 5)

Describing different paradigms shaping maternity care, Davies-Floyd pointed out that the way technology is thought of and used in a society “reflects and perpetuates the value system that underlies it” (Davies-Floyd 2001: 5). In Chapter 1, I have already outlined the factors behind historical and institutional maintenance of the technocratic model of care in Ireland. In the second part of this chapter, I explore the value system behind this model looking at the most crucial socio-cultural circumstances which maintain this intensely cultural and ideological project: modernity, the philosophy of technical fixes, the emergence of modern science as well as the notion of risk. These constitute a multi-layered context which reflects and shapes apprehensions and uncertainties associated with our society’s trust and reliance on technology.

2.2.1. Modernisation of maternity care: enablement or constraint?
Modernity as a project has been characterised, not only by offering more discipline and rational control, but also as a discourse of liberation (Wagner, P. 1994). While modernisation was to lead to increased freedom and autonomy of the individual from the restraints of nature and traditional forms of society (Misa et al. 2003), it was also about the increased mastery and control, and “formalisation of modes of action” to ensure greater manageability of modern society (Wagner, P. 1994: 26). It is both the “ethos of self-examination” and the “institutional Leviathan” which are part of modernity (Foucault 1984b). The coexistence of those two irreconcilable strands continues into late modernity and is present in both the enablement and constraint offered by modern institutions (Giddens 1990, Wagner, P. 1994).

However, there is little room for emancipatory potential in the technocratic paradigm in maternity care or rather, it is powerful modern institutions, such as the state and medicine, which benefit most from “enablement” offered by modern rational management rather than individuals those institutions are ostensibly to serve (Sakala 1993a). While the use of technology, understood as technological resources, could potentially enhance the scope of our agency within different, more comprehensive models of care, such as the one exemplified by the social model and midwifery approach, the technocratic paradigm is ultimately inherently autocratic and hierarchical, a birth machine predicated on the notion of “technological progress as a source of political power” (Davis-Floyd 2001: S7). From within it, “lay” individuals such as pregnant women and their partners, are not only portrayed as lacking scientific, technical knowledge of modern experts, seen as necessary to make decisions but also their agency is seen as an obstacle to rationalised and “technically perfected” social order (Bauman 1989: 154). In this way the disciplining, controlling aspects of modernity resurface in the technocratic project.

2.2.1.2. The technocratic paradigm, modernity and the ideal of progress

The ordering and separating approach of the technocratic paradigm is not only a consequence of modernity as a cultural project deriving from the Enlightenment, but

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29 This is indicative of the “compelling tangle” of modernisation and technologisation (Misa 2003: 1) and their simultaneous development. As Brey (2003: 33) observes in the same volume as Misa: it is modernity which “raises” problems for technology to “solve” and thus making technology a creation of modernity,
had also become “a socially accomplished form of life” of industrial society (Bauman 1991: 4). As such, this paradigm in maternity care epitomises the modern belief that society and circumstances of our lives are susceptible to improvement by human intervention through objective scientific knowledge, that by rational organisation and management of our affairs we would be capable to make our lives better and diminish uncertainty and ambiguity (Bauman 1991, Beck 1992, Misa et al. 2003).

Thus an inherent feature of modernity is faith in progress, science and technology providing a frame of reference for what actually counts as progress and for what is considered the most reliable means to achieve it (Sarewitz 2009). Beck (1992) calls the idea of “progress” a “secular religion of modernity” (ibid. 214) and describes it as a system of cultural norms and values where individual, social and economic interests are intermeshed. Yet, the pursuit of any “progress”, social, moral or technological, has come to be conceptualised and measured solely by techno-scientific innovation ensuring “wealth production” in the context of a market-oriented economy (Sarewitz 2009). It is thus difficult to argue for other types of solutions, often socially complex and difficult to measure, as bringing progressive improvement to our lives. Yet technological resources are only the most overt indicators of a modernising project and there are much deeper processes reshaping the entire structure of our society which now enters its “reflexive” or late modern phase (Bauman 1993, Beck 1992, Giddens 1990). This is the stage of modernity as a cultural formation when it undermines its own principles such as an uncritical view of the progress (Beck 1992). It is a more complex phase in the development of the industrial society critical of itself where the hazards produced by techno-scientific development are no longer seen as accidental “unanticipated consequences” but are acknowledged as inherent to modernity (Bauman 2001: 173). This is exacerbated by diminished potential for support from the traditional social structures and systems of knowledge which have been “modernised”. As a result establishing certainty becomes impossible in late modernity as it is the very institutions trusted to decrease it, such as science and technological development, which produce uncertainty (Bauman 1991, Beck 1992, Delanty 2013).

but likewise, it is technology which makes modernity possible, enabling it in tandem with science to fulfil its desires of remaking the whole spheres of human existence in a rational orderly manner.
Strangely, in an effort to regain certainty in late modernity we turn to the very tools which manufacture it as there seem to be no alternatives. Hence the intensified reliance on science and technology and associated expertise. Consequently, the technocratic paradigm in late modern maternity care is sustained and perpetuated by intensified focus on science and heightened efforts at even more stringent technological management, seen as the only way to reduce its ambiguities and uncertainties (Edwards and Murphy-Lawless 2006). Nash et al. (2014) identify two dominant aspects of modernity as “the expansion of science and technology driven by the belief that everything is solvable by these twin engines of development” and “the increasing production of risks related to that very blanket use of science and technology”. It is to these issues: the philosophy of technical fixes and associated belief in the technological imperative, as well as the role of science and risk management that I will look into in detail in the remaining sections of this chapter.

2.2.2. Fixes and imperatives: technical issues, technological solutions

“technology [is] setting the vocabulary of the world’s narrative in a way that allows nothing but technological action and that expresses any worry or trouble as a demand for a ‘technological fix’” (Bauman 1993: 187)

The technocratic paradigm “problematises” maternity care as a series of essentially technical issues, which can be resolved technologically. According to Zygmunt Bauman (1993) technology as a paradigm has the capacity to fragment the world into problems

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30 The notions of “technical” and “technological” are overlapping and are often used synonymously despite differences in the associations they carry. Based on my reading of the literature and definitions in the Oxford English Dictionary (OED 2007) and Roget’s 21st Century Thesaurus (Roget’s 21st Century Thesaurus 2005) in this research I use the term “technical” as mechanistic, to do with mechanics of the process, as its common usage links it with “specialist”, “practical”, “mechanical”, to do with technique (a method, a procedure) of doing something. In turn I use the notion of “technological” as having to do with the systematic and systemic solution to technical problems because its associations, above those of “technical”, are with “industrial”, and “relating to or using technology”. Technological is associated with the characteristics of large scale industrial solutions and the technology behind them and these build on the technical.

This is why I consider conceptualisation of “problems” in maternity care technical and proposed solutions as predominantly technological. However, the distinction is not clear cut and while “technical fix” can be seen as a reductionist view of birth “mechanics” and the “technological imperative” as more wide-ranging and systemic (Pacey 1983), their conceptual distinction is arbitrary and sustained for the clarity of my argument.
conceptualised as tasks for itself. Those “problems” would not have been necessarily conceptualised as problematic outside the technocratic paradigm. In this way, technology becomes “a closed system” consisting of “self-corroborating beliefs” (ibid. 187) which produces its own legitimation, and similarly to Ellul’s (1964) description of technique, is self-enforcing and self-perpetuating. This makes it extremely resistant to challenge, particularly the challenge which is not made on its terms:

“what one is least likely to do is to put up such a challenge to technology as would not be technological itself and would not lead... to further reinforcement of technological rule” (Bauman 1993: 197)

This encourages thinking about maternity care through a technical fix mentality and merely “following” technological imperatives.

2.2.2.1. Technical fixes and the technological imperative in maternity care: are they separate?

The technical fix and the technological imperative are inextricable concepts but I consider it useful to separate them to convey slightly different features of the technocratic paradigm. Both concepts forestall the conceptualisation of problems in our society outside the technological realm. The technical fix allows only for a technological action once the technical “problem” is identified, it is the “unconditional command” for the ‘fix’ to be found (Bauman 1993: 188). This is what is happening in technologically oriented maternity care as Rothman’s observes:

“An infinite number of procedures and interventions are so readily normalised because that fits in with our view of the world: one is compelled to take action in order to get results. In medicine, as in much else in technological society, even action with very little chance of success is preferable to no action at all, on the spurious assumption that doing something is better than doing nothing” (Rothman 1991: 40)

In this way, technical fix philosophy is perpetuating the belief in “quasi magical powers” of technology as a source of solutions to not only technical but also complex social problems, providing means to eradicating not only disease and disability but also poverty, inequality and environmental damage (De Miranda 2009: 25).
In turn, the technological imperative can be understood as bringing technical fix philosophy to its extreme and ‘fixing’ the problems with the technical fix itself. The crucial difference to technical fix is the emphasis on more technology and more technological complexity which becomes a goal as such. This is succinctly expressed in Bauman’s observation that “the more ‘problems’ technology spawns, the more technology is needed as only technology can ‘improve on’ technology” (Bauman 1993: 186). The term “technological imperative” has been introduced by Fuchs (1968, 1972) in the context of the discussion on the growing costs of health care stemming from the increase in high-tech treatments available. According to Fuchs (1972), it is a part of a medical tradition which emphasises “giving best care that is technically possible; the only legitimate and explicitly recognized constraint is the state of the art." (ibid. 66). The technological imperative is more than our preference for the latest and most technological type of health care as Fuchs suggests, it also equates them with ultimately the best we can and consequently must have (Gordon 1988). Thinking through the logic of the technological imperative supports the framework of intensive care medicine (Perkins 2004), and the access to “state-of-the-art” facilities equipped to provide “maximum multiple technological responses” becomes a preferable standard of care for all (Thomas 2003: 337).

The conceptual overlaps notwithstanding, the technical fix conveys a more techno-optimistic view of technology’s potential (Huesemann and Huesemann 2011), so pervasive in the public discourse on technology. It seems (almost unwittingly) oblivious to the problems with the technological development, and is predicated on inflated hopes of technological progress. The technological imperative seems to embody a much “darker” and compulsive aspect of our belief in technology depicted by the critics of unmitigated technological development such as Ellul. It speaks of our equally pervasive techno-arrogance, an outright refusal to consider the limitations of technology and alternative approaches to it. It supports its unmitigated power instead, without bringing to the surface all the vested interests behind technological development (Jenkins 2002, Pacey 1983). Such development in maternity care is crucially influenced by the combination of market driven innovation, health insurance and legal support for high-tech over low-tech responses, with women’s needs given often but perfunctory
attention (Perkins 2004, Thomas 2003). These conflicting impulses cannot be separated, and seemingly more innocent optimism can serve as justification for all that goes unacknowledged in our use of technology, and a tool for dismissing all criticism.

Perhaps Bauman who does not separate technical fixes and imperatives (Bauman 1993: 186-188) is right in this after all, as the two notions unite in an absolute conviction that the unwanted consequences and failures of technology are only a matter of finding the better one or the continuous effort to perfect the capabilities of the ones we already have.

2.2.2.2. The loss of “social thinking”

Beck observes that whenever disagreements in our society are discussed predominantly in “technocratic and naturalistic” terms (i.e. those taken from natural science)31, the importance of their inherent social, cultural and political aspects remains unrecognised and this results in the “loss of social thinking” (Beck 1992: 24). Similarly Pacey (1983) argues that thinking in technical terms prevents us from attending to socio-cultural values underlying technology. It prevents us from viewing the problems in our society as essentially social not technical and from searching for social and not only technological solutions to them. It allows us to conceptualise technological development in determinist terms, as a force external to society, and happening due to an internal logic. It is thus irresponsible or even impossible to thwart it and it allows for a limited set of responses: “uncritical embracing... defensive adaptation... or simple rejection” (Wajcman 2002: 351). Such determinist thinking about technology, presented as the primary agent of social change, allows for professional and economic interests behind its development not to be put under public scrutiny. Thus it precludes democratic engagement and genuine debate on the purpose, form and interests served by technologies we develop, as well as ethical issues involved (Feenberg 1999, Jenkins 2002, Pacey 2001). Although such a stance has been challenged as deficient, the critique has not sufficiently penetrated into the public domain or government policies (Bijker et al. 1987, Bijker 1995, MacKenzie and Wajcman 1999). The debate continues to be

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31 Beck contends that whenever technology and its risks are discussed using biological, chemical, physical and technological vocabularies, humans tend to appear in the debate as merely some type of “organic material” (Beck 1992: 24).
guided by successive technical fixes and unrelenting imperatives ensuring “progress”, used as political tools, justifying government policies and helping those who use technological expertise to maintain social power (Wajcman 2002). In maternity care, it results in social solutions not being given due consideration because this, contrary to offering “fixes” within existing arrangements, would require a shift away from the high-tech biomedical framework (Murphy-Lawless 1998). Fixes and imperatives are the marker of our reaction to health crises (e.g. seeing more equipment and more staff training to use this equipment correctly as solutions to address substandard care, and disregarding the examination of the blanket use of this equipment as part of clinically focused care as bringing its own risks and problems). They are also prevalent in our debates around the infrastructure (e.g. bigger high-tech hospitals seen as solution to overcrowding rather than turning to out-of-hospital models of care delivered in community settings). As long as technology is seen as “simply the product of rational technical imperatives” and “technical reasons” (Wajcman 2002: 351) the appeal of technical fixes in maternity care will continue.

2.2.3. Technology as scientific

“That technological innovation derives from scientific discovery, as it were in a linear sequence, is a myth, but a prevalent myth. As a myth it is tenacious because of its links to important legitimations of science as the horn of plenty, and of technology as the magic wand” (Kroes and Bakker 1992: 233)

To understand why technology use in maternity care is considered scientific, we need to turn to the way their relationship is conceptualised and to acknowledge the intensified intertwining of science and technology in late modernity as practices and forms of knowledge (Weber 2006). Scholars argue that this interdependence is reciprocal and involves both technologisation of science which becomes “technology-

32 The example of social solutions in maternity care can be found in research on social support during pregnancy and its impact on better outcomes for women and babies, the effect being particularly prominent for women from low socio-economic backgrounds or those with insufficient social support networks (e.g. Elsenbruch et al. 2007).

33 Weber (2006) observes “the intensified amalgamation of science and technology” (Weber 2006: 407), marked by increasingly merging boundaries between what is technological, scientific but also what is social. This entanglement has been expressed by a term “techno-science”, used by researchers in social studies of science and technology within the Social Construction of Technology (Bijker et al. 1987) and the Social Shaping of Technology approach (MacKenzie and Wajcman 1999, Williams and Edge 1996).
driven” and undertaken in “technological milieu” (Hottois 1984, in: Kastenhofer and Schwarz 2011) as well as the “scientization” of technology (Brooks 1994: 486).

However, their conceptual distinction, dating back to Aristotle, has been persistent in our perception of science and technology (Keller 1992). It is portraying science as theoretical, and a mere “discovery” of natural laws, and technology as practical knowledge of making things work. Imagining science as “pure”, objective and ahistorical, and technology as the practical, “productive” application of scientific discoveries endorses the view of technology as necessarily scientific. Although technology within such a model is subordinate to science34, through being seen as the enactment of scientific discoveries and embodiment of scientific truth (Brooks 1994, Sarewitz 2009) it inherits its validity, objectivity and ultimately, its power.

2.2.3.1. Scientific approach as privileged in its claims to truth

Modern science is a deeply privileged perspective and a practice strongly embedded in our culture as authoritative (Murphy-Lawless 1998, Rothman 2014). It is underlaid with the assumption that the world is measurable and that systematic use of the scientific method35 leads to establishing cause and effects relationships between phenomena, and results in our arrival at certain knowledge, or even the definitive truth, on their basis. These claims resemble religious and traditional practices which modern science had set out to replace as part of the Enlightenment, in its unwavering faith in human made order and reason. It is this quasi-religious faith which is often being disguised as science (Beck 1992: 169, see also: Bauman 1989, Lash and Wynne 1992). However, as scientists have observed themselves, doubt is essential to science for its development. Consequently, absolute certainty should not be one of its claims: “scientific knowledge

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34 Interaction between technology and science has been also emphasised by the opposite relationship, where it is science that is being dependent on technology as providing necessary resources, such as ideas, tools and infrastructure for science to extend its scope (Brooks 1994). I would argue, that although it perpetuates their entanglement further, it has been less prominent in our imagining of science and technology.

35 Modern science is characterised by development of scientific method as “a method of observation or procedure based on scientific ideas or methods... that has underlain the development of natural science since the 17th century” (OED 2007). It consists of systematic observation, measurement, and experiment, and the formulation, testing, and modification of hypotheses.
is a body of statements of varying degrees of certainty – some most untrue, some nearly true, but none absolutely certain” (Feynman, quoted in Keller 1992: 13).

Despite this, science is still mainly defined through its “pure” theoretical qualities “concerned with theory rather than method, or requiring the knowledge and systematic application of principles, rather than relying on traditional rules, acquired skill, or intuition” (OED 2007), an autonomous sphere of practice as envisaged by the Enlightenment thinkers (see Habermas 1993). As a result, “instructions” concerning the purpose and implications of using scientific knowledge, addressing its socio-cultural, political and ethical aspects, seem not to be part of it. There are only technical statements of correct conditions to replicate and apply the results of its findings. But it is not that these “instructions” of its use intrinsically do not belong to science. Rather, it is science which claims them unscientific value statements and views itself as a practice free from and immune to them, the “honourable” or “deplorable” use of science and its consequences being “offloaded” onto society (Beck 1992). It is the societal or political values which “interfere” with good science and sustain its “misuse and abuse of technologies” (Harding and Figueroa 2003). Conceptualising science as “pure” and neutral constitutes a powerful rhetoric for legitimising its biases and allows science, and consequently technology, to conceal the struggles for personal, political and organisational power associated with them (MacKenzie and Wajcman 1999, Harding 1986, Keller 1992). Moreover, this notion of science as a disinterested pursuit of truth has been actively encouraged by scientists and technologists themselves, in order to maintain professional status, and ensure funding of scientific research and development of technologies (Jenkins 2002). It awards science quite unrestrained power to deflect control over the direction of research and pursue whichever goals it sees worthwhile. As a result science functions like a Gramscian hegemonic system of internalised values, beliefs and interests, and as such suffuses the common sense of our culture (Martin 2001).

Beck (1992) observes that however strongly associated with certainty modern science is, in late modernity its claims to truth are demystified and it loses its credibility due to the new unknowns, uncertainties and hazards resulting from techno-scientific development. The benefits of both scientific and technological development are no
longer unproblematic. However, despite science becoming reflexive when forced to confront its mistakes, its “monopoly on rationality” persists as it manages to transform them into opportunities for expansion and further development, making itself immune to critique (ibid. 159). As already mentioned, in late modernity the reliance on science intensifies as the problems it produces escalate and because the social institutions which offered alternatives to science, such as tradition or religion, have been dismantled (Bauman 1993).

2.2.3.2. High-tech biomedicine as science: is obstetric use of technology scientific?

“Despite its pretences to scientific rigor, the western medical system is less grounded in science than in its wider cultural context... Western society’s core value system is strongly oriented toward science, high technology, economic profit, and patriarchally governed institutions. Our medical system reflects that core value system... most routine obstetrical procedures... are routinely performed not because they make scientific sense but because they make cultural sense.” (Davis-Floyd 2001: S5-6)

While the equation of scientific with the technological and privileged status of scientific knowledge perpetuates our reliance on technology, it is what has been termed an “absurd conflation” of high-tech biomedicine with science (Rothman 2014: 3) or its “scientific management with science” (Perkins 2004: 37) which facilitates unassailable authority of the technocratic approach to maternity care.

Obstetrics conceives itself as science and claims that “what it says and does is scientific truth” (Murphy-Lawless 1998). This requires it to obliterate the “varying degrees of certainty” acknowledged by Feynman, and to deny “any interruptions and displacements to which it is subject. For science to preserve its hegemonic account, it must deny events which fall outside its definitions” (Murphy-Lawless 1998: 215). Moreover, drawing on the “unimpeachable scientificity” of biomedicine (ibid. 24), obstetrics has neglected to examine scientifically its own practices and assumptions (Perkins 2004: 9). This demonstrates that obstetric “science” combines scientific knowledge with very particular beliefs about what constitutes wellbeing in our society and about women’s reproductive processes along with, as any other science, professional and economic interests (Jenkins 2002, Rothman 1991). Obstetrics is using
science in keeping with its modern ambitions of increasing rational order and advancing towards greater certainty and predictability and those often come into conflict with what benefits women and society. Those principles applied to maternity care result in the “scientization” of a certain worldview of birth “management” rather than scientific practice (Davis-Floyd 2004, Martin 2001). As already mentioned such confusion of scientific management with science sustains the status of biomedicine as scientific and has perpetuated industrialisation, standardisation and routine use of technology in maternity care (Perkins 2004). This allows the conceptualisation of maternity care through the technocratic paradigm: as if it is scientist's high-tech laboratory. The procedures for caring for birthing women become similar to protocols of the scientific method as if they were susceptible to systematisation, control and prediction, with a set of “objective” norms and procedures ensuring these are met. In this systematisation, obstetric technologies play a prominent role as applications of obstetric science.

2.2.3.2.1. Is it about well-being or management?

Dreger (2012) observed that “the most scientific birth is often the least technological birth” drawing on the fact that even the research conducted according to technocratic design, such as randomised controlled trials, have supported low-tech approaches as ensuring good outcomes and causing less harm. Dreger’s argument exemplifies the tension identified by Perkins around the association of the “scientific” use of technology and “scientificness” of the technocratic paradigm with the industrial definition of science and its “managerial” purpose. However, the purpose Dreger focuses on is salutogenic. While the dictionary meaning of “scientific” associates it with “based on

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36 Scientific management is “management of a business, industry, etc., according to principles of efficiency derived from time-and-motion study and similar studies of methods of work, production, etc.” (OED 2007). The recurring concepts in definition of scientific management are its cost reducing, efficiency increasing qualities. It seems more adequate to consider it industrial than scientific as it originated in the Taylorist model of industrial production based on the “accurate knowledge of how long it should take to do the work” (ibid.). However, it has been argued that its influence on those doing the work was not given much consideration when its principles were being formed (Lepore 2009).

37 Although laboratory experiments are seen as “the epitome of science” Gordon (1988) observes that many biomedical procedures cannot be assessed or even conceived in this way (ibid. 263).

38 By technocratic research I understand research based on experimental design, produced within high-tech clinical maternity care settings and involving focus on practices which are easily quantifiable (Downe and McCourt 2008).

39 The term salutogenic can be defined as creating well-being, focused on facilitating health rather than identifying pathology (Downe and McCourt 2008). Salutogenesis is “the generation of well-being”, the
or regulated by science, as opposed to traditional practices or natural skill; valid according to the principles of science” (OED 2007), when Dreger uses “scientific” she means “research-based”\textsuperscript{40}, i.e. demonstrated in systematic, methodical research to benefit us, to result in better outcomes. On the contrary, what is often meant by “scientific” in biomedicine is using science as “pure”, authoritative and thus a superior type of knowledge when it comes to women’s reproductive processes, and perhaps the most adequate term would be “science-governed”. This is the understanding which supports the opposite of what Dreger argues: the assumption of technocratic obstetrics that ultimately, the most scientific birth is the most technological\textsuperscript{41}. This is the substance of “obstetric therapeutics” (Perkins 2004: 37) at the core of the active management of labour where technocratic management of all births is asserted as ensuring better care and less suffering for women (O’Driscoll et al. 2003).

2.2.3.3. Insufficiency of relying solely on science

“within its own confines, scientific research limits itself as to what it considers worthy of study... there are dimensions which conventional or mainstream obstetric science neglects to consider which have decisive impacts on birth and birth outcomes” (Edwards and Murphy-Lawless 2006: 38)

Even if the confusion between science and scientific management is clarified, we cannot rely solely on science when it comes to valid knowledges in birth, and the only knowledge informing maternity care. Using scientific knowledge is neither inherently beneficial nor ethical, and there is no basis for its indiscriminate use. Science is just one system of discourse among others producing knowledge in certain ways (Haraway

\textsuperscript{40} I am drawing on the synonyms of “scientific” which are in general use. They denote “scientific” as: technological or technical, research-based, factual, knowledge-based, empirical as well as chemical, biological, medical. Scientific is also associated with: systematic, methodical, organised, orderly, rigorous, mathematical, regulated, analytical and rational (see: https://en.oxforddictionaries.com/thesaurus/scientific and https://www.collinsdictionary.com/dictionary/english-thesaurus/scientific. Accessed 4 September 2017)

\textsuperscript{41} This conclusion is again based on the second understanding of technology: hence even if no technological intervention is used, the scientific maternity care is conceptualised as continuous monitoring, screening for pathology, and technocratic notions of what is normal and the expected pace of birth “progress”.

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term was coined by Aaron Antonovsky (ibid. 19). I will return to the issue of salutogenesis while discussing risk in section 2.2.4.4.
1991a, Rothman 2000). However reflexive and open about its contingent and contextual nature, even Beck’s more reflexive, more “scientific” science is simply insufficient to make it the ultimate arbiter of complex human affairs (Sarewitz 2009). When Dreger focuses on arguing for more scientific birth as involving using less rather than more technology she aims to overcome widely held convictions about maternity care. However, in doing so she overlooks that the impulse to make birth and maternity care scientific rests on highly contested premises in the first place.

Scientific knowledge is “geared toward the typical and the general” (Gordon 1988: 279) and applying it to individual women requires situated understanding. Approaching maternity care as purely scientific is reductionist and inadequate as much as is a prescriptive reliance on evidence-based medicine in addressing women’s needs (Downe and McCourt 2008, Enkin et al. 2006). There are knowledges different to the rational and orderly gaze of modern science, and scientific knowledge derived from statistical population data must always be complementary to women’s embodied, experiential knowledges arising from their individual circumstances. These are crucial to achieve what biomedicine claims to accomplish with a reliance on science and technology.

2.2.4 Risk and modern management of uncertainty: is the most technological birth least risky?

It is impossible to problematise the technocratic paradigm in maternity care without engaging with the notion of risk. Risk has become an overarching concept in our maternity services and yet, it is only a particular “scientific” understanding of risk which dominates the debate about our use of technology. Consequently, it is precisely the problem of relying predominantly on science and its definitions, discussed in the previous section, which determines the obstetric management of risk and is the most powerful justification for the continuing hegemony of the technocratic paradigm. Under this paradigm the notion of healthy pregnancy had been replaced by pregnancy which is merely a “low-risk” one (Rothman 2014). Within such “scientific” terms of reference

42 Beck (1992) terms such understanding “techno-scientific risk”, while Lupton (1999: 6) uses “modernist technical”, which indicates the extent to which reliance on science and technology is its defining feature.
technology is seen as reducing risk and its potential for increasing or introducing it is downplayed.

2.2.4.1 Modernity and the “science” of statistics

The scientific concept of risk emerged from modernity’s order-creating, uncertainty-diminishing approach, “the belief that rationalised counting and ordering would bring disorder under control” (Lupton 1999). Thus, the focus shifted from the past towards “colonising the future”, predicting and controlling future circumstances through rational, scientific management of the present (Giddens 1991). This was possible through the reconceptualisation of hazards and dangers as no longer external workings of nature and fate but rather as coming primarily from within human society and thus resulting from its increasingly modern practices as well (Beck 1992, Lupton 1999). In order to continue being credited with preventing and containing the very dangers it produced, as these intensified, modern science had to transform them from “unpredictable and uncontrollable hazards into knowable and manageable risks” (Hardy and Maguire 2016: 84). These modern risks are abstractions and “imputations of dangerousness” based on probabilities (Castel 1991: 283) rather than “concrete” events that are bound to occur. They are derived from gathering numerical data and the constitution of statistical “laws” which govern such data, which in modern society become a new, authoritative way for gaining information about natural and social processes (Hacking 1991). In other words, risks emerged as a result of classifying and “mathematizing” efforts of science (MacKenzie in Hardy and Maguire 2016: 86) and became “a systematic way of dealing” with dangers it itself produces (Beck 1992). Thus, through their scientific reframing and definition, risks were appropriated by science as its area of expertise from the very beginning, and became conceptualised as “problems for technology, not merely problems of technology” (Bauman 1993: 199). In late modernity such “scientific construction” of risk is perpetually expanding in its society-changing scope (Beck 1992: 153-154). Risk-detection and risk management have become “the most indispensable... of science’s and technology’s social functions” (Bauman 1993: 207) as a “systematic way of dealing” with overabundance of late modern uncertainties. They are seen as working in tandem to limit our exposure to risks (Edwards and Murphy-Lawless 2006) and are trusted to make accurate statements
about them. This is what Bauman calls the “double agent” quality of science, where it is “doubly” responsible: for the risks it generates and for describing and finding solutions to them producing still more risks (Bauman 1993: 207). Intertwined with science, technology assumes a similar “double” role, introducing risks which it subsequently purports to manage.

2.2.4.2 Underlying values in obstetric risk assessment

Such scientisation of risk is crucial to sustain claims of obstetrics to its scientific status. Through its axioms and statistical calculations it persists in producing a “scientific” proof that the technocratic approach has achieved a reduction in maternal and infant mortality and when employed, will ensure this reduction continues into the future (Murphy-Lawless 1998: 162).

While obstetric understanding of risk presents itself as “objective” as if there was nothing social about it, this “scientificity” is built upon lack of acknowledgement of the assumptions informing the obstetric framework. These are predicated on belief that birth, and women’s reproductive processes in general, are pathological in their nature and that through systematic description and measurement, through devising rigorous scientific protocols they can be controlled, eliminating the uncertainties involved.

The idea of prevention is one of such assumptions underlying the use of technology in childbirth and the importance of the risk assessment protocols. Castel’s (1991) insightful, following remark illustrates how deeply embedded it is in the hopes of the modernist project:

“The modern ideologies of prevention are overarched by a grandiose technocratic rationalizing dream of absolute control of the accidental... In the name of this myth of absolute eradication of risk, they construct a mass of new risks... Thus, a vast hygienist utopia plays on alternate registers of fear and security, inducing a delirium of rationality, an absolute reign of calculative reason and a no less absolute prerogative of its agents, planners and technocrats, administrators of happiness for a life to which nothing happens” (Castel 1991: 289)
The idea of prevention is predicated on the “probabilistic and abstract existence of risks” rather than “the presence of particular precise danger embodied in a concrete individual or group” (Castel 1991: 287). As it is populations and subpopulations and not individual women and their concrete circumstances which are its focus, it allows the blanket use of technological intervention on healthy women to avoid outcomes which may never materialise for the majority of them (Walsh et al. 2008). Women with healthy pregnancies are regarded by obstetric risk protocols as merely not-yet-pathological, not-yet-having-complications. Such an approach, if unacknowledged, may replace “a potential risk of adverse outcome with the certain risk of dubious treatments and interventions” (Enkin et al. 2000: 52).

While statistical population data provides us with useful insights, drawing on it in order to determine the beneficial course of action for concrete individuals is based on flawed logic and thus problematic:

“The outstanding problem remains that women identified as low risk will have problems and even serious complications and that many women identified as high risk will have none.” (Murphy-Lawless 1998: 199)

Thus inevitably, diagnostic efforts of technocratic risk scoring systems have been announced unreliable (Wickham 2011: 22) and necessitating far more caution than their present use (Wagner, M. 1994). While in certain situations helpful in bringing to the fore some inadequacies and deficiencies of care, they can introduce and magnify certain risks as well. Consequently, they are a “mixed blessing” in determining best maternity care for individual women, particularly when employed in an unrefined rigid way, lacking reflexivity essential to make sense of the complex contexts of birthing in late modernity (Enkin et al. 2000, Murphy-Lawless 1998).

2.2.4.3. Problematic aspects of scientific notion of risk in obstetrics

The reductionist notion of “scientific” risk in obstetrics allows us to see technology as decreasing and controlling risk and making birth safer as a result. However, such a concept of risk is contingent historically and culturally and predicated on belief that

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science alone can judge the risks but also manage them (Bauman 1993, Edwards and Murphy-Lawless 2006). Scientific understanding of risk leads to “technocratic fallacy” (Beck 1992: 66), which makes us see only certain risks, and obstructs and denies risks outside the remit of modern techno-science, those too ambiguous or too complex to fit into its conceptual order:

“so long as the risks are not recognised scientifically, they do not exist – at least not legally, medically, technologically, or socially, and they are thus not prevented, treated or compensated for” (Beck 1992: 71)

Those unaccounted for risks are necessary to maintain claims of science to objectivity and rationality of risk definition, and thus ensure the continuing hegemony of its worldview in society.

2.2.4.3.1 Unacknowledged political realities of risk

Obstetric definitions of risk “exclude social dimensions of risk” (Edwards and Murphy-Lawless 2006). They obscure the power relations involved in dominant definitions of risk and thus conceal their oppressive nature as appropriate “formulae for administering populations” in advanced industrial societies (Castel 1991: 281). They facilitate the dominance of technocratic expertise and extend the control of modern institutions, enforcing their regulations over individuals and the way they function within such institutions (Walsh et al. 2008: 119). They also conceal the powerful influence of the market in promoting and perpetuating risk averse approaches (Downe and McCourt 2008), where the “commercial value of risk-fright” is a point of departure for technological products to counteract risk (Bauman 1993: 204).

In seeing risks from the vantage point of norms and averages established by population statistics, technocratic obstetrics has ceased to read the bodies of individual women (Murphy-Lawless 1998). This discourages its risk scoring efforts from conceptualising the individual, local contexts as important at all, be it women’s knowledges and needs, or knowledges and skills of individual practitioners caring for them. Instead, the predictable impersonal risk protocols are supported in their “procedural rationality” deeming individual “impulses” unreliable (Bauman 1994: 6).
Also, obstetric risk downplays the negative consequences of technocratic management of risk. It is relying on scientific knowledge to establish its own “acceptable levels” of risk (Beck 1992: 64) at odds with what may be acceptable for individual women bearing those consequences. This is exemplified in the obstetric approach to iatrogenic risks, resulting from obstetric treatments themselves, and “nosocomial risks” resulting from hospital environments where women are being “managed in what is essentially a factory-like setting” (Rothman 2014: 4). These are particularly pertinent in busy wards in large centralised units (Walsh 2006b, Walsh et al. 2008). Technological intervention is seen as advantageous and “safe” as long as its unwanted consequences appear manageable and under control with yet some other technological means offered by obstetrics, not when the harms are minimised (Murphy-Lawless 1998). However, distinctions between the acceptable “legitimate” effects and “unwanted” consequences are arbitrary and thus a matter of power of those who are trusted to make them (Bauman and Tester 2001: 144).

2.2.4.3.2 Comprehensive understanding of risk: seeing the systemic nature of risk

These unacknowledged political realities of obstetric risk definition make exclusion of knowledges other than the scientific unproblematic. However, those other knowledges: local, individual, experiential and embodied (Hardy and Maguire 2016) are crucial to form much more comprehensive, more relational ways of understanding risk (Nash et al. 2014). They help reinstate the social complexity of risk definition, without fragmenting it into increasingly narrow clinical factors. Without acknowledging the above contexts we are prevented from realising deeper societal processes at work in determining what constitutes risk for us. Limited to technical calculability and manageability, understanding of risk enables “successful” solutions by leaving “unknown residual risks” out of focus (Beck 1992: 29). While such limited focus is “the secret of the astonishing achievements of science and technology”, it ignores broader and far-reaching dimensions of risk and contributes to the creation of systemic risks.

While Rothman identifies nosocomial risks such as those “of overcrowding... of exposure to others and exposure of self” (Rothman 2014: 4), Anderson (quoted in Walsh et al. 2008: 120) specifies them as the “lack of continuity of care and continuous support by midwives”, “inexperienced doctors at the start of their rotation”, “absence of expertise” during holidays and weekend night shifts, “disagreements between midwife and obstetrician”, “inadequate handovers because of fatigue, intimidation”.

44 While Rothman identifies nosocomial risks such as those “of overcrowding... of exposure to others and exposure of self” (Rothman 2014: 4), Anderson (quoted in Walsh et al. 2008: 120) specifies them as the “lack of continuity of care and continuous support by midwives”, “inexperienced doctors at the start of their rotation”, “absence of expertise” during holidays and weekend night shifts, “disagreements between midwife and obstetrician”, “inadequate handovers because of fatigue, intimidation”.
Systemic risks, rather than being susceptible to efficient technical fixes require us to recognise structural problems across different levels of society contributing to the creation of risk in maternity care, such as those resulting from inequality, social exclusion and poverty (Murphy-Lawless 2016, Murphy-Lawless and Edwards 2015). Yet, these systemic risks have arisen within the context of society where responsibility for dealing with risks had become privatised and they are supposed to be confronted individually (Bauman 1993; Giddens 1990). The expectation that it is individuals who need to become skilled in “actively managing” risks, based on technocratic expertise “translating” scientific knowledge about risks into responsible behaviour, further deflects the attention from whose collective responsibility it is to address societal realities of risk. Thus, acquiescing to the technological framework for birth becomes regarded as a responsible way of containing risks (Coxon et al. 2014).

2.2.4.4 Challenging the notion of risk as central

“...insofar as the concept of risk remains central, alternative forms of knowledge are incorporated into existing bodies of risk knowledge, and risk assessors and managers continue to remain privileged” (Hardy and Maguire 2016: 98)

The above critiques demonstrate that we have to turn to a more comprehensive definition of risk than the obstetric one, encompassing what remains invisible or disregarded in a technocratic approach to risk. However, if we are to significantly unhinge the dominance of the technologised model in maternity care as the best and safest type of care, we need to address not only the definition of risk and its applications but dispute the pivotal role of risk in maternity care in shaping our thinking.

As yet, attempts to understand risk more comprehensively and acknowledge the uncertainties involved in our knowledge of risk have not been successful in deflecting the process of our intensifying reliance on risk assessment protocols. Those protocols have been expanding into consecutive areas of our society, their assumptions barely visible and hardly contested (Hardy and Maguire 2016)45. This expansion can be observed in the engagement of low-tech, less medicalised approaches with obstetric

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45 Hardy and Maguire (2016) describe the process of “riskification” drawing on the Foucauldian concept of “intensification” of discourse, where risk becomes so entrenched and powerful across many levels of society that even efforts to critique it can be assimilated into this discourse without diminishing its authority.
risk and its indicators, and access to those approaches being conditional on those indicators.

Thus, while the notion of risk is crucial to emphasise the “truly dangerous” risks in the system, and to forge the critique of systemic risk emerging as a consequence of obstetric science choosing to understand risk in a such a narrow way, we also need to see the “risk of focusing on risk” (Edwards 2005: 113): too much emphasis on risk is probably the most compelling obstacle impeding a radical overhaul of maternity care towards addressing the full spectrum of women’s needs in birth (Murphy-Lawless 1998, 2016).

In order to shift risk from its central position, an entirely different way of seeing is needed (Downe and McCourt 2008). The foundations for it can be found within “the body of knowledge and skilled craftsmanship” of midwifery (Rothman 2014: 5) which, while including ways to navigate dangers of childbirth, has retained the concept of childbirth as a normal event as well as a much more complex, contextual and ambiguous understanding of what constitutes wellbeing in childbirth (NMBI 2015, RCM 2004). Apart from a normality-focused approach of midwifery, Downe and McCourt (2008) propose the concept of “salutogenesis” or “the generation of wellbeing” rather than risk to assume a central role in conceptualising appropriate maternity care (ibid. 20). Based on insights of Antonovsky (1979) this salutogenic orientation has the potential to represent a much more complete, systemic understanding of health compared with that of biomedicine.

However, notions of normality and salutogenesis can be highly problematic and contentious issues in our risk society. The attempts to measure “salutogenically focused outcomes” in Smith et al. (2014: 151), operationalised as indicators of “effectiveness of intrapartum interventions” (ibid. 154), may be an example of applying the concept of salutogenesis in a manner similar to risk-assessment. Such operationalisation renders the systemic view of issues in maternity care invisible and suppresses more fluid approaches required in negotiating normalcy in childbirth (Wickham 2011). Likewise, the forceful critique faced by the UK Royal College of Midwives’ Campaign for Normal Births (Day-Stirk 2005; Sandeman 2017), a campaign aimed at inspiring debate and encouraging confidence in normality in childbirth, have demonstrated a deeply
entrenched belief to the contrary. Such critique resulted from the often unarticulated but deep fears which are easy to mobilise in late modern society: that the nature of childbirth is so risky that it warrants the routine use of technological means in all births.

2.3 Conclusion

“The term technocracy implies use of an ideology of technological progress as a source of political power... It thus expresses not only the technological but also the hierarchical, bureaucratic and autocratic dimensions of this culturally dominant reality model” (Reynolds 1991, in: Davis-Floyd 2001: 47)

In this chapter I outlined the conceptualisation of technology which situates it not only as resources within a complex system of maternity care provision, but also as a way of thinking, and as in the above excerpt: a particular model of reality. During my analysis of women’s accounts in the later chapters, this conceptualisation enables me to search for both: women’s understanding of technologies and technological procedures used in maternity care as well as maternity care practices governed by technocratic attributes such as efficiency, certainty, control and management. These definitions permitted me not only to see the challenge posed by women to the way technology is used in maternity care but also to demonstrate how their accounts feed into the extensive critique of technologisation of our maternity care provision. The explorations of modernity, science, technical fix philosophy and risk assessment, which were discussed in part two of the chapter, complete the sociological groundwork for this project and are essential for in-depth understanding of the way women make sense of the role of technology in our maternity care.
Chapter 3
Theoretical/methodological framework: integrating feminist poststructuralism and Foucauldian discourse analysis

3.0 Introduction: theoretical/methodological perspective

This research aims to look at women’s accounts of maternity care to reconceptualise our understanding of technology and reassess its effects in maternity care. Such reappraisal of technology has the potential to broaden the discussion around its use, and take it beyond the focus on particular devices, medications or the use of complex technological procedures (as discussed in Chapter 2). In this chapter, I outline how my theoretical/methodological framework facilitates such reconceptualisation. I begin this chapter with introducing the theoretical context for poststructuralism and discourse analysis. Subsequently, I describe the stance of feminist poststructuralism and the scholarship which shaped my understanding of it. I turn to poststructuralist conceptualisations of discourse and language and apply them to my research. I conclude this part by theorising ambivalence and resistance which were crucial concepts in making sense of women’s accounts of technology in maternity care. In the following section I focus on the methodological stance of Foucauldian discourse analysis and its varieties, and outline my understanding of it for the purpose of this project. I outline the concepts and techniques which were helpful in performing the analysis of women’s accounts. I conclude with demonstrating how I integrated feminist poststructuralism and discourse analysis in order to capture discourses which shape women’s understanding, and to grasp how this understanding is assembled by women from available discursive resources.

3.1 Poststructuralism and discourse analysis: untangling theoretical interconnections and complexities

In this research, theoretical and methodological approaches cannot be clearly separated because it is driven by theoretical assumptions on every level of its conceptualisation and design while its methodology is a source of epistemological insights. The approach and the status of this research as an account are informed by feminist poststructuralist epistemology and Foucauldian discourse analysis as perspectives which complement
each other, and thus I consider my theoretical/methodological framework a feminist poststructuralist type of discourse analysis. In the late stage of writing up this research I discovered the attempt to develop an “integrated” approach of feminist poststructuralist discourse analysis (FPDA) (Baxter 2008). It was envisaged to be much more open-ended and focused on multiplicity than more “objectivist” versions of discourse analysis. Although I refrain from labelling my research as being an example of the more unified approach of FPDA, this research is certainly exhibiting some of its features as it shares its commitment to “plurality, ambiguity, connection, recognition, diversity” (ibid. 2-3).

It is also impossible to demarcate clearly between feminist poststructuralism and Foucauldian discourse analysis because they are intertwined theoretically and share assumptions, both having arisen from similar philosophical debates around the nature of language, knowledge and representation, and their connection to “regimes of truth” and power relations. Foucault’s work has been at the centre of poststructuralist critiques and it has inspired feminist scholars, but it has also given rise to the study of discourse across disciplines not necessarily (or not explicitly) resting on poststructuralist assumptions. However, I consider it necessary for discourse analytic research to adopt at least some kind of anti-essentialist, anti-foundational stance, and challenging “empiricist, rationalist, humanist assumptions of our cultural systems, including those of science” (Hutcheon 1993: 247) which is the feature of poststructuralism.

The theoretical circumstances are further complicated by the fact that there are many varieties of poststructuralism and discourse analysis. Poststructuralism is associated with diverse work of authors such as Jacques Derrida, Michel Foucault, Gilles Deleuze and Felix Guattari, and its poststructuralist/feminist scholars are also numerous, including Judith Butler and Rosi Braidotti (St. Pierre 2000). Further, many authors might reject labelling their work as poststructuralist, which seems to be inherent to a poststructuralist stance with its avoidance of fixing meanings and synthesising them into categories. Similarly the varieties of discourse analysis have been formulated across disciplines of critical linguistics, psychology and sociology and cultural studies, to name but few (which I will discuss further in this chapter). Despite those multiple interconnections, for the sake of clarity of my argument, I decided to consider feminist
poststructuralism as my epistemological framework and Foucauldian discourse analysis, based on insights derived from social science research, is my methodological approach.

I acknowledge that this research had initially started as a broadly discourse analytic project, theoretical assumptions of discourse analysis providing also epistemological underpinnings to design and conduct it. However, when I reached the stage of making sense of the material generated during the interviews I realised that – although discourse analysis is already embedded in poststructuralism – I needed a more extensive framework. In order to make sense of women’s accounts and to appreciate their potential to disrupt the predominant views of technology, I needed theoretical and methodological framework which facilitates the search for different, more comprehensive conceptualisations and supports the search for what has been marginalised or absent altogether from our understanding of technology. To this end, I found the critical potential of feminist poststructuralism complementing Foucauldian discourse analysis in highlighting the plurality of understandings. Both perspectives underpin rejecting the possibility of arriving at stable, unequivocal understanding of what technology is and instead propose an understanding which is full of ruptures, slips and fractures (Davies and Gannon 2005). Such an approach opens the possibility of unearthing new understandings and making the present ones contingent and prone to historical change.

A feminist poststructuralist critique furnishes us with tools to examine “any commonplace situation, any ordinary event or process, in order to think differently [emphasis mine] about that occurrence – to open up what seems ‘natural’ to other possibilities” (St. Pierre 2000: 479) and this is what I consider a crucial aim of this research. It is to “deny the necessity” (Foucault 1997a: 140) of the predominant way in which technology appears and challenge the technological conceptualisation of maternity care. As Foucault (1988c) proclaims in his archaeological analysis, we need to look at our notions critically and “question... what is postulated as self-evident, to disturb people’s mental habits, the way they do and think things, to dissipate what is familiar and accepted, to re-examine rules and institutions” (ibid.: 265).
This has helped me to really grapple with the ambivalence and conflicts present in women’s accounts rather than just describe or acknowledge them. Feminist poststructuralism has deepened my conceptualisation of how the analysis of discourse can serve the goal of change and how women’s agency and resistance are possible within a social landscape occupied by many powerful discourses which prescribe the way technology can and cannot be discussed. To that end it is insufficient to simply elicit women’s accounts and then reassemble them in a coherent narrative enumerating the themes in what women say. It is crucial to critically examine how powerful discourses prevent women from fully accessing certain modes of thinking about and acting around technology in maternity care, and consequently, to fully express the discontent with the way it operates.

3.2 Poststructuralist stance: background

3.2.1 Crisis of legitimation and representation?

A poststructuralist stance stems from various critiques which afflicted humanities and social sciences in the 1960s and 1970s and resulted in the “double crisis” of legitimation and representation. This crisis, depending on emphasis, has been termed as an interpretive, linguistic, or rhetorical turn in social theory (Denzin 1995, Lather 1993), and targeted positivist approaches to social research and knowledge production. Within the approaches resulting from those crises, the researcher (or any other knower) cannot be considered as separate from the social reality and able to know it from the outside. This is why the role of the researcher is made visible as a central part in the process of producing “data”\(^46\). Also, within those critiques language is not considered as transparent and simply reflecting the understanding of those researched, an unproblematic medium of writing the research account. Traditional understanding of methodology as a prescriptive set of rules, which when correctly followed automatically, ensure truthfulness and validity of a research account, is considered a rhetorical device allowing the researcher to assume a “mask” of authority (Lather 1993: 675). This allows

\(^{46}\) This is why I am using the term “generate” and “produce” rather than “collect” to describe my relation to data. “Collecting” data is not about gathering what is out there and waiting to be discovered, as more objectivist methodologies would prescribe, but about the process of “constructing” certain material as source worthy of examination.
a particular methodology as a “regime of truth” to make claims on the world and the reader (Denzin 1995) and is termed by Lather (1993) as “validity of correspondence” which relies on an epistemology of truth as correspondence between thought and its object and presupposes transparency of narration of the research account (ibid. 675).

According to poststructuralist critique we need to move beyond the traditional criteria of valid inquiry and turn to criteria embedded in this “double crisis” instead (Lather 1993). It is no longer plausible to sustain the objectivist assumption of social science simply reflecting the world out there and being able to capture the experience of members of society in an unproblematic manner. It is also no longer plausible to legitimate knowledge simply by following procedures guaranteeing its truthfulness. Thus, both the accounts of those we listen to in order to understand social reality as well as our own research accounts cannot be taken-for-granted as reflecting the world out there. Our understanding is always part of the reality we are researching and there is no objective, external source to our knowledge. Instead, our understanding is based on assumptions stemming from what we value, and those assumptions might be associated with certain positions of social power.

However, I consider poststructuralism not only as critique but also an attempt to move beyond this crisis. This is why I am indebted to feminist poststructuralists in their conceptualisation of how research is possible after poststructuralism (Lather 1993) and how poststructuralist moment in theory can be re-forged into motion towards change (Davies and Gannon 2005). Thus, for poststructuralism, the ‘crisis of representation’ is not the end of representation as such, but rather the end of unproblematic representation of the social world and relations within it, “the end of pure presence” (Lather 1993: 675). As the traditional understating of validity is the one of power and violence (Hall 2001), other forms of conceptualising rigour and truthfulness of research are needed. Lather proposes “transgressive validity” which involves challenging its own validity claims by the research text and posing questions concerning interpretive practices that support its argument (Lather 1993: 676). The aim is not to proceed with our research as if it represents things in themselves but to appreciate the networks of social relations interwoven into our research and recognise what frames our thinking (Derrida 1978).
3.2.2 Beyond structuralism

An important impulse for poststructuralism was expanding on ideas of Saussure’s structuralist linguistics (Saussure 1974). Saussure considered language as constituting social reality for us and not reflecting it as if it simply existed “out there”. Consequently, our understanding of social reality is already mediated through language and never predates it. There are neither universal concepts which guarantee meaning nor is there a speaking subject that grants it (Gavey 1989). As a result language becomes an arbitrary system where meanings are relational and not intrinsic, and a site of social struggle (Weedon 1987).

However, while Saussure’s theory of language considers meaning constituted and possible solely through language, it also regards it as being single and “fixed” (Weedon 1987). Structuralism sustains the venture of valid undoubtable knowledge “through the charting of differences within structures”, assuming that pre-existing structures contain and stabilise meanings and coalesce into secure knowledge (Williams 2005: 1). The attempt “to isolate the general structures” (Spivak 1976: lv) not only of language but all human activity (undertaken for example within structural anthropology) makes it a subscriber to the objectivist stance where the impartial description of society and its “laws” is possible.

This is where poststructuralist theory moves beyond structuralism, by arguing for plurality of meaning and the impossibility of ever fully capturing its exactness. It moves beyond language as an abstract static system and sees it instead in “historically specific discourses” which compete over giving meanings to the world and reflect the relations of power (Weedon 1987: 108).

3.2.3 Postmodernism or poststructuralism?

Poststructuralist perspectives overlap with postmodernism and the terms are sometimes used as if they were synonymous. Many proposals which are discussed in this chapter are also associated with postmodernism and I acknowledge that they cannot be clearly separated (Agger 1991, Butler 1995). Yet, however elusive their boundaries, I see them also as significantly different in their points of “origin” and
reference, and my position is reflected in scholarship deeming poststructuralism a “theory of knowledge and language” in contrast with postmodernist preoccupation with “theory of society, culture, and history” (Agger 1991: 112). It is the context of “academic theorising ‘after structuralism’” that is for me more relevant than postmodernist issues of ”chronology, economics... and aesthetics” (Lather 1993: 688). My interests in theorising the production of knowledge and its effect on understanding of technology manifesting through the use of language, justifies premising this research on poststructuralist rather than postmodernist theory.

3.3 Feminist poststructuralism: building epistemological model for this research

As there are multiple ways of understanding poststructuralism, in this section I am focusing on those perspectives which I find helpful for the conceptualisation of my research and the analysis of my data. This is why I employ the work of feminist scholars who have been reworking poststructuralist perspective so as to further feminist goals of overturning oppressive social relations which disadvantage women’s experience and knowledge (Lather 1993; Gavey 1989; St. Pierre 2000; Weedon 1987). This framework is complemented by Foucauldian insights on knowledge, discourse and power (Foucault 1972, 1977, 1982), and Derrida’s concepts of deconstruction and difference (Derrida 1982, 1991b). Their work has been an inspiration to both polemic and further theorising for poststructuralist feminists (McNay 1992).

3.3.1 Feminist research and poststructuralism

The prevalent concern of feminist research in general has been the issue of knowledges and emphasising their connections to power which sustains existing patterns of oppressive social relations (Burns and Walker 2005, Oleson 2011). Consequently, feminists have been concerned with “unexamined assumptions about women and dominant forms of doing and knowing” such as the sources of knowledges circulating in society and the purposes those knowledges serve (Weiner 1994, in: Burns and Walker 2005: 66). Also, feminists scholars share a commitment to efforts which have potential to effect a real change to women’s social circumstances (Reinharz 1992). When it comes to research, feminist methodologies have been moving away from traditional epistemologies and methods of doing research, with their objectivist assumptions and
search for certain knowledge which refuse to include the personal and the political in science. Concepts transforming social science such as expanding the notions of reflexivity and positionality and introducing new forms of legitimation (validity) have been refined within feminism as well (Lather 1993). This is particularly prominent in the case of poststructuralist ranges of feminist theorising which question the very nature and limits of research (Oleson 2011: 133).

Feminist poststructuralism includes a variety of feminist scholarship applying the insights of poststructuralism to “meet feminist needs” (Weedon 1987: 20-21). As such it formed as response not only to developments in social theory but also to other varieties of feminism (Davies and Gannon 2005). Feminist poststructuralism aims to go beyond “already known and understood... to multiply possibilities, to demassify ways of thinking” (ibid.: 319) and in this way to resist uniform and centralised knowledges and introduce more diverse ones. It aims to “trouble both discursive and material structures” which restrain our thinking (St. Pierre 2000: 477) and in this way make us blind to power relationships involved in their establishment and it is this emphasis on relationships of power that sets it apart from “highly abstract and apparently ‘apolitical’” stances within poststructuralism itself (Gavey 1989: 464). Feminist poststructuralism seeks “to make visible the way they [categories] are constituted and to question their inevitability” (Davies and Gannon 2005: 318). Those categories are challenged as based on binaries of Western thinking which consider the dominant half of any binary as natural, rational and the norm (ibid.). In this way it brings their historicity and cultural specificity as well as their socially constructed status to the fore, making their current form questionable.

3.3.2 Epistemological stance

“...the emergence of knowledge is not natural or necessarily based on scientific rigour or rationality or cause and effect but is constructed within the play of the power relations circulating in discourse and cultural practice” (St. Pierre 2000: 496)

On what terms is producing valid knowledge possible? This quote provides a very succinct summary of feminist epistemology. Poststructuralism offers a radical approach to epistemology for social research which breaks with the “overwhelming totality” of
traditional assumptions of humanism and positivism in Western thought which include conceptions of truth and rationality which postulate universal reliable foundations for our knowledge (St. Pierre 2000). Instead poststructuralist epistemology turns towards “strategies, approaches, and tactics that defy definition and closure” (Gannon and Davies 2007: 81). The difficulty with poststructuralism lies in the fact, as St Pierre (2000) perceptively observes, that it is the humanist tradition which is “the air we breathe, the language we speak” (ibid. 478). For poststructuralist theorists all human knowledge is situated and local and underlined with values. Knowledge produced as a result of our research is not an exception. Similarly, the accounts we elicit from people in order to explore their understandings are irreducibly heterogeneous and do not carry an inherent meaning. Employing a poststructuralist framework entails renouncing the goal of finding “exact” explanations through our research. For poststructuralist feminists knowledge produced through research is socially constructed and never neutral, “transient and inherently unstable”, and “closely associated with power” (Gavey 1989: 462).

As a result of those assumptions, I do not consider women’s accounts to bring a fixed understanding of technology. In this research it is not my aim to search for some complete account of technology as women understand it. Instead, I accept and aim to convey the contradictory, conflicting nature of women’s accounts of technology. They are open to various readings, these being crucially guided by my interests as a researcher, my knowledge, experiences and values. Such a framework not only theorises the multiplicity and the irreconcilable nature of women’s accounts on technology but also allows me to proceed with my work in the context of the lack of absolute foundations and frames of reference for my understanding. It is a quest to pursue “a less comfortable social science” (Lather 1993: 673) which can only arrive at knowledge that is conditional and temporary. Such undertaking reflects the broader context of doing research within late-modern conditions of irreducible ambivalence (Bauman 1993).

3.3.2.1 Derrida’s deconstruction and Foucauldian analysis
“What deconstruction is not? everything of course! What is deconstruction? nothing of course!” (Derrida 1991b: 275)

“…in contrast to the various projects which aim to inscribe knowledges in the hierarchical order of power associated with science, a genealogy should be seen as a kind of attempt to emancipate historical knowledges from that subjection, to render them, that is, capable of opposition and of struggle against the coercion of a theoretical, unitary, formal and scientific discourse. It is based on a reactivation of local knowledges... in opposition to the scientific hierarchisation of knowledges and the effects intrinsic to their power” (Foucault 1980c: 85)

As the above quotes illustrate the work by Foucault and Derrida (and all poststructuralists) is characterised by attempts to disrupt established categories of our thinking and writing without resorting to “unity” (Foucault) or “identity” and “presence” (Derrida). Although primarily feminist and Foucauldian, my understanding of poststructuralism draws upon Derrida’s critique of language as generating meaning through identity rather than difference as well as Derrida’s concept of “deconstruction” (Derrida 1991b). Those ideas are helpful for me to illustrate how concepts and their definitions operate in this research and to outline the status of understandings generated in this research.

For Derrida meaning is never finite or stable, and it is continually “deferred” (Derrida 1982). The meaning of concepts is “inscribed in a chain or in a system within which it refers to the other, or other concepts, by means of systematic play of differences” (ibid.: 11) which are constituted historically. This is similar to Foucault’s rejection of absolute truths and his consideration of “truths” as being claimed from within discourses which are historically specific and being decidedly “a thing of this world” (Foucault 1980b: 131). Following Derrida, feminist poststructuralists also recognise that only “a temporary retrospective fixing” of concepts which govern our knowledge is possible and that this “fixing” is historically specific and contingent on its discursive context (Weedon 1987: 25). Consequently, establishing meanings and sorting them into neat categories having their “essence” leads to erasing of differences within concepts and is an act of “producing, and even enforcing, order out of randomness, accident, and chaos” (St. Pierre 2000: 480). This leads to obscuring power relationships. A similar movement is
present in Foucault’s archaeology where language is seen as constructing hierarchies which are then claimed to “reflect an innate, intrinsic order in the world” and is thus opened up to examination (ibid.).

Derrida critiques the logic of presence in Western thought and its concepts of absolute knowledge warranting meanings to form a coherent system (St. Pierre 2000). He argues that instead, it is a logic of difference which makes meanings possible within language and on this basis meanings can always be disputed and reinterpreted. This can take place through a process of deconstruction, which aims “to dismantle [deconstruire] the metaphysical and rhetorical structures which are at work, not in order to reject or discard them, but to reinscribe them in another way” (Derrida 1982: 256). Contrary to its negative connotations with “destruction”, for Derrida deconstruction is associated with the process of “disarranging the construction... disassembling the parts of a whole” (Derrida 1991a: 387). It is about “undoing, decomposing of structures” but as a necessary basis for understanding how they were put together in the first place and reconstruct them accordingly to this knowledge (Derrida 1991b: 272). It is thus a process of dismantling as well as rebuilding, of scrutinising how the whole is being produced and the forces that hold it together. Again this makes Derridean “method” bear a resemblance to the Foucauldian aim of disrupting predominant understandings, opening them to new interpretations and reinscriptions, in his historical analyses of discourse (Foucault 1979).

While I do not employ deconstruction in an explicit manner in my analysis, I consider it a useful inspiration for conducting a critique aimed at opening and disrupting taken-for-granted notions in a similar way to how Foucauldian genealogical analyses examine discursive construction of concepts that become considered as naturalised and seen as necessary. While I find it useful to dismantle and examine the terms on which this research is based, as well as to disrupt the notion of technology as women perceive it, it does not mean, however, that every concept in this research has to be undermined and “deconstructed”. It is my aim nonetheless to de-naturalise and de-stabilise the terms of our current debate and thus any concept can potentially fall prey to my “deconstructing” efforts if it appears to be culpable of obscuring unequal relations of power.
3.3.3 Conceptualising discourse

The notion of discourse is critical to poststructuralism (Gavey 1989, St. Pierre 2000, Weedon 1987) and constitutes a crucial theoretical concept for this research informed by the way Foucault uses it as an analytical tool within his work. The concept of discourse enables:

“a privileged entry into the poststructural mode of analysis because it is the organised and regulated, as well as the regulating and constituting, functions of language it studies: its aim is to describe the surface linkages between power, knowledge, institutions, intellectuals, the control of populations, and the modern state as these intersect in the functions of systems of thought” (Bové 1990: 54-55)

A feminist poststructuralist approach points to strategies of resisting and subverting oppressive discourses through dismantling and redeploying “discursive regimes and regulatory frameworks” to which individuals are subjected and through which they are constituted as subjects (Davies and Gannon 2005: 318).

3.3.3.1 Poststructuralist research and “definitions” of its concepts

Since both poststructuralism and discourse analysis critique the possibility of arriving at any finite understandings, it would be inconsistent to claim such finite understanding to exist for the very terms of their conceptual system. Similarly, arriving at clearly demarcated definitions within my research would be unfounded. Instead, feminist poststructuralism (and Foucauldian discourse analysis with a poststructuralist commitment) require a markedly different approach to producing a research account (Lather 1991, St. Pierre 2000). Poststructuralist theorising rejects the possibility of arriving at essentialising “what is” definitions and consequently, it is problematic to work with “concepts” understood in a traditional way as solid and undivided as if they were somehow “reflecting” the “truth” about their objects (Bové 1990). Following Derrida (1982) their meaning is continually “deferred” and “undecidable” and as a result there is “no univocal or unchallengable operationalisation of terms in research” (Agger 1991: 113). Thus, to stay attuned to a multiplicity of understanding, I needed to be mindful of “deferring” and not “fixing” the concepts in my research, both within the theoretical framework and later, in my analysis of women’s accounts. A similar
movement is present in the work of Foucault as he continually refrains from establishing unitary accounts and concepts throughout his writing and dedicates himself to “an ethos of self-critical reflection and conceptual experimentation which continually seeks to transform the limits of its thinking” (Owen 2014: xi).

Although I provided some definitions of terms of my research and aimed to grasp women’s understandings, I considered their status different to that of traditional research based on humanist assumptions. I did not consider definitions as precise statements on the essential nature of those concepts and phenomena, as dictionary definitions of the word “definition” would suggest (OED 2007). Instead, I considered definitions as deferred in their “definiteness” and exactness. I endeavoured to use the term “definition” in a Foucauldian manner, to answer different type of questions than those of “essence”, and to explore how the defined terms might function and with what effects (Bové 1990). However, I needed some definitions to anchor my analysis and make the production of this research account possible. Still, I was mindful that they were instrumental in enabling me and the reader to think critically about more customary understandings of the notions they describe. And necessarily, definitions in this research were based on my interests, knowledge and experience, and assumptions taken from my reading of the literature.

Definition of discourse is not an exception when it comes to the impossibility of unequivocal meaning for poststructuralists. Foucault (2002) admits to having “used and abused” the notion of discourse “in many different senses” in his work (ibid.: 120). He suggests in the excerpt below that it is the conceptualisations that stem from the concept rather than capturing what it exactly represents that truly matter:

“I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area” (Foucault 1974: 523-524)

According to Bové not only do we not but also we cannot provide definitions as they would end up “essentialising questions about ‘meaning’ or ‘identity’ of some ‘concept’ named ‘discourse’” (Bové 1990: 53). Instead, we should settle for examining the
function of a discourse, its location, the rules of its production and regulation and its social effects (Bové 1990).

### 3.3.3.2 Discourse and language

In order to apprehend the notion of discourse it is crucial to make some distinctions between discourse and language within my theoretical approach. They cannot be clearly delineated within poststructuralism and discourse analysis and their interlocking relationship implies that they are considered simultaneously. Poststructuralists adopt a structuralist notion of language as consisting of a system of differences. However, these differences “play”, they are produced “effects” which “have not fallen from the sky fully formed” and are the result of a “repression of difference” (Derrida 1982: 11). Thus, language becomes much more than the system of signs enabling the production of meaning and is considered to be a social practice connected to power (Hall 2001). It is a place of construction of the social world and it is actively shaping but also being shaped by society. Moreover, what is produced in language according to poststructuralism is not only meaning but also knowledge.

On the most elementary level, discourse is expressed and actualised through the use of language and it can be defined as “a group of statements which provide the language for talking about (...) a particular topic at a particular historical moment” (Hall 2001: 72). Those statements “cohere in some way to produce both meanings and effects in the real world” (Carabine 2001: 268). Discourse can manifest in “relations between statements and groups of statements [thus established]” but it also includes the relationship between these and “events of a quite different kind (technical, economic, social, political)” (Foucault 1972: 29). Thus, discourse can be enacted beyond language, in social practices and within institutions, modes of thought, and through subjectivities or subject positions it produces. In this, Foucault moves beyond understanding of discourse as a purely linguistic phenomenon and as simply stylistically, grammatically or lexically coherent writing or speech (Hall 2001):

> “Of course, discourses are composed of signs; but what they do is more than use these signs to designate things. It is this more that renders them irreducible to the language
(langue) and to speech. It is this ‘more’ that we must reveal and describe.” (Foucault 1972: 48-49)

Discourses are embodied in social practices and thus their effects extend into our everyday lives where they “systematically form the objects of which they speak” (Foucault 1972: 54). They are way of regulating “the forms of conduct” available for individuals in an attempt to “overcome the distinction between what one says (language) and what one does (practice)” (Hall 2001: 72). As a result they consist of rules which determine the formation of statements which are possible, reasonable or “real” within a particular form of knowledge about a particular object.

3.3.3.3 Discourse and language: operational definitions

“Over and above every opportunity for saying something, there stands a regularizing collectivity that Foucault has called a discourse” (Said 1983: 186)

As a consequence of the poststructuralist framing of the notion of discourse, I understand discourse as “a structuring principle of society” (Weedon 1987: 41) which manifests in socially prescribed ways of speaking and acting within society which constitute a set of acceptable propositions (Foucault 1980b: 112). However “discursive” a principle it is, it constitutes the “nature” of what it seeks to govern (Weedon 1987). In this way discourse produces the social world as it understands it, i.e. discourse has real effects on society and determines meaningful and legitimate ways of conceptualising technology and maternity care. This “structuring”, “regulatory”, and “governing” quality of discourse is present throughout Foucault’s writing, feminist poststructuralism and in discourse analytic research. Discourse is a regularity in our thinking which is connected to certain relationships of power, offering more and less legitimate positions from which women’s understandings can be argued. However, for Foucault (1980b) discourses are always determining and offering new possibilities. Women’s understandings of technology thus emerges as uneven and contradictory, where more powerful discourses may dictate ways of thinking and vocabulary while women strive to make sense of technology and maternity care outside hegemonic frameworks.

While discourse is this structuring principle in the way the world is conceptualised by people, language is a place of actualisation of discourse, a place where discourse is
enacted into existence by them, “where actual and possible forms of social organisation and their likely social and political consequences are defined and contested” (Weedon 1987: 21). In this research, following Weedon (1987), language is a place of actualisation of multiple discourses where women express their understandings and enact their conceptualisation of technological in maternity care. Fragments of different discourses can be pinpointed in women’s language. They are not simply reproduced by women who actively navigate amongst them as they work towards the understanding of our current technologised maternity care system. Thus, I am looking at women’s use of language to capture this work and to separate different discourses in operation, in their specific context and interests they serve.

3.3.4 Justifying a feminist poststructuralist approach

3.3.4.1 The impossibility of a poststructuralist position?

There are two aspects of feminist poststructuralism which were decisive in choosing it as a perspective for my research. First, it provides the conceptualisation of understanding as uneven and ambivalent, which I found to be an irreducible feature of women’s accounts and their understanding of technology. Second, it provides a framework for agency and resistance towards prevalent understandings. However, both of those aspects have their controversies and are connected to critiques of poststructuralist scholarship. What I see as a possibility and an opening for change has also been considered as a shortcoming of the poststructuralist position, the inherent ambiguity of the frameworks of our understanding precluding resistance and making agency futile. Their radical departure from traditional epistemology has fostered accusations of taking on positions that are marginal and impossible to maintain (Williams 2005). Critiques of poststructuralism charge it with dispersal of value resulting in its relativist position, its lack of basis for politics, and its incapacity to provide a basis for valid research (Lather 1991, McNay 1992, St. Pierre 2000). For this reason, rather than to be unanimously embraced by feminists, the poststructuralist project has been criticised (Gannon and Davies 2007) as incompatible with feminist goals of overcoming social relations that are disadvantageous for women and “reform-oriented research” (Oleson 2011: 261). However, feminist poststructuralists address and rework those
difficulties to enable movement beyond the seeming impossibility of a poststructuralist position, offering new possibilities for understanding. In this research I consider feminist poststructuralist conceptualisations as not forestalling understanding and social change but as incitement to them.

3.3.4.2 Addressing the charge of relativism and dispersal of value

How can we argue for the reconceptualisation of maternity care if we are left without a theoretical and political grounding for it? While the accusation of relativism poses a question of how we can determine the value of competing claims, feminist poststructuralism rejects the possibility of some universal external position from which those claims can be arbitrated. Instead of relying on universalist foundations, we need to “reinvigorate” bases for our knowledge by reworking them as contingent (Butler 1995). This is crucial for us to proceed with our research and to advocate for change, as claiming absolute bases for our knowledge obstructs its assumptions, making it more difficult for us to conceive ideas which are radically different to the status quo. It also allows us to evade responsibility for the social world as it appears beyond the reach of human activity within such a framework (St. Pierre 2000). Charging poststructuralism with relativism makes sense only within the traditional approach to knowledge where there is no middle ground between objectivism and relativism (Gavey 1989). It only becomes problematic if we insist on adhering to categories of foundational approaches to knowledge (Lather 1993). As understanding and knowledge are firmly contingent on social relations of power, these must be made visible and open to historically specific examination: “to explain the working of power on behalf of specific interests and to analyse the opportunities for resistance to it” (Weedon 1987: 40).

Poststructuralist re-interrogation of foundations is not a negative movement towards rejection of values and the possibility of any knowledge at all. The fact that “one cannot provide an ultimate rational foundation for any given system of values does not imply that one considers all views equal” (Mouffe 1988: 37). It is instead a position of acknowledging their local, embroiled character (Davies and Gannon 2005) and rejecting the possibility “to rise above the level of human activity” (St Pierre 2000: 499). The aim instead is to outline the temporary fixtures and conditions for knowledges we are
examining and disrupting their unquestionability (Weedon 1987). Haraway (1991b) proclaims the need for “situated knowledges” as the basis for our claims, i.e. localised knowledges critically positioned within “partial perspective” (ibid. 191-193). She critiques radical relativism as resembling humanist objectivism in being a view from nowhere and thus an “unlocatable, and so irresponsible” knowledge claim (ibid. 191). Situated knowledges help to capture the multiplicity of understanding and allow the possibility to forgo the binaries of our thinking.

But how can we argue for or against certain approaches to technology in maternity care based on situated knowledges? I find Foucault’s concept of “insurrection of subjugated knowledges” (Foucault 1980c: 81) is a helpful clue. We need to include and bring to the fore in our examination “these low-ranking knowledges, these unqualified, even directly disqualified knowledges” which are “incapable of unanimity” (ibid. 82). Including women’s accounts and regarding them as a source of legitimate conceptualisations can help us see past a single “regime of truth” (Foucault 1980b: 131) or a unitary discourse and find better ways of understanding and using technology.

Poststructuralists find it difficult to envisage how a critique of stable, universalistic categories of knowledge can be performed while leaving some categories intact. It is impossible to disrupt familiar assumptions, without also seeing the concepts of our theory as limiting because we otherwise may end up reproducing the very notions we challenge (Davies and Gannon 2005). Thus theories and concepts that allow new approaches are inherently unresolvable. This is the impossible position of poststructuralism: “all the defining concepts... are also deconstructed and deconstructible” (Derrida 1991b: 274). Our goal is not to devise theories which envisage some finite understanding but those that see understanding as historically, socially, and culturally specific, invested with power relations which need to be displaced (Gavey 1989).

47 Although Haraway (1991b) argues that “situated knowledges” are a form of “feminist objectivity” (ibid. 188), the category of “objectivity” being rejected in poststructuralism, her conclusions are similar to the poststructuralist ones in overcoming the conflicts of traditional humanist thought.
3.3.4.3 Theorising ambivalence: productive opening for knowledge

In feminist poststructuralism, ambivalence is part of the very nature of our understanding and multiplicity and paradox are necessary conditions for knowledge (Haraway 1991b). Consequently we have to pay careful attention to ambiguities while doing our research as they are seen as productive and providing an opening to new understandings. They facilitate a shift in established knowledges because “the silences and ambiguities of discourse provide the possibilities of refashioning them, the discovery of other conceptualisations, the revision of accepted truths” (Hekman 1990: 187). Thus, exploring and preserving ambivalence is an act resembling deconstruction when the goal is to “defer”, “dissolve” and “reinscribe” rather than generate identity and presence. Also, it is those ambiguities which offer the moments where we can best observe how the power of a particular discourse performs its work and move beyond any easy understanding (Jackson and Mazzei 2011).

Clarity is no longer our aim as it forecloses thought; it is not a resolution of ambivalence that we are after. Instead “our task is to live out the ambivalent limits of research as we move toward something more productive of an enabling violation of its disciplining effects” (Lather 1996: 541). Within a poststructuralist framework understanding “cleansed of doubleness, oppositions and multiplicity” belongs to the illusion of rational subject (Davies and Gannon 2005: 320) whose concealment of ambiguities is considered “the exercise of power disguised as reason” (Lather 1990: 329). Embracing ambiguities instead of resolving them, is a way of dismantling power through resisting the unitary and unproblematic in our understanding and in our research. Within poststructuralist stance we can still see what sense women make of technology, even if this understanding, like all understanding, is contextual and local.

3.3.4.4 Theorising resistance: beyond the impossibility of research and politics

3.3.4.4.1 Power, discourse and resistance

How can “reinscription” of notions of technology and maternity care be performed? How can we conceptualise resistance if social reality is mediated by discourse and it seems impossible to act outside it? In order to describe how resistance and change are
possible for feminist poststructuralism, I will turn first to the Foucauldian “capillary” notion of power (Foucault 1982), according to which, power does not operate in a top-down manner but from multiple points in society:

“in human relationships... power is always present... power relations are possible only insofar as the subjects are free. If one of them were completely at the other’s disposal... there wouldn’t be any relations of power. (...) there must be at least a certain degree of freedom on both sides. (...) This means that in power relations there is necessarily the possibility of resistance because if there were no possibility of resistance... there would be no power relations at all.” (Foucault 1997: 292)

Consequently, power does not belong to individuals, no matter how powerful their position in society, but exists only in relations, “power relations” being thus a much more appropriate term to describe power (St. Pierre 2000: 489). It involves “meticulous rituals of power” (Dreyfus and Rabinow 1983: 110, 188) in the form of multiple local tactics, mechanisms and effects rather than “grand, overall strategies of power” (Hall 2001: 77). This means that all individuals are bearers of power and partake in both its reproduction and disruption in society, if only by taking some already available subject positions or reiterating particular discourses and not others. Resistance is not enabled by the absence of power but is inseparably connected to power and there are multiple points of resistance in society as there are multiple points of power (Foucault 1979). This implies that power works in more subtle way than through command and dictate and is seen as productive. It produces ways of being and acting which seem beguiling and we adopt them as our own (Davies and Gannon 2005). While this can hinder resistance, the only situation where its avenues are extremely limited is within “the state of domination”, where power relations are arranged in such a way as to leave very little margin of freedom for individuals (Foucault 1997: 292).

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48 While I acknowledge that the power differentials between women’s knowledges and expert knowledge might make it difficult to imagine women as bearers of power, women can take part in, as well as undermine, the power of the technocratic biomedicine through access to their embodied experiential knowledges. These hardly count within the dominant paradigm but, as it is demonstrated in this thesis, they might become a source of powerful alternative conceptualisations which erode the technocratic paradigm and enable women to insist to be supported to labour on their own terms.
Similarly, although discourses are powerful and their effects extend into all realms of social life, they can be resisted because “shifts... do occur when people think of different things to say” (St. Pierre 2000: 486). Also, although discourse constitutes and reinforces power, it simultaneously “undermines and exposes it, renders it fragile and makes it possible to thwart it” (Foucault 1981: 101). There is always an interplay of those two contradictory potentials in discourse. As a result it is possible to begin reworking the discourses and practices surrounding and stipulating technology use in maternity care.

3.3.4.4.2 Agency and recognition

How can we exercise resistance and question existing social circumstances if there are no foundations guiding our efforts and legitimating one set of conditions as more advantageous than other? Despite the criticisms, feminist poststructuralism does not imply equality of all claims and does not lead to paralysis of agency and politics. It views the loss of transcendental foundations as “energizing rather than paralyzing” since it is their very contingency that provides the possibility of freedom and enables agency for political action (St. Pierre 2000: 483). We can discriminate between which action is legitimate and which not, however, as Mouffe (1988) observes “this can only be done from within a given tradition, with the help of standards that this tradition provides... there is no point of view external to all tradition from which one can offer a universal judgement” (ibid.: 37). If anything, a foundationalist approach makes our efforts more difficult because social change is determined by sets of conditions outside our reach.

There are always some discourses which govern our understanding of the world and we always act from within some discourse or another. However, in poststructuralism the necessity of being able to stand “outside” discourse and achieving emancipation from “discursive constitution and regulation” (Gannon and Davies 2007: 73) is not a condition for being able to exhibit agency. What is crucial for us to act and resist existing social arrangements is our capacity to recognise that discourses are constituted, that they are historically specific, that they come from within our society and as they are sustained by us they can also be questioned by us (Davies and Gannon 2005). Our capacity for agency comes not from being outside or against social structures but from recognition of the power of those structures and unfailing questioning of their constitutive efforts.
It comes from recognition of our immersion in and indebtedness to discourse and openness to create new frameworks which can disrupt old understandings (Davies and Gannon 2005). Although we are subjected to discourse and “forced” into certain subject positions, we can also actively assume a particular position. This allows us to become subjects of a particular discourse, disrupting its hegemonic power and actively navigating amongst the norms and values this discourse offers. As a result no single discursive practice or positioning within discourse, however powerful, has complete control over our understanding which is always multiple as discourse is always “filled with contradictory possibilities” (Davies and Gannon 2005: 318).

This is why feminist poststructuralism offers a framework to examine how power relations hinder change and undercut the expression of certain views around technology and maternity care by women, and thus how we can start reshaping them. We can conceptualise women’s accounts as exemplars of resistance because resistance is “local, unpredictable and constant” (St. Pierre 2000: 492). Resistance of individual women to the predominant discourses on technology in maternity care becomes the “first stage in the production of alternative forms of knowledge or where such alternatives already exist, of winning individuals over to these discourse and gradually increasing their social power” (Weedon 1987: 111).

3.4 Foucauldian discourse analysis: methodological assumptions and tools for this research

This section outlines my methodological approach. Poststructuralists are cautious about the rhetoric of methodology, often presented as a set of procedures which when followed meticulously will ensure the quality of our research and the legitimacy of our claims. These procedures are situated in and substantially shaped by institutional requirements of academia and the dominant paradigms of our disciplines and enmeshed in their power. Thus, in what follows, such “rituals” of methodology are problematised and instead the undecidability and situatedness of the process of research and its argument are emphasised (Agger 1991). Lather contends that methodology after poststructuralism challenges the researcher “not to see so easily in
telling stories that belong to others” and incites us to see “the unthought in our thought” (Lather 1993: 684).

With those considerations in mind I set out to outline my understanding and “employment” of discourse analysis in this research to answer the question “how do women understand technology in maternity care?” I will begin with explaining the type of discourse analytic approach I am engaging with and outline its characteristics. At the end of this section I will attempt to integrate discourse analysis with feminist poststructuralism as I embark on locating discourse in the work of capturing women’s understandings.

3.4.1 Varieties of discourse analysis

Discourse analysis refers to a variety of theoretical and methodological approaches developed simultaneously across disciplines including linguistics, literary analysis, psychology, sociology, cultural studies and historical analysis (Wetherell et al. 2001). The diversity of approaches towards discourse analysis contributes to the confusion about what it does actually entail (Gill 2000, Potter 2004). However, all discourse analyses are the aftermath of theoretical debates associated with the “double crisis” and critique of traditional social science, described above when discussing poststructuralism. In this section I outline where my research stands within methodological approaches to discourse analytic research.

Initially, I drew on a range of approaches without explicit poststructuralist inclinations, formulated within social sciences and embedded in Foucauldian concepts of discourse, knowledge and power (e.g. Burman and Parker 1993, Potter 2004, Potter and Wetherell 1987). As my research progressed, my approach was becoming more explicitly poststructuralist in its assumptions. I focused on complexity and ambiguity of understanding of the social world, on disrupting the traditional ways of doing research and on looking at power relations and their influence on the way in which we assemble our accounts of the social world. When specifying the type of discourse analysis which would suit this refined focus I was drawn to Potter’s (2004) distinction between two types of discourse analysis, both inspired by Foucault’s work. These were Foucauldian discourse analysis (FDA) and “continental discourse analysis” employing a Foucauldian
approach to discourse. The former is more ethnomethodologically inclined, i.e. concerned with detailed description of discourse in the context of specific interactions and texts, identifying rules that govern contextual meaning-making. The latter is embedded in the philosophical tradition of poststructuralism and focuses on “how a discourse, or a set of ‘statements’, comes to constitute objects and subjects... as distinct and factual” (Potter 2004: 201). Having explored their theoretical bases in the course of my research, I had found them often overlapping in their practical “methods” of doing research. Consequently, while in my theoretical stance I was drawing on the “continental” approach, methodologically I resorted to some of the practical strategies of FDA as well, whenever they appeared helpful and in agreement with theoretical frameworks informing this research.

3.4.2 What is discourse analysis?

Although all types of contemporary discourse analysis are to some extent influenced by Foucauldian concepts, Foucault did not attempt to formulate a steadfast method of enquiry and his work is a source of theoretical assumptions and methodological cues rather than a practical step by step approach for research. Consequently, there is no formally specified “method” of doing discourse analysis and individual researchers rework Foucauldian notions and “apply” them in a variety of ways (Carabine 2001, Gavey 1989, Rose 2006). Discourse analysis is more “a way of working” with the topic of our inquiry (Gavey 1989: 466), a way of developing a particular “analytic mentality” (Potter 2004: 192) which informs the manner in which we conduct our research. It provides an eclectic set of tools that enable us to work with the materials we gather during the course of research. However, what welds them into a separate methodological approach is careful theoretical conceptualisations. Thus theory, rather than predetermined procedures, is considered essential in guiding choices on all levels of research:

“discourse analysis... is a broad theoretical framework concerning the nature of discourse and its role in social life, along with a set of suggestions about how discourse can best be studied and how others can be convinced findings are genuine” (Potter and Wetherell 1987: 175).
This is why its practitioners are describing it as “a craft skill” which is learned by doing (Carabine 2001, Potter and Wetherell 1987, Rose 2006) and involving trying out different analytic strategies and being prepared to reject those that do not work (Tonkiss 2004: 254). Also, following Foucault, it requires us to renounce the goal of arriving at clear and consistent interpretations which would provide some kind of ‘truth’ about the subject of our examination, and acknowledge our research as producing knowledge which is partial, local and contextual. Consequently, most types of discourse analysis, the poststructuralist frame included, require “a radical epistemological shift” in how we conceptualise and conduct our research (Gill 2000: 177).

Discourse analysis uncovers the procedures, practices and institutions which assist in producing discourses and knowledges, and locates their power effects, the way they are “practised, operationalised and supported institutionally, professionally, socially, legally and economically.” (Carabine 2001: 276). Discourse analysis as methodology provides us with guidance about how regulatory practices of discourse can be captured:

“[the] task consists rather in making these discourses visible in their strategic connections than in constituting them as unities, to the exclusion of all other forms of discourse” (Foucault 1980a: 38)

The subjects of study in discourse analysis are various cultural practices embodied in materials we formulate as our data. Discourse analysis focuses on how people create particular accounts of the world and how they establish their accounts as truthful or natural through relying on discursive “regimes of truth” (Rose 2006). It assumes that the way their accounts are constituted and the resources they draw on in order to produce them, influence their way of thinking and acting in the social world.

3.4.3. How to perform discourse analysis?

Although discourse analysis is difficult to formalise and eclectic in its sources (Rose 2006: 149), its practitioners have attempted to make its analytic strategies more explicit. However, in this study these serve as guidance and are not considered to be prescriptive. Thus in Foucauldian discourse analysis as I understand it, it is “thinking with theory”, an approach described by Alecia Y. Jackson and Lisa. A. Mazzei in their book.
“Thinking with theory in qualitative research” (Jackson and Mazzei 2011), which is crucial in determining how we proceed with our research.

3.4.3.1. Suspending “pre-existing forms of continuity”

Discourse analysis requires “unrelenting scepticism” in approaching our materials (Hook 2007: 6) and being wary of notions which are taken-for-granted, or appear to be obvious and “common sense” (Gill 2000). In Foucauldian terms it is the necessity to suspend the “pre-existing forms of continuity”:

“We must renounce all those themes whose function is to ensure the infinite continuity of discourse... These pre-existing forms of continuity, all these syntheses that are accepted without question, must remain in suspense. They must not be rejected definitively of course, but the tranquillity with which they are accepted must be disturbed; we must show that they do not come about of themselves, but are always the result of a construction the rules of which must be known, and the justifications of which must be scrutinised” (Foucault 2002: 28)

However, in order to recognise those pre-existing notions regarding technology use in maternity care, we need a comprehensive knowledge of context within which technology operates (Gavey 1989). Throughout our analysis we need to keep connecting women’s understandings with our theoretical groundwork and the wider socio-cultural context in a continuous movement between theoretical, institutional, historical and socio-cultural underpinnings, and the details of different discourses enacted by women. Only then we may begin to see how discourse provides frameworks for their understanding of technology (Rose 2006, Tonkiss 2004). Only in this way can we start making sense of the intricacies of their operation. This context, carefully outlined in Chapter 1 and Chapter 2, is essential because what is actually said by women and their use of language is part of discursive practices:

“Without awareness of the social, political and cultural trends and contexts to which our texts refer, we would be unable to carry out any analysis. We would be unable to see alternative versions of events and phenomena that the discourse we were analysing had been designed to counter; we would fail to notice the (sometimes systematic)
3.4.3.2. Patterns of “what is” and “what is not”

On a very basic, preliminary level of discourse analysis, we are tracing persistent patterns of speaking, arguing and understanding within our materials (Carabine 2001, Rose 2006, Tonkiss 2004). This may reveal the consistency and coherence in women’s understanding, and point us towards the unitary and seemingly “natural” frame of reference which women may employ. We can also locate contradictions and conflict. However, these may be countered within a discourse and dismissed but also incorporated and reconciled with it without the discourse appearing inconsistent (Tonkiss 2004). Such conceptual flexibility of discourse, manifesting in the multiplicity of its argumentative schemes (Rose 2006), can be both the source of its power but equally an opening for its change as I already discussed when conceptualising resistance.

However, apart from looking at the patterns, discourse analysis requires us to attend to “what is and what is not” (Carabine 2001: 275), i.e. the emergence in women’s accounts of knowledges - and thus corresponding ways of conceptualising technological - claimed as natural, real, reasonable or true, and those which are not considered as such. What is not voiced, or seems to be difficult to voice about technology in women’s accounts? What do those absences tell us? What is continuously voiced and reiterated? This brings us to the issue of power, or more precisely, to the intertwining of power and knowledge in discourse (Foucault 1979: 100). It is this intertwining which, according to Foucault, makes certain objects thinkable in a particular way and others lacking a legitimate conceptualisation or not thinkable at all. Discourses are powerful because they claim that knowledges they are resting on are the “truth”. Consequently, I had to be as mindful of absences, omissions and silencing of certain ways of conceptualising technology when analysing my data as of understandings which were more explicitly produced in discourse. Particular arrangements of power/knowledge create conditions for certain statements and discourses to become possible, to emerge and to operate:
“... the conditions necessary for the appearance of an object of discourse, the historical conditions required if one is to ‘say anything’ about it... these conditions are many and imposing. Which means that one cannot speak of anything at any time; it is not easy to say something new; it is not enough for us to open our eyes, to pay attention, or to be aware, for new objects suddenly to light up and emerge out of the ground.” (Foucault 2002: 49)

3.4.3.3. Reading for detail: capturing the intricacies of discourse

In discourse analysis we focus on intricate detail in our materials and do not seek a general sense or a unitary summary disregarding nuance, contradiction and vagueness (Potter and Wetherell 1987). We are interested in how discourse is assembled and organised and how it functions, and not what is behind or what underlies it:

“the discourse analyst is concerned with the detail of passages of discourse, however fragmented and contradictory, and what is actually said or written, not some general idea that seems to be intended.” (Potter and Wetherell 1987: 168)

Also, women’s accounts are not considered as means of accessing realities beyond discourse such as women’s personal motivations and beliefs or to reconstruct an “accurate” account of events (Gill 2000). My aim in doing this research is a detailed, historically situated analysis of how women constitute their own understandings and how this is connected to the power relations within social groups and institutions (Gavey 1989). The aim is to explore the question of how discourses and accounts of the technological are manufactured and actualised through the use of language. We are unpicking what practices are permitted by discourses and “their details, their casual assumptions, their everyday mundane routines, their taken-for-granted architecture, their banalities” (Rose 2006: 145). Attention to the pre-existing forms of continuity means that seemingly “uninteresting” or even banal phrases which are persistently reiterated may provide fruitful insights into discourse and its effects in the real world49.

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49 During my analysis, I found examining closely those repeatedly articulated “uninteresting” statements a source of crucial insights into women’s understandings of technology in maternity care.
A process of their “daily reproduction” is not straightforward and demonstrates discourse performing its work (Skeggs 1997: 6).50

3.4.4. Discursive strategies

One of the useful tools for exploring the intricacies of discursive work in women’s accounts is identifying “discursive strategies” within them. Discursive strategies reflect the internal logic of discourse and provide “regulated ways… of practising the possibilities of discourse” (Foucault 2002: 78). They make connections between statements and other discursive events appear “natural” and “reasonable”. I understand them as the way the power effects and truth claims of discourse are evoked in women’s accounts. Discursive strategies are “the means by which a discourse is given meaning and force, and through which its object is defined” (Carabine 2001: 288).

This understanding is in contrast with a more vernacular understanding of strategies as an intentional “employment” of discourse to create “different kinds of effects” (e.g. Bryman 2012: 529). Reisigl and Wodak (2001) define discursive strategy as a “plan of practices (including discursive practices) adopted to achieve a particular social, political, psychological or linguistic aim” realised through systematic uses of language (Reisigl and Wodak 2001: 44). Although they agree with Bourdieu that strategies can be unconscious and applied “automatically” and while they might appear goal oriented, these goals “may not be the goals subjectively pursued” by individuals (Bourdieu in Reisigl and Wodak 2009: 32), they also see discursive strategy as potentially containing some “conscious intention”. However, in my research, discursive strategy concerns the reproduction of “regulated ways” rather than reflecting the intentions and goals deliberately pursued by women. Consequently, I see discursive strategy as such as a conceptualisation of a certain issue which at the same time maintains and obscures the prevailing social relations of power around this issue (Harding 1997). Discursive strategies which emerge in women’s accounts conceptualise the technological as if there was nothing social about it and conceal its imbrication with relations of power sustaining the technocratic paradigm in maternity care. Despite this, women’s

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50 “A process of reiteration (where representations continually reference themselves through daily reproduction) does have a real effects… Representations, however… are not straightforwardly reproduced but are resisted and transfigured in their daily enactment” (Skeggs 1997: 6).
understandings of the technological pose a challenge to those strategies and thus may dismantle them. In this way, the notion of discursive strategies allows us to observe how women’s agency is intertwined with the regulatory aspects of discourse.

3.5. Discourse and women’s understanding: integrating feminist poststructuralism and discourse analysis

My analysis attends to two aspects of women’s understandings. The first of those aspects, grounded in discourse analysis, involves seeing discourses as already quoted “regularizing collectivities” (Said 1983) at work in women’s conceptualisations of technology. The second, more poststructuralist move, requires looking at women’s accounts as an attempt to actively negotiate and invoke those “collectivities” as resources to build their own understanding. These two aspects are simultaneous, and only analytically separate and they point to different notions of ambivalence and resistance which they evoke.

3.5.1. Capturing discourse

In pursuing this discourse analysis I aimed to examine how discourses relating to technology in maternity care operate within women’s accounts. This required me to search for patterns governing what women are able to express, argue for and how, and to locate some organising principles in their accounts through connecting them to a wider sociocultural context. In this way I could begin to explore what discourses may be at work. This allowed me to examine how women’s understandings are put together from available discursive resources and how those discourses work to support certain knowledges and truths about the process of birth, the provision of maternity care and the role of technology in these.

Discourses are incomplete and contradictory but their power lies in appearing as solid and stable (Phillips and Hardy 2002). This incompleteness and ambivalence are necessary to allow discourse to change and modify its strategies without losing its unity (Foucault 2002: 83). However, to maintain their integrity, this ambivalence is subject to a constant “countering” activity of discourse, as its conflicts and fragments of alternative discourses are being incorporated in order to provide a unitary framework for
understanding. In Foucauldian terms, fragments of “disinterred knowledges” not necessarily provide new possibilities of understanding after gaining some cultural currency. Instead, they may be re-colonised by predominant discourses which are “quite ready to annex them, to take them back within the fold of their own discourse and to invest them with everything this implies in terms of their effects of knowledge and power” (Foucault 1980: 86). In this way the ambivalence may be “annexed” and made invisible, and thus change becomes difficult as its “insurgent” potential is impaired. I argue in this thesis that this is the case for the biomedical technocratic paradigm as a dominant discourse in maternity care.

3.5.2. Capturing women’s understandings

Women’s understandings are characterised by another form of ambivalence which can only be attended to if inconsistencies and conflicts in discourse escape the annexing activity of discourse, and become visible and irresolvable for women. It is the feminist poststructuralist recognition, a realisation by women of the insufficiency of available discourses to provide a framework for understanding. Women do not fully and unwittingly accept what discourses supply. As a result, they may begin to search for new conceptualisations, drawing on available discursive resources in an attempt to arrive at their own understanding. I am interested in this profound ambivalence when women realise that available discursive resources do not allow them to make sense of the way

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51 I consider the biomedical technocratic paradigm as the dominant discourse in conceptualising technology in Western maternity care systems. In my understanding of the “dominant” I acknowledge Foucault’s distinction between power and domination and his conceptualisation of the “states of domination” discussed in section 3.3.4.1 of this chapter. Such a state of domination occurs when “the power relations, instead of being mobile, allowing the various participants to adopt strategies modifying them, remain blocked, frozen” (Foucault 1997: 283). Power always comes with the possibility of resistance and only when “the possibility of effective resistance has been removed” (Patton 1994: 64) and “when stable mechanisms replace the free play of antagonistic relations” (Foucault 1982: 794) the state of domination has been achieved. However, I do not consider the biomedical technocratic paradigm as dominant in this sense, not allowing resistance but only a number of tricks and stratagems inadequate to accomplish a reversal of domination (Foucault 1997: 292) Still, it has an extremely powerful grasp on our imagination which sometimes resembles the state of domination. Moreover, its pairing with the state institutions as its proponents and with other powerful discourses such as, for example, “scientific” discourse on risk, makes it extremely difficult to navigate pregnancy and birth in our society and argue for better maternity care without concession to its terms.

52 Feminist poststructuralists contend that in the recognition of the power of discourse and its regulatory practices lies the possibility of women’s agency (Davies and Gannon 2005: 319).
technology is currently used in maternity care. This ambivalence when acknowledged and acted upon, can pose a challenge to the dominant discourse.

3.5.3. My own place in discourse

Apart from the ambivalence which can be observed in discourse and the ambivalence recognised by women, there is also my struggle with the ambivalence of women’s accounts in my attempt to make sense of what women were trying to tell me. This ambivalence may not have been recognised by women themselves, and as a result may be considered as “imposed” on their accounts. Women might not have realised the conflict where I see it, especially given the limited length of our conversation to explore it, compared with many months I spent on my analysis. However, my observation of such “unrecognised” ambivalence, as I see it, is an important feature of my analysis and reflects my struggles with understanding women.

This provokes a question about my positioning as an analyst of women’s accounts. Poststructuralist discourse analysis is acknowledging the partial, contingent, situated nature of its “findings”, they are a researcher’s interpretation producing and evoking yet another discourse. Thus, I was alert to my own assumptions while conceptualising and doing this research and cognisant of my own place in discourse. My analysis is contingent and manufactured and as persuasive as the analysed discourses with nothing obvious about its particular form (Potter and Wetherell 1987). Those issues are discussed in detail in the next chapter which outlines the practical aspects of doing this research and my experience of fieldwork and describes ways in which I ensured its quality and rigour.

3.6 Conclusion

This chapter has outlined the theoretical and methodological conditions for understanding and for production of knowledge in this research. I have also given an explanation as to how its conceptualisations can foster change in our approach to maternity care and its technologies. I consider outlining these conditions as a crucial frame of reference to comprehensively examine women’s understandings of technology, but also to demonstrate that it is their understanding and knowledge that
are essential starting point for thinking differently about our maternity care and addressing inappropriate use of technology.
Chapter 4

Doing the research

4.0 Introduction

This chapter is an account of how I worked the theoretical contexts and methodological perspectives described in preceding chapters into practical decisions when designing and conducting this research. It is an account of my development as a feminist poststructuralist researcher. I begin with introducing my understanding of ethical and rigorous research practice as an ability to critically reflect on the decisions made as I proceeded with this research in section 4.1. Section 4.2 discusses issues around the fieldwork such as my positioning and the process of recruitment, and gives the rationale for and the details of my sample. I also discuss ethical considerations while in the field. In section 4.3 I focus on the photo-elicitation interviews which served as a method of generating my data. The last section of the chapter (4.4) is dedicated to outlining how I analysed and made sense of my data and also I turn to what steps I had undertaken to ensure a plausible interpretation and sought to produce “responsible knowledge” (Skeggs 1997: 167) as a result of this research.

It is impossible, and indeed inappropriate, to completely specify the particulars of qualitative inquiry in advance of fieldwork because its design emerges as the research unfolds and uncertainty is its inherent feature (Lincoln and Guba 1985, Patton 2002). Thus, a crucial aspect of rigour in this feminist poststructuralist discourse analysis is a reflexive account of research, with a detailed description of how the dilemmas of fieldwork, data production, and analysis were navigated.

4.1 Ethics and rigour in the field and beyond

“Simply following one’s duty, looking up the appropriate action in a book of laws or rules, as it were, is anything but ethical—at best this is an administration of right and duties, a bureaucracy of ethics. In this sense an ethical act worthy of its name is always inventive (...) in response and responsibility to the other” (Bennington 2000: 68)”

“ethics cannot be divorced from competence in research methods, methodology, and epistemology” (von Unger 2016: 95)
This research rests on the assumption that reflexivity, i.e. continuous critical reflection on the political and social entanglements of our research, the conditions for knowledge we are producing and our responsibilities as researchers, is crucial for ethical and rigorous research. Consequently, I consider notions of ethics, theoretical and methodological robustness and production of trustworthy, valid knowledge as inseparable in the process of research (Lather 1993). Ethical conduct and rigour rest on an ongoing, dialogical engagement with the participants and the context of our research (von Unger 2016). They stem from the “concern for equity and the imposition of power within the conceptualisation and practice of research itself” (Cannella and Lincoln 2007: 315). It is reflexivity and a comprehensive “particularised” understanding of theoretical and social contexts of the issue under investigation which help us translate the principles of our research into practice. This allows us to proceed where no clear rules are available and helps to ensure the quality of our work. Without such understanding we are likely to settle for superficial, reductionist claims. This latter not only collapses the analytic potential of our research but also makes it in some respects unethical (Childers 2012).

Our assumptions have to be tested against concrete issues arising throughout the research and it is impossible to predict both ethical and epistemological dilemmas that might arise during fieldwork (Guillemin and Gillam 2004, Preissle and Han 2012). Thus, ethics as much as rigour of qualitative research cannot be reduced to following a list of prescriptive technical steps and such a “cookbook” approach has been critiqued for being premised on misunderstanding of its theoretical and epistemological foundations as well as their purpose (Barbour 2003, Harding and Gantley 1998, Sandelowski 1995). A procedural approach to ethics while serving as a precaution for protecting the basic rights of participants, is insufficient to deal with the realities of research (Guillemin and Gillam 2004) and can create “an illusion of ethical practice” (Cannella and Lincoln 2007: 315). Instead, within the feminist poststructuralist project, the “critical research ethics” is needed, characterised by the ability to think through ethical issues as they appear embedded in the social and political contexts of doing research (Cannella and Lincoln 2011: 83). Thus ethical practice and rigour include an examination of values which drive our research and involve countering the power which inevitably arises for us as
researchers in the context of inquiry. It may be tempting to consider oneself as the inquirer and thus the knower, and allocate our participants the role of those being known and subjects of inquiry (Cannella and Lincoln 2011, Harding and Norberg 2005, Oakley and Roberts 1981). Feminist theorists have been at the forefront of challenging such divisions in the process of research, and have contributed greatly to the development of notions of positionality and reflexivity applicable beyond feminist research (Burns and Walker 2005). Such an approach to ethics and rigour aids in balancing our agendas with those of our participants, involves constant examination of the premises of our research and necessitates justification for each decision we make as we proceed (Preissle and Han 2012, von Unger 2016).

4.2. Doing fieldwork as part of feminist poststructuralist inquiry

4.2.1. My positioning

I deliberately decided to conduct this study outside the formal health care system as I did not want to be associated with maternity hospitals or other health care settings. Thus I decided to recruit my participants in the local community, contacting groups and facilities where I expected to find women who have experience of maternity care, for whom the topic of my research would be meaningful.

The reason for this was to avoid the power dynamic associated with medical settings and professions working within them. I assumed that within such a context it might have been more difficult for women to express what is considered uncommon or

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53 Initially I envisaged recruiting both women and men based on the evidence of the differences in their approaches to technology (see, for example Keller and Kirkup 1992, Sandelowski 1994, Wajcman 1991, Williams and Umberson 1999). However, not only has recruiting enough men proven extremely difficult, also, exploring the gendered component in women’s and men’s accounts would have warranted an additional layer to my argument, which I realised was beyond the scope of this research. As a result, I ended up including only two men in my sample, one of them being interviewed together with his wife. This is why I decided to talk about my participants as “women” rather than “women and men” throughout the thesis. Men’s accounts, whenever quoted, are clearly indicated.

54 Many studies of women’s views on maternity care are either conducted within medical settings or have their participants recruited through health care professionals involved in their care. This creates a context where varying degrees of obligation between women and those providing their care are present. For example, in all studies on women’s perceptions of fetal monitoring reviewed by Smith et al. (2017) women were recruited antenatally through their hospital and those caring for them served as the gatekeepers. Moreover, women’s responses were recorded postnatally while women were still in hospital. Only in two studies was this followed by interviews within a few weeks of the initial questioning (Barber et al. 2013, Hindley et al. 2008).
inappropriate according to the assumptions supplied by biomedical maternity care and that they might have felt more “loyal” to their health care providers, making it difficult for them to express a criticism of our maternity services as they are. Moreover, I was also hoping to diminish the power differential between myself as a researcher, framing and conducting the study, and the women. I did not want to be considered an “expert” and thus, I emphasised in my conversation with women that I am not a medical professional and not “qualified” when it comes to childbirth, particularly with regards to the high-tech expertise which may be involved in their hospital encounters. By making my lack of “correct” professional knowledge explicit I aimed to reduce some of the distance between me and the participants as the knowledge makers. I emphasised that I was interested in their understanding and that I believed that their understanding is crucial to find out how maternity services should work in order to respect the needs of all women.

However, my “outsider” positioning had also made the recruitment extremely difficult. It was not only the difficulty of having to omit the “obvious” places where women who had experience with maternity services could be found, such as antenatal clinics and antenatal education classes. In those settings my affiliation with the School of Nursing and Midwifery would have perhaps proven more helpful than in community. It was also my not having sufficiently established links within the local community prior to the research, a consequence of having moved to Ireland only a few years before I commenced the research. This, coupled with the fact that this study was self-funded, was a source of major difficulty and forced some adjustments in my recruitment strategy (e.g. not recruiting men and turning to snowballing which I describe in section 4.2.4). However, after completing the fieldwork I realised that these adjustments were beneficial, for instance, in sharpening the focus of my study (recruiting mostly women) and creating a more comfortable and casual context for our relationship (snowballing). I was not a complete stranger and they were able to get some information about me and the project from a trusted person they already knew, before being interviewed.

Also, I realised that as I was Polish, it was probably much easier for me to recruit participants of nationalities other than Irish (particularly Eastern-European). This had sometimes proven frustrating, e.g. local community coordinators have “pre-selected”
those women for me, and in one case I was given a list of contacts where all the women but one were Eastern European. Eventually, while women in my sample are predominantly Irish, I consider it an asset that I interviewed women from different ethnic backgrounds. Talking to women accustomed to different systems (as I used to be myself), and particularly to two women from extremely low-resource countries, offered sobering insights into our use of technology in maternity care in Ireland. Also, I consider the ethnic diversity of my sample as an adequate reflection of women currently using Irish maternity services.

Furthermore, there were some advantages to being a foreigner doing the research. Lather (1991: 93) observed that it may help to “restore a needed balance between the researcher and the researched”, particularly if the latter are of lower socio-economic background. Also, women sometimes discussed certain aspects of maternity care in a manner intended for an outsider who needs additional explanation in order to understand. This sometimes meant that women became the experts, explaining some of the cultural intricacies of the Irish maternity care system to me, and thus perhaps, at least at some points in the interview, feeling more knowledgeable than I was. Perhaps this also meant they took less for granted during our conversation when it comes to Irish maternity services.

4.2.2. Outlining the sample and a note on defining women’s socio-economic status

Sampling in qualitative research is driven by its analytic goals as outlined not only by the topic of inquiry but by theoretical and methodological approaches (Noy 2008, Patton 2002). The variation which is sought in the sample is of analytic rather than demographic significance. This allows the researcher to explore the phenomenon under study in sufficient depth and address the research questions comprehensively (Sandelowsky 1995b).

The objective of my recruitment was to gather rich and diverse understandings of technology use in maternity care. Thus, it was important for me to recruit women who experienced different models of maternity care, particularly in the context of our statistics indicating a miniscule number of women accessing midwifery-led options and demonstrating that technological interventions are most common in women choosing
private obstetric-led care (Lutomski et al. 2014, Murphy and Fahey 2013), the issues I discussed in Chapter 1. Also, it was imperative to listen to women from a cross-section of social backgrounds, as research suggests that women’s socio-economic status impacts on the extent of their agency around technological expertise, available choice of alternatives and shapes their understanding of its role in maternity care (Bridges 2011, Lazarus 1994, Martin 2001, Oakley 1991). Even though the extent of options afforded to women with more resources and higher socio-economic status can still be limited, it is nonetheless greater than for those who “simply have to take what society chooses to give them” (Davis-Floyd 1993: 297). As a result, they can have diminished “bargaining power” when it comes to negotiating with technocratic biomedicine.

I acknowledge that no measure of socio-economic status is flawless, regardless of how many empirical measures of class we have available (Skeggs 1997, Wilkinson and Pickett 2018). In my research I gathered information about women’s education and occupation (see table with participants in Appendix 1), but when considering their social position I also relied, particularly during the recruitment, on the neighbourhood they were living in (Wilkinson and Pickett 2018: xx), or the one in which their children attended the crèche55. Based on the above characteristics and knowledge, it seemed that most women from my sample with a leaving certificate could be considered as belonging to a lower socio-economic class, and women with 3rd level could be usually classified as middle class. However, I also observed how women’s use of particular grammar suggested their social background which cut across such classification56. Thus, describing women’s social backgrounds had proven quite difficult to undertake in a straightforward manner. As a result there are exceptions when it comes to education/occupation being a marker of socio-economic status in my sample: Maebh and Janet with leaving certificates, born at the time when significantly fewer women progressed to 3rd level education, can still be qualified as coming from middle class backgrounds due to the fact that neither of them nor their daughters/nieces use

55 Both crèches used as sites of recruitment were part of social housing projects in the area not only classified as “disadvantaged” according to the most recent Census 2016 data, but with a strong identity of “being from the flats” which women brought up in the interviews.

56 For examples of classic studies of grammar as a marker of social position see: Bernstein (1962, 1971) and Trudgill (1974).
“working class grammar” during the group interview\textsuperscript{57}. Conversely, Eva and Tara, both from the same family, and related to Glenda, and both with 3\textsuperscript{rd} level education, can be considered as coming from working class backgrounds which is indicated by their use of working class grammar occasionally during the interview.

As Sandelowski (1995) observes, participants enter the sample “primarily by virtue of having direct and personal knowledge of some event (...) and only secondarily by virtue of demographic characteristics” (ibid. 180). Consequently, it was not my aim to make comparisons between women of different backgrounds and by type of care, although I did sometimes specify those to contextualise my interpretation of their accounts. Also, while I was striving to include women who experienced different technologies, I realised it was not a primary goal of this study, as it aimed to explore women’s diverse conceptualisations of technology and technocratically oriented maternity care in general. Most women in the sample have experienced what can be considered the “standard care” offered in Ireland (i.e. consultant-led care based in centralised hospitals, with emphasis on regular monitoring and adhering to predetermined, inflexible definitions of normality and progress), yet I consider the final sample as sufficiently diverse to cover a range of experiences with technology in maternity care as demonstrated in Appendix 1.

4.2.3 Recruitment: choosing sites in community

In order to ensure meeting my recruitment objectives I decided to purposefully select groups and facilities in the local community where women with different knowledges and experiences could be found such as, for example, crèches in social housing estates, parent and toddler groups in public libraries, groups meeting in community centres, pre- and post-pregnancy exercise classes.

I selected the communities outlined by the two postal districts of Dublin 8 and Dublin 7\textsuperscript{58} with which I was familiar: one was the area in which I was myself living, the other, the area of my children’s primary school. This was done to reduce the time and costs of

\textsuperscript{57} For characteristics of such grammar see: Cheshire et al. (2005) and Trudgill (1974).

\textsuperscript{58} However, some women included in my sample lived outside those communities. Some women I met through community groups travelled to the groups from different communities. This is the very nature of recruitment through snowballing.
the fieldwork (such as travel and childcare expenses), and allowed me to rely on some of the knowledge of the local community I already had. However, these were also the communities with a cross-section of people from different socio-economic backgrounds59, and thus ensured that I met the aims of my recruitment.

I contacted the facilities and groups mentioned above and identified gatekeepers who would permit me to speak to women. Also, I asked them if I could display the advertisement about my research on their notice boards (see Appendix 3). Although I was not successful in recruiting women through local advertising, asking permission for displaying posters and leaving participants’ booklets (see Appendix 4) created a context to make myself known to potential gatekeepers and was helpful in obtaining their assistance either in facilitating recruitment or opening other avenues for recruitment such as recommendations about and to other groups and individuals. After establishing contact with them I provided them with the access letter (see Appendix 2), as personalised as possible, containing information about the study, with my contact details as well as those of my supervisor, inviting them to seek additional clarification about the project if necessary.

4.2.4 Recruitment: turning to snowballing

As already mentioned, due to difficulties with recruiting suitable participants outside of medical settings and without the help of healthcare professionals as gatekeepers, at some point I decided to use a snowballing method to complete the recruitment according to my objective of having a socially diverse sample of women who experienced different types of care. I went back to one of my participants who had spontaneously offered help with recruitment after the interview, and I also asked people from my own social circle, after outlining what kind of participants I was looking for, if they could recommend me to someone or introduce me to a group which would be suitable for my research. I emailed them the participants’ booklet to forward to potential participants if requested. As a result, some women contacted me directly by phone or email, offering to be interviewed. Sometimes however, my “informants”

59 Based on the most recent data, those districts have been characterised as including the mix of areas ranging from “very disadvantaged” to “very affluent”, with two small areas of “extreme disadvantage” in Dublin 7. See: Census 2016 data collated by the government agency at www.pobal.ie.
provided me with phone numbers or emails of women or group coordinators who preferred me to initiate contact with them.

As a result of snowballing I was introduced to a group of women attending a post-natal pregnancy class by a friend who had just finished the class herself but was still in touch with the teacher (all the women in the class were strangers to me). Another friend introduced me to a woman from her lone parent support group, who recommended me to women who were her relatives. Yet another friend asked around in her workplace and I interviewed her colleague’s family members. A neighbour offered to speak on my behalf with women from his religious community. A woman who remembered me from a local playground, happened to work in local community centre and, apart from helping to set up a group interview, spontaneously volunteered to be interviewed herself. A local librarian invited me to come to a parent and toddler group but also contacted me with her daughter who had recently had a child. These offers were made after my “gatekeepers” asked me detailed questions about the purpose of my research. As they were in agreement with the purpose of my recruitment, I was happy to accept them. As already stated earlier, this resulted in women being more at ease from the start of our conversation.

Also, I interviewed my two then acquaintances (who since have become friends), after we met by chance while I was doing the fieldwork. When I mentioned the research, they offered to be interviewed. I knew one of them through an event she had organised, and the other one had attended a class with me in university many years ago. I was at first unsure about interviewing women I knew better than other participants. However, one of them was in a unique position compared to other women in my sample: she was an advocate for midwifery-led care yet she was not able to access it and at the time of the interview she was a public patient in a hospital, trying to navigate between what she was being offered and the type of care she wanted. The other woman was not only the first woman I met who decided on a full private package of care in a public hospital but also her view of appropriate maternity care was markedly different to women I had interviewed so far. As a result, I became curious about how a conversation with them might enhance my understanding of the topic, while mindful and reflexive about how knowing each other might impact on what might be said. Using photographs helped
immensely to focus our conversation, and prevented the interview from being too casual as we had a task to do (discussing photographs), and while I was prepared not to use those interviews for analysis, they provided me with important insights and eventually they were included.

4.2.5 Ethics in the field

During my fieldwork I adhered to ethical principles of informed consent, confidentiality, respect for autonomy and dignity of my participants. I was careful to ensure that their comfort and wellbeing were prioritised over my research objectives and I was mindful not to put them in the situation of undue pressure to participate (e.g. by explaining to gatekeepers that I would like women to contact me directly themselves if they wished to participate, unless they preferred otherwise). I made every effort to provide any clarification my prospective participants might need and that they were as much as possible in control of the circumstances of the interview, even though inadvertently I had control over this research: through my choice and conceptualisation of the topic, through questions I asked, though the photographs I chose to show to women, and most importantly, through my interpretation and representation of women’s voices.

As stated earlier, in this project ethical conduct cannot be ensured simply by abiding to prescriptive rules and is always contextual, depending on the actual person and their needs within the actual encounter. We cannot anticipate all the ethical decisions to be made and thus we need to rely on reflexive “situated ethics”, balancing principles and real life situations as they occur (Piper and Simons 2005).

How these assumptions were followed by me can be illustrated by the issue of informed consent and giving participants a set amount of time to reflect (seven days, as per the ethical application). I considered informed consent not a once off event complete when the consent form was signed. Instead I was aware that it is impossible to give all the details of research and predict all reactions and that informed consent is a process requiring me to continuously check with women and being sensitive to their understanding of research and to their needs (the former has led me to clarifying the research further as our conversation progressed and answering any question they might have about the research and about myself; the latter led me to asking women,
whenever I realised my questions referred to experiences which were difficult for them, would they like us to skip the question, or perhaps stop the recording, or were they sure they wanted to proceed with our conversation).

While initially I stated that I would abide by the rule of giving my participants a week to reflect prior to interview, during my fieldwork I realised how restrictive, impractical and sometimes patronising this rule could be in practice. The rule is important in emphasising that we need to make sure participants are given time to make up their mind about participation at their leisure. However, sending women away and forcing them to “reflect” for a week when they state clearly that they want to participate and that they would rather be interviewed in a day or two is a denial of their agency and can negatively impact on a relationship with them, as well as complicate the recruitment needlessly for all parties involved. Consequently, what felt comfortable for participants took precedence over the predetermined regulations. While most women took a week or more to decide about participation, in a few cases, and following women’s clear requests, the interview was conducted within a shorter time period.

4.2.6 The actual sample

When it comes to the number of participants, discourse analysis, similarly to all qualitative research relies on richness of gathered material rather than its quantity, as well as the depth of analysis (Rose 2006, Tonkiss 2004). Thus, I had to trust my knowledge and understanding of the topic, and above all my instinct and my learning from the interviews as the research proceeded, to ensure I had enough interviews to persuasively explore what women were discussing in their accounts. As an additional criterion, my recruitment was complete when I followed and responded to all the relationships commenced and established during my fieldwork. As a result of above considerations I concluded the recruitment when I was satisfied that I had recruited sufficient numbers of women from different social backgrounds, and who experienced different models of care, but most importantly that I had gathered rich material to comprehensively understand what women were trying to tell me and to answer my

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60 This had become apparent particularly when recruiting women through the community groups. They often stated they would like to be interviewed on the same week we made contact, wanting to have it off their to-do list or “before they forget all about this”.
research questions. Eventually, while more useful and revealing information could always be gathered, I consider my sample to contain a wide range of understandings and thus of adequate size and relevant enough to meet the above objectives.

For my analysis I included 24 interviews with 27 women and 2 men which took place in June 2013 (first round of fieldwork when I did my pilot interviews, I included 2 out of 7 of them in my analysis), and May to September 2014. The interviews were conducted mostly in participants’ homes but some preferred a different location and were interviewed in a childcare facility (4), public library (1), foyer of a local cinema (1) and workplace (1). Interviews lasted approximately one hour (the shortest was 43 minutes, the longest one hour 36 minutes) with the exception of one group interview which lasted two hours. I transcribed half of the interviews, the other half was done by a paid transcriber. Due to a fact that I am not a native English speaker, it was difficult for me to transcribe some of the interviews accurately within a reasonable timeframe. However, I reviewed all those transcripts and made necessary corrections myself. Also, three individual interviews (Marzena, Gabriela, Aleksander) were conducted in Polish. While those interviewees had quite a good command of English, I decided it would be much more spontaneous for us to speak in our native language. This has proven sometimes difficult for me as I was used to asking questions in English, and had to phrase them carefully to convey a sense similar to their English equivalents. I have myself translated the excerpts from the Polish transcripts needed for writing, trying to preserve women’s arguments and the flavour of their speech and trying to find as close equivalents as possible for the expressions they used.

4.2.6.1 Interviews not used in the analysis

I decided not to include in my analysis one particularly insightful group interview and three individual interviews as I ended up with low quality recordings. Women’s circumstances often meant that their children were present in the very room where the interview was conducted (nine interviews). While I strived to find strategies around those constraints, sometimes I failed to notice background noises which made the voices on the recording incomprehensible, making it difficult to analyse. Also, due to financial constraints I had no second person helping me with the group interviews (e.g.
taking notes and ensuring the quality of recording). During one group interview, I was invited to talk to a group which was too large (nine women) and participants often spontaneously split into groups, discussing questions among themselves. While I could somehow follow all the comments during the interview, the recording was a jumble of voices. I made notes after each of those interviews and they offered insights that furthered my understanding, yet I was unable to produce excerpts which could be used in the writing. Also, I noticed that insights from individual interviews were in fact scattered across interviews included in the analysis, with the exception of the group interview which provided a comprehensive account on the often patronising approach pervading the care of women who had their children as teenagers, and contrary to the system’s expectation, an evidence of their knowledge. However, this topic would warrant a separate study.

4.3. Generating data: interviews with photo-elicitation

In this section I describe the method of generating the data for my research, i.e. photo-elicitation interviews. I explain the objectives and address limitations of using such interviews as well as explaining how I selected the photographs.

4.3.1 Why interviews?

Interviews have been used widely in discourse analysis research. However, overreliance on interviews as a method of choice when generating data has also been critiqued for discourse analysis specifically by Potter (1996) and in qualitative research designs in general by Silverman (2014). While both authors argue for a greater use of “naturally occurring” materials in research, given their “artificial”, “manufactured” context and the influence of a researcher’s agenda and categories on their production, they agree that there is no type of data that is inherently superior. Instead, it is careful consideration of how certain materials facilitate our access and insight into issue under study and allow us to answer our research questions and how our materials fit with our theoretical assumptions (Carabine 2001, Rose 2006). What follows serves as justification for my choice of interviews, group interviews and a photo-elicitation method for generating the data for this project.
I decided to use interviews as rich material relevant to the topic of my study was difficult to access otherwise. Initially, in order to access women’s conceptualisations of technology I looked at online accounts from blogs, chat boards and discussion groups available in the public domain, as well as some published memoirs of pregnancy and parenting which seemed to comprise “naturally occurring” discussions of technology. These were to be combined with the interviews. However, while this provided me with an overview of how technology in maternity care is understood, it required sifting through large quantities of material irrelevant to the goals of my study. Also using online material precluded obtaining a broader context to accounts gathered in such a way. For example, it was usually impossible to identify the social context for such accounts, and the details of women’s encounters with maternity care services such as the type of care assessed. It was this “localised” context of face-to-face interviews that I came to consider a source of rich information for this research. Moreover, using the voices of people who are active online could have excluded voices underrepresented online and recruiting women for interviews according to the strategy described above (see section 4.2.2) presented the opportunity to balance such exclusions. Lastly, women often posted online to address a particular problem or intervention. This could have impeded framing technology in this research as a more comprehensive concept.

Having finally decided to focus only on interviews I carefully considered my objectives in conducting them. I intended the interviews to be “conversational encounters” rather than formal interrogations, as advocated by Potter and Wetherell in their early work on discourse analysis (Potter and Wetherell 1987: 165). As a result, I wanted to create such interview situations which would be comfortable and casual for women, where women could discuss technology in a way that respects their priorities and facilitates them in coming up with their own understandings. This is why I positioned myself outside “expert” medical settings (see section 4.2.1), decided to use photo-elicitation (see below) and started the interview with a broad open-ended question about women’s overall experience of maternity care. I also decided to conduct group as well as individual interviews hoping that this would facilitate the casual context of discussing maternity care and its technologies with people already familiar to women (e.g. interviews with spouses, neighbours, relatives). Due to constraints of funding and time,
only four such interviews were conducted. However, when analysing the interviews I realised that it was the casual character of interviews and the relationship between me and women which was more important than the number of participants in the interview.

4.3.2 Justification for using photo-elicitation

“Sociological questions are often not meaningful to non-sociologists. There is a need (...) of bridging gaps between the worlds of the researcher and the researched. Photo-elicitaiton may overcome the difficulties (...) because it is anchored in an image that is understood, at least in part, by both parties.” (Harper 2002: 20)

I explored women’s understandings of technology through conducting photo-elicitation interviews as described by Douglas Harper (2002), Gillian Rose (2006, 2012) and Marcus Banks (2007). This method of interviewing involves showing participants photographic material and discussing it as part of the interview. Photographs help to concretise issues which would have otherwise needed detailed verbal explanation (Blinn and Harrist 1991). Thus, use of photographs in interviewing is “an extremely effective way to convey highly complex and ideological concepts” (Bowden et al. 2016: 72). Consequently, photo-elicitation has been argued as useful in clarifying the purpose of research to participants and facilitating their better understanding of the topic. Also, photographs remind participants of what they had forgotten or see what is obvious in a new way (Banks 2007). Thus, I hoped that photographs may prompt women to reflect on the aspects of maternity care that they may not have otherwise considered. The use of photographs also meant that women’s responses to technology could emerge as reactions to them and allowed me to rely less on direct questions about technology.

I was apprehensive that understanding and discussing technology, particularly medical technologies used by medical professions within hospitals, could be seen as out of reach for women, making them uncomfortable to participate because of their “lay” knowledge. I wanted to avoid women feeling insufficiently informed and lacking expert knowledge to elaborate their views during the interview. I hoped that by using images I could lessen these reservations and bring the topic of my research closer to women, giving them confidence to discuss issues around technology in maternity care. Also,
using photographs has been advocated to enhance participant involvement in research (Collier and Collier 1986). The images helped women engage in our conversation, as what seemed abstract and perhaps not particularly relevant for at least some of them, became more comprehensible and easier to connect with their actual experiences of maternity care.

Practitioners of photo-elicitation agree that the use of photographs is helpful to establish a common ground between researcher and participants and to enhance their mutual understanding, particularly if there is a difference in experience, knowledge or status between them (Collier and Collier 1986). Photographs act as a “third party” in the interview (Banks 2007), and may lessen participant’s feeling of being directly interrogated as it is the photograph which becomes a subject of examination. This facilitates a less hierarchical and more relaxed context for the conversation as both researcher and participant turn to the significance of the discussed image, working together to understand it (Collier and Collier 1986, Harper 2002). This is particularly helped by the fact that looking at photographs is a familiar activity compared with the research interview.

4.3.2.1 Conceptualising a selection strategy for the photographs

In this section I will outline my understanding of the status of the photographs which I had shown to participants. I will outline my assumptions when choosing this and not some other set of images, and advantages and limitations of the final set of images.

Selecting the photos for my interviews was not an easy task. This was not only because of the vast amount of images actually available online but also the number of possible interpretations and possible potential of each image to serve as a prompt for discussion. The imagery of each photograph makes certain ideas and objects “visible in a particular way, and other things unseeable”, and within its “field of vision” certain subjects and practices are being produced as possible (Rose 2006: 143). Consequently, photographs may convey certain discourses and their imagery may steer participants in a certain direction. While I was mindful throughout the research about how their content might convey or obstruct certain messages, this content was not the subject of this study and I consider photographs simply as aids to communication and helpful prompts. It is
reactions to the photographs which are the material for my analysis. Thus, I did not attempt a detailed analysis of their rhetoric, as I needed to interpret them only insofar as to decide their relevance for my research. I selected the photographs in anticipation that they would help women consider technology and technological maternity care during the interview.

Making clear connections between research questions and the images used in the interview has been considered crucial to successful use of photo-elicitation in research (Rose 2006, Suchar 1997). My choice of photographs was guided by a careful conceptualisation of what content I was looking for and I evaluated possible photographs for their “fit” with the subject of the study, its aims and theoretical assumptions. It was also guided by my conceptualisation of technology in this research. However, my hunches as to what might be “particularly productive” and thus “work” in the interview and accidental discoveries also played a part (Rose 2006: 149). There were images which just happened to exist and images which I had in mind but could not be found. Images chosen in the end were selected based on my knowledge (e.g. what I considered to be routinely present and used in maternity hospitals). There would always be a photograph that could have been added and I kept thinking of additional photographs which were “missing” or could have “completed” my set of photographs. However, at some point I had to make some pragmatic decisions and start the interviews.

4.3.2.2 Towards a standard imagery of technocratic maternity care

Following the above assumptions I conducted a methodical search for the photographs over the span of a few months through Google images. This search had some similarities with one undertaken by Bowden et al. (2016) of birthing room photographs available online. While their search was limited to birthing rooms, it was perhaps easier to operationalise, whereas my topic of the search was much more abstract, and thus search phrases were more subjective, less concerned with quantitative “representativeness” and dependent on careful theoretical conceptualisations.

I started with a list of search terms consisting of what could be classified as “technological” aspects of maternity care within the hospital setting and what could be
considered as less technologised imagery or the imagery where the technological aspect is not conspicuous. I was looking for images of rooms with equipment and a clinical appearance, but also rooms which were in a hospital but “homely”, where most of the equipment is hidden. I searched for depictions of women being cared for within those settings as well as exemplars of equipment (both complex and simple, e.g. both high-tech CTG and the low-tech Pinard and Doppler). My searches included phrases such as “hospital birthing rooms” with sub-terms “high-tech”, “medicalised”, “low-tech” and “home-like”. I searched for “birthing centre room”, “home birth” and “water birth” hoping to explore women’s reaction to less technologised settings for birth. I searched for “women in hospital giving birth”, “women with fetal monitoring/CTG”, “women giving birth Pinard/Doppler”, “cesarean section”, “cesarean section theatre”, “cesarean section woman”, “woman giving birth induction” and I specifically sought for those with women’s care providers depicted as caring for them including “doctors/obstetricians”, “midwives” in the search. I searched for “technology childbirth”. Some photographs were found accidentally while browsing through blogs and websites and these were also included. When choosing the photographs I was hoping that they would be an adequate representation of what is accessible online and thus familiar for women.

As a result I gathered a wide selection of photographs of “technologised” and low-tech settings for birth and close-ups of a variety of devices present in the birthing room to evaluate what was available for me to access. I also had photographs depicting women being cared for within different birth settings. I included low-tech settings such as midwifery-led units and home-like facilities equipped with “devices” such as birthing balls and mats, as well as photographs from homebirths and women birthing in pools (these from the UK, as the above were not available in Ireland during the pilot phase of my interviews). An initial set of photographs was chosen shortly before the onset of pilot interviews which were conducted in June 2013 and included relevant photographs supplied by friends and colleagues as the search by Bowden et al. (2016).

As my conceptualisation of how to generate my data evolved after the pilot interviews, I realised that what I needed were the photographs which would evoke the sense of “standard high-tech hospital environment” for the users of maternity care in Ireland. These should be technological but not in an overpowering manner (see Appendix 7:
photos no. 1.1 – 1.3, 2.1 – 2.3, 3.1 – 3.3). Bowden et al. (2016) describe two types of technological birthing rooms which I consider as “standard”: those with an overt technological focus and those where such a focus is concealed by “homelike” decorative furnishings, considered “hybrid” spaces which “domesticate” hospital environment while maintaining its technological potential (Fannin 2003). The former correspond to photos 1.1 and 1.2 used in the interview, the latter to photo 1.3. In Ireland most of care during birth is provided within environments with a technological infrastructure for performing complex procedures as the most prominent feature, so while these are not ordinary in the context of women’s everyday lives, they are ultimately familiar as places for birth. While “homelike” technological rooms are not standard in Irish maternity care, they are included to explore if women see them as any different in responding to their needs.

As a consequence of looking for “standard” and familiar depictions of the birthing environment in the Irish context, I have only included a photograph with technology being conspicuous and its presence potentially overwhelming for participants at the end of the interview (see Appendix 7: photos 5 and 6.1 – 6.3, as well as photo 8). Similarly, I have also included photographs of a low-tech birthing suit with a birthing pool only after extensive discussion on standard hospital rooms (see photos 7.1 – 7.3). As this low-tech room had been opened in The Coombe Women’s Hospital a few months before the main round of interviews, it provided a local, familiar context for inclusion of such an environment in the interview making it a little less atypical for participants. The

61 Bowden et al. (2016: 74) characterise the “technological birth room” as focused on the bed, equipment, and easy maintenance of hygiene, i.e. as focused on “medical functionality”. The “hybrid domesticated” room, depicted by Fannin (2003), reflects an attempt to conceal this medical focus. While its “homelike” qualities suggest “a fusion of the physiological and medicalised approach” (Bowden et al. 2016: 74), it actually sustains the technological focus by the central position of the bed surrounded by the equipment.

62 After pilot interviews I had refrained from using images suggesting uniformly “alternative” approaches in maternity care (e.g. photographs from waterbirths and homebirths) because they were often perplexing for participants in a way that was not helpful in focusing our conversation (e.g. participants were extremely uncomfortable and aggravated or went off on a tangent and discussed, for example, the irresponsibility of people who engage in alternative birthing practices). Replacing such images with a low-tech elements within standard environments was planned to actually engage participants to discuss their possibility rather than dismiss them. While the very reactions of participants to those alternative environments would be worth exploring, I realised that reactions to them were material for a separate study and I thus decided they are outside the scope of my research. The photographs from the Irish public hospital were less unfamiliar alternatives and women could at least consider them as something they could engage with in a meaningful way and thus they “worked” much better.
photographs of those less ordinary environments: the overly high-tech and only recently introduced low-tech room with a birth pool had a function of “breaking the frame” (Harper 2002: 20-21) of taken-for-granted, normalised views of maternity care, at least for those participants who had not experienced or were not accustomed to them. They were also the only photographs which did not result from the online search, the high-tech being sent by a friend, the low-tech one provided by my supervisor.

4.3.3 Asking questions about technology

I prepared a list of issues I wanted to explore in the interview and sample questions to ask, as well as some prompt questions to accompany the photographs inviting women to elaborate on what they were seeing (for Interview guide, see Appendix 6). However, these were not intended to be asked in a uniform manner and the actual questions depended on what participants were bringing up and the flow of our conversation. The section with the photographs was fairly structured and I discuss the reason for it below.

I began the interview with an opening question asking women to describe their experience of maternity care to avoid asking about technology directly from the start. This allowed me to recognise women’s hierarchy of importance and observe the role of technology in their encounters with maternity care without actually bringing it up as a topic. I did ask about women’s first thoughts about technology afterwards, in order to clarify the topic of our conversation. However, depending on the interview, this was done more or less directly, e.g. sometimes I asked about technologies women remembered from the hospital or about changes technology had introduced into our lives.

In the second part of the interview we turned to the photographs. Keeping track of which photos were discussed in the interview initially proved a challenge for me as a sole researcher because I also had to focus on conversation with women. During the pilot phase, I spread the photos on the table and let participants choose which of them resonated with their view of maternity care or technology but this proved impractical and not feasible. Thus, I decided to show photos in a roughly similar order. I put them in the “thematic” envelopes containing between one to three photographs on a similar topic which were always shown together. This allowed me to get much clearer about
the purpose of using photographs and focused the interview. However, sometimes I changed the order of the envelopes or skipped one altogether if this seemed appropriate (e.g. if the woman had already discussed the “theme” from the envelope).

After discussing photographs I asked women about the future of maternity care as they see it and about imagining inventions which could help make birth better for women and their children. While each conversation roughly followed this structure, it was not my objective to abide by it in a rigid manner. I was flexible and sensitive to any issues voiced by women outside of this structure.

4.3.3.1 Definition of technology during recruitment and interviews

While I aimed to avoid suggesting what technology is and does for my participants, I had to somehow define the topic of our conversation during recruitment or clarify it during the interviews when women asked me directly about what I meant by technology. In those instances, similarly to my information leaflet (see Appendix 4), I rephrased the question and asked them about “medical procedures” they knew of or remembered undergoing in the hospital, and if they remained confused I asked about the medical “devices”. This meant supplying women with the very reductionist definition of technology I was striving to move away from in this thesis. While this was not ideal, it served the purpose of overcoming at least some confusion. However, when a term such as “technology” was not clear for women in the interview, I did not press further and moved to the photographs, as these were invaluable in conveying to women what our conversation was about.

4.3.3.1.1 On being asked questions about technology

Every summer at my university there are English courses for students from abroad. They are given a task to approach strangers and ask them a few questions prepared by their teachers in order to gain confidence in speaking a foreign language. The questions are always general in their nature. While I was on my break from work, two women who were such students approached me and asked me their assigned question. It was about my opinion on the most important technologies we currently have and technologies I could not live without. I was unable to give them any satisfactory response to their
question as I had just spent months thinking about what I even think of as technology. Unexpectedly, I found myself at the “receiving end” of my interview question and it occurred to me how difficult this very question might have been to the women I had interviewed, and how confused some of them must have felt. I had to admit that perhaps up till this point I did not fully realise what it was like to be asked questions about technology during the interview I myself had conceived. This was a humbling experience which revealed to me my own unawareness when it comes to the power of being the one controlling the interview situation. It helped me to put myself in women’s position and perhaps better understand the insights we went on to create together during interviews.

4.4. Analysis: “thinking with theory” rather than coding

“interpretation and analysis does not happen via mechanistic coding, reducing data to themes, and writing up transparent narratives... that reduce complicated and conflicting voices and data to thematic “chunks” that can be interpreted free of context and circumstance” (Jackson and Mazzei 2011: vii-viii)

“theory serves to hold me accountable to the complexities of doing research” (Childers 2012: 752)

Following the theoretical intricacies of feminist poststructuralism and discourse analysis introduced in Chapter 3, my method of analysis attempts to “disrupt regulatory practices of qualitative inquiry” (Childers 2012: 753). These rest on coding data into themes and categories and stem from the positivist approaches and notions of quantitative analysis where the aim is to achieve clarity and coherence through systematic application of predefined procedure (Childers 2014).

According to poststructuralist scholars coding leads to understanding which lacks depth and “takes us back to what is known” (Jackson and Mazzei 2011: 12) rather than producing insights which are extensive and new. While this practice may sometimes be helpful and makes analysis seem more manageable, it is often achieved at the cost of downplaying the messiness and doubt as part of our analysis (Childers 2012, 2014). Instead, Jackson and Mazzei (2011) advocate “thinking with theory” to mitigate against “pedestrian and uninteresting” outcomes of analysis based on mechanistic coding (St...
Pierre in: Jackson and Mazzei 2011: 11). If we are to avoid our research being merely “extended descriptive exercises with little explanatory power” (Young 1969: 492), we need comprehensive reading of theory to provide an “adequate conceptual foundation” of the purpose of our analysis (ibid.: 489).

As a result in my feminist poststructuralist analysis I was careful to pay close attention and embrace rather than discard conflict, rupture and irregularities in my data. It is the moments of irreducible puzzlement and ambivalence, both women’s and my own, which have often led me to the most profound realisations.

4.4.1 Initial analysis and coding

Coding, or any other systematic, *a priori* structural process of analysis, is a failed attempt to discipline a world that is uncontainable (Childers 2014: 819)

At the beginning of my analysis I endeavoured to code my materials in a conventional way to sort them into “themes”. Also, when I became sufficiently familiar with my interviews, I started using qualitative analysis software MAXQDA 11 to help me with this task. This process of “coding” was helpful in organising the interview material and gave me an overview of issues raised in the interviews as well as some regularities within them. However, it also resulted in an overwhelming list of “codes” difficult to contextualise, and difficult to connect to my theoretical concepts and assumptions. I learnt that simply “coding” my interviews was insufficient to meaningfully explore the ambiguity and conflicts I came across in women’s accounts. Also, some of my initial “findings” seemed somewhat predictable for a person well informed on my topic, and some could have been arrived at by reading already existing literature on women’s experiences of birth and medical interventions associated with it. Such experience of the initial coding resonates with the stumbling blocks described by, for example, Augustine (2014), Brinkmann (2014) and Childers (2014): feeling out of control, uncertainty and doubt. It forced them to question conventional practices associated with doing qualitative research and to resist their “seductive nature” (Childers 2014:

63 Scholars writing on doing discourse analysis advise that coding is “a way of organising the categories of interest” (Gill 2000: 179), yet warn against considering coding as sufficient to perform analysis (e.g. Gill 1993, Taylor 2001, Tonkiss 2004).
819) of making research appear more manageable. This was the point in my analysis when I went back to studying theory.

4.4.2 Folding in “thinking with theory” into my analysis

I went back to reading feminist poststructuralist scholars and carefully considered how genuine poststructuralist discourse analysis could have looked like. I engaged with current debates in qualitative inquiry about the ways of doing research “after poststructuralism” (Lather 1993) and “after coding” (St. Pierre and Jackson 2014). As a result “thinking with theory” as outlined by Jackson and Mazzei (2011) has become crucial to navigate my analysis and enabled me to “do more” with my data (Lather in St. Pierre and Jackson 2014: 715). Still, I did not discard the codes and themes from the initial stage. They became a thematic depository, expanded as I proceeded with my analysis, useful to navigate through the interviews and access necessary excerpts, as well as a storeroom for ideas still to be situated within my analysis.

“Thinking with theory”, i.e. immersing oneself in conceptual frameworks of methodological, epistemological and sociological theories and considering them central for analysis helped me make sense of my data in a way that was missing from the conventional approach focused on coding. Thinking with theory prompted me to start reading my interviews in a much more focused way. I started trying out different strategies to connect concepts from the interviews to theories I was reading. I explored the differences and similarities in the way women were reacting to the same photographs and questions, I explored recurring arguments and women’s strategies across interviews, I explored conflicts within one sentence in the same interview. I paid close attention to the unexpected turns in conversation and what appeared to be inconsistent. I took note of women’s intonation, use of vocabulary, of their eagerness, reluctance or even lack of interest to discuss certain issues, hesitations and silences. In the midst of this I went back and forth between theories from the earlier chapters of this thesis and the data from interviews several times. Such analysis has no step by step recipe, it is always partial and relies on intuition and learning by doing to make connections between different aspects of our research, as much as the extensive reading and, in the case of this research, following news reporting, policies and quality
assessments of Irish maternity care. It produces multiplicity and excess, full clarity never to be achieved but never being its goal in the first place. However, it enables us to see what we investigate in a more complicated way.

4.4.3 Representing women’s voices and producing “responsible knowledge”

Our analysis inevitably fragments our participants’ voices to some extent and represents them according to our research agenda. In order to avoid grave misrepresentation Skeggs (1997) suggests striving for “responsible knowledge” (ibid.: 167) as we proceed with our analysis. “Responsible knowledge” is as much an ethical as an epistemological endeavour and it rests on “constant critical reflexivity, sense of responsibility and commitment” (Skeggs 1997: 32) towards our participants and acknowledgment that there is more than one interpretation of their words, ours having the aim of being “the most plausible explanation” we can advance (ibid.). This allows us to make clearly located claims when producing our research account.

With this in mind, throughout the analysis I compelled myself to consider alternatives to my interpretation and suggested these in my writing. I also signalled uncertainties in my interpretation. In this way I aimed to convey the futility of thinking about technology in a singular, unitary way, and the necessity to include other ways of discussing it in the debates we need as a society. I asked myself about women’s actual interpretation issues brought up in the interview and how it might differ from mine. I paid attention not to fragment women’s accounts into parts which are easy to categorise, and can be reassembled into a coherent narrative, trying to preserve their context and complexity. I took care to interpret what women were saying within the context of the whole interview, their overall maternity care experience, and not use the excerpts from the interview in disconnection from this broader context.

Sometimes women’s responses to the initial interview question suggested a very different view of their care, and birth technology, compared with their observations at the end of our conversation. I could often see how their understanding of what technology is and does had substantially evolved and clarified as we proceeded. Thus I kept in mind what was said initially and eventually, what preceded a particular statement and what came after it, and how women articulated their understanding
throughout the interview. This was particularly important to preserve rather than curtail ambivalences and conflicts women were wrestling with in their accounts. To this end, the way I asked questions and made comments was important. Consequently, I checked how I phrased them in any particular case, what vocabulary was used, to see how it may have influenced the response. I flagged those excerpts where I felt the woman’s response was clearly steered in a certain direction by my choice of words. Also, I paid close attention to the way particular statements were spoken, e.g. women’s hesitations or confidence, animation or lack of interest in women’s voice and these aspects were part of interpreting women’s accounts. I examined closely women’s accounts for such excerpts where women brought up an issue of technology spontaneously and elaborated on it, rather than when I had suggested it, in the hope that this would help to balance my control over the topic of our conversation and its framing. While reading the interviews I had deepest respect for women’s knowledge and their effort to explore and understand the issues I had asked them to consider.

4.4.4. Conclusion: turning to analysis

This chapter concludes a preparatory part of my thesis outlining the background for my research, the essential definitions of its concepts, the epistemological and methodological frameworks for understanding and producing my own interpretation of women’s accounts, as well as the method of generating those accounts. In the chapters which follow, drawing on this preliminary work, I present my analysis of women’s understandings of technology in maternity care.
Chapter 5
Reassurance: What is technology? What does it do?

5.0 Introduction: on removal of doubts and fears

There was no machines, no scans, it was just... they would just listen to the heartbeat through [your] tummy and that was it. No modern technology. (...) [Now] I suppose the reassurance... there is more. If I would have had a baby thirty years ago I probably would have been terrified even more. Or you probably wouldn’t have known any different. (Cecilia)

This chapter is concerned with women’s conceptualisations of technology and aims to examine how women negotiate the claims of the maternity care system framed by the technocratic biomedicine. While this dissertation is an attempt to answer the question of how women understand technology in maternity care, in this chapter I explore women’s understanding through the following, more specific questions: What does technology actually “do” according to women? How do they see the purpose of its presence in the birthing room, how do they understand its function? In Foucauldian terms, this chapter is about the way technology “works” for women, both its effects, and the discursive resources available for women to craft their understanding.

Women’s understanding of technology is complex and ambiguous. Even for those who embrace high-tech maternity care, the reasons for this are multifaceted, and whether technology does actually fulfil its promises is problematic. As this is poststructuralist research, it is those ambiguities and disunities of women’s understanding of technology, rather than providing “fixed” definitions, which are my focus. These are seen as productive and necessary to help us see technology in a different way and to dispute the comparatively unproblematic view of birth technology in the dominant public discourses. These focus on discussing extensively its benefits, while its downsides, as observed by Bauman (1994, see also Bauman and Tester 2001), are given perfunctory attention, and are considered as an afterthought.

I begin with demonstrating women’s confusion with the notion and the function of technology in section 5.1. In section 5.2. I argue that apart from the association of
technology with high-tech resources in the provision of maternity care, technology for women is about a means of “knowing” (i.e. its use supplies information and conveys knowledge) and “doing” (i.e. it allows us to respond to problems when they arise).\textsuperscript{64} However, there is another quality of technology which derives from technological “knowing” and “doing”\textsuperscript{65} for women: it is reassurance. Yet, as demonstrated in section 5.3, the opposite of reassurance, i.e. anxiety and fear, also stem from technological “knowing” and “doing”, and are equally as pervasive in women’s associations of technology and their reactions to images of high-tech birthing environments. In the subsequent sections, I examine the issue of disembodiment induced by technology which hinders reassurance (5.4) and women’s recognition of other ways of knowing in maternity care which support it (5.5). I conclude the chapter by discussing the claim of reassurance provided by technocratic maternity care as reductionist and overstated.

Women’s association of technology with reassurance is facilitated by the assumptions of technocratic biomedicine. It is the unpacking of this association which is central to my conceptualisation of technology in this chapter. In the Oxford English Dictionary (OED) reassurance is defined as “\textit{a statement, comment, or other verbal communication that removes or allays a person's doubts or fears}”, as well as “\textit{a removal or allaying}” of such doubts or fears stemming from such a statement or comment “\textit{by something other than words, such as an action, attitude, or belief}”. It also refers to “\textit{a thing or fact which, or a person who, removes or allays doubts or fears}” (OED 2007). Thus technological resources, as well as technological knowledge and action, or a person skilled in the use and understanding of those, is reassuring when it alleviates a woman’s doubts and fears.

The opposite of the action to “reassure” is to increase anxiety, the dictionary suggesting its antonyms “to alarm” and “to unnerve”, the former defined as “\textit{an anxious awareness}”.

\textsuperscript{64} While technological “knowing” and “doing” are interconnected (e.g. information can lead to diagnosis of problems), their relationship is not straightforward (e.g. more often than not problems are not diagnosed based on the information) and this is why I see their analytical separation as helpful.

\textsuperscript{65} I call these “technological” to differentiate them from other ways of knowing and doing which matter in maternity care and are not technological or are considered low-tech, for example, women’s own capacities and knowledges, as well as ways of knowing and doing associated with the body of knowledge and skills of midwifery, which cannot be viewed solely through notions of rationality and knowledge which is certain, measured, quantified.
of danger”, the latter as making somebody “lose courage and confidence” (OED 2007). I argue that women’s voices captured in this research, as much as our everyday conversations about pregnancy and birth, or the popular depictions of birthing in the media are the evidence that these latter definitions of what constitutes the opposite of reassurance, describe quite accurately how many women feel about birthing in our current technocratically oriented maternity services.

5.1 Women’s initial responses to the notion of technology

Well technology has permeated everything, like there’s very few avenues of life that are unaffected by technology (Kay)

Everything’s to do with technology, yes. (Lynn).

The material for this section comes from women’s responses to a direct question about their associations with technology⁶⁶, and it thus explores women’s initial thoughts on technology in general as well as for birth. Those responses were sought after the interview had taken a sudden turn, from women’s intimate experience of maternity care to the topic of technology which might have felt remote and abstract to them (see Appendix 6 for Interview guide). This proved a surprising change of subject for a number of participants, despite their overall familiarity with the research topic. Consequently, it is possible that women’s uncertainty and hesitations answering the question about technology in general, presented in this section, is a result of this abrupt transition in the interview as much as women’s more general difficulty pinpointing its characteristics and giving examples. Despite their hesitations, the confusion around its definition, and their sense that information and knowledge about it is not made accessible to them, women’s reactions demonstrate a good sense of what technology is.

This section draws on the reflexive considerations from the previous chapter (see section 4.3.3.1.1) and, in line with poststructuralist assumptions, does not aim to search out what technology “really is” for women (see Chapter 3). It acknowledges that

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⁶⁶ In the interview I usually asked the following question: What do you associate with the word “technology”? While some women in response to this question were talking about technology in general, other women considered solely technology used in maternity care, as this question followed the description of their birth experience.
identifying technologies with clarity might not be an easy task for any of us due to its variety, complexity and ubiquity. Consequently, women’s responses have to be interpreted in the light of the above considerations.

Most women respond to the question about their associations with technology not by defining it but with actual examples:

The CTG, the... what you call it... I'm not sure if it's technology like... the drugs are technology...? I suppose the CTG, the epidural, the... [long pause] (Sybil)

Gala: First thing I think, there is the scan to know the position of the baby for delivery. (…)
Lenka: Yes, scans, they could see the heartbeat and all that.
Gala: You could see it on the monitor.
Lenka: ... and [see] how long you should take and how long... maybe an emergency caesarean. Yes, I liked it. What else... technology... they give you the option for epidural, for the gas and all that.

Beside me was the little screen for monitoring the baby’s heart rate and there was pages printing out of that the whole time I was there and... no, nothing else other than that really. (Nora)

Women’s accounts suggest that their first associations of birth technology are with equipment and medications. However, they also demonstrate women’s (and one man’s) uncertainty about its definition, as they hesitate and consider themselves not knowledgeable enough to speak about it with confidence:

machines they use to monitor, medicines as well, medicines, machines and knowledge of the doctors as well. (…) that machine I was on all the time... the heart monitor machine. The... I don't even remember, by the time you go into labour you don't even know. (…) You don’t really pay attention to what machines or what they’re using or what they’re testing or anything like that. (Cecilia)

the anaesthesia. Second time round we had more, first time was... my wife had a natural birth so it was only the anaesthesia I can think of. (…) But it was caesarean the second
time round so they hooked her up to all the equipment. What kind? I don’t know much, I wasn’t allowed to look at certain parts of the room. (Aleksander)

Knowledge of technology and its purpose feel impenetrable or out of women’s reach, it is in the realm of the experts trained to manage its use and purpose:

Well I know we’re going to use an app for the contractions (...) Other technologies? Uhm... well... I’m going to use my TENS machine. In terms of hospital technology, that’s all a little bit... (long pause) inaccessible probably, like even though we were shown where we have to go to the delivery room (...) I think you just can go "okay, well you guys know what you’re doing", you don’t really question it (Grace)

Within a technocratic approach, using technology is equated with expertise and as a result it appears for women inaccessible despite it ubiquitous presence, as observed by Lynn and Kay at the beginning of this section. Despite this omnipresence, one woman’s reaction is of sheer confusion:

What do you mean?
[Q: What was used during your birth...?]
What do you mean... by technologies?
[Q: Things like equipment. Where they using any...?]
No.
[Q: So there was nothing, all natural...]
Yes, just "leave me there" (laughs). (Shauna)

The responses above illustrate succinctly women’s uncertainties and hesitations when it comes to conceptualizing technology. However, in the last excerpt I am included as taking part in women’s struggle to arrive at the understanding of technology. For Shauna the question of technology is neither a clear nor meaningful one. Unsure of what is expected of her, she turns the tables on me and becomes the one asking me to define technology for her. After my awkward answer as I squirm not to “suggest” the definition to her and then end up suggesting enough to “spoil” her response, we move to another question.
However, some women are much clearer and more confident about the purpose of technology in the birthing room. They point to a much broader understanding of what technology is and what it does:

would you consider knowledge to be a technology? (...) we have used technology in order to give us knowledge of the physiology of the human body. So we know what the birth canal, at least medical professionals know what the birth canal looks like or how it works and so, that’s a positive, the knowledge, the intelligence about the female body.

(Lynn)

I think technology, it's two different capacities; I think the ability of technology to convey knowledge, not just information but knowledge, is incredibly important but the use of technology on things, on living problems if you like (...) I think it may get pretty evil. (Kay)

In this more comprehensive understanding, technology is associated not only with narrow technological expertise but overall, with providing us with knowledge which can be used for different purposes. And it is those two qualities of “knowing” and “doing” which I examine in the next section.

5.2 What does technology do? Technology as “knowing” and “doing”

There is a number of ways for the midwifery or the obstetric team to know how the baby's heart is doing. First is to actually look at the screen and there actually be the heart rate on it. The second thing is that there's actually a paper print out so it's a cardiograph and you'd actually see exactly! - we could read it fairly quick so I don’t how they weren't able to read it – so the CTG graph comes out. And then the third indicator is an alarm – no sorry, there is two more! – so an actual audio alarm goes off if the baby's heart rate is... there is concern... you know just to check up and there is also the light [laughs in disbelief] at the top of the machine to flash as well. So there is plenty of indicators with this machine to notify the staff if the baby is in trouble saying 'listen, something's gone on here, I don't like what's happening, get me out or do something'. (...) the reason we were so conscious of the alarms from the very beginning was that the alarms went off with my first three boys (...). **Alarms go off. Big panic. Suction, forceps.**
And then your healthy baby is there. (Roisin Molloy, The Ray D’Arcy Show, RTE Radio 1, 8th May 2015)

In the account above Roisin Molloy, whose baby died soon after birth as a result of substandard care in Portlaoise Hospital\(^7\), explains how continuous fetal monitoring works and what could have been done based on the information gleaned from it. Apart from associating technology with resources such as machines, surgical procedures or medications, and the expertise involving their use, this is how technology has come to be seen in a public discourse: as providing objective information or knowledge which determines possible practical actions to be undertaken as well as providing means for such action.

5.2.1 Knowing, seeing, hearing

“The power of authoritative knowledge is not that it is correct, but that it counts” (Jordan 1997: 58)

Roisin Molloy in her account of her baby’s birth and death as she began to understand the context, initially invested technology with allowing us to see, hear and consequently know. The women in my interviews see technology in a similar manner, where technology-enabled “knowing” is seen as complete and thus fully reliable, particularly if performed continuously:

when we went to the normal doctor, the GP, she had some small contraption thing and **you could hear** the heartbeat, every time I heard it I’d cry. (...) and then in the hospital when you could see the nuchal test, the first scan... when **you could see**... we could see his hands moving and punching around and you’re looking and you’re hoping he has a big nose because they say a small nose is a sign of Down’s syndrome, because we did the test **to see** because I was old... and the other test, the one they found out is it a boy or a girl... you realise that test is not about is it a boy or a girl, that is **seeing** is the heart

\(^7\) Roisin’s son Mark Molloy died on 24th January 2012. The circumstances of his death, and the deaths of three other babies in HSE Midland Regional Hospital, Portlaoise between 2006 and 2013, as well as their parents’ struggle to obtain information, were exposed in RTÉ Prime Time Investigates programmes on 30th January and 3rd April 2014. This had triggered the reports by the Department of Health (DoH 2014) and the Health Information and Quality Authority (HIQA 2015). I acknowledge that this is Roisin’s initial understanding of CTG and that this may have evolved during many months of investigations which have only recently concluded (Cullen 2019, O’Regan 2018).
all there, does he have two legs, does he have ten fingers so then you think all these things [as technology], and then my parents are like ‘oh my god we had nothing like that in my day’... and then the baby’s heartbeat the day of the labour, all the belt and the thing, so they monitor everything so they can see (Claire)

**They can see.** I was in the labour ward with my little boy and on the machine it showed that he was in distress (...) they could see he was distressed because of the machines. (Cecilia)

it’s monitoring constantly (...) it’s continuous and they capture anything if the alarm goes off. (Gina)

That's the thing... that tells them everything that's going on, is it? (Tara)

According to the women I interviewed, technology allows us to find out whether there are any complications and does it in an undeniably valid manner. Technocratic biomedicine encourages the notion that information provided by technology is authoritative and the most legitimate (Jordan 1997). As a result women invest it with capturing “everything”, “anything” or “all” and “seeing” something on the screen becomes equivalent with knowing exactly what is happening to their babies.

**you get to see** the baby (dreamily), it gives you that hope, the baby is alive because you can hear the heart beat very clearly. (...) it lifts you up (Eshe)

it was really reassuring and getting to see the baby moving because you’re always panicking, it didn’t move today, it must have moved and I just didn’t notice. It is just so reassuring to see it. (Eva)

it was really super advanced technologically. And it was 3D, **you can see everything.** (Gabriela)

our anomaly scan was amazing. She was able to explain everything to us and she turned on this red and blue light and **she could show** the blood in the heart chambers: if the red and blue are going into each other it would be a heart defect, and they were measuring parts of the neck to show that the baby would be able to walk properly (Sheila)
And they were obviously doing scans. But I had additional scans back home [in Poland] anyway. Why? To see my son. To calm myself down. For my own state of mind. (Marzena)

However, women’s responses also demonstrate how this “knowing” is not only about its presumed role in achieving a good outcome, it is equally about “managing” their emotions. Such “emotion work” is entangled with societal values and beliefs (Edwards 2009: 36) and according to those beliefs, technological expertise is where women are to turn with their apprehensions, to get “hope”, to “calm themselves”.

5.2.2 Doing

The complexities, conflicts and paradoxes of technological knowing are similar to those of technological “doing” which is another prominent feature of technology in the birthing room for women. In Chapter 2 (see section 2.1.1), I discussed technology as a resource allowing us to act, to “manipulate and control the natural world” and, in the context of health care, technological “doing” can be conceptualised as “solving a particular health problem” (Wagner, M. 1994: 5) and this is how it initially appears in women’s accounts:

I do think it [CTG] is good for women that have problems with their children, may have a heart problem, you can get the baby come out quicker and then save the mother. (Sally)

I suppose [technology] it’s good to have because you can prevent deaths or if the baby is in distress you can quickly do a section if you need to if you haven’t planned it. With the scanning machines you can pick things up earlier. (Kelly)

Consequently, its sole presence appears to women as ensuring the availability of means for a rapid diagnosis leading to a prompt treatment of any complications that may arise. Technology as “doing” is most clearly visible when its lack is viewed by women as the inability to do anything at all:

[in the past] it was just you on your own giving birth and there was not that much we could do. You would have had a baby and that’s it. Now that you know we have a modern technology should anything happened, even if you have your baby early, you
do know that the chances are that we have medicine, the equipment and everything for you and the baby to be ok. (Cecilia)

I delivered the baby on my own, I could have been in a field doing it, there was nothing, there was nothing at all and I didn’t feel any support or any intervention (Eva)

In the accounts above, giving birth before birth technologies were available, or away from those technologies, is associated with the lack of means to act and assist women in any way. However, for Eva, this is evoked by repeated disregard for her requests for assistance from her carers, which she emphasises throughout the interview, and not by the unavailability of technologies.

Technological action is seen as more accurate and immediate, its results superior and more certain compared with the absence of technology:

[technology] gives this certainty that the child... is in good hands. And that women are not suffering as much as they used to in the past. Also, the risk is lower, it is sometimes a risk to give birth naturally but now you can do a caesarean. (...) In case of complications you can always respond, you can help. (Aleksander)

I think going in to have a baby now, it’s... you have the worry about the baby but that’s like with every worry and modern technology can’t save you and your baby from certain things. But for majority of things in your life and baby's life you know that you are in safe hands. (Cecilia)

Technology is seen as responsible for saving the health and lives of women and babies, and relieving the pain of labour and birth which under the technocratic paradigm is yet another problem or a “complication” for technological “doing”68. Interestingly, in both the above excerpts participants refer to having access to technology as being in “safe hands”, though it is not actually the “hands” associated with the low-tech skills of midwives which are being used but sophisticated technological implements. The hands are used only to skillfully operate these technological resources.

68 For a discussion of pain in childbirth as pathological and considered solely as “complication” within the biomedical approach see: Leap and Anderson (2008). Leap and Anderson (2008) term such an approach a “pain relief paradigm”. They discuss an approach alternative to and coin the term “working with the pain” to describe it.
5.2.3 Doing and knowing as inseparable

However, for the most part, as in Roisin Molloy’s previous account, technological “knowing” and action are inseparable and conceptualised as if “naturally” following from each other:

they can tell, they can do the test to see what is required (Cecilia)

[this checks] if the baby’s heart keeps beating, if the heart rate is good or if the baby is perhaps stressed out. They knew, for example, when our daughter was being born, they knew... there was a moment when she, I don’t know, stopped breathing? Or her heartbeat stopped... while pushing. They knew how the baby was doing. And perhaps this is why, if the baby’s heart would stop, they can always do a section and take the baby out quickly. (…) Otherwise they don’t know. They see what is going on inside on the screen, and they can make a decision. (Aleksander)

They were able to tell that there was a problem. They could see [on CTG], they were considering to do the section straightaway, in case anything was wrong, to take him out, to save him. (Gabriela)

that’s to monitor the heart and that’s for the drip. (...) so if anything goes wrong their response can be quicker. (...) With labour, if everything goes ok it’s great but there are lots of things that can go wrong so the sooner you know there is something wrong the better it is. (Javier)

if I had a question about my labour, I’d like for them to go back and to be able to say, “This is what happened on the CTG and that’s why we did it.” (Sheena)

Oh I’m very happy in the hospital, I do not want to have a baby at home, give me technology and give me the obstetrician... I don’t care if we were within radius [of the hospitals], you hear all these things going on, give me the experts and give me ‘what if something goes wrong’. (Claire)

At the first glance it seems that women’s understandings of technology closely resemble August Comte’s assertion regarding modern science, which is “to know in order to
predict, to predict in order to be able to act”, and by extension, through their interlacing relationship, modern technology (see section 2.2.3). Thus initially, the techno-scientific “knowing” seems to be valued by women for its ability to predict complications and deal with difficulties, providing means to act in the birthing room. This also echoes the dictionary definitions of technology explored in Chapter 2, where it was associated with a particular type of knowledge ("knowing"), and application of this knowledge ("doing"), apart from being defined as the more tangible products of this application (resources) (see section 2.1.3) featuring in women’s initial reactions to technology discussed above. Yet for women the above capacities of techno-scientific knowing and doing are merely the means to an end: to ensuring their children’s and their own wellbeing. What is equally important however, is the potential of technology, persistently alluded to by women, to calm their worries and alleviate their fears, in other words, to reassure them.

Technology for women becomes the means of building their confidence and achieving a sense of security during pregnancy and labour, as much as the guarantee of good outcomes. It is this “removal of doubts and fears”, i.e. reassurance, which I consider the main quality of technology emerging from women’s accounts. And it is this quality that in women’s accounts emerges as resting on the most problematic premises which I set out to examine in the subsequent sections of this chapter.

5.3 Questioning the reassurance from knowing and doing offered by technology

“the fact that there is apparently enough doubt in the mind of the doctor that he may have ‘missed something’ confirms for the patient the validity of his fears. With each new attempt to gain the certainty that there is nothing wrong the patient's anxiety - and hence perception of threat – increases” (Warwick and Salkovskis 1985: 1028)

What also emerges in women’s accounts is that technology is actually a source of knowledge as much as confusion and that technological action can be inappropriate or may induce its own harms. This means that using technology in maternity care might

Bauman (1993: 188) provides Comte’s maxim in French: “savoir pour prévoir, prévoir pour pourvoir”. It is translated by Martins (1998: 158) as “to know in order to predict, to predict in order to be able to act” and considered as the motto of “technocratic positivism” (ibid.).
contribute to increased fear and anxiety, which is the very opposite of reassurance. How can such contradictory effects be possible?

5.3.1 Knowing too much?

While the accounts of technology in the previous section might suggest women’s acceptance of it, women soon turn to the ambiguities of technological knowing (and doing), and the inherent complexities and uncertainties it creates. This is particularly prominent when it comes to women’s accounts of fetal monitoring as they dispute its contribution to their “knowing” and reassurance:

the downside of technology is you will be listening to the heartbeat all the time, it’s constant (...) **if you know all the information you start to freak yourself out**, you start to get yourself all worked up and in turn it creates difficulties for the babies, it puts the baby under stress, that’s why they perform caesarean sections, the babies are going into distress I think. (Jill)

at the end of this hour and 20 minutes on this machine you can get really sucked into looking at it and you’re going "oh my god what’s the heartbeat doing" and then you get sucked in and you start thinking you understand it and you don’t actually understand it and it can make you more nervous when you’re there (Sheila)

they checked me and you can see the contractions and you can hear the heartbeat and it’s very reassuring, until you hear it getting faster and you’re thinking, “Hold on, what the hell’s wrong?” (Eva)

The information provided by monitoring is actually as stressful as it is revealing for women and can eventually make them more nervous. Also, according to women, it is not only dealing with difficulties but potentially causing complications for the baby as well:

my son went into distress, that’s why I had to [have a section]... cause they put so much stress onto me. They were "you have to stay still" (...) They do that because of the heartbeat, I understand that but **if you will leave a woman there to relax the way she wants to relax, the baby won’t get into distress then**. (Sally)
the heartbeat wasn’t showing on the monitor. They did this thing then when you have to put that on the top of the child’s head when the baby is inside. **The minute they did that... my daughter’s heartbeat started dropping.** They said “the heartbeat is dropping, we have to rush you up”. And I was nearly there, I was only 1 cm away to having her, a natural birth. (Sally)

I could understand why **the hospital wanted it.** I saw no benefit to it for me but I understood why they wanted to monitor that particular thing and at the time I didn’t realise I could have asked them to monitor in a different way although I probably would have encountered resistance because of the process of induction. Because you know the **induction can stress the baby.** Never mind the CTG is stressing the b’jaysus out of the mother. (Kay)

In this way women dispute a technocratic understanding of wellbeing which separates the baby and its mother and often sees their needs as being in conflict (Davis-Floyd 2001, 2004). Thus, technological knowing becomes problematic for its two effects: increasing woman’s anxiety and leading to doing too much, i.e. undertaking unnecessary action which has potential to cause harm, or such action whose benefits are outweighed by harms.

### 5.3.2 Doing too much?

Technological doing is as problematic for women as technological knowing, for according to them the temptation is that too much is done. This again has the potential to introduce unnecessary difficulties, which can be detrimental or even dangerous:

Maybe because we have all those technological advancements we think that they can fix everything? They can fix a lot, there’s definitely stuff that has improved with technology but sometimes the technology can be **applied when it’s not necessarily needed,** in my uneducated view. Stuff given to healthy mothers that they don’t necessarily need. (...) If you are **treating someone as high risk even though they are not high risk by applying all this technology to them,** it may become a self-fulfilling prophecy, it may limit them in certain ways (Sybil).

[the oxytocin drip] reminds me of what I had. The birth might be much **more painful** because it is faster than it perhaps should. I mean you can drive somewhere in one hour
but you can also drive there in 30 minutes. But in 30 minutes it is so fast that perhaps it becomes dangerous. (Gabriela)

The above excerpts reveal the examples of the technological imperative and technical fix philosophy (see section 2.2.2) where technological “doing” prevails making it difficult to keep the balance between the imperative to “do something” and the fact that sometimes refraining from “doing” is a more justified course of “action”:

And sometimes when you devise a technology, there is no return. When we make this step forward it is difficult then to stop and to go back. (Aleksander)

the use of technology on the human body, it can be...it’s incredibly... useful. It has such great utility 1 out of 10,000 cases but of course those are those cases that feed into that cycle of this... the heroic use of technology (…), to save that baby that would have died ten years ago. And for most people that technology is actually counterproductive and yet because it’s there it has to be used. (Kay)

However, using technology cautiously, and keeping its “heroic” uses in check is difficult to conceptualise within the technocratic approach where “every possible event” is anticipated due to the omnipresent adherence to a risk averse approach:

I think it’s for every possible event, but then I suppose you raise the question, if you have all of these things to hand, is there a feeling that you need to justify their existence by actually using them. So if they weren’t there or they were in a side room or something, would people be less likely to depend on them? (Lynn)

A similar point is made in the exchange between three other women:

Sheila: in preparation, they’re going to put a drip into you before they know if they’re going to use it or not. (...) it’s in case they need it but you could be going around with a drip in your hand for so long and it’s kind of needless but I get that it’s for an emergency but at the same time... it’s obviously there.

Maebh: It also implies that there are so many emergencies now that they’re getting ready for everything. And I would wonder about that, is it actually necessary because it’s enough what you have to deal with besides and you know this thing goes into your tissue.
Phoebe: I got a drip and they wouldn’t take it out because after a while I wanted them to take it out because it was really irritating me but she was like no, the fibroids. You’ll need to...

It is the effect of the power of technocratic biomedicine to assume that such an approach, anticipating and testing for numerous complications, would be reassuring for women, as observed by Warwick and Salkovskis (1985) at the beginning of this section:

the thing about the technology is, it can do things that then maybe get beyond your control. So for instance, you know being induced, that was the thing I was most terrified of with the oxytocin and the speed of contractions and the pain and the intensity (...) so many women I know who would have been really strong and empowered (...) were begging for an epidural because they... because the thing has taken control of their bodies and they can’t cope with it. (Lynn)

I remember being scared when they said that they couldn't get him out and they would use forceps, I was like "n-o-o-o!". And they said ‘oh no we actually suction’. (...) I would have preferred him just to come out. I was worried about it sucking his head into a weird shape, it was just a little baby’s head. (...) I didn't want... it's invasive. You want something be coming out when giving birth, you don't want something being pushed in, it goes completely against what's going on. (Tara)

The above excerpts demonstrate that rather than being reassured, women become fearful of the intrusiveness of technologies, which makes it difficult for them to be in control of what is happening to them and to protect their children. While women speak of technology as reassuring them about the outcome, the concerns about its harms make them more worried and anxious than the biomedical approach would lead us to believe, as all women discuss the increased fears resulting from its overuse and overreliance on it.

5.3.3 Reassurance of technological environments?

While the above conceptualisations demonstrate the intertwining of fear and reassurance in women's reactions to technology, it is when women look at the photographs of the actual hospital environments, designed with technological “knowing” and “doing” in mind, that their coexistence becomes clearly visible. The
photographs of the “standard” rooms in Irish maternity hospitals embody the technocratic biomedical approach which determines their design and content (see section 4.3.2.2). Birthing spaces relying on a different philosophy of care tend to look differently (Bowden et al. 2016, Fannin 2003, Jenkinson et al. 2014). While most women’s reactions to those environments were ambivalent, the reactions which were unequivocal came from women explicitly contesting them:

Horrible, oh god, it’s just... like birth is not... you’re not sick! Why would you need a hospital? The monitors and scary equipment and bright lights and - Jesus look at those yokes up on the bed for the feet! – ah, will you stop, you’re not meant to give birth lying down! (Jill)

Oh my god... what’s that?! Is that the strapping? Oh gee. I’m so glad I’m not pregnant. (…) It’s threatening actually. (Lynn)

Everything is like... totally clean, totally sterile. Everything in that situation, just looks like somewhere you go to have something done to you rather than where you’d go to do something that you do. (Kay)

Those women were openly critical of technocratic maternity care, Jill and Lynn having given birth at home and Kay in a hospital, after not being able to secure midwife-led care. They reject technocratic objectives ingrained in this environment such as the focus on pathology and designing a space with women as passive recipients of treatment in mind (suggested by the lying down position and being restrained by stirrups) rather than with women as active and capable when having their babies. However, there is one woman who, despite her subscription to private obstetric care, is unapologetic in querying the “reassurance” of this environment:

I think they’re very sterile, cold, you’re in a hospital, you’re here just to get the baby out as opposed to, this is a big moment in your life. (…) Nothing is focused on emotion, there’s no emotional side to it at all, (…) there’s nothing relaxing or comforting or reassuring about the room whatsoever. (…) I felt it was just, we’re here to get the baby out of you and that’s pretty much it. (Eva)

However, most women negotiate between cautious critique and guarded praise of high-tech environments rather than pronounce them, or the approach which they represent,
as inappropriate for birth. They come up with justifications of their appearance, struggling to overcome their negative feelings:

It looks very much like a hospital environment (...) I guess it's good to know that they are well prepared but maybe looking at these machines, maybe it'll make me feel anxious (...) I think that would make me feel anxious... while things are going well, but if they needed it, I'd be really glad that it was there straightaway. Maybe... it could be curtained off? [But] I could deal with it. Yes, it could be improved but I deal with that as it is. (Sybil)

I suppose people might have a bit more anxiety the more things they see. (...) Actually, when I look at it closer it’s not as bad as I think really, so that’s an incubator, I would say it just keeps the baby warm. And this here is for a drip, if they need to give oxytocin or different fluids or whatever through here. And it’s quite normal above every bed the suctioning and oxygen. So actually there is a not masses of more high tech stuff to be honest. (...) I don’t know, maybe somebody would find reassurance. (...) it’s a lot of wires, but there is nothing really you can do about that. (...) (Should they be different?)

To be honest the woman is in there just to deliver (...) I suppose you really don’t take too much notice, you are concentrating on having a baby (Kelly)

Lenka: Yes, they look like... from one hand a bit scary, too many cables, too many machines but from the other hand you feel like "ok, it will be a good care". (...) Well, they could be more friendly for me but I don’t know how it would be possible because machines have to be there. (...) Gala: I wouldn’t mind, no. As long as they have everything, the scan, the monitor for the baby and your heartbeat and all... and that thing there is for the baby. It all has its purpose. Though... as Lenka said sometimes you'd be more scared with the cables and all but I think... you just go in there, you give birth.

Women talk about their fear and anxiety, yet they consider it appropriate to “manage” and diminish their importance. In order to reconcile their feelings with the promises of reassurance, they announce the way birthing rooms look like does not matter, reiterating a more legitimate focus defined by biomedicine: “delivering” a baby and having access to machines.

5.3.3.1 Unchangeable and unquestionable: “that’s what it is”
One of the most powerful effects of the technocratic paradigm is that technological environments and the care they proffer appear as the only “right” option, which prevents women from imagining alternatives, despite their fears. This difficulty can be observed when women resort to using tautological idiomatic phrases, such as “it is what it is” which describes an inevitable circumstance which “is simply a fact and must be accepted or dealt with as it exists” (Concise Dictionary of English Combined 2015: 64):

“Some [of the rooms] are just... obviously there’s lots of machines around. You are nearly worried sometimes going in seeing too many machines, for some people it might reassure them. But you would think is that all for me, do I need all this monitoring? You don’t want to have too much. (Does it matter?) Probably not. From my experience I was only in there three hours and most of that you don’t really remember because you’re just hoping that you get some pain killers or baby arrives quickly (laughs). (...) It’s very cold environment (...) But I would think that’s what it this. (...) Obviously you’d like a bit more - if you can - more comfort. But there is short amount of time you are in there, it’s more about... having their... the equipment beside you, having the midwife, the qualified doctors and nurses (Cecilia)

The above excerpt demonstrates that this woman has needs which span beyond the technocratic, yet in her account they are repeatedly subsumed under this perspective. Another tautological statement with the same effect, “this is a hospital”, is suppressing the possibility of non-hospital birth environments:

(Does it matter?) Yes, absolutely, [the rooms] should be more... no I know they’re comfortable, you have everything you need, but they just don’t feel like, it’s not... how would you say that... you feel like you’re in a hospital. And that really puts you ill at ease because you don’t fully relax, (...) you are trying to convince yourself there is nothing bad and you will be probably fine, to put yourself at ease. (Nora)

My room... resembled an ordinary room a bit. And those are typically... I don’t know, as if I was going in for a heart surgery (laughs). (...) In a way those machines give me a sense of safety, if anything happens, even if I don’t know what they are there for I hope they are for saving life (laughs). Listen (changes her tone) this is a hospital, not a hotel (...)

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70 Pullman (2013) defines tautology as “a circular argument” and a persuasive tool, “a kind of proof, a maxim that supports a decision to let something happen because it seems inevitable” (ibid: 19). He gives ‘It is what it is’, the phrase used by Cecilia, as an example of a tautological statement.
the life-saving equipment should definitely be there. I know they have no money to make it nicer or more comfortable. (Gabriela)

At the end of the day, you’re in hospital anyway so, I was happy enough with the way this one looked (...) but this one and that one would scare me, it looks like you’re going in for a big major operation (...) it looks too cold, a lot of steel things, just no. (Does it matter?) Well, yes and no. Yes, as in you want as much comfort as possible, but then no as in you’re going to be in so much pain you’re not going to care where you are as well. (Glenda)

Women attempt to get used to and work around this environment rather than embrace it. While conceptualising alternatives is hindered within the dominant paradigm, women eventually do undermine it in the above excerpts by refusing to fully accept that their fear of those spaces does not matter, as within the technological paradigm it is disregarded for the sake of efficient management of risk and women’s birthing bodies.

5.4. Technology and disembodiment: technocratic approach and women’s confidence and courage.

Technology used within the technocratic paradigm supports disembodied ways of knowing and doing.\textsuperscript{71} Within this approach women’s knowledge and what they can do, as well as the practices built upon the central status of women’s knowing and doing, become discouraged and less valid. As a result, women become mistrustful of their embodied knowledge and are not able to rely on it for reassurance in the birthing room. Thus, while often fearful and confused as a result of technological “knowing” and “doing”, they are forced to rely on it, even though it is external to the sensations and abilities of their bodies and they perceive it as “independent” from them:

If anything suddenly happens, if the baby suddenly starts suffocating, or the heartbeat grows weak, or any other problem, I think with the monitor at least... I know it’s not 100 per cent certain but I prefer having it to not having it. Because you wouldn’t be able to tell [that there is a problem] just looking at my reactions in labour. I don’t trust my body enough. (Marzena)

\textsuperscript{71} For discussion of disembodiment as an effect of technology see: Lam (2015) and Young (1984).
I think that this machine [Doppler] is not as precise. I think the other one [CTG] shows exactly, you can see it on the chart, what is happening at each stage. And here, somebody has to be very skilful actually, to pick up anything. (...) I think here **they expect that the machine is wise**\(^\text{72}\). When the machine was beeping (...) they knew what was going on, that something was wrong. I don’t know, I’m not a midwife but from my observations they do reckon with what this machine says. (...) I’m not an expert but there may be some technology in it that reduces unimportant noise (...) so the traditional method [Doppler] requires more skill, more experience actually. (Is experience required with the CTG machine then?) [Pauses and responds confidently] No. I think no, because the machine does the most work automatically. If somebody knows the parameters, if they are correct or incorrect, if you just see those parameters, you know if it’s bad or not. (Gabriela)

In the second excerpt Gabriela observes that those caring for women also become reliant on machines which appear to be “wise” enough not to need the wisdom of a health professional. It is the CTG machine that is “reckoned with” rather than women and their bodies. And it is the unspecified “they” recurring in women’s accounts throughout this chapter who seem to benefit from and be enabled by capacities offered by technology in the birthing room:

beeping is horrible, and if it keeps beeping then someone is going to come in (...) I was happy with them not being there but we had to kind of manage this machine, this **stupid** [emphasises] machine because I could feel what was going on, I was in labour, the baby was fine. The machine was giving me no reassurance; I did not need that information, I didn’t. But the hospital staff did; if that machine didn’t register anything for say a period of 10 minutes, there was a feeling like "Oh then they [emphasises] **might think there was a problem.**" Now I knew there was no problem so there was this very large disconnect between... you know what they were using this machine for ostensibly and what my experience of it was (Kay)

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\(^{72}\) Describing the machine Gabriela uses word “*mądra*”, which is sometimes translated from Polish as “smart”, “clever” or “intelligent”. However, “smart” has been to some extent adopted in everyday Polish as a term to describe smart technologies (particularly phones), and she could probably have used this term if that was what she meant. Also she could have used “*Inteligentna*” which closely resembles English “intelligent”. “*Mądra*” comes from “*mądrość*” (wisdom) and in Polish has no association with “cleverness” and being “crafty” or “cunning”, hence translation to “clever” machine did not seem to convey what Gabriela wanted to say.
because of the waters, they were concerned about the baby’s heart rate and they kept me on continuous CTG and what was really annoying about that was because my body just wanted to... just naturally, I just wanted to move the whole time (...) They couldn’t get a good trace if I was up and moving so, they said that baby was happier as well when I was lying on my left side. So that was torture, that was really, really hard (Sheena)

This leads to a disconnection between women’s needs and the apprehensions and actions undertaken by those caring for them. It is “they” who are worried and concerned based on abstract protocols stemming from obstetric notions of risk, and it is the machine’s output that is a cause for concern. It is seeing technology as essentially “unknowing” or “stupid” which allows women to identify this disconnection.

5.5. “Other” ways of knowing and doing as reassuring?

It is striking that even those women embracing high-tech maternity care end up doing “emotion work” necessary to align their feelings with the “feeling rules” (Hochschild 1979: 563)73 of technocratic biomedicine in order to feel reassured in high-tech environments, their appreciation tinged with initial panic:

Jesus, this looks terrifying! When I see this bed with... the stirrups. But the other room with dim lights, it looks more homely and this is exactly what terrifies me about it. That something must be missing there. (...) This is the way it should be when you have a baby, absolutely! This gave me a sense of safety, being surrounded with all the monitors and all the possible... (...) The more technology, the safer I feel. (Marzena)

the first time I was in a delivery suite I was really panicked. What frightened me the most was all of the medical equipment and as a pharmacist I trained in hospital (...) it was when I saw the resuscitator and all the equipment for babies, it freaked me out. (...) I never thought about that, until you actually see it, yes, we possibly need to use this. (...) I don’t think it should be different, no, because the second time round I was used to it, I was absolutely fine, I knew what to expect and I was in and out maybe three times before I actually went into labour. (...) By the time I delivered, I was used to it and I was possibly glad all that equipment was there (...) it was the initial shock. I think if I was going to a lovely furnished room with the bed and nothing else, I would be going,

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73 According to Hochschild (1979) “feeling rules” regulate both our display of emotions as well as what emotions are “legitimate” to be actually felt.
“Where is everything that we need?” I don’t want a comfy bed, I want all the stuff that we might need. (Gina)

As Gina proceeds to engage with the “cultural imperative to curtail anxiety for the sake of the foetus” (Thomas *et al.* 2017: 894), her fear is temporary and the reassurance with technological environment seems genuine. For Marzena however, it is difficult to achieve any solid reassurance either way within the approach manufacturing fear and undermining women’s ability:

I preferred to have it all, obviously. And it was all there really. (…) I was worrying a lot, reading a lot, I was aware of all the possible dangers (…) and it was important for me, in case something went wrong, to be surrounded by all this so they can help me. (…) I felt lost. Totally lost. (…) I didn’t feel so strong at all. I don’t cope well with pain (…) I was terribly afraid of pain. (Marzena)

Significantly, there is a point where both Marzena and Gina abruptly turn to what is not a technological reassurance:

Actually [with sudden realisation]... the fact that somebody is there with you, watching over you, is perhaps even more important than being surrounded with all the monitors. And with all the equipment. (Marzena)

What made birth easier for me... [with sudden realisation] was actually the midwife. You’re assigned a midwife in labour and particularly, the second time round, the midwife I had was really, really good, she was really supportive, she explained exactly what she was doing (…) she’d be in every half an hour, every 20 minutes and she would tell you how things were going, that was really good. Really relaxed and then she actually turned off the lights and said, “You didn’t sleep last night, have a sleep.” She was very sweet, I think that was the communication, was the most helpful thing. (Gina)

These excerpts demonstrate how as my conversations with women progress, even those women who do not initially discuss alternatives to the technocratic “standard”, begin to recognise the skills and expertise other than technological which can provide accurate knowledge on which to act. Those skills and expertise do not involve technology and instead rely on experience of a health professional or techniques which are considered low-tech:
the older nurses and midwives would come in and they'd feel all the way around, they could tell then by feeling where was the baby's spine (...) they wouldn't use that machine. They would just feel. (...) It is really the same thing. **I mean the modern way is easier and quicker. When you have ten people in the room I was in, all getting monitored...** everybody there had diabetes, high blood pressure so doing the monitors, getting them on, it's just quick way with the machine. But I do think you need to go with your... the old style way as well sometimes, just to see what it's... **sometimes the machines aren't going to tell you everything.** You could say something and the machine may be saying another thing. So it's nice to have the both I think. That would be the best way. (Cecilia)

Sheila: the girl came in and she put the machine on to listen and she couldn’t... I think she heard my heartbeat and she thought it was the baby’s heartbeat and she pressed the bells. It was all like emergency and the doctor came and everyone came in and it was all like this big to-do and I was going “oh for God’s sake”. The next morning, a different midwife came in, an older midwife, she was Australian and she didn’t even put the thing on to me at all, **she just listened** in with a little thingy like this, whereas the other one made me stay on the machine for an hour and 20 minutes after the doctor left, I had to get an internal and everything and in the end one of the other nurses said it was probably the wrong heartbeat. (...) one of them was obviously **very reliant on the machine** whereas the other one was really calm and she just used that “heary thing” and listened.

Maebh: That’s the technical word for it! (everybody laughing).

you are numb from there down so you really can’t tell when you are having the contraction, well I could but I couldn't really feel them coming the way I did before the epidural (...) they did keep referring to this [machine] (...) something on that told them to tell me “push, bear down, big push”. (...) [but] **the midwife was able to tell me** about one putting a hand on my stomach, to me a lot of that is probably just procedure, it has to be there... but you can tell the contraction is starting cause there is... you can tell if **you are a midwife and you skilled enough you'll know.** (...) and if you look yourself everything tightens up, up, up. (Tara)

It is the midwives who are “able to tell” and are clearly well skilled to know what is happening, often without resorting to technology. Technocratic care and its “modern way” might be quicker, allowing hospitals to manage high numbers of patients but it is
insufficient to gain knowledge of the realities of women’s bodies. Thus, a much older body of knowledge than the biomedical, coming from midwifery practice, is as essential as our access to technology.

Contrary to the claims of technocratic biomedicine technological “doing” and “knowing” is actually not “all” for women, and it is not the only way of “doing” and “knowing” that is available. As women realise this, they begin to dispute its unanimous, unquestionable character:

they can now hear the heartbeat, they make you move this way and they make you move that way, and how they can actually know? Cause the baby would be moving around (Sally)

they wouldn’t know that I’ve had a fibroid if I didn’t have that scan (...) now they’re explaining that I have to get a special injection because maybe I won’t contract properly but at the same time I don’t know if they’re just... saying "oh, you won’t contract" and then I get an injection that I don’t really need so I don’t know, it’s very hard to know. (Sheila)

when she came she wasn’t breathing and she was having seizures. They had to take a sample from her spine. That they have the level of something... but there was too much, it was too high, and they said there was no chance she was going to be a normal baby (L gasps). She was definitely going to be abnormal (L gasps: and now this is not true!) At that point, you just pray to god to give you some strength. (...) And you are just resisting whatever the doctor says. (...) At the end they did the scans and everything was perfect again (Gala)

Technology induced disembodiment eliminates women’s own embodied experiential resources of reassurance. Whenever technological “knowing” and the benefits of its potential “doing” are unclear, women are left to rely on what their carers know and do for reassurance. Women are forced to rely on professional expertise for reassurance while having limited access and agency around it.

5.6 Conclusion: when does fear become confidence and courage?

“with effective guidance and support [woman’s] emotions can move from fear to courage” (Bone et al. 2009: 57)
“Patients seem to feel the therapeutic effect of reassurance where the environment (...) is seen to be informal, unthreatening and caring (...) where the staff are friendly, kind, pleasant and where patients are encouraged to express their feelings” (Fareed 1996: 278).

“That’s not technology then I suppose... what you really need, what you rely on is the human touch.” (Maebh)

In this chapter I explored how for women technology is about knowledge and being able to “do something”, and how these capacities for women are means of reassurance, and constitute what is fundamental for them about technology in the birthing room. However, within technocratic maternity care these qualities of technology emerge as its unfulfilled promises, often resulting in their own opposites: uncertainty, confusion, additional harm and fear. Technological maternity care is clearly heightening women’s fears about their own and their babies’ wellbeing. Technocratic approach views pregnancy and birth as inherently “high-anxiety” events, and as a result women’s distress is conceptualised as a “natural” component of women’s reproductive processes. This allows to disregard the amplified character of women’s anxiety and fear when they are birthing unsupported in any other than a technological way. It also permits the system to disregard women’s enormous emotional work required to deal with technology used within the current framework. Instead, women’s “excessive” negative emotions are seen as in need of management, either by “therapeutic” intervention during labour, or by counselling women for “tocophobia”, rather than looking at the practices of biomedicine which contribute to it.

Women’s voices challenge technological knowing and doing as envisaged by obstetrics. They also challenge reassurance as “conventional justification” for high-tech maternity care. Reassurance becomes an overstated claim feeding into unwarranted and unnecessary use of technology, based on societal beliefs about women and what is good

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24 Such “conventional justification” for screening and diagnostic interventions has been argued as overestimating technologies in provision of health care (Kroenke 2013, McDonald et al. 1996, Thomas et al. 2017). While fleeting “short-term emotional relief” might be often achieved, the “long-term cognitive assurance” leading to lessening of anxiety and confidence about the lack of disease has been problematic (Rolfe and Burton 2013: 410) and people were often left with “residual anxiety” despite receiving a “normal” test result supposed to reassure them (Baillie et al. 2000, McDonald et al. 1996, Rolfe and Burton 2013, Thomas et al. 2017).
for them. Those beliefs undermine women’s confidence and feed into their further reliance on medical intervention where offering genuine support would perhaps have helped them avoid it (Edwards 2004a, Fox and Worts 1999).

When asked about what matters to them by Downe et al. (2018) women did not discuss technology but mentioned their fears of it, associated with impersonal interventionist care, considered distressing rather than inducing relief and feelings of safety. In Hodnett et al.’s (2013) review of evidence for continuous one-to-one support, the most important sources of reassurance came from emotional support, “information about labour progress and advice regarding coping techniques”, comfort measures, and supporting women to articulate their needs (ibid. p. 3). Similarly, in Fareed’s (1994, 1996) research exploring the notion of reassurance, people did not bring up technology and high-tech expertise and instead focused on humane aspects of care. This demonstrates that reassurance is discussed when people engage with the role of technology in health care but this often does not work the other way around, i.e. reassurance, when imagined on its own, is not a feature of technology per se but of the relationship between those receiving health care and their caregivers, and what the latter can do to ensure it. It is only in its technocratic incarnation, that reassurance becomes a mechanistic process resulting in a straightforward manner from the availability of complex resources and expertise and, as such, allows the status of technology in the birthing room, and the risk protocols which perpetuate its use, to remain unquestioned.

In the quotes at the beginning of this section reassurance is a matter of “effective guidance and support”, of a caring environment and staff who encourage those they care for to express their needs, and of “human touch”. Throughout the chapter it is the ways of doing and knowing where the above are central, often embodied by the knowledge and skills of the midwives, which women insist is reassuring for them. However, philosophically and conceptually, these do not belong in the technological

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75 Reassurance has been explored in research as a feature of a doctor-patient relationship, and seen as something medical professionals can provide by what they do, say and how, and whether they listen to the patient (Coia and Morley 1998, Fareed 1994, Kroenke 2013, McDonald et al. 1996).
approach to maternity care. Yet it is these, rather than technology on its own, which enable women’s fear to become courage and constitute genuine reassurance.

And it is to those “not crucial” aspects, excluded and unacknowledged in the technocratic biomedical approach which women persistently bring up in their accounts that I turn to in the next chapter.
Chapter 6

Subjugated knowledges: What is missing from maternity care when we think technologically?

6.0 Introduction

“What medical dominance has done is not only take over from midwifery and woman’s own embodied knowledge of birth, but denied that such knowledge ever existed or could exist. Scientific or ‘medical’ knowledge is real and authoritative; other knowledge is reduced to ‘intuition’ or ‘spiritual knowing’” (Rothman 2014: 6)

“If obstetrics does not rethink and expand its ethical code, it cannot stop treating women inhumanely. Its values decrease women’s autonomy, ignore their feelings and knowledges, and harm their bodies, minds and spirits” (Edwards 2005: 250)

In this chapter, in contrast to the previous one, I discuss aspects of maternity care which are excluded or unattended to in its technocratic understanding, but which are persistently discussed by women. I focus on “what is not” from women’s perspective. Women’s voices do not have an authoritative status within the technocratic approach76, and as a result their understandings are seen as resting on “subjugated knowledges” (Foucault 1980c: 82) discussed in Chapter 3. These are considered as “merely” personal, experiential, embodied ways of knowing, “unqualified” and “insufficiently elaborated” (Foucault 1980a: 38), and allow for the categorisation of women, and all those who rely on such knowledges, as incompetent and “unscientific”. In both a Foucauldian approach and within feminist poststructuralism, these knowledges are legitimate source of knowledge and need to be brought to light “against the claims of a unitary body of theory”, while preserving their ambivalent and unquantifiable status (Foucault 1980c: 83). This is crucial in order to displace relations of power and make the “subjugated” ways of caring in maternity care visible. Thus, I endeavour to reconstruct how women

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76 While concerns for a humane, person- or woman-centred approach is part of the rhetoric in debate about maternity services - as exemplified by the discourses of policy documents, official reports, maternity hospital websites and advice books - such rhetoric rings hollow within technocratic biomedicine where women’s needs can be overridden with the medical understanding of risk and its prescriptive risk management strategies. This is further discussed in Chapter 7.
rely on these “subjugated knowledges” in order to traverse the existing technocratic framework, despite its powerful grip on their imagination.

One of the ways of expressing subjugated knowledges is women’s resistance to the technological content of the photographs. While the circumstances depicted in photographs are slightly different (some women are upright on the ball, some are lying down; one looks happy, others look serious or focused which may suggest discomfort), it is clearly visible that all women are connected to the monitor or have some kind of wires attached and they are in a fairly standard hospital environment. However, when asked about the quality of care depicted in the photographs, women focus on the humane aspects more than technological ones. These aspects include the presence of a caregiver, their reassurance and support, and I will turn to these in the first section. In the second section I will discuss women’s need to be respected as individuals and not objectified, exemplified by their focus on dignity and privacy. In the last section, I will focus on the importance of being able to work with their bodies, exemplified by the importance of position and mobility during labour and the way women discuss “active” birthing practices such as sitting on the ball and walking.

It can be argued that the fact women do not discuss technology in the photographs at length only indicates their lack of interest or perceived incompetence to discuss it, or that it is simply easier for them to relate to the humane aspects. However, after listening carefully to what women are trying to say, I argue that this “omission” demonstrates that while the technological dimension remains important for women, they refuse to accept it is all that should matter in maternity care, thus undermining and invalidating the full scope of the technocratic approach.

6.1 Effects of discourse: “they have everything”

77 The material for the first section comes primarily from responses to images of women being cared for in standard hospital birth settings (see Appendix 7, photographs no. 2.1-2.3 and 3.1-3.3). The insights in the following sections are based on women’s reactions to photographs of a low-tech room with a birthing pool (see Appendix 7, photographs no. 7.1-7.3), which I will refer to as the “low-tech room” for the remainder of my analysis. This room opened in The Coombe Women’s and Infants University Hospital in Dublin in 2014, the year when the interviews for this project were conducted, and those images had proven instrumental in eliciting reactions to less dominant approaches to care while maintaining the familiar and institutionally endorsed context of the hospital considered local for many women.
The presence of medical resources in the photographs, particularly in the form of fetal monitoring, is almost always acknowledged by women and considered an indicator of good quality of care. However, most women do not elaborate on technological equipment with the exception of a few, who venture to explicitly critique its prominence. Women raise the “legitimate” aspects of the technocratic approach (such as appreciation of technical resources and their life-saving risk-managing qualities) briefly and only when prompted, never in separation from “subjugated”, humane dimensions of care:

This one is lovely, **she’s getting like a human touch**, it’s really helpful to have the physical touch and support. She looks like she’s really getting close and like talking her through everything, and getting even down on her lap as opposed to standing up and saying ‘you need to do this’. She looks like in a bit of pain. And this one, this is all the same lady? (...) I don’t know, she must be wearing some kind of bra still which I thought would be uncomfortable, when I came out of the shower I had like a nightie on and I didn’t wear any underwear, if you gonna push you don’t want pants on, it might like block you from pushing and **she’s obviously all hooked up to monitors**. She looks on her own there but that might be like people are behind the camera. (Kelly)

This is similar to observations in the exchange between four women below:

S: She looks delighted with herself.
M: She looks like she’s delighted and she has everything she needs...
S: This is what you want definitely. The interesting thing is she’s still **connected up to things** but she obviously still has the freedom to be moved or whatever.
J: She looks like a Buddha to me. She’s really concentrating.
M: But she looks quite confident. The overall body language in this woman here is that things are absolutely fine, she has the support she needs, she’s not looking to anybody. I think she’s gone in confident and she’s happy and she knows what she’s about to do.
S: This one is like things are getting done to her (the rest express agreement)
P: But this lady here is like I’m getting down to business.
J: Yeah, she looks like “I’ve a job to do”.
P: She looks like she’s had some painkillers. (laugh)
M: Yeah I know she has business to do alright but I still think at the same time... I think **if there was somebody in the picture with her**, behind her that she would have... do
you know what I mean, she’s just ok but... It’s kind of a chore that has to be done and I have to do it on my own and... I **could do with a hug.** (Sheila, Phoebe, Maebh, Janet)

Women’s quintessential responses above demonstrate their insistence on the importance of humane aspects of care, rather than availability of technological resources, and it is this insistence which guides the analysis in this chapter. Women emphasise humane aspects such as the meaningful presence of their carer, individualised care which respects women’s personhood and provides them with support to work with their bodies. However, despite being crucial for women, these aspects are not seen as crucial within technocratic biomedicine. As a result, a woman’s care can be considered appropriate without those humane aspects being addressed.

Only rarely are women’s first reactions about noticing and appreciating the technological resources and these are revealing examples of the effects of power of the technocratic framework:

> They have the balls and everything…. She looks like she's happy enough... with all of the monitors, all the machines. They all have their baby monitored throughout (...) I think **everything** is there. These are the machines you’d be familiar with, that you'd be looking at yourself and you get to see all the heart rates. So these are the ones you see all the time. (Cecilia)

What resurfaces in this excerpt is the claim that technological expertise is “everything” and “all” there is to have, and that its continuous watch is advantageous (“throughout”, “all the time”). Yet, commenting on the following photo this woman shifts her focus to continuous presence of the caregiver, there “all the time”:

> She seems to have all the... equipment and the ball... obviously she's being strapped to be monitored. The midwife seems to be **beside her all the time**. I know she's not in the first photo but the midwife is there, **reassuring her and holding her hand.** (Cecilia)

Here is a similar example of negotiating between technological expertise and somebody being there (or not) for the woman:

> They seem like they are doing... well. The two ladies are moving around. The girl on the bed doesn't seem very happy and she is on her own, well, there is no one else in the
picture. She’s being monitored, and the girl on this ball gets monitored as well but she doesn’t seem unhappy, she seems more focused. [Q: Does it look like a good care?] I don’t know. They’re all being monitored to be honest. She looks like she needs someone to support her. It’s remarkable that they are all being monitored. (Sybil)

The above excerpts indicate that for women there are missing aspects in this “they have everything” approach. It is noteworthy that both women do not respond to the question of good care with either a positive or a negative answer. Instead, they observe that women in the photographs “seem to be doing well”. The images of standard hospital care evoke hesitant responses from women. They become unsure whether the care can be considered “good” if women are monitored by fetal monitors but left alone, unsupported. This to me indicates a rupture in their understanding, as after all these images represent the prevailing technocratic approach offered to them. This rupture eventually provides them with a discursive space to confront the dominant framework. Even though women do make concessions and rely on dominant conceptualisations, it is not proof of unconditional acceptance. Rather, it evokes the difficulty we all grapple with when we try to think and argue outside the socially powerful position of technocratic biomedicine. The above account where the need for support and presence is wedged in between acknowledgements of the technological, may well be the most attainable way to talk about better maternity care\(^\text{78}\), and is one of the effects of power of the dominant discourse.

6.2 Meaningful presence as a subjugated aspect of care

In these photos I see them alone, this woman is with someone. (Lenka)

They pretty much just left us in the cubicle to do our own thing, we’d never had a kid before, we didn’t really know what was going on. (Eva)

In this section, it is “being with” (Chokwe and Wright 2012: 2) or “enduring presence” of their caregiver (Berg 2005: 13), and not being left alone, that are demonstrated as

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\(^{78}\) As Parry (2006) wrote, “The medicalised birth is [now] so ingrained in our society that people can think of no other way to frame their experiences” (p. 464). When medical interventions become routine, the concept of what a normal birth looks like changes (Lothian, 2006; Munro et al., 2009; Parry, 2008).
crucial for women. Writing about the “genuine caring”\textsuperscript{79} in midwifery, Berg describes such presence as including “nearness and availability, in both an emotional and a physical sense” (Berg 2005: 13) as well as time spent with a woman. It also means keeping the number of people taking care of a woman to a minimum so that this presence remains meaningful for her. This is best facilitated by support for one-to-one models of care where trusting relationships between women and their caregivers are central, and these are best achieved with midwifery care (Hodnett \textit{et al.} 2013, Hunter \textit{et al.} 2008). However, the technocratic framework downplays the importance of genuine presence, and conceals its own influence on women being left on their own. This is exemplified in an account of a woman who - for the most part of the interview leading up to this comment - emphasises her trust in the “white coats” and their technologies in a deliberate, self-assertive manner:

What I like the most is that this girl is smiling, there is somebody with her, and what’s more, she has all the monitors. The other one looks unhappy, as if she’s been grounded and couldn’t move, and besides there is nobody around her. For me it’s... you see, \textit{it’s that there is somebody there with you}. It matters enormously. Because this one... (realises) yes, the fact that there is somebody with you is perhaps even more important than being surrounded with all the monitors. And with all the equipment. (pauses) As for the rest? It doesn’t matter where she is, if she’s on the ball or not... but that there is actually somebody and that they are watching over you. (Marzena)

This woman suddenly realises the significance of someone “being with” her. While she continues to restate the importance of technological expertise, at this moment she recognises the rupture in the uncontested power of the biomedical approach to birth. It is a power which compels participants to repeatedly justify and make do with existing arrangements contrary to their needs, as rationales behind them are obstructed:

This woman is left on her own. She is hooked up, alone, she has to cope with pain on her own. For the other one there is help, there is somebody experienced who can tell her how to cope with pain, somebody helping her. Even if you went to antenatal classes, when you are actually having a baby, the pain is so bad that you forget, you don’t think

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\textsuperscript{79} Berg defined “genuine caring” as referring to “authentic, true, natural, valid, ingenuous, and not-false attributes... each woman being cared for as a unique individual” (ibid.: 11).
about what you’ve learnt, all the breathing techniques and so on, you only think of the pain. So it’s important [to have support] but it is also additional cost and perhaps if it was a private hospital it could afford to have one person with a patient all the time... There should be [a person with you]... whenever possible but it’s not always possible, unfortunately, if there are too many patients. (Aleksander)

L: This would be... this is not a nurse, this is a mother or friend, yes? Well, she looks alone there, I don’t know, she looks alone... But probably at certain stages they leave you alone if they... they monitor.

G: I would say on this one she is alone, yes. No one there to reassure her. I think this [photo] is ok, at least someone is there to just... (…)

L: Well, **I was always expecting that I would not be there alone** but... actually I liked that my husband wanted to be there with me. So I can’t say I was alone.

(…)

G: Normal delivery takes a lot of time.

L: (animated) That's why you have to be alone sometimes. You can’t have one person there all the time, no. (Gala and Lenka)

The woman in the second excerpt attempts to reconcile her expectations with realities of the biomedical approach turning to her husband as a figure of “enduring presence”\(^80\), while the other participants justify the lack of presence with the limited resources (e.g. money, time). However, the lack of investment is prompted by viewing one-to-one care and relationships as a “luxury” in the technocratic discourse, and something that can be dispensed with rather than an essential requirement for women’s wellbeing (Newnham 2014: 263). Also, women recognise the connection between being “on the monitor” and being left alone but at the same time they diminish the impact of such a practice, as it seems appropriate within the clinical management of birth. Again, they merely “make do” with the realities of technocratic care:

They all look grand to me. Sometimes you just want to be on your own when you are going through that. And this happened to me when they put these [CTG], they do kind of go off because you need to be on these for a long time when they are checking you

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\(^80\) Disappointment similar to Lenka’s can be found in Berg’s own research (Berg and Dahlberg 1998).
(...) you'd be on your own but this big noise goes off if something is wrong. (...) If you literally move there is loud beep nearly like a fire alarm. (Saoirse)

This one [woman lying down], she's left on her own and she was told "press the monitor if you need me'. Sure, that can happen. (Eshe)

However, for some women the dominant arrangements are less invisible and they name the realities they encounter for what they are:

Well, that’s me, on your own, lying on a bed with a monitor and that’s pretty much it, on your back, you can just stay there. This is yes, she’s laughing, this isn’t reality, I’ve yet to see anybody who actually did this. This is what they would have shown me in antenatal classes, “Oh look, here’s the nurse and she’s checking everything is great. And here’s you’re bouncing on a ball, you’re so happy, this is so fun.” and then this is the reality, when you actually go through the door is this. And this is probably somewhere in between, you can have a ball if you brought it on your own and we’ll still leave you on your own with your ball. (Eva)

6.2.1 Fragmenting gaze and disregard for a meaningful presence

"a 'problem', to become a 'task', is first cut out from a tangle of its multiple connections with other realities (...) it is thanks to this deliberate condensation of effort and voluntary forgetting about the rest that technological action is so wondrously effective"

(Bauman 1993: 194)

It is the fragmenting gaze of modern techno-science which values continuous technocratic surveillance and management over sustained meaningful presence of a birth attendant. This gaze dismembers women’s experience of pregnancy and birth into a set of disconnected problems for technocratic expertise, ignoring what this expertise deems uninteresting or belonging to a separate area of knowledge:

you were sitting down in a queue, there might be thirty people and we were just going in, one after the other, someone would come out the door and someone else would go

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81 Specialisation, separation and discontinuity are important features of modernity, described by classical sociologists such as Emile Durkheim and Max Weber, as well as those describing late modernity such as Anthony Giddens and Zygmunt Bauman.

82 E.g. A technical, superficial understanding of reassurance allows midwives within these technologised hospital settings to separate reassurance from trusting relationship and woman’s emotional safety and make it reliant solely on technological surveillance.
in. So it just felt a bit rushed, that they didn’t really have the time to... I don’t know, I suppose chat and have more of an understanding of what you’re at. (Nora)

I found early pregnancy really [emphasises] tough, that was the hardest part, everything has been easy since then. (...) I told the midwife I had been extremely sick and it was just like "Oh well, that’s just what happens" (...) Well... it was really bad, not exaggerating. When you can’t actually function, then it’s bad. (...) I looked up 'extreme morning sickness' and things like that. That was the only support which I went out and got myself but there was nothing from the doctor or the hospital, like it didn’t matter. (Grace)

Women’s reaction to such fragmentation is marked by genuine anguish about being routinely advised not to come “too early” and only “in established labour” as well as inappropriate “early discharge” after the birth. While these may be intentioned to spare women unnecessary intervention and avoid infection, they are also a feature of institutional management of hospital activity and capacity, where women’s actual needs are disregarded. The notions of “early” labour and the “postnatal period” rest on modernity’s “meticulous functional dissection and separation of tasks” which promotes narrow “technical” (or clinical) responsibility for woman’s wellbeing rather than a humane and a moral one (Bauman 1989: 100):

on your first you don’t know what to expect (...) as (contractions) were more frequent we rang and went to the hospital and she said to be honest you got a couple of hours, they were very nice and said if you want to come in you can but try staying at home for as long as you can and maybe when they are 5 minutes apart come in. (Kelly)

I thought "I'm handling this pretty well" (...) and I went to hospital thinking "I must be 5 or 6 cm" and she's like "You’re 1 cm". I was like... heartbroken. They kept me in overnight and I was up and down the stairs and walking everywhere. The pains were getting really bad but they checked me at about 10pm and she was like "You are 1 cm". So I was "I couldn't possibly be!" I remember sitting there and there was a girl sitting across to me in the assessment unit and she was getting pains every couple of minutes and she was really bad. She [midwife] said when you’re as bad as that come back to us. I said "I'm getting my pains as regularly as her". She was like "they are not doing anything". I was insisting please just check me [again]. She checked me and said "Ah, you are ready for the labour ward". And then I really cried. (Miranda)
These women are not considered “eligible” for the “enduring presence” of their caregivers unless assessed within the “objective” biomedical framework as requiring it. Women internalise these criteria but at the same time realise how their diktat sharply contradicts the realities of their birthing bodies. It also ignores their needs after the birth:

I suppose people are being discharged very quickly which a lot of people seem to like but maybe for some people they would be very nervous, maybe that’s not good for everybody, going home so early. [but] because there is such a high demand on the beds, I think probably they, once they do their checks and it’s all routine post baby being delivered, they probably discharge them. And everybody gets by, don’t they really? (Kelly)

I was only a new mum so if that baby had stopped breathing in my hands I probably wouldn't even know... you just didn't know what to do. My mum came and my mother-in-law and my partner was in and out ‘cause the nurses weren't coming over, we had to ask them for a bottle of milk for the baby. We weren't sure. They wanted to send me home then, 4.30pm. I only had my baby 11.30 and 4.30 they ask "do you wanna go home?". And I was like "I don't know what to do with the baby. I don't want to go home. I'm only a first time mammy". They didn't show me how to bath the baby, didn't show me how to feed the baby. The midwife (...) was like "that's not our problem". I'm like here is a maternity hospital and isn't it meant to show us all these things? (Shauna)

The fragmenting gaze of the technocratic approach does not warrant sufficient support beyond application of its expertise and thus women are expected to cope without the presence of the person skilled to support them. Yet, the woman in this last excerpt, rather than justifying and acquiescing to this separating approach, resists it and demands maternity care which is comprehensive.

6.2.2 Fragmenting the presence: fathers in the birthing room

Finally, technocratic fragmentation in maternity care means that it is possible to care for women while not being there for their partners. The research on fathers’ presence in the birthing room demonstrates that their needs attract scant attention from
maternity care providers (Draper 1997 and Bartels 1999 in: Mander 2004: 79)\textsuperscript{83}, who consider them as “means” (e.g. good for supporting the woman and practical help) rather than “ends” in themselves. The woman, and - as a separate entity - the baby, are at the centre of biomedical attention and fathers are advised they can be sharply dismissed if complications arise (Johnson 2002). They have no clinical need and consequently, are outside of the concern of maternity services:

[the nurse] said "just so you know if you go down, we’re going to leave you there". And he went "that’s absolutely fine". (...) I saw he was quite panicked because the heart rate was quite low but again they were very “are you ok? we are a little concerned about you but if you drop, you are going to stay dropped, because we’re only concerned with your wife and getting the baby out”. (Phoebe)

[the midwife] was very straight, she was... no messing with her, before we started she said to me ‘now, if something happens to you, if you faint, if you’re not well, we won’t do anything because she is the priority and the baby, so you’re on your own’. And you know I mean it’s good to... [Q: That they made it clear...?] Exactly. (...) And half way through labour I think ‘Jeez I’m not feeling well’... I think I’m going to faint so it was a great experience I mean... (...) the men just need to keep a low profile. Just to be there but you don’t really matter, I mean you do matter but... (Javier)

While participants accede to these disclaimers, again their unease is palpable. After all, it is difficult to fully reconcile any meaningful presence, a truly caring relationship for a woman, while her partner is excluded from it.

6.3 Respecting personhood: privacy and dignity

“Protecting women’s dignity does not require more time; rather, it demands a consciousness of the importance of this particular dimension in care.” (Berg 2005: 18)

“privacy is achieved by individuals when others cannot, or do not, exercise the power available to them” (Burden 1998: 16)

\textsuperscript{83} Mander (2004: 75-82) offers a comprehensive review of literature on father’s presence in the birthing room, their experiences and their needs.
Another “persistent pattern” present in women’s reactions to birthing environments and images of care is women’s need for their personhood to be acknowledged and respected during care. Ignoring women’s personhood allows their objectification, propagates passivity, and forces them to make the best out of limited notions of care. Such care, by definition, cannot be women-centred. These issues are articulated in women’s accounts of privacy and dignity during labour as they insist on being treated as individuals, rather than in an impersonal and objectifying manner. They need to birth in an environment which protects them from exposure, and allows a personal space where they feel secure to work with their bodies:

That was probably a big thing for having a baby that you have a nice private room. (Cecilia)

I was speaking with people that I know, some of them were told just to walk corridors for hours. Which is not nice with your first baby and I don’t really want to and it’s a public corridor, everybody is watching me. And this is the nice big room, you can just walk around. You don’t have to go outside. (Cecilia)

A really good room to be in is when you are on your own. But when it’s packed full of people it’s not (a) good place to have your baby. It’s not. They kind of overload women... it’s not very private. It’s not very good when some women are packed in all together. (Sally)

[You need a room] to get into positions that you mightn’t want other people to see you in, in a private way. So walking up and down the halls, which is what a lot of women are told to do, you know, you can’t get into these positions and also, it’s not very private, whereas this room, one person in the room is perfect. (Gina)

Obviously this is a shower curtain, so it’s nice and dignifying you know. (Kelly)

Women’s concern for privacy is not surprising, given that the need for privacy is considered as basic (Bäck and Wikblad 1998, Leino-Kilpi et al. 2001). It is particularly important for labouring women as anxiety, fear or embarrassment, and feeling observed have been argued to hinder labour and increase the need for technological assistance (Anderson 2002, Buckley 2011, Odent 2007). Disregard for privacy (e.g. doctors being able to appear unannounced, at any time, without knocking) is one of the
ways of reinforcing the medical power (Fahy 2002). Thus by insisting on discussing the importance of privacy in reaction to images of high tech environments women dismantle some of this power.

The need for privacy is overlapping, as the last excerpt suggests, with related concept of universal human dignity. While this term is barely used by women themselves, the concern for human dignity, understood as feeling respected as an individual, is present in their accounts:

to feel safe and to feel that people minded you and that they’re actually interested in... in you, and interacting with you in such a way that it makes it nice (Maebh)

the midwives were very good but there seem to be a lot of maybe different staff and sometimes you didn’t know who they were, so many different students. This is only from maybe working in a hospital but I think it’s really important to introduce yourself and say who you are... so that’s a slight negative that maybe I picked up on it. That’s really important. (Kelly)

What I didn’t like about it (hospital) was queuing up with a bottle to have a pee in, I thought it was derogatory and impersonal and I... I didn’t feel treated very well by the staff, I didn’t feel respected, I was just another number. I didn’t like it, I didn’t feel comfortable. So I hired my midwife and she came to visit me and sit down and have a conversation and a cup of tea and she’d ask me how things were and she would do a urine sample and other people weren’t looking at the urine, I wasn’t queuing up... it was just really personal and I really liked that. (Jill)

you lined up, everybody had to put their urine bottle up on top of the shelf and then you went off and you were weighed and they did your blood pressure and... there was one nurse in particular who was quite notorious for being... maybe she thought she

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84 Within the health care context privacy and dignity are both about respecting the dignity of a person and approaching women as individuals. While privacy refers to freedom from disturbance and being observed as well as control over personal and sensitive information, dignity is more about feeling respected as an individual and thus includes respect for privacy. A publication by the Department of Health UK (DoH UK 2006) enumerates the following features of dignity and privacy in health care context: concern for dignity involves treating people as individuals and putting them at the centre of care, being patient and non-patronising, ensuring people can rest and relax in a safe environment, consideration for cultural needs, making sure people are not left isolated, alone or in pain. In order to ensure that the report recommends “services made up of smaller, more specialised teams who have the time to get to know people individually” (ibid.: 5); concern for privacy is defined in much more practical terms and involves curtains around hospital beds which fully close, examinations carried out in a private room with the door closed, allowing people to wash and use the toilet in private, discussing medical information with a patient in private (ibid.: 7-8).
was being efficient but she was a bit of a bully and if you couldn’t remember... when you’re in there and somebody says who’s this urine bottle from, and you’re looking up, you can’t remember... it used to remind me of when the cows would be brought in and they need milking and you’d see them walking down the road like they had to go from the field into the milking parlour... and we were a bit like that, everybody just walked in as if you were mindless and then you did exactly what you were told, if you could remember what you were told! I think that’s how the system worked. It wasn’t a very... nice environment you know, it was just very thump, thump, thump [imitates the sound of a machine]. Now I’ve been there with my daughter since and... everything was really fine, people are treated as if they are individuals having babies now. (Maebh)

These women speak about the “risk” of objectification and disrespectful treatment due to the technocratic conceptualisation of good maternity care as rational scientific endeavour, where women and their bodies are considered “objects of expert knowledge and passive recipients of technologies to reduce risk” (Chadwick and Foster 2014: 78). This allows to frame attention to woman’s emotional needs and respecting their personhood by their caregivers, as incidental to or outside of the remit of clinically oriented maternity services. The excerpt below exemplifies the result of such conceptualisation:

I didn’t really understand that the epidural made your legs paralysed because no one ever had that conversation with me. So I couldn’t understand why I couldn’t just get up and have a shower, I actually didn’t know I couldn’t stand up. (...) and then literally out of nowhere, someone just came and I didn’t know who she was or what she was doing and she just started taking up my clothes and washing me. I was like, “What the hell?” I totally didn’t know what was happening and I don’t know, it was just like there was no privacy, no nothing. I would have liked to maybe sit and wash myself as opposed to some woman that I didn’t even know, just comes in, literally took off my top, I didn’t know what was going on. Then she just starts washing me, I’d just had a baby and she was like... I hadn’t a clue what was going on and then, that pretty much sums up the birth. (Eva)

The above excerpt demonstrates “efficient” completion of task but disregards humanity of those involved, in line with what Bauman describes as “procedural rationality” which governs the technocratic paradigm (Bauman 1994: 6). It allows the taking of efficiency
to its extreme, where “everybody’s action must be totally *impersonal* (...) it should not be oriented to persons at all, but to the *rules* which specify the procedure” (ibid.). The result is what Berg terms as “suffering inflicted by care”: being deprived of one’s dignity, not being listened to or taken seriously, reduced to mere physical body (Berg 2005: 18).

6.3.1 A dignified way to give birth?

Dignity is a “multivocal” concept (LaVaque-Manty 2017: 308). While the above excerpts relate to what we might call a universalist sense of dignity, women also refer to a more normative notion of dignity. The universalist concept of dignity is about respect for humanity of a person, while the normative one is about the “respectful” and “appropriate” manner to act for individuals in the society, and is often used in a strongly gendered sense, imagining a particular (i.e. different to men’s) “respectful” way to be and act for women. Such a normative concept is tied to the notion of the autonomous rational individual of Western technocratic society, able to control her own behaviour and thus exercising control over her own bodily processes. In such a context, childbirth is an event when appropriate, “civilised” boundaries for behaviour potentially break down (Chadwick and Foster 2014: 76-77). This makes circumstances associated with it, e.g. positions adopted, lack of clothing, sounds made, presence of bodily fluids, verge on animal-like and un-reasonable, thus “undignified”. Women are forced to confront this confining notion of being “undignified” when they are giving birth within the technocratic framework:

I was like this too **with my legs up**... but no one really comes into the room cause you’re up in the maternity suit so it’s only doctors and your partner so it’s not like it’s visitors are going past you. The door is closed and people knock when they come in so you wouldn’t really be worried... [Q: About privacy?] Yes. That door (on the photo) I think is open... but that’s just probably the doctor going in and out. But she’s more covered here (on the other photo). I wouldn’t like the door open like this, screaming like "argh!"... but when you are in labour you **really don’t care**. You don’t think this... just think "just get this baby out of there!". (Shauna)

I had these **little stirrups** at the very end when I was pushing. (...) I walked around at the start and then I got to the point where I was dilated and I was lying on my side for a while and at the very end I was lying on the bed **with my feet up**. (...) At that stage I’d
given up. I was like "whatever" (laughs). Yes, it’s funny, when you go in first you’re quite... I suppose you’re unsure and then after an hour, it all goes out the window, the guys (midwives) have told you what’s happening and what’s going on and you nearly forget where you are. You’re a little bit less, you go in first in your pyjamas and then all of a sudden it’s just your dignity has gone out, you’re more concerned with getting the baby out than anything else. (Nora)

The above accounts show the importance of privacy for women (closed door, no strangers, being comfortable enough to be naked) but also women’s apprehension about being in “undignified” “legs up” positions required by technocratic context. They talk about “giving up” and attempt to diminish their needs to “just getting the baby out” at the late stage of their labours, in line with technocratic paradigm which delegitimises women’s concerns. Women downplay these using quantifiers such as “a little”, “a bit” when describing practices which make them uneasy, and soften their criticism by starting sentences with “it’s just” and finishing them with “it doesn’t matter”:

The nurse had asked me would I mind if these people come in because this is like some random managers standing there and taking notes. I’m in too much pain, I don’t really care who’s watching. (Glenda)

However, despite calling it “giving up” there is strong sense in Nora’s account of midwives attempting to reassure and protect her so she can suspend her reservations. This is what moderates somewhat the technocratic parameters of her care and perhaps her “lost dignity” is, after all, about “feeling safe enough to let go” (Anderson 2000).

The strongly gendered concept of dignity portrays women as modest, quiet and calm, and in general, “composed” rather than “hysterical”. It reappears in women’s accounts as one of the regulatory practices of technocratic biomedicine as an essentially patriarchal practice, aimed to control women while claiming to “assist” them:

It’s not something that I would have liked, that’s what’s coming to mind to be honest. I don’t know, I don’t think I fancy sitting down. (...) I don’t know I don’t think I would like to be sitting there, dressed like that. I may sound prudish or something, but in hospital I prefer to be in a bed than bouncing up and down on a ball. It’s really exposed or something. When you’re pregnant and in delivery, you’re in a quite vulnerable state and I don’t think I would like to be like that. (...) I don’t know, the fact that I wasn’t exposed,
I was fully dressed and I had blankets and everything and they only took them down when they wanted to check something and also, during labour, you’re not actually allowed to make any noise. (...) They said to me, “You won’t make any noise during labour because if you’re making noise, you’re wasting energy and all of your energy should be focused on delivering your baby. So we don’t want to hear.” So even when you made a noise they said, “No, you’re pushing in the wrong place, any guttural or throat noises, we don’t want to hear any of that. Focus your mind on down there and that’s where all your energy is and if we hear any screaming, if we hear any noise, that’s wasted energy.” So there was no sound, I never even heard another woman having... I certainly didn’t make a sound and with both of them I didn’t hear a sound from any other of the four delivery suites. (Gina)

This excerpt illustrates societal pressures on women within this patriarchal technocratic framework to behave as befits the modern rational subject which frames childbearing, and women’s bodies in general, as undignified in their “uncontrollable materiality” (Grosz in Chadwick and Foster 2014: 77), also exemplified by another woman:

(the midwife) could train an olympic team... push, you can do it, one more push! I need to be shouted at... and then at one time I went... grrr, and she said ‘don’t grunt’ and I’m like ‘I’ll fucking grunt if I want to’ and she said no, then she explained why. (...) No, she says ‘use the energy, put your chin down and push, use the energy for pushing and you’re wasting it grunting’. (Claire)

This is yet another of biomedicine’s ways of erasing women’s embodied knowledges and claiming expertise over normal birth, exemplified here by its sounds, conceived as animal-like and potentially humiliating without its control. More “efficient” physiology of normal birth is supplied instead, as a means of remaining “dignified” because within technocratic society “the bodily state of birthing poses a serious threat” (Chadwick and Foster 2014: 77). Gina and Claire openly state in the interview that they prefer technocratic care as in their view it ensures safe birth. However, for Gina such care is equally meant to protect her personhood and dignity as the excerpt above demonstrates. However, such precautions would not have been necessary within the maternity care that does not imperil them in the first place. Eventually, technocratic management of her birth does not live up to its promises of dignity:
they tried to deliver her with the ventouse, maybe three or four times, I thought it was absolutely rubbish, it’s a bit graphic, but when he was pulling with the ventouse to try and get the baby out, I was literally just sliding down the bed (laughs). We were all going down and I obviously was drugged so, I thought it was really funny and he said to me, he was quite narky, “this requires some maternal effort, as in you push when I pull.” (Gina)

This brings out the conflict around dignity at the centre of technocratic birth which offers to maintain modesty and composure to those who accept it but at the cost of more exposure and “indignity” than would be necessary if not for routine “technological gazing” (Fahy 2002: 7). Technocratic management requires unobstructed access to women’s bodies, equating this access which “seeing” and “knowing more” and demands women’s unreserved submission to expertise without “false” modesty. This is labelled as appropriate, responsible behaviour, in what has been termed a “coercive contract” between women and obstetric science (Murphy-Lawless 1998). Thus, for Gina in the last excerpt, the most feasible “enablement” of technological management seems to lie in the disembodied state it allows, and this is her way to protect her sense of personhood in birth experience which under technocratic paradigm is undignified either way, medicalised or “natural”.

6.3.2 Feminist critique: objectification of birthing women

What emerges from women’s accounts epitomises the way the technocratic paradigm subjugates women’s ways of being, and subjugates other (than controlling) ways of caring for them. The threat arises not from the intimate character of the birth, the nakedness and uninhibited behaviour as such but from objectification and disregard for women as unique individuals. This is demonstrated in women’s unanimous rejection and distaste for stirrups, associated with the lithotomy position favoured by obstetrics as “the most satisfactory”, with stirrups used “for better exposure” (Cunningham et al. 2016, online edition). For women it is an epitome of objectification experienced during

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85 Procedures involved in monitoring or for dealing with complications are often intimate and require exposure of woman’s body (e.g. particularly vaginal examinations, internal CTG, catheterisation, strong light for surgical procedures, etc.). Moreover, whenever technological intervention is necessary this usually involves exposure in front of experts who are strangers unconnected to woman’s overall care, as some of them are there for a specific task to be dealt with (e.g. an anaesthetist).

clinical procedures and stirrups, a seemingly insignificant equipment, elicit women’s consistent attention and sometimes terror:

When I see them that freaks me a bit now, it’s like Jesus you know it’s obvious that you have to put your legs into [stirrups]... (Claire)

So the machinery itself wouldn’t bother me. Now these things, the stirrups they bother me because when I went in for my checks in the midwives office she has got a chair with these and I used to be like “oh my God” just the thoughts of being up in that chair but that’s the only thing that would bother me (Phoebe)

the first thing that actually jumps at me are these stirrups or whatever you call them, oh god take them off the bed. Imagine if you walk in and that’s what you see. (Sheena)

Now, I don't like looking at these [stirrups], we don't like them, right? They should be hidden under the bed. They should be there because obviously it’s practical, and they’re the stirrups but when I see them I think of forceps, I'm like "nooo"... (Tara)

While such a framework for protecting women’s personhood is missing in technocratic maternity care, it does exist within a midwifery approach where genuine caring, and thus protection of women’s privacy and dignity are inseparable from caring (Chokwe and Wright 2012), regardless of complications and need for using technological expertise (Berg 2005). It is the philosophy of genuine caring which is “dignity protective” (ibid.) rather than adherence to technocratic protocols which often “protect” hospital policies at the expense of women’s needs (Edwards 2004a). Within the context where women and their abilities are nurtured and protected, such preoccupation with the “risk of exposure” becomes a less pressing, less relevant concern because it is looked after by those caring for women (El-Nemer et al. 2006).

6.4 Supporting women’s ability to work with their bodies

“I fear that this semi-recumbent position is still encouraged for many women around the world, even in the face of so much evidence about the benefits of upright birth. In my experience women in labour who have the freedom to listen to their bodies almost never lie down to give birth. I have been a midwife for a quarter of a century (...) and I can count on one hand the number of times I have seen a women actively choose a supine or semi-recumbent position for pushing her baby out. (...) women are giving
birth in an all fours or kneeling position, which seems to me to be one of the most natural positions for women to feel safe and ‘grounded’ while bringing their babies into the world” (Reed 2017: 12)

“being forcibly locked into any position during labour is less preferable than being able to freely change position as desired (...) But this unmechanical behaviour is too incompatible with the technocratic model to be a viable option” (Davis-Floyd 2004: 125)

The importance of position for labour and being able to move freely is another aspect extensively discussed by women when reacting to the images of high-tech environments:

That is a very good care, yeah. I don't like that one [photo of a woman lying down]. See, these women want to handle their pains their way. How is this woman going to handle that pain? (...) I was [like this] on my first baby. I stayed at home with my second one for a bit so I could handle my pains. In a hospital you’re just lying on your back. Especially when you have back labour, it’s a terrible pain. You’re grand, you’re ok but... you do wanna move around. Because how are you going to help yourself feel to cope with pain, hold on to stuff, even just be out of the room. You can't do that if you’re lying there with all the wires wrapped around you. (Sally)

I never remember, ever, having to wonder about how do I get on and off the bed or how do I manoeuvre myself, she (midwife) was amazing and I don’t remember her even leaving the room at all, she was always there... I did have a wobble and I did say, “I want the epidural.” and actually, that was the only time that my midwife wasn’t there, she had gone on break and I had the other midwife come in and she had told me... I was so tired and she told me to lie down and in the space of ten minutes I was like, “I need an epidural”. (...) my biggest concern was I didn’t want to have a catheter so I said, “Let me go to the loo first” and once I sat on the commode I said, “Actually I’m grand now, I don’t need an epidural.” That was a lot more comfortable because I was upright so, I didn’t end up having it in the end but if I had been lying down... (Sheena)

They are monitoring the baby for 20 minutes upon arrival, it's something they do on everyone they explained that to me but... I didn't like it. I didn't like having to lie still in the throes of labour and contractions. Admittedly, I got really down on this. It's they need that for their file, the person came, they were fine, blah blah. They didn't really
give a shit about me. Because I clearly, I did not, and I told them, I do not wanna lie like this, it is the longest 20 minutes of my life. (...) No, you have to lie flat, no, you couldn’t move. (Tara)

However, these excerpts suggest that it is being truly facilitated to do whatever one needs to do, rather than just being upright or able to move that is important. Still, women do see upright positions as symbolic markers of an enabling, facilitating approach, where options are genuinely available:

The room looks much nicer. It doesn’t look as sterile, the fact that she’s out and about, to me looks like they’re quite open to what she wants to do. (...) To me, it looks like a good experience because it looks like she’s up and about doing what she obviously wants to do herself. (Nora)

That one looks kind of happy, I know there is lot of... she’s hooked up to things and all. But I don’t know like if it’s particularly bad, it’s not like she has to be in the bed, she’s obviously still free enough to do what she wants. She obviously was free to... make herself as comfortable within that environment, she is probably as comfortable as she can be within that environment. (Sheila)

Yet noticeably, while upright positions are considered crucial by women, and are recommended at hospital antenatal classes, they are presented as problematic:

She just said that "Oh, you can do that position or that position" but I just remember her saying that if you’re on all fours, that’s a difficult position for the midwife to view what’s going on. (...) I mean there must be a reason why we always see women lying on a bed flat and the midwives... (...) but also maybe it’s, what’s the word? Convention? That this is the way it is. (Grace)

Presenting certain positions as unconventional strengthens medical authority over a woman’s behaviour and movement considered appropriate. As a result, upright positions seem to be adopted as an accidental discovery rather than a genuine option, and it is sometimes difficult for women to even name them:

I don’t know if she needs to lie like this. The other women, they know what they want, they are aware - this is not Poland that you need to lie down - it’s whatever is comfortable for you. (whispers) Do you know I had my son on all fours? (laughs) I really don’t know if she needs to lie like this. (Gabriela)
I was on the bed and I turned myself around and I had my daughter like - what way would you describe it - squatting? (Tara)

This strangeness of upright positions is consistent with the lithotomy position being regarded as most favourable for surveillance and management of pathology within technocratic approach. And thus, it is this position which seems easiest to adopt as in this interview with a couple:

Javier: We tried to do sideways and it didn’t work... These two look ok, what I like is that they give you the option, if you want to have the ball you can have the ball and that they are open... I mean they tell you ‘if we notice any danger we’ll change’ but if you want to have it like... squatting they are open to that, I like that.
Claire: Oh yeah, we tried a few positions for labour to start with and I tried on my knees, we couldn’t do that, we tried sideways, we couldn’t do that so then I ended up on my back... I mean we had enough, it didn’t matter about the ball in the end.

Women consider lying on their back for birth as “ending up” or “giving up” but no other position is seen in such light. They are merely “allowed to try” a number of positions within a disembodied protocol which disregards the knowledge coming from their bodies, their efforts at odds with what is prescribed, and what always “works”. This again exemplifies the regulatory aspects of technocratic discourse, here intensified by the resort to its understanding of risk, where woman’s spontaneous activity is “screened” for danger and conditional on its expertise.

6.4.1 Walking and the birthing ball: resisting the technocratic understanding of “natural” active birth

The issues around women’s freedom to move and act in an unconstrained way are exemplified by the way they discuss both the birthing ball and walking in labour. While those two practices are associated with normal or active birth, and portrayed in hospital

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87 Trying out different positions during labour in a prescriptive checklist manner is consistent with the technocratic framework. It disregards women’s embodied knowledge and fosters separation from what their bodies urge them to do. In this context adopting positions which are helpful for labour and coping with pain can become more difficult.
88 Such regulatory discourse is echoed in the Irish National Maternity Strategy (DoH 2016) where women are facilitated “insofar as it is safe to do so”, safety being defined by technocratic biomedicine.
89 “Natural” birth within the technocratic paradigm is different to normal birth advocated in a midwifery approach. Even if no surgical intervention or medication is used, childbirth is understood mechanistically and requires technocratic management, by applying to it timeframes for progress, scientific measurements and putting it under technological surveillance.
maternity care as such, these are subsumed under technocratic “management” of normal birth and its prescriptive framework discussed above. Walking and using the ball are often applied mechanistically, an activity with a technical purpose of efficient progress of labour, resembling an active management philosophy reliant on techniques imposed on women, rather than the result of facilitating an approach where listening to women is central. For many women in my interviews, this can make the ball and walking inadequate responses to their needs and paradoxically, rejecting them becomes a form of resistance.

6.4.1.1 Walking: “natural” means to achieve progress

Walking is “subclinical” and thus has little merit within biomedicine. Ultimately, all women are able to walk, at least those not anaesthetised or attached to a fetal monitor. Therefore, they can be “told to” or “sent to” walk and left alone to do so:

Walking up and down the halls, which is what a lot of women are told to do (Gina)

I was speaking with people that I know, some of them were told just to walk corridors for 6 hours and when they got back to the bed they were told to go up the bed and walk up the corridors. (Cecilia)

I wasn’t dilated at all and they sent me walking and I was walking for about, I’d say, half an hour (...) I was lucky that my midwife was telling me to go walking, that I was up and about because it was more comfortable for me (Nora)

Walking seems not women’s own effort but an option “given” to them, as if women could be prevented from walking if they wished to do so. Still, within the effects of the power of the technocratic model, this is precisely what happens, and walking, as anything else, needs expert endorsement. However, beyond this endorsement, as those excerpts demonstrate, women are unsupported to walk in labour. The way they describe “walking the corridors” suggests that there is nobody doing the walking with them, their caregivers not physically or emotionally present. Surprisingly, even women’s

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90 Within active management “something” needs to be done continuously to ensure progress, even if it is such low-ranking activity as walking. If nothing is being done and progress is not “satisfactory”, technological intervention takes over and then it is acceptable for a woman not to walk anymore, as the intervention ensures the progress in place of her efforts.
b birthing partners are absent from those accounts of walking, and while we can assume their presence with women, perhaps they seem to be “sent away” as much as the women themselves. Also, the lack of real support to move around freely is reflected in women’s observation that there is actually nowhere to walk:

it’s literally, they had four delivery suites and the hall in between and then the hall out, but once you go outside that, it’s across to the maternity ward so, there’s nowhere really to walk. No facilities like that. (Gina)

ey they were as good as they could be but I think if I had been in like at home environment where you could go and walk around your back garden or you could stretch yourself out or maybe have a bath. (Phoebe)

ey were told to (...) walk up the corridors. Which is not nice with your first baby and like I don’t really want to and it’s a public corridor, everybody is watching me. And this is the nice big room (low-tech birthing room), you can just walk around. You don’t have to go outside. (Cecilia)

The last part of the comment refers to a low-tech birthing room, which – on the contrary – is spacious enough to walk inside it:

There is lot of space to pace up and down (Javier)

It’s good that there is this space so she can move, she can do the walking or do the bouncing on the ball. (Gabriela)

Yet this room is an exception rather than the rule in Irish maternity hospitals so the majority have to do with the corridors, which do not provide a secure environment, with their lack of privacy, presence of strangers, their noise and business. Also, women observe that walking is discrepant with being continuously connected to monitors and drips. It is precisely those that epitomise the technocratic approach, where enablement seems to be conditional on and inseparable from control:

I was told "Oh yeah, move around. You can go to the toilet, you can do whatever you want” but I couldn’t! Because I actually physically couldn’t unless I took the drips off my... you know. The cords and the wires wouldn’t go that far. You have one bit, you
have the drip on the little wheelie stand but you can’t take your fetal monitor into the toilet with you, yeah. (Kay)

you can’t really just roam freely around, you’re still restricted (by the monitor). I know when I was in labour, I went for walks. Obviously, there’s a certain point where you can’t because the contractions are coming hard and fast. (Lynn)

Thus, walking becomes more of a concession made to accommodate “active” birth in the hospital, preserving the technocratic framework, where the woman’s need to move unconstrained based on the signals coming from her body is dismissed.

6.4.1.2 The ball: inscribing low-tech with technocratic principles

Similarly to walking in labour, the ball for many women symbolises active birth, freedom to move and being supported in working with one’s body in labour. Some women see the ball as part of what they term a “new” approach which facilitates rather than constrains them:

It makes sense to have like the way their new thinking, they get some space and the ball and the shower or a bath that’s all, you couldn’t do that in a small room without the bath. (Kelly)

you just come in, lay in a bed and have your baby, like the old way you had to do it, but this is new kind of "being up and about" and bouncing on the ball (Nora)

Photographs of women sitting on the ball convey a sense of a flexible, open approach which women articulate as an important need in labour. Also, such an approach is again associated with a low-tech room:

This to me is probably more accepting of people’s needs and what they might want to do themselves. They both [women sitting on the ball] look to me as if this was their choice and this is how they wanted to do it (...) Having the options I think was really important... if I wanted to use the ball it was there, and being able to walk around and have the feeling that you had that control. That you could decide, it wasn’t the case of you just stay in the bed until you’re ready to have the baby. (Nora)
[the low tech room] **looks like there’s lots of options** for somebody as well, it’s like even with what has to get done, **you can go in and decide** how I would birth because of what would suit me now... (Sheila)

Accordingly, not being actively offered the ball is seen as the lack of options:

I was fed up and in so much pain. I was after saying I didn’t want the epidural and I was asking when the midwife came around (...) "I want a gas and air" and it was after saying I didn’t. And she was really nice and I think if she has had been more like "oh, you can get out of bed, do this and that, you can use a ball" and offer other things but she wasn’t. She wasn’t pushing the epidural on me but it wasn’t like "here is the other options for you". (Miranda)

Finally, women realise that there is scant support or encouragement for the “new way” when they are told to bring their own ball:

They seemed very open to... there was a lot of space and stuff and I know they said you can bring your ball there and that kind of stuff. (Sheila)

And then they said to bring a fitness ball, so we were going to bring the fitness ball, we had the bloody fitness ball at home, too big for the taxi, and so we left it at home... (Claire)

Encouraging! No, that’s what they say, “you can do this” (...) and when you’re in the labour room, if you want to bring a ball, you have to bring your own. I’m in labour and I’m carrying this and it has to be inflated. Who’s going to do that when you’re in labour. (Eva)

It would be difficult to imagine women being told to bring biomedical supplies, at least not in a high-resource context of a Western hospital. While the ball is not an essential piece of equipment, it is still an important marker of active birth in a hospital environment which is not conducive to women’s mobility in labour (Fahy and Parratt 2006, Foureur 2008). This demonstrates that the ball in technocratic maternity care is a permitted yet subjugated practice and an equivocal piece of equipment. It is familiar, recognised instantly for its function (regardless of intention to use it) but at the same time it is unfamiliar and strange and not a standard furnishing of a birthing room or a standard thing to use, suitable only for some particular group of women:
So I’m not sure what you would do with the sling or the pole, but the ball obviously and the mat and then the bed for helping you get on all fours. Yes absolutely, it’s a good facility to have. I would imagine if you’re obviously planning on that kind of birth. (Gina)

if you go in and say well this is what I want and I went to the antenatal classes and I did talk to friends and I think, I don’t know, I think it’s kind of older women, or kind of... not old...maybe older women... or sometimes more... foreign people, the foreign women, Eastern European that kind of go for... they kind of... they are more... not aware...in the countries where birth and all this is different to the way it is here (Miranda)

Its strangeness manifests through the language women use, many of them calling it a “fitness” or an “exercise” ball, emphasising that it does not fully belong (for disparate reasons) in the birthing room. It may as well act as a “technical fix” to their needs or be a marker of not being taken seriously, as women talk about undignified “bouncing” and “jumping around”. Thus some women comment on it in a condescending or explicitly mocking tone:

This woman is really trying to make use of this ball but it won’t help her in a couple of hours. (Marzena)

she’s just trying to help get the baby down in the right positon... is that why she’s bouncing like that? (Gina)

And there’s the ball again. [sarcasm] Yeah... I don’t know, she looks full on, she looks like... see this thing here, this is like the trace machine, it’s spitting up paper the whole time... (Tara)

In this last quote, it seems that this woman resists the prescriptive use of any piece of equipment, be it the low-tech ball, or the high-tech monitor. And similarly to walking, women recognise the concessions to the technocratic framework when using the ball, as duplicitous:

She’s on a ball and yet she’s strapped to something (Eva)

It feels like there’s a conflict between the touchy feely, the freedom to have your yoga ball and all of that and then, it’s like well you can have these, but you also have to be plugged into this monitor and drip or whatever it is (Lynn)
Flexibility and openness in supporting women is still missing despite the balls and the emphasis on mobility in labour. These may be annexed by technocratic maternity care to serve its own ends, and resemble Ellul’s technique (Ellul 1964) in supplying efficient protocol and prescriptive rules controlling women’s behaviour, and this is what women resist, even if they do want to move and have normal birth:

"The midwives wanted me to sit on one of these balls and do all of that but I wasn’t into it and I have to be honest with you I was like get that away from me. (...) No. Get that out. I don’t know what’s the point in these balls, I didn’t want to sit on it. It’s an exercise ball and I’m sure sitting on it may relieve your back but if you kneel down on your knees and stretch your back that also relieves that. None of this stuff existed years ago. (Tara)"

They do seem to have that little exercise ball everywhere, don’t they? (Q: Have you used it?) No, I think I just knelted on my bed or something. (Glenda)

Women’s accounts suggest that it is perhaps not another piece of equipment which they need to work with their bodies. It is the approach where whatever piece equipment is offered, it is used to facilitate women’s abilities and empower them. Women’s accounts demonstrate ways of resistance to the technocratic discourses around the use of the ball and walking in labour and their constraining effect on birthing women.

6.4.2 Options without support

Being offered options within such a highly prescriptive system is more about control than enabling women. Edwards (2004: 117) observes that “women just do not do what they feel is right without support”:

"there's stuff for [use] here (in the low tech room), the balls and things like that whereas going into hospital I never knew I should bring the ball in, did they have a ball in there, am I allowed to do this... I was never told, I didn’t plan to bring it anyway. But it's nice if you had the room with the open availability and you won't feel... silly in a way for asking. You don't really know, that's the thing. You're not really informed... you're not really informed that much about what you can do... (Cecilia)"

91 The Albany Midwifery Practice is an example of such a flexible approach. In a book of photographs published by one of its midwives Becky Reed, women birthing actively are shown using many furnishings to support themselves, the birthing ball not as prominent, being just one of the options (Reed 2017).
When you are about to deliver, the very first position... it is very difficult to deliver if you are just lying on the bed (...) I mean the position... I found the position very important for the birth and I found it difficult. I was basically in the lying position, I didn’t try any other position but I found it was really difficult. (...) They gave me options but they helped with the... they were holding my legs at the end. (...) I wasn’t trying any other positions. Perhaps I was supposed to be more creative about this myself...

(Lenka)

Those excerpts demonstrate that where skills to facilitate certain options and support for them are lacking, those options become illusory and dependent on women’s own resources, the responsibility for accessing them delegated onto women. As a result women are seen as not interested in options “freely” available to them. If spontaneous movement in labour remains subjugated practice, then even being out of bed in an upright position on the photographs becomes insufficient for women, and an empty gesture:

Again like the prominence of the fetal monitoring, it's just (...) it doesn’t look comfortable or natural. The position is good but I would imagine that if she wanted to stand up and place her hands on the bed and kind of sway with their hips, that she wouldn’t be able to do that. The wires, she might not stretch that far. (...) What I see in even the happy ones is this kind of tokenism, sort of like "Oh, we'll let you... do this", "as long as you let us tie you up and wrap you in wires and cords and stuff then, sure, you can have any position you want" (...) there’s an understanding that they have to pretend that it’s your experience and that you’re in charge but you’re not actually. (Kay)

6.5 Conclusion: Subjugated knowledges are key to enabling care and women’s empowerment

Women’s voices presented in this chapter yet again undermine the seemingly uncontested nature of technocratic discourse. For women, technological “enablements” while acknowledged, when applied within the dominant framework are often ambiguous and even disingenuous, serving institutional objectives rather than truly supporting women in birth (Walsh 2006b). What emerges from the analysis of “excluded” aspects of maternity care, is the tension between women being enabled in their ability to give birth and enablement offered by technological expertise which
allows it to overstep this ability and is currently considered the “true” enablement. This is the tension between women’s need for such care which is truly empowering and supportive and the system of care which is controlling and patronising. This is particularly important in the light of research identifying that empowerment, in its material, psychosocial and political form, is “necessary to achieve the highest attainable standard of health”, and thus central in mitigating against health inequalities and ensuring women’s wellbeing (Marmot et al. 2008: 1667).

Based on women’s accounts the potential for enabling, empowering care lies in the meaningful presence of a caregiver, personalised respectful care, and being facilitated to labour according to one’s needs. Yet, within the dominant framework, maternity care is considered adequate even if all of the above are not provided, despite mounting evidence that disregard for these may produce harmful effects both in clinical terms as well as in terms of overall health and wellbeing of women and in the wider society (e.g. Davis-Floyd 2001, Downe and McCourt 2008, Tew 1998, Wagner 2001). While these may be partly catered for and accommodated by health practitioners within technocratic maternity care, they are not systemically supported as they do not fit its lexicon of protocols and rules. However, the issues women talk about in this chapter are central to the ethos of midwifery\(^2\) and thus midwifery provides a model for such empowerment in maternity care as argued incessantly by numerous academics, activists and the midwives themselves.

\(^2\) It is important to note, as Rothman (1991) observes, that the ethos of a midwifery approach can be actualised not only by midwives but by any practitioner in any setting, once they are guided by its philosophy, as I have discussed in the Introduction to the thesis.
Chapter 7

Appropriate birth technology in women’s view: dismantling technocratic regimes of truth.

7.0 Introduction

In this chapter I aim to reconstruct from women’s accounts what they consider to be appropriate maternity care wherein technology is used in an appropriate manner. In the broadest sense, appropriate care has been considered as such where “the expected health benefit (...) exceeds the expected negative consequences (...) by a sufficiently wide margin that the procedure is worth doing” (Chassin et al. 1986: 58) and can be viewed as similar to the concept of evidence-based care. However, there are other aspects of appropriate care such as its cost-effectiveness (WHO 2000: 13-14) or “justice of resource allocation” (Hopkins et al. 1993: 117), as well as its consistency with “ethical principles and preferences of the relevant individual, community or society” (WHO 2000: 2). I focus on the latter understanding of appropriate care which reflects women’s hopes and needs, respects their knowledges and values and does not disregard the discomfort and harm inflicted, and also considers its socio-cultural context.

I examine how women negotiate discursive strategies of the technocratic “regime of truth” and its notions of what is appropriate in maternity care. These discursive strategies, i.e. regulated ways of maintaining and obscuring the prevailing social relations of power associated with this regime (see Chapter 3) help to maintain and sanction its functioning as “true” (Foucault 1980b: 131). Yet, women’s insights provide conceptualisations of appropriate care which depart from this regime and suggest ways to challenge it.

In this chapter I explore three discursive strategies which women are compelled to negotiate in their accounts. The first strategy (section 7.1) constructs humane and technological aspects of maternity care as if they were in essential conflict, and maintains them within a rigid hierarchy where the humane can be subjugated by the technological. The second strategy (section 7.2) maintains that it is women’s decisions and the flawed nature of their reproductive processes, much more than the
technocratic philosophy of biomedicine itself, which produce “risk” and are thus responsible for the current extent of technological intervention in birth with all the dilemmas that this entails. The third one (section 7.3) is the strategy of “technical fixes and technological imperatives” (see Chapter 2, section 2.2) which maintains the technological as the most crucial aspect of future maternity care, and the provision of more sophisticated, fine-tuned technologies as the ultimate solution to ensure better outcomes.

The starting point for this chapter is the range of women’s reactions to photographs of the two intensely high-tech developments in maternity care: Neonatal Intensive Care Unit (NICU) (section 7.1) and the operating room where a woman is undergoing a caesarean section (section 7.2), which the majority of women in my sample did not experience during birth, and for this reason I found showing women these photographs particularly helpful93. The material in this chapter also comes from women’s responses to the question about their view of the future of our maternity care, and “inventions” to be developed which could help women and infants (section 7.3). While asking about inventions, I hoped to suggest that women might articulate their understandings of the technological focus in future developments in maternity care. In their responses, however, women often worked against rather than with this suggestion, focusing primarily on non-technological aspects of the future, to do with the social, the humane and with the provision of basic care.

7.1. Cautious about the NICU: contesting terms of access to intensive care technology

Of course, I can give out about the unnecessary intervention and use of technology but I do acknowledge that sometimes it is essential. (Lynn)

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93 Only one woman in my sample gave birth by emergency caesarean section, twice, due to fetal distress). Additionally, the wife of one man in the sample had a caesarean section for placenta praevia. Similarly, only two women had their babies admitted to NICU. I acknowledge that the lack of direct experience may have affected their view of those technologies, perhaps making it easier for them to insist on a balanced approach to their use. Still, some women experienced complications which were clearly life-threatening for them (eclampsia, severe haemorrhage, stillbirth, diagnosis of fetal distress) despite not having a caesarean section or their baby admitted to NICU. Thus, I consider it justified to see women’s perspectives as their balanced account of birth technology, and acknowledge that their unease about the way it is used is often spoken from the position of those who realise that their health or survival may have depended on it.
In this section I examine women’s reactions to a photograph of a NICU\textsuperscript{94}, considered as a clearly life-saving technological environment. The way in which women negotiate the technological aspects of care in the background of this photograph and the humane ones\textsuperscript{95} in its foreground, helped me to unearth how technocratic biomedicine encourages the conflict between humane and technological in provision of maternity care. Women refuse to see this conflict as obvious and unavoidable, and insist on an approach which could foster the balance between the humane and technological instead. I demonstrate how the strategy of maintaining such conflict subjugates the role of the woman, as well as the role of a humane environment, in the infant’s survival and wellbeing.

The technocratic framework dichotomises safety and women’s emotional needs and their knowledges when complications arise (Rothman 1991) and thus does not accommodate conceptually the balance between the technological and the humane. Achieving this balance has been recognised as a significant challenge of contemporary health care provision (Barnard and Sandelowski 2001, Berg 2005, Chokwe and Wright 2012) and has been the basis for Davis-Floyd’s (2001) distinction between technocratic, humanistic and holistic paradigms.

There have been persistent concerns about appropriateness of some NICU admissions and efforts at reducing their harmful effects when admissions are deemed necessary (e.g. Battersby et al. 2017, Hallsworth et al. 2008, Zeitlin et al. 2016). For some infants “transitional”, less technologised care options, have been suggested as more suitable (Battersby et al. 2017, Schulman et al. 2018). Thus, the terms and the extent of NICU

\textsuperscript{94} Although this study is focused on technology used during labour, I consider it justified to focus on neonatal intensive care technology as well. If we conceptualise NICU as about infants only, we are accepting the modern division of expertise into specialised areas and how it contributes to the fragmenting continuum of care. Within such a framework it is easier to separate infants from their mothers when providing care and to diminish mothers’ importance in ensuring their children’s wellbeing. It seems this is precisely what is happening, according to women. Also, I am focusing on mothers’ rather than fathers’ roles, as this study has been predominantly based on mothers’ accounts, and the photograph which was discussed features the mother and not a father. However I acknowledge fathers’ importance in caring for infants in NICU (for a comprehensive review of fathers’ role in the NICU see, for example: Shorey et al. 2016).

\textsuperscript{95} I consider “humane” as unique to humans, impossible to address or simulate artificially to the extent of fully matching its human equivalents. “Humane” is about human senses, emotions and uniquely human capabilities such as, for example, human relationships, caring, love, human warmth and touch and these are not susceptible to mechanisation and technologisation. Also, while I acknowledge that technological activity constitutes one of the important human activities, in this research for analytic purposes, I am following the juxtaposition of the humane and technological aspects of care present in biomedical discourse to explore their conflict. Moreover, the exploration of blending ontological distinctions between human and technological (see, for example, Haraway 1991a) are not the focus of this thesis.
use is not unproblematic. Yet, within a technocratic framework, NICU is seen as the ultimate level of care for an infant.⁹⁶

7.1.1 Engaging with the technological

The suffocating amount of machinery in the cramped space is usually women’s first observation, with some of them absolutely shocked at the scarcity of space and its hostile, alienating quality:

> It looks... (speechless) like... so crowded with the technology! (Kelly)

> It’s just so cluttered with all sorts of things, there’s just no breathing space in it at all! (Grace)

> Holy Mary mother of god! That’s a lot for a fact. But if my baby had problems then... I don’t know... actually no, even for me... this makes a horrible impression even on me. (Marzena)

The last quote is particularly significant because it comes from Marzena, who is, for the greater part of the interview, very comfortable with technologised clinical spaces. Yet this one reminds her and other women of places not only unwelcoming of, but also outright dangerous for humans:

> When you see your baby inside this robot... it’s insane... then you realise that your baby is seriously ill. If it requires that much. (Marzena)

> you could almost see like it was a jungle or something except where everything is made out of plastic and steel and... she's just got the one, no, two foot square space in the room that is not taken up with machinery and fabricated objects (Kay)

> it looks like a horror where they’re dragging these people into this room to chop them up (Glenda)

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⁹⁶ While the positive effect of NICU care on the mortality of very low birth and very premature infants is well established (Chien et al. 2001, Menard et al. 1998, Phibbs et al. 2007), the benefit for other birthweight categories and infants born closer to term is less substantial, raising the question of appropriateness of NICU care for some of them. The possibility of supply-sensitive care, i.e. more infants being admitted to NICU when additional beds are available without proven health benefit has been raised (Carroll 2015, Freedman 2016). NICU care can be provided “needlessly”, particularly in the context of lack of clear data indicating which infants would benefit (Goodman and Little 2018).
There is a sense of inappropriateness which prompts women to question them, despite their perception of having insufficient knowledge to do so:

It just look scary and intimidating and stressful (…) and she looks really tense as well, the mother… and you can see the tubes going over to the baby and things like that but I guess they need to be so, that’s just the way it is. (…) Yeah, I wonder what it’s all for? I wonder, is everything in that photo, every piece of equipment necessary? But I don’t know how… I would... I don’t understand but... (changing her tone to sarcasm) So you’re... really? All of that? (Grace)

At the same time, they imagine that the lack of equipment may concern them almost as much:

If you went into a room with no equipment you’d be worried, thinking "where’s all the equipment" should anything go wrong here. So you can’t have the best of both worlds... You don’t want to see it cause it’s scary but then you want to be reassured, "no, it better is (scary)". (Cecilia)

However, as the above quote suggests, it is the effects of the technocratic framework which contribute to perpetuating women’s concerns, as the alternatives are conceptualised in negative terms (“no equipment”) and thus undermined as insufficient. Rather than imagining appropriate care comprehensively, it is reduced to the “appropriate” quantity of high-tech resources.

7.1.2 Engaging with the humane

Still, for some women, the bond between the mother and baby, the fact that the mother is breastfeeding, are the first aspects they see on the very same photograph:

It’s a lovely photo. It's obviously a baby getting a feed from its mom. I can see that the baby is hooked up to different things. Yes, it’s a really tender moment. In that sterile atmosphere. (So this sterile atmosphere is not really that important?) I'm sure it's important but I guess the main thing I'm focusing on is that she's there with her baby, a nice bonding moment and feeding her baby. I'm sure it's not easy in that environment for the baby or for the mom. (Sybil)
Wow, a lot of equipment in a very small space. (...) It’s a nice photo though. **What’s lovely about it is that in the midst of all that equipment, she’s breastfeeding her baby.** It’s like the most natural thing and then all this equipment around it. (...) When my daughter was born because she had such a long labour, they made sure she was here (on the chest) straight away, kangaroo care, and they were really, really into breastfeeding in [hospital], the lactation expert visited you and taught you how to breastfeed (...) and obviously they had pumps for expressing to feed the babies who couldn’t breastfeed, but I think yes, there’s definitely room for both. (Gina)

For these women, this photograph perhaps represents the sufficient balance of humane and technological in our maternity care, and while not ideal, seems appropriate within the circumstances. Interestingly, one woman completely ignores the equipment, and situates this image within her own experience:

> Awh, this is the best moment... because you actually have your baby with you, it’s the best moment. The contact with the baby. I think they should do it straight away like they took mine, they washed her, they weighed her, they check the eyes, the ears and the nose and then they gave her to me. Probably it would have been better if they had given her to me straightaway, I know they had to clean her... but yeah, give her to me. Straightaway she was looking for me, looking for it [breast], she was opening her mouth and closing it. Straight away I did it [fed her] (...) the nurse came up and said to me ‘all the other kids are sleeping, I’m going to take her and give her a bottle’ and I said ‘don’t, don’t give her a bottle!’ They took her and 5 minutes later she came back with the baby and said ‘she didn’t want it’. There you go, she was refusing it. (Roberta)

Her voice exposes the inappropriateness of the technocratic framework, where even apparently healthy babies have to undergo certain procedures before being given to their mothers. It also raises a question of whether its objectives are about ensuring wellbeing or rather about maintaining control.

7.1.3 Woman lost in technology: the power effects of technocratic discourse

7.1.3.1 Technological and humane: is there a conflict?

> once they start using something like that, then you’re removed, if you like, from the picture. (Lynn)
Women’s multiple reactions introduce the complex contexts of coexistence of high-tech expertise and a humane element in current maternity services:

I think sometimes you do need all of the machines and everything and you can still have your baby, and breastfeed your baby, and have your skin-to-skin contact (...) it’s all medicalised and yet she’s just like... normal births. (Miranda)

However, the “truth regime” of technocratic biomedicine juxtaposes technological and humane and maintains them within a rigid hierarchy where humane is subjugated and can be overpowered by technological for the sake of “scientific” risk management:

[a friend] had a really terrible time because she was so late being sectioned that the baby was in distress and had to be resuscitated. (...) But my other friend had an elective (...) she was separated from the baby afterwards, and she was healthy, the baby was healthy, they didn’t need resuscitation. So she would have liked that the baby was with her afterwards. (...) my first friend had the emergency, there was a necessity for her baby to be in intensive care for 10 days... **you can understand that the cuddle is not a priority at that point.** But for my friend with the elective... (Sybil)

There is very little space here. Very little. For me... as long as you are in good hands and it’s safe, it’s ok. [On] entering such room, I would have thought “it must be like this everywhere” and who am I to say anything about this, [to] tell if it’s too much or too little. (...) **it’s better to choose the lesser of two evils, if this equipment helps, it’s better to be close to such equipment...** that there’s no increased danger for the baby and to be able to enjoy your child later, to be close with your child later, **rather than increase the risk** now even a little but without the equipment. But it must be tried and tested, and not just for the sake of it. (Aleksander)

Those two excerpts demonstrate how such conceptualisation of humane and technological within technocratic biomedicine undermines the importance of closeness between the baby and its mother, despite the emphasis on an uninterrupted skin-to-skin contact and despite the “bonding” rhetoric in our maternity services arguing that this closeness is crucial (Edwards 2005: 122). It is their contact which can be interrupted and delayed, not the “contact” with technology, supposedly without too much damage (or “risk”). While the latter may sometimes be necessary, the former when done routinely as a matter of principle prevents us from imagining balance between the humane and technological in maternity care.
7.1.3.2 Women as intruders not caregivers

Women see this balance as crucial in this profoundly technological context but they also recognise their diminished role in such an environment:

Ay! It's horrible!!! (pauses) Little space, too many things, oh, it is inside the... the... what's the name... (intensive care for babies?) Yes, premature babies or sick babies. But it's (gasps)... very very small space. I don't see how... because when you are breastfeeding your child, you're bonding with your child... but this, I don't see how... because you are afraid, those machines I'm sure they are not just there, quiet. They are like beep! beep! beep! (imitating loud sounds of different pitch). You hear a lot in your head, you can't even focus on the baby. And the baby is attached to one cable and you are worried, you don't want to pull the baby too much. I mean, let's say it's ok, the baby is attached to something, that's fine, that's helping the baby. But I still feel this is too bulky, way (emphasises) too bulky (lowers her voice, then pauses)... like my goodness... (…) the room needs to be bigger because now look, this woman where she's sitting now, all she's getting now is just stress because of these machines. The machines are going ding! beep! you know. Every machine is making its own sound. So really I feel like it's just too much even if they have to be there. (…) Look where the door is, you have to squeeze through. What if you touch what you are not supposed to touch? (Eshe)

This woman acknowledges the necessity of such high-tech expertise but, like other women, she is reluctant to fully accept the terms on which this expertise is currently provided. It is particularly striking as this is the voice of a woman from Lesotho, who had her first child there and her second in Ireland, and she clearly acknowledges the superiority of Western health care saying: “in Ireland obviously you have a better care than wherever you were”. She emphasises the importance of humane aspects, such as the mother’s closeness with her baby, breastfeeding, peaceful, welcoming surroundings to ensure these, rather than such which induce unnecessary distress for both the woman and baby. In Eshe’s account the woman seems to be an intruder into this highly technical space and needs to “squeeze through” the machinery. She appears a potential hazard to the baby, her presence disruptive of the elaborate arrangements of NICU which she can misplace, or spoil their efficient, sterile character. While the technological is associated with safety and deemed central in the technocratic framework, the
humane ends up being restricted for safety reasons or by the lack of space. Within NICU only machines and the babies on which these machines perform their procedures are welcome and accepted, with no space for the ordinary human activity which is seen as best limited to a minimum.

Yet, for women it is not the woman’s presence in NICU that is inappropriate. What is problematic is the excessive “activity” of machinery and machine-made sounds which women “see” despite the silence of the image. Similarly to Eshe above, they are concerned about harmful effects of such an environment on healing for the woman as well as for her baby:

It’s too much going on in that. I’m sure you’d have too many noises going on and something’s beeping here and that starts beeping and this starts beeping, there’s too much going on. (Glenda)

I suppose it has to be like that, if they are in the intensive care I’m sure all those machines have a function, but I suppose it doesn’t seem... I don’t know if it would be that relaxing in terms of the little one... I was sitting with my baby on the ward and she’d be sleeping and it was quiet enough and there was no noise... and this just seems to me that there’s an awful lot for the baby to be taking in. (Nora)

Interestingly, women’s concerns correspond to the very real harm of the noise on infants’ wellbeing, reflected in research aiming to reduce noise in NICU and mitigate its negative effects (Almadhoob and Ohlsson 2015, Graven 2000).97

7.1.3.3 Subjugating women’s “intensive caring”

Women notice that their role is incidental and subordinate to the role of high-tech expertise as if they could not provide anything that this expertise could not supply. Not only are they not directly involved in the care of their children, but even their presence at the bedside is being limited:

I remember her having things stuck on her chest and she had a nasal gastric tube as well, which was horrific seeing that on her, she was so brand new, but... oh and a

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97 The ever-present noise of machinery in NICU has been identified as harmful for infants, impacting on, for example, their cortisol levels, respiratory and sleep patterns, heart rate, and potentially delaying their recovery (Almadhoob and Ohlsson 2015, Committee on Environmental Health 1997, Graven 2000).
soother, I was totally anti-soothers and she’d a soother and I was like ‘oh!!’ (...) It doesn’t matter what you want, now they do it and ...yes, there was very little room for the mother (...) I wanted to sit there and just be with her all of the time. (...) and they we like “look, we don’t have enough room for you to sit here all day and you need to be resting in bed.” So it was awful, it was terrible, but I would go down a lot to try and feed her. (Sheena)

I wouldn’t care that much but... that is too much. Too much stuff around. (And your baby was in the intensive care...) And there was a pipe coming out of every hole: the nose, the mouth... navel. And I was in and out, I had to go. Very difficult. To the point I didn’t wanted to talk about it (lowers voice and whispers)... that tough. (Gala)

Within the biomedical perspective women are barely “allowed” to “go up” and feed their children rather than be present without restrictions and be acknowledged as “primary caregivers” (Lee and O’Brien 2014, Warre et al. 2014). This reinterpretation of women’s position as subordinate if not superfluous is based on “the common premise that only NICU professionals with special skills can provide care for the infant” (O’Brien et al. 2013):

God, there is lot of equipment. It’s scary, isn’t it? The poor little baby. Although it’s really reassuring that the baby has all that equipment and that the mother is allowed in to breastfeed the baby. (So it’s scary but justified?) Yes, I suppose, it’s all there should anything go wrong (...) at least they have everything there. (...) But it’s nice that the baby is intensive care and mother is able to go down to it. I have friends who had babies in NICU and didn’t see them for 3 or 4 days. Because both of them couldn’t leave where they were. My friend was very sick after birth and she couldn’t go up to NICU. (Cecilia)

Awh... There’s so much going on in the background... she’s only allowed to get to the room to breastfeed. Yeah, that’s awful, that’s... like... I love that she’s breastfeeding and she has everything off so she’s probably comfortable in the situation but when you are in that situation to be honest you don’t see half of that stuff. It’s just part of it and you accept it because... who am I to question a doctor? To say that shouldn’t be here or why it’s in the room. (...) But at least she’s breastfeeding. Lots of people won’t do this, "no, they are too small, too tiny”. And it’s the best thing for them. Even if you express and bring it in and give it to them in the bottle. When they are really tiny like that they need all the help they can get basically. (Tara)
For women, being close to their children and breastfeeding are as essential as high-tech expertise\(^\text{98}\). These are “the best thing” and part of “all the help” that babies can get and the focus of care when complications arise, a position that is incompatible with the hierarchies of a technocratic framework.

Such diminished roles of the women and of the humane in care are also illustrated by women’s focus on the lack of the most basic “equipment” facilitating their presence and help when it is claimed to be permitted and desired, such as an appropriate chair to sit on and breastfeed. This makes them feel unwelcome and prevents them getting comfortable when caring for their children in the NICU:

It doesn’t look comfortable, she looks like she’s on a little tiny chair feeding the baby. Look at that, one chair. Oh my gosh [animates], that’s one thing I’d say about [hospital], the chairs, they were horrid! They were like this, they weren’t anything of a comfortable chair. (Q: Is such an environment justified?) Yes, yes. Especially for the neonatal intensive care, but it doesn’t look very comfortable for her. She’s feeding the baby properly, but she looks like she’s on that same wood chair. (Nora)

She just looks like she’s sitting in a chair, just a normal chair, where is the proper big armchair? Again, it’s like your comfort is real important when it comes to it. (Glenda)

[technology] is taking up all of this space and all of this is for these two people yet, they have so little space and she’s huddled in over her baby, looking quite uncomfortable. Should she not be in a nice big comfortable chair there as it’s one of their first feeds? \textbf{Should it not be more focused on them?} (…) and that really rings bells with me, when I was with my daughter, I had a little plastic chair in intensive care. \textbf{All of the machines are there for my daughter, but breastfeeding’s going to be so important for her.} So let’s get the comfortable chair in, which is going to be as important as some of those big machines because you need to get the breastfeeding right. (Sheena)

\(^\text{98}\) Being close to their mothers and being breastfed is crucial for the wellbeing of babies admitted to NICU as it improves outcomes and lowers the extent of complications, even in the context of the Western healthcare (e.g. Flacking \textit{et al.} 2012, Hylander \textit{et al.} 1998, Vogel 2018, Vohr \textit{et al.} 2007).
While crucial for infant’s wellbeing, women’s “intensive caring” for their children by breastfeeding them and being with them is subjugated\textsuperscript{99}, and women’s comments on NICU reject such subjugation as clearly inappropriate:

That does not look like a baby who just had its life saved (...) [the woman] looks like she’s doing fine without all that (...) it really looks like a... victory against all odds, against all this technology, like she actually... wow. (Kay)

I’ve got to be rude for lack of a better way of saying it, but it's like saying "Fuck you!" to all of the... this technology. That in spite of everything, this is the best thing I can do for the baby. (Lynn)\textsuperscript{100}

While NICU has been described as a high-resource setting providing care which is stressful to infants and their parents, and which entails the risk of iatrogenesis and contributes to excessive costs of health care if overused (Freedman 2016, Schulman et al. 2018), its “technological” priorities appear to continue. The predominance of clinical, machine-induced stimuli (e.g. ubiquitous noise, bright lights, medicinal odours) and an environment deficient in human warmth, touch, sound and smell, have been found to introduce complications of its own.\textsuperscript{101} Thus, transforming it into an environment where the humane is central, and infants are with their mothers, has been advocated as crucial for better clinical outcomes as well as emotional and social ones (Graven and Browne 2008). Perhaps this is the substance of the conflict that women recognise: that the environment where infant’s life and health is saved and sustained is crowded with quite

\textsuperscript{99} The approach of “intensive caring” by a parent as the primary caregiver in NICU dates back to 1979 when Tallinn Hospital in Estonia engaged parents in the care of extremely premature babies due to acute staff shortages (Levin 1994). Based on resulting observations, the team of doctors, nurses and parents in Mount Sinai Hospital in Canada developed the “family-centred developmental care” (FCDC) or Family Integrated Care model (Bracht et al. 2013, Craig et al. 2015). Strikingly, women’s insights in my study closely resemble the aspects of this approach and are a testament to their knowledge of what is actually best for their children, even in the context of NICU. I came across the FCDC approach only after drawing conclusions from women’s accounts which prompted me to read about appropriate use of NICU resources.

\textsuperscript{100} I acknowledge that such reactions are encouraged by the fact that the woman and the baby on the photograph both look well. Perhaps the photograph of a baby who is visibly struggling, would not elicit such comments. Yet the remark about “the very basics” by Maebh in an exchange quoted on the next page leaves a question mark on such an assumption, as Maebh makes her comment after witnessing her granddaughter spending 3 months in the intensive care environment.

\textsuperscript{101} For example, unpleasant procedures in NICU (such as tube feeding or ventilation) can lead to the development of “oral aversion”, i.e. “the reluctance, avoidance, or fear of eating, drinking, or accepting sensation in or around the mouth”. These may lead to inadequate nutrition. See: Bird Ch. (2017) at https://www.verywellfamily.com/oral-aversion-in-the-premature-baby-2748511
lifeless matter, and is missing what is humane and basic, as in this exchange between Sheila, Maebh, Sheena and Janet:

S: Our other sister, one of her babies was born very early, she had to be in a unit for 3 months, she was born so teeny tiny and the thing is obviously she’s grand now but I mean without that technology... obviously our sister wanted to touch her more and she wasn’t allowed touch her at the start or anything.
M: She was born at 30 weeks and she was 3lbs, she was like a little skinned frog.
P: She was tiny.
S: But all the machinery of course kept her alive.
M: I’ve a feeling even without the machinery she would have been alive. She can fight.
J: A strong girl.
M: Yeah she’s only a little wiry bit but very able and a very strong child.
S: The photo is good, isn’t it?
M: It is, because you have all the technology, you have everything in the background that you could possibly find a need for and in the middle of it all you are back to the very basics.

7.2 Appropriate use of caesarean section? Women’s bodies as responsible for producing risk

they need to be done, when you need the section you’re just happy that everything is alright with your baby (Miranda)

if I was haemorrhaging or if the baby’s position had gotten twisted up or if the cord was prolapsed, yes, I would be very grateful for that technology. I think I would much rather be alive and have a baby who is healthy and alive than to be dead. Or have a severely disabled child. But I think the chances of those things happening are much, much, much less. (Kay)

In this section I focus on women’s perspectives on caesarean section to unearth another powerful strategy of technocratic biomedicine claiming that it is women rather than its practices which are responsible for high rates of intervention. We are repeatedly told
that it is primarily the “worsening risk profile for mothers”\textsuperscript{102}, which explains the consistent increase in caesarean section in Ireland, an argument which dominates official public discourse, health policy making and clinically oriented research\textsuperscript{103}. Although technocratic biomedicine is inclined to welcome technological intervention and thus make it more likely, it is women’s bodies and decisions rather than its practices, which are seen as producing “risks”.

When women attempt to make sense of high rates of intervention in our maternity care, the politics of the technocratic “regime of truth” is difficult to reconcile with their experience, their observations and their knowledge. Yet it is often powerful enough to hinder the conceptualisations of care more appropriate than its own. The excerpts at the beginning of this section, one focusing on the benefits of a caesarean, the other expressing the need to consider its more appropriate use, reflect the issues examined in this section, and are relevant to intervention in maternity care in general.

7.2.1. Negotiating consequences: a different set of risks?

Women consider caesarean section as a major, last resort operation, to be avoided if possible. They carefully consider its impacts, such as a longer and more painful recovery, as well as its effects on their own and their children’s wellbeing. This cautious, balancing approach suggests what may constitute its appropriate use for them:

A section would be my worst nightmare. I’ve never been in hospital, I’ve never had an operation. Imagine having to go through that, plus “Is my baby okay?”. You know that you’re just being cut open (…) people can’t get up to feed the baby with the stitches, you can’t drive, you can’t do anything. (Eva)

\textsuperscript{102} This is the headline on the website of the Economic and Social Research Institute (ESRI) in Ireland introducing its research on examining variation in caesarean section in Irish maternity units (Sinnott et al. 2016). Although this research discusses complex factors behind the current caesarean section rate, much of its reporting has focused on characteristics of women such as obesity and age, rather than institutional and organisational factors or medical practice, see: https://www.esri.ie/news/irish-research-shows-that-the-increasing-use-of-caesarean-section-in-ireland-reflects-a-worsening-risk-profile-for-mothers/ Accessed 15th May 2018.

\textsuperscript{103} For examples of press reporting see: Baker (2016), Kelleher (2017), Shanahan (2016); for examples of clinically oriented research see: O’Dwyer et al. (2013) and Walsh et al. (2011).
I just see it’s such a serious operation. Even the amount of people that are there. Whereas when you have a baby the natural way it’s just you and the midwife. (...) it’s a little bit shocking that you need 5 or 6 people to have a caesarean. (Cecilia)

they say you can’t even drive for so many weeks afterwards, it’s just so painful. You can hardly laugh because when you laugh, your stomach tenses. Uggh, I can’t imagine how painful. Not having a c-section is painful enough, I can’t imagine what being cut open is. (Glenda)

most women who had a caesarean say it’s not painful during the operation but after...! There are 6 weeks after the operation, all the problems. (Lenka)

Thankfully I never made it into [operating theatre] for either of the births. (Tara)

Some women explicitly state that caesarean operations seem to create additional risk when compared with vaginal birth, both for the mother and the baby, unless there are complications:

I think it’s a last resort. There are circumstances when for mother’s health, for child’s health caesarean needs to be performed but I think in general we should be having babies ourselves because it’s healthier this way. (Marzena)

That was my worst fear, I didn’t want to go down the section route at all (...) I just think it seems more of a risk to me than having the baby yourself because you’re going under and you’re having the anaesthetic and all that. (Nora)

Moreover, women’s reluctance to undergo caesarean section stems not only from the awareness of its physical aftermath, but also the mental toll of the procedure, as their concerns extend beyond the clinical considerations:

my friend had c-section, she couldn’t walk for 8 weeks. She was in bits. (An emergency one?) No, this was her third and I think she had it on her first, so it goes on then... she was in a bad way for a few weeks. (Shauna)

They left [my friend] for ages (...) it was long time and a lot of pain and it turned out there was a medical reason, they probably should have done [the section] earlier. It was very... really really full on for her, I can’t remember the exact details but it was pretty hairy for a while with her. (Tara)
However, despite the added psychological “costs” of caesarean section, according to women it is equally the effect of previous traumatic experiences (whether involving caesarean or not), which for them explain some women’s decision to have this surgery without medical reason to do so:

My sister had three [caesareans] because her first baby got stuck. So she had a terrible… she had twenty odd hours of labour and then an emergency section so, her second two daughters were planned sections. (...) but I certainly didn’t want a section because I know afterwards, it’s so…so much… really, really difficult. (Gina)

But then people choose to have caesareans. (Why?) I don’t know. Maybe if you had a traumatic birth on your first. I’ve one friend who had a really bad labour, had emergency section and then she nearly had a hysterectomy because they couldn’t stop her bleeding so then she chose to have a section, cause it was traumatic and all bad. (...) I don’t think it happens in Ireland much unless the baby is breech, unless you had a traumatic birth experience. I don’t think people would choose that easily and that quickly. (Cecilia)

The negative aspects of the surgery also include compromising women’s connection and closeness with their baby:

another big one with c-sections is that obviously, with breastfeeding, you want to be able to feed your baby immediately, but often in recovery, they don’t allow you to have your baby with you. (Sheena)

Sections obviously are needed for some things but… it just looks kind of sad. (...) they gonna just take the baby away, bring it to the resuscitation machine and check the baby out. It’s hard to get hold of, to hold the baby properly. (Miranda)

Actually I’m glad I didn’t have a baby this way. Because it is good… the feeling that you’ve accomplished something, on your own. And this, they do it for you (...) I’m glad that I had the connection with my child throughout [the birth], I guess that’s why it was so important for me. I was so proud that I gave birth myself. (Marzena)

The above quotes demonstrate that for women a more comprehensive and a “different set of risks” (Edwards 2005: 110) is relevant compared with definitions of risk by the technocratic approach of obstetrics. Obstetric risks, often located in the “medicalised
and institutionalised birth environments and practices” it fosters (ibid.), are invisible and considered unimportant in the face of benefits offered by caesarean.

7.2.2 Women’s responsibility for intervention: negotiating effects of power

“The ideology and the structures of care, training and skills developed by obstetrics remain relatively unexamined and blameless.” (Edwards 2005: 131)

It is the defective nature of women’s reproductive processes, women’s incapability to withstand childbirth, or their allegedly “personal” decisions such as, for example, having children later in life, or lack of exercise and improper diet, which create risk and thus explain increasing technological intervention. Within this strategy “risk” resides in individual women and can be a result of their “natural characteristics” such as, for example, parity and age (Rothman 1991). Through such strategies, technocratic biomedicine shifts the responsibility for high intervention rates away from its objectives and practices onto individual women, seeing them as inadequate to act knowledgeably in relation to childbearing:

“mothers sit at their desks now, have little activity, don’t exercise and so on. If you exercise you are exposed to small… injuries [...] you better tolerate such painful physical effort. And we just sit too much and cannot cope with this pain. And I think we should just give the pain relief, this epidural, even on demand. I am not a doctor, perhaps it is very bad for us and there are some horrible side-effects, I don’t know. But if there aren’t, it should be given to mothers. Because then we will have less caesarean sections. If mothers know they can have their baby without pain or with less pain, they will have babies naturally.” (Gabriela)

This excerpt demonstrates how women attempt to practise the possibilities supplied by obstetric discourse, where it appears that the only avenue open to women to avoid one technological intervention is to turn to another104. However, Gabriela’s remark on access to pain relief is perhaps as much an appeal for support as the plea for a technocratic solution, as her earlier comment suggests:

104 Such thinking has been identified as a feature of clinically oriented programmes attempting to reduce caesarean section rates, where this surgery is being replaced by highly interventionist regimes for vaginal birth involving increasing use of oxytocic drugs, episiotomies, and instrumental deliveries, such as, for example, Active Management of Labour (Davis-Floyd 2004, Sakala 1993a).
“the low-tech room, I think this for the woman and some pain relief, perhaps she will be able to manage and not ask for caesarean? (…) If they show her ‘listen, here is what we have, if you are having a baby with us, we have such rooms too’. Perhaps this woman will think: yes, I will try, I will be able to cope. I will have the strength, as there will be help.” (Gabriela)

Another example illustrating the intricacies of women’s attempts to understand and justify higher caesarean section rates is here:

L: Most of the women I know would prefer normal delivery… they didn’t like the idea… but for the sake of rescuing… or probably those ones who really can't bear the pain, perhaps for them this is the option…
G: You know some women, they don’t dilate, they can't dilate. They can’t open. They need that. And when the baby is in distress too. They have lots of reasons for doing it.
L: I think they are much more concerned about safety. They do them much quicker (…) They try to encourage natural birth but they are over-concerned in certain cases. And I think it even depends on the generation because women are becoming weaker and weaker. My grandmother or great-grandmother, they delivered in the field… even no exercise and all that (…) even the food we eat (…)
G: The lack of staff too. Normal birth takes lots of time… But this is a quick-quick and go. They save time.
L: Although you do need a lot of staff for caesarean… but it's quick. (Lenka and Gala)

Women’s accounts above vacillate between, on the one hand, the discourse of women’s incompetence (“women are becoming weaker”, “no exercise”), and on the other hand, the failings of the current system of care and the way biomedicine is practiced (“they are over-concerned”, “this is a quick-quick and go”). Here is another woman struggling to navigate between those two discourses:

I do think maybe a lot of sections might end up… that they don't need to be… unless we ourselves are doing something to unhinge births and giving into… no! It's obviously when someone needs a section they need it! But maybe we've mollycoddled ourselves during birth now for a lot of generations and this is it manifesting? I really don't know. (…) if you've got back a hundred years when nobody was sectioned I'd like to see what the mortality rates for infants were (…) The mortality is definitely there but it's only a small part of it. I don't think that many babies would have died as a
consequence of sections not being available back then. **Women were tougher back then** I have to be honest with you. My nan’s generation and the generations before, women were just tougher, they were. They had ten, twelve babies, it was just part of life. (...) When you walk out and you look at everybody, everybody in this world had been born. So it’s not a big deal and now we’ve turned it into a big deal. (Tara)

While Tara appears to “blame” women, she points to the societal context of risk averse society (she says “we” rather than names particular parties) as responsible for high rates of intervention. Her account is moving beyond the narrative of women’s weakness as she attempts, with the discursive resources available to her, to question caesareans as solely responsible for improving outcomes and advocates for a shift towards normality as the solution to high-rates of intervention in maternity care.

Women attempt to think along different trajectories to these supplied by technocratic biomedicine, even though they still work through its arguments on responsibility, such as the one about the need to be “fit for birth” to ensure better outcomes (Nash 2011):

My own mother... she had twins without an epidural, all natural, no stitches. (...) When she would hear people talking about how bad their births were she always just thinks ‘I was really lucky or they were really unlucky or what’s going on here?’. (...) [Nowadays] I suppose it may be litigation... uhm... maybe it’s best practice not to deliver twins vaginally? (...) If I was going to have natural birth with no stitches I take that any day. Obviously there was no guarantee but... (...) she was young, healthy, didn’t have any weight, (...) she had taken care of herself. (Sybil)

I think every baby is in distress, they try to manoeuvre their way down. I think that sometimes they are too quick nearly to give you caesarean. I'm not a doctor (...) but out of all of my friends, there's about ten of us, I'm the only one who had the baby naturally. (...) one of my friends was booked in because the baby was breech (...) but what the rest of them had is that during the labour the baby was in distress. No reason given, the baby was in distress (...). I know they don't want to risk with babies should there be more distress but I mean.... your body is well able to do it. (...) if they could give it a bit more time. And they don’t want to or maybe they just too rushed to give it a bit more time. Or maybe there is a genuine concern. But all of my friends, they all had caesareans. (...) most of them would be healthy, fit young women. Sometimes if you are overweight it can be harder on the baby, harder on the birth and on the labour. (...) but there
would be no reason why their baby would be in distress: [they had] full term, smoothly progressing pregnancies... (Cecilia)

Yet again, those women see being healthy and fit, and having an uncomplicated pregnancy as decreasing the risk of complications, and for this reason are perplexed by the extent of intervention. However, Cecilia questions rigid timeframes for “progress” and begins to recognise how available “discursive resources” do not allow her to reach a satisfactory understanding. They prevent her from clearly indicating how medical practice is responsible for increasing caesarean section rate.

7.2.3 Subverting obstetric narrative of responsibility

Well, I don’t know why they would make me to have caesarean really. (...) For me, I would have it if it’s the last option (emphasises). That’s what I told them as well, I will only take epidural or any pain killer if it’s the only thing, the last thing (emphasises again) I have to do. (Eshe)

For participants of my research apportioning blame to women, their behaviour and their “incompetent” bodies as producing “risk” cannot explain caesarean section rates satisfactorily. Women’s puzzlement at such a narrative runs across their accounts. Still, women eventually subvert the narrative of their responsibility and inadequacy, and turn to practices of the biomedical system of care, which is concisely suggested by Eshe, where it is “them” who are accountable for “making” women have caesareans, dictating what women can and cannot achieve:

Maybe hospitals are afraid that people will try and... sue them. But I just think they're done too quickly. And maybe more so, well, most of [my friends] were in private hospital and it was done very quickly. One of them had her first child in private hospital, had a cesarean, straight away, the baby is in distress. She went to public hospital the second time. The baby was in distress as well and she just said: “no, let me push on and we’ll see what happens”. And they did let her and the baby was fine. So I don’t know it is just the different hospital by the way of thinking. But you would think maybe it’s just easier sometimes to give a caesarean rather than take the risk. (Cecilia)

The statistics are so high. So many people I know end up getting a c-section, and they don’t seem to be high risk when they go in, but because of the pressures on the hospitals to get people in and out, there’s a pressure to perform and I know that if I had
gone into hospital, there’s no way (emphasises) they would have let me go for that length of time. (…) there’s a lot of scaremongering (…) the medics can totally freak someone out by saying, “You’re baby is in danger, they’re deprived of oxygen.” What’s the term they used? In distress. The minute you hear that word, of course you’re going to say, “Just open me up now, take the baby out!” Kill-me-first kind of thing. (Lynn)

In their accounts women reverse the dominant narrative: it is hospitals, not women, which have become fearful, susceptible to “pressures” and having “their way of thinking” contributing to high caesarean section rates. While biomedicine maintains its claim of women not being “fit enough” to give birth being of “inappropriate” health, age, parity, fitness or weight, women’s determined search for understanding poses serious challenges to this claim:

“Ok, I know women are older giving birth, and maybe there is more of likelihood of complications but… that can also be an excuse. (…) I just don’t understand why it has to be so so technological. If we can scan for so many things in advance and predict so many things, so many complications then why does it have to be so tightly controlled? If you can see that a woman is low-risk, that everything… that she is young, she’s healthy, then why does she have to be on this kind of rollercoaster that's more likely going to end up in her having a caesarean? (Lynn)

Blaming women’s “worsening risk profile” becomes a convenient argument which provides a “productive focus” for clinically oriented research (O’Dwyer et al. 2013: 469), easy to translate into guidelines and practice. This results in advising women to “optimise” their behaviour, rather than addressing systemic and deeply political realities of the technocratic maternity care and the risks it creates, which would upset its hierarchies of social power. Blame is allocated and “risks” are “selected” to validate this power (Coxon et al. 2014).

Yet eventually, according to Gabriela, while unadmitted, there are limits to biomedical as well as societal “irresponsibility” when it comes to using technological intervention:

I think it can have a negative effect, we invent good things for a particular purpose but then we use them to completely different… I think if we start doing caesareans, caesareans and more caesareans, normal birth will stop. (…) We are forgetting what birth is about, that it all serves a purpose, the way nature made it, we don’t know
everything about birth yet. There are questions where no doctor knows the answer, why this happens the way it happens and not the other way. (Gabriela)

7.3 Is the future technological? Negotiating the effects of technological imperatives

There are so many things out there now, I can’t imagine what it would be like in the future. I think pregnancy is pregnancy, there’s nothing you can change about it, just diagnosing certain things earlier for the safety of you and the baby. They do diagnose things pretty quickly. (Cecilia)

This section rests primarily on women’s responses to the question about the future of maternity care, and the future inventions which could make it better for women and babies. Although the word invention has a clear association with technology\(^{105}\), not many women acted on this suggestion and proposed an “invention”. Likewise, for the most part women did not discuss the future in terms of intensifying technological solutions, and “state-of-the-art” facilities, going against the grain of another powerful strategy of technocratic biomedicine: the philosophy of technical fixes and technological imperatives discussed in Chapter 2. This strategy maintains that “problems” in maternity care are technical in nature, and that better technological solutions to them can always be found.

Admittedly, women’s lack of focus on technological invention may be partly due to the perception of having numerous ones in place already. Also, it seems that even for those women who are quite comfortable with technologised birthing, such as Claire and Gina, no invention is capable of fundamentally “improving” the very process of giving birth:

C: Well, I don’t think you can rush nature or play with nature, the baby is going to come when the baby is going to come, you could not do anything, the induction even with that, we were blessed in the end, we could have been there for days because we got a leaflet with the induction saying day 2, day 3...

\(^{105}\) For example, the Oxford English Dictionary defines “invention” as “something, typically a process or device [emphasis mine], that has been invented”. See: https://en.oxforddictionaries.com/definition/invention.
I: I still think you have to let nature take its course even if you have all the help and the technology. Technology should never be a substitute, let nature work and then use technology as complimentary... not as a substitute. (Claire and Javier)

I can’t think of anything that can make it any better really because we are what we are and we have to deliver a certain way and I think when you compare sections to natural deliveries, natural delivery wins hands down, provided the pain isn’t too bad. (Gina)

Leaving the complexities of what constitutes “nature” aside, women articulate that there are limits to what we can technologically achieve in maternity care. This challenges the conviction that more technical fixes can ultimately be found. Still, women imagine some future inventions consistent with this philosophy as well: a miniaturised chip under the skin for continuous health surveillance (Marzena), a magnet to turn the breech baby (Kelly), and methods predicting accurately one’s due date, timing of birth or its complications:

if possible to know better your due date. I don’t know if science can do anything here (...) I would like something to know that ok, it will be tomorrow! Or maybe it would be harder for me if I knew it was tomorrow... I would have it at the back of my mind. (Lynn)

It would be great to see... if you’re going to encounter problems, not just think that you might, but this is definitely gonna go wrong. Good accurate predictions so you could manage your expectations accordingly. But other than that, no. (Can we predict these?) I don’t think so! (laughs). (Sybil)

For Sybil, anticipating the birth of her first baby in a few weeks' time, this “invention” perhaps reflects both induced hopes and unaddressed fears of technocratic maternity care. Also, even though these women do suggest technological inventions, they often undermine their very purpose straightaway seeing them as inhumane, impossible and undesirable.

7.3.1 “So there is no pain”?

I will say no [invention is needed], because the best thing they ever invented is epidural. Yeah, it’s just... like another world after the pain goes away, you’re like oh my god, the birth is done. (Roberta)
The notable exception to dismissing invention is the need for pain relief, which could be made stronger and better (e.g. with no side effects, allowing mobility). This is addressed radically by Aleksander, who proposes growing the baby outside woman’s body, again, taking it back immediately:

[Something] so there is no pain. This is what women are afraid the most. And also, at the end of pregnancy when your back is sore, your spine suffers and you sleep badly, that the baby perhaps could grow outside. (Would you like that for your child?) There you are, not at all! Because there is this closeness (...) [not present] when it would be growing outside. (Aleksander)

Glenda shares this “no pain” view, albeit after prolonged hesitation:

(After prolonged silence) Something stronger maybe than epidural or some sort of stronger pain relief. (...) It does work, but you still feel the pain. I assumed the epidural, that I won’t feel pain at all. (Glenda)

However, for the majority of women, the need for improvements in pain relief may result from the insufficiencies of the current system and its “pain relief paradigm” (Leap and Anderson 2008: 32). Within this approach, pain is considered solely in terms of pharmacological techniques to relieve it, rather than as a physiological aspect of birth that women can cope with when supported:

Once you mentioned the epidural that you can still walk around with, that sounds fantastic (...) if they could manage to get an epidural where you had no pain, but you could still actively get involved in your labour in terms of all these positions etcetera, so you could actually, as in more like my second delivery, where I felt like I was a little bit more part of it, a little bit more in control of what was happening and she’s like, “Come on, we’ll get this baby out by lunchtime.” and I think, “Yes, we possibly could get this baby out by lunchtime.” (Gina)

It’s mostly the pain relief. You just don’t know whether they have time issue on that, when it’s available. Because the anaesthesist has to do it and if they are not there you

106 Lean and Anderson (2008) characterise this paradigm as viewing women as unable to cope with pain of labour. This pain is seen as “barbaric” and needless, thus using available technological resources to eradicate it is justified, their benefits seen as outweighing disadvantages. The authors propose the “working with pain paradigm” instead which they see as empowering women rather than patronising them.
just don’t get your pain relief. On my second pregnancy there was nobody there and I had to wait. If they could have someone there or a quicker way... I know it’s a very serious thing... but it’s reassurance of knowing you have someone there that will do it for you when you ask for it. They nearly brush you off saying "you should be fine", you do or you don’t get it, they don’t really care. (Cecilia)

Something about pain relief because it’s very limited, if you’re too late for an epidural, you’re too late and that’s just it and then if gas and air doesn’t work for you, you haven’t got a lot of choices left. (Eva)

These accounts suggest that improvements needed are as much about the pain relief as about women’s need to feel truly involved, about trusting their caregivers to support and reassure them, and about having a range of options to cope.

7.3.2 Systemic issues: “that’s nothing to do with technology”

When talking about the future of maternity services women identify problems which are seemingly not technological because they cannot be reduced to straightforward technological solutions. Women talk about fragmented care and disconnection of their caregivers from their care:

[If we could] get them all on the same page. The doctors have their own views, their own studies. In my experience every second doctor I saw was telling me a different story. (…) A consistency and to read through the charts. When I was monitored every two days, whoever was on the day ward was the doctor that saw me. So each doctor would say their own opinion. (…) it would be nice to see a consultant or whichever doctor... but the consistency of having a doctor. It’s probably very hard with all the different shifts to see your own doctor. (…) But if they all have different views... (…) I mean... who do I trust in? (Cecilia)

just a general improvement in communications between all the different services that are available. It is very difficult to find out what your local area... some of the GPs aren’t that familiar with what all your options are for childbirth. They don’t offer antenatal care, it’s a little bit disjointed. So maybe a big system that would link everything a little bit better together. Something in general, not necessary just for antenatal care, like centralised notes. (Sheena)
The above have been considered as problems of “communication” and “information management” in official reports (e.g. HIQA 2013, 2015)\(^{107}\), and remediable by better protocols. Women may turn to the officially suggested technical fixes such as centralised notes, as these seem a solution in a system where it is appropriate for a woman to see a number of different professionals throughout pregnancy and birth. However, these are unlikely to alleviate systemic fragmentation, without a challenge to the assumptions of technocratic care. Although women point to problems of communication, their accounts suggest that “communication” is actually about trusting their caregivers and consistency of having one person responsible for their care. This indicates that it is trusting relationships and continuity of care and carer that can ameliorate the disjointed nature of their care. In other words, the “invention” necessary to address problems of “communication” and fragmented nature of care is about ensuring these are fundamental and systemically supported in provision of maternity care rather than about quick technical fixes such as centralised notes.

Other systemic issues women recognise are those of understaffing, overcrowding and lack of resources in hospitals:

\[\text{the only thing and it is nothing to do with... the master of the hospital was on the radio (...) and she said there aren't enough obstetricians and they are understaffed and they work very hard and the midwives, you see how hard they work... and it's only... it's not even a complaint but just the waiting times for appointments (...). That's the only thing and that's nothing. That's nothing to do with technology. (...) I can't think of anything (...) they're all running around, the staff, so maybe more staff and then that's the only thing, and then if there's more cutbacks that mightn't happen... but it doesn't mean if there's more money that you get more... it's not like when you are in private the system is wonderful, you are all still the same... (Claire)}\]

The effects of the power inherent in the technocratic framework are such, that it appears as somehow disconnected from systemic issues of lack of staff and resource allocation:

\(^{107}\) This “poor communication” problem with the guidelines to remedy it, is present across the reports investigating poor practice in Irish maternity hospitals (see for example HIQA 2013, 2015).
If the hospital had facilities that they didn't need to manage the care so intensely. More space, more resources. So if they want to speed up someone’s labour it’s because it needs to be speeded up for whatever reason that might be, not because of low resourcing issue (Sybil)

The above “problems” are structural issues perpetuated precisely by the technocratic paradigm with its commitment to an interventionist approach, investment in high-tech infrastructure rather than appropriate staffing and staff support (Hunter et al. 2008), and large centralised hospitals with their assembly-line culture (Walsh 2006b). Despite this deep impact of the technocratic paradigm on all levels of care, it manages to “offload” the problems it creates onto “erroneous” social arrangements (Bauman 1994, Beck 1992) surrounding maternity care, leaving its assumptions intact. In Claire’s account, such claims are intertwined with observation that after all much more than resources are needed to address our current problems. However, other women are more unforgiving in their critique, despite the difficulty to directly connect the technocratic approach with those systemic problems within the dominant discourse:

our healthcare model is wrong to the fucking core and it’s full of bureaucrats and executives, the Health Service Executive... that makes me thinking of men in suits! (...) I think obviously they don't want [care in community] funded, they want to keep everything into the hospital (...) and they are crowded. There is understaffing issues, you do hear the news that in comparison to other places in Europe we’ve got a third of the portion [of midwife to woman ratio] of another countries. They’re expected to do too much. And that’s when the level of care flips and stuff happens that shouldn’t happen. (Tara)

I think it’s getting worse. You just hear all these stories now, women dying... you haven’t heard of women dying before so it must be worse. Ye-e-ears ago when our grans were young, yes. Well, they didn’t have all these machines and detectors where now you have them all the modern things, we are not a third world country and yet women are dying because... because... the doctors are so busy or they don’t want to take an extra 5 minutes and really give that woman a head to toe check over. (...) When I had my miscarriage they sent me home with tablets to take. (...) I’d been rushed to hospital the next day to be given blood cause I lost so much blood. (...) It’s just...there is no need for this in this time, this... this day that we live in. (...) Even if I
had a private... They just don't care! They're so busy that it's just another woman...

(Shauna)

7.3.3 Social imperatives? Equitable access to midwife-led care in the community

Sheila: I don’t know how much more it can change.
Janet: **It can change with better equipment.**
Phoebe: It could change with less equipment.
Maebh: **I would go for the less equipment, fewer pieces of machinery and something like the [low-tech] room there, and I would think definitely more midwife led care.**

The above excerpt demonstrates how women negotiate the technological imperative and how some of them explicitly reject the idea it encourages: that technological inventions are what we need to improve and focus on:

**God, I think we have too much.** We need to scale back on the inventions and just let women have their babies. (...) **I think we should concentrate more on the person giving birth as an actual... person, you're not just here to get this product out.** (Tara)

I don’t know if an invention or just making the hospitals a bit more inviting. (Nora)

My god. I can’t think of anything. I suppose I would be thinking less about technology and machines and more about basic care. I think the basic care needs to improve. Like the ratio of midwives to labouring women, like breastfeeding support. Some girls I know paid €60 when they came home from the hospital to have the lactating consultant come to them. **Do you know, that should be provided** (...) So those kind of things I’d like to see, more than a particular technology. (Sheena)

Those women refuse to think in terms of technical fixes, and envisage a different kind of future for maternity services where these are supportive and person centred, and the provision of primary care central to them and reflecting their lived experiences. This is visible in women’s insistence on the unrestricted presence of their close ones (parents, children, friends) being as important as inventions:

I don’t know about an invention but I would think the most important thing would be that you could have the person you want there. (Sheila)
they’ll just say resources, “We haven’t got the space for you to have two people in the room, we need to be doing our job.” That’s completely fine, they can do their job, deliver healthy babies in a safe environment with an extra person in the room. (Eva)

it would be good if they allowed other family members, the children for example, to watch the birth too. I know they have no resources but in the future... it would be good if they could allow more than one support person. Because... you won’t refuse your husband to be there but perhaps your mum or a friend has a better effect on you. (Gabriela)

It is telling that such basic “solutions” are seen as prevented by resources in the system which relies on high-resource expertise. The above quotes demonstrate women’s focus on basic care and normality, rather than on access to sophisticated technology. The appropriate maternity care which emerges from their accounts is often about equitable access to less technologised options of care, suggesting women’s recognition of not only geographic but socio-economic inequities fostered by a system with such a significant share of private practice:

I’d love (emphasises) to see it go more holistic (...) you hear places like France, friend of mine lives there and the health care there is a-ma-zing. And it’s **the same for everybody**. (...) I’m just saying the **Domino** care I had was fabulous and even when I spoke to someone about it when I was pregnant (...) they were "oh god, I wished I lived in your area" because it’s available there. (So you’d wish our system...) was more like that for everybody, yes. That it was more of a community thing and you only went to the hospital when something went wrong. (Tara)

I would say, in the future, the likes of the **Domino** and all that. (...) there’ll be more options. For Domino, you have to be in a certain area. I suppose that has something to do with, they haven’t got enough nurses. I’d say in a couple of years, when they’ve settled in (...) maybe we should just **offer this out to everybody**. (...) I’d like to hope they would because it was pretty helpful. (Glenda)

I’d like to see more options available and it being **less about your geographical location**. (Sheena)

I think the **Domino** Scheme will probably get quite a bit of traction because it just seems... it’s just flexible for people! (...) the **birthing pools and the balls** and all of
that, I think they’ll become the norm as opposed to, at the moment, they’re not really the norm. (Nora)

My friend is in UK and she was saying that homebirth is really encouraged and midwife-led care is the norm, that unless you need it you don’t see a consultant. (…)

And obviously that’s all through the NHS. It’s like a Domino scheme all the way but you don’t have to be as low risk. It’s more normal for everyone (…) I would like to see Ireland to go towards that. (Sybil)

In the above accounts, a Domino scheme appears as the most familiar alternative to the standard currently offered to women. In the system of scarce alternatives, it epitomises the future of maternity care for many of them. However, some women imagine a more radical departure from the current provision of care:

down the road there’s a health centre, if there was a sort of a little birthing unit you know… set up properly... where you would have the midwives (…) where you knew your child was going to be born into a community. Now I know we’re moving away a lot from communities and I think that that’s a shame. They planned it all around the units... big enough to take whatever was necessary (…) something where people are... you know them (…) they’re interested in you and even some of the older women are out that could act as a... support. (…) But I think that’s a bit of a pipe dream. (Maebh)

I hope what we see is a movement back toward local where a woman can labour in her house or birth centre if she needs additional care but I would hope that we would move all births out of hospital. Even high risk births would take place in specialised birth centres where the operating rooms would be, I just think there’s something wrong with giving birth somewhere where like the next thing that could happen would be a colonoscopy or it’s something like that. (Kay)

108 The Domino scheme is a hospital-based scheme with an outreach in community. It is closely aligned with hospitals which provide it and Domino midwives, apart from working in community and assisting at homebirths, also work shifts on the standard hospital wards, its downside being the lack of continuity of carer and potentially closer alignment with hospital care protocols and practices. Such an approach differs markedly from models with more autonomous midwifery practice such as, for example, independent midwifery and caseload midwifery, which follows a woman and offers continuity of carer.
I guess it will go... that there's different kind of ethos around birth. You'd hope that there would be more of a swing towards the natural process. (...) But I'm sure there will continue to be a lot of intervention and stuff like that. (Sybil)

Women turn away from hospital-based intensive care models envisaged in technocratic biomedicine. If there are any fixes and imperatives that are needed, for women, they are the social and cultural ones. Thus, some women identify the need to truly value their knowledges, as well as the midwifery body of knowledge, displacing high-tech expertise from its central position:

I suppose it’s the recognition, appreciation say...the knowledge that midwives would have that they do have ... that there is more of a focus on practice of birthing and... recognition that the mother is... has a huge role in the process, that she’s not just like... some kind of birthing machine as well. (...) So... improve the technology but improve it in such a way that it's gonna give women more mobility, more freedom, to actually... be like that woman [from NICU] breastfeeding her child within her own home. (Lynn)

And I think women realising how well their bodies do work (...). It’s like you can have baby it’s fine, it’s hard work, it’s like mountain climbing, you’ve got to kind of train for it a bit and you’ve got to get in a good head space but it is something that anyone could do rather than (...) "Oh, people who do home births, oh you’re so brave, oh you’re so strong. Oh, I couldn’t do that myself”. I’m like "Your grandmother did. How are you so genetically different, that you couldn’t possibly?" (Kay)

In their above comments women expose a vast discordance between what is routinely offered to them in large state-of-the-art hospitals, and what they see as appropriate maternity care.

7.4 Conclusion

And maybe what we’re looking for is some perfection which isn’t out there but just to strive... (...) I do think if you bring the extra personal touch I think everybody relaxes a little bit more, if it’s not so high-tech and if it’s not so expected of you that you have to do this, this and this then it would go more smoothly because I do know (...) there was a huge difference between giving birth to my first son (...) and giving birth to the others. The atmosphere was certainly much more relaxed and it was easier to do. (Meabh)
What emerges from women’s accounts presented in this chapter is that striving for more appropriate, more humanised maternity care is crucial for women, as expressed in the account above. However, there is a deep disconnection between women’s notions of what is appropriate and those of technocratic biomedicine, and looking at its strategies allows us to expose the roots of this disconnection: the lack of conceptual foundations for comprehensive understanding of women’s needs in childbirth, and resulting lack of commitment to truly serve women, babies, and their families (Davis-Floyd et al. 2009).

Women’s suggestions, emphases, and reservations reveal them as much more knowledgeable than technocratic biomedicine would like to accept, as their observations integrate what is scattered across “traditional” research evidence and its perception of good practice. For women, maternity care should be about the “balancing” perspective (Berg 2005), and technological intervention must be used cautiously and judiciously. Their puzzlement as to rationales for using it suggests the need for thorough self-examination of the assumptions of our maternity services, by its planners and practitioners. What is needed is a system with a “complex and multi-faceted view” of what affects good outcomes in labour and birth and sees women as capable, trusting in their ability to give birth, which preclude “any narrow view of the locus of responsibility” (Sakala 1993b: 1244). What is also needed are maternity services which are focused on humane “imperatives” for the future and provision of basic care rather than on ever more complex high-tech responses.

Yet again, as in previous chapters, foundations for such a system are grounded in the midwifery models of care. Yet, all the strategies of technocratic discourse explored in this chapter: its envisaged conflict between humane and technological aspects of care, the use of intervention and the future developments it considers as appropriate, strongly reflect the professional hierarchies between obstetrics and midwifery, and the reliance on risk discourses to maintain those hierarchies. Unless the power imbalance between those professions is addressed and the premises of risk management denounced, a major overhaul of existing maternity services to make them more appropriate will not be possible. Eventually, what technocratic biomedicine proposes is not appropriate at all, and what is necessary is far simpler and basic:
No malfunctioning system can manufacture trust. Technology cannot provide certainty about pregnancy and birth. What is needed is not more technology badly used, but an excellent community midwifery service (...) [with] technology properly used when problems are suspected. How much more evidence do we require to convince us? (...)

Remember, at heart this is simple: one woman, one midwife (Murphy-Lawless 2010: 23).
Chapter 8

Deceptive promises: women’s understandings and the discourse of technocratic maternity care.

8.0 Introduction

“A critique is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kinds of assumptions, what kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest. (…) criticism (and radical criticism) is absolutely indispensable for any transformation. A transformation that remains within the same mode of thought, a transformation that is only a way of adjusting the same thought more closely to the reality of things can merely be a superficial transformation. On the other hand, as soon as one can no longer think things as one formerly thought them, transformation becomes both very urgent, very difficult, and quite possible.” (Foucault 1988b: 154-155)

This research was undertaken with the aim of listening to women’s voices in order to search for different “modes of thought” for our maternity services and the role of technology within them. It aims to provide the conceptual tools for a radical critique of the current technocratic system of care.

This chapter aims to bring together all the social, political, and theoretical contexts for our use of technology in maternity care discussed in this thesis, with women’s understandings of technology. Women’s voices show the profound ambiguity of their understanding of technology and its “doing” in maternity care. For women, while technology is often welcomed in the birthing room and considered important for safe maternity care, its current role in maternity services contributes to the tremendous difficulties women face when they try to secure such care options which make them actually feel safe emotionally and physically. The central finding from this research is that for women, technologised maternity care is satisfactory and safe only superficially and actually offers them a very limited notion of care, while it has a potential for substantial harm and suffering which is not acknowledged within the technocratic framework.
The dominant approach views high-tech biomedicine coupled with a risk approach and managerial governance of health services as the most reasonable frameworks for maternity care. This means that any change in the way technology is used in maternity care has to be argued from within those frameworks and must rest on their methods of legitimation (e.g. evidence based preferably on the quantitative, clinically oriented methodology of randomised controlled trials or of systematic reviews). While women struggle to articulate the critique of the existing social arrangements which support the provision of technocratic care, they do disrupt their seeming impenetrability with their emphases, with what they choose to discuss and focus on, with their hesitation and reluctance. As women de-emphasise technology in their accounts, they resist fully engaging with the backbone of the dominant approach, and their voices begin to expose a vast discordance between the care provided in large state-of-the-art hospitals as “standard”, and what they see as appropriate. This research demonstrates how, as women realise the discrepancies of technocratic care and its deceptions in their accounts, they undermine the seeming “consensus” around the current scientific, objective “care” as the only possible approach.

This discussion starts with my explanation in section 8.1 of how my theoretical and methodological decisions enabled creating particular data and a particular reading of women’s voices. Section 8.2 focuses on what I consider the common themes in women’s accounts. In section 8.2.1, I argue that women insist on being listened to rather than overpowered by technologies, on having their individual needs prioritised over the priorities of technocratic management. In section 8.2.2, I demonstrate how women consider humane imperatives over technological ones, and how their understanding of solutions favours the social and personal over technical fixes predicated on a reductionist understanding of what can be done and potential harms involved. In section 8.2.3, I argue that women consider midwives and their support skills and knowledges as genuinely enabling compared with ambiguous “enablements” offered by high-tech expertise and its practitioners. Each of those themes is juxtaposed against the dominant discourse of public debacles as well as policy documents and official reviews of maternity services. In section 8.3, I argue that in order to use birth technology appropriately and to have appropriate maternity services, technology needs to be
explicitly acknowledged as infused with sets of values stemming directly from the technological society, and these technocratic modes of thought in our maternity services need to be exposed. Following Bauman (Bauman 1989, 1993, 1994), I argue that addressing the ethical responsibilities involved in caring for women appropriately is crucial and that our use of technology urgently needs to be infused with moral and not technocratic and clinical imperatives. In section 8.4, I return to the arguments made already in the last three chapters about midwifery being an essential source of alternative “modes of thought” for a deep transformation of our maternity services and our current relationship to birth technology.

8.1 Women’s voices in feminist poststructuralism: counteracting the technocratic framework

Before I turn to the common threads in women’s accounts, I will discuss how my particular reading of women’s voices in this research has been enabled by epistemological and methodological decisions. These were guided by a “feminist sensibility” (Craven and Davis 2014: 1) which implies being sensitised throughout the research process to relationships of power and ways in which they can marginalise particular groups and their perspectives (Craven and Davis 2014, Lather 1993, St. Pierre 2000). This facilitates a radical rather than superficial critique of the existing social arrangements when it comes to the role of technology in maternity care.

My particular reading of women’s accounts would not have been possible using objectivist epistemologies which mimic the ideological assumptions of our technocratically governed health care system and specifically those of obstetric medicine. These detach their claims from what is considered “subjective” and “contaminated” by value statements and aim for what is “rational” and “neutral”. This is why adopting a feminist poststructuralist framework was crucial. Such a framework provides us with tools to expose the alliance of objectivist claims with powerful interests and becomes a source of “counter-storytelling” to disrupt and dislodge the prevailing “regime of truth” and its effects in public policy and social life (Davis and Craven 2011: 191). This helps us resist “neutralising” women’s narratives and forcing them into yet
another rationalist discourse in our research, aligned with the most powerful voices in society (Craven and Davis 2014, Lather 1991).

This research was undertaken with the aim of listening carefully to women’s understandings, and approaching them in a way that enables me to move past the current dominant conceptualisations of maternity care and imagine more appropriate ways of envisaging technology and maternity care. To this end, as I described in Chapter 3, I deliberately devised my theoretical and epistemological framework in such a way that would consider women to be legitimate knowers when it comes to what technologies and maternity services we should have. Women’s voices, as I argue in section 8.2.1, continue to be considered as less valid despite the official rhetoric of “women-centredness”. In this research however, women’s perspectives were privileged and central, and this is reflected in my analysis. While this inherently creates a research account that is localised and partial, it serves a purpose which is political as much as methodological of “amplifying” women’s marginalised voices (Davis and Craven 2011: 197) and denying the “necessity” of voices which are powerful and considered authoritative (Foucault 1997).

It is, however, not enough to assume theoretically that women’s voices are a legitimate source of knowledge. We must make a genuine effort to create contexts where participants feel knowledgeable. I hoped to put women in the position of being ‘skilled’ to discuss technology by using photographs in my interviews. I anticipated that these would make clear for women the purpose of our conversation and make the topic relevant for them (see section 4.3.2).

When it comes to analysing the material from the interviews, my “findings” were also enabled by having careful operational definitions of technology, understood not only as high-tech resources and expertise but also as the dominant technocratic framework (see Chapter 2). It was also crucial to have a clear conceptualisation of what constitutes the alternative approach, i.e. the midwifery model, and to be clear about its characteristics in order to recognise these in women’s accounts during my analysis (see Introduction to this thesis). This allowed me to “extract” from the interviews examples
of women discussing the technological as well as the alternatives to it, even if these were not actually named as such or articulated explicitly.

8.2 Common threads in women’s accounts for appropriate technology in maternity care

8.2.1 Women and their knowledge matter

“what matters to women is also what is likely to generate the safest and most humanised maternity care provision” (Downe et al. 2018: 14)

Women in this research recognise that technology and high-tech expertise tend to “remove” them and their abilities and knowledge from consideration. They recognise their own erasure from the current maternity services and consider it inappropriate and unsafe, which is particularly apparent in their responses to the high-tech NICU environment in Chapter 7. While women and their knowledge are erased in the technocratic approach, it is women, their reproductive physiology and their decisions, which are blamed for creating dangers necessitating technological intervention. This confirms women’s exclusion as reasonable and necessary, and a “safety issue”, and allows for the approach of technocratic obstetrics to be argued as better equipped to reduce dangers to women and their babies than women themselves. Such discursive strategies draw their persuasive force from the powerful alliance of patriarchal ideology with scientific risk discourse relying on technologies. However, women are ambiguous about this logic of blame and their alleged “incompetence” when it comes to birth. In their accounts analysed in Chapter 7, when discussing the reasons for skyrocketing caesarean section rates, women attempt to find a more plausible explanation than that of the dominant discourse when it comes to women and their reproductive processes, which opens up to scrutiny the assumptions of that discourse.

Edwards observes that “patriarchal thinking paved the way for obstetrics” (Edwards 2005: 70), and consequently, as long as this thinking is not made explicit and open to examination, its authority when it comes to childbirth will remain undivided, and it will continue to perpetuate women’s subordinate position. Public debates about our maternity care confirm the deeply embedded paternalism in Irish maternity services. Examples abound. Women’s calls to the Liveline programme in April 2019 (see Lynott
2019) exposed this patronising approach to women while having their babies as endemic in the Irish maternity hospitals. Similarly, the CervicalCheck scandal has exposed consultants’ attitudes towards women as “verging on misogyny” (Gabriel Scally, quoted in: Loughlin and McEnroe 2018). Further back in the past, such ferocious procedures as symphysiotomies (O’Connor 2011), and an excessive number of hysterectomies (Matthews and Scott 2008), have been performed without women’s knowledge or consent. This demonstrates that within the system underpinned by patriarchal values where women are disregarded, there is a great potential for technocratic experts to be given a free rein to use technology in a controlling and a dangerous way.

Our National Maternity Strategy is no exception to this disregard for women and their voices, particularly in the context of the “public consultation” process accompanying its inception. In the report following this consultation (Keilthy et al. 2016: 14), it is clear that listening to women and their wishes was emphasised repeatedly by women who participated in this process. The voices of those women also envisage maternity services characterised by appropriate, judicious use of technological intervention, and equitable access to a range of midwife-led options, where continuity and one-to-one care are an expected standard. All those suggestions parallel the voices of women in my study. However, while women’s suggestions from the consultation process are quoted, they are not actually reflected in the Strategy. The main body of its text is completely divorced from the substance of women’s observations and the arguments they make. The Strategy, while quoting them, does not engage with or act upon them; if anything, it contradicts them. Further, these excerpts appear in separate boxes which visually underscore their separate status. This exposes “public consultation” as a tokenistic gesture by a regime which is clearly preoccupied with its own notions of health care provision, and not those it is meant to serve.

109 Joe Duffy’s RTÉ Liveline programme received over 1000 calls and emails between 2nd and 12th April 2019, each concerning unnecessary suffering inflicted by care characterised by indifference, paternalism and disregard for women’s expressed concerns and requests for help.
Similarly, in the Department of Health report on perinatal deaths in Portlaoise Hospital (Department of Health 2014)\textsuperscript{110}, the voices of women and their partners who lost their babies are not included as a valid contribution to planning more appropriate services. Despite having a separate section on “patient-centredness”, the report actually disregards their voices. “Patients”, while “consulted”, are discussed mostly in the context of improved protocols for “patient safety culture” (Department of Health 2014: 36). Women’s and their partners’ voices are classified as “complaints” and “personal accounts”, unable to “typify the experience” of an average hospital patient, and in need of validation by the hospital’s own “investigations” (ibid.). This is probably the quintessential reaction from those in a position of power within technocratic maternity services to women’s voices describing instances of poor care. For example, the response to the Liveline calls, mentioned earlier, of a former Master of the National Maternity Hospital, Rhona Mahony, is strikingly similar in its dismissal of women’s voices. For her, women’s accounts of patronising, disrespectful treatment are “not comprehensive” and “at odds” with her experience as a doctor (Rhona Mahony: quoted in O’Mahony 2019). This lack of listening to women’s voices precludes addressing the issues identified by women as problematic in this research.

8.2.2 Humane imperatives

“bureaucracy is not merely a tool, which can be used with equal facility... for cruel [or] humane purposes (...) Bureaucracy is programmed (...) to measure the optimum in such terms as would not distinguish between one human object and another, or between human and inhuman objects” (Bauman 1989: 104)

\textsuperscript{110} A full title of this report is “HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date)”. Throughout this chapter I refer to this report as “the Portlaoise report”. This report was a result of an internal investigation by the Department of Health into events in the Portlaoise hospital. There was a later external and highly critical report on Portlaoise issued by HIQA, an independent authority when it comes to quality and safety in the Irish health services (HIQA 2015). However, it is this earlier report which presents a more complacent approach to “appropriate” maternity services. While both reports exemplify the technocratic view of maternity care, it is this first report which, while admitting to some deficits in the quality of care, found the Portlaoise hospital safe.

The publication of the HIQA 2015 report was delayed some weeks while mediation ensued between the HSE and HIQA over the findings of the draft report after the HSE Director General threatened to seek legal action against HIQA to prevent publication of the final report on the grounds that the draft report findings were unfair to staff in Portlaoise Hospital (Wall 2015).
Maternity care which emerges from women’s accounts of what they need and want is embedded in humane rather than technological imperatives. In this way women supersede high-tech expertise and its embodiments from their central position in the dominant approach. As women argue it, technology is not the only and not even the predominant “solution” in maternity care; humane and social aspects of care, and the balance between them and the technological, are equally important for women. In their systematic review of studies looking at what matters to women, Downe et al. (2018) argue that women universally hope for care which:

“enables them to use their inherent physical and psychosocial capacities to labour and give birth (...) in a clinically, culturally, and psychologically safe environment with continuity of practical and emotional support from a birth companion(s), and with kind, sensitive clinical staff, who provide reassurance and technical competency. Most women place a high value on their capacity to give birth physiologically (...) for the short and longer term physical and psychological wellbeing of themselves, their baby and their family; (...) Even where intervention is needed or wanted, women usually wish to retain a sense of personal achievement and control by being involved in decision making.” (Downe et al. 2018: 8-9)

This echoes my findings about the importance of humane imperatives as the core in appropriate maternity care, “technical competency” being just one of the aspects of care.

Women see technology as having formidable capacities which are beneficial but also potentially overpowering and frightening for them. Women insist that despite, or perhaps because of this powerful potential, technology should play a supportive role in maternity care, and its use should be judicious, informed by the values which are important for them, and not as if its use was “objective” and “independent” from them. As a result, women are able to conceptualise potential harms of technology in a way which is more comprehensive than its obstetric conceptualisations.

For women, the technological focus of care diminishes or ignores their needs for humane care and conflates what can be done to assist them in labour with what can be achieved by high-tech expertise. Women in this study recognise how the technocratic approach imposes its prescriptive techniques on them, rather than truly facilitates
them, for example, when it comes to adopting certain positions in labour or using birthing aides. However, this approach conceals the fact that whether basic human needs are met or not is left to its discretion. It does so by conceptualising women’s capacity for knowledge, their bodies and their abilities as not to be trusted, in need of screening for risk and endorsement for safety, on its own terms. Yet women reject the notion that maternity services are appropriate when humane aspects of care are ignored and technological procedures are prioritised. According to them, it is misguided, and in fact unsafe, to separate the humane and the technological and this is true for women even in emergency situations when they consider using technology as clearly warranted (see section 7.1).

In contrast, maternity services as envisaged in public debate and health policy are oriented to efficient enactment of rules and protocols within institutions, rather than people and their humane needs. For example, in the National Maternity Strategy the focus is on maternity hospitals with their imperatives and not women and their agency. This is illustrated by one of the points of its executive summary stating that it is “leadership, governance, clinical commitment and clinical effectiveness” which are necessary to “deliver safe quality maternity care” (Department of Health 2016: 5). Such “safe quality care” seems to rest solely on clinical expertise, and the governance model borrowed from a private business approach, characteristic of neoliberal health care provision. The essence of this approach, if distilled from the Strategy and other health policy documents, rather than being about women, is an attempt to display a managerial competence which is more fitting to managing resources and the “risks” of large institutions, than to respond to human imperatives which would allow for a more comprehensive response to women’s needs in childbirth. This ties in with the argument in Chapter 1 that Irish maternity policies continue to be governed by imperatives of clinical efficiency in managing the risks of childbirth as defined by obstetrics. This approach has facilitated inappropriate, excessive use and implementation of technologies (Perkins 2004, Tracy 2011), and leaves all the issues raised by women invisible and unaddressed. However, as observed by Bauman in the quote at the beginning of this section, in such bureaucratic systems, in this instance for health care provision, it is irrelevant whether the “objects” of management are human or not.
8.2.1. Socio-cultural “fixes”

Women in this study imagine the future developments in maternity care predominantly in terms of the social and humane, and refuse to think solely in terms of technological solutions (as discussed in section 7.3). Yet, the improvements in care in the public debate and in policy are conceptualised predominantly through technical fixes or the imperatives of technocratic “governance” of care provision. An example of this can again be found in the Portlaoise report (Department of Health 2014) where technological “doing” and “knowing” are taken for granted as infallible and objective and the only concern is for them to be applied correctly, rather than appropriately used. Consequently, the report aims to improve the outcomes and the quality of care by better regulation of the use of technology. Such a focus disregards the assumptions which contribute to the routine, non-evidenced use of technology. This focus also disregards the role of such inappropriate technology use in the ‘adverse events’ that the report aims to investigate and prevent. It disregards issues such as the lack of commitment to continuity of care and one-to-one care, and improvement of working conditions and support for staff. Instead, better guidelines, more frequent training of staff and developing better “surveillance systems” for monitoring obstetric “risks” and regular publishing of quantitative data of “clinical performance” are suggested. These are narrow technical fixes, not meant to upset the existing arrangements and the concept of “safety” based on current assumptions. The debate focused on these avoids bringing ideological factors underlying poor practice in maternity care to the surface. However, as women suggest in section 7.3, safety could be better facilitated by what we may term “social fixes”: care in the community rather than large institutions with their conveyor-belt care, and care by people women trust and know well. Thus, women’s voices link to the arguments made by those advocating a radical shift in thinking towards relational continuity as central in maternity care provision and to team or caseload midwifery models (Homer et al. 2019, Sandall, Coxon, et al. 2016).

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111 E.g. Hospital Patient Safety Indicators Reports have been published monthly by HSE since January 2017 as a result of the Portlaoise report: https://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/hospital-patient-safety-indicators-reports/
8.2 2.2 Beyond reductionist definitions of harm

Women’s voices in this research suggest that technology use within the current maternity services is excessive for them, amplifies their apprehensions and induces fears. As I argue in Chapter 5, the sense of reassurance is often too narrow to be genuine. However, within technocratically oriented maternity services the anguish expressed by women seems to be addressed mostly by resorting to more technology or is considered something to “get over” for the sake of accessing better clinical care, considered a “true” reassurance. This is in contrast to the term “false reassurance” which has been used in the context of consumer products, such as monitoring apps for pregnancy and labour and monitors for home use, with women’s lack of training in using these technologies and inability to interpret them correctly have been pointed out (Margaret McCartney, in: Inside Health 2019). However, my research demonstrates that “false reassurance” comes equally from the use of technologies by highly trained professionals if it rests on unexamined convictions regarding its benefit accompanied by a patronising approach to women’s need and ability to know what happens with their bodies.

Women’s reluctance to focus solely on technology offers a more comprehensive understanding of what constitutes harm compared with obstetric notions of risk. It includes harms of objectification, of lack of dignity and privacy, of being left alone and unsupported, of being unnecessarily separated from their babies (see Chapter 6). Women express their scepticism towards this sole preoccupation with dealing with pathology when providing care and designing birthing rooms as high-tech clinical environments. In this way women resist the straightforward association of having access to technology with safety. This is particularly apparent when women discuss CTG, caesarean sections and the NICU environment credited by high-tech approaches with ensuring better outcomes, making the benefits of those technologies much more problematic compared with the unshakeable belief in their superior status within obstetrics.

Based on my analysis of women’s accounts I argue that the approach reflecting women’s voices would require a shift of focus away from obstetric risk and the narrow
understanding of responsibility as a delimited clinical judgement. Instead, a model with a more considered approach to technology, which acknowledges, reflects on and aims to keep in check the harms of using technology, is necessary for maternity care provision. This is one of the important aspects of the social/midwifery model, focused on the facilitation of health and wellbeing when providing maternity care. Going back to the examples from the policy, our National Maternity Strategy claims to embrace the “health and wellbeing approach”\(^\text{112}\) (Department of Health 2016: 54). At the same time it adopts “a risk based approach” (Department of Health 2016: 86) which advocates obstetric risk protocols as central to provision of care. These protocols are predicated on the belief that intensive technological solutions are appropriate in maternity care for all women, and are the polar opposite of the health and wellbeing approach. The coexistence of two such irreconcilable paradigms in the Strategy, as if they were compatible, is deceptive, and obscures that currently it is the risk approach that has the upper hand in shaping our maternity services.

8.2.3 Esteem for low-tech practitioners and their knowledges: technology as supplementary within the context of relational care

Technically... technologically... cleanliness wise... those pictures are fine but I don’t get the feeling that she’s greatly loved. (...) we’re forgetting interpersonal relationships here. (Maebh)

they went through the whole stupid fucking box-ticking procedure. (...) they were trying to put a trace on me (...), and I’m telling them "no, get that off me, it’s happening", and they are telling me I have to sit still. I said "no, I won’t have this, I’m having this baby now, where is my midwife, where is my midwife?" (Tara)

I found the consultant a bit more removed [than the midwife], they were really just checking the few things they had to check (...) I think there’s more of a connection with the midwife (...) she’d be more personable around you, while the consultant, I just felt it very formal. “I need to check your blood pressure, I need to do the scan and that’s it and I’ll see you in a month.” (...) My consultant was lovely, she was really, really nice,

\(^{112}\) Tellingly, the health and wellbeing approach is confused in the Strategy with health promotion activities geared towards improving behaviour of individuals regarding nutrition, exercise or tobacco and alcohol intake (see: Department of Health 2016: 54-64), rather than requiring a systemic approach that must be adopted to facilitate health and wellbeing.
but you were sitting down in a queue, there might be thirty people and we were just
going in, one after the other, it just felt a bit rushed, that they didn’t really have the time
to... I don’t know, I suppose chat and have more of an understanding of what you’re
at". (Nora)

Throughout the interviews women persistently emphasise the midwives and their
skilled support\textsuperscript{113}, rather than technologies, as genuinely enabling for them, even as they
discuss the images of highly technological environments. While midwifery may not be
mentioned explicitly, women’s insistence on the importance of the continuous presence
and the trusting relationship with those caring for them, on being facilitated to work
with their bodies, and their cautious approach to interventionist, prescriptive responses
to their labours, suggest the components of a midwifery approach and not of high-tech
obstetrics to be crucial. The excerpts above demonstrate clearly how women negotiate
and contrast those two paradigms of thinking about their needs in childbirth: what is
“fine” technologically and procedurally, is insufficient for humanised care. Such care is
not simply about being properly “checked” and monitored but about the relationship,
about being “loved”, and about the attention to women’s unique circumstances. In
contrast, high-tech biomedicine, focused on its protocols of care, appears for women
distant and “formal”, disinterested in their individual circumstances. This need for being
loved and cherished while giving birth has been also observed by El-Nemer et al. (2006:
125-126) in their research. Moreover, “love” has been identified by Oakley as a unique
skill of midwifery and a “fundamental necessity” in contemporary maternity services
(Oakley 1993b: 76-77).

Women’s descriptions demonstrate that the role of technologies and high-tech
expertise is supplementary, and should be subsumed under a philosophy of care which
fundamentally values the relationship with their midwife, and focuses on meeting their
humane needs. Women’s recognition of the role of midwifery and its body of knowledge
has been reflected in the literature where comprehensive systems of midwifery care for
all women have been advocated to be a solution to intensifying problems with maternity

\textsuperscript{113} While midwives support rather than high-tech expertise on its own was enabling for women, it was
equally the lack of support from a midwife which was central to women’s feeling not cared for and
disempowered. Both instances in the interviews demonstrate the importance of skilled support which
rests on the ethos of midwifery for women.
services in their current form globally\textsuperscript{114}, necessary to restrain the excessive use of technology creating dangers for women and babies (Edwards \textit{et al.} 2018; ten Hoope-Bender \textit{et al.} 2014; Murphy-Lawless 2012; Renfrew \textit{et al.} 2014; Sandall, Coxon \textit{et al.} 2016; Sandall, Soltani \textit{et al.} 2016).

However, if women see midwives and their skills as fundamental, and care which is solely technological as deficient, the dominant discourse envisages midwifery as a subordinate practice. The distinct voice of midwifery has been absent from Irish health policy since the beginning of the Irish state (Dunlea 2018). Midwife-led options continue to be subsumed under biomedical objectives and the governance structures of maternity hospitals, with midwives’ practice not recognised as independent and their skills not seen as autonomous, as discussed in Chapter 1. Tellingly, the National Maternity Strategy considers terms such as midwife-led and obstetric-led as “profession-centric” (Department of Health 2016: 3), disregarding the differential in professional power that ensures that obstetricians “lead” the care of 95% of women, as indicated by the statistics quoted in the Strategy (ibid. 15-16).

Midwives are clearly a “resource” prioritised by women over technology and technocratic solutions. Yet, in the public debate and our health policy documents (Department of Health 2014, 2016, HIQA 2013, 2015) midwives are not presented as a “resource” prioritised for investment. Instead investment in high-tech infrastructure is favoured (Hunter \textit{et al.} 2008). Also, contrary to women’s voices, it is technology which is emphasised and extensively discussed when poor practice results in “adverse events” in Irish hospitals, rather than acute shortages of midwives within an overburdened, under-resourced system (Edwards \textit{et al.} 2018, Murphy-Lawless 2011). In the debates following the investigations into perinatal deaths in Portlaoise, problems with the technology of fetal monitoring and its correct interpretation have been persistently identified as the core issue (e.g. Cullen 2015, O’Regan 2018) over a focus on comprehensive, sufficiently resourced one-to-one midwifery care for every woman. Similarly, the practice of leaving women alone for prolonged periods of time with

\textsuperscript{114} For example Renfrew \textit{et al.} (2014) based on their analysis of 461 systematic reviews identified that “56 outcomes, including survival, health, wellbeing of women and infants, and efficient use of resources can be improved by practices that lie within the scope of midwifery” (ibid. 1130).
technology as the only “carer”, as well as the lack of continuity of care for women or any genuine relationship with their carers contributing to tragic outcomes is not discussed as problematic. Instead, the Minister of Health explicitly rejected a connection between those events and acute shortages of midwives, denying that those “staffing [or] resource issues are any excuse for failure to be able to read a CTG, as has been told to me by one of the families, or [for] turning the CTG machine down.” (James Reilly, quoted in: Gleeson 2014). When the Portlaoise report actually attends to appropriate staffing, it is reduced to applying quantitative “workforce planning tools” and improved rostering (Department of Health 2014) as the crucial “fixes” which are needed, rather than envisaging a system where these tools are used in addition to measures ensuring relational continuity and genuine midwifery care.

8.3 Ethical dimension: resisting controlling use of technology

“Since what we do affects other people, and what we do with the increased powers of technology has a still more powerful effect on people and on more people than ever before - the ethical significance of our actions now reaches unprecedented heights” (Bauman 1993: 218)

Women’s voices demonstrate a crucial deficiency of the technocratic approach. It fails to acknowledge the presumptions and values which infuse our use of technology and shape our maternity services, and it fails to encourage reflection on whose interests these actually serve. Previous sections highlight examples of the values perpetuated by technocratic maternity care which do not benefit women: deprecation of their knowledges and abilities, deprecation of midwives and their unique skills and knowledge, and disregard for humane imperatives of care. This parallels its characterisation by Davis-Floyd (2004) as comprising a patriarchal view of women, the supremacy of science and technological expertise over people and their experiential knowledge, as well as control over facilitation (ibid. 161).

The appropriateness of care as much as appropriateness of technology use is by definition not a concept which rests on “objective” knowledge but is about particular, located values. As already discussed in Chapter 7, it is about benefits which are desirable or considered acceptable within particular social, economic, and environmental
contexts, and for the particular individual or the particular community (Chassin et al. 1986, Hopkins et al. 1993, WHO 2000). However, the aspiration of high-tech biomedicine to appear scientific requires a denial of value statements having a part in it, as I argued in Chapter 2. Women’s voices expose the “politics of truth” (Foucault 1980b: 131) of the approach to maternity care which disavows values in order to appear “neutral” and thus unquestionable. However, no technological artefact or endeavour is morally neutral (Winner 1999) and in order to work, technology relies on “close focusing” (Bauman 1993: 194) which requires a narrow definition of a “task”, leaving out of focus the multiple connections with realities other than the technological and reaching beyond the task. Bauman argues that to counteract such reductionist thinking necessary for its effectiveness, technology urgently requires moral scrutiny and some ethical regulation ingrained into its use (Bauman 1993: 219), to ensure that it serves, rather than overpowers us.

Currently, the use of technology in maternity care seems to be driven predominantly by the “ethics” of risk management, where those deemed as experts calculate and prescribe what is safe, and by extension responsible. Women’s voices in this study are doubtful of such “ethics”. In order to disrupt the powerful alliance of a patriarchal value system and the risk discourses relying on technologies, the assumptions and practices of obstetric medicine and its use of technologies have to be examined through an ethical stance, beyond the narrow clinical responsibility they currently espouse.

Bauman (1993) observes that in modernity most of human activity considered important happens at a distance yet humans rely on a “morality of proximity” when enacting ethical values, i.e. morality which requires us to be in physical or geographical proximity to each other in order to experience and fully understand the consequences of our actions on other people. This is why consequences stemming from the “formidable powers” of technology, according to him, have long “outgrown” our “moral imagination” (Bauman 1993: 216). The technocratic approach fragments our responsibility towards each other as it makes it difficult to imagine this responsibility

115 For example, the motivations behind technology designed to favour continuous rather than intermittent observation, or for speeding up certain process rather than allowing it to proceed in its own time cannot be considered as neutral.
beyond undertaking efficient action. Forming trusting relationships between women and midwives, continuity of carer models, and commitment to a one-to-one care approach in midwifery have potential to prevent the fragmentation and facilitate the “moral proximity”. In this way it allows a notion of responsibility in caring for women which goes beyond prescriptive clinical rules and protocols, at a point when these latter regulatory tools have become conspicuously an end in themselves in the subsequent policies and reviews of our maternity care. In order to curb these excessive, unsustainable and essentially inhumane appetites of the technocratic framework, the approach explicitly addressing its ethical consequences, as much as ethical consequences of any system of care, seems crucial.

8.4 Midwifery as providing “modes of thought” which counteract a technocratic framework

I couldn’t have the epidural it was too late, it was too late for everything and the pain was just unmerciful, I was screaming and I expected that when you are naturally in labour, without any pain relief, that they guide you when to push and when not to do it and I expected them to say, “Don’t push, don’t push, pant. Now, push now.” I expected all that and nothing happened. They literally stood (...) at the end of the bed and watched me, that’s the god honest truth, they just stood there and watched and I was like, “Help me please, help me!” and they were like, “You’re grand, there’s nothing we can do, you’re having a baby, you just need to push.” (...) the pain was just horrific, and I literally felt like I was dying and no one was helping.” (Eva)

Despite its professional status, midwifery knowledge and skills continue to belong to a subjugated way of caring under the current paradigm, subsumed under the pre-eminent importance of the technological. This makes them invisible in our maternity care, and this is exemplified by Eva’s powerful, yet unsettling voice in the excerpt above. Within the framework favouring excessive technological action, there is suddenly “nothing” to do as Eva’s birth proceeds spontaneously. The strategy of the dominant discourse emerges: it obstructs the skills of “doing” other than its own, disqualifying midwifery’s “doing” as if it was “nothing”, as if it did not exist. In this way the technological “doing” described in Chapter 5 is what counts and prevails as those present with this woman come to view the situation as “nothing we can do”. In this excerpt, all the humane issues
discussed by women in Chapter 6 are absent: the genuine presence, the support to work with the body (including skills to prevent tearing during pushing), and most of all, the woman as a person with her unique needs.

Eva’s voice demonstrates how the erasure of women and their voices, and the erasure of midwives and their professional skills in the dominant discourse, parallel each other (Murphy-Lawless 2011: 449). The status of women and the status of midwives as those skilled to support women in childbirth cannot be understood separately in our society, yet this connectedness is unacknowledged in the technocratic framework. The erasure of this interconnection undermines what women see as most crucial for appropriate safe maternity care: the relationships between them and their midwives within a system which actually facilitates these and in which midwives are supported systemically to practice their skills and protect women in a way a technocratic medicalised system cannot and would not, as its philosophical foundation disregards the listening to women and “being with women” central to the ethos of midwifery.

Consequently, a midwifery approach becomes a source of alternative conceptualisations, able to counteract the technocratic modes of thought. It offers a potential to resist the controlling and coercive use of technology, and to resist seeing women and their reproductive processes through a patriarchal lens of deficiency, dependence and fragility which justify and normalise routine management (Sweetman 2017). As such, it provides us with a feminist discourse crucial to women’s empowerment, and to protecting them from technocratic practice with its excessive reliance on technologies. Thus midwifery becomes a source of a crucially feminist praxis (Meleo-Erwin and Rothman 2011, Rothman 2000), promoting women’s autonomy and self-determination within trusting relationship with their caregivers, where caring is understood as inherently enabling (Chokwe and Wright 2012, Halldórsdóttir and Karlsdóttir 1996b, McCance et al. 1997). Within such a paradigm, technology use can become truly enabling, without compromising women’s ways of knowing and being.

116 As mentioned in the Introduction any practitioner can practice according to the midwifery model. However, as women have particularly emphasised their relationships with their midwives in this research, I consider talking about “midwives” rather than “care providers” justified.
8.5 Conclusion: women’s voices eroding the foundations for the technocratic approach

“This country is one of the safest in the world in which to give birth. Our maternity services are very good and very safe. We put a huge emphasis on making sure that they are safe and there is a very strong message from government to all hospitals to ensure that maternity services are safe and that women are safe in childbirth.” (response of Tánaiste Eamon Gilmore to RTE Prime Time exposure of deaths of babies in Portlaoise hospital, quoted in: Keenan 2014)

there have been times when things could have been better (...) But across the board we get very good feedback, and we always deliver babies as carefully as we can. (response of the former Master of the National Maternity Hospital Rhona Mahony to women’s accounts from Joe Duffy’s Liveline programme, quoted in: O’Mahony 2019)

In my research, based on women’s voices, I aimed to move past the “modes of thought” which perpetuate the difficulties with our current technology use and which are preventing an essential transformation of our ailing maternity services. In the light of my analysis, the alleged “safety” and “very good feedback” argued in the excerpts above by Eamon Gilmore and Rhona Mahony are disingenuous, fuelled by a kind of willed ignorance of the complexities involved in truly supporting women in childbearing. They are spoken from positions of political power aimed to persuade women that their apprehensions are unfounded and thus should not be taken seriously. My analysis attempts to erode the foundations for such claims by offering conceptual tools which would enable us to see past their doctrine on “appropriate” maternity services.

Women consider a different set of priorities for technological “knowing” and “doing” compared with how obstetrics presents and mainstreams its discourses in policy documents and debates in the public domain. Women want a balanced approach which ensures both access to technological capacities when necessary and having them integrated into a system which is caring, sensitive and supportive, where women are cherished and non-technological or low-tech practices are held in high esteem.

For women the way birth technologies are used is confusing, as it contradicts their own recognition of what their needs are and what their experiential, embodied knowledges make clear to them. In the search for understanding, women are cautious about
technologies and often disengage with the components of the technocratic approach despite its powerful influence on their perception of quality and safety in maternity care. This contrasts with the examples of the dominant discourse discussed in this chapter, where uncertainty and caution are dismissed, and technologies are presented as enabling safer care in a straightforward way, sufficient on their own as a source of solutions. With correct supervision and regulation, and occasional amendment of the protocol to ensure its flawless operation, technology is seen as synonymous with safety and reliability, thus reassuring women that a good outcome can be expected. However, such perception of technology means that if a poor outcome occurs and the protocol has been indeed followed correctly, such poor outcome would be considered inevitable, as everything what could have been done was done, a circular argument which maintains the assumptions of our technocratic maternity services impenetrable to critique and extremely difficult to challenge.\footnote{I would like to acknowledge Nadine Edwards for drawing my attention to this circular argument within the technocratic maternity care.}

However, women’s voices expose such portrayals of the role of technology as deceptive. Technocratic care and its risk management strategies are presented as based on scientific knowledge, and thus the most reasonable, as if there was nothing to know and understand beyond what we are already doing, except for further refinements of still more technology as can be found in systems of centralised monitoring (Wickham 2009, 2016). This deception is akin to the “superficial transformation” depicted by Foucault in the excerpt quoted at the beginning of this discussion. I have demonstrated above how Irish health policy and responses to substandard care in Irish hospitals exemplify such “transformation”, and are to do with maintaining systems of knowledge and practice preserving the professional power rather than benefiting women, their families and the society.

Women’s suggestions summarised in this chapter can only be incorporated into our maternity services if our understanding of what ensures that care is safe and of the highest quality will radically change and expand. This requires us to admit that if we see problems in our maternity care exclusively as problems of institutional “governance” and “scientific” management, we have fundamental ethical problems in our maternity...
care provision. Without this admission we will not be able to recognise practices involving technology which are overpowering and cause harm to women. The approach of midwifery, and not high-tech obstetrics, as the dominant emphasis, has a clear philosophical basis for such ethical, more appropriate practice. However, transformation which is not superficial requires more than employing additional numbers of midwives as some official reports and policies suggest (Department of Health 2014, 2016, HIQA 2015, KPMG 2008). It requires the introduction of that comprehensive system wherein practicing midwifery is genuinely supported, rather than subjected to technocratic guidelines and protocols which at present “suffocate” genuine midwifery practice and the “living relationship between a woman and her midwife” (Murphy-Lawless et al. 2018: 146).
Chapter 9

Conclusion

The aim of my study was to explore women’s conceptualisation of technology in the context of the highly technologised maternity services in Ireland. Based on women’s voices I argue that what is supposedly being offered by the technocratic approach in maternity care, such as enhanced safety and quality of care, reassurance, and an assurance of less suffering and pain, is a deceptive promise. It is not that technology cannot play a part in ensuring these enablements for women. Rather, it is the narrow and complacent understanding of what constitutes enablement within technocratic obstetrics, which prevents these promises from being kept for women.

A framework for understanding which extends beyond this study

My reading of women’s voices was enabled by employing feminist poststructuralism and Foucauldian discourse analysis which have provided a crucial epistemological, methodological and political grounding for listening and interpreting women’s accounts of technology in my research. These approaches are about thinking differently through the issues concerning our society as well as about amplifying marginalised perspectives and knowledges. They have sensitised me to the relations of power at play in women’s accounts and the impact of those relations of power on women’s conceptualisations. They have prompted me to examine the seemingly uninteresting, “obvious”, commonly repeated statements and find some new understandings there. They have also encouraged me to arrive at new insights through embracing ambivalence, apparent contradiction or conflict, the insights I might have missed if I had been guided by the aim of resolving these ambiguities or discouraged by the impossibility of their resolution. However, it is also resorting to a photo-elicitation interview and the photographs which allowed me to arrive at those insights, as it enabled me to engage with women and facilitate them in such a way so they would be able to expand on their observations of technology in maternity care. I have learned during the analysis that the photographs often permitted me to make the argument I would not have been able to make otherwise, or to strengthen certain claims based on women’s reaction to the photographs.
Consequently, building a conceptual framework suitable to examine women’s understandings of technology in maternity care have been an essential part of this research. It allowed me to listen to women’s voices in a way that disrupts taken-for-granted interpretations of birth technology in our society, and furthers new understandings. I consider the theoretical/methodological framework and its combination with photo-elicitation interview one of the most original contributions of this research. Without the feminist poststructuralist lens and the Foucauldian discourse analysis, and without employing photo-elicitation, this would have been a research with a very different, and perhaps less compelling insights.

A similar epistemological and methodological approach to this research could be applied to explore other marginalised knowledges. This approach could be utilised to explore other research subjects which are similarly difficult to convey to participants, and where powerful and deeply ingrained assumptions govern and shape our understanding. For example, exploring the approaches to technology of maternity care providers, could shed further light on our struggles with appropriate technology use in maternity care. This could help us imagine how to disentangle their current practice from the technocratic approach, and to understand how they could practice their skills, including those involving complex technology, under a different model.

The power of technocratic paradigm, midwifery and technology

My interpretation of women’s voices suggests that detechnologisation of maternity care and appropriate approach to technology use is urgently needed, and that these can be ensured by the system of comprehensive midwifery accessible for all women, where care is tailored to the needs of individual women and relational continuity is central. Numerous researchers and practitioners have arrived at similar recommendations (e.g. Hunter et al. 2008; Murphy-Lawless 2011a, 2011b, 2013; Sandall, Soltani et al. 2016; Wickham 2016). However, my research offers a detailed description which demonstrates how technologisation - and the technocratic approach perpetuating it - is actually enacted and thus why it is extremely difficult to challenge in women’s everyday encounters with maternity care. This follows Foucault’s assertion that if we are to understand how the dominant discourse such as technocratic biomedicine is exercised
we need to study its strategies and mechanisms and examine how its power is maintained through the study of its daily local applications (Foucault 1980c, 1988). It is such detailed descriptions which I see as novel and another crucial contribution of my research, providing an important position from which to argue the shift of our maternity services towards the midwifery/social model.

Women in this research often imagine a balanced approach where midwifery and technology are not in conflict but cooperate. However, the two do not operate in a social vacuum and are entangled in a sustained power struggle between midwifery and obstetrics. Consequently, an appropriate model for maternity services must be in place where neither midwifery nor technology is subjugated or rejected. It is the midwifery/social model which offers an overarching framework in maternity care for midwifery to thrive as well as the most appropriate utilisation of technology and obstetrics. This allows for such co-existence of midwifery and technology which is most beneficial for women, midwives and for medical professionals who use technology to deal with complications. Women’s voices in this research demonstrate that the current approach of technocratic biomedicine as an underlying “ideology” of maternity services, and its hierarchies as to what is important, are an obstacle to such beneficial co-existence.

Still, it is not easy for us to see and comprehend the deceptions of technocratic maternity care as its assumptions are deeply embedded in our extremely complex technological society. These assumptions are reproduced and maintained daily, ubiquitous yet concealed. Through my analysis I hoped to “translate” at least some of the structural, systemic mechanisms involved in technologisation of our maternity services into lived realities of women’s lives. After all, bridging the gap between “private troubles” and “public issues of social structure” has been advocated as the substance of the “sociological imagination” (Mills 1959: 8). According to Bauman (1999) practising “the art of translation” of our private troubles into issues concerning the whole of the society is urgently needed if members of the society are to come together and undertake collective action (ibid. 2-3). This research aims to perform such translation and to offer tools for understanding, necessary for collective awareness and political action oriented towards change. My translation can be instrumental in loosening the
powerful grip of technocratic modes of thought on our imagination, and crucial for “private troubles” associated with biomedical maternity services to add up and “condense into common causes” for members of our society (Bauman 1999: 3).

Thus, similarly to Murphy (2018), it is not the efforts to produce more research evidence demonstrating that we need to shift our maternity services to the midwifery model, or proving the benefits of midwifery, that stem from this research. We have a sufficient research basis for these. Instead, what is of primary importance is a research agenda which asks questions about the effective methods of action to introduce or “scale up” midwifery models in practice and in a context sensitive way (Homer et al. 2014, ten Hoope-Bender et al. 2014, Renfrew et al. 2014). What is also crucial is that we “nurture” and protect the midwifery initiatives already in place and that we focus on learning from them (Walsh and Newburn 2002a, b). We need research work which aims at reflection on how we can overcome the existing coalitions of social power, and which clarifies how they have continued to hinder the introduction of midwifery models for decades at both local and systemic level despite the evidence supporting them (Mander and Murphy-Lawless 2013, Murphy-Lawless 2010, Murphy-Lawless 2013, Murphy-Lawless et al. 2018).

What is also necessary is broadening the scope of our campaigning and activism, making our collective efforts to improve maternity services about wellbeing of our communities and the whole of the society (Edwards et al. 2018, Murphy-Lawless 2018, Murphy-Lawless et al. 2018), and about ensuring appropriate maternity services with appropriate use of technology are available to all women (Anglin 2013, Daellenbach and Edwards 2011, Edwards et al. 2018, Meleo-Erwin and Rothman 2011). In other words, preparing for and undertaking action rather than stopping at conducting research is crucial.

The substance of the decisions around “appropriate” maternity care and birth technology in Ireland is most acutely exposed in the debacle surrounding the move of the National Maternity Hospital to a new purpose built facility for 10,000 births annually. Large hospitals can be considered an ultimate technological solution in maternity care, as they integrate all clinical, pharmacological, organisational and
surveillance technologies on a single site. While the current infrastructure is indeed crumbling and severe overcrowding is a problem, the essential question to ask is whether such large numbers of women indeed have a need for care delivered in an acute hospital setting, and whether they would be well served by such a hospital while the development of the infrastructure for midwife-led services in community settings continues to be ignored.

It is a deception maintained within the technocratic approach, and perpetuated by those with power to shape our maternity services, that in order to improve the quality and safety of care for women, there is an unarguable need to have a new bigger hospital (Clarke et al. 2017, Cullen and Power 2017, O’Brien 2018). While the former master of the hospital Rhona Mahony argues that it will “revolutionise healthcare for women and children” (Mahony, quoted in: Clarke et al. 2017) echoing the discourse of the National Maternity Strategy on the “radical overhaul” of the services, what is being proposed is merely an extension of the dominant approach of high-tech obstetrics. And the assertion of the Minister of Health, Simon Harris demonstrates clearly that the new hospital is crucially not about women and their wellbeing but about high-tech expertise and maintaining those who are using it in their position: “it’s about access to theatres, to intensive care facilities, to high dependency units, to consultants (...) It’s about empowering doctors [emphasis mine] to make clinical decisions.” (Harris, quoted in: Cullen and Power 2017).

It is an exceptional yet singular voice of Philomena Canning, our most distinguished independent midwife, and a tireless advocate for women’s rights in childbirth, which puts straight the realities of the Irish maternity services in this debate:

“if centralisation leads to industrialisation and this leads to the denial of women’s human rights in the labour ward, then the last thing women need is a shiny, new birth factory.” (Canning 2017)

And this is also the most important pronouncement stemming from women’s voices in this research: if the way technology is currently used disempowers them, perpetuates their fears, and leaves them feeling unsupported, then the last thing they need is more
technology and maternity services designed around the assumptions of high-tech expertise.
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<th>Education</th>
<th>Nationality</th>
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<td>Irish</td>
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<td>2. Aleksander</td>
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<tr>
<td>3. Lynn</td>
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<td>5. Grace</td>
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<td>9. Sheila</td>
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<tr>
<td>Pheobe</td>
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<td>Janet</td>
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<td>British</td>
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<td>19. Glenda</td>
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<td>22. Roberta</td>
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<td>24. Shauna</td>
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<td>Hairdresser</td>
<td>Leaving cert</td>
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**Appendix 1** List of participants (continued)

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<th>Children</th>
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<tr>
<td>1. 4 + 3 yr old</td>
<td>Public (standard)</td>
</tr>
<tr>
<td>2. 3 yr + 6 mths old</td>
<td>Public (standard)</td>
</tr>
<tr>
<td>3. 10 + 6yr old</td>
<td>Independent midwife, homebirth</td>
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<tr>
<td>4. 7yr + stillbirth 24 wks</td>
<td>Public (standard)</td>
</tr>
<tr>
<td>5. 38 wks pregnant</td>
<td>Domino, hospital birth</td>
</tr>
<tr>
<td>6. 4 mths old</td>
<td>Domino, hospital birth</td>
</tr>
<tr>
<td>7. 21 + 11 yr</td>
<td>Independent midwife, homebirth</td>
</tr>
<tr>
<td>8. 33 wks pregnant</td>
<td>Semi-private</td>
</tr>
<tr>
<td>9. 39 wks pregnant 3 mths</td>
<td>Public (midwives)</td>
</tr>
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<td>10. 1 yr old</td>
<td>Semi-private</td>
</tr>
<tr>
<td>11. 2 yr old + 35 wks pregnant</td>
<td>Public (standard)</td>
</tr>
<tr>
<td>12. 8 + 7 yr old</td>
<td>Domino, hospital birth</td>
</tr>
<tr>
<td>13. 2 yr old + 24 wks pg</td>
<td>Semi-private</td>
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<tr>
<td>14. 10 mths</td>
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<td>15. 3 yr + 6 mths pg</td>
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<tr>
<td>16. 3 + 1 yr old</td>
<td>Private</td>
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<td>17. 12 + 2 yr old</td>
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<td>18. 6, 4, 2 yr old 11, 6, 4 yr + 7 mths</td>
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<td>19. 5 yr old</td>
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<td>20. 4 + 2 yr old</td>
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<td>21. 7 + 2 yr old</td>
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<td>24. 7, 4, 1 yr old</td>
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* These women experienced care in public or private hospitals in the 1970s/early 1980s. Their accounts indicate circumstances which are sometimes difficult to compare in a straightforward way with what we associate with the different types of care in the Irish maternity services today. As a result their accounts are sometimes spoken from a position of outsiders to the current system, who reflect on the significance of changes that have occurred.
Appendix 2: Access letter for community groups coordinators

Re: Potential research project

Dear Madam,

My name is Malgorzata (Gosia) Stach and I am writing to you in connection with a research study I would like to conduct entitled: Understanding technology at birth: women’s accounts.

I would like to ask for your help in recruiting participants for this study among the parents in the (name of the facility/group). It would be most helpful if I could distribute information booklets and/or talk to them about the study.

The purpose of this study is to examine how people understand medical technology in birth and what are their needs when it comes to technology use in birth.

I am undertaking this project because most women using Irish maternity services are undergoing at least some technological intervention in birth and there is a very small percentage of births that end up without any use of technology. That is why I would like to find out what is the value of birth technology for them and what are their needs regarding information on medical technology in order to make confident decisions about it during birth.

This project will involve interviews and/or organising a group discussion which will be conducted at a place convenient to participants. I hope that the information collected will be of benefit for improvement of the quality of maternity services in the future.

The research project is being undertaken as part of my PhD study. It has been approved by the Faculty of Health Sciences Ethics Committee, Trinity College Dublin.

I would be delighted to meet you at a time and place of your convenience to discuss this proposal.

Yours sincerely

Contact details:

Gosia
085 784 53 15
or stachm@tcd.ie

My research supervisor Dr Jo Murphy-Lawless can be also contacted at 01 8377668.
Research participants needed

What do you think of our maternity care?

How could it be improved?

I am looking for participants for interviews.

I am a PhD student in the School of Nursing & Midwifery, Trinity College Dublin and I would like to hear your opinion about **how medical interventions should be used during birth for the benefit of women and their babies.** At present most births in Ireland involve using some medical procedures.

No professional knowledge is required and you don't have to be a parent to take part, pregnant women are welcome! Dads' opinions would be great as well.

For information or to take part please text or call **085 784 53 15** (Gosia) or email **stachm@tcd.ie**.

It would be of much help if you could take part!
Appendix 4: Information leaflet for participants

My name is Malgorzata (Gosia) Stach and I am a PhD student at the School of Nursing and Midwifery, Trinity College Dublin.

What is the study about?
This study looks at how women experience maternity care and how they understand medical technology that may be used during birth.
Most women in Ireland when having their baby undergo at least some medical procedures. This usually involves using some technology.

If you agree to take part:
I would like to talk with you during the interview to hear about your experience of maternity care.

I would also like to hear about your experience of medical technology such as, for example:
- medical devices used during birth
- diagnostic tests to check wellbeing of woman and her baby
- drugs used for pain relief or to start or speed up birth.

How should we use them for the benefit of women and their babies?
You do not have to be familiar with any professional knowledge. It is about your opinion.

Discussing photos:
For some part of our conversation I will be using photos of hospital rooms and medical items, of women with midwives or doctors caring for them. The photos won’t be showing any graphic details.

Our conversation:
- will take approx. 45 minutes for an individual interview, 1-1.5 hour for a group interview
- will be arranged at a time and place convenient to you
- will be recorded to ensure that I have an accurate record of what was said
- is strictly confidential (all identifying names will be replaced by an identification number and you will not be identified in any written report)

Your participation is completely voluntary:
- you are free to withdraw at any time (before, during or after the interview)
- you don’t have to answer all questions and you can stop the interview at any time
Appendix 4: Information leaflet for participants (continued)

Further information and to take part:
Please contact me (Gosia):
085 784 53 15
stachm@tcd.ie

It would be of much help if you could take part!

INFORMATION BOOKLET

Title of the study:
Understanding medical technology at birth.
Appendix 5: Informed consent form

CONSENT FORM

Project title: Understanding technology at birth: women’s accounts.

In signing this consent form, I agree to take part in this research study and I am happy to be interviewed by Malgorzata (Gosia) Stach PhD student, Trinity College Dublin.

I understand that the study focuses on how people understand medical technology used in birth.

I have been informed that:

- my participation is entirely voluntary
- I can withdraw my participation at any time or refuse to answer any specific questions during the interview
- the interview will be recorded
- the information provided will be strictly confidential and no reports will identify me in any way.
- should the data from this research be used for any other analysis additional consent will be sought from me

I have been informed that during the interview we will discuss some photos and I am aware that their content is not meant to be offensive or upsetting.

I have read, or had read to me, the information leaflet for this project and I understand the contents.
I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

Participant’s name: ………………………………………………….
Contact details:…………………………………………………………………………

Participant’s signature:……………………………….. Date: …………………..

Statement of investigator’s responsibility:

I have explained the nature and purpose of this research study and the procedures to be undertaken. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given consent.

Investigator’s signature: …………………………………….. Date: …………………..
Appendix 6: Interview guide

These are exemplar questions. My goal was to follow women’s accounts as they tell them rather than ask particular questions.

Objective 1: Exploring women’s experiences of care

The objective at the beginning of the interview is for me to get familiar with women’s experiences of maternity care. It is crucial for me to learn about their hierarchy of importance and observe what part technology plays in this experience before specifically exploring technology in the interview.

For women who were pregnant with their second or subsequent child: Please, tell me about your experience of birth. What was your care like? Were you happy with your care? What did you like/didn’t like about it? What was important?

For women who were pregnant with their first child: Please, tell me about your experience of care during your pregnancy. Are you happy with it? What do you anticipate your birth will be like?

Objective 2. Exploring technology: preliminary questions

Associations of technology

What do you associate with the word “technology”?

What technologies are useful to you in your everyday life? What are advantages of having technology? Are there any downsides of technology you can think of?

First thoughts on technology in birth

What do you associate with technology for birth? What technologies for birth have you heard of? What do you remember from hospital? What do you think of them?

Do you think birth has changed much because of technology, comparing with what our mothers experienced?

Objective 3: Exploring technology: using photographs of birth settings and birth technologies

For sample questions accompanying the photographs see Appendix 7.

Objective 4: Coming to a close: what maternity care should we have?

1. In terms of the future of maternity care, how do you think it would change? How would you like it to change?

2. Can you think of any invention which could help women and babies to have better care? Anything we do not have that you would like to see invented?
Appendix 7: Photographs and sample questions asked about them

What follows below are sample questions. Additional questions depended on women’s reactions to particular photographs or were asked when women appeared unsure and needed an additional cue.

Envelope 1: Hospital rooms: two “technological” birth rooms (Photo 1.1 and 1.2) and one “hybrid domesticated” room (Photo 1.3) with its technological quality softened by homelike furnishings and decoration (see: Bowden et al. 2016). Questions: What do you think of such rooms as places to have a baby? Should they be any different?

Photo 1.1

Photo 1.2

Photo 1.3
Envelope 2: Women being cared for within technologised environments

Question: Looking at those photographs, what do you think of these women’s care?

Additional questions: Is it a good care? Do you see anything that may be missing from their care?

Photo 2.1

Photo 2.2

Photo 2.3
Envelope 3: A “birth story”: three photographs from one woman’s care

Question: What do you think of this woman’s care?

Additional questions: What is good about her care? Is there anything you would change?
Envelope 4: Alternatives to EFM: Doppler and Pinard

Questions: Do you recognise these? Were they used during your pregnancy/labour? Would you trust these for monitoring the heartbeat?

Envelope 5: Operating theatre

Question: This is an operating theatre. Have you any thoughts on this environment?
Envelope 6: Caesarean section

Questions: What do you think when you see this? What is happening here? Do you know anyone who had a caesarean section? What did they tell you of their experience?
Envelope 7: Low-tech room with a pool in the Coombe Hospital in Dublin

Question: What do you think of this environment for birth?

Photo 7.1*

Photo 7.2*

Photo 7.3*
Envelop 8: Neonatal Intensive Care Unit (NICU): extremely high-tech environment

Question: This is the last photograph, what do you think of it?

* I did not have digital copies of photos 7.1 – 7.3. The images which were shown to women were of placards displayed in the waiting rooms of the hospital where the pool had become available. Images 7.1 – 7.3 are photographs of those placards.