

Change and Entrenchment in Irish maternity care policies and
antenatal practices: An Institutional Ethnography

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Signed By Margaret Dunlea
Student number:12329004

A handwritten signature in black ink, enclosed within a red rectangular border. The signature appears to be 'Margaret Dunlea' written in a cursive style.

Dedication

To my mother who loved life itself.
“There piped a piper in the woods, strange music, soft and sweet”
(The Magic Piper E.L. Marsh)

&

To my grandson James, for bringing us joy and wonderment.

Summary

Change and entrenchment in Irish maternity care policies and antenatal practices: An Institutional Ethnography

Background

The Mother and Infant Care Scheme (MICS) (1954), enacted following the Health Act of 1953, is widely acknowledged as the foundation of the Irish state-run maternity service as we know it today. Its underlying approach was shaped by the conservative, patriarchal society from which it emerged and the powerful obstetric profession. The MICS effectively institutionalised what became a heavily centralised, biomedical model of maternity care that was heavily determined by obstetric-dominated government policy. The entrenchment of the biomedical model for all births has persisted, despite mounting evidence supporting the biopsychosocial model of care. The consensus is that current Irish maternity services are out of step with international best evidence. Meaningful, whole systems change in the Irish maternity services is urgently needed.

Methodology

This study is an exploration of change and entrenchment in Irish maternity services policies and practices using an institutional ethnographic approach; this is related to the need to go beyond the local particularities of people working within institutions to the broader 'relations of ruling' that shape those daily realities. The study consists of macro historical analysis of the key tenets of Modernity that underpin the biomedical model and the power-relations embedded in government policy and legislation since the introduction of the MICS in 1954. The study also involved a micro analysis involving observational recordings of the antenatal encounter followed by interviews of service-users and providers as part of the methodology; micro refers to antenatal data generation and macro refers to primary archival documentation. I used a critical institutional ethnography with a feminist perspective, framed by Dorothy Smith, drawing on Foucault's critique of power/knowledge. This reflects an interpretive ontology and epistemology which assumes that realities are multiple, socially constructed, context-specific and relational.

Results

The study reveals that the routinized antenatal practices and discourses reflect the wider historical, political, structural and cultural power-relations and social processes. The link between modernity, the capitalism mode of production, state run maternity services, obstetric hegemony, the side-lining of midwives and women's disempowerment are made. These organizational and institutional processes are not so much overtly political as part of an entrenched power establishment that goes unchallenged and unseen. The power of the biomedical paradigm is its ability to reproduce the social structure and processes that support it, without appearing coercive. Healthcare professionals, through their discourses and practices, knowingly or unknowingly, perpetuate traditional, patriarchal views of power embedded in the biomedical model, thus perpetuating the subjugation of childbearing women and midwives. Medical hegemony was such that Irish obstetrics, not alone remained a 'traditionally' unchallenged site of power from the foundation of the state onwards, but right up through the 1970s and beyond, where obstetrics knowledge and expertise continued to single-

handedly drive maternity care policy. This study demonstrates that government policies have still not made the connection between obstetric modernist thinking, the bureaucratic centralised approach, the biomedical model, the technocratic imperative and the current problems in maternity care. This amounts to a gendered politics of knowledge and expertise, where women's voices continue to be silenced or trivialised.

Conclusion

Maternity services are complex, multi-layered, interconnected systems. For meaningful change to occur, whole system change that disrupts the current power-relations is required. Up to now most changes have been partial, fragmented and local which impedes their integration into the whole system, making them vulnerable to being withdrawn by the ruling elite. Enacting and embodying changes in discourses and practices at local level can influence a change of attitude among service-users and providers. An in-depth understanding of the biomedical paradigm in obstetrics, in terms of the three imperative: obstetric, risk and technological, and the bureaucratic, institutional structures that perpetuate it are urgently needed if meaningful change is to occur. Unmasking power-relations by exposing how power works in institutions can be emancipatory and makes resistance and change possible. Because the midwifery profession is traditionally subordinate to obstetrics, its continued existence is always under threat. To safeguard the midwifery profession and thus safeguarding women's choices and the provision of a quality and safe maternity services, solidarity and concerted campaigning is needed and all midwives need to be politically active.

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1. Chapter One Introduction

An urgent need to understand why the Irish maternity services appeared to be so resistant to change was the starting point for this doctoral thesis. The persistence of the highly centralised biomedical model was deeply worrying, given its association with a highly interventionist and de-personalised service (O'Connell & Downe 2009, Healy 2017). In order to better understand and influence change and entrenchment in the Irish maternity services, we need to go beyond the local particularities of peoples' work practices within institutions to the broader 'relations of ruling'¹ that shape those daily realities (Smith 1990: 74). Foucault tells us "how some of our ways of thinking and doing [in the present] are historically linked to particular forms of power and social control" (Sawicki 1991:47). Similarly, it is widely acknowledged that our way of thinking and doing maternity care in Ireland is rooted in the Mother and Infant Care Scheme (MICS) (1954), which emerged from a highly conservative, patriarchal, and stratified 1950s Ireland (Oláh, 1998, Valiulis 1995, O'Connor 2000, Kennedy 2002, Connelly 2003). The MICS prioritises medical-led maternity care, where general practitioners (GPs) and hospital obstetricians share a medical monopoly on antenatal care and where more than 95% of births take place in a consultant-led and midwife-managed hospital setting (Kennedy 2002).

Currently there are 19 maternity units and hospitals in Ireland, consisting of five standalone obstetric-led maternity hospitals and fourteen smaller obstetric-led maternity units within acute general hospitals (HIQA 2020a). Two of the standalone maternity hospitals are run by the Health Service Executive (HSE), while the three Dublin maternity hospitals are voluntary public hospitals, that are publicly funded and have service-level agreements with the HSE (ibid.). Governance of the voluntary hospitals is not directly through the HSE but through the Mastership system of governance, that is under charter or statute dating from 1756 (Rotunda), 1876 (Coombe) and 1936 (National Maternity Hospital) respectively. This is where the Master, who is an obstetrician with overall executive powers for the running of the hospital for a fixed period of seven years, works alongside a hospital board of guardians and directors, often appointed by the Minister for Health. The only two private stand-alone maternity hospitals, both situated in Dublin, have recently closed (Mount Carmel, the last private maternity hospital in Dublin closed in 2014). Regardless, obstetricians in Ireland have always and continue to treat their private patients in publicly funded hospitals (HSE 2020). The first break in obstetric dominated maternity care came when midwifery-led antenatal initiatives were introduced on a

¹ Smith refers to the trans-local (institutional and organizational) social relations that shape, coordinate, and control local activities within institutions as 'relations of ruling'(1990b).

pilot basis in the late 1990s. In 2004 the first two alongside midwife-led units (MLUs), widely available internationally, were established in Cavan and Drogheda on a pilot basis (Begley et al 2011, Dencker et al 2017).

It is widely acknowledged that the antenatal encounter is the building block of the maternity services and provides a platform from which to support women's, families', and communities' experiences at this pivotal time in the course of their lives (WHO 2016a). Women's experiences of their initial encounters with healthcare providers sets the tone for future experiences and expectations (Bondas & Erikson 2001, Novick 2009). Maternity care experiences can have a positive or negative impact on the woman's immediate and long-term psychological wellbeing, her preparedness for birth and her belief in her capacity to birth without routine intervention, and on the developing mother-infant, family, and societal relationships (WHO 2016a).

Yet despite this, Archie Cochrane, the father of evidence-based medicine, as early as 1972 wrote that "by some curious chance, antenatal care has escaped the critical assessment to which most screening procedures have been subjected" (1972:12). In Ireland, by international standards, very little has changed in how healthcare professionals and the public in general think about and do maternity care, since the introduction of the MICS over 60 years ago (Health Information and Quality Authority (HIQA) 2013). This is despite mounting evidence supporting alternative models of care (Begley 2011, Brocklehurst et al 2011, Sutcliffe et al 2012, Sandall et al 2013, Sandall et al 2016) and demands for reform of the service by maternity care activists (Association for Improvements in the Maternity Services in Ireland (AIMSI) 2010, 2012, Cuidiú, 2011), journalists (O'Doherty and Regan 2006) and researchers (Murphy-Lawless 1998, Kennedy 2012). The general consensus is that Irish maternity services are out of step with international best evidence (Kinder Report 2001, KPMG Report 2008, Begley et al 2011). Change in the culture and provision of antenatal care is the first step to impacting substantive change in the maternity services as a whole.

It is in this regard, that I have undertaken an exploration of change and entrenchment in the Irish maternity services with an empirical focus on the micro realities of antenatal care. By moving beyond these local realities to the broader institutional structures and processes at macro level, that shape these micro realities, gendered power relations become visible.

The 'macro' refers to the large-scale groups, relationships, and trends that make up society while the 'micro' refers to the local small-scale interactions and aspects of social life (Cole 2019). Of particular interest is this study, was how ways of doing and thinking about the maternity services, embedded in these social processes and power-relations, are perpetuated, resisted, and challenged. It was hoped that by making explicit what change agents are at play and how power works in institutions, that individual's role in perpetuating hegemonic structures are recognised, and resistance and change in the institution under examination becomes possible. Both Michel Foucault and Dorothy Smith share a research interest in the

interconnection between macro and micro processes, and aspects of their research approaches were used to guide this research. The use of a feminist lens, that pays particular attention to gender power-relations in terms of gender hierarchies (Smith 1999) is central to both institutional ethnographies, grounded as it is in the feminist movement, and studies involving the maternity services, where service-users and service-providers are female, and where there is a long-documented history of subordination of women to men (O'Connor 2000). Using sociological theory grounded in empirical evidence, I explored the link between modernity, the capitalist mode of production, hegemonic truth and knowledge discourses², and modern ways of thinking. Also, using historical documentary evidence and empirical data, the link between modern ways of thinking, the consolidation of obstetrics, the subordination of midwifery and the introduction of state-run maternity care is made explicit. Until now, there is a dearth of empirical research exploring maternity care from a macro and micro perspectives in the Irish context, and in particular, how these perspectives influence one another, making it a worthy topic of inquiry. While local contexts will always have their own particularities, the modern biomedical model of maternity care, found in the Irish context, is similarly found in most income rich countries, to some degree or other (Wagner 1995). Having a better understanding of how hegemonic power relations in institutions, work to perpetuate the status quo or resist change, will be of interest to stakeholders elsewhere, who want to negotiate changes in their maternity services, making this study relevant in other jurisdictions. Carrying out this exploration is my unique contribution to this body of knowledge. The study findings will be of interest to anyone who has an interest in providing a quality and safe maternity service and wants a service that is built on best available evidence.

1.1. How is this thesis structured?

Because this is an institutional ethnography (IE) the chapters are not arranged in the usual format, for example introduction, background, methodology, method, concept analysis, literature review, data analysis, finding, discussion. Data generation, analysis and findings are iterative processes and happen simultaneously. The introduction, methodology and methods are followed by the macro analysis from chapter 4-10. These chapters use data generated from government archives and historical accounts, both primary and secondary data and relevant sociological and midwifery literature, to explore and make explicit how power-

² At the most common-sensical level, discourse is a mode of organizing knowledge, ideas, or experience through an orderly verbal interchange of ideas that takes the form of an extended conversation (Merriam Webster 2020). According to Foucault, discourse can be enacted beyond language and embodied in social practices and thus their organising and regulatory effects extend into our everyday lives (Foucault 1972). Because discourse constitute the 'nature' of what it seeks to govern and attempts to re-produces the social world as it understands it (Weedon 1987), they can be viewed as "power-related structures of how we understand reality" (Al  x and Hammarstr  m 2007: 170).

relations, discourses, and wider political processes at institutional and establishment level, organise and shape local practices and interactions in the maternity services. Gendered and hegemonic power-relations are explored and how they work to reinforce the status quo are made explicit. Discourses that came to dominate government policy rhetoric and were used to drive the change and reform agendas in maternity care; biomedical and social models, risk and safety, the need to protecting normality, continuity models, women-centredness, individual choice, are genealogically examined in terms of their dynamic origins, the multiple agents involved, and the multiple contexts in which these concepts emerged. I argued that these discourses are open to different interpretations and subject to appropriation by the hegemonic elite to reinforce their authority, strengthen their professional status and maintain the status quo. An exploration of change processes and their sustainability within the current hegemonic system was also undertaken. While I never set out to conduct a detailed analysis of the history of the maternity services in Ireland, it became necessary in order to contextualise the trajectory of change and entrenchment in the Irish maternity services. Chapters eleven and twelve are the micro analysis using data generated from the participant observations of the antenatal encounter and interviews of participants involved in them. How local practices and discourses are impacted and shaped by micro level processes and power-relations and continue to impact change and entrenchment in the maternity services are explored. The purpose of each chapter is outlined below.

Chapter 2. Theoretical and Methodological Framework. This chapter interrogates the theoretical and methodological framework underpinning this study. Central to the chapter discussion is an exploration of the value of ethnography in general, and institutional ethnography in particular, as a legitimate approach to social research in general and health care research more specifically. Feminism is in keeping with institutional ethnography and any research involving maternity care that is predominantly by and for women. How critical institutional ethnographic (IE) using a feminist lens informed by Dorothy Smith's and Foucault's work on power-knowledge and governmentality informed my analysis is discussed. I make the case for the need to go beyond coding and thematic analysis to mapping the links between the participants' lived realities with broader organizational and institutional processes and power relations that organise and coordinate those realities.

Chapter 3. Research Methods. The purpose of the chapter is to outline the research process undertaken to conduct this study. First, my positionality and presuppositions are outlined and their impact on the research process is discussed. Second, the research process, including design, aim and objectives, ethical issues, negotiating access, recruitment, data generation, storage and analysis are critiqued. Institutional ethnographers begin with a 'problematic' situated in people's real-life experiences (Kearney et al 2019:19). I use reflective accounts

from my fieldnotes to make my decision trail more explicit. I end with a discussion on the importance of rigour and the researcher's reflexivity and competence in appraising quality in qualitative data.

Chapter 4. Modernity and Maternity. The chapter is an in-depth analysis of the tenets of modernity and how this complex worldview has impacted the trajectory of the maternity services, particularly how it is implicated in the dominant role played by of the biomedical paradigm. The aim of the chapter is to critique the emergence of modernity and Western rational thinking in the wake of scientific discoveries, and to explore how this new way of thinking underpins obstetric thinking and impacts how modern maternity care is organised. Issues discussed include how authoritative knowledge regimes and dichotomous thinking are the root of modern day inequalities, in particular the subjugation of women. How theses belief systems, along with risk discourse are the organising principles in modern day maternity care is then discussed. It is hoped that this sociological perspective will afford a better understanding of how the biomedical model of maternity care came to dominate pregnancy and birth and remains so entrenched in the Irish context. I argue that it is only by acquiring this in-depth understanding of the genealogy of the biomedical paradigm, which makes explicit its complexities and influences, that a change in perspective and awareness will ensue, which may influence change in practice.

Chapter 5. The historic roots of medical hegemony in the Irish context. In order to assess entrenchment and change in the Irish maternity services, the historic roots of medical hegemony need to be explored. First, I explore the social and cultural context of 1950s Ireland from which the foundation of the maternity services emerged. Second, I discuss the power-relations that influenced the origins of mother and child welfare and of state-run antenatal care. Third, I present a detailed analysis of the influential, hegemonic discourses that hampered the introduction of the originally proposed Health Act (1947), the controversial Mother and Child Health Services Scheme bill (1947) which led to it being replaced by the profoundly amended Maternity and Child Health Services Regulations (Health Act 1953) (later referred to as the Maternity and Infant Care Scheme) (MICS) (Health Act 1970). The link between modernity, the capitalist mode of production, state run maternity services is made. The latter involved obstetric hegemony and the side-lining of midwives and women. Finally, the key tenets of the MICS and their impact on the subsequent development and trajectory of the maternity services, including service-users' and providers' experiences of the service, will be discussed. It is anticipated that employing a feminist lens to this historical critique offers an opportunity to make explicit the gender imbalance at the heart of this patriarchal system and may offer insights into the workings of maternity institutions. By making the macro level processes that inform micro level realities explicit, it is hoped that we may resist them and be freed from them.

Chapter 6. Critique of the biomedical model. By the 1970s, cracks began to appear in the biomedical model as it was not living up to its promise on safety, while it was becoming more and more associated with de-humanising care. This chapter starts by outlining the general criticisms of the biomedical model. The methodological difficulty with measuring women's satisfaction with care is also presented and caution is urged if using women's satisfaction surveys to inform change in service provision.

Chapter 7. The bio-psychosocial model of care. This chapter explores the biosocial psychological paradigm as a viable alternative to over-medicalised pregnancy and birth. The link between the social model of care, the philosophy underpinning midwifery and what women value in maternity care is made. The role of the midwife, who embodies the social model of care and the philosophy of being with woman is now widely acknowledged as central to providing a quality and safe maternity service. The acknowledgement that most women of reproductive age are well and healthy and can achieve a normal birth without medical assistance is the starting point in this alternative paradigm. What is proposed is that medical intervention is reserved for those with proven medical indications, where there is real and present danger. The evidence supporting a midwifery, caseload community model of care is presented. I argue that caseload models are unworkable within the current bureaucratic institutional setting. This is because woman-centred care is incompatible within the current bureaucratic institution setting, where the needs of the institution takes precedence over the needs of the woman. I end by concluding that meaningful change in maternity care requires radical whole system changes from the bureaucratic biomedical model, which is organised around the needs of the institution, to a community-based, caseload model, that is organised around the needs of the woman.

Chapter 8. A review of government maternity care policy documents and legislation from the 1970s onwards. This chapter explores hegemonic discourses that impact change and entrenchment in Irish maternity policies and legislation, from the 1970s onwards. I argue that while women in Ireland gradually acquired increased legal and economic rights and more control over fertility, this was not the case when it came to the politics of pregnancy and birth. The continued subjugation of midwives in Ireland is evidenced by the lack of a professional midwifery body right up to the mid-1990s, leaving midwives voiceless and in an inherently weakened position politically. Irish politicians, the majority white middle-class and male, placed sole confidence in the expertise of obstetricians, in all matters concerning the maternity services. From the foundation of the state and right up through the 1970s and beyond, obstetrics knowledge and expertise was an unchallenged site of power and continued to single-handedly drive maternity care policy. This amounted to a gendered politics of knowledge and expertise, where women's voices, both childbearing women and midwives, were silenced or trivialised. This impacts the ideal of giving women choice of place of birth and professional

in attendance. I argue that the idea of 'free choice', a key tenet of modernity, is problematic when it comes to maternity care, given the dictates of the scientific paradigm and the strict limits placed on childbearing women's choices within the medicalised and risk averse maternity services. The need to advocate for woman-centred maternity care is evidence of its incongruence with modern day institutions. So too, the need to emphasise individual freedom reflects that individual autonomy is under threat in modern day institutions. I demonstrate that individual freedom and individual choice discourses are open to appropriation by those with power and privilege to support their own vested interests that are focused on maintaining asymmetrical power relations. I argue that using the discourses of woman-centredness and individual choice to drive maternity care reform can therefore be problematic. Therefore, despite the rhetoric of woman-centred care and individual choice dominating maternity care policy, obstetricians have remained firmly in control and have continued to ensure the biomedical entrenchment of maternity care. The limitations of legislative reform, that does not have the backing of the dominant hegemonic groups, to impact women's choice when it comes to place of birth, is also demonstrated here.

Chapter 9. Drivers for change and change processes in complex The purpose of the chapter is to outline changes to the maternity services that came in the form of midwife-led initiatives from the 1990s onwards, including the social and political context and drivers for these changes. Whether these reforms in the maternity services were driven by consumer demands for woman-centred care and individual choice, lobbying by birth activist groups and a newfound midwifery solidarity, the evidence-based agenda, professional vested interests or were the unintended consequences of government policy are discussed. Change drivers and change processes will also be explored, along with legislative changes that affected midwife education, identity, and scope of practice. What emerged was that the health service in general and the maternity services in particular is a complex multi-layered system. I argue that change in complex systems is not linear or rational but is unpredictable and may have multiple drivers with often unintended consequences. Disruptive events in an normally static system can lead to temporary uncertainty and instability that create opportunities to challenge the status quo. The 'midwife-led' initiatives of the 1990s therefore, while they mark the first challenge to medical hegemony enshrined in the MICS and mark the first hope of real change in women's agency in the context of reproductive health, have remained local initiatives only.

Regarding the status of midwives in Ireland and elsewhere, I argue that because of their subordinate relationship to obstetricians and their competing domains of interest, the midwifery profession is always going to be under threat. Sustained activism is therefore required. This sustained activism is not sustainable if left to a small group of individuals, no matter how committed. To safeguard the midwifery profession long into the future, I argue that midwives need to become political active. Support for these assertion are presented in the chapter.

Chapter 10. Universal Healthcare back on government agenda. This chapter explores the development of a framework known as Sláintecare (Houses of the Oireachtas 2017b). This All- Party Oireachtas framework is committed to the development of universal healthcare and to end the heavily criticised two-tier public-private system. The impact of Sláintecare on the future trajectory of the maternity services is explored. I argue that excluding maternity care from the Sláintecare Report is a major concern as it underestimates the power and influence of the obstetric profession in Ireland. It signals a continuation of obstetric dominated government maternity care policy and may lead to failure to implement Sláintecare altogether.

Chapter 11. The First National Maternity Strategy. This chapter offers a critique of the National Maternity Strategy and asked whether it supports an overhaul of the maternity system or is it merely a rhetorical tool that further supports obstetric hegemony. I argue that the Strategy's attempt to appease everyone results in an ambiguous coexistence of conflicting goals and ideologies of reproduction. This in turn reflects the steering group's inability to reconcile their differences that reflect the historical discordance at the heart of the Irish maternity services. Despite the apparent compromises, the existing power relations are not challenged or disrupted and continue to dictate the terms upon which maternity care is practised unabated and constitutes 'the way things have always been done' and 'the only way of doing maternity care' in Ireland. I argue that the power of the biomedical paradigm is its ability to reproduce the social structures and processes that support it, without appearing coercive. I argue that despite its limitations, change is still possible if midwives take full advantage of the uncertainty and ambiguity embedded in the Strategy. This will require collective solidarity among midwives so that their collective voices are heard. Finally, I argue that the government must be held to deliver on all of the promises embedded in the Strategy, and this includes the development of ABCs.

Chapter 12. Micro analysis: bureaucratisation and the biomedical model The aim of this chapter is to explore and make explicit how the bureaucratisation of mainstream antenatal clinics is inextricably linked to perpetuating the biomedical model of care. Medicalisation, institutionalisation, and bureaucratisation are co-dependent and interconnected aspects of modern maternity systems and the capitalist mode of production. The development of obstetrics necessitated the institutionalisation and bureaucratisation of pregnancy and birth, which made mass processing of pregnant women possible. I argue that patriarchal infrastructural power, embedded in modern maternity care institutions, not only facilitates but requires a bureaucratic management system to perpetuate its traditional power base.

Chapter 13. Micro analysis: transactional and interactional approaches to encounters. The purpose of this chapter is to explore change and entrenchment in Irish maternity services in terms of the power-relations, practices and discourses embedded in the antenatal encounter. In the biomedical model, doctor-patient power-relations have traditionally been

represented as at the very least unequal if not altogether oppressive (ibid.). This inherent power imbalance in the doctor-patient dyad is due to the doctor possessing legitimised expert knowledge which the patient may depend on for survival. Midwives, who are associated with a more holistic, social model of care, have typically been represented as less authoritarian in their dealings with women, in their idealized role as caring and compassionate healthcare professionals (Kirkham 2000). Crucial here are the different philosophical perspectives. Whether this is born out in practice is explored.

Chapter 14. Conclusion and Recommendations. How change and entrenchment in Irish maternity care in terms of the power-relations, practices and discourses are embedded in the antenatal encounter are explored. First, I argue that many healthcare professionals, politicians, and other change agents have a superficial understanding of the social processes and power-relations that underpin the biomedical paradigm. To understand how power is exercised, by whom and what strategies are used to perpetuate or resist it, an in-depth understanding of the biomedical paradigm is needed. I argue that counter-discourses that become mainstream and are used to drive change and challenge the dominance of the biomedical model, are often ambiguous, open to different interpretations, and subject to misappropriation by a hegemonic obstetric elite to reinforce their authority, strengthen their professional status, maintain the status quo, and to justify further entrenchment of the biomedical model. Although discourses about reform, using terms of reference familiar to service-users and campaigners have become mainstream in government maternity care policies, I argue that they are rhetorical, for the most part, having failed to be translated into daily working practices. Given their original emergence as counter measures to the biomedical model, I also argue that any attempt to translate these discourses into practice, within the existing bureaucratic biomedical system is problematic and is destined to failure.

2. Chapter Two Theoretical and Methodology Framework

2.1. Introduction

In this chapter I discuss how institutional ethnography (Smith 2005), using a critical feminist perspective and Foucault's work on power/knowledge (Foucault 1980), emerged as the right 'fit' for both structuring my thesis and as a heuristic tool for data analysis. The need to go beyond relativism, that tends to be apolitical, to a critical paradigm, that is political and emancipatory, is discussed. Also, the shift of focus from the nature and meaning of antenatal care to the workings of institutions is explored. I make the case for the need to go beyond coding and thematic analysis to mapping the links between the participants' lived realities with broader organizational and institutional processes and power relations that organise and coordinate those realities. The importance of making explicit the ontological and epistemological assumptions that underlie the chosen research approach is made. As my epistemological understanding informs my research question and every step of my research design and analysis, theoretical and methodological approaches cannot be separated.

2.2. My research paradigms

Each research paradigm's ontology, epistemology, methodology, methods, and findings are interdependent as they share the same philosophical perspective (Scotland 2012). A full understanding of the range of research paradigms, be they positivist or interpretivist will enable the application of the most suitable research approach to the research undertaking³. Ethnographic inquiry generally starts off broad and 'apparently' unfocused at the beginning. Initially my research question was not refined, and my inquiry was very much inductive in nature. Deciding the true focus of my research question was very much an iterative process, and emerged through in-depth engagement with the data, as I negotiated my way through the research process. In qualitative research, not having a pre-set focus from the beginning, makes the possibility of an innovative, scholarly inquiry more likely. Going beyond the nature and meaning of the realities of antenatal care to the broader power relations, embedded in the

³ A paradigm is a philosophical and theoretical framework or the full spectrum of beliefs and knowledge within a discipline (Hammersley and Atkinson 2019). A methodology is a general research strategy, research design, or research approach to the research process (Hammersley and Atkinson 2019). It is also referred to as a theoretical framework that outlines the way in which the research will be conducted and directs the researcher to the best methods to use for the production and analysis of data that best answer the research question (Scotland 2012). A method implies a systematic procedure, technique, or way of doing something (Merriam-Webster Dictionary). In relation to the research process, it is the procedure for collecting data (Scotland 2012). Ontology is the study of being and ontological assumptions are concerned with what constitutes reality, in other words what is (Crotty, 1998). Epistemology is concerned with forms of knowledge and ways of knowing (Cohen et al 2007, Davis and Craven 2011). Epistemological assumptions are concerned with ways of knowing and how knowledge is created, acquired, communicated, legitimated, and validated (Cohen et al 2007, Scotland 2012).

organizational and institutional processes, that shape these realities, provided a means to explore change and entrenchment in the Irish maternity services policies and practices (Smith 1990b).

In terms of data analysis, it became important to identify the similarities and differences between interpretive relativist and interpretive critical paradigms. Both these perspectives challenge the positivist ontology and epistemology, that espouses the universalities of humanity, the existence of an objective reality, scientific certainty, and a singular truth (Hammersley and Atkinson 2019). The positivist epistemology presents scientific knowledge claims as uncontested certainty and matters of 'fact' (Guba 1999, Hammersley and Atkinson 2019). Phenomena such as nature, gender, truth, power, choice, and individuality are perceived as discrete entities with no set agenda; they are merely representing reality (Lemke 2000: 8). The limitations of the sole use of the positivistic approach to inform healthcare research is widely acknowledged (Walsh and Downe 2006) as it fails to reach a nuanced understanding of the culture of the organisation and why people do what they do (Hammersley and Atkinson 2019).

Both interpretive relativist and interpretive critical paradigms share the same epistemological assumptions, which is one of subjectivism and an understanding that realities are socially constructed and knowledge is co-produced. Here the knower (researcher) and would be known (informant/participant) are relational and subjective (Guba & Lincoln, 1994). The interpretive relativist paradigm views reality as individually constructed; therefore, there are as many realities as individuals; it differs from person to person (Guba & Lincoln, 1994, Schutt 2009). A relativist logic is by its nature apolitical (Fraser 1984).

A critical interpretive paradigm, which I subscribe to, is informed by pre-existing social processes and powerful prevailing discourses because "the reality into which we are born is already imbued with shared meaning as we are born into culture" (Guba & Lincoln, 1994: 24). This means that "knowledges and truths are socially constructed and context and time specific" (Guba 1999:20).

Coding data into themes and categories aims to expand our understanding of the phenomena under study (Cohen et al 2007). Some qualitative methods opt for prescriptive coding and categorisation of the data, which appears to sit better with a positivistic, more quantitative approach, as it aims to achieve clarity and coherence through systematic application of predefined procedure (Childers 2014), when in fact reality is messy.

Where the relativist paradigm uses coding and thematic analysis to aid our understanding in a discrete phenomenon, institutional ethnography embedded in a critical interpretive paradigm, recognises social phenomena as being context and time specific, and incorporates multiple layers of social complexity (Kannampallil et al 2010). By systematically removing the data from its historical context and social circumstances, some coding and thematic analysis lends itself

to the objectification of the data, implying that knowledge is universal and waiting 'out there' to be discovered, as opposed to being constituted and reconstituted in complex routine daily interactions. My concern initially was that if I use coding and categorisation to analyze the observations and interviews, the result will not offer any additional insight to the body of knowledge that already existed on the nature and meaning of antenatal care. Jackson and Mazzei (2011) concur with this view positing that coding can lead to understanding which lacks depth and "takes us back to what is known " (pg.12). As I navigated the research process, my research focus became more defined. My theoretical problem moved from explicating the nature and meaning of antenatal care, to explicating the workings of institutions, where antenatal care is delivered, in keeping with the aims of institutional ethnography. My analysis was grounded in exploring the interrelatedness between the macro and micro components of the analysis.

What follows is a discussion on why ethnography in general and Institutional Ethnography (IE) more specifically best suited my research purposes.

2.3. Ethnography

The meanings attributed to the term ethnography are multiple, being considered both a method and a methodology (Hammersley and Atkinson 2019)⁴. Traditionally rooted in anthropology and sociology, the meaning of ethnography is encoded in the term's roots, *ethno* (people) and *graphy* (describing) and refers to the study of the behaviour of cultural groups (Guba 1999, Hammersley, and Atkinson 2019). The ethnographic approach had ethically questionable beginnings; with roots in western capitalist expansion and colonialism, it began as a method of inquiry of cultural groups referred to as 'primitive' by so-called privileged western intellectual elites (Guba 1999, Behar 2003, Hammersley, and Atkinson 2019). In late modernity this Eurocentric ethnographic approach, rather than becoming extinct, was transformed into a project of emancipation, shaped by the desire to explore specific social groups from their embedded perspectives and the embedded nature of subjective experiences as opposed to the researcher's perspective (Geertz, 1973, Behar 2003). This represented a new way of knowing and a shift in approach from an ethnography *of* the 'other' told by experts to an ethnography *for* people, using their own words (Guba 1999, Hammersley, and Atkinson 2019). Ethnography is now widely accepted as a legitimate approach to social research as it can unpick complex issues of the contemporary world, beyond the reach of questionnaires and

⁴ Traditionally, ethnography involves 'participant observation' and immersion in the everyday socio-cultural environment or community of inquiry, referred to as 'field research' (Hammersley and Atkinson 2019). One could be said to be 'doing ethnography'; the term 'ethnography' thus becomes synonymous with fieldwork (Hammersley and Atkinson 2019). Ethnography can also be viewed as the written account of a particular ethnographic project (ibid).

statistical analysis (Hammersley and Atkinson 2019). Its use in health service research has gained increasing credibility over recent years by providing in-depth insights into what and why people and organisations do, and how and why service-providers and service-users act as they do (Hammersley and Atkinson 2019). Policy-orientated ethnographic studies may be translated into useful and usable practical recommendations that might have some political and policy implications (Neyland and Surridge 2003). Ethnography can also provide a nuanced understanding of the culture of the organisation (Jordan 1993, Hunt and Symonds 1995, Kirkham 1999).

The ethnography approach sheds light on a familiar, self-evident reality of the social world, by critiquing the normative discourses and taken-for-granted practices of what is a mundane and un-extraordinary event. The meanings embodied in day-to-day activities are far more complex and far less clear cut than may be first assumed. As an experienced midwife who is familiar with the nuances and practices of maternity care, I take much of what we do for granted, and explain why we do what we do as merely reflecting common sense; a collective knowledge system and self-evident truth (Gramsci 1971)⁵. As a collective knowledge system, it is a potentially powerful factor for impacting entrenchment and change in society (Gramsci 1971). Yet, Gramsci argued that “common sense can be profoundly misleading, obfuscating or disguising real problems under cultural prejudice” (Gramsci in Harvey 2007: 39). As a researcher entering the field of research, I needed to be cognisant of the counter-intuitive aspect of ethnography research, where common sense notions about what are routine, self-explanatory, and ordinary events are challenged, offering an opportunity to rethink what is taking place and encouraging a change of perspective (Hammersley and Atkinson 2019).

A critique of what might be viewed as common sense, similar to an exploration of culture is central to ethnography enquiry (Back et al 2012). The function of culture according to Geertz (1973) is to impose meaning on the world and make it understandable through a shared system of meanings among particular social groups (Geertz 1973). Quoting Max Weber on culture; “man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning” (Weber in Geertz 1973:5). The important question of how common sense and cultural beliefs are constituted and what power-relations inform these are relevant, when it comes to understanding entrenchment and change in the maternity services. How I arrived at institutional ethnography (IE) will now be discussed.

⁵ Gramsci defines ‘common sense’ as “all those heterogeneous beliefs people arrive at not through critical reflection, but encounter as already existing, self-evident truths” (Crehan 2016: Preface p. x). Common sense constitutes a collective knowledge system (Gramsci 1971). Notions of common sense are constituted and reconstituted in routinised practices of cultural socialisation, often well embedded in institutional settings and national traditions (Crehan 2016).

Table 2-1 Reflection 1. Change in my research focus

My research question initially intended to explore the nature and meaning of the antenatal encounter, with the hope that it would improve our understanding and make explicit why the maternity system is so resistant to change in the Irish context. Because I valued observing the realities of peoples' worlds, I always planned to take an ethnographic approach. But it was later, while analysing the participant observations and interviews generated at micro level of antenatal care, that I realised that this data alone would not explain why the Irish maternity system was so resistant to change. This empirical data, I realised, was a stepping stone to the broader social process and power-relations at institutional level (macro-level) that impacted these daily realities. Institution ethnography would better address the question of change and entrenchment.

2.4. Institutional Ethnography (IE)

Institutional ethnography (IE) is a critical theory/methodology that is historically embedded and "problematizes the everyday actualities of people's everyday lives" (Smith 1990: 5). The problematic attempts to explain how everyday lives are organized and coordinated by institutional forces (Kearney et al 2019). The problematic is thus used as a starting point, to direct attention to the broader organizational and institutional processes and power relations that impact people's everyday actualities. It does this by setting out "a project of research and discovery that organizes the direction of investigation from the standpoint of those whose experience is its starting point" (Smith 1990b:6). The aim is to make explicit how the organisation of our local everyday lives is permeated by the wider relations of ruling/governing (ibid.). Relations of ruling:

They are those forms that we know as bureaucracy, administration, management, professional organisations, and the media. They include the multiplicity of discourses, scientific, technical, cultural, that intersect, interpenetrate, and coordinate the multiple sites of ruling (Smith 1990b:6).

So, when explaining local interactions and practices, an institutional ethnographer must always keep the institutional forces in view, moving the analysis from the micro to the macro, back and forth. Smith does not define institutions as concrete organisational structure but as "complexes embedded in the ruling relations that are organized around a distinctive function," such as healthcare (Smith 2005). The power of the institutional processes is that it remains unknown

to the subject, which means that those who are subordinated by it, unknowingly participate in its reproduction (Smith 1990a). Dorothy Smith argues that IE is about “discovering how we are ruled and participate in our ruling” (Smith 1999: 11). Making the relations of ruling visible helps people to see “the workings of institutions and where they are situated within them” (Smith 1990a:6). It is through knowledge of our own positioning that makes opportunities for changes possible (Virgili and Zanatta 2018). While texts play a key role in many forms of critical qualitative inquiry, in institutional ethnography it is seen to play a mediating role between “the everyday work people do and how everyday doings are organized and coordinated” (Campbell and Gregor 2002). This is about making explicit how the social organisation of knowledge and power regimes at institutional level and beyond, are constituted and used to critique individuals’ everyday lives. You cannot talk about IE without discussing in more detail its central concepts, standpoint theory and relations of ruling.

2.5. A sociology for women and from women’s perspective

Dorothy Smith is a sociologist who proposed a revolutionary critique of mainstream male-led sociology and dominant discourses of social science, which ‘has neglected women’s everyday realities’ (Lemert 1992:63). With its roots in an ethnographic and a Marxist-feminist viewpoint and the women’s movement of the 1970s, Smith proposed to write a feminist sociology **for** women and **from** the woman’s standpoint, as opposed to **of** women, beginning in the everyday worlds of women’s lives” (Smith 1992:88-89). In the former, sociology is written from the participants’ standpoints, in the latter, the research is about the participants, who are the objects of inquiry. She set out to resolve the problematic relationship between objective structures and subjective experiences (Lemert 1992). Smith renounces research projects that start by claiming to have developed a coherent objective stance prior to an encounter with reality (Smith 1987:11). A feminist sociology must start with actual, local, subjective experience (Smith 1990). By focusing on the subjectivity of the subject, Smith aims to be transformative by “revolutionising the ‘objective truth’ of official sociology” (Lemert 1992: 65). This politicised women’s experiences of inequality and oppression and places their concerns front and central stage (Smith 1990).

By making a distinction between writing a sociology **for** as opposed to sociology **of** people, “she proposes a standpoint epistemology from women’s perspectives” (Lemert 1992:64); this is commonly referred to as standpoint theory. Women’s empirical experiences and ways of knowing are coordinated and framed by ‘gendered relations of ruling’ (Smith 1990). Standpoint theory is not meant to end with an ethnography of women’s worlds, it was the necessary preliminary step to understanding how power-relations work in sex-gender systems as it explains how women’s oppression was designed, maintained, and made to seem natural and desirable to everyone (Smith 1990). Political and social gendered relations of ruling are

embedded in institutional bureaucracy (Smith 1990a). These gendered relations of ruling “coordinate the everyday” (Smith 1990). The feminist lens is central to proponents of IE (DeVault and McCoy 2002). As a form of scholarship and again like the tenets of critical ethnography and feminism, institutional ethnography is committed to political activism and social change, engaging in research that is socially and politically relevant to the study participants (Davis and Craven 2011, Ohaja 2015, Newnham 2018).

2.5.1. Relations of ruling and the social organisation of knowledge

Smith’s main interest was in the social organisation of knowledge and power, particularly institutional knowledge/power and how people’s daily lives are coordinated by ‘gendered relations of ruling’ (Smith 2012:24). Smith argues that there is a singular relationship between the standpoint of men, their claims of objectivity and rationality and relations of ruling (Smith 2012). This involves the use of a dominant gender subtext of the rational and impersonal ‘male’ discourses to objectify, standardise and generalise female subjective experiences and thereby frames them in the relations of ruling (ibid.). “Objectified scientific knowledge comes from a standpoint of their ruling and from a standpoint of men who do the ruling” (Smith 2012:24). Men who do the ruling are the beneficiaries of objectified, scientific knowledge. Smith describes ‘relations of ruling’ as a concept that grasps organisational regulatory power specifically the distinct forms of organizing and ruling in patriarchal institutions associated with contemporary capitalist society; “it brings into view the intersection of the institutions organizing and regulating society and their gender subtext” (Smith 2012:24). Smith aims to produce for people what might be called “maps” of the ruling relations and especially the institutional complexes in which they participate’ (Smith, 2005: 51). Making the workings of power visible can be emancipatory, making resistance and change possible within a social landscape occupied by many powerful discourses, that works to erode our capacity to imagine doing it any other way. The Feminist lens is a central tenet of institutional ethnography.

Table 2-2 Reflection 2. Re-visiting feminism

The feminist lens is important for any study about maternity care. Yet many, who have an overly simplistic view of what feminism is, underestimate its role in shaping maternity care systems. Many argue that feminism is outdated, redundant, a thing of the past. After all, have we not moved on from the repressively gendered unequal society of 1950s Ireland? Many view the increase in the number of women obstetricians in recent years as evidence of a move towards gender equality in these traditionally patriarchal institutions. Similarly, does a woman obstetrician being appointed to a Mastership position

only ever previously held by male obstetricians, offer evidence that women's status in these traditionally patriarchal institutions is at last being acknowledged and rewarded? Are these women occupying high ranking positions in what was traditionally 'a man's world' feminist? And importantly, how does this relate to the feminist social movement? Feminism is a political movement for social justice, equality, and the end to exploitation (hooks 1981). Many women in high powered positions in hierarchical institutions 'work the system' to become one of the rulers. They do not challenge the patriarchal system but perpetuate it. This reflects a neoliberal approach where the individual's focus is on self-advancement and not social justice. In contrast, some women do use their position of power to challenge the system. In 1977, the anti-interventionist stance of the first female obstetrician to hold the post of Honorary Consultant in Obstetrics and Gynaecology at the London Hospital and Medical College, Wendy Savage, led to her being suspended, but later exonerated by a public inquiry. In contrast to the female Masters of the voluntary hospitals, the Wendy Savage Support Campaign helped to put women's reproductive rights on the agenda.

2.6. Arriving at a feminist perspective

Feminism is more than a label, it is a political movement for social justice, equality, and the end to exploitation of oppressed peoples due to race, class, and gender (hooks 1981, Butler 1990, Smith 1999, Davis and Craven 2011, Olufemi 2020). The feminist movement was the first to reveal how gender assumptions are used to shape our world and explain how and why the world operates as it does, regardless of their empirical reality (Smith 1999, O'Connor 2000). By removing the shackles of biological determinism, feminism proposes a new way to think about our potential as human beings (Olufemi 2020). The feminist movement is, therefore, a force for social change (Guilliland & Pairman 2010).

2.6.1. Gender categories and biological determinism

Feminist researchers pay particular attention to gender categories in terms of gender hierarchies and how they are presented as natural and inevitable. Biological determinism is the belief that women's and men's social roles are determined by their distinct biology as the natural and inevitable organising principle in society (O'Connor 2000). Traditionally, the woman is constituted as fragile, emotionally, and irrational and the man as the 'natural' protector, strong and rational (O'Connor 2000). This is referred to as a biological essentialist approach (Valiulis 1995, O'Connor 2000, Connolly 2003), where an innate essence of womanhood and

manhood are thought to exist outside of history and social relations⁶ (Murphy-Lawless 1998). The assumption underpinning feminism is that gender is not natural and inevitable, arguing instead that gender is based on socially constructed male and female characteristics (Murphy-Lawless 1998, Smith 1999, O'Connor 2000, Connolly 2003). Because gender is the social construction of biological sex, it is socially and historically specific, it varies both over time and between countries, and it facilitates an examination of the role of the state [and institutions] in constructing 'feminine and masculine lives' (Jenson, 1986: 9).

2.6.2. *Patriarchy*

Walby (1990) defines patriarchy "as a system of social structures and practices in which men dominate, oppress and exploit women" (Walby 1990:4). Socially constructed gendered hierarchies, internalised by both men and women, are seen to institutionalise and perpetuate patriarchy as a social system of domination, grounded in gender inequalities and social exclusion (Walby 1990, O'Connor 2000). Therefore, the institutionalisation of these gender categories benefits those in positions of power.

2.6.3. *Feminism is for everyone: challenging misconceptions*

Feminism is notoriously misinterpreted and defies simple explanation (Beasley 1999). Over-simplistic and misuse of the term feminist abound (Hunt 2004). There are those who shrug their shoulders and scoff at the very idea of a feminist ideology⁷. There are those that say feminism is outmoded and unpopular (Stewart 2004). There are those who make it their business to deride, malign, trivialise and deny the task at hand (Olufemi 2020). This is to be expected, for after all critical feminism provokes, challenges, contests, and critiques repressive, capitalist structures. One commonly held misconception is that feminism only concerns women's oppression. This is a mistake. As bell hooks put it, "to be 'feminist' in any authentic sense of the term is to want for all people, female and male, liberation from sexist role patterns, domination and oppression." (Hooks 2019:496). As the title of the special edition of *The Lancet* editorial on gender equity states, 'feminism is for everyone' and the fight for gender equity is everyone's responsibility (hooks 2019:no page number). Gender inequalities limit **all** human potential (Olufemi 2020). Also implicated in the struggle for gender equity are the intersectionalities of class, age, racial background, or religious lines.

⁶ Social relations: refers to the coordinating of people's activities on a large scale, as this occurs in and across multiple sites, involving the activities of people who are not known to each other and who do not meet face to face (DeVault & McCoy 2016: 17).

⁷ By ideology is meant "an interlocking set of ideas and doctrines that form the distinctive perspective of a social group" (Waitzkin 1989: 221). The quality of ideology to impact how individuals perceive and interpret their experience, contributes to how ideology can have a profound impact on social life (ibid.)

2.6.4. Feminism, research, subjectivity and reflexivity

In academic circles, feminism challenges positivism and the scientific community's dependence on and valorisation of objectivism; knowledge/truth claims that are represented as value-neutral, inevitable, and merely reflections of reality (Davis and Craven 2011). Instead, feminist research plays a central role in introducing subjectivity and reflexivity as a scientifically legitimate knowledge source (Davis and Craven 2011). Given that gender is a key source of social inequality, impacting decision-making, stakeholder engagement and the uptake of interventions, 'good' research in healthcare is research that takes account of gender-relations in their study design, how the study is conducted and reported (Tannenbaum et al 2016).

2.6.5. The feminist perspective and maternity care

Utilising the feminist perspective is particularly relevant in studies of maternity care, where there is a long history of subordination of women to men (O'Connor 2000), and where the historical legacy of the gender divisions of labour is pervasive (Murphy-Lawless 1998). Gendering of medicine prioritises particular types of 'male' knowledge while it simultaneously denigrates female knowledge (ibid). The medical system values the work of the privileged few, traditionally men, while women, who take disproportionate responsibility for care work, are undervalued and underpaid, thus perpetuating gender and economic inequalities. The private/public divide of the Irish maternity services also separates and stratifies women in terms of class and socio-economic status and racial background (Boland 1995, Valiulis 1995, Connolly 2003). In dealing with these layers of subordination, a mutually beneficial relationship between feminism and midwifery inquiry has long been recognised (Kirkham 1986, Guilliland and Pairman 2010) and was recently reiterated by the English midwife Helen Shallow, on the Birth Practice and Politics Forum website (BPPF), where she posits that "midwifery would be far better served if midwives and managers addressed the crisis in our profession and the childbirth arena by analysing the issues through a feminist lens" (Shallow 2019).

Midwifery as a feminist profession, works in partnership with women and is concerned with obtaining justice for childbearing women and protecting women's rights to a normal pregnancy and birth (Guilliland & Pairman 2010). Equally, women's belief in midwifery's ability to open their childbirth options, will give midwives a social mandate for midwifery practice and in doing so, will contribute to safeguarding the midwifery profession (Guilliland & Pairman 2010). A critical feminist lens is very suited to my research purposes.

2.7. Foucault's perspective on power and disciplinary power

Foucault challenges the widespread traditional view of power, embodied in Western liberal democracies, as an essentially negative concept, exclusively located in the State and Official

Institutions (Laws, Government, and Police) (Foucault 1977). Power in this context is represented as a top-down act of sovereign domination over the free subject (ibid.). According to Foucault, power is not a purely negative phenomenon used to coerce, repress, or force us to do things against our will. According to Foucault 'power is diffuse rather than concentrated, embodied and enacted rather than possessed, discursive rather than purely coercive, and constitutes agents rather than being deployed by them' (Gaventa 2003: 1). For Foucault, power is relational and omnipresent in everyday social interactions (McWhorter 2010). 'Power is everywhere', in every repetitive action and interaction (Foucault 1980). Foucault sees the "micro-physics" of power, "as constituted by a power that is strategic and tactical, rather than acquired, preserved or possessed" (1977: 55). Power comes into being through praxis (ibid.). Disciplinary power involved the expansion of disciplinary institutions that facilitated the constant observation, recording, regulation and control of people (Foucault 1977). This idea of disciplinary power challenges the assumptions underpinning modern humanist theory⁸, that drove the social reforms in the late 1800s and early 1900s. Foucault argues that the shift from torture to incarceration during this period, was as much if not more to do with 'disciplining power' than a benevolent act, ostensibly done in the name of humanitarianism.

The panopticon, a circular prison with cells arranged around a central viewing point, from which prisoners could at all times be observed, is the architectural structure which symbolises the omnipresent surveillance of individuals in modern society (Foucault 1979a). The person who is subjected to this kind of 'gaze' cannot know when they are being observed and when they are not. Through this constant observation and careful moulding of the individual, with routine daily practices and interactions, the individual is eventually socialised into a tacit acceptance of how things are, seeing them as inevitable, and comes to know what to expect and what is expected of her/him. This had a conditioning effect on the individual who eventually internalised the regulatory regime. Over time, this can be so embedded and internalised as to be beyond our perception. Individuals becoming self-disciplined and self-monitoring, without the need for excessive external force (Foucault 1979a). Foucault refers to disciplining power as "normalising individual judgements and behaviours through the disciplining effect of repetitive actions and discourses, that occurs in everyday interactions in state institutions" (Foucault 1975). For Foucault, disciplining power is about creating and maintaining social norms and is a more efficient and effective use of power in the context of capital expansion, as instead of killing the prisoner, reformed prisoners ensure a healthy, obedient, and self-disciplined workforce. Thus, disciplinary power requires the cooperation of the subjugated

⁸ Humanism is defined in the Webster's New World College Dictionary as "the belief that human needs and values are more important than religious beliefs", ... "works towards advancing the well-being of humanity as a whole through benevolent acts, on moral, altruistic and logical reasons" (Mifflin 2014).

subjects in order to work (Fahy 2002). At the heart of these modern institutions is a historically contingent patriarchal system of power, knowledge, and gender imbalance. Omnipresent surveillance (the gaze) of the individual is central to the operation of disciplinary power.

While disciplining power is focused on controlling individual bodies, biopolitics is manifest at the level of population control. Biopolitical power is about the normalisation of population by maintaining statistical norms and reducing the possibility of outliers or deviants (McWhorter 2010). Disciplinary and bio-power create a 'discursive practice' or a body of legitimate knowledge and behaviour that defines what is normal, acceptable, and deviant (Foucault 1975,1980). These 'discrete' forms of discipline operate to improve capabilities in both individuals and populations in terms of improved health, wellbeing, and safety. Yet, far from being simply altruistic, population level management, administration, and control, are very much about protecting state security, ensuring productivity of the workforce and by implication, aiding in capital accumulation, while simultaneously rendering the population predictable, malleable, and docile (McWhorter 2010). How disciplining power and bio-political power at the macro and micro level effect change and entrenchment in the maternity services is what concerns me here.

2.7.1. Foucault: Power/ knowledge

Foucault also contests the modern idea that knowledge and power are distinct entities, independent of each other. Instead, he convincingly argues that knowledge is power (Foucault 1980). Whoever embodies 'authoritative knowledge' has influence [power] over other people's behaviour (ibid.). According to Foucault, 'legitimate knowledge' is constituted as 'regimes of truth' that tend to define what is normal, common sense, acceptable, taken-for-granted public opinion and deviant (Foucault 1994). Because of claims of objectivity and uncontested truth, the power-relations implicated in this knowledge production remained hidden from view, resulting in the widely accepted "regimes of truth" (Foucault 1994). Thus, regimes of truth become internalised as the accepted social and moral norm. Foucault contests the objectivist approach to knowledge, claiming that what is presented and exported as 'fact' and fundamental to all humanity, with universal appeal, is representative of a Western, white, male, middle class belief system (Foucault 1980). The biomedical paradigm is internalised as the accepted social and moral norm that underpins modern maternity care (Davis-Floyd 2009). "Accepting a discipline's knowledge claims has the effect of increasing the power of that discipline" (Fahy 2002:11) and legitimates its practices. Medical expert knowledge legitimises the medical surveillance of the female body and is embodied in Foucault's idea of the 'medical gaze' (1976), which in turn legitimises objectification of the female body as an object of inquiry. Foucault's ideas of 'power/ knowledge' and 'regimes of truth' are useful analytical tool in feminist inquiry.

2.7.2. Foucault and discourse

At the most common-sensical level, discourse is a formal and orderly verbal interchange of ideas that takes the form of an extended conversation (Merriam Webster 2020). Critical discourse is “a mode of organizing knowledge, ideas or experience, that is rooted in language and its concrete contexts, such as history or institutions” (Merriam Webster 2020). According to Foucault power is discursive and inter-relational (Foucault 1972). “Discourse can be enacted beyond language, in practices [technical, economic, social, political] and within institutions, modes of thought, and through subjectivities or subject positions it produces” (Foucault 1972: 29). 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). Discourses are ‘regularizing collectivities’ and key organising principles in society (ibid.). They have their effect by regulating ‘forms of conduct’ considered acceptable and reasonable for individuals, and by doing so attempt to “overcome the distinction between what one says (language) and what one does (practice)” (Hall 2001: 72). Because discourse constitutes what it seeks to govern, it perpetuates power-relations in society (Weedon 1987). Hegemonic discourses constitute ‘regimes of truth’ as a mechanism by which to govern, without encountering resistance (ibid.). Feminist discourses offer an alternative ‘regime of truth’ and a legitimate standpoint from which to critique women’s lived realities (Smith 1980).

2.7.3. Foucault and Governmentality

Foucault’s analysis of governmentality extends the analysis of power, and the way power operates at a micro-level of social interaction to the macro-level of wider historical processes and discourses (Macleod and Durrheim 2002). Foucault defines “governmentality” as the “conduct of conduct” and uses it as an analytical tool to study the discursive processes and practices that made ‘modern modalities of government’ possible (Zanotti 2013: 288). Extending the same analysis from the micro to the macro-level, Foucault sees governmental power as historical and relational, and emphasises that “the only way to truly understand how power works, it must be studied through exploring the practices of government and the contingencies and historicities of its manifestations” (Zanotti 2013:). Foucault’s concern is not with government institutions as discrete systems of power or entities in their own right, but with the study of the discourses, processes, and practices through which, for example, biomedicine became coherently and powerfully embedded in, and dominates all experiences of, pregnancy and childbirth. Chapter 4 explores the processes, discourses and practices that impacted the historical development and entrenchment of State-run maternity services.

2.7.4. Foucault and a 'history of the present'

According to Foucault, present ways of thinking and doing are historically shaped by particular forms of power and social control (Sawicki 1991). Foucault's idea of a 'history of the present' offers a framework where history is used to problematize the present (Foucault, 1977). This enables the examination of the complex interplay between routine discourses and practices dominating at local level and the wider historical and institutional construction of discourses at macro level (Skehill 2007). This reflects a relational ontology that, similar to Smith, focuses on the actualities of people's lives, their inter-relationships. Foucault's archaeology and genealogy methodologies are analytical tools that are useful in eliciting "the construction of and relation between discourse and discursive practice" (Satka and Skehill 2011: 194); in other words what we think and what we do.

2.7.5. Foucault, Smith, Feminism: convergence and divergence

Feminist ethnography, similar to Dorothy Smith's Institutional Ethnography (IE), has historically come from the perspective that sought to privilege women's lived experiences of asymmetrical power relations, as valid modes of scientific investigation, which had, up to that point, been considered anecdotal and unscientific (Davis and Craven 2011). Both institutional ethnography and feminist research prioritised contextual and experiential methodological approaches, where knowledge production is inseparable from praxis (Davis and Craven 2011). Contrary to the Cartesian mind/body dualism, "praxis is the synthesis of theory and practice and the reciprocal relationship between them" (Crowley 1998). Here praxis is transformative, providing emancipatory and revolutionary potential, but only if there is awareness (Crowley 1998). As a form of scholarship and again similar to the tenets of institutional ethnography, feminist critique is historically committed to political activism and social change (Davis and Craven 2011, Ohaja 2015, Newnham 2018). Unpacking women's lived experiences by exposing the taken-for-granted gender assumptions that shape them, renders the assumptions visible and open to revision (hook 2019:493).

Methodologically, I needed a heuristic tool that would link the past with the present; that would demonstrate the complex interrelations between the wider macro and local micro domains. The 'micro' refers to the individual aspects of social life while the 'macro' refers to the large-scale groups, relationships, and trends that make up society (Cole 2019). This is where Michel Foucault's and Dorothy Smith's work on power relations come in. Both the incompatibility and complementary nature of the theoretical perspectives of Michel Foucault's and Dorothy Smith's institutional ethnography have been proposed in the literature (Phelan 1990, McWhorter 2010, Macleod and Durrheim 2002, Satka and Skehill 2011). Satka and Skehill (2011) suggest "that

using specific aspects of Michel Foucault and Dorothy Smith's theoretical perspectives can offer an innovative and original way to enhance critical research methods in relation to practice issues" (Satka and Skehill 2011).

Foucault's and Smith's theoretical stances and methodologies converge in many ways, sharing similar assumptions and philosophical debates. Both critique positivism and the dominant discourse of scientific knowledge as objective, neutral and generalisable. Both address the complexity of social systems and the complex interrelationship between the macro/micro, structure/action dualisms in social sciences, that offer an alternative to an over-simplistic and reductionist interpretation of the present is addressed (Satka and Skehill 2011). Both focus on power as a topic of inquiry, contesting the official theories of power as located only in the state, instead arguing that the power that matters most in people's lives comes from repeated daily interactions, which are informed by wider power-relations and dominant discourses. Therefore, they both expand political power to include power located in social interactions, prioritising an analysis of the politics of personal relations and everyday life (McNay, 1992, McWhorter 2010). They deploy a critical paradigm to explain these routinised behaviours and practices in terms of the dominant discourses, power-relations and relations of ruling that inform them, but that often remains invisible to those who are being subjugated (ibid). Both explain ritual daily practices in terms of normalising routine and the invisible rules and ruling relations of the institution. As Foucault (1988c) posits, by critically questioning "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" (Foucault 1988c :265).

Both prioritise contextual and experiential methodological approaches and give priority to the actuality of practice and relational ontology over grand theory and objective scientific discovery. Although feminism was never a subject of scholarly inquiry for Foucault, he did recognise sexuality as a site of political struggle and central to this was a critique of biological determinism, a critique of modern humanist theory and a critique of scientific claims of absolute truth (McNay 1992, Macleod & Durrheim 2002). The argument that unlike institutional ethnography and feminism, Foucault's work is not historically committed to political activism and social change has been contested (Phelan 1990, McWhorter 2010, Macleod & Durrheim 2002). Many of his broad ranging and flexible methodological tools have been useful in the analysis of gendered relations on a micro and macro level (MacLeod and Durrheim, 2002) and have been used successfully to enhance feminist inquiry (Satka and Skehill 2011).

Divergences do exist. One key divergence is that while Smith works within the subject/object dichotomies, Foucault rejects all essentialist dichotomies (Lemert 1992). For Foucault both the object and subject are 'discursively constituted' ... "within a system of rules that govern what can count as a real object or process" (Nash, 1994: 66). For Smith, objective thinking disrupts subjective experience; text mediates but does not represent actual reality (Smith 1990b).

In this inquiry I take a pragmatic approach, using specific aspects of their methodologies that help explain the power-relations that inform maternity care in general and antenatal care in particular. Foucault's work on governmentality, power/knowledge, and his idea that a 'history of the present' offers a framework where history is used to problematize the present (Foucault, 1977) and is a useful analytical tool that can be used alongside IE for this inquiry. This is because it enhances a critical analysis of pre-existing power-relations and social controls that inform our ways of thinking and doing in the present.

Table 2-3 Foucault & Smith: Theoretical and Methodological Convergences

• Both problematise the relationship between object/subject, macro/micro, structure/action • Both critique positivism, objectivism and claims of neutrality in terms of equating 'objective science' with 'good science' • Both critique traditional notions of power as objective, external to and pre-existing social interaction and practices • Both critique biological determinism and modern humanist theory • Both prioritised contextual and experiential methodological approaches • Both deploy a critical paradigm to explain routinised behaviours, dominant discourses, and practices • Both elucidate dominant discourses and practices in terms of the power-relations, public processes and ideologies that inform them • Both acknowledge that these powerful processes are often internalised and remain invisible to those who are being subjugated. • Both acknowledge that subjugated subjects wittingly or unwittingly participate in their own subjugation. • Making these powerful processes visible can be emancipatory and impact change in systems

Informed by Foucault 1976, 1979a, 1979b, Phelan 1990, Smith 1987, 1990b, 2005, Lemert 1992, McWhorter 2010, Macleod and Durrheim 2002, Satka and Skehill 2011.

2.8. Conclusion

This chapter has outlined the theoretical/methodological approach that best answers my research question. Dorothy Smith's institutional ethnography using a critical feminist approach and Michel Foucault's work on power/knowledge, provides the best fit in terms of exploring the interconnection between local micro interactions/practices and macro institutional forces and gendered ruling relations embedded in modern day institutions. . Making the workings of power in institutions explicit, and where you are positioned within it visible, may lead to an alteration of perspectives that might, in time, make resistance and whole system change possible.

3. Chapter Three Research Method - Doing the Research

3.1. Introduction

The purpose of the chapter is to outline the research process undertaken to conduct this research. First, I will situate myself within this research and discuss how I arrived at this research question. Second, I will outline the research process, including design, aim and objectives, ethical issues, negotiating access, recruitment, data generation, storage and analysis and end with a discussion on appraising quality in qualitative data. I conclude this chapter with a discussion on the importance of rigour and the researcher's reflexivity and competence in appraising quality in qualitative data.

3.2. Researcher's Biography: What I bring to this research

From the outset, I positioned myself as Irish and European. The late 1970s and 1980s mark my formative teenage and early adult years in what was a dramatically changing Irish society (see section 8.1). For the first time women had access to education and paid work and were beginning to be recognised as having a role to play in society other than a stay at home mother. Despite these changes, Ireland in the 1980s still remained a very conservative, stratified, sexually repressed and patriarchal society (Murphy-Lawless 1998)⁹.

During the economic downturn in the early 1980s, I travelled to England to embark on a midwifery career, which marked a turning point in my personal and professional life. For the first time I felt liberated from the constraints of Catholic Ireland and the omnipresent conforming gaze of Irish society. Working alongside my obstetric colleagues for over 20 years, I recognised that all healthcare providers in the maternity services were constrained, to some degree or other, by the bureaucratic institutionalised nature of the maternity services. Alongside my colleagues, I embraced the new birth technologies for women deemed high risk as unproblematic. The expansion of birth technologies to all childbearing women, regardless of risk, was a subtle and more gradual process. The feminist concept of 'the personal being political' (Merton 1968) was experienced first-hand when the Association of Radical Midwives (ARM) and the National Childbirth Trust (NCT) together contested the medicalisation of normal pregnancy and birth and campaigned for the improvement in the maternity services in England. Suddenly, being a midwife meant being political. Long before I was able to articulate it, I became an advocate for justice and equality in my everyday interactions with women during pregnancy and childbirth, always positioning myself as the woman's advocate and not with the rules and protocols of the institution.

⁹ The 1986 failure to legalise divorce, the 1983 failure to legalise abortion and the 1988 Supreme Court ruling against the dissemination of abortion information are only three examples of such repression (Murphy-Lawless and McCarthy 1999). It was not until 1985 that the sale of condoms without prescription to over 18-year-olds was legalised. Even then they were to be sold only through pharmacies (ibid.).

In 1986, I first travelled to the Middle East and embedded myself in a different cultural milieu where, as a stranger to this culture, I became acutely aware of women's subordinate status in society, which in turn made me reflect on women's subordinate status in Irish society. Discrimination in Saudi Arabia was not confined to women. Immigrants, regardless of gender were equally disempowered. Yet, when it came to labour and birth, Saudi women appeared less compliant and less easily convinced by the promises of safety, embedded in the medical model of childbirth, when compared to their western counterparts. Oftentimes, religious ideology was more influential than biomedicine when it came to decision-making in childbirth. My appreciation of alternative ways of doing pregnancy and birth that were at times counter to, and at other times, heavily entrenched in the medical model, in which I was acculturated, was later reinforced by my reading of Brigitte Jordan's seminal book *Birth in Four Cultures*, first published in 1978.

Intrigued by the multiple ways of knowing and informed by my lived experience of different cultural milieux, I undertook a B.Sc. honours degree in anthropology at University College London in 1994. For the first time, I read feminist anthropological texts and understood better how the apparent 'natural' and biologically determined roles available to women in society are not 'natural' at all but socially constructed. This revelation informed my work as a midwife and sparked an interest in gendered power-relations which was a precursor to undertaking this doctoral thesis.

In 1998, after more than 15 years living and working abroad, I returned to live in Dublin. Ireland was in the throes of the 'Celtic Tiger' (an economic boom) and appeared to have moved on significantly in economic and socio-cultural terms, compared to the Ireland I had left in the 1980s. But not so when it came to the Irish maternity services. When I took up employment in a major teaching hospital in Dublin, I was immediately struck by the subordinate position occupied by women and midwives in what was a highly patriarchal, institutional model of care. Irish midwifery and what was constituted as midwives' work appeared to be out of step with their counterparts in the UK. This observation of the daily lives of midwives in Ireland informed the topic of inquiry for my master's dissertation in University College Dublin (UCD) in 2001, entitled *The Relation of Organizational Work Empowerment and Level of Reported Autonomy in Midwifery Practice in Ireland*. The primary finding was that midwives wanted more autonomy and decision-making powers but felt confined by the workings of their organisations (Dunlea et al 2002).

Following in my grandmother's footsteps, I became a mother at the age of 40 and had my second son when I was 43, both in the Irish maternity services. My first child was born shortly after my return to Ireland. Although a midwife, I was unfamiliar with the Irish maternity services and struggled to find information regarding midwife-led services, which was not available routinely. On inquiry from family and work colleagues, I was inundated with suggestions

regarding which consultant obstetrician I should book under. This was an anathema to me. Attending the midwife-led antenatal clinic in the outpatient department had to be abandoned after routinely waiting more than three hours for a brief visit with the midwife. To avoid the overcrowded public outpatient clinic, I eventually attended the semi-private clinic, which meant receiving no input at all from any midwife. As a midwife myself I made the mistake of thinking I would not miss out too much with this arrangement. My antenatal care, while professional, efficient, and respectful, was fragmenting and disempowering. I really missed out on the midwife/mother relationship. This experience of attending the maternity services as a service-user raised many issues of concern, not least how the role of midwives in antenatal care in Ireland came to be so limited, compared to the UK, where I had worked for several years and where team midwifery was the norm. I wondered why midwives and women put up with this inferior position.

It was during my lived experience of attempting to balance motherhood and the tapestry of caring responsibilities, continuing education and paid work, that the self-imposed expectation that I, as a 'modern Irish woman', should be able to fulfil multiple and often conflicting roles, began to appear unrealistic and coercive. This realization coincided with my first experience of the power of collective solidarity among like-minded women in the community who, similarly overburdened, offered mutual practical and emotional support to each other, in our struggle to balance work, mothering and child rearing duties. In the vain attempt to ameliorate my circumstances by getting regular hours as opposed to shift work, in 2001, I became a midwifery educator, and in 2006 I became an Assistant Professor of Midwifery in Trinity College Dublin, while still providing a midwife antenatal clinic as part of a team of midwives, in a linked maternity healthcare institution.

I questioned why the Irish maternity services were slow to adopt a more woman-centred and empowering model of care and why women and midwives appeared to be implicit in accepting this. My PhD emerged from my experience of maternity as a woman, mother, and midwife. My personal biography, along with my BSc. in Anthropology, influenced my chosen research design, institutional ethnography, which prioritises real world experiences and explains local realities in terms of wider institutional power-relations and social processes.

3.3. Research Design

My research design is institutional ethnography (IE) which is historically grounded in the feminist movement and adopts a critical feminist perspective.

3.4. Research Question

What impacts change and entrenchment in Irish maternity care policies and antenatal practices.

3.5. Research Aim

To improve our understanding of change and entrenchment in the Irish maternity services by making explicit how hegemonic power works within modern institutions. This is achieved by going beyond the local realities of antenatal care to broader institutional social processes and gendered power relations that have shaped and may continue to shape these realities if they are not made explicit.

3.6. Objectives

- To explore the particularities of participants' local realities of attending and providing antenatal care (see Chapter 11 & 12 for explanation of micro in terms of macro analysis)
- To make explicit the role of the wider social processes and power relations at institutional level (macro-level) in shaping local realities of antenatal care (micro-level) (see Chapter 11 & 12 for explanation of micro in terms of macro analysis).
- To explicate how hegemonic power works within modern institutions (maternity services) and how these impacts change and entrenchment in Irish maternity services (see Chapter 5 for historical roots of medical hegemony and section 7.3 for how medical hegemony continued to shape maternity care policy, and Chapter 10 for how existing power relations are perpetuated).
- To make recommendations, emerging from these insights, for a more nuanced, coordinated, strategic campaign for social change in the maternity services, that acknowledges the complexities of institutional systems (see section 13.13).

3.7. Research site

The observations were conducted in urban antenatal clinics, in both community and hospital outpatient settings. The interviews were conducted in the participant's home, in the participant's office, or an alternate place convenient to the participant. Sometimes, the women choose to meet in a local coffee shop. Confidentiality was maintained as we usually chose a quiet time to meet and a quiet table in a corner, away from other people. Interviews conducted in the hospital or clinic setting took place in private rooms where privacy and confidentiality could be maintained.

3.8. Participants

Service-providers providing publicly funded antenatal care and pregnant women who attend their services in the greater Dublin Area participated in the study. Fourteen observations of antenatal encounters were conducted in both hospital outpatient and community settings. Some of the antenatal observations involved the same healthcare provider with different service-users, and some involved the same service-user with different healthcare providers.

participants included 7 childbearing women, 12 midwives including two clinical midwife managers (CMM), 7 general practitioners (GPs), and 2 obstetricians. One practice nurse and 2 practice nurse managers were also interviewed.

3.9. Selection Criteria

3.9.1. Service users and providers

- Pregnant woman 18 years of age or older attending state funded public antenatal care with GP and/or midwife and/or obstetrician
- Both primigravida and/or multigravida were invited to participate
- As no translating service was available the woman needed the ability to converse in English
- General practitioners, midwives or hospital doctors providing public antenatal care.
- Leaders in healthcare with a particular interest in antenatal care provision

3.10. Ethical Issues

The three ethical principles of autonomy, beneficence, and justice, most visible through mandatory ethical approval procedures, were the organising framework underpinning this research. Ethical approval was applied for and granted from the appropriate institutions (for ethical approval process see next section). It is the responsibility of the researcher however, to constantly re-examine and evaluate the ethical aspects of their work throughout the research process (Speziale & Carpender 2007). No harm came to the participants and there was no situation where interviews had to be ended due to emotional issues experienced by participants while conducting the study, supporting the ethical principle of beneficence. The need to balance the principles of rigorous investigation with the needs of participants emerged when my role as researcher and midwife sometimes became blurred by service-user participants. On one occasion, although clearly not the focus of my inquiry, I listened without interruption as the woman spoke of her postnatal experience following the birth of her first child. In this instance, my role as midwife had to take precedence over my role as researcher. Following the interview I advised the woman to raise her issues of concern with her community midwife on the next visit and also gave her contact details of the Mental Health Team, should she want to contact them directly. No other sensitive issues arose while conducting the research, as the interviews, for the most part, involved participant's views on the maternity services being provided and not sensitive information regarding their deeply held beliefs and values. The ethical issue of justice, concerns treating the participants fairly and upholding their dignity and respect at all times during the participant/researcher relationship and was strictly adhered to when conducting this study.

Prior to agreeing to participate, information regarding the research was provided to the participants in the Participant's Information Leaflet (PIL) (Appendix 1-3) and included the

potential risks and benefits of participation and the right to withdraw from the study at any stage in the research process. Informed consent is grounded in the ethical principle of autonomy, where consent to participate in the research is voluntary. All participants consented to participate in this study freely and without coercion. My understanding as a researcher, of the need to inform participants fully regarding what they were consenting to is evident in the detail contained in the consent form (Appendix 4-6). Ethnographic research is not a one-off event or discrete episode at the beginning of data collection but is more often seen as a process (Murphy & Dingwall, 2007). Through an ongoing contract of negotiation, written consent forms were completed by participants on multiple occasions, prior to commencing audio-recorded observations and again prior to audio-recording the interviews. This renegotiation of consent during each stage of data collection offered participants additional opportunities to ask questions and withdraw from the study at any time during the process, with impunity. Director of Midwifery and general practitioner helped with suggesting a gatekeeper such as hospital or practice receptionists and ward managers once access to the research sites were granted. Posters were also displayed in prominent places within the institutions to inform service-users and providers of the study. The use of gatekeepers, while useful at the onset, was later replaced with recruitment through the snowballing effect, where one participant recruited further participants to the study and people's interest in participating in the study approached me directly. General Data Protection Regulations' (GDPR 2018) principles were adhered to. Participants also completed a demographic form with key socioeconomic information relevant to the study (Appendix 17).

While anonymity was not possible due to the qualitative nature of the data collection, every effort was made to uphold confidentiality. This involved omitting some details in the transcripts used to verify the confirmability of the researcher's interpretation, because it may have revealed the participant's identity. Privacy was maintained by arranging interviews at a time and place agreeable to the participants. Finally, as an academic with 30 years of midwifery experience, and an honours degree in Anthropology, I felt adequately qualified to conduct the research. I also attended two Annual Summer Research Workshops in Dublin City University and an Ethnographic Workshop in Maynooth University, along with Endnote and Data Management Software.

3.10.1. Applying for ethical approval

Applying for ethical approval was a lengthy and arduous process, which took over 12 months to secure. It proved to be a process that was excessively bureaucratic and embedded in power-relations. For the purposes of conducting this study, I needed research ethical approval from five sites, the relevant third level institution, the Irish College of General Practitioners, and the three maternity hospitals where I planned to conduct my fieldwork. There were no regional

research ethics committees (REC) or standardised application procedures in this jurisdiction. All sites had their own REC that had to be approached separately in order to gain ethical approval. Most RECs (Research Ethic Committees) meet once a month or every two months. Scheduled meetings become less frequent during the summer months. Forms had to be supplied in electronic and hard copy format. In the first round of applications alone, a total of five electronic copies and fifty-one hard copies were delivered by hand to various research committee sites. Approval at one REC did not influence subsequent approval at other sites as the RECs did not collaborate.

The ethnographic approach as a legitimate form of inquiry in healthcare research was not well-known by the Research Ethics Committees (RECs). As a consequence, two of the three hospital sites declined ethical approval on the first attempt. Reasons given for being unsuccessful included the belief that non-participant digitally recorded observation of the antenatal encounter would breach patient confidentiality and doctor/patient privilege. I subsequently arranged to meet with the Directors of Midwifery in person in order to ameliorate any cause for concern. I also corresponded with the RECs chairperson in both sites and took on some of their recommendations, amending my application accordingly. I pointed out that participation in the study was voluntary and that written consent would be obtained prior to each stage of data collection. I also stressed that as a healthcare professional and academic, I was governed by a code of professional conduct and the ethical principle for conducting research involving human beings encapsulated in the Helsinki Accord. I also confirmed that participants could withdraw from the study at any time during the process. Ethical Approval was granted from a third level institution (Appendix 12), from two hospital sites (not included as PDFs only due to confidentiality), and from the ICGP (13). One hospital site declined granting approval (Appendix 14).

There was no active communication between the various RECs, although it was proposed to conduct the same study in all sites.

3.11. Negotiating Access

Following the granting of ethical approval by each institution involved in the study, permission to access women, midwives and obstetricians was sought (Appendix 7) and granted through the Directors of Midwifery acting as gatekeepers and the Masters of the hospitals (usually an obstetrician who is Chief Executive Officer with a clinical role) at the relevant research sites. Following the granting of ethical approval from the ICGPs, GPs were also accessed using a gatekeeper. The purpose of the gatekeeper is to protect the potential participant from feeling pressured to participate out of loyalty to the researcher or for fear of retribution.

3.12. Recruitment

Given that getting ethical approval was a logistical nightmare, taking over a year to be granted ethical approval from four out of the original five RECs approached, once granted, I had really hoped to press on with recruitment as quickly as possible. But recruitment was also fraught with difficulties. Originally, I intended to begin participant observation of the antenatal encounter starting with the woman's first General Practitioner (GP) visit. I contacted two GPs and two hospital staff who agreed to select 10-12 GPs out of a list of GP signed up to the Combined-Care Scheme in the Greater Dublin Area and sharing care with the hospitals recruited for the study. A Letters of Introduction (Appendix 9) outlining the purpose of the study and containing the researcher's contact details, data collection methods and Participant Information Leaflet (PIL) (Appendix 2) was sent to 40 GPs selected by the gatekeepers. Only three responded and were willing to participate. Reminder letters were sent after the summer holidays, in September 2014, following the gatekeepers' recommendations after discussing the initial poor response rate, but no further GP participants were forthcoming. A different approach to recruitment was necessary. Once access was granted through the Directors of Midwifery, a poster (Appendix 18) was used to advertise the study, along with nominated gatekeepers (clinic receptionists and managers). Thereafter recruitment was via the participants, either a service-user or provider, who informed the other of the study and sought permission for me to observe the antenatal encounter and conduct interviews afterwards. I also attended the hospital and community outpatients' antenatal clinics on regular occasions in the hope of being approached by service-users or providers indicating a willingness to participate in the study. A 7 days cooling off period was offered but not taken up by any of those who agreed to participate. As all the women participants were availing of the free combined-care scheme, care was always shared between GPs and midwives either in the hospital or community clinics and on some occasions the woman attended the practice nurse midwife attached to a GP practice, in place of or as well as the GP. Some women also attended the hospital consultant or a doctor in training from the team, either as a routine visit or due to a referral. Due to the difficulties encountered with GP recruitment, I was not able to access the woman's first antenatal visit with the GP, nor did I attend any booking visits. Participant observations of the antenatal encounters were therefore carried out when the women were between 20 to 38 weeks' gestation.

3.13. Data Generation: micro and macro

Primary data generation at micro-level involved audio recorded participant observations of antenatal encounters between the service-user (pregnant women) and provider (GPs, Hospital doctors, midwives). This was followed by unstructured audio-recorded interviews of service-user and provider. Interviews in the context of conducting an institutional ethnography are not

about understanding individual experiences. IE “is an approach designed for the investigation of organizational and institutional processes” (DeVault & McCoy 2006: 15). Participant’s accounts are windows to revealing ‘the relations of ruling’ at the level of the wider institution, that shape their local daily realities (Smith 1996). Macro data generation involved written records of the State contained online in The Irish Health Repository (LENUS), in the Government of Ireland Oireachtas debates, government publications and archival material including Department of Health and Health Service Executive Publications, policy documents, circulars, various readings of government Bills, as well as historical publications, relevant books and journal articles. Both primary and secondary sources were used (table 3-1).

Table 3-1 Macro and Micro Data Generation

Micro data	Macro data
Participant observation • 14 audio recorded participant observations of antenatal encounters between 20 to 38 weeks' gestation, in both hospital outpatient and community settings. involving service-users (pregnant women) and providers (GPs, Hospital doctors, midwives), conducted over a period of years. Interviews • 7 childbearing women, 10 midwives, 7 general practitioners, 1 practice nurse, 2 consultant obstetricians, 2 clinical midwife managers (CMM) and 2 practice nurse managers.	Documentation & Text • Written records of the state contained online in The Irish Health Repository (LENUS) pertaining to healthcare and maternity care research and publications • The Government of Ireland Oireachtas debates, policy documents, circulars, various iterations of government bills pertaining to the maternity policy and relevant health acts dating from 1947 to the present. • Government publications and archival material online including Department of Health and Health Service Executive Publications. • Maternity hospital annual reports • Newspaper media reports

	● Historical and sociological publications, relevant books, and journal articles. ● Both primary and secondary sources were used.
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The research task for me was to integrate macro and micro data in accordance with the principles of IE in order to answer my research question. I present my analysis of macro data in chapters 4 to 10. The micro data is presented in chapters 11. There is also some integration of data within chapters.

Ethnographic interviews are described as unstructured (Hammersley and Atkinson 2019). At the beginning of each interview, open-ended non-directed questions about the general workings of the antenatal clinic were used, and the approach to questioning was inductive in nature. Participants were not directed to answer specific questions but were encouraged to share their thoughts and opinions freely. Service-provider participants were urged to reflect on how antenatal care worked, what insights might explain why they practiced as they did and how it might be different. Service-users were also asked to explain how and why it worked as it did and how they experienced negotiating the service. Towards the end of data collection questions became more deductive in nature, as the focus of the research narrowed (Hammersley and Atkinson 2019). Questions such as the main aim of antenatal care, the use of technology during the encounter, whether women got to know their healthcare providers, whether change was possible were addressed.

Demographic Information (Appendix 17) such as age, first or later pregnancy, educational status, employment history, work experience was collected once for each participant, at the end of the observations and/or interviews, whichever was more convenient.

3.14. Data Processing/Storage

Data have been kept securely in accordance with the accepted best practice recommendations. All data were held in accordance with The Data Protection Act (1988) Amendment (2003) and followed the GDPR Act (2018). In August 2019, in order to show compliance with GDPR, I completed a Data Protection Impact Assessment (DPIA) statement, which was reviewed and approved by the data protection officer at Trinity College Dublin. No one other than the researcher and supervisors had access to the data. Data were coded prior to analysis and sharing with supervisors as per requirement of GDPR 2018. USB keys were encrypted, and data were kept on my work computer which is password protected.

3.15. Data Analysis

Institutional ethnography (IE) explains local realities in terms of wider institutional processes and cultural hegemonies¹⁰ that impact the organization and coordination these local realities (Smith 1990). This IE approach guided my analysis and helped to address the social complexities of complex systems, of which maternity care is one, and to make sense of the 'messiness' that is inherent in all institutional ethnography endeavours. Following my discussion in chapter 2 on methodological approaches, while thematic analysis of the antenatal data would have addressed my initial research question regarding the nature and meaning of the antenatal encounter, it did not address the new focus of my inquiry, an exploration of change and entrenchment in the maternity services generally and antenatal care more specifically. This meant that I had to go beyond thematic analysis, grounded as it would be in the antenatal data, to an exploration of the interconnection between the antenatal data and the broader institutional forces that shape the antenatal experience.

I used antenatal data (participant observation and interviews) as a starting point to my enquiry. Participant observations of the antenatal encounters and interviews were recorded and listened to repeatedly. The antenatal encounters tended to follow the same formal structure, and the recordings of the encounters were often very similar, with the dialogue appearing to be very nearly verbatim in many instances. Thus, a selection of the recorded encounters and interviews that illustrate typical patterns in the sampled interactions were transcribed. Excerpts of these encounters were used to explicate the analysis.

The power relations and hegemonic discourses that inform how and why we do what we do are not always explicit at local level. To make sense of how power worked in institutions and why routine maternity practices work to perpetuate hegemonic systems necessitated an exploration of broader social 'relations of ruling' (Smith 1990b: 6) at institutional level that informed local practices. This involved problematise what appears to be self-evident in the local interactions, 'to dissipate what is familiar and accepted and to re-examine rules and institutions' (Foucault 1988c: 265). Therefore, analysis of languages and texts used during the antenatal encounters are not taken to simply reflect reality but are understood in terms of the

¹⁰ Cultural hegemony is social domination maintained by peaceful means, using a dominant ideology that reflects the beliefs and interests of the ruling class (Cole 2020). Gramsci, the Italian philosopher who coined the term, posits that dissemination of these dominant values, ideas, norms and expectations are achieved using institutional structures, processes, discourses and imagery. The power of ideology is its ability to reproduce the economic system, social structure and process that supports it. People are effectively socialised into a tacit acceptance of how things are, seeing them as legitimate, natural, inevitable and for the benefit of all, when it really is only for the benefit of the ruling class. By internalising the dominant ideology, the dominated participate in their own subordination. The particular social, economic, and political orders, that suits the vested interest of the powerful, is thus maintained. <https://www.thoughtco.com/cultural-hegemony-3026121>

broader social process and social relations of ruling from which they emerge. Keeping the institutions 'relations of ruling' (Smith 1990b: 6) in view, during data analysis, is fundamental when conducting an institutional ethnography.

For my analysis to be exhaustive, I also needed to 'think with theory. This involved an in-depth engagement with social theory to better understand the link between micro and macro processes (Jackson and Mazzei 2011: 11). This was an iterative process, moving from an inductive approach; theorising involving in-depth engagement with observable data to a deductive approach; theorising involving an in-depth understanding of social theory (Glaser and Strauss 1967) and back again, in an attempt to explain what is going on and how and why it is perpetuated. All knowledge synthesis starts as an inductive process, regardless of its epistemological assumptions (Noblit and Hare 1988:17).

This analysis is about the nature of power and knowledge and how dominant ideologies and discourses in institutions are constituted and reconstituted as objective truths, which affects entrenchment and perpetuates hegemonic systems of domination. To understand how power worked necessitated acquiring, what was referred to by an American sociologist C. Wright Mills as 'a sociological imagination;' how the relation between self and society can be understood (Mills 1959:3). (see chapter 5 Modernity and Maternity). After prolonged scholarly engagement and allowing time to elapse before returning to the analysis, fresh insights were made, in what was essentially an iterative process.

For stages of my data analysis see Table 3:2.

Table 3-2 : Stages of Data Analysis in this Institutional Ethnography

- Stage 1. Data analysis starts with a description of antenatal care from the perspective of service-users and providers, obtained through one to one interviews, and the researcher through participant observation of antenatal encounters- micro analysis
- Stage 2 Institutional ethnography explains and understands what is happening locally and currently, in terms of the wider historical institutional forces and power-relations. Capitalism and Modernity, the emergence of the nation state, modern ways of thinking and the history of state-run maternity services emerged as key factors that impacted on how maternity care is currently experienced. These factors required more In-depth exploration – macro analysis.
- Stage 3. Following this step I returned to the antenatal data and attempt to make explicit how current local practices and discourses continued to reflect

these wider social processes and power relations, using concrete empirical evidence.

- Stage 4. Finally, change and entrenchment in the Irish maternity services is explored and explained in terms of the interplay between micro and macro analysis.
- Key sociological theorists were used at each stage of analysis to aid understanding and offer explanations. Inductive and deductive analysis was utilised when moving from micro and macro analysis to theory and back again.

3.16. Appraising quality in qualitative research

Quality matters in qualitative research although how quality is measured is contentious (Cutcliffe and McKenna 2004). It is vital that we recognise that the positivistic conventions of validity and reliability are unsuitable for appraising quality in qualitative research (ibid.). The belief that the more the researcher shows that she followed a prescriptive set of rules during data interpretation, the more verifiable it is and the more legitimate it becomes as science is problematic (Cutcliffe and McKenna 2004). Yet, it is incumbent on the researcher to show the quality of qualitative research in designing and conducting the research. Concepts integral to showing quality in qualitative research are the researcher's reflexivity, the researcher's positionality, and finally the decision trail, which are applied in this study. Guba and Lincoln (1994) identify four operational techniques by which to demonstrate the rigour of the data which can be proposed as qualitative equivalents for concepts of validity and reliability: credibility, dependability, confirmability and transferability. These concepts were only partially helpful.

3.16.1. *Rigour and reflexivity and positionality*

Qualitative research needs to be rigorous (thorough) and trustworthy and central to achieving this is the researcher's reflexivity. There is a general agreement that researcher reflexivity, referring to the effect of the researcher's presuppositions, at every stage of the research process (Koch 1998), is a key tenet of qualitative research (Walsh and Downe 2006, Corlett and Mavin 2018). The knowledge-base and ethical stance that are part of my disciplinary background as midwife and lecturer very much informed how I observed and contributed to the development of my reflexivity. The reflexive researcher asks the question, what is my impact on the research process? Reflexivity requires the researcher to focus on the researcher/researched relationship (Koch 1998, Walsh and Downe 2006). As far as my historicity goes, my past experiences and my current positionality as woman, mother, academic and midwife for over 30 years, as described above in 3.2, are the conditions by which I meet and interpret the world, including this research. These presuppositions were not

barriers to data generation and analysis, rather they enhance it, because they are known and acknowledged by me, the researcher. Rosaldo (1993) supports this view, arguing that far from being a disadvantage, subjectivity and reflexivity of the researcher enhances quality knowledge generation and arriving at new levels of understanding. Understanding what deeply held presuppositions the researcher brings to the research process involves ongoing self-appraisal and self-critique (Koch 2006). This was achieved by using a field diary and jotting down ideas and problems that needed further reflection, as they arose, further reading of social theory and academic discussions.

Table 3-3 Reflection 3. Insider/Outsider

My positionality during data generation was to straddle both insider/outsider positions. Where some of the service-providers were concerned, I was known to be an midwife with many years of experience. Having that knowledge and experience in common helped me understand their experiences from an insider's perspective. During our conversations and my observations, participants occasionally directed a question to me, inquiring what I thought or what would I do in similar circumstances. But I was also conducting research and this made me very much an outsider which presented a different power dynamic. I was more of an outsider than an insider when it came to the service-users, being viewed in terms of a partnership in knowledge creation but also as an expert. My role as researcher and midwife intertwine.

I was very much aware of and acknowledge the existing and shifting power-relations that emerge during the research process and the researcher's privileged position held in society as perceived by some of the participants (Holt, 2004). Being mindful of my authoritative position and possible influence during the research process mitigates against unchecked imposition of my privileged world view. There was a constant need to negotiate and mitigate my influence on the researched through the process of reflexivity (see table 3-4). The reflexivity approach rejects the positivist observer-observed dichotomy in knowledge creation, where the researcher's work is presented as representing an 'objective depiction of a stable other' (Lindlof and Taylor 2002: 52). I acknowledge the subjective nature of knowledge generation that embraces ontological and epistemological relationality. Different power-relations were embodied in the researcher/healthcare provider encounter, when compared to the researcher/woman encounter. While aware of my authoritative positionality when it came to the interviews with the women and one newly qualified midwife during the study, I was also made aware of occupying an inferior power position in an interview with an obstetrician, who coming from an objective knowledge perspective, spent much of the interview promoting his own agenda and imposing his privileged world view, while I spent much of the time trying to return the conversation to the focus of my inquiry. Power is more explicitly being negotiated back and forth throughout the interaction. In keeping with Institutional ethnography and Dorothy Smith's argument for a sociology **for** and **from** woman's perspective, this amounts to doing research **with**, as opposed to **on** the participants, thus challenging the traditional

hierarchical relationship of the researcher and the researched (Walsh and Downe 2006). The gender of the participants is not the issue here but my approach to knowledge generation. My research approach advocated by Dorothy Smith reflects an interactive and relational approach to knowledge creation as opposed to the idea of knowledge as an objective truth and the preservation of the designated expert.

3.16.2. *Rigour and my decision trail*

Rigour in qualitative research involves the researcher being accountable for the decisions made during the research process and this involves leaving a decision trail. Having a decision trail, as I understand it, enables the reader to understand the range and type of “events” and “influences” which come to bear on the actions of the researcher.’ This helps to establish the trustworthiness of a study (Koch 1993: 91), and is an essential part in appraising the quality of qualitative research (Walsh and Downe 2002). Confirmability is achieved by making explicit decisions made at every stage of the research process so that another individual can follow the rationale and explanations offered (Guba and Lincoln 1994). The decisions made are convincing, credible, recognisable and appear logical to the participants, other researchers, healthcare providers and the wider readership. The theoretical framework that underpins the research approach is clearly outlined in chapter 2 above. The primary method of data generation at micro-level, using interviews and observations and documentation, is a suitable starting point to answer the research question when using institutional ethnography, because as Smith argues, social theory of institutions must be grounded in the real world. This data goes hand in hand with the complementary aspect of data generation in IE, namely the mapping of power-relations and institutional/organizational processes (macro-level), that Influences micro-level data. Both arms of the data, micro and macro present an honest and authentic description and accurately represent the participant’s experiences. The interpretative iterative process is detailed, comprehensive and exhaustive which adds credibility to the findings (Speziale & Carpender 2007). Triangulation between different data sources including interviews and observations of both service-users and providers, government documentation and texts also add to the credibility of the findings. In their original work, while Guba & Lincoln (1989) refer to transferability and Sandelowski (1986) uses the term ‘fittingness’ when evaluating the applicability of the findings in contexts other than the study context or how well it fits with people’s own experiences in similar contexts. While local contexts will always have their own particularities, the modern biomedical model of maternity care, found in the Irish context, is similarly found in most income rich countries (Wagner 1995). Having a better understanding of how hegemonic power relations in institutions work to perpetuate the status quo, will be of interest to all stakeholders who want to negotiate changes in modern maternity services. The study’s findings are therefore transferable to similar contexts and circumstances. The findings are incorporated into relevant literature and the conclusions and recommendations emerge from the data.

Table 3-4 Reflection 4. Mitigating my influence on the researched

The need to constantly negotiate and mitigate my influence and privileged power position on the researched through the process of reflexivity is clear in the following account, when one less confident and junior healthcare provider, felt her practice was under scrutiny by my presence during the encounter, causing her to check in with me on occasion as to whether she was “doing okay”. I offered her reassurance and explained that my intention was not to critique hers or any other individual’s practice, but to look for patterns in the routines and mundanities of the antenatal encounter that linked to broader institutional and organizational processes and power relations, that may shed light on why we continue to do things the way we do and help us better understand how change and entrenchment happened in the current services.

There is also the issue of the Hawthorne effect, first described in the 1950s by researcher Henry A. Landsberger, when referring to the alteration of behaviour by the subjects of a study due to their awareness of being observed (Levitt and List 2009). Subsequent research has demonstrated that this effect is much exaggerated (Levitt and List 2009). I felt that the procedural and pre-described nature of the antenatal encounter meant that my presence was not going to make much difference to them carrying out their routine, as normal. That my presence during the antenatal encounter would either be taken for granted and accepted by the participants, who had already consented to my attendance, or that they would be on ‘their best behaviour’, so to speak. For reflection on Hawthorne effect see table 3-5.

Table 3-5 Reflection 5. The Hawthorne Effect

My experience was that my presence at the encounters led participants to over-emphasise what they already considered to be ‘best practice’. Participant’s choosing to be on their best behaviour in order to make a good impression, was not going to be a problem in this study. This data should not be viewed in any way inferior or second best, where best is objective, fly on the wall data generation and second best is the participants being on their best behaviour. This tendency to over-emphasise what they considered to be best practice, was in itself illuminating and did not detract from the findings but enriched them, as it helped to make the rules and workings of the institution, embodied in best practice, more explicit. Some of the midwives and obstetricians were known to me as professional colleagues. Because the topic appeared uncontroversial and the routine nature of the antenatal encounter, my presence during the antenatal visit had little effect. Our shared professional experiences made their verbal accounts more fluid. There was a sense that we all shared the same views.

In an attempt to make service-users feel more at home, I interviewed them in a place that was chosen by them, oftentimes in a coffee shop (see section 3.13 on maintaining confidentiality) in their own locality or close to their antenatal clinic. The meetings were informal and friendly.

I explained to the women participants that my aim was to find ways that the service could be improved and that I needed their opinions and experiences in order to do that. Sharing my biography, my role as midwife and mother and the purpose of carrying out the research with the participants adds “an authenticity and honesty that is distinctive” to qualitative research (Walsh and Downe 2006: 115) and makes the research process and findings appear more genuine and believable, thus impacting on its credibility (Corlett and Mavin 2018). Walsh and Downe (2006), also posit that because the researcher’s reflexive account is “paramount for judging the integrity of the work”, it should be made available to those analysing the quality of the research (Walsh and Downe 2006:16). A way of doing this is by leaving a decision trail which can be a complex undertaking in institutional ethnography.

Mindful of the guidelines by Pat Thomson on making clear in a methods chapter of a PhD precisely how the data has been generated in the course of the doctoral research (2014), I have presented as a table the process I undertook in my stages of data analysis. In nursing studies this is commonly referred to as an ‘audit’ or ‘decision trail,’ a concept popularised in the work of Lincoln and Guba (1985) which has been a core text for nursing and midwifery research (Cutcliffe and McKenna 2004). However, the critique by Cutcliffe and McKenna (2004) of the use of ‘audit’ and ‘decision trails’ leads me to understand the limitations of audit trails to establish credibility in data findings because of the heavy reliance on what is essentially a model of audit taken from mathematics. The more societal phenomena can “be reduced to a mechanistic mathematical model, the more legitimate they become as science” (Merchant 1983:278). Similarly, Gadamer argued that only those aspects of social life that were verifiable through scientific investigation and objectification were valued (Gadamer 2018). Cutcliffe and McKenna make the point that this does not transfer over easily to more socially complex contexts (ibid: 127) and tends to inhibit the application and discussion of philosophical approaches which run counter to the thinking behind the ‘audit trail’ as outlined by Lincoln and Guba. Cutcliffe and McKenna argue that the use of the strict decision or audit trail ‘may do little to establish the credibility of findings (ibid.: 132). I have tried to set out what I have done aware of these criticisms. Therefore, I am using the term ‘decision trail’ with caution, realising that it is a standard term of reference. In my view, the reflective logs are an integral part of clarifying my rationale for decisions made and directions taken in the research process. Some academics distinguish between decision trails and reflexivity while I see both as inextricably linked. For me, philosophical reflexivity, in line with the work of Dorothy Smith, has been central every step of the way as a backdrop to my work.

In this institutional ethnographic study of the Irish maternity services, the aim is to make explicit the power-relations that are so deeply embedded and internalised as to be beyond the everyday perception of those being ruled and those doing the ruling (Smith 1990). The hope is that making the ruling relations explicit will be emancipatory, make resistance possible and impact change in practice (*ibid.*). On the other hand, participants may not share the researcher’s interpretations of the data or may in fact resist them, because the researchers interpretation may challenge the status quo and unsettle pre-existing power-relations. Regardless of whether there is agreement or not with the interpretation, all participants should be able to follow the logic of the interpretation and be able to make sense of the way in which

the researcher came to it. It is hoped that by showing the researcher's reflexivity and positionality that it will add to the trustworthiness and credibility of my findings.

Table 3-6 Reflection 6. Modernity and its role in shaping modern maternity services

The metaphor of the female body as a defective machine and the use of the industrial conveyor belt model to organise maternity care were known to me at the outset of this study. How they were connected to scientific discovery, modernity, dichotomous ways of thinking, risk discourse, obstetric dominance and the subjugation of women and midwives in maternity care and why they continue to persist today were not so clear. Also, how this modern world view differs from earlier world views, and impacts change and entrenchment in our maternity services was not explicit and called for further investigation, hence the in-depth literature review on modernity.

3.17. Conclusion

The purpose of the chapter was to outline the research process undertaken to conduct this research. The research process, including design, aim and objectives, ethical issues, negotiating access, recruitment, data generation, storage and analysis were critiqued. The importance of researcher positionality to the research process has been discussed. Also, the role of reflexivity in qualitative research has been elucidated. The importance of reflexivity is evident at every stage of the research process, indicating the rationale for how I ended up with my study design, how my position as a midwife/researcher impacted on the researched, how problems encountered were overcome and how the findings were interpreted using a modified decision trail, incorporating reflexivity. The credibility of the findings is achieved by using macro and micro data to support interpretations, making the process transparent to the reader and by incorporating the findings into existing literature on the topic. When conducting an institutional ethnography, the daunting process of obtaining ethical approval should not be underestimated.

4. Chapter Four Modernity and Maternity: Evolving biomedical paradigm

4.1. Introduction

In order to understand change and entrenchment in the maternity services it became necessary to explore the key tenets of modernity and modern scientific thinking. This is the first of eight macro analyses chapters that examines how the modern world view influences how maternity care is organised at institutional level and how this impacts everyday routine practices and interactions at local level. From the 1650s onwards, modern thinking “proceeded to mechanise and rationalise the world view” (Merchant 1983:45). Why the biomedical paradigm came to dominate what is a predominantly physiological, social and cultural event was explored. This was done by first exploring authoritative knowledge regimes underpinned by dichotomous thinking, that are at the heart of modern ways of knowing. Secondly, the preoccupation with population averages denoted in the population bell curve and what came to be constituted as normal versus abnormal or risky, and how this impacted maternity care was examined. The pervasiveness of risk discourse as an organising principle in late modernity societies and institutions is also investigated (Beck 1992). I argue that it is only by deconstructing the biomedical paradigm and unpacking the cultural hegemony of risk discourse, that the pervasiveness and perpetuation of the biomedical model will be better understood. This understanding may afford a change in perspective that might eventually lead to a change in practice.

4.2. The move from tradition to modern world view

Modernity was in effect a cultural revolution, driven by the emergence of Western rational thinking, scientific discovery and the use of mechanisation to create social order. This represented a break from traditional ways of viewing reality, which was explained in terms of humans’ inter-relatedness with nature and the cosmos and the ‘subordination of the individual to communal purposes of family, community and state’ (Merchant 1983: 270). Nature in the traditional world view was identified as “a living and sacred being and as the benevolent, nurturing and protecting mother earth, where humans were the bespoke guardians of the planet and fertility cults played a vital role in safeguarding the cosmos and maintaining order” (ibid.:270). Social order was perceived to be maintained by the workings of nature and fertility cults and divine intervention (Giddens 1999). Disorder was equally explained in terms of the Gods being displeased, manifesting in natural disasters. With modernity, the widespread beliefs in humans’ need to protect, respect and live in harmony with ‘mother earth,’ were gradually replaced with the belief in ‘Man’s’ mastery and control over nature (Giddens 1999,

Bauman 2017). Scientific rationality and mechanisation was used to predict and possible prevent natural disasters, as opposed to believing them to be God's will and therefore unpredictable and out of Man's control. By offering a means to predict, manipulate and control nature, science replaced traditional uncertainty with certainty and predictability (Toulmin 1990). In this modern world view order was re-defined to mean "the predictable behaviour' of nature and society governed by rationally determined [universal] laws and powered by Man-made intervention in a secularized world" (Merchant 1983:172). With advances in science and technology "Man" could control, manipulate and fix the natural and social world like never before. Ecological malfunctions, once perceived as divine intervention, could now be sorted using a "technological fix", reflecting a modern, mechanical conceptual framework (Merchant 1983: 277). Prior to the advent of science and technology natural disasters were perceived as unpredictable, random, and morally blind (Bauman 2017).

Modern societies initially welcomed science and technologies as beneficial, progressive and sophisticated (Greenlee and Bryder 2016). With the benefit of hindsight, however, we can see that advances in science and technology while advantageous, have also had unintended and oftentimes detrimental consequences, for both the natural and social worlds (Giddens 1992, Beck 1992). Both Beck and Giddons argue that while these detrimental consequences could not have been predicted, many are now beyond Man's control (ibid.).

4.2.1. The medicalisation of the social

The modern world view was influenced by the Cartesian's mechanistic metaphor of the body-as-machine developed during the 1620s-30s. This assumed the existence of basic scientific principals in the form of universal laws, which brought order to the world and were mechanistic in nature (Merchant, 1983). Hence, the newfound domination of nature and social domination proved to be mutually implicated (Delanty 1999). Just as advances in technology made the control and manipulation of nature possible, so to, advances in technology, particularly the expansion of institutional bureaucracies such as factories, prisons and hospitals, that were central to industrialisation, were linked to the rational and instrumental control of people (Foucault 1994). Institutional bureaucracies, with their emphasis on rules and regulations, offered a means to monitor populations and discipline individual's behaviour (Bauman 1994). Another part of the changing nature of modern life was the medicalisation of the social by the late 19th and early 20th century (Van Teijlingen 2005). This eventually extended to all things social, including physiological pregnancy and birth, a predominantly social and cultural process (Oakley 2000, Edwards 2005). Just as a healthy, compliant workforce was a prerequisite for economic growth and state security (Earner-Byrne 2006, WHO 2018), so too, docile and compliant childbearing women were a prerequisite for a modern state-run maternity service. The mechanical conceptual framework used to control problems occurring in ecology, was now

also applied to managing 'medical' problems. This gave rise to the 'technological imperative' a term coined by Fuchs (1972) referring to doctor's aspiration of "giving the best care that is technically possible" (ibid. 66). Both the idea of the technological fix and the technological imperative are inextricably linked, where technological innovations are presented as the all-encompassing solution to societal problems, even if the problem originated as an unintended consequence of the use of technology in the first instance (Stach 2020). Key to the medical cultural revolution was the idea of professional expertise. Doctors needed to reconstitute pregnancy and birth as a 'condition' that required expert management, in order to justify their role in the newly emerging and lucrative private obstetric business. This shift from a social to a biomedical approach to pregnancy and birth coincided with the professionalisation of obstetrics and their increasing social control and monitoring of pregnant women (Conrad and Schneider 1980).

4.3. Flawed dichotomous thinking

Modernity brought with it a new understanding of the world through dichotomous thinking and artificial binary opposites such as mind/body dualism, modern/traditional, science/nature, male/female, rational/emotional, order/chaos, private/public, work/home; where the latter is viewed as inferior to and made invisible by the former, which holds a place of authority (MacKenzie and Van Teijlingen 2010, Edwards 2005). As Jacques Derrida, referring to dichotomous thinking puts it "we have not a peaceful coexistence of facing terms but a violent hierarchy. One of the terms dominates the other (axiologically, logically etc..), occupies the commanding position" (Derrida in Dickens 1990:147-158). Descartes's, dichotomous distinction of the mind (soul) from the body opened-up the body to scientific scrutiny by medical men for the first time, while the mind or soul could still remain under the control of religious dogma (Davis-Floyd 2004). The following discussion reveals how this flawed dichotomous thinking that underpins the scientific biomedical paradigm is divisive and at the root of modern-day inequalities in the current state-run maternity services. This has resulted in midwives' and women's subjugation in state maternity care (Murphy-Lawless 1998). I argue that in order to make equitable changes in the current provision of maternity care, there is a need to move beyond dichotomous thinking to a more all-inclusive philosophy where diversity is expected and mutual respect of the 'other' is a guiding principle in policy and practice development.

4.3.1. Authoritative knowledge is scientific knowledge

Scientific knowledge encapsulates what is generally constituted as indisputable scientific certainty and matters of fact (Chin and Kramer 1999). From this perspective, the only legitimate knowledge and the only legitimate way of knowing is through a narrowly viewed definition of

scientific inquiry (Belenky et al 1986, Chin and Kramer 1999, David-Floyd 2003). With its roots in Cartesian dichotomies, just as science is valued over nature, scientific knowledge is valued over experiential knowledge and so on, (for more on dichotomies see Section 4.2.1 above). This brings us to the important question of who controls and defines 'legitimate knowledge'. Smith (2012) and Foucault (1980) contests the objectivist approach to knowledge, claiming that what is presented and exported as 'fact' and fundamental to all humanity, with universal appeal, is representative of a Western, white, male, middle-class belief systems (Foucault 1980, Smith 2012), that is Eurocentric, androcentric and at the root of gender inequality (Smith 2012). Smith (2012) identifies that previously established 'official' sociology knowledge was similarly written from the standpoint of men who ruled society. Just like scientific knowledge, 'official' sociology knowledge prior to the 1970s was presented as neutral, universal, and transcendental but, it too, proved to be Eurocentric and androcentric and reflected the pervasiveness of gender inequality in society. Underpinned by dichotomous thinking; nature versus science, man versus women, this dominant androcentric approach to knowledge lends support for biological determinism, patriarchal ideology and women's subordination (O'Connor 2000, Devane and Murphy-Lawless 2015, Ohaja 2015). Similarly in obstetrics, obstetric knowledge was presented as scientific knowledge that merely reflected universal truths (Jordan 1997). Jordan, a renowned anthropologist, who did an extensive multi-culture study on knowledge in maternity care systems, used the idea of obstetric "authoritative knowledge" to elucidate why, by the early 20th century, pregnant women's and midwives' empirical experiential knowledge was eclipsed by the self-proclaimed expert knowledge claims of obstetricians. Drawing on Smith's work, we can conclude that similar to scientific knowledge and 'official' sociological knowledge, obstetric authoritative knowledge "comes from a standpoint of their ruling and from a standpoint of men who do the ruling" (Smith 2012). In modern society maternity care is dominated by obstetric authoritative knowledge claims to the exclusion of women's subjective experiences. Drawing on Foucault argument that knowledge is power (Foucault 1980), if midwives, policy makers and the public accept obstetric authoritative knowledge claims, whether wittingly or otherwise, it has the effect of increasing the power of those making the claim (Fahy 2002:11). Societal recognition of midwives' and childbearing women's knowledge as legitimate knowledge to inform practice is therefore pivotal to the survival of midwifery as a distinct profession and the empowerment of childbearing women (Guilliland and Pairman 2010). "Midwifery...value scientific knowing but also include multiple subjective ways of knowing as legitimate knowledge and believe that more than one knower can be authoritative" (Hunter 2008c: 407). Utilising midwives and women's knowledge to inform practice will also help to make midwives' work in partnership with women explicit (ibid). The importance of developing a more inclusive body of knowledge, that includes the standpoint of women and midwives is demonstrated in the literature (Rothman

1984, Belenky et al 1986, Oakley 1989, Davis-Floyd and Davis 1996, Hunter 2008c). With regard to exploring entrenchment and change in the maternity services, going beyond dichotomous thinking to the legitimisation of alternative and co-existing ways of knowing in Irish maternity care, that includes the standpoint of women, is also a prerequisite for challenging hegemonic obstetric discourses and practices and for making meaningful change possible. This is not about contesting medical knowledge in and of itself, it is about questioning the reach and impact of obstetrics' authoritative knowledge. It is about "re-conceiving the nature and boundaries of expertise" (Epstein 2008:502). Fahey (2002) suggests that disputing medical knowledge claims that are not evidence-based and not in women's best interest may be a useful strategy in reducing medical dominance.

4.3.2. The medical gaze, objectification, and woman embodiment

The shift of focus from the socially situated whole human being to a focus on the problematic body parts emerged in the 18th century, when for the first-time anatomy began to play a vital role in medical education (Foucault 2003). The study of anatomy, a new field of knowledge about the body (anatomy) and an exclusive intellectual property of the newly emerging medical profession, informs our acceptance of their expert knowledge claims. The use of the stethoscope meant that, for the first time, internal happenings of the human body became knowable and accessible to the 'medical gaze' (Foucault 1976). The question the doctor asked the patient was transformed from "what is the matter with you?" to "where does it hurt?" (Foucault 1993). This medical separation of the patient's body from the patient's person (identity), (Foucault 1976) sanctioned the objectification of the individual as legitimate object of scientific inquiry and had a dehumanising effect on the doctor/patient relationship.

Similarly, reproductive technologies such as advances in fertilisation techniques, embryonic and fetal surveillance, became the exclusive intellectual property of the emerging profession of obstetrics, again adding legitimacy to their expert knowledge claims. Drawing on Foucault's work, as routine attendance at antenatal clinics became the norm, pregnant women became subjected to the 'medical gaze' where the female pregnant body as opposed to the woman became the legitimate object of inquiry (Foucault 1976). Ultrasound and CTG rendered the internal happenings of the uterus transparent and became a means of making the fetus inside the womb observable and knowable and fully accessible to the 'medical gaze' of the obstetrician, with little or no direct input needed from the woman. It effectively diverts attention from the woman, as a human being, focusing instead on the problematic bodily condition, in this case the pregnant uterus and the fetus, as representing the sum of a person.

Reflecting a corollary of the Cartesian mind-body, science/nature separation, the conceptual separation of mother/fetus is fundamental to technocratic biomedical notions of pregnancy

(ibid). For the first time ever, the mother and fetus became constituted as separate, if not competing entities (Edwards 2005). In the words of Iris Marion Young, in her landmark paper on pregnancy embodiment, first published in 1984.

"It either is a state of the developing foetus, for which the woman is a container; or it is an objective, observable process coming under scientific scrutiny; or it becomes objectified by the woman herself, as a condition in which she must take care of herself." (Young: 45).

In the biomedical paradigm, pregnancy does not belong to the woman herself, nor "is it experienced for its own sake, noticed and savoured" (Young 1984: 47). During the pregnancy the emphasis and priority is given to the baby-as-product and pregnancy is viewed as a process of producing a baby; pregnancy is therefore constituted as a passive biological process and the embodied subjective pregnancy experience is marginalised (Brown 2017). This correlates with Simone de Beauvoir's account of pregnancy, "she does not really make the baby, it makes itself within her" (Beauvoir 1997:513, orig. 1949). This shift in emphasis from surveillance of the pregnant woman's body to surveillance of fetus development in the womb, constitutes a seismic shift of control of the pregnancy in general, and the fetus in particular, from the woman who embodies the pregnancy and birth experience and to the experts: the technicians who use these new technologies (Oakley 1986)¹¹.

The medical gaze is powerful, only if women believe in its authoritative knowledge claims and accept it as uncontested truth. Women bought into the idea of expert knowledge and new technological advances. Pregnancy became reconstituted 'as a distinct type of social behaviour falling under the jurisdiction of the medical profession' (Oakley 1986: 4). So as soon as a woman becomes aware that she is pregnant, the 'good mother' is expected to pursue this regime of medical health surveillance actively (DeVries et al 2001). Women internalised the idea of pregnancy as 'an observable condition' that warrants 'expert' technological surveillance and medical management (Macintyre 1977a). Accessing these new technologies are not only desirable but are considered essential to ensuring the ultimate reward, their babies' wellbeing. Drawing on Foucault's idea of disciplinary power (Foucault 1980), because the dominant gaze is internalised, women's embodied experiences are subverted, and they become docile, obedient, and conforming subjects, while simultaneously obstetric authoritative knowledge is perpetuated, and care offered is perceived to be optimal. This undermines women's subjective experiences of pregnancy and confidence in their own ability to birth without medical expertise.

¹¹ Routine universal screening tests became the norm and with advances in hospital-based pregnancy technologies, surveillance of the fetus in utero became possible for the first time. While not routinely available during the 1970s, ultrasound became an integral part of the hospital antenatal 'check-up' by the 2000s.

Women already objectified, through internalisation, unwittingly, become part of their own objectification and dehumanization. As well as normalising women's subordination, internalisation of the medical gaze also normalises the patriarchal gendered power-relations at the heart of the biomedical system of maternity care and so the asymmetrical, hegemonic system is perpetuated and is tautological in its effect. In contrast, the non-conforming subject is 'punished' by being constituted as deviant and open to accusations of being a bad mother.

4.3.3. Metaphor of female body as defective machine

Another corollary of the Cartesian mind-body dualisms and the Cartesian mechanical metaphor of the body-as-machine (Merchant 1983) is the metaphor of the female body as defective machine (Davis-Floyd 2004). The mechanisation of nature, society and the body appeared alongside the dominant Catholic belief system, itself embedded in the idea of biological determinism; where men were naturally dominant and rational, and women were inferior and emotional and closer to nature (Kramer and Sprenger 2009). In this modern mindset, both women and nature are devalued. The integration of these two belief systems, first the widely held patriarchal belief system, and the second, the growing cultural acceptance of the metaphor of the body-as-machine, made it logically consistent that the male body was viewed as the prototype, while the female body was viewed as somewhat defective (Martin 1987, Davis-Floyd 1992, Murphy-Lawless 1998). The binary belief in the mastery of science over nature, the mastery of men over women, and the metaphor of the female body as a defective machine, reflect obstetric thinking where "the natural process of pregnancy and birth [that is defective] is freed from the constraints of nature and open to improvement' by medical men" (Arney 1989:25). Emphasising the disease-like nature of pregnancy, its riskiness, also helps to justify medical surveillance and routine technological intervention (van Teijlingen 2005). This in turn reinforced the normalising power of the medical gaze.

4.3.4. Institutions, bureaucratisation, Industrial metaphors and asymmetrical power-relations

Institutional bureaucratisation, the utilisation of industrial metaphors of throughput to describe the organisation and coordination of modern maternity care and the biomedical paradigm are according to Martin (1987) interlinked and co-producing. This bureaucratic, protocol driven way of 'managing' antenatal care brought about a production line approach that is systematic, standardised, task-orientated, fragmented, time constrained and impersonal (McCourt et al 2006, Kirkham 2010). This is consistent with the active management of labour protocol developed in Ireland by a lead obstetrician Dr Kieran O'Driscoll (1979) and described as the conveyer belt or factory system of birth (Kitzinger et al, 1990, Murphy-Lawless 1998, Barrington

2003, Walsh, 2006, Higgins 2007), which according to the author's conclusions of a Cochrane Review entitled *Package of care for active management in labour for reducing caesarean section rates in low-risk women*, is "a highly prescriptive and interventional" approach to childbirth (Brown et al 2008). Again, drawing on Foucault's work (1979), all disciplines of power/knowledge and authoritative knowledge regimes depend on maintaining existing institutional structures and practices that constitute and reconstitute these asymmetrical power-relations that lie at the heart of patriarchal systems. According to Davis-Floyd (2001,2008) the hegemonic core values and belief systems are embedded in institutional routines, normalising rituals and daily routine interactions that have become normalised. These rituals acculturate service-users and providers alike into the institutional norm of the medical model of childbirth (Davis-Floyd 2001, 2008). Not only do doctors think and say they know best, the institutional rituals and practices reinforce this and gradually women begin to believe this to be the truth, thus perpetuating their own subordination and diminishing any possibility of resistance.

In summary, objective scientific knowledge claims and flawed dichotomous thinking, far from overcoming the constraints of traditional ways of knowing, became the modern dogma on knowledge as the only way of knowing (Giddens 1992), lending itself to the manipulation and control of midwives and childbearing women (Murphy-Lawless 1998). Elite obstetricians were respected unconditionally, as experts by the pregnant woman and other healthcare professionals (Murphy-Lawless 1998). Women came to distrust their own capabilities and instead come to rely on the belief that pregnancy and birth required obstetricians in attendance. Alongside patriarchal ideologies, authoritative knowledge claims and the view of the female body as a defective machine, the risk averse approach came to justify medical surveillance of all childbearing women in pregnancy (Martin 1987, Kitzinger et al, 1990, Murphy-Lawless 1998, Barrington 2003, Impey et al, 2003, van Teijlingen et al 2004, Walsh 2006, Wagner 2006, Higgins 2007). What follows is an exploration of the impact of risk, another key tenet of modernity that underpins the biomedical paradigm, on how we do maternity care.

Table 4-1 The biomedical paradigm and the impact of modern dichotomous thinking

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|---|
| <ul style="list-style-type: none"> ● Examples: Cartesian's mind/body dualism, science/nature, rational/emotional, objective/subjective, male/female, modern/traditional, public/private, work/home ● Change of worldview from protector to controller of nature ● Modern dichotomous thinking is divisive and subjugating and fuels societal inequalities ● The medicalisation of the social, linked to capitalist development and the mastery of science over nature |
|---|

- The medical gaze: objectifies the 'patient' [pregnant woman] as legitimate object of scientific inquiry
- Focus on disease/condition and not on the person
- Facilitated by increased mechanisation and technological innovations
- Facilitated by medical professional's claims of expert knowledge
- This expert knowledge claim was legitimated and internalised by the wider society
- Exemplified in obstetrics: the natural process of pregnancy and childbirth are medicalised and "improved"
- Reflects mind/body dualism and male domination over female subject
- Obstetric "objective" knowledge valued over midwives' and childbearing women's "subjective" knowledge
- Mechanistic metaphor: female body viewed as defective machine, which requires and legitimates doctors' surveillance
- Just as the medical gaze separates the patient's condition from the patient's person, the obstetric gaze separates mother and baby, as distinct, if not competing, entities

Informed by Foucault (1975 1980), Young (1984), Belenky et al (1986), Martin (1987), Davis-Floyd (1992), Jordan (1997), Giddens (1999), Murphy-Lawless (1998), Chin and Kramer (1999), David-Floyd (2003), Edwards (2005), Smith (2012).

4.4. Risk society

Risk, a key tenet of the technocratic biomedical paradigm, defined in statistical terms as "the probability of an event multiplied by the magnitude of losses or gains associated with the event" (Gephart, Van Maanen & Oberlechner 2019: 3-19), began to dominate society and technocratic biomedical thinking from the 1980s onwards (Lupton 1999a). The task of interpreting, eliminating, and overcoming possible future risk in the pursuit of scientific certainty had become key to scientific inquiry (Murphy-Lawless 2017). This was made possible through probability calculus, which meant that the possibility of something happening in the future could be predicted and controlled, thus offering some degree of certainty and predictability in future events where there was once uncertainty (Toulmin 1990). While traditional belief systems are past-oriented with aspirations to uphold ties with traditions (Giddens 1992), modern belief systems are future-oriented, with an aspiration to control the future through risk calculation (Giddens 1992). Preparing for the risk of something happening in the future has replaced the focus on what is happening in the present. Because risk is supposedly calculable, we have a sense of having certainty, of being in control over future events.

Even the notion of risk and its reach has changed over time. Initially science and technology were exclusively the prerogative of the perceived experts. Risk at this time was thought of in positivistic terms, as objective and external to the individual (Beck 1992, Giddens 1992). Risk calculation therefore was thought to be a straightforward matter, objective, measurable and knowable, and governed by universal laws of probability (*ibid.*) Later as technology became more accessible to the ordinary person, it began to invade and influence people's everyday

public and private lives, social policy (Giddens 1992), including matters of birth, life, and death (Murphy-Lawless 1998). The positivistic perspective on risk, therefore, was replaced, in later modernity, with a view of risk as being a socially constructed phenomenon (Beck 1992, Giddens 1992, Gephart et al 2016). Beck (1992) referred to society in late modernity as 'risk society'.

A risk averse society is associated with the over-surveillance and over-monitoring of populations and individuals, made possible by technological advances (Beck 1992). This risk averse culture has now extended to the maternity services. McLaughlin notes that "uncertainty and risk are closely linked in maternity care given that uncertainty and risk have come to mean the same thing; this implies that "what is risky is that which is unknown" (McLaughlin 2002: 365). Removing risk became synonymous with removing uncertainty, which is equated with improving safety. Yet, far from alleviating uncertainty, the omnipresent influence of technology into every aspect of our daily lives has paradoxically created what is now referred to as 'manufactured uncertainty' (Giddens 1992) or 'manufactured risk' (Beck 1992). Manufactured risks are the unintended consequences of human's technological successes. It is the reach of these new technological interventions, themselves linked to ideas of progress and capital accumulation, that has led to the creation of newer risks, that were often unintended and unforeseen consequences of technological innovations. These humanly engineered risks are no longer under human control (Beck 1992, Giddens 1992, and Gephart et al 2009). Global warming, and genetic modification fall into the category of man-made risk (Beck 1992, Giddens 1999), as do escalating intervention rates in maternity care (Davis-Floyd 1993, Murphy-Lawless 1998).

Viewed as a physiological process and part of the life cycle, humans have always known that pregnancy and birth could sometimes be hazardous or dangerous. Birth [and pregnancy] is normal until it isn't, until there are indications that something is wrong (Savage 1986). The dominant biomedical paradigm views all pregnancies and births are only normal in retrospect (Percival 1970, Savage 1986 vxi, Gould 2000). An exploration of the historical emergence of both the notion of risk and normality is necessary to extend our understanding of why maternity care changed from a wellness biopsychosocial to a biomedical paradigm over the twentieth century.

While the idea of being normal has existed for centuries, both the notion of risk and normality emerged in the context of the statistical analysis of population norms, based on population averages (Bernstein 1996, Murphy-Lawless 1998a). When one considers 'normal' in terms of physiological pregnancy and birth, one thinks in terms of the individual's social and physiological wellbeing, while when we consider 'normal' in statistical terms, we are referring to the 'average', as denoted by being at the centre of the population distribution bell curve (Murphy-Lawless 1998, Downe et al 2011). This equates to being within the 'normal range' or

'within normal limits' and correlates with specific notions of safety in Western medicine (Murphy-Lawless 1998, Downe, Wickham, Kirkham 2011). What is perceived as statistically normal can become abnormal by moving a degree on either side of the bell curve, so until the pregnancy and birth is over, there is always the possibility of the abnormal occurring. Outliers or anyone outside of the 'normal range' correlates with high risk, when mathematically speaking, they are simply not average (Murphy-Lawless 1998). The outlier/risk correlation is firmly rooted in technocratic epistemological framework. Therefore, along with high risk, the technocratic definition of normality has given us the concept of low risk or 'within normal limits' but not no risk (Kirkham 2011). Routine interventions are constituted as a "corrective" mechanism to ensure the woman's pregnancies and labours stay within a predetermined "normal" range, rather than in response to a clinical indication (van Teijlingen 2005). In a risk averse society, obstetric medicine claims that all pregnancies and births are potentially 'risky' because there is always the possibility of the abnormal occurring, and that routine medical supervision achieves risk reduction by intervening at the earliest sign of pathology (DeVries 1993, van Teijlingen 2005).

4.5. The pervasiveness of risk in maternity care

Anecdotally, assessing and preventing risk is commendable and appears logical as it aims to protect what we value. Yet, risk assessment is not neutral and can have unintended iatrogenic¹² consequences. Iatrogenic risks associated with intensification of unnecessary intervention is on the increase (WHO 2009). This has major implications when it comes to maternity services. Currently, risk discourse underpins the planning and development of maternity care services at national and local levels and at the level of everyday practices and individual decision-making (Murphy-Lawless 1989). A deconstruction of this concept and its pervasive impact is necessary if we are to challenge the way in which the notion of risk is being used to organise the maternity services and if we are to find practical alternatives to risk discourses. The logic behind a risk-averse conceptual framework is captured in the belief that 'it is better to be safe than sorry' and 'the just in case' phenomena. It is not that modern societies are inherently riskier. It is the society that is overly preoccupied with safety and controlling the future that perceive their reality to be inherently risky.

Risk assessment and risk management strategies are central to the provision of antenatal care, in what is now a highly technocratic biomedical model of care. The key premise of antenatal screening programmes is that early identification and proper management of risk factors reduce pregnancy-related morbidity and mortality (Enkin et al 1989, NICE 2008,

¹² Iatrogenic refers to the adverse effect, complication or negative outcome inadvertently resulting from medical diagnostic procedures, treatment or interventions (Gebhart and Schmidt 2013, Khaskheli et al 2014).

updated 2014). It appears to make sense. The booking history, what should be a relatively neutral undertaking, has been replaced by a risk assessment, which in turn undermines what may have been a wellness approach to pregnancy (Oakley 1984, Weir 2006). While many screening tests can offer an unequivocal diagnosis (positivistic risk), many are not diagnostic but offer the statistical probability of a risk occurring (imagined future risk). Hospital guidelines and protocols that support risk assessment, aim to standardise care, protect the public from harm and to ensure that all conceivable risk is avoided (NMBI 2014). Again, this is driven by the scientific claim that risk minimisation through risk assessment optimises safety and is part of the organisation's wider safety culture (HIQA 2016a, NHS QIS, 2005). In maternity care risk minimisation is associated with routine medical interventions. A critical examination of the underlying assumptions inherent in the following statements: that risk is objective; that risk perception is shared; that risk assessment is always beneficial; that risk categorisation is neutral in its effect; that medical intervention to minimise risk is always warranted and beneficial, reveal that the concept of risk is more complex than first thought.

4.5.1. Risk is not objective

The first assumption is that risk assessment is straightforward, objective, and non-controversial. This represents a positivist perspective of risk. Murphy-Lawless (2016: 8) draws our attention to the 'problematic pinning down of risk'. Of interest is who defines risk categories, who identifies the risk to be explored, how are risks ranked and what risk is prioritised over others and why? For Beck, risk definition, essentially, is "a power game" (1992:333). Despite claims that risk assessment is objective, it always depends to some extent on human judgement and decision-making (ibid). Risk assessment is never free from the reaches of social and political influences and ramifications (Scamell 2015). Also, while some risks are amplified, others are ignored (Douglas 2002). It is usually 'the experts' or those who hold positions of power that define risk and have the capacity to control and manage risk assessment and risk profiling. In maternity care obstetricians are the self-prescribed authority in determining and defining risk factors (Williams and Mackey 1999). Obstetrics is a risk-based practice. Obstetricians' experiences tend to be highly interventionist and litigious, which tends to result in a narrow biomedical definition of risk based on clinical risk, over social, cultural, and experiential considerations (Walsh et al 2008). In obstetrics 'expert opinion', presented as best evidence, therefore, tends to be highly interventionist and litigious (Jha and Rowland 2014). Oftentimes in the reporting of risk, the severity of a possible outcome becomes more important than its probability (Symon 2006). Once the woman is designated high risk, the risk becomes constituted as an entity in its own right. The more risk averse the culture, the more women are categorised as high risk, further justifying obstetric involvement in their care.

4.5.2. Risk perception differs

The second assumption is that we all agree on what is risky but oftentimes, a woman's understanding of risk differs from that of her healthcare provider. Risk perception is informed by what is perceived as good quality evidence. Good quality evidence is thought to be objective, and the population based randomised controlled trial (RCT), which itself is thought to be objective, is positioned at the top of the evidence hierarchy (Petticrew and Roberts 2003). Healthcare providers are more likely to have an epidemiological understanding of risk (Symon 2006). Studies on risk perception among childbearing women show that far from sharing the narrow view on what constitutes risk in obstetrics, women's perception of risk is much broader and is embedded in their own lives; it is informed by their own knowledge base, their past experiences, belief system, the context in which risk occurs, what matters most to them, and how much they have-to-lose-or-gain (Stahl and Hundley 2003, Gigerenzer, 2004, Heaman et al 2004, Carolan 2008). Also views on "what constitutes acceptable risk" can differ between the pregnant woman and healthcare provider and needs to be taken into consideration (Lane 1995: 56). Women's differing perceptions of risk remain largely unacknowledged in national guidelines (Devane et al 2007), while non-compliance to the dominant risk discourse is frowned upon (Davis-Floyd 1992, Davis-Floyd et al 2009, O'Connell & Downe 2009). Using a narrow biomedical definition of risk based on a narrow definition of evidence, often leads to overly simplistic medical interventions with limited success (Walsh et al 2008, Murphy-Lawless 2014). Even when a broader definition of risk and evidence is used, there is a tendency among healthcare professionals to adopt the technical aspects of the intervention over the social ones, because it fits with the dominant technocratic paradigm (Downe and McCourt 2008). The WHO consensus conferences on obstetric technology in the USA, Brazil, and Italy in 1984–86 agreed that research evidence that does not support the status quo is met with scepticism or inattention by obstetricians and policy makers (Oakley 2016). This over emphasis on medical risk, adapted by governmental bodies and healthcare professionals to inform policy decisions, has the effect of reinforcing and upholding the existing unequal power-relations within the maternity services.

4.5.3. Risk assessment is not reliable

The third assumption is that accurate risk assessment is indeed possible. This has led to the ongoing measurement and monitoring of women during pregnancy, to identify individuals whose measurements fall outside of normal limits and are therefore considered high risk (Kirkham 2011). Yet many argue that risk prediction and selection in maternity care is not really possible (Van Teijlingen 2005), hence the biomedical belief that no pregnancy is normal except in retrospect (Savage 1986: vxi) and that all births are potentially pathological (Davis-Floyd 1992). An audit of antenatal care as far back as the 1980s confirmed that many obstetric complications cannot be predicted, except by classifying large proportions of pregnant women

as high risk (Chng et al 1980). A Swedish study that reviewed almost 4000 pregnancies concluded that initial risk status was a poor predictor of pregnancy complications (Berglund and Lindmark 1999) and is oftentimes based on information that has little predictive value (Williams and Mackey 1999). A more recent study carried out in the US concluded that prenatal clinical risk assessment does not identify the majority of pregnancies at risk for preterm delivery or IUGR (Lu et al 2003). Stahl and Hundley (2003) observe that while high risk labelling does not always result in poor outcomes, it may result in unwarranted intervention. In addition, women with identified risk factors often have a straightforward pregnancy and birth, and conversely, women with no apparent risk factors can still develop complications (Murphy, 1994, Honest et al 2004). From an economic perspective, this intense focus on risk means that there is money to be made on diagnosing risk. The role of market forces such as the pharmacological and biotechnological on the everyday construction of health risks goes largely unnoticed and unexplored.

4.5.4. Risk categorisation is not neutral

The fourth assumption is that risk categorisation is neutral with no harmful effects. A woman's pregnancy may be labelled high risk "when the probability of an adverse outcome is greater than the average probability of an adverse outcome" (Wickham 2004 no pg. number). Evidence shows that high risk categorisation can severely impact the woman's pregnancy and birth experience, increasing anxiety and may channel women into a clinical pathway which may not best suit their individual needs (Enkin et al 1989, Williams and Mackey 1999, Carolan and Nelson 2007). A pregnant woman's embodied experience of health and wellness may be undermined during the antenatal encounter due to the omnipotent presence of latent risk (Oakley 1984, Lupton 1999a, 1999b, Weir 2006). Women's agency is replaced by conformity and an over-reliance on the expert opinion of the medical professional (Lupton 1999a, 1999b) who is in the business of calculating risk and 'knows better than women.' A balance between the medical risk averse approach and a more humanising social wellness approach to care is urgently needed. What is needed is a difference in emphasis, from an all pervasive risk averse pessimistic approach to a present oriented, wellness, optimistic approach, unless proven otherwise.

4.5.5. Risk assessment is always beneficial

The fifth assumption is that advances in reproductive technologies and medical interventions always benefit humanity, are always called for, are used appropriately and may even be lifesaving (Stanworth 1987). In the minds of the general public, the availability of antenatal diagnostic technologies equates with a modern progressive maternity service. Antenatal

technologies such as ultrasonography¹³ and amniocentesis, offers a chance for would-be parents to know that their baby is developing normally. To avail of advances in antenatal diagnostics appears to all would-be parents to be a logical and a moral imperative, particularly in highly neoliberal, fetocentric medical environments. It raises people's expectation to achieve the 'perfect baby' with respect to the possible prevention, early detection, and elimination of fetal anomalies, which in turn reinforces the universal demand for access to these technologies as every citizen's right (Hildingsson et al 2002). Risk assessment in this context appears to offer only advantages, with few if any disadvantages. On closer inspection, antenatal fetal anomaly risk assessment does not offer a realistic assessment of the limitations in the diagnostic potential of these antenatal procedures (Hildingsson et al 2002, Walsh et al 2008). The above advances in reproductive technology, while beneficial in part, have also led to false negative and false positive results followed by the unintended termination of healthy foetuses due to false positive genetic results, and have made possible the application of eugenics policies that would place a higher value on some lives than on others (Stanworth 1987). There is an urgent need to evaluate the appropriate use of technology in maternity care. This needs to evaluate what was considered 'appropriate technology' in maternity care was identified by the World Health Organization (WHO) in 1970, over 50 years ago (Oakley 1986).

4.5.6. Medical intervention does no harm?

Finally, a sixth assumption is that medical interventions do no harm and are used only when indicated. In maternity care, risk thinking provides a negative visualisation of future events, where "a focus on the worst possible scenario that could happen, functions to shape healthcare practice in the present" (Heyman 2010: 22). This is 'the present magnification of possible future risk' (Heyman 2010:22). In a risk averse society technological intervention is justified, regardless of how tenuous the risk. With the benefit of hindsight, we now know that the reach of technological interventions to avoid imagined risk and uncertainty in maternity care have often untold and often unforeseen consequences (Dahlen 2010). The tendency is to over-diagnose and overestimate risk means that healthcare professionals are more likely to make a false positive diagnosis than to make a false negative diagnosis; that is, healthcare workers are more likely to diagnose a problem when there is none, and more likely to miss a problem that does exist (Wickham 2005). Risk society tends to be a high interventionist society. Beck suggests that in a risk averse society, people generally tend to act in the face of uncertainty,

¹³ First introduced in Glasgow in 1958 its use became more widespread in the 1970s when measurement of crown-rump length in early pregnancy made an accurate assessment of gestational age possible. In the 1980s transvaginal scans were introduced which made Doppler imaging for the study of fetal and umbilical blood flow and cardiac anomalies possible (Campbell 2019).

rather than wait for events to unfold (1992). So instead of choosing a 'wait and see' approach, which reflects the social model of maternity care, medical intervention is the first line of action when risk is suspected, and when there is a degree of uncertainty, resulting in an escalation of what has become routine and often unwarranted interventions associated with the biomedical model of maternity care.

Obstetrics is increasingly occupied with debating, preventing, and managing risks that it itself has produced (Davies-Floyd 2009). This equates to manufactured risk referred to by Beck (1992). Reproductive technology is a case in point. Doctor Peter Boylan reported that:

"Many of the complex problems associated with assisted reproduction are the result of donor egg pregnancies. One finds women in their late 40s and perhaps into their 50s presenting with pregnancies, sometimes with twins. They also have hypertension or diabetes so their pregnancies are far more complex than would have been the case a decade ago" (Houses of the Oireachtas 2018: 13). The fundamental irony of the risk culture, embedded in the biomedical paradigm, is that medical interventions, that were supposed to minimise risk and were seen as part of the solution to optimising safety in maternity care, have now become part of the problem (Davis-Floyd 2009, Reiger 2010) and, when overused or misused, are responsible for increasing unnecessary morbidity and mortality (Davis-Floyd 2009).

4.5.7. A risk averse culture is a fear-based culture

The culture of the organisation is crucial to how risk and safety are perceived (MBRRACE Confidential Enquiries 2015). I have already stated that a culture that is preoccupied by safety and controlling the future becomes risk averse. A risk averse culture is a fear-based culture (Dahlen 2010) where clinical decision-making takes a fear-based approach as opposed to an evidence-based approach (Wickham 2004), and where defensive practices and fear of litigation are normalised (Johanson et al 2002, McAra-Couper et al 2010). Working in fear-based culture disempowers professionals, leading to the erosion of skills and confidence.

The view that the escalation of risk assessment in maternity care is the direct result of the spiralling number of litigation cases is widely made (Bates 2001, Flynn 2002, and Walsh 2003). The culture of increased litigation in obstetrics is very much seen as a by-product of medical hegemony, global capitalism, and the emphasis of 'patient' as consumer who has 'value free' choice (Davis-Floyd 2004, Ritzer 2008). Because doctors promised to eradicate perinatal morbidity and mortality, expectations are high as is the belief that all morbidities and mortalities are preventable (Johanson et al 2002). When doctors fail in their promise 'to produce' the perfect baby, childbearing women and their families want answers and want to attribute blame (Kirkham 1999). Sub-optimal care may be due to the inappropriate use of interventions with iatrogenic effect, or the failure to use appropriate and timely interventions. If a doctor

recommends against intervention and something goes wrong, he/she is more likely to practise defensively the next time round; to intervene sooner than s/he would have previously, for fear of litigation (Johanson et al 2002). This is because few women sue following trauma resulting from unnecessary intervention (Johanson et al 2002), because they assume it was necessary, and life-saving, that everything humanly possible was done. Most women sue because of the underuse of technology (Davis-Floyd 2004:305), which is easier to see and prove. No life-saving action was taken. This is because in legal terms, the costs of perceived omissions of care, are seen to be much greater than the cost of over-intervention and over-monitoring (Beck 1999). This is influenced by the risk averse biomedical culture where doing is valued over not doing. Adopting a 'wait and see' approach is viewed by some as a sign of 'inaction' and is seen as negligent. 'Not using technology' therefore, opens health care providers to the accusation of negligence, the threat of litigation, and financial and reputational ruin. So, far from challenging medical hegemony, the increase in litigation cases results in defensive practice, and a further rise in intervention, and an even deeper entrenchment of the medical model of pregnancy and childbirth, and so the cycle continues. Private practice is associated with inappropriate and overuse of technology (Hopkins et al 2000, Johanson et al 2002).

Women can also choose an interventionist birth on the grounds that they perceive it is safer. They generally categorise obstetric intervention in positive terms and give this as a legitimate reason to choose obstetric management on subsequent pregnancies, 'just to be safe' or 'just in case things go wrong again'.¹⁴ While women may choose a highly technological, interventionist pregnancy and birth, presuming it to be a safer, more civilised, and a more modern experience, it may also be a logical response to the fear and anxiety generated by obstetrical warnings of risk and promises of technological salvation (Campbell and Porter 1997). This is how the biomedical paradigm has the ability to self-perpetuate, and thus inhibit change in practice. One of the critical components of the biomedical model is, according to Davis-Floyd (2004) that "the system becomes tautological, and its self-perpetuation is ensured" (Davis Floyd?? 2004: 306). Fear of litigation, instead of challenging the biomedical model, acts as a legal and financial deterrent to adopting a more humanised pregnancy and birth culture (ibid). Defensive practice, which results from fear of litigation, undermines obstetricians

¹⁴ The investigation into consultant obstetrician, Michael Neary who performed 129 unnecessary caesarean hysterectomies in Our Lady of Lourdes Hospital is a case in point (Harding-Clark 2006). Many women recounted that before the story broke, they were convinced that the operation performed by Doctor Neary was lifesaving and their experience reinforced the absolute necessity to have a private obstetrician in attendance during childbirth (ibid). This exemplifies the internal logic and consistency of the technocratic model, and the uncritical and unconditional trust women place in the biomedical paradigm including the unquestioned belief that obstetric interventions are always warranted and lifesaving.

and midwives' respect for and confidence in supporting physiological pregnancy and birth. This results in adopting a cautionary, early-interventionist approach to practice, described as a 'too much too soon' approach (Miller et al 2016). This refers to the routine over-medicalisation of normal pregnancy and birth in well-resourced countries, where the inappropriate use of routine medical intervention is increasingly harmful in its effect (Miller et al 2016). With the increased litigation in obstetrics, Medical Malpractice Insurance (MMI) policies and increasing costs began to have a major impact on curtailing and restricting healthcare practices (see chapter 9).

That iatrogenic risks associated with unnecessary intervention is on the increase is clear, given the spiralling number of obstetric litigation cases in Ireland in recent years. A report in the *Irish Medical Times* two decades ago (2000) suggested that "Ireland is set to become the international honeypot for medical litigation as indemnity claims in Ireland outstrip those in the USA" (Author *Irish Medical Times*. April 2000) and in many ways this has been borne out. According to the NTMA, although clinical claims comprise only 30% of the overall number of active cases in the year ending 2018, they result in 74% of the outstanding liability, due to the high liability associated with maternity services claims (NTMA 2018:42). In response to the parliamentary question on the funds spent by the HSE on legal fees concerning all maternity related cases for the years 2007 and 2015, it was confirmed that over 96 million euro was spent on both legal costs it incurred in defending actions and the payments of legal costs to plaintiffs for the actions they pursued (*HSE PQ DÁIL QUESTION NO: 6217/16*). This figure excludes payment for damages (ibid.). Again, paradoxically, instead of raising the alarm bells, iatrogenesis when it occurs, becomes the rationale for choosing further overly medicalised, interventionist pregnancy and births in the future, because the underlying assumption among the public is that medical intervention, made possible by advances in childbirth technology, and associated with progress and safety, is always called for and often lifesaving. The possibility that the medical intervention in the first instance was unwarranted, unsafe and lead to the life-threatening complication that needed further expert medical intervention is not considered.

4.5.8. Risk averse culture & over medicalisation

Paradoxically, in a risk adverse culture such as obstetrics, a technological 'fix' is seen as the default solution to risk minimisation in maternity care, regardless of whether the risk was originally created by the overuse or misuse of medical technological intervention; referred to by Beck as 'man-made' risk (Beck 1992). Maternal mortality rates are increasing in high income countries despite or perhaps because of the availability of reproductive technologies and high intervention rates (Newnham et al 2018). The optimal population caesarean section (CS) rate is 10-15% (WHO 2015). A figure above that may be considered excessive as it does not positively impact morbidity or mortality rates (Betran et al 2015). In high-income settings,

emerging evidence suggests that overuse of obstetric interventions in healthy women is implicated in the rising caesarean section rates (Fox et al 2019). CS rates have doubled globally over the past 15 years to 21% (Boerma et al 2018). In Ireland the national average CS rates in 2019 was 31% (National Healthcare Quality Reporting System Reports (NHQRS), 2019, Organisation for Economic Co-operation and Development (OECD), 2019). Bump2Babe, the Consumer Guide to Maternity Services in Ireland (Cuidiú, the Irish Childbirth Trust, 2018) revealed that in 2017, seven of our 19 maternity units had induction of labour rates of 42 per cent and over for first time mothers. The United States (US) for example, has the highest maternal mortality rate in the developed world, increasing from 7 per 100,000 by 1982 to 13 per 100,000 in the mid-2000s to a staggering 26.5 maternal deaths per 100,000 in 2015 (CPC (Clinical Placement Co) 2018). Similarly, despite the availability of high-tech interventionist environments, preterm births and low birth weight babies are on the increase in high-income countries (Healthcare Pricing Office 2014). A recent study found that in subsequent births following caesarean section, mothers are more likely to experience preterm birth and stillbirth (Keag et al 2018). The extent of medicalisation in Ireland is reflected in some of the highest caesarean section rates in Europe. Decisive action by the government that ensures maternity units across the country maintain evidence-based caesarean section rates is required and obstetricians should be held accountable for rates above this level.

4.5.9. Risk and choice

There is also a complex interrelationship between risk and choice in maternity care (Symon 2006), where obstetric risk and woman's choice are juxtaposed (for more on risk and choice see Section 7.2.3). Risk constrains choice, the greater the perceived risk the less choice is available. "Choice requires a weighting up of risks and benefits in an ordering of preferences based on their utility" (Jomeen 2012: 60). How risk is categorised will impact on women's ability to choose. Risk categorisation can be viewed as a hegemonic strategy with a moral imperative to encourage or persuade the pregnant woman to do the 'right thing' or make the 'right choice' (Jomeen 2012). In maternity services "expectations are high and fear of loss [is] most accentuated" (Symon 2006:2). In this context there is a tendency "to routinely exaggerate low risk which have a high potential impact", further limiting choice (Symon 2006: 2). Controlling the risk agenda and by implication the choice agenda has the effect of reinforcing and upholding the existing unequal power-relations within the maternity services.

Table 4-2 Key Tenets of the Biomedical Technocratic Paradigm

• Cartesian mind/body dualism/dichotomous hierarchical thinking, the mastery of man over woman • Cartesian belief in universe governed by universal laws that are mechanistic in nature • Scientific rationality and probability calculus – concerned with predicting and controlling possible future risk and removing uncertainty • Scientific rationality and the mastery of science over nature
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- Scientific, mechanistic and technological innovation can improve on nature
- The hegemony of obstetric authoritative knowledge and indisputable truth claims
- Patriarchal ideology and practice – Male appropriation of reproduction
- Female body perceived as defective machine– justifies medical interventions
- That all pregnancies and births are potentially ‘risky’
- That pregnancy and birth are only normal in retrospect
- Results in the normalisation of these hegemonic truth claims
- Truth claims perceived as legitimate, inevitable, natural, necessary.
- People are effectively socialised into a tacit acceptance of how things are
- Leads to exclusive obstetric dominated government policies and state legitimisation of medical hegemony.
- The contributed to the entrenchment of the biomedical model in maternity care
- Obstetrician’s surveillance of all pregnancies and births justified
- Midwives’ role in normal pregnancy and birth is undermined and midwives are disempowered.
- Childbearing women are subjugation and objectification
- Industrial metaphor: industrial conveyor belt model of pregnancy and childbirth leads to fragmented, de-humanised care.
- Compliance and conformity to the hegemonic view is expected
- Non-compliance is couched in terms of deviance; misguided, selfish, irresponsible, amoral.
- Over time individuals become self-disciplining and self-monitoring, without any identifiable, observable, or evident coercion from others. - self-compliance is normalised
- The subjugated become part of their own subjugation
- Risk averse society – risk minimisation is an organising principle in society.
- Has led to the pervasiveness and amplification of possible future risk in all aspects of society.
- Risk amplification leads to a culture of fear and blame and is highly litigious.
- Risk amplification leads to defensive practice and escalating unwarranted intervention with iatrogenic consequences
- The ‘logical solution’ to iatrogenesis is the technological fix
- Paradoxically, iatrogenesis leads to more rather than less biomedical technological intervention
- The technocratic biomedical paradigm reproduces organizational and institutional processes that support the hegemonic group
- Social order and the status quo, that suits the vested interests of the powerful, is sustained and perpetuated

Informed by Kitzinger 1980, Oakley 1981, Murphy-Lawless 1998, 2011, Jordan, 1993, Davis–Floyd and Sargent 1997, Hartley 1999, Downe et al 2001, 2004, van Teijlingen 2005, O’Connell & Downe 2009, WHO 2017.

4.6. Conclusion

The aim of this chapter was to explore the key tenets of modernity and explain how and why the biomedical technocratic paradigm of maternity came to dominate what is predominantly a physiological, social, and cultural event. The tendency is to oversimplify the biomedical

paradigm and what are complex safety-risk-medicalisation-normality interconnections. Yet, from this analysis it is clear that it is far more complex and far more pervasive than first thought. This oversimplification of the biomedical model prevented agents of change from fully understanding the extent of its impact and influence and how it works to reproduce and perpetuate traditional hierarchies. This failure to fully interrogate the biomedical model may go some way to explain its hold on the Irish maternity services and how it acts as a barrier to change. It may also help explain why many stakeholders continue to adopt a positivist view on risk categorisation and risk aversion, thinking of it as an unproblematic, uncontroversial, and objective concept. Many are still blissfully unaware of its detrimental impact on diminishing our trust in the natural processes and women's ability to birth without medical assistance. By interrogating assumptions underpinning the biomedical model, its impact in the organisation, coordination, and perpetuation of the hegemonic system of maternity care is elucidated. The entrenchment of the biomedical paradigm may be explained in terms of its tautological nature; its ability to self-perpetuate using the technological fix, with its apparent rational internal logics and consistencies. The technological fix or technological imperative is where more technological interventions are seen as the logical solution to problems that originated in the inappropriate use of technology, to the neglect of a more humanistic model of care, and so the cycle continues. With the benefit of hindsight, it has become increasingly clear that far from reducing morbidities and mortalities in every case where medical technological intervention is applied, the medical model, with its overemphasis on risk aversion and its associated high and often unwarranted intervention rates, brings risks where oftentimes there were none, and so is now thought to be doing harm in some instances (Davis-Floyd et al 2009, Walsh 2012).

The extent and pervasiveness of the biomedical model is now considered the single most likely barrier to achieving a normal birth (Downie et al 2001, Davis-Floyd et al 2009, Jomeen 2010, Brocklehurst et al. 2011, and Dahlen et al 2014). Overuse of obstetric interventions and increasing litigation has led to an emerging global concern about the adverse public health and economic impact of routinely medicalised and institutionalised pregnancy and birth (Wagner 1994, Walsh 2006, Kings Fund 2008, Brocklehurst, et al. 2011, Lavender et al 2012, Betrane et al 2015, WHO 2015, Miller et al 2016, Boerma et al 2018, Sandall et al 2018, WHO 2018, Fox et al 2019). The over-medicalised, over-interventionist and dehumanising practices associated with this biomedical paradigm are now widely acknowledged to be at the root of many of the current problems in maternity services (Begley et al 2009, Tobin 2014, Wickremasinghe 2015, Healy et al 2017). Yet, for many service-users and providers, who have never experienced non-technological pregnancy and birth, they have no basis for comparison. Communicating what is missing in technocratic maternity care and why it matters is the biggest challenge to midwives and academics in the 21st century (Davis-Floyd 2004). The need for an alternative, sustainable and safe model of pregnancy and birth for healthy women, to the

increasingly unsafe biomedical, technocratic model, when used inappropriately for low-risk women, is urgently needed. There is a need to move beyond dichotomous thinking, which has proven to be divisive and subjugating, to a more all-inclusive philosophy where diversity and mutual respect for the 'other' is expected, is necessary for meaningful change to happen. This includes recognising and respecting multiple ways of knowing: embodied, experiential, intuitive and scientific. A better understanding of the biopsychosocial paradigm of maternity care, known more commonly as the social model of care, may be part of the solution.

Table 4-3 Reflection 7. To influence the present, we need to understand the past

The analysis of the empirical data of antenatal care revealed that many things about the organisation of the antenatal clinics, such as the combined-care scheme, were taken 'as given' and accepted uncritically as the way things have always been done in Ireland. In order to influence meaningful change in a system that appears resistant to it, we first need to know how that system came to be organised in this way. This reflection led me to explore and make explicit the power-relations that underlie state-run antenatal care in Ireland, the 1953 Health Act and Maternity and Infant Care Scheme (1954), which are the origins of the modern-day maternity services. The interrelationship between modern ways of thinking, the emergence of state-run maternity care, obstetric hegemony and the subordination of women and midwives needed to be explored and made explicit.

5. Chapter Five the historic roots of medical hegemony in the Irish context

5.1. Introduction

Foucault's view that present ways of thinking and doing are historically shaped by particular forms of institutional power and social control are vital ones, in keeping with Institutional Ethnography (IE). The Maternity and Infant Care Scheme (1954) emerged as the dominant institutional process that continues to shape, coordinate and control present day maternity care, including the antenatal care experience. The purpose of this macro analysis was to explore the inter-relations of gender, power and knowledge regimes in the origins and future trajectory of the state-run maternity services. The interlinking of the emerging state run maternity services with obstetric hegemony, the side-lining of midwives, women's disempowerment and the capitalist mode of production is made. In order to set the scene, I first explore the social and cultural context of 1950s Ireland from which the foundation of maternity services emerged. Second, I discuss the origins of mother and child welfare and its later replacement with state-run antenatal care. Third, I present a detailed analysis of the patriarchal power-relations and hegemonic discourses embedded in Irish society in the 1950s that hampered the introduction of the originally proposed Health Act (1947), the controversial Mother and Child Health Services Scheme (1947) and its replacement with the profoundly amended Maternity and Infant Care Scheme (MICS 1954). Finally, the key tenets of the MICS and their impact on the subsequent trajectory of the maternity services are discussed.

5.2. Ireland in the 1950s: background and social context

The MICS emerged from an ultra-conservative, patriarchal, and sexually oppressed society, with deep-seated gender and class inequalities (Oláh, 1998, Valiulis 1995, O'Connor 2000, Connelly 2003). Ireland was experiencing very high rates of unemployment and emigration during this period (Connelly 2003), and the new state was virtually bankrupt.¹⁵ Deep-seated poverty was endemic with 300,000 houses without sanitary facilities in 1948 and 80,000 people still living in one-room dwellings according to the 1946 census (Census of Ireland 1946). The gendered aspects of public policy that typified the state in 1950s Ireland had four key elements: "a strong emphasis on gender difference; the hierarchical ranking of male and female; a clear division between the public sphere and the private /domestic sphere; and subjugation of individual rights within the family" (Connelly 2003:80). Women's role within Irish society was delineated to that of wife and mother and confined within a Catholic patriarchal family structure that was organised around male breadwinner privilege (Oláh, 1998, Valiulis 1995). Men in contrast occupied the economic public sphere while male elites exclusively occupied the

¹⁵ By 1952, 40% were still engaged in agriculture (Dtinail MacAmhlaigh, Dialann Deorai (Dublin, 1960), p. 2.)

political sphere where their authoritative knowledge/power impacted policy decisions (ibid.) What little social welfare existed in Ireland during this period reflected the needs, interests and authority of men, providing for their economically dependent, stay-at-home wives and children (Earner-Byrne 2006, Ferriter 2005, Gottfried, 2000). The focus was on the 'middle-class, 'middle-income' families, that conformed to this ideal model of male breadwinner and wife and mother confined to the home (Connolly 2003). Social welfare assistance was unavailable to women who were on their own, the poor, the unmarried and widowed mothers. Access to work for these women was an absolute necessity unrecognised in public policy (Connolly 2003). The constitutional¹⁶ structure of Irish society is founded on the principle of the subjugation of women and is deeply enshrined in the Irish Constitution (Article 41.1.1, Article 41.2.1, Article 41.2.2 of the Constitution of the Republic of Ireland 1937) and legislation¹⁷ enacted in this period and were used by the State to impose restrictions on women's lives and was also viewed as an attempt by the state to police women's sexual pleasures and restrict women's fertility and reproductive rights (Lee 1989, Murphy-Lawless and McCarthy 1999, Inglis 2003, Mahon 2020). This subordinate position of women, sanctioned by the Catholic hierarchy (Cahill 1925), who were given a "special position" in the Irish Constitution, was sustained by beliefs in biological determinism, and was represented as part of the civilising process crucial to maintaining social, economic, and moral order (Thane 1978, Brown 1978, Inglis 1997, Connolly 1998). What it did was ensure the continued economic dominance of the ruling class (Inglis 1997). The Constitution, therefore, in defining the role and status of women, sanctioned the state's gendered policy regime, institutionalised women's inferior position in society,

¹⁶The Constitution delineated the role of family in Irish society:

Article 41.1.1 "The State recognizes the Family as the natural primary and fundamental unit group of Society and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law. (Constitution of the Republic of Ireland 1937).

The Irish Constitution delineates the role of women in Irish society:

Article 41.2.1 of: "the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved (Constitution of the Republic of 1937).

The Constitution also provided a legal, economic and moral basis to limit women's political and economic role in Irish society stating:

Article 41.2.2 "The State shall, therefore endeavour to ensure that mothers shall not be obliged by economic necessity to engage in labour to the neglect of their duties in the home" (1937 Constitution of the Republic of Ireland)

Irish womanhood and motherhood were interchangeable in the Irish Constitution (O'Connor 1998).

¹⁷ In 1929 under The Censorship of Publications Act all literature and written information on contraception and birth control were banned (Ferriter, 2009). In 1935 The Criminal Law and Amendments Act banned the sales, supply and importation of contraception. The Conditions of Employment Act in 1936 limited women's access to employment and The Marriage Bar of 1950s, forced women working in the Civil Service, in local authorities, health boards and in teaching to resign on marriage from their permanent posts (Connolly 2003, Mahon 2020). In the 1946 census only 2.5 percent of Irish married women were classified as employed compared to 25 percent in Britain.

restricted women's access to employment, treated married women as the legal inferiors of their husbands, and attempted to control women's fertility and reproductive rights.

The abject poverty of the working class, the lack of women in the workforce and women's complete dependence on men for money and resources considerably weakened Irish feminism by limiting their political capacity for collective solidarity (Esping-Andersen, 1985). This meant that Irish women were constituted as silent and passive citizens in the new state, effectively absent from the political decision-making process and underrepresented in legislative bodies (Hoskin 1981, Gibbons 1996). It was within this society where women's political, economic and reproductive rights were severely curtailed (Valiulis 1995), that the debate regarding the future state-run maternity services took place.

5.3. The origins of mother and child welfare and of state-run antenatal care

Prior to modern state-run antenatal care, mother and child welfare was primarily the responsibility of class-based charitable and voluntary organisations, either non-denominational or protestant (Earner-Byrne 2006). These charities centred on Dublin, where there was widespread poverty and substantial in-migration of rural populations (Ferriter 2005, Earner-Byrne 2006). Ostensibly, the aim was to supply food and educational services to mothers during pregnancy and supply clean milk to infants whose mothers were too malnourished to breastfeed (Earner-Byrne 2006). The humanitarianism movement proposedly drove social reform in the late 1800s and early 1900s and worked towards advancing the well-being of humanity as a whole through benevolent acts, on moral, altruistic and logical grounds. Foucault challenged this idea that humanitarianism alone was behind social reform during this period, arguing instead that it is as much to do with disciplining power as it is to do with humanitarianism (Foucault 1976). (For more on disciplining power see chapter 2, Section 2.11.2). This is demonstrated in the following discussion, on the role of the Catholic Church and the State in mother and child welfare.

Prior to Irish Independence, colonial rule had relinquished the welfare responsibility of its citizens, for the most part, to the Roman Catholic Church (Inglis 1997), which acted like "a State within a State" (Kelly 1995). This explains the assumption commonly held by both prominent Fianna Fail and Fine Gael members, that it was not the duty of the state to provide universal medical care for all its population, without due regard to individual need and proven eligibility (Barrington 1987). Developing a public health service was not a priority for the virtually bankrupt newly appointed government. People of scarce means were reliant on Catholic Church charities for their educational, nutritional, medical and spiritual welfare. Compliance with Catholic social teachings were a prerequisite for salvation in this life and the next. Consistent with Foucault's idea on disciplining power/knowledge (Foucault 1982), the implicit belief in the moral authority of the Catholic Church to punish and reward was widespread.

The Roman Catholic Church was initially underrepresented in maternal and child welfare. This sparked a fear among the Catholic hierarchy of losing ground to other denominations (Earner-Byrne 2006). The Dublin archbishop McQuaid's primary concern was with Catholic supremacy in terms of social services rather than the welfare of poor childbearing women¹⁸ (ibid.). Since "charity and spiritual welfare were opposite sides of the same coin", the archbishop's primary focus was on the spiritual welfare of the child rather than on the physical welfare of the mother (ibid). This was all the more powerful if the archbishop's influence appeared in the guise of charitable good deeds. The Roman Catholic Church's reach into Irish society continued post Irish Independence to such an extent that they became the principal cultural and structural regulator of society, family life, sexual morality, reproduction, education and health care provision (Inglis 1997), with a deep suspicion of socialism and state control (1931 papal encyclical, *Quadragesimo Anno*: 158-160). Their pervasive reach in matters concerning health and public welfare ensured their unrivalled influence and control in Irish society before the introduction of state-run maternity services, and explains their reluctance, during the controversial Mother and Child Scheme, to accept the role of the state in providing for the needs of its citizens (Kelly 1959). It is clear from this analysis that the Catholic Church's involvement in mother and child welfare was more about maintaining control and influence in society than humanitarian in its intent.

The loss of young men post the two World Wars was a key driving force for state involvement in antenatal care across Europe, while less so in Ireland (Earner-Byrne 2006). The impetus in Ireland was state security and capitalist development and the need to control the quality and quantity of the population in the wake of both continued population decline¹⁹ post the Great Famine and the highest perinatal mortality rates across Europe (Earner-Byrne 2006). A capitalist mode of production both facilitates and is dependent on a far more intensive management of the populations' health. Population health was and is still recognised as a precondition for economic prosperity (WHO 2020). Population health is not only linked to economic production however, but to women's capacity to reproduce. In 1932, the Irish infant mortality rate was 72 per 1,000 live births, while in Dublin alone, the rate was 100 per 1,000 births (Report of the Department of Local Government and Public Health, 1932–33:54). This high rate persisted right up to and beyond 1949 (Ferriter 2005), when the Health Act that was the precursor to the Maternity and Infant Care Scheme was being debated.

¹⁸ By 1943, having effectively closed down 'the competition', the Catholic church had 17 maternity centres across Dublin and were feeding 500 mothers a day (CSSC financial statement 1 June-30 September 1943, p. 3 McQuaid papers).

¹⁹ This was partly due to late marriage, high rates of permanent celibacy, and high rates of out-migration (Murphy–Lawless and McCarthy 1999).

The role of the Irish state during this period was focused on investigating the causes of the high infant mortality rates more so than providing maternal and child welfare. Dr Kerry Reddin, who was in charge of the maternity and child welfare services for Dublin Corporation, noted:

“Large numbers of babies die in the first month of life. Many of these deaths are directly attributable to conditions in the expectant mother which can only be met by intensive pre-natal work, propaganda and improvement of the midwifery service.”
(Reddin 1932: 218).

The impact of this was that for the first time, following the reporting on the Department of Health Survey of Conditions in Dublin 1938, the link between high infant mortality and gastro-enteritis was made. Managing women’s nutrition and educational needs during pregnancy was for the first time considered pivotal to infant survival (Report of the Department of Local Government and Public Health, 1932–33). This, along with the decline in maternal mortality during the 1930s in some areas, gave rise to a greater focus on infant mortality over maternal mortality (Report of the Department of Local Government and Public Health, 1927–8:41). The Department of Health’s Chief Medical Officer, Doctor James Deeny extended the gastro-enteritis programme to include women’s health before and after pregnancy²⁰. Initiating a National Nutritional Survey in 1946²¹, he secured the co-operation of the three long established Dublin voluntary maternity hospitals, who had a reputation for working in close co-operation with Dublin Corporation and represented a forceful lobby for improving ante-natal care (Browne 1995, Farmar 1994).

State-run antenatal care was first introduced in Boston, Sydney, Edinburgh and England in 1911, 1912, 1915 and 1929 respectively (Oakley 1984: 50-51, Drife 2002). The standard schedule of hospital based antenatal appointments first emerged from a report from the Minister of Health in the UK in 1929 (Oakley 1984) and was adopted elsewhere. By 1932, antenatal care in Ireland was still almost exclusively the preserve of class-based charitable and voluntary groups and was very much a local and community affair (Barrington 2000, Earner-Byrne 2006, Harvey 2007). Gradually mother and child welfare become routine practice in the Dublin voluntary maternity hospitals (Solomon 1932:382) with outreach community services run by Jubilee nurse/midwives, and midwives attached to the various voluntary maternity hospitals (Browne 1995, McMahon 2006). The relationship between the state and

²⁰ The Minister for Local Government and Public Health, Sean MacEntee, Dr Ward and Chief Medical Officer Doctor James Deeny, under a Fianna Fail government, introduced the 1945 Public Health Bill, aimed at giving the newly established Health Department (1947) increased legal powers to control the spread of diseases, including tuberculosis, gastro-enteritis, venereal disease and puerperal sepsis.

²¹ This culminated in the Health Service Act of 1947, when for the first time in Ireland, a separate Department of Health and Social Welfare was established. Noel Browne was appointed Minister for Health in 1948 as part of a new coalition government (1948- 1951), headed by John A. Costello as Taoiseach, and it was left to him to implement the changes.

the voluntary and community sector continues to be a problematic one today, regarding respective roles of the voluntary and community sector on the one hand and the state on the other (Harvey 2017).

The proposed Mother and Child Health Service Scheme (1947) was seen as the first step in the development of a state organised health care system, with equality of access and free at the point of use (Whyte 1980, Browne 1986, Harvey 2007). Both the Catholic Church and the medical profession had vested interests, on spiritual and economic grounds respectively, to maintain control of maternal and child welfare, and by association women's reproductive and family rights. It was not until the Mother and Child Scheme (1945) was proposed that the control exercised by these established hierarchies was, for the first time, severely challenged (Kelly 1995).

5.4. The controversial Mother and Child Health Services Scheme (1947)

While commonly referred to as the church–state clash or a clash between Archbishop McQuaid and the Minister for Health Doctor Noel Browne, this is an over-simplification. The views of contemporaries suggest it was much more about the alliance between three patriarchal elites; the omnipresent Catholic Church and the medical profession that made a force to be reckoned with, in collusion with the ultra-conservative coalition party and a bankrupt state apparatus, that made the scheme a non-runner from the beginning (Kelly 1995, Wren 2003, Ferriter 2005). As is discussed later in this chapter, the dominance of patriarchal hierarchies in Irish society during this period is inextricably linked with the subordination of women in society in general and the midwifery profession in particular.

5.5. Opposition from like-minded powerful patriarchal elites

Doctor Counihan in his historical review of The Medical Association and the Mother and Child Scheme (2001) summarised the original scheme as:

“A maternity service, conducted by midwives backed by hospital staff on the lines of the district service provided by Dublin maternity hospitals...outside the county boroughs, domiciliary delivery care was to be given by salaried midwives and dispensary doctors, the latter paid by a composite fee of £4. As an interim measure, until additional dispensary doctors were appointed, private practitioners could enter the scheme and receive a slightly larger fee” (Counihan 2001:112-113).

The original scheme campaigned for free access to primary care via the dispensary doctor, a state employed GP and free medical services for mothers during pregnancy and childbirth and up to 6 weeks after birth. Free healthcare would require salaried doctors employed by the State (Barrington 1987). In the original scheme the district midwives and dispensary doctors were

central to the provision of maternity services with the hospitals acting as a backup resource for the community.

The Catholic Hierarchy perceived the Mother and Child Scheme (1947), which proposed universally free health care, as contradicting the principle of subsidiarity that underpinned Catholic social teaching (Kennedy 2012). State intervention could only be tolerated in the case of 'extreme necessity' - "when the family's capacity to service its members is exhausted" (Esping-Anderson 1990:2). Instead, they emphasised the centrality of Christian charity, the sanctity of the family, and the importance of protecting private enterprise from state-centralised social policy. Both the church and medical profession launched a sustained campaign against the scheme, forcefully arguing that the bill was fundamentally amoral and unconstitutional as it contradicted the principle of subsidiarity conferred in the constitution, which referred to the sanctity of the family as 'moral institution' with 'inalienable statute' (Ferriter 2005). This was despite the obvious benefits bestowed on pregnant women and their babies by introducing the scheme.

There was no doubt that the right of every citizen to universal healthcare would have meant a shift from proven eligibility to universal entitlements. This would have had a democratising impact on social relations, effectively secularising the whole notion of entitlements, which up to that point was controlled by the Catholic Church (Earner-Byrne 2014). So, while the Catholic Church opposed the bill ostensibly on moral grounds, in reality it was more about losing their unquestioned locus of control and moral supremacy on matters relating to the regulation and control of women's reproduction. According to the Catholic Church, the institution that controlled the mother, controlled the family and the wider society (Earner-Byrne 2014).

The rigid class and status difference in Ireland in the 1950s would have been severely challenged by the introduction of the Scheme (Ferriter 2005). According to Esping-Andersen (1990) social stratification is part and parcel of welfare state regimes. While many welfare regimes premised on social democratic ideals aim to improve equality and access for all²², a welfare regime based on subsidiarity aims to preserve rather than challenge traditional class and status differentials (Esping-Andersen 1990). Welfare and access to welfare in Ireland was traditionally controlled by and organised along class lines; with the 'deserving poor' dependent on the charity of the middle and upper classes in order to gain access to healthcare. British

²² The 1942 Beveridge Report (Report on Social Insurance and Allied Services) Sir William Beveridge set the groundwork for the establishment of the National Health Service in Britain (NHS 1946), which extended the remit of the state with regard to welfare provision, premised on universally free healthcare, with equality of access depending on need (Dáil Eireann Debates, 23 November 1943. Department of the Taoiseach, 'Social insurance and allied services, Beveridge Report, 1944–45'). This follows the Bismarckian reforms of the 1880s, where, for the first time, premised on social democratic ideals, there was direct, state intervention in the economic lives of its citizens, through the introduction of insurance schemes for all employees (Kelly 1995).

landlords, the Catholic hierarchy, the obstetric profession and the committee members of the voluntary hospital boards all played their part in controlling access to welfare and hospital beds (Wren 2003, Ferriter 2005). Eligibility for the 'red card' available through the poor law system since 1851, gave access to free dispensary and home birth services (ibid). If one did not qualify as 'deserving poor' one had to pay out of pocket and could end up destitute. Minister for Health Doctor Noel Browne argued that the originally proposed *Mother and Child Scheme* would ensure access to state-run maternity care and state control of voluntary hospitals would be based on universal eligibility and not on proven entitlement and would ensure that medical appointments in voluntary hospitals would be made on merit rather than on class or sectarian religious grounds (Browne 1986).

The Irish Medical Association (IMA), who were very well organised and resourced, came out in solidarity to oppose the Bill²³ became embroiled in Catholic polemics. They argued on 'moral grounds' that the Bill would interfere with their right to treat patients 'according to their conscience' (Wren 2003) but again their objections to the bill were more about 'the socialisation of medicine' that would impact their private earnings and necessitate doctors to become state salaried employees (Barrington 1987, Deeny 1989).²⁴ ²⁵ Private practice was growing in popularity both in the community and hospital setting at this time, with only 40 per cent of patients in the Dublin voluntary hospitals receiving free treatment by 1935 (Barrington 1987: 119-22). James Deeny argued that the Irish Medical Board effectively hijacked the church's social teachings on subsidiarity in order to legitimise the medical profession's unwillingness to expand Irish social welfare legislation, because it best suited their vested interests (Deeny 1989), despite the advantages it would bestow on Irish women and children (Kelly 1995)²⁶. The protection of private medical practice was at the heart of the IMA opposition to the Scheme. The Catholic Church and medical profession united to vehemently oppose this challenge to their hegemony and vested interests.

²³ A ballot sent by the Irish Medical Association to its members asked if they would work for a scheme which "included free treatment for people who are able to pay for their own medical care" (White, 1980:206; Barrington pp. 207-208) The bill was opposed by 78% of the 54% of its members who participated in the ballot (Wren 2003:37).

²⁴ John A. Costello, the Taoiseach, agreed with the bishops' condemnation of the Mother and Child Scheme, as did Tom O'Higgins – a prominent member of both the Fine Gael party and the Irish Medical Association (Deeny 1989). The Department of Finance shared this view objecting that the "the socialisation of medicine" would cause the disappearance of private practice (Deeny 1989:11).

²⁵ Deputy Tom O'Higgins, the chief medical officer for County Meath, said general practitioners in private practice would be completely wiped out, given that they made 70 and 80 percent of their income from looking after young children (Barrington 1987).

²⁶ Liam O'Brian encapsulates this view when he wrote to Michael Hayes of Fine Gael:

"I and many can't resist the feeling that the bishops were pulled by the doctors who wanted to remain gentlemen and not let officials near them or their tax returns' 158 (Ferriter 2005:503).

Finally, how the new scheme would be funded proved contentious. A free scheme was considered too expensive and not feasible given the lack of resources in the Irish Free State. Financing a free health service through taxation was likely to overburden the middle-income taxpayer, as there was high unemployment. Also given that the Catholic hierarchy identified with the propertied class and were major employers in Ireland during this period, it is likely that their social insurance contributions to finance a free health service would have been substantial (Barrington 1987).

The controversy over the Mother and Child Health Services Scheme (1947) outlined above, elucidates a pattern of patriarchal power relations that hampered the introduction of the scheme at a pivotal time in the development of the Irish maternity services, with far reaching consequences for the Irish Health Service and the trajectory of the welfare regime (Kennedy 2002, Daly 2012). James Deeny, the chief medical officer to the government at the time argued that the defeat of the scheme “set back public health in the country for years” (Deeny 1989: 178). It meant that the blueprint for the introduction of a comprehensive state-run maternity service was gone.

Table 5-1 Reflection 8. The absence of women's and midwives' voices

Given the lack of midwives' influence in government maternity policy, starting from the 1947 Health bill and the 1953 Health Act, I wondered whether district midwives were really established in Ireland prior to the MICS (1954) and if so, what status did they hold in the communities they served. Alternatively, was there a tendency among midwives to imagine 'a golden age' of midwifery that never really existed. Also, given that historically, successful birth activist campaigns worldwide involved collaboration between women and midwives, I wondered why the same did not happen in the Irish context. Also, what accounted for successive government's failures to recognise midwives' valuable contribution to the maternity services warranted exploration. I decided that an exploration of the role of the midwife prior to state-run maternity systems was necessary to show whether a pattern to subjugate midwives and the midwifery profession, on the part of the establishment, was evident leading up to and following the establishment of the MICS. Indeed, the interrelatedness of gender, power, and knowledge discourses in the establishment of the profession of midwifery needed investigation. Also, whether there was a link between state-run maternity care, state regulations of the profession and the subjugation of the midwifery profession warranted further exploration.

5.6. Midwifery and Professionalism: The absence of midwives' voices

When exploring change and entrenchment in Irish maternity services, it is necessary to explore, not only those voices that dominate policy decision-making, but also those that are conspicuously absent and why. Prior to state regulation (Health Act 1918), in 1905 there were 605 midwives in dispensary districts (Local Government Board Ireland Annual Report 1905, p. xxiii). According to the census records of 1927 there were 491 midwives in Ireland, while there were 5,341 nurses. Given that there were 700 dispensary districts in Ireland at that time²⁷, each employing at least one if not two midwives, this is likely to be an underestimation (Loughrey 2019). In addition the 1940s-50s, there were some 161 Jubilee nurse/midwives employed by The Queen's Institute and around 50 employed by the Lady Dudley scheme (Connell-Meehan 2005). Browne, in his memoirs, noted over a seven-year period between 1896 and 1903 that there were 12,811 deliveries on the Rotunda District Service alone (Browne 1995), presumably with the district midwife and, when required, dispensary doctor in attendance. There are many documented accounts of midwives being accepted and respected in the communities they served (Loudon 1992). In Cork, James Wolveridge wrote about the midwife as far back as 1671:

“Of the many remarkable characters that have been formed by the spirit and habits of Irish feeling among the peasantry, there is not one so clear, distinct, and well traced, as that of the midwife” (Carleton 1840:202).

Yet, many district midwives lived in abject poverty, had appalling working conditions and endured professional isolation with one midwife usually covering a whole district (O'Dwyer and Mulhall 2000, Connell-Meehan 2005). In 1943, a medical member of the Dáil protested that midwives' pay was “a scandal” and that many were “practising on the verge of starvation” (Dáil Éireann Debates 92: 1933-34:67). Benoit et al (2005) argues that the social location of the midwifery profession, a female-dominated occupation, within a maternity services that addresses women's needs, reveals society's fundamental beliefs about women's position in that society. When it came to establishing a state-run maternity service in Ireland, women's voices in general and midwives' voices in particular were noticeably absent. The different welfare regimes emerging across Europe at the time revealed different societal attitudes to women, their position and role in society. Irish social policies in 1950's Ireland was based on the principles of subsidiarity (for more on subsidiarity see section 5.4). The aim of the welfare regime in Ireland was not to strive for gender and class equality, rather, it was to preserve traditional class and status differentials that exist within the traditional hierarchical patriarchal family structure (Esping-Anderson 1990). The ultra-conservative, deeply stratified and

²⁷ Under the control of the poor law (public system) 1981 (Loughrey 2019).

patriarchal nature of Irish society was central to the type of welfare regime established in 1950's Ireland (Connelly 2003).

The intersection of the patriarchal institutions, and their role in organising and regulating society, and their gender subtext is evident here (Smith 1990, 2012). Drawing on Smith's work (1990, 2012) the practice of ruling in maternity services in the first half of the 20th century was from a standpoint of men who did the ruling. This involves the use of a dominant gender subtext of the objective, the rational and impersonal 'male' discourses to objectify and subordinate women's subjective experiences. Women's voices were silenced because it was in the nature of a patriarchal society that in public life, the normal situation was for men to talk for women (O'Connor 2000).²⁸ When the Irish Housewives' Association (IHA), founded in 1942, protested outside the Department of Health in support of Browne's free maternity scheme in April 1951, "their arguments found little resonance in a society where the subordination of women was seen as 'natural', 'inevitable', and 'what women want'" (O'Connor 2000:20)²⁹.

The same was true when it came to the regulation of midwives, where the failure to establish an independent Professional Association or Independent Midwives Union at this time³⁰ meant that there was a lack of collective solidarity among midwives. In contrast the Royal College of Midwives in Britain was originally established in 1881 (re-established in 1941) (RCM 2018) and a separate Midwives' Union was established in England in 1910 (Loughrey 2019). Instead, Irish midwives opted to join the Irish Nurses Union; a misnomer given that dispensary midwives outnumbered nurses when it was originally established in 1919 (*ibid.*). The reason behind this move was that including nurses meant a bigger number of members and bigger was better when it came to worker's solidarity. Despite this, they appear to have had little influence in the future trajectory of the fledgling midwifery profession. Midwives, socially isolated into separate

²⁸ When women did speak up their views were denigrated along sectarian lines or branded as communist by the Catholic Church; who still commanded a high degree of obedience (McQuaid to His Excellency, the Most Reverend Ettore Felici, 15 April 1951; McQuaid papers in Ferriter 2005:463). The Joint Committee of Women's Societies and Social Workers lobbied against the Conditions of Employment Act in 1936 that limited women's access to employment and the passage in the 1937 Constitution that defined women as 'mother in the home' but had little impact (Connelly 2003:69).

²⁹ These women's views were duly dismissed as representing a minority Protestant vision of citizenship and motherhood, despite the fact that it was a non-denominational organisation (Tweedy 1992)

³⁰ The need for collective solidarity was not lost on Irish midwives. A letter sent by a district midwife to the Irish Independent in January 1919, highlighted the harsh working conditions of the district midwife and proposed setting up a District Midwives Union (Loughrey 2019), as opposed to uniting in solidarity within a Professional Association, which was the preferred option for the class-conscious middle-class professionals (Loughrey 2019). Despite receiving overwhelming support from other district midwives, in 1919 midwives opted to join the Irish Nurses Union; a misnomer given that dispensary midwives outnumbered nurses when it was originally established (*ibid.*). This was initially a branch of the Irish Women Workers' Union and was set up primarily to improve pay and set professional standards and provide national representation for its members (INMO Website). In the 1930s, it became the Irish Nurses Organisation (INO) (Higgins 2007).

districts and with grueling working conditions, had little time for activism when it came to their professional interests. In this weakened professional and economic state, there was inequality of access to political decision-making, an absence of professional midwifery representation when it came to developing the midwifery profession and a lack of support for the district midwives when it came to the Mother and Child Scheme debate.

Following the Health Act 1918, it was illegal for the lay midwives to work, and they risked incarceration if they did so. The impact of state regulation on the demise of the 'handywoman,' is well documented (Robins 2000, Higgins 2007). During the transition period, those lay-midwives with good reputations and considered suitable by the patriarchal hierarchy, could apply for a licence to practice. With the professionalisation of midwifery, midwives embraced the need for more formalised, standardised training (Robins 2000).

But the curtailment of midwifery did not stop with the demise of the lay midwife. Section 43 of the Midwives Act 1944 stated that the board could "regulate, supervise, and restrict within due limits the practice of midwifery by midwives and the conduct of midwives" (Midwives Act 1944). Paradoxically, state regulation of midwives, far from protecting their new found professional role, led to the contraction of the midwifery profession. Following the rationalisation of midwifery training and registration, eligibility to apply for formal midwifery training plus the training itself came under the control of medical and nursing hierarchies, who were the perceived authority for defining the attributes and character of a 'good midwife' (Robins 2000:11). Training in the voluntary hospitals continued to be under the supervision of the master of the hospital (Browne 1995). The profession of obstetrics was already well established by the early 20th century³¹. From here on in district midwives were required to have completed registered general nurse training, midwifery training, and six months district nurse training, in order to access district midwifery work and to be accepted onto the register (Connell-Meehan 2005, McMahon 2015). While in 1948, only 17% of practising midwives were trained general nurses, by 1954 there were just 19 applicants for midwifery registration who did not have a prior nursing qualification (O'Connell 2019).

A further blow to midwifery autonomy and the status of midwifery came with the dissolution of the Central Midwives Board, established in 1918 and its incorporation into the General Nurses

³¹ The growth in professionalism, viewed as a defining characteristic of industrial societies (Saks 2016), was rooted in the gendered-centric division of labour and encapsulated the neo-Weberian concepts of social closure and patriarchy (Witz 1992). Challenging modern humanist theory that professionalisation was ostensibly motivated by altruism, Saks (2016) demonstrates that key to developing the obstetric profession was the need to restrict access and monopolise specific working activities, as a means to control and safeguard obstetric vested interests and maintain their elite status, where obstetricians assumed 'power over' rather than 'power with' the midwifery profession (Guilliland & Pairman 2010:21).

Board (NMBI 2020) in the 1950s Health Act (Higgins 2007). This resulted in midwifery being gradually subsumed under and incorporated into the nursing profession (*ibid.*).

The desire among some in the medical profession to eliminate their professional rivals altogether and secure their own supremacy is evident in a motion put forward by the medical profession to replace the title 'midwife' with the title 'maternity nurse' (Brown, Report DLGPH 1942-4319, Higgins 2007). This was successfully defeated by the Central Midwives Board prior to its dissolution on the grounds that Irish trained midwives should continue to be eligible to work in Britain and not because midwives were viewed as a valued asset to communities across Ireland (O'Dwyer and Mulhall 2000, Higgins 2007).

By 1954, following the work of successive midwives' boards, and assisted by statutory provisions, the role of the midwife and her subordinate relationship with the medical and nursing profession were clearly established (Robins 2000, Higgins 2007). Just at a time when the district midwives' role and responsibilities were being expanded in Britain, in Ireland midwives' unique identity, professional status, education, training, scope of practice and decision-making powers were being severely challenged, both legislative and in practice, by the state and the medical profession, in their attempt to consolidate their power base over maternity care. Legislation and regulation focused primarily on the contraction and restriction of the midwifery profession as opposed to safeguarding the profession and midwives' full scope of practice. This resulted in a trained and disciplined workforce, under the jurisdiction of the medical and nursing profession. This lack of professional midwifery solidarity and representation in government maternity care policy decision making, acted as a barrier to reform in the Irish maternity services (Higgins 2007). Women tended to accept their subordinate position in society as a given. Midwives, like women generally in Irish society during this period, were professionally, politically, and institutionally excluded, marginalised, and silenced. Making the gendered relations of ruling visible, can help us to understand "how we are ruled and participate in our ruling" (Smith 1999: 11). Understanding "the workings of institutions and where you are situated within them" (Smith 1990:6) is the first step to challenging the ruling relations. It is through knowledge of our own positioning within institutions that we open up opportunities for political activism and social change (Virgili and Zanatta 2018).

5.7. Hospitals, technology, and obstetric credentials

It is evident that "hospital institutions and their associated technological advances were instrumental in establishing obstetricians' credentials and cultural identity, at a key transitional moment in the history of obstetrics and midwifery" (Murphy–Lawless 1988b: 297). The Dublin

voluntary maternity hospitals, while attending to the 'deserving poor', provided an opportunity for surveillance and monitoring of inner city childbearing women. This gathering of health data meant that there was steady supply of subjects for formal training of midwives and surgeons (Ross 1986: 151). Given that complications in pregnancy and childbirth were relatively rare, vast numbers of women were required to generate enough "material" for doctors to study obstetrics (O'Connor 2001). Murphy-Lawless (1989) further contends that "the establishments of male midwifery and its institutional base, the lying-in hospital, must be viewed as part of that vast movement beginning in the 18th century that Foucault (1981) terms " bio-politics" in which the economic and political potential of women as reproducers was recognised" (296). Biomedical science and bureaucratic forms of organisation complement each other, as both prioritised scientific rationality and efficiency. What is clear is that hospital birth has been around for over two hundred and fifty years, while the medicalisation of childbirth is a much more recent phenomenon. The distinction between hospital birth and the medicalisation of childbirth is made. Murphy-Lawless (1988b: 297) argues that it was the hegemony of medical discourses alongside technology and pharmacological advances³², and not hospitalisation per se that "shaped for women the experience of how and when women gave birth". Oakley (1980) argue that medicalised childbirth, as distinct from hospitalised childbirth, was a cumulative process over a long period of time.

5.8. The Maternity and Child Health Services regulations 1953

The Maternity and Infant Care Scheme (MICS) provided for in the Health Act, 1970 (section 62 and 63), and operationalised as the combined-care scheme (CCS), was largely a continuation of the scheme implemented under section 16 of the Health Act, 1953, which was introduced "for the lower income groups in 1954" (DOH 1997: 9). Following the Health (Amendment) Act, 1991 "women were no longer required to provide financial information to establish eligibility for services under the scheme" (DOH 1997: 9). The Health Act, 1953 set the trajectory for a means-tested, two-tiered public/private health service, unique to the Irish context, which prioritised secondary hospital-based care over primary care. As the following

32

Chronology of reproductive technological advances

1845 Chloroform anaesthesia and blood transfusions

1880 Listerian antisepsis

1889 First caesarean section was performed in the Rotunda

1935 Ergometrine

1936 Sulphonamide

1970 Cardiotogograph

1980 Ultrasonography

Informed by Deeny (1989,) Browne (1898), Browne (1995), Johanson et al 2002. Loudon 2000

discussion will show, the MICS effectively institutionalised the consultant-led technocratic, biomedical model of childbirth as the only way of doing pregnancy and childbirth in the Irish context. First, I will explore the combined-care scheme, second, I will explore the key tenets of the MICS mentioned above. The key role of financial incentives in Irish health care will also be explored (Brick et al 2012). I will argue that from the beginning, Irish, state-run maternity care reflected obstetric dominated Irish government policy, that served the vested interests of the medical profession and above all safeguarded private practice. It is important to note that the biomedical paradigm, known more commonly in practice as the medical model of childbirth, is not confined to a professional grouping but refers to a technocratic way of practising associated with obstetric-led centralised maternity units (van Teijlingen 2005, Wickham 2011).

Following the MICS, under the combined-care scheme (CCS), the health authorities were statutorily required “to make available medical services, under section 16 of the act, for women in respect of motherhood by making agreements with appropriate registered medical practitioners and hospital authorities for the provision of such services and willing to accept her as a patient” (S.I. No. 158/1964 - Maternity and Child Health Services (Amendment) Regulations, 1964). This involved a common ‘package’ of scheduled doctor’s visits, alternating care between dispensary doctors and hospital obstetricians during the antenatal period with no designated role for the district midwife (Wiley and Merriman 1997, O’Connor 2002). This made legal provision for the medical monopoly of antenatal care, providing doctors with a state mandate to provide care during pregnancy, with no designated role for the district midwife. Consistent with this general de-valuing of the role of the midwife within government legislation was the attempt by some doctors to replace the midwife altogether when they proposed to replace the title ‘midwife’ with the title ‘maternity nurse’ in the 1950 Health Act. The same sentiment is evident in the regulatory body’s decision to dissolve the Central Midwives Board and incorporate it into the General Nurses Board (An Bord Altranais) (Brown, Report DLGPH 1942-4319). From the beginning state-run maternity care reflects obstetric dominated Irish government policy, that wittingly or unwittingly, led to the gradual phasing out of the role of the district midwife, whose positions were not filled on retirement. The premise underpinning the combined-care package is that all pregnancies and births are potentially risky. Like the expansion of the biomedical model elsewhere, risk discourses justified obstetric involvement as the ‘appropriate’ authority for all antenatal and intranatal care, and hospital as the safer, modern alternative to home birth (Sullivan and Beeman 1982, Oakley 1986, Davis- Floyd 2006). The general untested claim, propagated by proponents of the biomedical ideology, was that the reduction in maternal morbidity and mortality rates was as a direct consequence of medical involvement in birth, so too reduction in perinatal morbidity and mortality could also result from medical involvement in pregnancy (Wagner 1994, Tew 1995, van Teijlingen 2005). Infant attendance for free dispensary services post birth was also legislated for (S.I. No.

158/1964 - Maternity and Child Health Services (Amendment) Regulations, 1964). This aspect of the MICS, which focused on the baby's welfare, is likely to have drawn women, who wanted to epitomise 'good mothering' into the service.

5.9. From state-employed dispensary doctors to self-employed GP

Following the MICS, dispensary doctors and, later, GPs replaced the district midwives as the first point of contact for the maternity services (Kennedy 2002, Hall et al 1985), placing them in a powerful and influential position to guide women's decisions on future antenatal care (Kings Fund 2017). The intention to protect and promote the business model of private practice, embedded in the MICS, continued in the 1970s Health Act, when the dispensary system was abandoned altogether and self-employed general practitioners replaced state salaried dispensary doctors (Irish Statute Book 1970). Professionals working in the private sector are much more likely to be influenced by market forces. The opportunity to safeguard primary care, the role of the district midwife and state-salaried GPs was lost. Instead, private GPs were now offered a financial incentive to provide antenatal care (ANC). Those GPs who opted to join the General Medical Services Payment Board (usually referred to as GMS (General Medical Services)),³³ set up following the 1970 Health Act (as amended), were financially incentivised through a fee-for-service contract with the HSE to provide public maternity care under the combined-care scheme (HSE Circular 40/19). In response to a parliamentary question posed by T.D. Clare Daly, the current annual cost of the MICS GP contract to the taxpayer is an estimated 17 million euro per annum (HSE PQ DÁIL QUESTION NO: 18692-14). GPs were now free to set up practice wherever they wanted to the neglect of disadvantaged and rural communities.³⁴ GPs also had the right to refuse admittance of patients to their practice and could refuse to offer antenatal care to a woman requesting a home birth, on grounds of safety, without being held legally or professionally accountable. The changing role in GP practice when it came to help in domiciliary birth, is clear in the following excerpt.

GP2 [...] absolutely not , NEVER, we're GPs we're general practice, I think that would be outside our remit, I think we need to be specially trained in obstetrics and that would be a specialist training, then we wouldn't be GPs anymore so I could never see it happening [...] if you talk to a guy working in the practice with me [...] he would have gone around the flats delivering babies, absolutely, and he still remembers kinda that, obviously, but no, it's not , you see that was general practice, it was the accepted norm that GPs were delivery babies and all GPs were

³³ The GMS is now referred to as the Primary Care Reimbursement Services (PCRS) scheme.

³⁴ This problem is one that still persists today. A recent report in *The Irish Times* states that in an attempt to remedy the ongoing problem of the shortage of GPs, the HSE has proposed appointing 15 GPs on a salaried basis to work in rural and urban disadvantaged areas over a three-year period (Martin Wall, *The Irish Times*, Jan 22, 2018).

delivering babies and it was part of your work. You might deliver a high volume of babies so then you were competent, but that's not the case now, if you were going to deliver a baby you would do it once in the blue moon, you're not trained to do so, and I don't see any point were GPs would be EVER delivering babies.

Immediately following the introduction of the Maternity and Infant Care Scheme, referral by a GP for obstetric in-patient care had to be considered an 'urgent necessity' (Department of Health 1994: 9). Over time, with increasing medicalisation, referring all pregnant women to the obstetrician became constituted as normal practice for dispensary doctors. GPs gradually become more like gatekeepers for the hospital obstetric services (Kennedy 2002).

5.10. The obstetrician: the privileging of private obstetric care

Similar to GPs following the establishment of the MICS, obstetricians are financially incentivised to sign a consultant employment contract with the HSE that puts them in the enviable position of being simultaneously self-employed and employees of the state, with the right to treat private patients under their employment contract with the HSE (HSE 2019). Private maternity care is a lucrative business (O'Connor 2002). As upper-class women began to embrace modern medicine and pain relief, home births came to be perceived as the poor woman's option (Kennedy 2012). Prior to the MICS, in the 1930s, once puerperal sepsis could be treated, the three Dublin Voluntary Maternity Hospitals began to move from focusing on the 'deserving poor' to 'women of means'³⁵ thus, it had the makings of becoming a lucrative business (Murphy-Lawless 1989, Porter 2006). According to a senior obstetrician, Peter Boylan (2014), "the market for private obstetrics is worth at least 49 million annually; this is divided among the country's 120 obstetricians (Boylan 2014). These incomes are further boosted by public salaries (ranging from €125,000 to €150,000) and private gynaecological fees" (O'Connor 2006:110). Antenatally, the private 'patients' attend a named obstetrician in their private, more comfortable and less crowded consulting rooms, thus avoiding the long waiting times in the overcrowded public hospital outpatient departments (Wall 2009). It is state-paid midwives, working in the current 19 public maternity hospitals, that offer front-line care for the consultant's private 'patients', at the taxpayers' expense. Thus, it makes sense that any reform that shifts maternity care out of the reach of obstetric control is likely to be fiercely

³⁵ By 1935, the voluntary hospitals were seen to favour private patients, with only 40 percent of patients in the Dublin voluntary hospitals receiving free treatment (Barrington 1987: 119-22). So, by the 1930s, it was not just 'poor women' from the working classes who needed medical assistance in hospital, but women of the upper classes, who would traditionally have availed of medical assistance in the home or in private birthing centres.

resisted. Kennedy argues that the payment scheme has contributed to the institutional inertia of the Irish maternity services (Kennedy 2012).

Following the introduction of the MICS, demarcation between 'normal' and 'abnormal' became increasingly blurred (Walker et al 1997) and obstetricians extended their role to include 'normal' pregnancy and birth. This was to have profound consequences for the midwife-woman relationship, for the midwives' ability to support physiological pregnancy and birth and for the woman's status and decision-making powers (Kirkham 2010). The move from home to hospital birth, enshrined in the MICS, led to the centralisation of maternity services on an industrial scale. with increasing bureaucratisation, maternity care gradually became functional, task orientated and fragmented in nature (Donegan, 1978; Oakley, 1984, Martins 2001, Davis-Floyd 2008) which translated into professional detachment, and depersonalised care (Thompson 2004, Hunter 2008b, and Walsh 2006).

5.11. The midwife: from autonomous practitioner to doctor's assistant

Prior to the MICS, Jubilee, Dudley and/or district state-salaried midwives and dispensary doctors were known and trusted in the community they served, attending to *their* 'patient' in their own home or the local dispensary (Meehan 2005). This created a strong sense of social connectedness within the community and was central to the dispensary midwife fostering good relationships with the women, their families and the community. Midwives also worked in the voluntary hospitals setting and collaborated in outreach programmes for domiciliary birth (Browne 1995). There were few contacts during pregnancy until the 1930s and the district midwives were generally taken up with supporting women around the time of birth. It appears that the introduction of state regulations and state-run maternity care coincided with the medical control of the scope and philosophy of midwives' work. Clearly no coincidence. The MICS heralded the beginning of the end to the collaboration³⁶ that existed between the maternity hospitals and outreach district domiciliary services, and between the dispensary doctor and district midwife.

The valuable role of the district midwife, already embedded in the community, was not legislated for or given statutory weight by the enactment of the 1953 Health Bill. The already diminishing status attributed to midwifery in the 1950s Nurses Act is also replicated in the definition of 'midwife' incorporated in the Health Act 1953:

³⁶ Collaborative practice occurs when "multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care." (WHO 2010:7). True collaboration is dependent on professional autonomy, mutual trust and respectful working relations among different professional groups and a clear understanding of team members roles and responsibilities (Munro et al 2013).

“Midwife means a person registered in the register of midwives, the word ‘nurse’ means a person registered in the register of nurses and includes a midwife and the word “nursing” includes midwifery” (No. 27 of 1950, Irish Statute Books).

The ambiguous status of the midwife continued in the Nurses Act 1985, where the nurse is defined as “a woman or man whose name appears on the register and includes a midwife” (ABA 2000). Thus, a midwife became a person on the Midwives Division of the Nursing Registrar and midwifery was designated a branch of nursing (O’Connell 2019). When the Organisation for Economic Co-operation and Development (OECD) calculates the number of nurses per 1,000 population across Europe, the Irish figures include midwives (HIA 2018). While attempts to replace the title midwife with ‘maternity nurse’ in the 1950s Health Act failed (Brown, Report DLGPH 1942-4319), in the popular imagination and in practice, the role of the midwife became merged with that of the nurse, so much so that today much of the public refer to the midwife as ‘nurse.’ So, paradoxically, the introduction of state control and regulations of the midwifery profession, simultaneously saved the midwifery profession from extinction, while severely contracting midwives’ scope of practice.

Following the introduction of the MICS and continuing the trend following the establishment of the Central Midwives Board (CMB) in 1918, a campaign to discredit district midwives was launched (Barrington 1998). While the district midwife’s role was marketed as representing supposed outdated and dangerous practices, the obstetric-centralised service was marketed as safe, sophisticated and modern (ibid). If an elite group want to make people choose a certain service over another, the best strategy is to make it difficult to choose the alternative (Scott 2018). The district midwives’ role was gradually wound down. District midwives’ positions were not replaced following retirement. As domiciliary births reduced, the social location of district midwives, situated as they were at the heart of the community was lost (Mander and Murphy-Lawless 2013). The demise of the district midwife was aided by the absence of any collective solidarity among grassroots midwives to protect their livelihoods and the apparent collusion of the professional regulatory authority, to curtail the role of the district midwife (An Bord Altranais).³⁷ The demise of the district midwife was accepted as a *fait accompli* by the professional regulatory *body*, who focused their effort on the regulation and control of hospital midwives. As the midwives’ scope of practice contracted, correspondingly the doctors’ scope of practice expanded to include what was traditionally midwives’ work in caring for healthy well women.

Government healthcare policies, while ostensibly safeguarding the midwifery profession, ensured that midwives lacked control over the nature and context of their work (O’Connor 2002). The dissolution of the dispensary system in the 1970s Health Act led to the extinction of the district midwives. The only option left to midwives was to work in the consultant-led, hierarchical hospital setting. For most midwives, the impact of medicalisation on their status

³⁷ The ABA is a non-commercial state body (DOH 2018).

was not immediately apparent. Midwives in the main did not realise they were witnessing the near demise of their profession. They had already internalised their subordinate position in society as normal and inevitable. Similar to other jurisdictions, within these increasingly regulated hospital institutional structures, where priority was given to the biomedical technocratic approach, the midwife's role was transformed to that of assistants to the doctors on duty (Kennedy 2002), or 'a handmaiden of technocrats' (Benoit 1989: 172). The regulation of midwives and the accompanying shift to stratified, hospital working practices affected the autonomy and status of the midwifery profession (Lovell 1980, Shearer 1989, Saks 2016). Midwives and the midwifery profession became defined, not in terms of their relationship with women and the community, but in terms of their relationship with the medical profession (Benoit 1989). Antenatal care was driven by institutional imperatives of throughput. As episodic care became the norm, midwives' work became task orientated, fragmented, impersonal and dehumanizing. This had a negative effect on midwives' work experiences (Kirkham 1999, Kirkham and Stapleton 2000), as it increased stress and burnout among midwives (Sandall, 1997), and undermined the midwife-mother relationship (Kirkham 2010). As midwives became socialised into the biomedical model, they began to perpetuate their own position of subordination in relation to the medical profession, gaining credibility, prestige and affirmation through their relationship with senior obstetricians and peers, as opposed to the women they served (Kirkham 2010, Saks 2016). The centrality of gendered authoritative knowledge claims in shaping institutional norms, professional roles and the distribution of power and privilege is evident here. The asymmetrical power-relations characteristic of oppressive institutional regimes are obscured and internalised, making resistance impossible. It stands to reason that these nurse/midwives, socialised in the biomedical model, would not have viewed themselves as experts in physiological pregnancy and childbirth. District midwives' unique and autonomous way of practising 'with women' was severely eroded by the move into hospital. When antenatal care became the norm, midwives focused on how best they could assist the doctor to do his/her work. They were integrated into the hierarchical nursing administrative structures; senior nurse/midwives were offered nursing appointments, where nursing was the default position. For example, the role of Director of Nursing (Midwifery) and administrative rules and regulations for nursing staff also affected midwives, who were considered part of nursing (O'Connell 2019).

The erosion of midwives' identity, both within the legislation, at institutional level, in practice and in the public imagination hindered the development of midwifery as a profession in its own right and led to the midwifery professional being underdeveloped and marginalised in the Irish context. The interrelatedness of gendered power knowledge belief systems in the professionalisation of midwifery while simultaneously restricting its scope of practice has been demonstrated here. This process eradicated the role of the district midwife in the community

and utterly undermined their perceived value, visibility and status in society, including jeopardising midwives' own sense of their unique identity.

Table 5-2 Reflection 9. Does the status attributed to midwives reflect the status attributed to women generally?

Given that midwifery is predominantly a female profession in a service that is traditionally controlled by patriarchal elites, I wondered whether there was evidence in the Irish context that the subordinate role of the midwifery profession reflected societal attitudes about gender and gender power-relationships, in terms of women's value, their autonomy, their contribution and role in society. An exploration of the discourse on choice of home birth from the 1970s onwards reveals that this was indeed the case, that the subjugation of women general and midwives more specifically are inextricably linked.

5.12. Women's changing status: the docile body

The medicalisation of childbirth in Ireland was to have unexpected and profound impacts on women's status and decision-making powers during pregnancy and childbirth. Similar to the UK and elsewhere, all women were now expected to attend formalised doctor-led antenatal clinics in institutional settings (Oakley 1984). Not to do so was framed as deviant and not acting in the best interests of the unborn child (ibid). Pregnant women, healthcare professionals including midwives, and the public at large, for the most part, embraced state-run antenatal care as safe and a sign of modernity and progress. After all, equating access to medical expertise and technology to safety appears rational and intuitive. The incentive for poor working class women to embrace hospital birth was its convenience and being free of charge. As exemplified in the Dail Debate of the 1952 bill,

"The majority of people of the working class prefer to go into hospital because it is cheaper and easier for them [...] they have not got much accommodation in these small houses" (Houses of the Oireachtas 1952).

Lynsey Earner Byrne, the Irish historian, also suggests that health visitors at the time were advocates for hospital birth arguing that women would get food and much needed rest (2020). While recognising that the choice for hospital birth was possibly the best choice, under the circumstances, it would be an oversimplification to say that public demand drove hospital birth, rather it was the lack of an affordable alternative care options that made the rise in hospital births inevitable. Women's choice of hospital birth was ultimately dictated by the endemic poverty and overcrowding in the urban areas, and the gradual withdrawal of community

domiciliary services, while simultaneously incentivising hospital births as freely available to all except for the privileged 10% of the population. So while hospital birth was free, the majority of the population would have to pay out of pocket for a domiciliary birth (Barrington 1987).

It is only in hindsight that the unintended consequences of the medicalisation of pregnancy and childbirth became evident to all concerned. While antenatal care is proven to have many benefits (NICE 2017, WHO 2018), it also involved many ritualistic practices and regulations that proved to be detrimental to pregnant women's status. The medical gaze had the effect of objectifying women as mere containers for the unborn child, alienating them from their embodied pregnancy and birth experiences (Oakley 1984). The normalisation of the female body as defective, reconstituted women as helpless victims to a physiological process that was unpredictable, oftentimes defective and something which they had no control over.

Women lost control of their bodies and their babies, and with increasing risk categorisation, they lost belief in their own ability to birth, and they became dependent on the expert to oversee events (Oakley 1984, Young 1984, Kitzinger 1988, Wagner 1990, Beauvoir 1997, Murphy-Lawless 1998, Davis-Floyd 2004, MacKenzie and Van Teijlingen 2010, Kirkham 2010). (For more discussion on the medical gaze and objectification of the pregnant woman see Section 4.3.2) By internalising the medical gaze, women began to participate in their own subordination. So, while initially embraced as a sign of modernity and linked to safety, the move to obstetric-led hospital care negatively impacts women's status, participation and decision-making powers during their pregnancy and birth. Paradoxically, as the idea of the female body as defective was internalised and despite losing control to a defective physiological process, the burden of individual freedom meant that responsibility weigh heavily on childbearing women. This is because the belief of female body as defective coincided with the belief in individual freedom and choice, which were normalised in the context of consumer society (Bauman 2000). So, while reifying the idea of individual choice, the modern biomedical paradigm was also associated with increasing individual's feelings of guilt and blame, when things went wrong (Edwards 2005). In the maternity services, blame first centres on the woman in the context of her defective female body, and second on individual practitioners, but rarely on the culture of the institution.

Table 5-3 Reflection 10. Means-testing and the organisation of the maternity services

The move to universally free maternity care in the 1970s Health Act was out of step with the dominant government policy which favoured a mean-tested, private/public, two-tiered health service. I wondered what motivated this apparent U-turn and how it would impact on obstetric private practice, central to
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government policy up to that point. An in-depth exploration of who benefited from this decision was revealing.

5.13. Means-tested two-tiered maternity services: The root of inequality.

Prior to the Health Act, 1953, hospital confinements were less frequent. The glut of hospitals following the legacy of the hospital sweepstakes in the early years of the new state, made it pragmatic to prioritise secondary over primary care. The structure and financial incentives basis of the health service encouraged a high level of hospital admissions and lengthy hospital stay to fill vacant beds (Department of Health and Children 2010). Following the MICS, maternity care would now be biased towards the most expensive and medicalised responses to pregnancy and birth, which helped the vested interests of obstetricians. Antenatal in-patient services and hospital births were free or heavily subsidised for the overwhelming majority of the population. In contrast, access to primary care was means-tested and was free to only the poorest in society (Section 20, Health Act 1954 Irish Statute Books).³⁸ Childbearing women who did not qualify for free antenatal visits but found the cost prohibitive were incentivised to avail of free in-patient antenatal care³⁹ for a treatment, which could have been offered by the dispensary doctor or district midwife (Wren 2003, Daly 2012). This was further exacerbated by the lack of investment in primary care, resulting in the dispensary doctors and district midwives being overworked creating a strong incentive for dispensary doctors towards high hospital referral (Daly 2012). Financial incentives through state remuneration of GPs have always remained central to the workings of the scheme as the Report of the MICS review groups suggests (DOH 1994:12).

The stance by Irish politicians to oppose universal healthcare, marks a major divergence from the European development of universal healthcare systems, which were the norm across Europe in the 1950s (Barrington, 1987; Wren, 2003) and derives from the egalitarian ideologies which have informed the development of European healthcare systems (Smith and Normand, 2011). Means-testing, by maintaining a distinction between those who pay and those who do not pay for medical care, protected doctors private practice and removed the threat of them being legally obliged to become salaried employees of the state. In a further attempt to safeguard private practice, which was exclusively reserved for medical practitioners, legislation

³⁸ In 1953 eighty-five percent of the population was entitled to a free hospital bed, whereas only approximately 30 per cent of the population was entitled to free primary care through the new medical card system (Barrington, 1987).

³⁹ In-patient services increased as 'patients increase to fill the available hospital beds' (The Medico-Social Research Council 1972).

to establish the VHI was successfully passed in 1957⁴⁰ (Irish Statute Book 1957). The VHI, originally a non-profit making, semi-state body with the Minister for Health as its sole shareholder, was established as a monopoly⁴¹ to provide affordable health insurance for the wealthiest 15 per cent of the population not covered by the state (under the 1953 Act) (McDaid et al 2009). The VHI is now a commercial state body (DOH 2018). Motivation to join the scheme was aided by government tax incentives at source and employers' group schemes, which took the contribution for the VHI directly from the employee's salary (Murphy-Lawless 2014). The Irish Medical Association appealed to the middle classes to maintain the distinction between private and public fee-paying patients (Wren 2003). Ability to pay for private medical insurance was perceived as 'a social virtue' associated with high social status and 'superior' care and a privilege only afforded to the middle classes in Irish society (Murphy-Lawless 1998). Correspondingly non-fee-paying patients were stigmatised as being of low socio-economic status whose only option was the more 'inferior' midwifery care. The normalisation of private insurance is evident in the numbers that joined VHI over the subsequent years, reflecting the deep social stratification in Irish society⁴² (Daly 2012).

Following the Health (Amendment) Act, 1991 maternity care was free to all and "women were no longer required to provide financial information to establish eligibility for services under the scheme" (DOH 1997: 9). Taken at face value, this move appears to be driven by the equality and fairness agenda, but you would be wrong. Rather, this was motivated by expanding the private sector even further, by stratifying even further the public/private divide. By this time, private maternity care supported by private health insurance was well-established and removal of means-test was not going to impact this. But with the introduction of universally free maternity care, the option of using public beds for patients choosing private consultant care was now removed. The tactical removal of means-testing drove privatisation. Following the removal of means testing in 1991, some hospitals run by religious charities were designated as solely private fee-paying hospitals while other, ostensibly public hospitals, commissioned the building of private wings, where doctors served the needs of the wealthy (Wiley and Merriman 1996, Wren 2003). Access to a single bedded room in a public hospital was now

⁴⁰ By Doctor Tom O'Higgins a prominent member of both the Fine Gael party and the Irish Medical Association (IMA). A key opponent of the MICS (1953), the IMA sought to introduce a voluntary health contributory scheme, sowing the seed for the private health insurance industry. This contrasted with Britain where National Health Insurance as opposed to private health insurance was introduced.

⁴¹ Up to 1994 the VHI Board had continued to operate with a virtual monopoly over private health insurance when the Health Insurance Act of 1994 opened Irish health insurance to competition from multinational insurance corporations (McDaid et al 2009).

⁴² In 2007, 51.5% of the population had private health insurance (Burke 2009). Since 2007 there is a sharp downturn in numbers paying private health insurance with over 250,000 people leaving insurance schemes. Huge wage cuts, new taxes, unemployment, and endless rises in insurance fees have left people with no choice but to cancel cover, especially those with young families (Wren 2003, Burke 2009).

only possible if one has private medical cover (Wall 2009). By 2009, approximately 20% of all beds in HSE public hospitals and voluntary public hospitals had been chosen for use by private patients (McDaid 2009). This effectively put the control of private beds into the hands of the hospital consultants⁴³ and effectively safeguarded even further private practice in public hospitals.

The power of the medical profession to protect its vested interests is also evidenced when one examines the detail in the VHI policy, where cover was limited to hospital obstetric-led treatments and diagnostics, prioritizing births needing medical assistance and only in-patient, not out-patient treatments (Daly 2012). Domiciliary birth and private midwife care were not initially covered by the scheme. This two-tier private/public health care system, that is unique to Ireland, is now widely acknowledged as at the root of inequalities in the current health service; it was referred to as 'Irish Apartheid' by the Irish social policy historian and journalist Sarah Burke (2009:41). Private health insurance meant that access to hospital care was not now solely based on need, but on one's financial circumstances and ability to pay (Burke 2009). Private care options are only available to those who can afford to pay for it, while those who cannot pay have no option but to take whatever service is offered.

The KPMG report (2008) an Independent Review of Maternity and Gynaecology Services in Greater Dublin Area, commissioned by the HSE to consider the best configuration of hospital, primary and community maternity and gynaecology services reported that the structure of private medical insurance in the Irish context has played a key role in preserving private practice and doctor-led services. We can conclude that the means-tested, two-tiered health service and private medical insurance that prioritised secondary over primary care, perpetuates the dominance of the biomedical paradigm in the Irish context.

Table 5-4 Key features of the MICS: Barriers to Change

Key feature of the MICS: Protection of private medical practice • Means-testing private/public mix in public hospitals • Government consultant contracts support private practice • Government financial incentives for hospital consultants and GPs support private practice • Prioritising hospital over community services • Voluntary health Insurance that supports private/public divide in public hospitals • Denigration of the midwife's unique role • Clinical Indemnity Insurance that restricts clinical practice of midwives

⁴³ In Dublin, consultant fees generally range from about €3,500 to €5,000 (Martin Wall, *The Irish Times* 6th Oct 2009). In 2017, births cost in the region of between €2,000 to over €4,000 and the individual woman will pay out of pocket for a number of uninsurable hospital expenses (Pope 2017).

Barriers to change

- Persistence of hierarchical patriarchal power-relations
- The entrenchment of the biomedical model following the MICS
- The hegemony of the obstetric profession's expert knowledge claims and the pervasiveness of biomedical risk discourse following the MICS
- The subjugation of midwives and women in the Irish maternity system following the MICS
- The lack of collective midwifery solidarity and midwifery professional representation in government maternity policy decision making

Informed by Brown 1978, Inglis 1997, Oakley 1984, Wagner 1994, Kelly 1995, Tew 1995, Connolly 1998, O'Connor 2000, Wren 2003, Ferrier 2005, Earner-Byrne 2014, Brick et al 2012

5.14. Conclusion

The purpose of this macro analysis was to explore the inter-relations of gender, power and knowledge regimes in the origins and perpetuation of the state-run maternity services. The link between state run maternity services, obstetric hegemony, the side-lining of midwives, women's disempowerment and the capitalist mode of production was made. The historical roots of medical hegemony in maternity care are deeply enshrined in the gender division of roles in 1950s Ireland, which served to silence and subjugate women. The dominance of patriarchal power-relations in maternity care policy is further highlighted by the unconditional acceptance of obstetric hegemonic discourse by the ruling establishment that supports their own vested interests. The power relations and vested interests of the Catholic church and the medical profession, in cooperation with the government, that underpinned the withdrawal of the 1947 Health act, a blueprint for a state-run maternity service that was committed to universal health care was explored. This came to be withdrawn at a pivotal time in the development of the Irish maternity services and was to have far-reaching consequences for the Irish Health Service and the trajectory of the welfare regime. The severely modified MICS (1954) supporting a mean-tested, two-tiered public/private health service that prioritises hospital over primary care is the key to how the current maternity services are organised and coordinated. It is argued that this system is at the root of social inequalities in the health services (Burke 2007). Central to the workings of the MICS is State protection of private medical practice, with significant payment packages for GP's and obstetricians. How the midwife, who is already side-lined by the 1918 Health Act, is further side-lined by the Scheme is explored. With government policy advocating a move from home to hospital birth, women and midwives lost control of reproduction to GPs and obstetric consultants. The introduction of the MICS was undoubtedly the single most poignant point of policy development, which effectively institutionalised obstetric dominated government maternity policy within asymmetrical gendered power-relations. Once embedded, the combined-care scheme has

remained virtually unchanged since its introduction over 60 years ago (The Health Information and Quality Authority (HIQA 2013).

Table 5-5 Reflection 11. Evidence for alternative models of maternity care

Once it became evident that the medical model was not living up to its promise on safety for all childbearing women, the need to explore alternative to this overtly medicalised, interventionist model of care for women of low risk emerged (Wagner 1994, 2001, Brocklehurst, et al. 2011, Lavender et al 2012, Sandall et al 2018, WHO 2018, Fox et al 2019). An in-depth knowledge of these alternative models of care was required if I was to explore how best they could be implemented. This necessitated a literature review on models of maternity care that work and their implementation process.

6. Chapter Six Critique of the Biomedical Model

6.1. Introduction

The belief that reduction in maternal mortality in 1930s UK and 1950s Ireland was a direct consequence of medical technological expertise and their direct involvement in maternity care was, for a long time, accepted unconditionally (Wagner 1994, Loudon 1992, Tew 1995). Yet, more recently, when a deficit of empirical evidence emerged to support this claim, this belief came under increasing scrutiny (Wagner 1994, Tew 1995).⁴⁴ By the late 1970s the biomedical model was no longer accepted unconditionally as key to optimising safety in pregnancy and birth. Similarly in Ireland, while medical authority and expertise still had a stronghold, a minority of childbearing women, birth activists and some service-providers began to question the hegemony of the biomedical model and campaign for change in the maternity services (Murphy-Lawless 1998, Kennedy & Murphy-Lawless 1998, O'Connor 1998, O'Connor 2000, Kennedy 2002).

The aim of this chapter is to critique the biomedical model, to outline the drivers for change, and to review the evidence for alternative approaches to maternity care provision. Difficulties encountered with attempting to measure women's satisfaction with maternity care are outlined and caution is urged when using these surveys to inform change in maternity services. The evidence supporting a midwifery, caseload community model of care is presented.

6.2. Cracks in the biomedical model: drivers for change

Against a backdrop of expanding global capitalism (Tracy 2011, Benoit et al 2005), drivers for change in income rich countries from the 1970s onwards included the growing criticism that this model was not meeting childbearing women's physical, emotional and psychological needs. Rather, the biomedical model of childbirth was experienced as dehumanising (Oakley 1986, Martin 1987), and was, instead, associated with high intervention rates and less than optimal safety rates (Oakley 1986, Martin 1987, Kitzinger et al, 1990, Davis-Floyd 1992, Wagner 1998, Murphy-Lawless 1998, Barrington 2003, Impey et al, 2003, van Teijlingen 2005, Walsh 2006, Wagner 2006, Higgins 2007). Other drivers for change included the rising consumer movement (Tyler et al 2002, Ritzer 2008), the natural childbirth movement (Gaskin

⁴⁴ Epidemiological evidence suggests that other wider social and environmental factors, including improvement in sanitation and women's general health, have had a more significant impact on mortalities, than obstetric-led antenatal care and hospital births alone (Oakley 1984, Loudon 1992,1993, Wagner 1994, Tew 1995). Evidence from Wales and England during the early 1930s confirmed that the maternal mortality rate was lower among working class women mostly cared for by midwives, who were less likely to intervene, than among women from non-manual labour households, who were cared for by obstetricians (General Register Office, England & Wales 1938 quoted in Loudon 1992,1993). Refining emergency obstetric procedures of fully trained birth attendants, both midwives and obstetricians, did also have an impact on maternal mortality (Wagner 1994).

1977, Kitzinger & Davis 1978, Kitzinger 1989, Flint et al 1987, 1993) and the increasing demand that practice be based on best available evidence⁴⁵ (Cochrane 1972, Enkin and Chalmers 1982, Greenhalgh et al 2014).

Archie Cochrane, the father of evidence-based medicine, as early as 1972 wrote that “by some curious chance, antenatal care has escaped the critical assessment to which most screening procedures have been subjected” (1972:12). A scientific evaluation of the content, quantity and quality of antenatal care was required (Cochrane 1972, Blondel et al 1985, WHO 1987). Following the World Health Organization’s Alma-Ata Primary Health Care Conference in 1978 (Oakley 1986), maternity care reached the international public policy agenda when, for the first time, the efficacy of the taken-for-granted components of antenatal care came under international scrutiny. The general consensus by attendees [comprising 134 countries and 67 international organizations including many non-governmental organisations] (Tejada de Rivero 2003), was that many of the components of antenatal care were based on ritual, tradition or expert opinion rather than rigorous scientific evaluation (Chalmers et al 1989, , Hall et al 1980, Robinson & Thompson 1991, Thompson 1991, Rosen et al 1992, Villar and Bergsjø 1997, Villar et al 2001, Hall 2001, Dodd et al 2002, Hunt and Lumley 2002, Walker and Rising 2004, Dowswell et al 2010). Consistent with the emerging evidenced based agenda, between 1984-86, the three WHO-convened consensus conferences on obstetric technology in the USA, Brazil, and Italy chaired by Dr. Marsden Wagner, identified a desire to end the ‘we’ve always done it this way’ school of thought in obstetrics (Oakley 2016). The publication of *Effective Care in Pregnancy and Childbirth* (Chalmers et al 1989), the first ever systematic attempt at applying current evidence to maternity care practices, was a game changer and a landmark development in obstetric and midwife thinking.

By the early 1990s, as a countermeasure to the over-medicalisation and dehumanising of pregnancy and birth, a plethora of government reports from income rich countries, for the first time challenged the dominant obstetric-led model of maternity care. There was a growing recognition that alternative models that minimise interventions, maximise normal, physiological pregnancy and birth and empower both childbearing women and midwives were needed (Davis-Floyd et al 2009, Wagner 1994, Goer 2004, Brocklehurst et al. 2011). National strategies for the future organisation and provision of the maternity services were produced in England and Wales (Winterton Report HCSC 1992, Changing Childbirth Cumberlege Report DOH England and Wales 1993, Audit Commission, 1998), Scotland (Scottish Office Home and Health Department (SOHHD) 1993, Scottish Executive 2001), New Zealand (DOH NZ 1989),

⁴⁵ Evidence- based care is defined as the “conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients”, in the context of the patient’s wishes and needs and the practitioner’s clinical expertise (Sackett et al 1996: 312).

Australia (NSWDH 1989, DHV 1990) and Canada, among others, in an attempt to address these public health issues causing concern. For the first time women's needs appeared to be acknowledged and positioned centre stage in state maternity care policy internationally. More recently, the Birthplace Cohort Study provided empirical evidence that again challenged the widely held belief that access to obstetric care automatically confers benefits (Brocklehurst et al 2011). Indeed, the opposite is now proven to be true for low-risk women, where proximity to the dominant biomedical interventionist model of birth, far from improving outcomes, was found to mitigate against physiological birth, where physiological birth is most often the safest birth (Brocklehurst et al 2011). The routine use of the biomedical model for low-risk pregnancies is now more commonly associated with increased, unnecessary medical intervention with possible iatrogenic effects (Downie et al 2001, Jomeen 2010).

6.3. General criticism of Irish state-run antenatal care and the combined-care scheme

The MICS operationalised as the combined-care scheme, favoured alternating antenatal care between a medical-led centralised hospital services and primary, community services. Traditionally, women see a different healthcare provider (midwives, obstetricians, GPs) for every episode of care and throughout the childbirth continuum, pregnancy, labour, birth, and early parenthood period. In a review of women's experiences of the Irish maternity services in the Plan for Women's Health (DOH 1997), women reported wanting the "health service to be more open to consultation, involvement, respect, empowerment and choice" (DOH 1999:45). The lack of adequate information imparted to women regarding many aspects of their pregnancy, the carrying out of procedures without adequate and informed consent⁴⁶, and the removal of women's dignity and autonomy in the hospital setting, were highlighted as key issues of concern in the first Report of the Maternity and Infant Care Scheme Review Group (1994 published by the DOH 1997). By the 1990s, the Department of Health and Children acknowledged for the first time that the essential needs of the vast proportion of childbearing women and their families were not being met (DOHC 1999). In 2006, a national maternity survey commissioned by the *Irish Examiner* newspaper and conducted by Lansdowne Market Research found that 63% of the 500 mothers surveyed across Ireland (two out of three women) were dissatisfied with some aspects of the maternity services and believed it could be improved

⁴⁶ "Requiring informed consent is an expression of respect for a person's autonomy (i.e., the ability to make decisions free from external influence) and the patient's right to bodily integrity. The doctrine of informed consent also recognises the right of individuals to weigh risks and benefits for themselves. For consent to be deemed valid, it must be voluntary and informed, and the person giving consent must have sufficient capacity to make the decisions at hand. As is the case in all other clinical contexts, pregnant women should be afforded the opportunity to make informed decisions about their maternity care" (DOH 2016:77).

(O'Doherty and Regan 2006). Criticisms on antenatal care centred on reduced levels of satisfaction with overall organisational and interpersonal aspects of care, specifically issues of overcrowding, understaffing, prolonged waiting times, the hurried and impersonal treatment of the antenatal encounters, and lack of choice in service provision and models of care (ibid).

In a survey conducted by the AIMS in 2014, GPs were found by 51% of 2,835 survey participants as the main source of information on maternity care options, but many reported that their GPs did not inform them of choices about midwife-led care models, instead focusing on the choice between public, semi-private and private care (AIMS 2014). Again, in the Irish context, a follow-on survey conducted four years later, found modest improvement in relation to choices available to Irish women attending the maternity services (AIMS 2018). The majority of the 2,835 respondents rated information on care options as fair (31.7%), with a further 27% rating it as poor and very poor (8%), 28% rating it as good and only 6% rating it as excellent (AIMS 2018). The Independent Review of Maternity and Gynaecology Services in the Greater Dublin Area (KPMG 2008) reported that true choice in alternative models of care was severely limited in the Irish context and that fundamental reform was required. Similarly, the Select Committee Report: "Choice in Maternity Services UK" (HSE 2003) the role of the GP as first point of contact in pregnancy was also heavily criticised on the grounds that it curtailed choice for women experiencing a normal pregnancy by not informing them of midwife-led models of care.

Concerns have also been raised regarding the lack of maternity care close to home and the long distances some women had to travel to attend hospitals for antenatal hospital appointments and to give birth (Condon Report in 2000, O'Connor, 2003, Bonham, 2005, Regan, 2006),⁴⁷ which was a direct consequence of obstetric dominated government policy to close smaller maternity units (For more discussion on the Condon Report see chapter 9 Section 9.6).

Confusion among both GPs and pregnant women regarding the range and level of service that is included in the Irish Scheme (DOH 1997), and confusion regarding roles and responsibilities among healthcare professionals in a similar UK shared-care model (Kirkham and Stapleton 2001) was also reported. Role confusion in turn resulted in duplication and omissions of care and lack of accountability among healthcare professionals (Kirkham and Stapleton 2001, Lavender and Chapple 2004). In 2007 the Confidential Enquiries into maternal deaths in the UK (not including Ireland), the CEMACH's report *Saving Mothers' Lives* (Lewis 2007) for the first time commented on the care provided by GPs in 66 cases, emphasising the need for more

⁴⁷ It has been reported that some women travel over 80km (50 miles) and up to 160km (99 miles) to attend antenatal hospital appointments (Condon Report in 2000, O'Connor, 2003, Bonham, 2005), with 20% of Munster women travelling 50 KM (31 miles) or more for antenatal care and to give birth (Regan, 2006).

effective communication between GPs and others who are caring for pregnant women, especially midwives.⁴⁸ It is clear that maternity care schemes involving different healthcare providers for every episode of care and throughout the childbirth continuum, are associated with poor interdisciplinary and poor service-user/provider communication. The link between poor-quality communication, poor teamwork and poor clinical outcome is well noted in the literature (Kings Fund 2008, DuPree et al 2009, HIQA 2013).

The centralisation of antenatal clinics in hospital outpatient departments was also an issue of increasing concern as the number of births in Irish maternity units increased from 54,000 in 1999 to over 74,976 in 2010. This meant that there were in excess of 150,000 individual antenatal care appointments per year in each of the three Dublin Maternity Hospitals, which led to severe overcrowding within the current outdated infrastructure (Hogan 2011, Murphy-Lawless 2011). Despite the birth rate falling steadily since 2010, at 59,796 annually, it still equates to the highest birth rate in the EU (European Union) (Wren and Connolly 2016, Central Statistics Office (CSO) 2020). Adding to this pressure on the service was the critical reduction in front line staffing levels due to the 2008-2014 economic downturn (Haughey 2001, McNally 2001, Ingle 2007, KPMG 2008, O'Regan 2011, Murphy-Lawless 2011, Raleigh 2012). State backed financial incentivised packages for early retirement of senior healthcare staff (HSE 2007) and the reduction in working hours of doctors because of the Working Time Directive (British Medical Association, European Working Time Directive) added to staff shortages. The final report of the HSE Midwifery Workforce Planning Project⁴⁹ (Sugrue and Roche 2016) confirmed a shortfall in the Dublin maternity hospitals of 123 midwives (Coombe –37, National Maternity Hospital–40, and Rotunda-46). These working conditions lead to low morale among staff working in the Irish maternity services (INMO 2014). Thus, the cumulative impact of centralisation, overcrowding and severe understaffing, a direct result of government maternity care policy rooted in the MICS, has resulted in a service that is now generally viewed as working beyond capacity and not fit for purpose (Kennedy and Murphy-Lawless 1998, Haughey 2001, O'Connor 2001, KPMG 2008, O'Regan 2007, AIMS 2010, O'Regan 2010, Hogan 2011).

⁴⁸ The report Mothers and Babies: Reducing risk through Audit and Confidential Enquiries across the UK (MBRRACE -UK 2009-2012) for the first time included maternal confidential enquiries in Ireland (Knight et al 2014).

⁴⁹ This was based on standards set by BirthRate Plus: Safe staffing for maternity services (Ball and Washbrook 1996) in the UK.

6.4. Midwives' role: the evidence

For decades, the underutilisation of the midwife has been acknowledged internationally (Walker 1976, Chng et al 1980, Hall et al 1980, Thomson 1980, Robinson et al 1983, Lipsett 1984, Robinson 1989, Lipsett 1991, Wagner 2001, Kirkham 2010).

Research into the role of appropriate healthcare providers in the provision of antenatal care was first conducted in Scotland in 1995. Tucker et al.'s (1995) Scottish multicentre RCT using a sample size of 1765 women at low risk of antenatal complications, that compared routine antenatal care offered by general practitioners and midwives with shared-care led by obstetricians, found that routine involvement of the obstetrician for low-risk women antenatally did not appear to improve perinatal outcome compared with involvement of an obstetrician when and if complications arose (Tucker et al 1995). They concluded that obstetricians' expertise should be reserved for women with complications.

Similarly, the WHO systematic review of RCTs on Antenatal Care (Khan-Neelofur et al 1998), conducted by the WHO Antenatal Care Trial Research Group, compared the effectiveness of different healthcare providers in terms of outcome, found no difference in risk of caesarean, anaemia, urinary tract infections, or postpartum haemorrhage between midwife, general practice, and obstetric care for women of low risk (ibid). Khan-Neelofur et al (1998), along with Beake et al (1998) and Page et al (1999) also reported a trend toward lower preterm birth, lower perinatal mortality, less antepartum haemorrhage, reduction in clinical interventions and similar or higher reported satisfaction in the midwife-led groups.

Evidence into midwife-led models of care have since consistently been evaluated favourably, are considered as safe as traditional medical-led models of care and are associated with fewer medical interventions and improvement in continuity of carer, the latter emerging as a vital component of woman-centred care (Biro et al 2000, Homer et al 2001, Spurgeon et al 2001, Waldenstrom et al. 2001, Hicks et al 2003, Begley 2011, Brocklehurst et al 2011, Sutcliffe et al 2012, Sandal et al 2013, Sandal et al 2016). Multiple systematic reviews into evaluating new models of antenatal care with standard models of care (Villar et al 2001, Dowswell et al 2010), and midwife-led models throughout the continuum of care with standard models of care (Hatem et al 2008, Sandal et al 2013, Sandal et al 2016) support these findings.

There is now a general recommendation internationally that midwife care should be offered to most women attending the maternity services whether in the form of midwife-led care for women with uncomplicated pregnancies, or as part of the multidisciplinary team for women with known complications (Midwifery Matters DoH 2007, Brocklehurst et al. 2011). As Sandall et al (2012:323) succinctly puts it "every woman needs a midwife, and some need a doctor too." At 'The International Conference on Humanisation of Birth' held in Brazil in 2000, Marsden Wagner argued that having primary maternity care in the hands of midwives is a central strategy in the humanisation of birth (Wagner 2001).

The most extensive examination to date of evidence-based maternal and newborn care is the meta-synthesis conducted by Renfrew et al (2014) involving a Cochrane review of reviews including the analysis of 461 systematic Cochrane reviews. The authors found 56 outcomes that can be improved by practices that lie within the scope of midwifery and concluded that the midwife is one of the most efficacious interventions for a quality maternity service (Renfrew et al 2014). These include incidence of low-birth-weight babies, preterm babies, early miscarriage before 24 weeks (Renfrew et al 2014). Midwives were found to be most effective when integrated into the overall health service (Renfrew et al 2014).

As evidence supporting midwife-led care accumulated and service-user demands for choice increased, government health policies in many high-income countries opened women's access to midwives during pregnancy. Midwife involvement in antenatal care for women considered low risk became the norm in many Western countries. In the UK, a 2015 national survey found that 58% of childbearing women had exclusive midwife-led antenatal care (Redshaw and Henderson 2015). Similarly, data on service provision in New Zealand in 2010 found that approximately 78.2 % choose the midwife as lead maternity carer (LMC). In Scandinavian countries over 80% of women attend a midwife during pregnancy (Wagner 2001, KPMG 2009). In Scotland it is the national policy to recommend the midwife as first point of contact with the maternity services, while in England, all women have access to a midwife or doctor as first point of contact antenatally (National Health Service (NHS) Quality Improvement Scotland 2009).

In stark contrast, and despite the introduction of some midwife-led initiatives in the 1990s, only 5.5% of the 2,836 respondents of the AIMS Survey reported that antenatal midwife clinics were available to them (AIMS 2014).

Then there is the question of appropriate location of care, either community or hospital setting. According to Burst (1990) "real" midwifery is not determined by the locale or the presence of normalcy, but by the quality of the relationship. "Real midwifery is 'with woman,' wherever she may be and in whatever circumstances she may be in" (Burst 1990: 191). Hunter's (2004) UK qualitative study however, concluded that the technocratic institutional context of 'modern' maternity care seriously hampering the formation of meaningful therapeutic relationships, seen as central to midwifery practice. That the 'with woman' ideology of the midwife is in conflict with the 'with institution' ideology of the hospital setting where the midwife is under pressure to meet service needs, to the detriment of woman-centred care (ibid). Likewise, Fielder et al (2004) describes midwifery culture in hierarchical hospital settings as non-connected and polarised, with midwives thinking and doing seen as mutually exclusive. There is now a growing recognition internationally that community-based, midwifery continuity of care models facilitate quality midwife-woman relationships (Fielder et al 2004, Hunter 2004, Wagner 2001). This is because midwives working in the community are freed from the constraints of obstetric

dominated institutional structure and in the community setting, midwives can better control the content and nature of their work. Out of hospital births are associated with less intervention, more normal physiological birth and high satisfaction rates, when compared to hospital births (Johanson et al 2002, Brocklehurst et al 2011, Scarfe et al 2018, Hutton et al 2019). One birth centre in Sweden reported a normal physiological birth rate of nearly 90% (Waldenstrom et al 1997), while the Edgware Centre in London reports a rate of 85.6% (Saunders et al 2000). According to the AIMS electronic survey (2014): Maternity Care Choice in Ireland – Women Speak, of the 2, 836 respondents, the overwhelming majority (90.3%) said women should have the choice of community-based midwife-led care and just under half - 42.6% - said they would personally choose community-based midwife-led care if it were available. According to Renfrew et al (2019), midwifery care across the continuum from pregnancy to birth and beyond is a vital and constructive solution to the challenges of providing high-quality care for all women, newborn infants, and their families. It is also the answer for promoting a health and wellbeing approach. Despite the WHO's claim that midwives should play a more vital role in the provision of maternity care (WHO 2017), the vital role of antenatal midwife continuity of care pathways in mitigating adverse obstetric outcomes has yet to be acknowledged by policy makers and obstetricians in the Irish context.

The Radical Association of Midwives UK (ARM 2013) argues that government funding for community maternity care should be ring fenced, controlled by midwives and used for women and their families within their communities. Despite the introduction of some midwife-led services in the 1990s, government maternity policy in Ireland following the MICS has always favoured centralised hospital obstetric units in favour of community midwifery, which continues to be under-funded and under-developed (Burke 2009).

Antenatal care in Ireland is clearly out of step with international best practice standards. The first step must be to ascertain what women want from the service.

6.5. Women's satisfaction with care: the problems of measurement

In order to introduce reform in terms of woman-centred care (see section 8.4), healthcare providers and policy makers first needed to ascertain what women wanted from the services. This required a thorough assessment of women's needs and a measurement of women's satisfaction with different components of care. From the 1970s onwards, reports of women's experiences and satisfaction with antenatal care and childbirth, were for the first time evaluated internationally, in England (Micklethwait et al 1978, Garcia 1981, O'Brien and Smith 1981, Garcia 1982, Enkin and Chalmers 1982, Mason 1989, McCourt et al 1996, Williamson and Thomson 1996), Scotland (Sullivan and Beeman 1982, Reed and McIlwaine 1980, Reid and

McIlwaine 1980, MacIntyre 1981, Reid et al 1983, Reid & Garcia 1989), and Australia (Brown and Lumley 1993, Biro 2003), New Zealand (Dobbie 1990).

The definition and conceptualisation of satisfaction with health care is complex and multidimensional (Haines et al 2013). Many argue that the results of satisfaction surveys are misleading if taken at face value, and therefore should be evaluated critically, when used to plan the future provision of maternity services (Sullivan and Beeman 1982, Fitzpatrick 1991, van Teijlingen et al 2003). This is due to several methodological problems inherent in measuring satisfaction, not least how satisfaction is defined (Williams 1994, Avis et al 1995). In their seminal study on satisfaction with maternity care, Porter and Macintyre (1984) describe conservative or deferential responses to antenatal care provision. The authors, reporting on a range of innovations in the organisation of maternity care in Aberdeen, Scotland, in the early 1980s, found that women's views were limited by their experiences; that whatever system of care they experienced was likely to be the best (Porter and Macintyre 1984). Women tend not to perceive any alternatives to the care they had experienced (Sullivan and Beeman 1982). Those who had not experienced service innovation were considerably more negative about it than those who had (ibid). The overwhelming majority of women in Ireland have no experience against which to compare their care (Murphy Lawless 2011, Larkin et al 2011). Therefore, hypothetical questions on satisfaction surveys concerning practices, not experienced first-hand by women, will inevitably produce a negative response.

Studies have shown that birthing women who know their birthing midwife antenatally valued it, but those who do not, did not especially value knowing their birthing midwife (Edwards 2000, Farquhar et al 2000). Van Teijlingen et al (2003), in a Scottish Birth Study, conducted over a 10-day period in 1998, suggests that little has changed in relation to measures of satisfaction being flawed. Service-users still tend to "value the status quo over innovations of which they have no experience" (van Teijlingen et al 2003:80). Again, the research found that "people's experiences and expectations are shaped by what they 'know'" (van Teijlingen et al 2003).

In studies conducted in both Ireland and the UK, women who had already experienced combined-care/shared-care, favoured GP involvement in antenatal care (Smith 1996, Collins 2001, Byrne et al 2018). The main findings of the first AIMS survey (AIMS 2007) with 326 respondents, evaluating women's experiences of maternity services in Ireland over the previous five years, reported that the majority of women were very satisfied or satisfied with the levels of care and information they received during pregnancy, with 44.8% indicating 'excellent' care and 39.3% indicating 'good' care. The AIMS survey, was repeated between July and December 2009 and revealed a 46.6% 'excellent' and a 37.3 % 'good' satisfaction rating during pregnancy (AIMS 2010). Women's satisfaction survey conducted in a large Dublin maternity hospital, similarly, reported high levels of satisfaction with the model of care with which they were familiar (Byrne et al 2018). Of the 501 women who had experienced

combined-care, 70% (351) of them were satisfied with it (Byrne et al 2018). Similarly, findings from a survey conducted in the Rotunda hospital found that only 10% of the women who had previously experienced a hospital birth, would consider a homebirth (O' Donovan et al 2000). Also, the National Maternity Hospital DOMINO (**D**omiciliary **i**n and **O**ut) scheme, found that 97% of women who took part in the scheme reported a high degree of satisfaction with the service (Brenner et al 2001). This suggests that if health policy decision makers use maternal satisfaction survey results indiscriminately, to shape entrenchment and change and the future provision of maternity services, policies are likely to support existing services as opposed to evidence-based innovative services, which the women have not experienced.

An important finding in the Scottish Birth Study is that significant differences occurred in level of satisfaction among women when a comparative analysis of different components or models of antenatal care were compared (van Teijlingen et al 2003). For example, women who had one or two caregivers in their pregnancy were significantly less likely to report being dissatisfied, when compared to women who had multiple caregivers. The fewer the number of caregivers the more likely women were satisfied with care (van Teijlingen et al 2003). Having adjusted for confounding variables, the difference between these two subgroups was statistically significant (ibid). This has implications in terms of measuring satisfaction with provision of care and satisfaction survey design and analysis. The conclusion is that comparative analysis between alternative models of care is required in order to measure satisfaction rates in any meaningful way.

One of the important determinants of satisfaction is the fulfilment of expectations (Bjertnaes et al 2012, Gaile et al 2015). Those with low expectation of service provision tend to be women with low socio-economic status, women below 25 years of age, low income, no third level education, and women who experienced intimate partner violence (Gaile et al 2015). Low expectations of service provision are associated with higher reported satisfaction rates (Bjertnaes et al 2012, Gaile et al 2015). Other reasons for high satisfaction rates include the reluctance among service-users to criticise their healthcare providers, so-called "gratitude bias" (Gaile et al 2015). This phenomenon is worsened by the 'halo effect' following the positive birth outcome, when the joy surrounding the birth negates any negative experiences resulting in the subsequent positive evaluation of care. Finally, the socially desirable response or an "ingratiating response bias" occurs when people respond in ways that are more acceptable to others, regardless of the truth (Vaughn 2017). This also has implications for high maternal satisfaction rates. Taking these factors together makes the distinction between "very satisfied" and "satisfied" especially important for all studies in maternity care (van Teijlingen et al 2003: 80). Anything below 'very satisfied' implied deficient care with significant room for improvement. Finally, and most importantly, satisfaction with care does not guarantee that the care is of a good quality (ibid). In summary, satisfaction surveys are methodologically flawed

and can be misleading if taken at face value to inform future provision of maternity services, as they tend to support the status quo.

While measuring satisfaction with care has proven problematic, what women value in antenatal care has remained consistent over the years. In a recent meta-synthesis of findings for a new evidence informed framework for maternal and newborn care, involving 461 systematic Cochrane reviews, and presented in the Lancet Midwifery Series, women who have experienced midwife-led care models, above all desired respectful, clinically competent and continuity of care that is authentically personalised (Renfrew et al 2014). Women also valued effective communication, high-quality information, having a sense of control, and the ability to participate in their care and make choices (ibid). Another Cochrane qualitative evidence synthesis, conducted by Downe et al (2019) on the provision and uptake of routine antenatal services confirmed the above findings and added that what women also value was access to excellent quality, free, local services, that were culturally sensitive with sufficient time allocated for staff to provide relevant support, information, and clinical safety.

So, while acknowledging the limitations of satisfaction surveys, the realisation that the current medically dominated service was not meeting women's needs, led to a search for an alternative model of maternity care, namely the biopsychosocial paradigm of maternity care, known more commonly as the social model of care.

6.6. Conclusion

This chapter starts by outlining the general criticisms of the biomedical model that was not living up to its promise on safety and was experienced by service-users as de-humanising. I have cautioned about using women's satisfaction surveys to plan the future provision of maternity services as women tend to favour the status quo over innovative changes of which they have no experience; what is the best. A search ensued for possible alternative to the biomedical model. The evidence for the role of the midwife in maternity care is presented.

Table 6-1 Reflection 12. What distinguishes midwifery care from other clinician's care

According to Michel Odent, the French obstetrician and advocate of natural birth, to rediscover midwifery is the same as giving back childbirth to women (Oden 2015). Wagner (2001) concurred arguing that the appropriate use of the midwife is key to re-humanising maternity care (Wagner 2001). What distinguishes a midwife from other clinicians who care for pregnant women, emerged as an important question when conducting this study. The philosophy underpinning midwifery and how it links to the social model of care also warranted further exploration. Finally, what the social model of care looks like in practice and how

it differs from the biomedical model of care needs further exploration. The unique role of the midwife as distinct from the doctor was not always evident in the participant observations of the antenatal encounters conducted for this study.

7. Chapter Seven Midwifery philosophy and the biopsychosocial paradigm

7.1. Introduction

The social model of maternity care, as a practical and philosophical alternative to the biomedical mode is discussed. The link between the social model of care, the philosophy underpinning midwifery and what women value in antenatal care provision is made (for the key tenets underpinning midwifery and the social model of care see table 7.3). The key tenets of the social model of care are outlined. Finally, I demonstrate using empirical evidence, that a caseload model is unworkable within the current bureaucratic institutional setting.

7.2. Being with woman

Hatem et al (2009) defines the role of the midwife as “in partnership with the woman, the lead professional with responsibility for assessment of her needs, planning her care, referral to other professionals as appropriate, and for ensuring provision of maternity services” (Hatem et al 2009:12). This was in keeping with the WHO/ICM/ FIGO consensus in 1976 that midwifery “was a discipline in its own right” (Oakley 1984). But midwifery “is more than what we do, it is how we do it, [...] it is a philosophy and not a function” (Murphy 2010: 122). According to Patricia Aikins Murphy (1987) “it is the attitude with which these skills are performed that sets us apart” (Murphy 1987:122). Similarly, according to Burst (1990) “midwifery is how we approach the woman and include her and her family in the process” (191). The essence of the philosophy of midwifery is ‘being with’ woman. It is about being actively present and in partnership with the woman, it is about making that personalised connection while optimistically waiting for things to unfold (Murphy 1987).

This approach is about seeking active participation rather than informed compliance when it comes to decision making (Goth 2019). This would involve “opt in” screening, where time is spent on giving clear and balanced information on the risks and benefits of the options available and declining screening would be a realistic option (AIMSI 2014). Hence, the risk of ‘making a decision about me without me’ is minimised (HM Government UK 2010). The ‘What Matters to You?’ survey released by AIMS Ireland, highlighted that “52% of those surveyed did not receive information on potential implications to have or not have tests, procedures, treatments to assist with their decisions, and only 50% felt able to make an informed refusal

during their labour and baby's birth" (AIMSI 2014). 'Being with woman' is operationalised as relational continuity and encapsulated in the term woman-centred care, and both terms are fundamental to the philosophy of midwifery (Leap 2013, Yanti et al 2015) and central tenets of the social model of maternity care (Renfrew et al 2014, Downe et al 2019). (see chapter 7, section 7.4 for more on woman-centred care). What distinguishes a midwife from other clinicians who care for pregnant women was not always evident in the participant observations of the antenatal encounters conducted during this study (see reflection box 12). Another tenet of midwifery and the social model of care is adopting a wellness approach to care, which will now be discussed.

7.3. A wellness approach

The theory of wellness underpins the social model of care and is a key tenet of the philosophy of midwifery. Known as Salutogenesis, this theory espouses an optimistic as opposed to a pessimistic view of future possibilities (Downe 2010). Physiological pregnancy and birth is honoured, respected, and trusted and medical intervention occurs solely in cases of real need (Davis-Floyd 1992). Downe (2021: personal correspondence) suggests that "as opposed to only focusing on the possibility of risk we should also maximise the possibility of a normal outcome, where this is what is wanted by the woman, "opening up options to women, rather than closing down their expectations". Similarly, Edwards (2008: 467) posits that "optimistic watchfulness is safer than pessimistic surveillance because optimism inspires confidence while pessimism instils fear". The focus is on what makes things go well rather than what makes things go wrong (Downe and McCourt 2004). When embarking on her pregnancy and birth journey, it should be possible for the woman to view it as an opportunity for personal and family growth and development, rather than a hazardous journey with many dangers to overcome. Women should be given a safe space to foster self-empowerment, to fully embrace and relax into their pregnancy and birth experience, as opposed to fostering fear, guilt, blame and a desire to numb down the experience and simply get it over with (Gaskin 2015). Women's belief in themselves and their capacity to birth successfully without routine medical intervention, is dependent on their self-belief, and that of their midwives [and obstetricians] supporting them (Kirkham 2010, De Jonge et al 2020).

This biopsychosocial paradigm is about the balancing of risk with a health and wellness approach. While risk assessment is accepted as an essential aspect of antenatal care, is it not the only aspect of antenatal care that calls for attention. Healthcare professionals use as their starting point the need to promote, support, and protect physiologic pregnancy and birth, as long as it is safe to do so.

The biopsychosocial paradigm is not averse to technology but is a low-technological health and wellness approach, that advocates the appropriate use of technology (Stach 2019) and a

judicious use of risk assessment (Buckley 2015). It takes advantage of the benefits of modern technological advances, not as a routine but when medically indicated, agreed by the women, proven to be of benefit and in the best interests of the woman and her child. This approach is not about denying real risk. It is about avoiding unnecessary intervention that may prove to be iatrogenic. So, against a background of being optimistic that things will work out, the midwife is ever attentive and instigates appropriate and prompt escalation when indicated. With this in mind, a positive birth experience is not dependent on mode of delivery, not the idea disseminated in the media that birth should be ‘normal at all cost’, but on the prioritising of physiological birth, on women's involvement in decision-making and on the appropriate and timely use of interventions, when required.

While the biomedical paradigm starts out with the view that all pregnancies and births are potentially pathological, justifying routine intervention, the social model starts out with the view that most are normal, and some are not. Birth [and pregnancy] is normal until it isn't, until there are indications that something is wrong (Savage 1986). So, contrary to the medical risk averse approach that is future orientated and preoccupied with the pinning down of possible future risks, the social model of care represents a present orientation of events as they unfold. This requires an acceptance of the ambiguity of not knowing future events.

Distinguishing physiological from pathological pregnancy and birth makes room for both the autonomous role of the midwife in normal pregnancy and birth and the autonomous role of the obstetrician when complications occur. Midwives, who are associated with the social model of care, have typically been represented as less authoritarian in their dealings with women, in their idealized role as caring and compassionate healthcare professionals (Kirkham 2000). In the social model of care, the institutional hierarchy is replaced by a collectivity and mutual respect and trust for the other's role (Shallow 2020).

Evidence of a sharing of power during the midwife-woman antenatal encounter as opposed to the traditional biomedical unequal enactment of power relations, would be one way to identify the philosophy of midwifery in action. Another tenet of midwifery and the social model of care is recognising, protecting and promoting normal pregnancy and birth, which will now be discussed.

Table 7-1. Reflection 13 The different meanings of normal in maternity care

While conducting the participant observations of the antenatal encounters and interviewing both service-users and providers in relation to their experiences, it became clear that what was constituted as normal among childbearing women had multiple meanings. Some childbearing women referred to their desire to have a normal birth in terms of facilitating the physiological process as “doing it myself”. Another referred to normal birth in terms of what was typical “as having

an epidural because both my sisters had epidurals”, while another referred to normal in terms of not having routine intervention, “I don’t want my waters broken”. A detailed interrogation into the normal birth discourse, in terms of understanding its role in affecting change and entrenchment in the maternity services became necessary.

7.4. The politics of normal

As far back as 1970s, autonomous midwives have been acknowledged as experts in recognising, respecting and safeguarding normal pregnancy and childbirth (The International Confederation of midwives (ICM) 1976, The European Directive on Midwives (80/155/EEC), WHO 1976, The International Federation of Gynecology and Obstetrics (FIGO) 1976). This discourse of protecting normal birth is synonymous with birthing women’s empowerment and midwifery autonomy and is considered the driving force for reform in childbirth politics, policy and practice (Hunter 2007, NICE 2014, WHO 2016, 2017). As protecting normal birth is seen as central to the role of the midwife, to discredit the desire to protect normal pregnancy and birth, is to discredit midwives (Olivia Silverwood-Cope 2018). The very fact that it needs protection suggests that normal pregnancy and birth are under threat in some way in the current system. Yet, what normal actually means is itself a contentious issue in maternity care (Comaroff 1977, Graham and Oakley 1981, Downe et al 2001, van Teijlingen 2005, Brubaker and Dillaway 2009, Darra 2009). The question of who controls and defines the concept, and how its meaning has changed over the years have stimulated much debate. While there is a general consensus that the concepts “natural’ and ‘normal’ have been with us since time immemorial, ‘normality’ is a relatively new concept with its roots in population statistics and is more associated with the biomedical paradigm. The different meanings of normal in the context of maternity care will now be discussed.

7.4.1. Natural childbirth

The ‘natural childbirth’ campaign was constructed in the late 1950s and early 1960s as an alternative model to counter the over-medicalisation of childbirth (Murphy-Lawless 1998, Benoit et al 2010, NHS 2006, RCOG 2001), and represented the first major challenge to the hegemony of the biomedical reproductive paradigm. It adopts an essentialist approach, which presumes a universal innate essence of motherhood that exists outside of culture and society (Murphy-Lawless 1998). This reflects a biological determinist perspective which posits that “understanding how women’s social roles are generated revolves around the female body as the organising principle” in society (Conboy et al 1997: 5). Yet just as the biomedical paradigm is a social construct, so too is the notion of natural childbirth, both approaches having embedded in them distinct social and cultural practices that extend beyond biological

determinism (Mansfield 2008). The idea of 'normal' in maternity, while rooted in the woman's biology and her biological processes, uses the physicality of pregnancy and birth as its starting point (Sweetman 2017).

Davis–Floyd and Sargent (1997) argue that in humans, pregnancy and birth is never simply a biological act that is individually experienced: rather it is “socially marked and shaped with a distinct cultural imprint” (Jordan, 1993: 5). Kitzinger (1980:2) wrote over three decades ago: “Bringing new life into the world has always been one of the great acts with symbolic significance beyond the task of pushing an infant out of a female body.” Pregnancy and birth are not just about reproducing the species, it is about perpetuating society; “for millennia it has been consciously and intentionally designed by humans in ways that reflect core aspects of their culture” (Davis-Floyd 2001viii).

A pure essentialist approach counteracts this feminist epistemology that espouses the social constructionist view of womanhood and underlines the divisive relationship that has existed between much feminist thinking and motherhood research (Murphy-Lawless 1998).

7.4.2. Changing notions of normal: statistical norm

With the pervasiveness of normality biomedical discourse in maternity care, the idea of normal rooted in the natural has given way to the idea of normal as typical and routine as denoted by being at the centre of the population distribution bell curve (Murphy-Lawless 1998) and therefore expected in maternity care (Begley and Devane 2003, Powell-Kennedy 2010). We may refer to normal in terms of “what is optimal in maternity care” (Downe 2004). Beech of AIMS UK, questions whether obstetric birth has become synonymous with ‘normal’ birth in the minds of service-users and providers, given the routine hospitalisation of birth (Beech, 1997). In an attempt to better understand women's experiences, AIMS (UK) distinguished between ‘obstetric delivery’ and ‘normal birth’ (Beech, 1997, Downe et al 2001)⁵⁰. Similarly, Oakley et al (2011), in their analysis of childbearing woman's views on birth, notes that contrary to women in the 1970s, women having babies in the first years of the twenty-first century accept the

⁵⁰ An obstetric labour constitutes any one of the following

- Induction of labour
- Acceleration of labour
- Artificial rupture of membranes
- Epidural anaesthesia
- Episiotomy

Of the 956 births recorded as normal or spontaneous, 596 fulfilled the definition of obstetric delivery (62.3%, CI 59–65%). This reached 60% for multiparous women (393/650, CI 56–64%) and 66.3% for primiparous women (203/306, CI 61.3–71.3%). Roughly 2/3 of what was classified as ‘normal births’ were in fact ‘obstetric deliveries’ as defined by AIMS UK classification (AIMS UK 1997).

definition of even natural childbirth as a medical event. The meaning of protecting 'normal birth' has moved away from the essentialist 'natural' childbirth as a kind of spontaneous biological process and has come to mean an approach that supports women's ability to give birth without routine medical interventions (Downe, 2008, NICE 2008, 2014, Akrich et al. 2014).

Powell-Kennedy (2010) sees 'normal' as it pertains to pregnancy and childbirth, as problematic, as it is a word that dichotomizes; if you are not "normal," then you must be abnormal. Normal is defined as much by what it is not, as it is defined by what it is, "regular, usual, typical, ordinary, and conventional; physically and mentally sound; free from any disorder; healthy" (2010:199). Oakley in her book *Women Confined* (1980) contends that maybe a reconceptualising of pregnancy and childbirth as a human life event as opposed to a normal life event is more meaningful to extend our understanding of women's reactions to childbirth.

In an attempt to counteract the biomedical hijacking and pathologizing of 'normal' by interchanging it with 'normality' in terms of population norm, midwives have had to re-think normal in terms of women-centredness, that is normality seen in relation to the woman's individual physiological and social context (Walsh and Steen 2004); encapsulated in the terms 'normal for her' and 'normal under the circumstances' (Kirkham 2011) This attempt by midwives to reclaim normality in terms of woman-centredness has helped to tilt the decision-making power back in the direction of pregnant woman and the midwife. There is not a 'singular normal' as in the case of the population bell curve. This is not a 'prescriptive normal'. Because of the wide variation of what is considered normal it is too large for a single uniform definition (Wagner 1994). What we must espouse is the idea of 'normalizing uniqueness' (Davis and Davis-Floyd 2004) or 'unique normality' (Downe and McCourt 2004).

No detailed debate has occurred in the Irish context regarding the meaning of normal and normality in maternity care. The concept: "protecting normality" continues to be a contentious issue in the politics of birth and a heuristic tool in the campaign for resisting medical hegemony. Notwithstanding these controversies, or perhaps because of them, the term is unlikely to be abandoned any time soon. Another tenet underpinning midwifery and the social model of care is the prioritising of meaningful therapeutic relationships, encapsulated in the term relational continuity, which will now be discussed.

Table 7-2 Reflection 14. Justifying the need for a literature review on continuity models

Continuity of care models were presented as possible solutions to the bureaucratic fragmented and dehumanising nature of the biomedical model. The fragmentation of the concept 'continuity of care' into continuity of care and carer; with a shared philosophical approach aspect, a relational aspect and a continuum of care aspect has occupied midwifery research for over the past 40
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years. What drove the need to differentiate, what appeared to be a pretty straight forward concept, into measurable elements and what were the advantages, if any of this approach warranted exploration. Also, whether this differentiation was the result of attempts at implementing continuity models into what was already a fragmented institutional structure is explored. In terms of exploring continuity and change in the Irish maternity services, the introduction of continuity models has been slow. Why this is the case is unclear. Thus, a comprehensive literature review of the meaning of continuity and the experiences of implementation of continuity models into practice was undertaken.

7.5. Continuity: concept and implications for practice

Continuity of care models were presented as possible solutions to the bureaucratic fragmented and de-humanising nature of the biomedical model. (Sturmberg 2003). It was hypothesised that the organisational patterns of maternity care would be found along a continuum, with continuity of care at one end and fragmented care at the other, and that women who received the greatest degree of continuity would be the most satisfied and receive a better quality of care, while those receiving the greatest degree of fragmented care would be the least satisfied (Green et al 1989, Green et al 2000, Sandall et al 2013, 2016). That reducing the number of caregivers would reduce the problems of fragmentation and impersonal care associated with multiple service providers. Yet, confusion surrounds the concept of continuity regarding its nature and meaning, its clinical importance and its impact on safety and quality service. In terms of exploring continuity and change in the Irish maternity services, a critical analysis of international research exploring the implementation of continuity of midwifery care models, along with the conceptual developments of continuity of care in practice, should help to clarify some of these issues. By making explicit factors that can act as barriers to or influence the successful implementation of midwife-led continuity of care models in the Irish context are examined, it is hoped to avoid the pitfalls that hampered successful implementation in other jurisdictions.

As various continuity models were introduced in the late 1980s and 1990s, mostly in the UK, several authors explored the many takes on this increasingly complex and multidimensional concept (Currell 1990, Murphy-Black 1993, Garcia et al. 1996, Lee 1993, 1997, Green et al 1989, Green et al 2000, Sandall et al 2013, 2016). Continuity of care is both process and outcome focused. It encompasses chronological continuity throughout the childbearing continuum, continuity within and between episodes of care, and continuity of a known caregiver in labour (Green et al 2000, Sandall et al 2008, Sandall et al 2013, Sandall, Coxon et al 2016,

Sandall, Soltani et al 2016). Interdisciplinary continuity refers to a shared philosophy of care within and between disciplines involving information, policies and management continuity (Waldenstrom 1998, Green et al 2000, Haggerty et al 2003). Continuity of care, which is achieved with team midwifery, refers to a shared philosophy of care among a group of caregivers, with the provision of consistent information, advice, and support and the adherence to set guidelines and protocols (Waldenstrom 1998, Green et al 2000, Sandal et al 2016). Continuity of carer, on the other hand, is associated with caseload midwifery, and extends beyond a shared philosophy of care to include an opportunity of developing a trusting relationship with a 'known' midwife (Waldenstrom 1998, Green et al 2000, Sandal et al 2016). This latter overarching concept has been written about extensively within the midwifery literature. It has been referred to as 'relational continuity'; defined as "a therapeutic relationship between a patient and one or more providers that spans various health care events and results in accumulated knowledge of the patient and care consistent with the patient's needs" (Haggerty et al. 2007:341), or 'partnership caseload' in which "a therapeutic relationship where both service-user and providers experience interdependent trust and partnership" (Walsh 1999: 166).

The need to distinguish between continuity of care and continuity of carer became necessary during the implementation of these new models of care into the already existing bureaucratic biomedical system. This is because the explicit definition of continuity had implications for practice, research design and successful implementation of sustained reform. Difficulties with implementing continuity of care models will now be discussed followed by an exploration of what components of continuity are linked to women's satisfaction and improved quality of care.

7.5.1. Team midwifery

Beginning in the late 1980s, randomised controlled trials (RCTs) that compared team midwifery with standard medical-led share-cared, were conducted internationally and one of many outcome measures was women's satisfaction with continuity of care (Flint et al 1989, MacVicar et al 1993, Kenny et al 1994, Rowley et al 1995, Harvey 1996, Biro et al 2000, Homer et al 2001, Waldenstrom et al. 2001, Hicks et al 2003, Begley et al 2009). Implicit here is prioritising a partnership between the woman and the midwife (Guilliland and Pairman 2010). Flint states that

"To be a midwife is to engage in a close and intimate relationship which often lasts only as long as the pregnancy, birth and puerperium, but the effect of which travels down through the centuries in the image women have of themselves and their abilities and worth. Midwives and women are intertwined" (Flint 1986:14).

Throughout the next decades following the seminal and internationally influential 'Changing Childbirth' report in England (DOH 1993), many of these team midwife models appeared to lose sight of the importance of the relational aspect of continuity from 'a known midwife', instead focusing on offering a shared philosophy of care from among a group of likeminded caregivers. This was because in practice many of the team midwifery models were achieving continuity of care and not carer as originally intended (Waldenstrom 1998, Farquhar et al 2000), resulting in low-continuity schemes rather than high-continuity schemes (Todd et al 1998, Farquhar et al 2000), and in many instances satisfaction with care was not associated with continuity as delivered in these models of care. Possible reasons for this are discussed later on in this section.

An early attempt to introduce team midwifery took place in South London; 'Know Your Midwife' scheme, a randomised trial of continuity of care by a team of four midwives (Flint and Poulengeris 1987). The degree of continuity and reported satisfaction among women were among the outcome measures. Women in the intervention group (n = 503) did attend the obstetrician at booking and again at 36 weeks and 40 weeks' gestation. The control group (n= 495) availed of standard fragmented care between GPs, midwives, and hospital doctors. Although the woman attending the midwife team reported being satisfied with their care, when it came to measure the link between continuity and satisfaction, there was conflicting information as to which group saw more caregivers, the experimental group, or the control group (Flint and Poulengeris 1987, Green et al 2000). The team midwifery initiative did not automatically achieve more continuity of care compared to the standard model of care.

A study conducted in Sweden by Waldenstrom (1998), compared the satisfaction of 410 women giving birth at an in-hospital birth centre in Stockholm according to level of antenatal, antenatal/intranatal and postnatal continuity. Levels of satisfaction were generally high but Waldenstrom attributes this not to continuity of carer *per se*, but to the attitudes of carers, the philosophy of care and the calm environment in a birth centre. She concludes that continuity of carer is not as important in a unit where there is a shared philosophy of care. What is important is not who provides care but rather what philosophy underpins how the care is carried out.

Green et al (2000) in their literature review comparing the relationship between women's reported satisfaction and continuity reported that there appeared to be no difference in reported satisfaction rates between those who knew the midwife and those who did not, and therefore the authors concluded that women valued continuity during labour more than continuity between episodes of care, that women value continuity of care over continuity of carer. They suggest that the value to women of this one specific aspect of continuity, 'knowing the birthing midwife' may have been exaggerated. If satisfaction for team midwifery care is not linked to

continuity, the question of what part of team care accounts for the high satisfaction rates required attention.

The reason why many of the team midwifery models in practice were achieving continuity of care and not carer as originally intended (Waldenstrom 1998, Farquhar et al 2000) needed further exploration. A closer look at how continuity was measured in these early studies is informative. Green et al (2000) in a systematic review of UK evidence on continuity of care between 1980 and 1996, found that five studies (Flint et al 1989, MacVicar et al 1993, Kenny et al 1994, Rowley et al 1995, Harvey 1996) defined satisfaction with continuity in terms of whether or not the woman had a 'known carer' in labour. This was also the case in a RCT conducted in 1996 that compared team midwifery care with standard care in a tertiary level hospital in Melbourne, Australia (Biro et al 2003).

These first continuity of care initiatives, while ostensibly focusing on providing continuity throughout the childbirth continuum, in reality prioritised continuity between antenatal and intrapartum episodes of care (Green et al 2000). In England the government, in order to measure the delivery of continuity in practice, set a series of targets which were to be achieved over the proceeding five years, one of which was that 75% of woman in each maternity unit, should know their midwife in labour (DOH England and Wales 1993). A known carer was found by identifying the midwife carer's previously occurring signature in the woman's notes (Green et al 2000). It would appear that continuity of care in these early team midwifery schemes was reduced to a quantifiable measurement of a previously recorded signature in the notes. This appeared to be a case of hitting the target while missing the point. These studies were not measuring 'relational continuity' but appear to be mere tick box exercises in an attempt to achieve the 75% target set by the recommendations of the Changing Childbirth report. Also having 'met' the midwife antenatally was different from 'knowing the midwife' (Farquhar et al. 1996). What these studies reported was that women do not highly value continuity between antenatal and intranatal episodes of care, as practiced within a large team midwifery scheme (Farquhar et al. 1996). It has already been well established in the literature that in maternity care, women do not value what they have not already experienced (Porter and Macintyre 1984, Sullivan and Beeman 1982, van Teijlingen et al 2003).

In an attempt to achieve the Changing Childbirth target of 75% of women knowing their birth midwife, the number of midwives per team antenatally, began to increase. The bigger the teams antenatally the more likely the woman would meet the midwife attending her for childbirth, but also the less likely she would achieve authentic relational continuity during the antenatal period (Williams et al 2010). According to Morgan et al (1998) the higher the level of antenatal continuity of carer, the lower the level of truly 'knowing the midwife' at the birth (60% v 74%).

The importance of the relational aspect of 'knowing a midwife' has been reported by women (Lee 1993). When asked what 'knowing a midwife' meant to them, women reported qualities of friendship, confidence and trust as being of paramount importance (ibid). The importance of the professional 'patient' relationship was also the subject of a literature review led by Sandall (1995) where she concluded that the nature of the relationship between professionals and patients has a major influence on 'patient' satisfaction and that levels of satisfaction were directly associated with therapeutic outcomes and health status. Crosstabulation carried out by Farquhar et al (2000) to examine if seeing a greater number of midwives reduced the chances of a relationship developing between the women and the midwives confirmed that this was indeed the case. Farquhar et al (2000) compared women's views of team midwifery with more traditional models of midwifery care. The majority of women who had known their birthing midwives antenatally reported that it made them feel more at ease, however, the majority of those in the standard care group, who had not met their birthing midwives previously, reported that it did not affect them one way or the other (Farquhar et al 2000). In the survey conducted by van Teijlingen et al (2003) most women valued having one primary person who was responsible for providing their antenatal care (88%), with women who had met the midwife during pregnancy rating it as very important (65%) compared to 52% of who had not previously met the midwife attending them in labour, who rated it as not important (van Teijlingen et al 2003). Again, while two-thirds of women who had one person responsible for providing antenatal care rated it as very important, only one-fourth of women who had not experienced this thought it to be important (ibid). Green et al (2000) suggests that a problem with finding a link between continuity and satisfaction is that it is based only on group averages. Few studies have assessed whether women who actually received higher levels of continuity, are the women who are reportedly most satisfied (Green et al 2000). Another suggestion is that it is the Hawthorne effect in operation (ibid). Women who were not randomly selected for the team midwifery group were disappointed because they felt they had missed out and may therefore have been less satisfied with care (ibid).

The prioritisation of measuring continuity between the antenatal and intranatal episodes of care, within the current, inherently fragmented industrial structure, was fundamentally flawed as it did not measure meaningful relational continuity but merely measures whether the woman had 'met' the midwife previously. It was also linked to low continuity antenatally. Green et al (2000) suggest that this focus is a high price to pay if it is provided at the expense of forming meaningful relationships in pregnancy. The advantages of having a 'named midwife' to provide antenatal care cannot be underestimated (Changing Childbirth, DOH England and Wales 1993). Also, with caseload models, antenatal continuity is not inversely associated with 'knowing your midwife' in labour, as long as caseload is organised around the principles of woman-centred care.

So, before deciding if continuity of care is valued over relational continuity of carer, it became necessary to review studies that compared continuity of care (team midwifery) and continuity of carer (caseload midwifery) models, with continuity and satisfaction as outcome measures.

7.5.2. Caseload midwifery

As evidence for midwife-led care increased and team midwifery care became embedded and normalised in many maternity units across the UK, Australia, and New Zealand, midwifery researchers began to compare different models of midwifery-led care in an attempt to identify what components of care really matter to women. In Ireland at that time, we were out of step with developments regarding introducing team midwife-led care models that was going on elsewhere in income rich countries. Midwifery caseload models were compared with other established models of care ranging from the traditional model (medical-led shared-care found in the UK, Australia, and other countries) to rostered hospital midwife care to community team midwifery (McCourt et al. 1996, Turnbull et al 1996, North Stafford 2000, McLachlan 2012, Tracy et al 2013). Some of these later studies included women with both low risk and high-risk pregnancies (Fereday et al 2003). The first attempt at caseload midwifery was the 'One-to-One' midwifery practice at the Hammersmith Hospitals NHS Trust (McCourt et al. 1996). This was organised around a team of 6 midwives who worked in pairs and were geographically based (ibid). One 'named' midwife provided most of the midwifery care to 'her' women throughout the childbirth continuum and a back-up midwife provided care when the named midwife was not available. The evaluation of women's responses was conducted between August 1994 and August 1995 based on a longitudinal, self-completion questionnaire, interviews, and focus groups. Women in the study group (n= 728) received the new service mentioned above and women in the control group (n= 675) received conventional care that was shared care between GP, rostered hospital doctors and rostered midwives. Partnership caseload models offered greater continuity between episodes of care (antenatal and intranatal care) and within episodes of care when compared to conventional shared care (McCourt et al. 1996). Higher rates of continuity of carer were associated with more satisfaction with their care during these phases (McCourt et al 1996). Only two studies during this initial research period, where partnership caseload schemes (each midwife carried an individual caseload of around 40 women per year, working with a partner who provided care when the named midwife was unavailable) were compared to 'conventional' team midwifery care (Page et al. 1999 and North Staffordshire et al 2000), reached the 75% DOH (1993) target for continuity of carer in labour provided by a professional with whom a relationship had been formed antenatally. The finding that women strongly favoured continuity in labour from a known midwife was, for the first time, statistically significant (Page et al 1999, Benjamin et al 2001). This association of partnership caseload midwifery with greater continuity and greater satisfaction among service-users, is

now well supported in the literature (Cheyne et al 1996, McCourt and Page 1996, Farquhar et al 1996, Allen et al 1997, Pankhurst et al 1997, Page et al 1999, North Staffordshire et al 2000, Benjamin et al 2001, Johnson et al 2005, Foster et al 2016). So, contrary to the earlier findings, these studies support the view that women value continuity of carer over continuity of care. Women who reported the highest percentage of named midwives, the highest continuity of carer antenatally, and who were the most likely to say that they had formed a relationship with their midwives, also reported being the most satisfied (Page et al. 1999 and North Staffordshire et al 2000).

In a more recent study, **CO**mparing **S**tandard **M**aternity care with **one-to-one** midwifery **S**upport (COSMOS) and RCT conducted in Australia the association between continuity of carer and satisfaction with care across the maternity continuum was explored (Foster et al 2016). Continuity was measured using both medical records data and women's self-reported recollection of having previously met the midwife caring for her in labour. Recruitment of 2,314 pregnant women, at low risk of complications and stratified by parity, took place between September 2007-June 2010. Of the 2,314 women recruited to the study, 1,156 were allocated to caseload midwifery and 1,158 to standard midwifery care. Women allocated to 'standard care' received either midwife-led care with varying levels of continuity, obstetric trainee care and care that was 'shared' between general practice and the tertiary hospital. Women allocated to the intervention group received care from a 'primary' caseload midwife, had one or two visits with a 'back-up' midwife, and attended an obstetrician at the booking visit, 36 weeks and postdates (if required). If complications developed, the primary midwife collaborated with obstetricians and continued to provide caseload midwifery care.

Antenatally, there was no difference in the total number of antenatal visits reported between the groups and caseload midwifery was associated with seeing fewer different midwives than those in standard care. Significantly more women in the caseload midwifery group had higher satisfaction ratings for all aspects of care than in the standard care group. Antenatally, women in the caseload group were over three times more satisfied than women in standard care (Foster et al 2016). A strong argument is made for the link between antenatal partnership caseload models and reported maternal satisfaction. To aid in implementing continuity of carer models, a practical guide for midwifery continuity of care models has recently been published (Homer et al 2019).

7.5.3. Key components of caseload midwifery

Once it was established that caseload midwifery models (relational continuity models) were valued over team midwifery models, that were associated with less continuity, further studies were conducted to explore what specific components of caseload models were valued by women. Caseload relational continuity models are associated with more effective

communication between and more meaningful engagement with the maternity services resulting in a better uptake of care (Allen et al 2016). The opportunity to discuss problems over time meant that women were more willing to confide about problems and disclose sensitive information (McCourt et al 1996 Beake et al 2013). Women report receiving better quality and more consistent information, being more informed regarding choices available, being more involved in decision-making and having more time to make those decisions, having the feeling of being listened to and that ones' concerns were being taken seriously and having more time to discuss issues (McCourt et al 1996, Shields et al. 1998, Spurgeon et al 2001, Huber and Sandall 2009, Brintworth and Sandall, 2012, Foster et al 2016). Women who experienced caseload midwife-led models also report enhanced emotional and social support and describe a sense of safety, calm and trust that accompanied the relational continuity aspect of the care (Shields et al. 1998, Huber and Sandall, 2009, Beake et al 2013, Foster et al 2016). Having more time to discuss issues in a safe and trusting environment also enhanced their confidence regarding preparation for the birth and parenthood (McCourt et al 1996, Spurgeon et al 2001, Huber and Sandall, 2009). McCourt et al (1996) reported that women in the continuity model felt better prepared for birth than the control group women (18% vs 12% "very well prepared") and better prepared for parenthood (26% vs 15% "very prepared"). The authors concluded that this can be attributed to the content and nature of the antenatal encounter which may be linked to relational continuity during the antenatal period (McCourt et al. 1996). Having the same midwife or small group of midwives providing care and knowing the midwife who would be present at the birth was also valued (McCourt et al 1996, Spurgeon et al 2001, Leap et al 2011, Dahlberg and Aune 2013, Sandall, Soltani et al 2016). Interpersonal relationships were found to be crucial components of a quality and safe maternity service (Siddiqui 1999, Walsh 1999, McCourt et al 2006, Hunter et al 2008, Edwards 2010, Kirkham 2010, Mander & Murphy-Lawless 2013, Leap et al 2011, Dahlberg and Aune 2013, Sandall, Coxon et al 2016, Foster et al 2016, Homer et al 2017). Alongside relational continuity, the personal attributes and philosophical commitments of the midwives alongside appropriate institutional infrastructure were identified as key components valued by women attending the maternity services (Fereday et al 2003, Allen et al 2016). Successive Cochrane systematic reviews have more recently highlighted the possibility that adverse outcomes, including preterm birth less than 37 weeks and fetal loss before and after 24 weeks, could be reduced by altering the standard antenatal care package to include midwife-led continuity of carer models (Villar et al 2001, Farquhar and Ferrante 2000, Sandall et al 2013, Sandall, Soltani et al 2016). Allen et al. (2016) mixed-method study included data from 1971 young women and babies collected during 2008–2012, plus analysis of focus group interviews with caseload midwives and pregnant and postnatal women, reported more meaningful engagement with the maternity services and better uptake of care, especially with younger women, which may modify predictors of preterm

birth. These activities include earlier booking visits, disclosing risks, engaging in self-care activities, and accepting referrals for assistance (Allen et al 2016). Women also develop greater emotional resilience, ideal gestational weight gain, less smoking/drug use, and fewer untreated genito-urinary infections, all of which are predictors for preterm birth (ibid). These studies also add weight to a growing body of evidence linking caseload midwifery with improved perinatal outcomes for vulnerable women who may be considered ‘high risk.’ Providing preventive and supportive care by one caregiver, or a small number of caregivers, may be a factor (Symon et al 2016, Homer et al 2017). Supporting women emotionally and reducing maternal stress may have measurable medical benefit and might result in less need for technological intervention (Hodnett et al 2008, Symon et al 2015, Sandall, Soltani et al 2016). Similarly, evidence from large cohort studies have shown that non-medical risk factors play an independent risk-enhancing role in perinatal and maternal outcomes (Rogers et al 1998, Agyemang et al 2009, de Graaf et al 2013).

The World Health Organization’s (WHO 2016) guidelines on antenatal care state that “midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well-functioning midwifery programmes” (WHO 2016: 89). The WHO (2017) also suggests that when it comes to antenatal care there is “an urgent need to expand the agenda to go beyond survival, with a view to maximising the health and the well-being of women, families and communities” (Tuncalp et al 2017:860–862). It has already been identified that key concepts that underpin the philosophy underpinning midwifery closely resemble the key tenets of the social model of care. Both the philosophy underpinning midwifery and the key tenets of the social model of care in turn, closely resemble the qualities reportedly valued by childbearing women and found in the literature as necessary for providing a safe and quality maternity services (Renfrew et al 2014, Downe et al 2019).

Table 7-3 The philosophy underpinning the midwifery profession/the social model of care

● Makes a distinction between physiological and pathological processes ● Holistic, health and wellness approach with optimistic approach to future events ● Optimises the normal physiological process ● Optimises woman centredness operationalised as relational continuity ● Works in partnership by seeking active participation as opposed to informed compliance ● Chooses a balanced approach to risk assessment and an appropriate use of intervention with a judicious use of technology
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- Shares power during interactions

Kirkham 2000, Edwards 2008, Leap 2013, AIMS 2014, NMBI 2014, Renfrew et al 2014, Buckley 2015, Gaskin 2015, Yanti et al 2015, Murphy 2010, Downe et al 2019, Goth 2019, ARM 2020

7.6. Conclusion

In this chapter the social model of maternity care is presented as a workable alternative to the biomedical model, where health and wellness are acknowledged, where normal physiology is optimised, where intervention is minimised and technology is used judiciously, and a balanced approach to risk assessment is adopted. The link between the social model of care, the philosophy underpinning midwifery and what women value in antenatal care provision is made. The acknowledgement that most women of reproductive age are well and healthy and can achieve a normal birth without medical assistance is the starting point. The role of the midwife, who embodies the social model of care and the philosophy of being in partnership with woman is now widely acknowledged as central to providing a quality and safe maternity service that is women centred. Having a midwife who is socialised into the bureaucratic, biomedical model of care lead an antenatal clinic will not achieve meaningful reform. Midwives need to know it is not just what they do (Scope of Practice) but how they do it (philosophy of care) that is important. The problem of fragmenting the meaning of 'continuity' into three distinct categories; the first referring to a shared philosophy of care, the second referring to relational continuity that facilitates therapeutic relationships and the third referring to chronological continuity throughout the childbearing continuum, raised issues about what actually were researchers measuring during these studies. Despite these attempts at fragmenting the meaning of 'continuity' after 40 years of research on the topic, the conclusion is that while we might prioritise the relationship aspect of continuity models, we need all three aspects of continuity for it to be meaningful in practice. The evidence supports a midwifery, caseload, community model of care as an optimal model to be used for the majority of well women, alongside the biomedical model that should be reserved for women with high risk pregnancies. I argue that the biomedical model requires the infrastructural power exercised by bureaucratic organizations to maintain its dominant position. Therefore, caseload models that require a shift of power-relations, is unworkable within the current bureaucratic institutional setting. Similarly, woman-centred care, which is operationalised as relational continuity models, is incompatible within the current bureaucratic institution settings, where the needs of the institution will always take precedence over the needs of the woman. For true reform to occur in the maternity services, radical whole system changes from the bureaucratic biomedical model, which is organised around the needs of the institution, to a community-based, caseload model, that is organised around the needs of the woman, is urgently required.

8. Chapter Eight Government policy and legislation between 1970s to 2010

8.1. Introduction

The purpose of this chapter is to review government maternity care policy documents and legislation from the years 1970-2010, in terms of exploring entrenchment and change in the Irish maternity services. The focus is on the various change discourses employed to drive change or reinforce entrenchment in the maternity services and the various change agents. Whether change discourses evident in maternity care policy documents translates into change in practice is addressed. Also, whether a continuation and perpetuation of power-relations and vested interests embedded in the MICS (1953) is evident in maternity care policy and practice during this period will also be explored. First, in order to set the scene in terms of cultural influences and social context, women's changing social status and roles in society during this time frame will be explored.

8.2. Women's position in Irish society: 1970 onwards

Up to the 1970s, with no access to contraception, family sizes tended to be largest (7-9 children) amongst poorer women, evident in the Coombe hospital in Dublin being referred to as 'the home of grand multiparity' (Feeney, quoted in Murphy-Lawless, 2002: 913). Poorer women had far poorer health and who were living in deeply inadequate conditions (Murphy-Lawless, 1987). Middle class women in contrast, had recourse to private medicine and if they wished to, were already using the contraceptive pill from the 1960s onward (ibid.). The 1970s heralded the removal of restrictive legislation⁵¹, including the overturning of the contraception ban,⁵² the introduction of equality legislation⁵³ and the removal of the "special position" for the "Holy Catholic Apostolic and Roman Church" in the Fifth Amendment of the Constitution Act, 1972^{54 55} meant that the influence of Catholic social teaching on women's daily lives was loosened and women gradually acquired increased legal rights and control over fertility. These changes in legislation were primarily driven by membership of the European Economic

⁵¹ The reduction of the minimum voting age from 21 years to 18 years was enacted in 1972 (Fourth Amendment of the Constitution Act, 1972). The marriage bar was repealed in 1973, the contraceptive ban for unmarried women was repealed in 1979 (Health (Family Planning) Act, 1979 (no.20 of 1979)).

⁵² Ireland's ban on contraception was finally overturned in 1973 after 27-year-old May McGee won a landmark case in the Supreme Court. Despite this result politicians failed to legislate for contraceptives until 1979 and many of the restrictions remained in place for a further 15 years (Scannal's 'The McGee Case' RTE One June 4th, 2019).

⁵³ Employment Equality Act in 1977 and The Maternity Protection of Employment Act in 1981 The total number of women in the workforce grew from "26% in 1961, to 32% in 1981, and 40% in 1987" (Mahon 2020: 4).

⁵⁴ Fifth Amendment of the Constitution Act, 1972. Removed from the Constitution the special position of the Catholic Church and the recognition of other named religious denominations.

⁵⁵ The authority of the Church was on the decline, as exemplified in Mass attendance dropping from 90% of people in the 1970s to 25% in 1995 (Potter 2011)

Community (EEC) in 1973.⁵⁶ By this time Ireland was already a member of the United Nations (UN) since 1955, and the World Health Organization (WHO). The 1970s also saw marked economic development with the beginning of the new consumer movement that led to reduced emigration for the first time. In 1971, the newly founded Irish Women's Liberation Movement published their first manifesto entitled *Chains or Change* with five key demands, "equal pay, equality before the law, equal education, access to contraception for the poor, and justice for deserted wives, unmarried mothers, and widows" (Mahon 2020: 3-4). Following a UN initiative to examine the status of women in Ireland, the first Commission on the Status of Women (1970-72) conducted research on barriers to women's participation in the labour force and presented recommendations on equality and equal pay for women in employment and proposed changes in family law and tax allowances aimed at gaining equality for women (Mahon 2020). The expansion of further education to women⁵⁷ meant that women were less compliant to Catholic social teachings (Cook, 2004, O'Leary 2012).

The reshaped sexual patterns that resulted from these social and legislative changes are evident in the dramatically changed demographic since the 1970s (Cook, 2004)⁵⁸. Yet Ireland still remained a very conservative, and sexually repressed society, exemplified by the failure to legalize abortion in 1983⁵⁹ (Irish Statute Book 1983) and divorce in 1986 (Irish Statute Book 1995)⁶⁰ and the 1988 Supreme Court ruling against the dissemination of abortion information⁶¹ (Murphy-Lawless 1998).

Single issue pressure groups emerged for the first time in the late 70s and early 80s, with the first Irish Association for Improvements in Maternity Services in Ireland (AIMSI) established in the late 1970s. Cuidiú, an Irish branch of the National Childbirth Trust, "a parent-to-parent

⁵⁶ Re-named the European Union (EU) in 1973.

⁵⁷ No free secondary education was not introduced until 1969. Following lobbying from the Commission on the Status of Women, founded in 1970 with the goal of gaining equality for women (Mahon 2020), a basic grant system for third level education was introduced in 1972. The number of girls accessing secondary and third level education dramatically increased (ESRI 1981). Between 1971 and 1981 the number of girls at secondary school increased by over 100 percent and the number at third level increased by 180 per cent (O'Connor 1998).

⁵⁸ Average completed family size fell dramatically from 12-14 children in 1971, to 2.2 in 1986 to 1.38 child in 2016 (ESRI 2017). The average age for having a baby, whether married or single, increased from 21 in 1970 to 31 years in 2012 to 32 in 2016 (ESRI 2017). In 2013, the largest proportion of births (36.7%) took place in the 30 – 34-year age group, while almost 6% of births were to mothers aged 40 years or greater (Healthcare Pricing Office 2014).

⁵⁹ Eighth Amendment of the Constitution Act, 1983, acknowledged the right to life of the unborn, with due regard to the equal right to life of the mother.

⁶⁰ Fifteenth Amendment of the Constitution Act, 1995. Provided for the dissolution of marriage in certain specified circumstances.

⁶¹ It was not until 1985 that the sale of condoms without prescription to over 18 years olds was legalised but even then it was through pharmacies and at the owner's discretion. Sterilisation through tubal ligations also became legalised from the mid-1980s (DOHC 2006), but availability was restricted by many hospital boards on religious grounds (The report on the Lourdes hospital inquiry into peripartum hysterectomy, DOHC 2006).

voluntary support charity” was established in 1983 to help new parents prepare for childbirth and parenthood (Cuidiú 2019).

Reflecting women’s status in society generally, during the 1970s and 80s, there continued to be an absence of collective solidarity and political activism among midwives, who remained in an inherently weakened position politically, and in the public consciousness. The legacy of the 1950s Health Act meant that in the 1985 Health Act, midwives were still subordinate to obstetricians and subsumed under nursing. Midwives made no attempt to delineate their unique role and responsibilities, or to negotiate jurisdiction over normal pregnancy and birth, and they were still without a professional organisation. By the 1980s, due to another economic downturn, many midwives were forced to emigrate to the UK, Australia and wider afield in search for work.

Right up to the 1990s gender inequality “remained a major barrier to human development” as evidenced by the United Nations Human Development Report (1995:75)⁶², but the momentum for Irish women’s agency and empowerment was slowly gathering pace as demonstrated by the passing of the divorce legislation in 1995⁶³ (Irish Statute Book 1995). The Freedom of Information Act introduced in 1997 (Irish Statute Book 1997), gave patients access to their medical records for the first time (DOH 1997). Public perception of women’s ‘appropriate’ position in Irish society was challenged in 1990, when Mary Robinson, a lawyer, was elected Ireland’s first woman president. In her inaugural address Robinson stated,

As a woman, I want women who have felt themselves outside history to be written back into history, in the words of Eavan Boland, “finding a voice where they found a vision”. (President of Ireland 1990).

Women’s economic contribution vastly increased from the 1970s through to the 1990s, where Ireland experienced unprecedented growth (McDaid et al 2009). This, along with more equitable access to contraception, give all women greater agency in matters concerning female reproduction (Cook, 2004, ESRI 2013). Yet, one area slow to change was the politics

⁶² The Human Development Index (HDI) is a statistical composite index of life expectancy, education, and per capita income indicators; when the lifespan education level of the gross national income GNI (PPP) per capita are higher, the country scores higher on the HDI. The Gender Inequality Index (GII) measures the human development costs of gender inequality for women in 159 countries. The human development Index (HDI) of women falls below those for men in every country, and the shortfall in the GI relative to the HDI reflects this inequality. The 2010 Human Development Report introduced an Inequality-adjusted Human Development Index (IHDI), that is a “measure of the average level of human development of people in a society once inequality is taken into account”. Ireland ranks 17th on the United Nations (1998) Human Development Index while it ranked 27th on Gender Development Index, a shortfall of 10 points, the largest difference among the top 25 countries. This shows the unequal opportunities that women face relative to men in the Irish context. In contrast, Canada and Norway rank the highest with no or only 1 point shortfall (United Nations UDR 1998: 75).

⁶³ Fifteenth Amendment of the Constitution Act, 1995. Provided for the dissolution of marriage in certain specified circumstances.

of pregnancy and birth (Murphy-Lawless 2014). As the following discussion on the establishment of Comhairle na nOspideal 1970-2004 elucidates, this was because the Irish maternity services was already under exclusive male obstetric authority and control.

8.3. Comhairle na nOspideal 1970-2004: Obstetric informed maternity care policy

The complete confidence among Irish politicians on the sole expertise of obstetricians, is evident with the establishment of Comhairle na nOspideal, under the Health Act, 1970 (No. 1 of 1970), with a statutory function to advise the Minister for Health on matters relating to the organisation and operation of hospital services (Comhairle na nOspideal 1976-1978). Weber suggests that an 'elective affinity' exists between the state and professional elites; a small, homogenous group of upper middle class, white men, to whom the state willingly handed over matters concerning maternity health (Willis 2006: 76). Successive political regimes and the obstetric profession, both like-minded elites, reinforced a system of patriarchal domination over poor women's bodies when it came to pregnancy and birth. In keeping with a technocracy, where deference is paid to those with perceived technical expertise, Irish government policy on maternity care was informed by obstetric dominated Comhairle na nOspideal right up to its dissolution in 2004 (Health Act 2004, Section 57-Irish Statute Book). From the outset, and without consultation with childbearing women or midwives, Comhairle na nOspideal recommended in favour of 100% hospital birth,⁶⁴ on largely unsubstantiated grounds of safety (Comhairle na nOspideal Report DOH 1976, 1981, 1997). This policy led to a sharp decline in domiciliary births from the 1950s (Barrington 2003, Kennedy 2002, Higgins 2007) from 33 per cent to less than 1% in 1999 (262 births) and just 0.2% (176 births) in 2012 (ESRI, 2013). As stated in chapter 5, district midwives and domiciliary births were now almost a thing of the past. By the 1990s, government maternity care policy reflected the general acceptance among obstetricians that access to hospital birth and birth technologies was the safest and modern way to give birth (Gray 2002).

But obstetric dominated government policy was not to end with the abolition of domiciliary services. The 1968 Fitzgerald Report (Fitzgerald Report 1970) confirmed that there was a total of 169 small hospitals in Ireland that provided a variety of midwifery services while only three hospitals, all in Dublin, had more than 300 beds. Both the Peel Report (DHSS UK 1970) that explored the future of domiciliary births in the UK, the Comhairle na nOspideal discussion document on the Development of Hospital Maternity Services (1976) agreed that it was safest for all births to take place in consultant-staffed maternity hospitals (ibid). This decision was not

⁶⁴ This decision was influenced by the Peel Report (1970) conducted in England and chaired by Sir John Peel, which recommended that facilities should be provided to allow 100% hospital delivery (Department of Health and Social Security, 1970). This was not evidenced-based but proved popular.

evidenced based. A births-per-consultant ratio of 1,000:1 was recommended to ensure that consultants maintain their expertise (O'Connor, 2001). Each bed was to accommodate three women per 24 hours in keeping with the industrial model of maternity care (ibid) The knock-on effect of this increased centralisation led to the closure of all 'small' maternity hospitals, defined as those with less than 1000 births per year. That was because these units could not financially sustain the employment of sufficient obstetricians and anaesthetists to ensure 24/7 obstetric and anaesthetic cover (O'Connor 2001). The percentage of births in maternity units considered to be too small to call for full time obstetrician cover fell from 19.8% in 1978 to 5.5% in 1993, a loss of a minimum of 90 maternity units since the 1970s (Kennedy 1998, Thompson, 2007). An opportunity by the Irish government to support and develop primary care midwife-led services as workable alternatives to closure of smaller consultant-led maternity units was lost. For the sake of comparison, as of September 2020, Northern Ireland with a population of 1.8 million, and 23,000 births per annum, has eight MLUs, five alongside midwifery units (AMU) and three freestanding Midwifery Units (FMU), here women with normal, low-risk pregnancies can access full midwifery-led care (DHSSPSNI 2020). Scotland, with a similar population to Ireland has 17 midwifery-led units (Health and Social Care Integration Directorate (DSCD) NI 2017). In Ireland, with a population of 4.9 million, and a birth rate of 59,796 in 2019 (CSO 2020), there are only two Midwifery led Units (MLUs) (Begley et al 2009). Obstetric dominated policy is also evident with the widespread introduction of the Active Management of Labour (AML) protocol, formally introduced into all obstetric units in Ireland by 1972. AML involved adherence to a uniform disciplined approach where consultant obstetricians became actively involved in *all* labour, regardless of risk (O'Driscoll & Meagher 1968). This, along with 100% hospital birth, extended the reach of obstetricians to the entire population of childbearing women and left no space for women's choice or the autonomous role of the midwife. 'The competition' was effectively subdued and the fate of the midwife was sealed.

How obstetricians conceptualise their role in the process of pregnancy and childbirth is evident in the following government publication, where alongside the unquestioned support for 100% hospital birth is the recommendation for 100% consultant involvement in antenatal clinics, reflecting an unquestioned support for the MICS and the combined-care scheme (Comhairle na nOspideal 1992).

"Antenatal care shared between the general practitioner and the obstetrical staff in the maternity hospital is a growing feature of the obstetric services in this country. It is the common practice for a patient to approach her own general practitioner for the initial visit early in pregnancy. She is then referred by him as soon as possible to the hospital clinic for a booking visit, at which she is seen [by] a consultant obstetrician, who arranges whatever investigations are required [and they] are undertaken at that stage. Thereafter, she is referred to the general practitioner for

continued antenatal care until later in pregnancy, when further attendance at the consultant clinic is often desirable” (Comhairle na nOspideal 1992: 26).

The discussion document also recommended that

“Antenatal clinics should be conducted regularly, by consultants from the main maternity unit [and that] it is of the greatest importance that the holding of such consultant clinics should be a prominent feature of a re-organised system of obstetric care (Comhairle na nOspideal 1992:13).

The bureaucratic, time constrained, throughput nature of antenatal care is also detailed in the document

“In present day practice one consultant would see four first visits or ten to twelve follow up visits in one hour [...] [so, if] hospital was providing the bulk of antenatal care, in a 2,000 delivery there would be 400 antenatal patients visiting per week in the hospital. [...] in any event, there would be approximately 40 first visits per week to the hospital clinics.” (Comhairle na nOspideal 1992: 26).

The continued assumption is that consultant-led hospital care during the antenatal period, should the need arise, equates to safety. Thus, hospital admission in the antenatal period was normalised.

“a generous proportion of antenatal beds is essential and skimping on these could have immediate consequences in terms of perinatal mortality and morbidity” (pg. 25).

This is despite the conclusion from the first review of the MICS conducted in 1980 (DOH 1981), that there was no statistical relationship between the take up of the Scheme and a reduction in the perinatal mortality rate (Kennedy 1998). The power and influence of obstetric dominated Comhairle na nOspideal in monopolising government maternity care policy is evident in the National health policy framework for Ireland during this period, that omit any reference to the maternity services from their publications (DOH 1994, DOHC 2001, McDaid et al 2009).

Finally, the discussion document recommended continuance of the Mastership system of governance for the three Dublin voluntary hospitals.⁶⁵ Established some 240 years ago, the male hierarchical Mastership system predates Irish independence from Britain and its origins are steeped in women’s subordination and control of poor women’s bodies (Hynan 2019 unpublished paper). The Mastership combines the roles of Chief Executive Officer (CEO) and Lead Consultant Obstetrician and Gynaecologist, with overall corporate and clinical responsibility (DOH 2016: 102), along with the Board of Governors, traditionally made up of doctors and clergy (Browne 1995). The preservation of the Mastership system of governance

⁶⁵ The Master, usually an obstetrician, is both a Chief Executive Officer (CEO) and a practising clinician at that institution and is appointed for a 7-year period (KPMG 2008).

perpetuates patriarchal and hierarchical organisational structures and ensures their uncontested influence on both clinical and managerial decision-making at all levels of maternity care, from the individual woman, hospital policy at local level and maternity policy at national level.

The cumulative impact of the shift from public dispensary doctors to private GP practice, the push for 100 percent consultant-led hospital birth, the initiatives to close small maternity units, and the development of the active management of labour (AML) policy in Dublin, all testify to the increasing entrenchment of the technocratic biomedical model during the 1970s and beyond. The Irish state acted in collaboration with the obstetric elites⁶⁶ to legitimise medical hegemony and by doing so perpetuated the subordination of women and the patriarchal hierarchical ideology and the vested interests of the obstetric profession (Mander and Murphy-Lawless 2013). The role of the concept of women-centred care, as a change agent in maternity care is now discussed.

8.4. The rhetoric of women-centred care and maternity care reform

By the 1970s the majority of childbearing women and midwives had bought into the biomedical model as the only way of doing pregnancy and birth. Yet a minority, but growing group of birth activists, motivated into action through their less than satisfying and often dehumanizing experience of pregnancy and birth, began to question the taken for granted norms, asymmetrical power-relations and social constraints that underpinned maternity care (Goer 2004). A woman-centred approach, that provides services that are service-user orientated, responsive to the woman's needs and crucially, are in the best interests of the woman, took centre stage in the drive for maternity care reform in Ireland (DOHC 1970, 1997, Kinder 2001, KPMG 2008, Begley et al, 2009). The fact that activists needed to advocate for woman-centred care in a modern maternity service, that is for and delivered by women, is shocking, and suggests that it is under threat. Originally proposed as a workable alternative to the biomedical technocratic approach to maternity care, woman centred care is recognised nationally and internationally as central to providing a quality and safe maternity service (NMBI 2014, Renfrew et al 2014, WHO 2016), and led the campaign to re-humanising maternity services (Wagner

⁶⁶ I think it is important to distinguish between the obstetric elite, who collaborated with government decision makers to shape the maternity services and obstetricians who focused less on actively shaping the maternity services and more on their daily practices. While it is feasible to think that elite obstetricians may have had the women's and babies' welfare in mind at the onset of state-run maternity care, why they continued to advocate for 100% consultant-led maternity care despite evidence that it was not delivering on safety, despite evidence for alternative models and despite demands from women for alternative models cannot be explained other than in terms of a need to protect their vested interests.

2001). The seminal report *Changing Childbirth* [England and Wales], operationalised woman-centred care in terms of the three c's, choice, control, and continuity (DOH England 1993).

As early as the 1970s there was an acknowledgement on the part of the Irish Government that a mismatch existed between maternity services provision and what Irish women actually wanted. In Section 58 of the Health Act 1970, the Irish government acknowledged that models of maternity care were changing, and that the health system had to be seen to be responding to women's increasing demand for choice about type of care and place of birth. Government policy documents acknowledged that women wanted "a maternity service that was safe, accountable, woman-centred, and equitable across different parts of the country and accessible to all" (DOH 1970: pg.7), while simultaneously recommended in favour of 100% consultant-led antenatal care and hospital birth (DOH 1970, 1976, Comhairle na nOspideal 1976, 1993, DOH 1981, 1997). Both incompatible views coexisted, representing the growing incongruence between what a growing number of childbearing women wanted compared to what obstetric informed politicians were providing. The continued recommendation for 100% consultant-led care, along with the widespread adoption of the active management of labour into daily practices, meant that the concept of woman-centred care was alien to Irish obstetrical thinking (Gray 2002). Importantly, government maternity policy decision makers never really listened to or acknowledged women's lived realities. They focused on woman-centred care as an ideal, buying into what was now mainstream rhetoric, while neglecting to focus on how this could be achieved in practice. They failed to engage in meaningful discussion on what changes would be required in the current biomedical system to make these woman-centred changes successful. The concept of continuity and continuity of care models were noticeably absent from government rhetoric.

Right up to the 1990s the Maternity and Infant Care Scheme Review Group (The McQuillan Report 1994 published in 1997) continued to fully endorse consultant-led services while simultaneously recognising women's desire for choice of place of confinement and acknowledging that "the mother's voice is sometimes lost in the organised hospital situation." (DOHC 1997). A plan for women's health (1997-99) which followed, set down the principles for the development of women's services, saying "women want our health service to be more open to consultation, involvement, respect, empowerment and choice" (DOHC 1999) but an interrogation of what woman centred care really meant or how it would be achieved within the current biomedical model of care was still missing from government thinking. The links between rhetorical policy and actual practice was never made or remains underdeveloped.

The Report of the Commission on Nursing (Carroll 1998) was established to avert industrial action of the Irish Nursing Union (INO), due to the growing dissatisfaction concerning pay, career and working conditions among nurses and midwives. The Report encourages submissions from birth activist groups, professional bodies, and the public. The strike (October

1999) did eventually go ahead as the government did not agree on pay related recommendation (Doran: Forward in Loughrey 2019). The Commission however was important for midwives as it endorsed the 1980 EEC Midwifery Directive that recognised midwifery as a separate profession from nursing and proposed the introduction of direct entry midwifery education at undergraduate level, change to legislation that would include midwifery in the health act and professional bodies, and also recognised the incongruity between consultant-led hospital setting and women-centeredness and recognised the link between developing woman-centred services and developing midwife continuity services in the community setting. During the same year that the Commission on Nursing was published, a national conference (1998) entitled 'Mother and Child 2000' gathered a broad coalition of practising midwives, childbirth activists and academics to urge policymakers to promote woman-centred care (Kennedy and Murphy-Lawless 1998). A key demand of the conference was that the report of the 'Maternity and Infant Care Scheme Review Group', completed by the Department of Health in 1994 but not published would be published without further delay. The report when finally published, (also referred to as the McQuillan Report) (DOH 1994 published 1997), did not waver however, in its dodged commitment to consultant-led care for all women, while recognising that arrangements must be made to cater for those who insist on accessing alternative care pathways (DOH 1994 published 1997).

If we want to learn whether elite groups valued woman-centred care, instead of exploring what they say they value, we need to explore what they actual do. In this way the values that underlie their behaviours are laid bare. This reflects the difference between espoused values (what people purport to believe) and values in use (actual behaviour) (De Caluwe et al 2003). Whether these incongruities between women-centred care and the current biomedical model were given any thoughtful consideration among the hegemonic elite is unlikely. As we can see from this critique of government policy and legislation, the only real choices available to childbearing women continued to be dictated by the obstetric profession and supported unconditionally by government ministers who continued to be deferent to their esteemed medical colleague's. Despite the rhetoric of women-centred care entering mainstream and being referred to in successive government policy documents (DOH 1970, 1976, 1993 and 1994), obstetric dominated maternity care became even more entrenched in practice. This is exemplified by the extension of the policy of consultant-led hospital birth to the closure of all rural maternity units, further limiting choice options for women. The policy of woman-centred care was never enacted and its impact on practice therefore remained limited. Ironically, the rhetoric of woman-centred care that dominated successive government policies, both in Ireland and elsewhere, stems from the fact that the bureaucratic, biomedical model mitigates against

woman-centred care, that bureaucratic institutions, by their very nature, are institutional centred and not woman-centred.

It was not until the late 90s that a tipping point of sorts was reached, and the first woman-centred midwife-led initiatives were rolled out in practice (see chapter 9). But the level of continuity provided in these schemes varied. It was only when the Kinder Report (2001) was published, that the blueprint for a truly woman-centred model of maternity care was agreed and acted upon. The Kinder report, which recommended the establishment of the two midwife-led units in the North-eastern Regional Health Board (NERB), not only emphasised the need to provide “a woman-centred, quality service which is safe, accessible and sustainable” but found a meaningful way to incorporate the views of women in the planning, development, and delivery of the service (see chapter 9, Section 9.6 for more on MLUs).

Despite these initiatives (DOHC 1997, Kinder 2001), a review of maternity and gynaecology services in the Dublin area in 2004 revealed that ‘no participant [...] thought that the maternity services were women-centred at the time’ (Women’s Health Council, 2007). Similarly, Breda Kearns, Vice Chair, AIMSI, speaking of the Irish maternity service in 2017, stated that “options of care and birth choices remain a postcode lottery (Houses of the Oireachtas 2017a). The role of the concept of individual choice, inextricably linked to the concept of woman-centred care, as a change agent to drive maternity care reform is now discussed.

8.5. The rhetoric of choice and maternity care reform

Since the 1990s, individual choice, associated with the rise of the consumer movement and embedded in the idea of ‘value free’ choice and individual freedom (Symon 2006) was becoming a growing philosophy in maternity care in the UK (Johanson et al 2002), hence the emphasises that childbearing women should have choice, continuity and control (DOH England 1993). Having choices has generally been lauded in maternity care and is thought to impact positively on women’s experiences (DOHC 1997, Kinder 2001, KPMG 2008, Begley et al, 2009). This is because the belief in having and making choices increases an individuals’ sense of control and autonomy (ibid).

Given the growing conflation of women-centred care with individual choice, it is important to understand its origins in the emergence of Western forms of liberal⁶⁷ government (Hindess (2001) and as the reconstituted ‘autonomous subject’ freed from traditional societal constraints. Just as the need to advocate for woman-centred maternity care is evidence of it

⁶⁷ Liberalism is commonly thought to be based on the principle that prioritises the maintenance of individual liberty as an end in itself (Hindess 2001). This principle sets the parameters for the role of government and the type of government that will be acceptable (ibid). In contrast, Foucault sees liberalism as ‘a distinct form of political reasoning’ that ‘obeys the rule of maximum economy’ (Hindess 2001:93).

being under threat in modern day institutions, so too, the need to protect individual freedom is evidence of it being under threat in modern day institutions. In the words of Foucault, that 'one might be governing too much' (Hindess 2001: 93). Within institutions, individual choice is always subjugated to the needs of the institution.

The idea of 'free choice' in maternity care, therefore, should be viewed as problematic to drive maternity care reform, given the workings of institutions, the dictates of the scientific paradigm and the strict limits placed on childbearing women's choices within the maternity services (Edwards 2004, AIMS 2010). Many argue that the idea of choice in maternity care is merely an illusion perpetrated by the powerful as a strategy to control the ruled (Jomeen 2012, Symon 2016). That the myth of having free choice promotes conformity, docility, and obedience among childbearing women and facilitates being ruled without any observable coercion from the rulers. For individual choice to become a reality in practice, would require a dismantling of the bureaucratic institutional maternity care system, which mitigates against individual choice.

Also, because choice discourse is a tool of the powerful, it is vulnerable to abuse by those with power and privilege in order to perpetuate the biomedical model. An example is obstetricians justifying non-medically indicated, elective caesarean sections on the ground of patient request. What follows is a discussion on the role of legislation in driving maternity care reform.

8.6. Legislation and maternity care reform

A critical analysis of court judgements and the limitations of the judicial process to drive maternity services reform will now be discussed. I argue that the combination of the unrivalled hegemony of medical authoritative knowledge that is accepted unconditionally by the judiciary, plus the proliferation of the risk and safety discourses, are central to the legal debates around choice of home birth that informed the rulings made in the courts at this time.

In the *Spruyt and Wates v Southern Health Board* legal case in 1988, the question of whether the domiciliary midwifery services should be provided through a general practitioner or through a midwife was raised. The judge ruled that there was a statutory obligation under Section 62 of the Health Act 1970, to provide women with community midwifery care, and the applicants should be indemnified against costs incurred. However, instead of enacting legislation that acknowledged the autonomous role of the midwife in facilitating domiciliary births, the judge, in keeping with the MICS legislation, and therefore being tautological in its effect, proposed that the services could be provided for by the family doctors. Given the GPs lack of indemnity cover, lack of competence in home birth and lack of interest in providing this service, this was always going to be a non-started. Again, in the 1999 *Maguire v South Eastern Health Board* legal case, the judge found against the plaintiff Ms Maguire, who was expecting her 6th child and who was refused the option to have a home birth on the grounds that the Health Board

had a policy that all births should take place in a properly equipped and staffed maternity unit, reiterating obstetric dogma, and again reinforcing the status quo.

A judgement delivered in November 2003 by Mr. Justice Geoghegan, the case of O'Brien v South Western Area Health Board found that despite Section 62 of the Health Act, 1970⁶⁸ that replaces almost verbatim section 16 of the Health Act, 1953, there was no statutory obligation on the HSE to provide for a home birth service. He found that the obligation to provide access to free maternity care would be fully complied with by the provision of medical, surgical and midwifery services within the confines of a hospital. According to the judge, section 62 of the Health Act, 1970, does not lay down a national prescription, as to how these services are to be provided. Therefore, the decision whether to provide home birth is not down to the woman's preference, but down to individual health boards. The risk averse discourse that supports hospital birth as the safest place to birth, that underlies obstetric thinking is evidenced here.

"The policy of the East Coast Area Health Board has been set out in the affidavit of Dr. Brian Redahan who is general manager of that area health board. He has stated that within the functional area of that board there are comprehensive medical, surgical and midwifery services available for expectant mothers and their unborn children. He explains that the view of his board is that consultant staff maternity units are considered to be the safest environment for deliveries, especially in case of the many complications that can arise. Dr. Redahan goes on to assert that even if Ms. Brannick's construction of section 2 was accepted, the domiciliary services claimed could only be provided on behalf of the board by registered medical practitioners who had contracts with the respondent for the provision of such service and he goes on to say that there are no medical practitioners in the functional area who have entered into such contracts"

(Mr. Justice Geoghegan the case of O'Brien v South-western Area Health Board).

Another case taken by Aja Teehan in 2013, seeking an order to compel the HSE to grant her application for a home birth after a caesarean (HBAC) was also rejected. She alleged that the HSE operates a very restrictive inclusion criteria for eligibility for home birth, and that this is applied across the board and not on an individual assessment basis. This means that she

⁶⁸ "62. (1) A health board shall make available without charge medical, surgical and midwifery services for attendance to the health, in respect of motherhood, of women who are persons with full eligibility or persons with limited eligibility.

62 (2) A woman entitled to receive medical services under this section may choose to receive them from any registered medical practitioner who has entered into an agreement with the health board for the provision of those services and who is willing to accept her as a patient.

62 (3) When a woman avails herself of services under this section for a confinement taking place otherwise than in a hospital or maternity home, the health board shall provide without charge obstetrical requisites to such extent as may be specified by regulations made by the Minister."

cannot have her baby at home, as a midwife will not get State's Clinical Indemnity cover to attend. Similar to previous cases, the judge's ruling centred on perceived safety and risk, as defined not by the woman but by the medical profession. Matthias Kelly SC, for Ms Teehan, told Ms Justice O'Malley his client was trying to minimise the risk for herself by requesting a home birth (McGreevy 2013). Ms Justice Iseult O'Malley rejected her application on the grounds that it would be **"manifest irrationality"** for the courts to change the criteria for home births as set out by the HSE (McGreevy 2013). According to Ms Justice Iseult O'Malley, this amounted to compelling the HSE "to accept liability for a risk that it does not believe is justifiable" (O'Malley 2013). The risk referred to is the possible risk of uterine rupture following a previous caesarean section, which is low (Turner et al 2006). She concluded that the criteria for eligibility for home birth was not a judicial decision but a "clinical decision, based on assessment of the risks involved" (ibid). Paul Anthony McDermott, for the HSE, also defended the HSE decision not to permit Ms. Teehan to have a HBAC on the grounds that **"the policy was rational and based on medical evidence"** (McGreevy 2013). It is worth noting that while not commonplace, the practice of homebirth after a caesarean section (HBACS) is increasing in other jurisdictions such as the US (MacDorman et al 2012) and the UK (Chamberlain et al 1993). As it stands, women relying on the publicly funded homebirth service currently have no access to HBACS. Women who can afford it, can avail of the services of a private midwifery company, UK Birth Centres/Neighbourhood Midwives, who have clinical indemnity to offer HBAC as an option to women in a few locations in Ireland (HBA 2015). Again here, women who have an alternative to the medical view of what constitutes risk are cast as irrational. There is a heavy personal and financial cost in terms of the stress involved and legal fees, for the women who take these cases to court, with little success as we have seen. The limitations of legislative reform, that does not have the backing of the dominant hegemonic groups, to impact meaningful changes in the maternity services is evident here. The biomedical paradigm, with the backing of obstetric authoritative knowledge that is presented as the truth, is reiterated by the judiciary, and so the biomedical system is sustained and reproduced. While childbearing women, 'appeared' to have a statutory right to a domiciliary birth, GPs and not expectant women or midwives were the gatekeepers for accessing domiciliary birth and obstetric approval was required. In a letter sent to the CEOs (Chief Executive Officers) of the Health Boards in 1996 to consider the issue of domiciliary births, the Department of Health policy is clearly stated,

Although the policy of the Department is that births should take place in consultant-staffed maternity units, a small number of mothers insist on having a home birth. There is a statutory entitlement to assistance from the health board, but it is difficult in practice to meet this requirement [...] The Ombudsman has recently taken an interest in this area. He stresses that the statutory duty must be implemented, but,

in view of the practical problems and the proposed pilot schemes, he is prepared to accept the current ex-gratia approach (provided it is implemented consistently in all boards) as an interim solution. [my emphasis] (EHB 1997:3)

In effect, the State could not stop women from exercising their right to have a home birth, should they desire one, but neither did they have any statutory obligation to help women exercise that right. The Ombudsman put the Department of health under pressure to act on providing for women's statutory entitlement for home birth. Home birth was to be made available only when women could 'not be persuaded otherwise' (Maternity and Infant Care Scheme Review Group DOH 1997). The midwifery pilot schemes were presented as a possible solution to this problem but ended up being tokenistic at best. Later high court rulings removed the statutory right to a home birth altogether and instead left it to the discretion of the health authorities. It appears that when an individual woman goes to court to contest her rights as a citizen, she is in effect taking on the patriarchal system, that works to protect the vested interests of the hegemonic elite and maintain the status quo. In the opposite scenario, where the aim of legislation is to operate constraints on the individual, as in the case of legislation illegalising abortion (the 8th amendment to the Irish Constitution) government intentions are more explicit and more enforceable. Legislation works well when its intentions are punitive or restrictive but not to ensure gender based equalities and individual freedoms.

No legislative changes were made to the combined-care scheme guaranteeing women's access to a midwife during the antenatal period and during a homebirth. The autonomous role of the midwife was not recognised. Neither were GPs and obstetricians legally obliged to collaborate with midwives to support homebirth requests or to attend a homebirth if required (DOH 1970, 1994). Instead, midwives' status as subservient to doctors went unchallenged and midwives' work continued to be under the control of the medical profession. GPs could and did refuse to accept women requesting domiciliary birth under the combined-care scheme and refused to provide back-up without being held to account. A genuine spirit of compromise and collaboration in support of women's choice to birth at home was not forthcoming from the legal profession, the medical profession or from the voluntary hospital institutions, who refused to extend practising rights at hospitals to privately practising midwives (Oboyle 2009). For the small minority of GPs who were experienced and competent with supporting homebirth services, indemnity insurance restrictions imposed on homebirth services meant that the choice to support women requesting homebirth was removed. Indemnity insurance restrictions were also mentioned in the primary data generation for this study.

GP1: ...even if I wanted to participate in homebirth, which I don't, GP indemnity insurance does not cover it

Obstetricians' views could be summarised as follows

HD2 I would tell you that most obstetricians would not be philosophically well disposed to homebirth, some are but many are not.

While the majority of childbearing women, influenced by the risk agenda, were socialised into believing that homebirth was too risky, for those who wanted a homebirth, the choice did not rest with the pregnant woman and her family as autonomous subjects, informed or otherwise, but with the unrivalled hegemony of the perceived 'medical experts whose opinions were accepted unconditionally by the judiciary and by multinational insurance companies, against a background of the proliferation of the risk and safety agenda. This amounted to patronising assumptions of the ruling elite, regarding what was best for women and their families, in what continued to be highly conservative patriarchal society. It is worth noting that the commonly held assumption, that hospital births were safer for low risk women was later proven to be incorrect (Brocklehurst et al. 2011).

8.7. Conclusion

The purpose of this chapter was to explore entrenchment and change in the Irish maternity services by reviewing government maternity care policy documents and legislation from the years 1970s to 2010. Throughout the 1970s and beyond, while women gradually acquired increased legal and economic rights and more control over fertility, when it came to the politics of pregnancy and birth, there was still a long way to go. The continued subjugation of women in Ireland is evidenced by the sustained absence of solidarity and political activism among midwives during the 1970s and 80s. Despite international development in Midwifery, midwives in Ireland remained without a professional organisation right up to the mid-1990s, leaving them in an inherently weakened position politically, and in the public consciousness. Evidence of a continuation and perpetuation of power-relations and vested interests embedded in the MICS (1953) in maternity care policy and practices right up to the 2010 is demonstrated. Despite the rhetoric of women-centred care and individual choice entering mainstream and dominating successive government policy documents (DOH 1970, 1976, 1993 and 1994), it is clear from the discussion above that these concepts are problematic for driving maternity care reform, given their emphasis is evidence of them being under threat in the current institutional setting. There is also a notable absence of the concept of continuity of care in government documents during this time period. The idea of 'free choice' in maternity care is also problematic, given the choices are extremely limited if not non-existent in the current hierarchical system. It has also been demonstrated that both discourses are vulnerable to being reconstituted by the dominant group to sustain and perpetuate their dominance. Using these discourses to drive maternity care reform, therefore, have major limitations and are unlikely to succeed.

The limitations of legislative reform, that does not have the backing of the dominant hegemonic groups, to impact women's choice when it comes to place of birth, is also demonstrated here. Medical hegemony was such that Irish obstetrics, not alone remained a 'traditionally' unchallenged site of power from the foundation of the state onwards, but right up to the 1970s and beyond, where obstetrics knowledge and expertise continued to single-handedly drive maternity care policy. This is because the Irish establishment; politicians, legislators and

lawyers, the majority male, placed complete confidence on the sole expertise of obstetricians, in all matters concerning the maternity services. This amounts to gender politics of knowledge and expertise, where women's voices and everyday realities were silenced or trivialised. Despite the rhetoric of woman-centred care and individual choice dominating maternity care policy, obstetricians remained firmly in control and continued to ensure the biomedical entrenchment of maternity care. Further critique of government maternity care policy with a review of The first National Maternity Strategy 2016-2026, Creating a Better Future Together (DOH 2016) (chapter 10) and Sláintecare Report (Houses of the Oireachtas 2017b) (Chapter 9) will reveal whether obstetricians continue to remain firmly in control of maternity policy up to the present day. First, I will review the role of midwives and birth activists in implementing change in the maternity services.

9. Chapter Nine Drivers for change and the change process in complex systems

9.1. Introduction

Maternity systems fit the definition of complex systems; one in which there are many components and high interrelatedness between the large numbers of components (Kannampallil et al 2010). Because of the complex, multi-layered, and inter-relational nature of the maternity services I argue that change is not linear or rational but may have multiple drivers and its effect is unpredictable with often unintended consequences. Meaningful change in institutional culture requires disruption of the status quo and taken for granted social norms (Barry and Dalton 2018). In institutions, the norm is to favour the institutional needs over individual needs and to value the traditionally male obstetrician's role over the midwife's role and where the childbearing woman is at the bottom of the hierarchy. For Foucault, institutional social norms are created and maintained through the disciplining power of repetitive actions and interactions in state institutions (Foucault 1975). These repetitive actions and discourses embody and define what is normal, acceptable and deviant (ibid.). Disruption of the status quo depends, therefore, on our capacity to recognise and question socialised norms and constraints. In maternity care this means unmasking and making explicit how power works in institutions. Murphy-Lawless proposes that meaningful change in the maternity services requires radical changes in the philosophy and organisation of care. It requires radical change in 'the fundamental assumptions that inform current ways of working' (Murphy-Lawless 2013:18). Radical change requires genuine political action where "politics is by nature active and disruptive" (Yarbrough 2012: 28). Wolin (1994) considers genuine political action as a rare occurrence, when despite asymmetrical power relations, diverse interests came together to address common concerns for the betterment of society" (Wolin 1994:28). As Bauman (2016) succinctly puts it in an interview for *El País*, real dialogue is not about talking to people who believe the same things as you. But genuine political action is not just a coming together of interested and disparate parties but requires 'disruption of the hegemony of the established system' (Yarbrough 2012: 28). Changes in institutional culture therefore, "must be grounded in changes of the status, authority, recruitment and institutional hegemony of the intellectual class" (Chaney 2012:5). This always involves a loss of gained entitlements (Barry and Dalton 2018) where power, rights and privileges are no longer automatic (Kaufman 2011). So, depending on where you are situated within the institution, change can be considered as a threat or an opportunity. A 'whole-system-change' approach is a critical feature of successful change management in complex systems (Datée and Barlow, 2010, Barry and Norton 2018). The purpose of the chapter is to explore whether changes to the maternity services that came about since the late 1980s, constituted moments of genuine political action or were merely exercises in diplomacy and appeasement. These changes include the introduction of the

practice nurse/midwife in 1989, the establishment of the first Midwifery Association of Ireland in 1995, the midwife-led community initiatives in the 1990s and the proposal to develop primary care in 2000. Other changes in the maternity services included the setting up of the first Midwife-Led Units (MLU) established in 2003, and the introduction of the HSE National Homebirth Service in 2008. Change drivers and change processes will also be explored, along with legislative changes that affect midwifery's professional status, education, identity and scope of practice. Whether the introduction of the practice nurse/midwife in 1989, represents real political change will now be critically analysed.

9.2. Practice Nurse/Midwife

The 1970s Health Act heralded the demise of the dispensary nurse and the district midwife. By the end of the 1980s, few self-employed community midwives remained (Kennedy 2002)⁶⁹. This deficit of district nurse/midwives drove the demand for practice nurses (who were also midwives) to help in GP practices. Primarily economically driven, the practice nurse (PN) was introduced in 1989 (DOH Circular 5/1989) to address the heavy workload and the shortage of GPs following privatisation. Employing PNs (midwives) made economic sense as a cost-saving measure, as PN's work presented a cheaper alternative to GPs' higher paid salaries, while also offering workload advantage. PNs were now to become private-employees of general practitioners as opposed to state-employees, further supporting doctor's private practice, a key principle of the 1953 Health Act and underpinning the 1954 MICS. Self-employed Irish GPs were already receiving financial incentives from the HSE to provide antenatal care.

Circular 47/2002 Part II paragraph 4 states:

"The medical practitioner shall provide the services in person except where he is unable or has a good reason to do so. In such a case he shall, with the agreement (except in case of urgency) of the woman or a parent of the child, as the case may be, arrange for another registered medical practitioner to attend to provide the services. The Health Board will not be responsible for any payment to the latter practitioner"

Under the General Medical Services Payment Board (usually referred to as GMS Scheme) (see section 6.3), a subsidy was made available to GPs towards the cost of employing a practice secretary and a practice nurse, the latter needed to be registered on the General Nurses Division of the register (DOH Circular 5/89).

They were now to receive a subsidy, commonly referred to as 'the grant' towards the cost of employing a practice nurse. In contrast, in the UK the Practice Nurse was state employed and

⁶⁹ In 1955 there were 20,665 domiciliary births out of a total of 61,622 which was 33.5%, but by 1980 there were just 0.3 %, with only 202 births out of 74,064 (Kennedy 2002 citing Central Statistics Office data).

dates from the 1960s, when the role received significant government financial support and development (Cartright & Scott 1961) and expanded in the 1990s, with the introduction of the 'internal market' (Duncan & Hayes 2017). Among GPs at a local level, there was no questioning of midwives' competence in providing antenatal clinics. As one GP in this study summarised it,

GP2: but if you look at what is the norm, it is the norm for practice nurse who is trained in midwifery to do antenatal checks, it's part of her level of competence, and she's doing it regularly enough and she's keeping up to date.

Many Irish GPs delegated antenatal care, that they were contracted by the HSE to provide under the Maternity and Infant Scheme Contract (DOH 1970), to the practice nurse.

Another issue was indemnity insurance. GPs are not covered under the state's Clinical Indemnity Scheme and must obtain their own private medical indemnity insurance, at an average cost of €3800 per GP per annum in 2006 (Medisec Ireland, 2007). Therefore, privately employed practice nurses (midwives) are not automatically indemnified by their employer through the principle of vicarious liability. All midwives, if not covered by their employers' indemnity insurance, must have individual, appropriate and adequate indemnity for their own practice (INMO 2009, RCM 2012), which can be cost prohibitive and means they are economically dependent on being covered under their employers' indemnity insurance cover. Regarding the type of cover offered, both the Medical Defence Union (MDU) and Medisec differentiate between a practice nurse and a nurse practitioner/midwife, where employees of GP members are indemnified when conducting basic antenatal care including weight measuring, blood pressure and urinalysis but are not indemnified when undertaking assessment of fetal growth, presentation or viability.

Work carried out by the practice nurse/midwife, as an employee of the GP, requires overseeing by the GP. This is a delegated role where the power and overall responsibility stays with the person doing the delegating. On the other hand, work involving extended roles involving autonomous practice, such as that carried out by the nurse practitioner or autonomous midwife is not automatically covered by their employer's insurance through the principle of vicarious liability. GPs are either unwilling, due to financial incentives or unable due to government legislation, to relinquish full control and accountability to the midwife. Drawing on the definition of the role of the midwife and despite her/his qualification, a midwife working in a GP practice required GPs permission in order to carry out that "for which she is educated for and is competent and authorised to perform" (NMBI 2014). Midwives in the practice setting context do not have control over midwives' work. They neither have the authority to practise as midwives in their own right, nor do they have control over their scope of practice. Rather, this is very much dictated by the terms of their indemnity insurance cover. Decisions regarding cost

of cover for midwives in the practice setting and terms of that cover are in turn influenced by obstetricians who act as expert risk and safety advisers to multinational insurance companies. Another blow to the autonomous role of midwives practising antenatally came with the exclusion of Direct Entry Midwives (DEM) to the role of Practice Nurse. Because the setting up of the Practice Nurse Subsidy pre-dates Direct-Entry Midwifery training, DEMs are not recognised under the scheme, preventing them from applying for such a position. An answer to a Parliamentary Question submitted by T.D. Roisin Shortall, dated February 2021 seeking clarity on this anomaly confirmed that there are no plans to amend the eligibility criteria for the payment of the practice nurse subsidy (PQ 630 Question Reference(s): 5089/21). So not only is midwives' work curtailed but some midwives are also excluded from working as PNs. The long tradition of the Irish state discriminating against midwives while supporting private medical practice is evident here.

If meaningful change in institutional culture requires disruption of the status quo and taken for granted social norms, there is no evidence of this happening here. There is, also, no attempt to unmask and make explicit how power works in institutions. The status of midwives as subsidiaries to doctors in the Irish Health Service did not change with the introduction of the Practice Nurse/Midwife. In the following paragraph, the impact of the first ever Midwifery Association of Ireland (MAI) in driving maternity care reform will be discussed.

9.3. Birth activist groups and the MAI

The momentum for change in women's status and role in society gathered pace in the 1990s. Women's rights groups became more vocal and more organised (Akrich et al 2014). Birth activist groups made up of lay people such as *The Association of Improvement in Maternity Services in Ireland* (AIMSI) and *Cuidiú* (like the National Childbirth Trust UK), increasingly began to challenge the dominance of the medical paradigm in maternity care (Akrich et al 2014). In the UK at this time, midwives and childbearing women joined forces in a formidable alliance to lobby government policy makers for improvement in maternity care (Expert Maternity Group. Changing Childbirth DOH 1993). The first attempt at generating professional solidarity among midwives in Ireland came with the establishment of the Midwifery Association of Ireland (MAI) in Cork in 1995.⁷⁰ The aim of the MAI was to give an independent voice to midwives' concerns about the lack of autonomy in midwifery and the lack of recognition of their contribution to the maternity services (Birmingham 1995). Submissions were made by the MAI to the Commission on Nursing, along with submission from the midwives branch of the INO and birth activists. Concern was also raised by the MAI about increasing intervention in

⁷⁰ Many of the founding members were members of the Irish Nurses Organisation (INO) and were frustrated by the lack of INO midwifery representation and support for midwifery to be recognised as a distinct profession from that of nursing (Birmingham 1995).

childbirth (ibid). While membership was small, the association actively represented the profession in local, regional, and national issues. They called on the Commission on Nursing (1998) to recognise midwifery as an entity distinct from nursing, campaigning for change in legislation to the Nurses' Act to recognise midwifery as distinct from nursing (NMBI 2011). They also campaigned for the introduction of direct-entry midwifery education programmes. The Commission on Nursing duly reported that "many midwives [...] expressed the view that midwifery practice had become increasingly constrained in recent years and those midwives were becoming deskilled in the provision of maternity services" (DOH 1998 Paragraph 10). The report endorsed the MAI's and EEC Midwifery Directive (80/155/EEC) that promoted the midwife as an autonomous practitioner, prompting the call for direct-entry midwifery education programmes, the amendment of the Nurses Act 1998 to include midwives, and an acknowledgement on the part of the government of the importance of midwifery in the development of women-centred community maternity services. Following the Commission on Nursing (1998) Report direct-entry midwifery educational programmes were introduced in 2006, along with the establishment of the Midwives Committee of the Irish Nursing Board (An Bord Altranais 2006). It appeared that the change in the status of midwives as distinct from nursing was at last being recognised, and this required meaningful political action and disruption of the status quo. Yet, while moving in the right direction, the status of midwives as subsidiaries to doctors in the Irish Health Service was not subjected to change and legislation to support the implementation of the distinct role of the midwife was not forthcoming. No changes were made to the MICS. Despite their initial successes, the MAI disbanded in 2009 due to work and family commitments of its core membership⁷¹.

The MAI was re-established in Dublin in 2016 by a group of newly qualified midwives, who like their predecessors, are committed to keeping midwifery issues of concern on the political agenda and ensuring appropriate and effective midwifery representation at local and national level (Webster personal correspondence 2020). Strategies used include organising conferences and focus group workshops, disseminating research, releasing mission statements on topics of concern, and making submissions on the part of their members to relevant regulatory bodies and members of the political establishment, producing a quarterly newsletter and providing an online discussion forum offering support and a sense of community to its members. In 2019, they released their first political manifesto to inform candidates running for the national election of their key political concerns.

⁷¹ Activism for change is demanding work that requires time and commitment from a substantial number of dedicated individuals and is not sustainable if left to a small group of individuals, no matter how committed.

A discussion on whether the implementation of the first community midwife-led initiative and government policy towards the development of primary care represented meaningful political action that disrupted the status quo and the hegemony of those in power will now be discussed.

9.4. Community midwifery led initiatives: 1990-2010

A review of domiciliary midwifery practice between 1993-1997 revealed that the only autonomous midwifery practice at this time was performed by Independent Midwives (IM) and that there were only 15 Independent Midwives still practicing in Ireland⁷² (O'Connell & Cronin 2002). The first government supported midwife-led initiatives came when the Review Group and the 1995 Discussion Document: A Plan for Women's Health 1997-1999, sanctioned the piloting of hospital outreach midwife-led services schemes (DOH 1997). The Expert Group on Domiciliary Births (DOH 1997) similarly endorsed previous recommendations to advance midwife-led pilot projects to address childbearing women's demands for improved choices in care pathways. One could suppose that the government, at long last was listening to women and developing services around women's needs and wishes. Yet, pressure on government from the Ombudsman to provide for women's statutory entitlement for homebirth (EHB 1997), also drove the change. The KPMG Report (2008) suggests that the implementation of the pilot midwife-led services in the 1990s, may have been motivated more by the needs of the institutions, given that the hospital outpatients' services were overstretched and no longer fit for purpose than by the needs and demands of women using the service (KPMG 2008). Also implicated in this decision may have been the fact that non-consultant doctors were in short supply as a result of the EU directive to reduce doctors' hours (ibid.). The report suggested that

“The capacity of the hospital facilities is no longer sufficient to meet the service needs required by the population growth. The hospitals have started to carry out some of their antenatal activity in the community” (KPMG 2008: 6).

Eventually, in 1999 four pilot projects offering community-based antenatal and postnatal midwife/GP services, while facilitating home birth and/or a hospital-based birth were launched (DOMINO -domiciliary in and out-Scheme) (Table 9-1). It was proposed that women using these schemes would benefit from receiving continuity of care from a team of midwives working with maternity hospitals outreach programmes or as part of community domiciliary services.

Table 9-1 Midwife-Led Pilot Projects

• An Integrated Home Birth Service- Western Health Board • A Community Midwifery Service Cork-Southern Health Board
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⁷² Of 585 women who planned to give birth at home, 500 women achieved this with a 96.9% (n = 554) spontaneous vaginal delivery rate for women who commenced their labour at home with minimum use of intervention and perinatal outcomes comparable to the hospital setting (ibid.).

- | |
|--|
| <ul style="list-style-type: none">• A Domiciliary Outreach Programme- National Maternity hospital• A fourth project later established in the South-eastern Health Board |
|--|

The 1990s 'midwife-led' initiative did not reflect the whole system's change. These initiatives were not designed to provide an alternative to the biomedical model, they were not intended to challenge or replace the system but were required 'to fit' into the existing system. When referring to changes introduced to the maternity services in the UK in the 1980s, Graham and Oakley (1980 1:70) made the distinction between changes *in* the existing organisation of care and changes *of* the system of care. If true reform requires changes in the dominant power relationships within the institution that was not the case here. The problem with changes that operate within the system are not the changes themselves, but the limited nature and sustainability of the changes, and their vulnerability to resource cuts and closure at the whim of the authorities (Oakley 1985).

The status and autonomy of midwives did not change with these new initiatives. There were no legislative changes acknowledging the midwife as an autonomous practitioner. There were no legislative changes to the roles played by midwives in the MICS at macro-level or the combined-care scheme at operational level. There were no plans to amend government financial incentives that favour medical-led care and are central to the prejudicial workings of the combined-care scheme. Despite involving the midwife in antenatal care provision, pregnant women still had to access the GP as first point of contact with the maternity services and to book directly with an obstetrician, and not with a midwife, despite attending midwife-led care and potentially never actually meeting the obstetrician. No national advertising campaign promoting the value of midwife-led care and their new role in ANC was undertaken by the HSE, as was the case in other jurisdictions where more wide-reaching reforms were introduced (NHS Quality Improvement Scotland 2009). In this study GPs reported receiving no formal information regarding the launching of the midwifery-led initiatives or what those services entailed. In addition to this, the midwife-led pilot projects were geographically limited. All of these factors suggest that these changes was tokenistic at best, were always meant to be local and were never intended to address whole systems change.

Again here, we see the requirement of doctors, as designated by the current hierarchical structure, to delegate the work of midwives to midwives. Drafts of the Midwife-led Care Guidelines, drawn up by midwives in consultation with the multidisciplinary team, required approval by a lead obstetrician who had the final say, prior to being implemented. To implement the midwife-led initiatives in practice was dependent on finding doctors amenable to the plan, in the first instance. These doctors had to be willing to delegate care of low-risk pregnant women, legally under their care, to the care of a midwife. For various reasons including legislation, government financial incentives, indemnity insurance and ideas around

professional responsibility and accountability, consultants and GPs were unable or unwilling to relinquish ultimate control of care to a midwife who was not in legal terms, viewed as a professional in her own right. Many midwives argue that it is a misnomer to refer to these schemes as midwife-led, rather, are they not still consultant-led and midwife managed.

The practical difficulties encountered when trying to implement continuity models, as part of the existing system and not in terms of replacing the existing system, is evident in the 1990s 'midwife-led' initiatives. Operationalising continuity of care models within the current centralised biomedical system has proven difficult, if not altogether impossible to achieve. Alternating antenatal appointments between GPs/hospital doctors as part of the combined-care scheme were to continue, with the midwife added to the mix or replacing the consultant in some cases. As empirical evidence from this institutional ethnography demonstrated, the DOMINO Schemes, which advocated continuity of carer throughout the continuum of pregnancy, birth and early parenthood were, over time, re-organised around the needs of the institution rather than the needs of the woman. DOMINO midwives, rather than being guided by the needs of the woman, attending the woman in labour at the proper time, were instead rostered to cover the staffing shortages on the labour ward on a weekly basis (see chapter 14). As the international literature has demonstrated, while intended to improve on continuity of carer, these schemes were in practice, sometimes associated with less rather than more relational continuity (see chapter 6). Thus, continuity between antenatal and intranatal episodes of care only happened by default if the midwife happened to be available and was most often prevented by the DOMINO midwife's institutional commitments. What is evident when trying to integrate continuity models into the traditional fragmented model of care, is that the needs of the institution will inevitably take precedence over the needs of the woman.

Despite these limitations, the four pilot 'midwifery-led' projects were evaluated favourably by childbearing women and healthcare providers and recommendations to develop a more equitable and comprehensive midwifery-led service across Ireland were made (EHB 1997, Brenner 2003). Yet, they were never made available nationally. The only community midwife-led services available to women were linked to these acute hospital outreach 'pilot project' services (KPMG 2008). Failure to roll out community midwife clinics nationally suggests that the pilot schemes were tokenistic at best aimed at appeasing consumer demands. Also, it suggests that obstetric dominated government policy lacked real commitment to community midwife-led services or that the change met with resistance from vested interest groups who would be negatively impacted by it. It may also reflect a failure on the part of the change agents to grasp the complexities involved when introducing new models of care into complex systems. Not only were the initiatives not introduced nationally, one midwife-led initiative in Galway, despite glowing reviews and the expressed wishes of childbearing women and birth activists to maintain the service, was closed and the money diverted to employ a neonatologist (DOHC

2003). Making changes *in* the current system, as opposed to changing the current system altogether, has the effect of perpetuating existing power relations, where prioritising the institution over the individual still is unchallenged and the balance of power remains unchanged (Oakley 1985).

Originally evaluated favourably, the midwife clinics that continued post the pilot projects, scarce as they were, did have an impact among the women they served and the local service-providers. With the setting up of the midwife-led clinics, the change *in action* was transformative. Change in this context happens *in* and *through* practice. Once ‘word got out’ midwife-led services did not take long to become routinised, integrated and normalised. In this study GPs revealed that once they became aware of the midwife clinic options, either through personal experiences of attending a midwife-led service or vicariously, by listening to the testimonies of their client’s experiences of midwife-led services, they became open to discuss these options with women antenatally (see chapter 12 for micro-analysis).

Despite the evidence that all women should have access to a midwife, as lead-care providers for healthy well women and as part of the multidisciplinary team for those with known or developing complications during pregnancy (Hanafin and O’Reilly 2015), access to midwife clinic’s across Ireland is limited. Currently, besides those attending the limited outreach midwife-led initiatives, only those attending specialist antenatal clinics (diabetic clinic, haematological clinics, teenage clinics, infectious diseases clinic) have access to a midwife in the Irish context. In 2014 only 5.5% of the 2, 836 respondents of an AIMS Survey reported that antenatal midwife clinics were available to them (AIMS 2014). So, despite these midwifery-led initiatives of the 1990s, on a national level, access to midwife-led care and genuine choice for women remained patchy at best and maternity care remained broadly unchanged. The status of midwives as subsidiaries to doctors in the Irish Health Service did not change with the introduction of the midwife-led initiatives. Plus a large cohort of women who are categorised as medium and low risk have no access to a midwife during the antenatal care. When attending the hospital antenatal clinic these women are generally seen by junior trainee doctor (Senior House Officer), with limited experience. The impact of the strategy to develop primary care on driving change in the maternity services will now be discussed.

9.5. Proposals to develop primary care

Primary care services provide the first point of contact in the healthcare system (DOHC, 2001a). Rooted in the 1953 Health Act and the MICS (1954), Ireland is unique in the EU in not having universal coverage of primary care (Wren and Connolly 2016). A decisive shift towards primary care where “the vast majority of healthcare needs can be addressed at the most appropriate level of complexity and most cost-effective” (DOH 2015:13) came in 2001, when the government published the first ever policy for the development of primary care services: Primary care: A new direction (DOHC, 2001a). It was proposed that the changes would represent a whole systems change approach as it would affect both the organization and

orientation of the health care system (McDaid et al 2009). GP services were now to become more widely available as part of the establishment of multi-disciplinary primary care teams (DOHC 2001a).

Government funding to back the recommendation to develop primary care became an issue. In the same year as the report was published, a *Value for Money Audit of the Health Services*, commissioned by the government (Deloitte and Touche 2001) found that funding up to that point, had continued to be largely based on historical precedent, that favoured hospital over the community services (McDaid et al 2009). Despite government rhetoric on improving equality, the audit reported that the Irish government's focus has tended to be on improving efficiency rather than on improving equity in resource allocation per se (Deloitte and Touche 2001, DHC 2001). In another study conducted by O'Loughlin and Kelly (2003) using a three-round policy Delphi survey to explore the views of 52 senior health service personnel in Ireland, to decide ways to improve equity in resource allocation, there was a high consensus in favour of the development and implementation of a more equitable needs-based resource allocation method. A low consensus was found however, as to its feasibility. Potential obstacles found included methodological difficulties, insufficient resources, and resistance from potential losers (ibid). Six years after the publication of the report, community-based services were still allocated only 16% of health resources (Harvey 2007). Seven years after the primary care strategy was introduced, The Independent Review of Maternity and Gynaecology Services in the Greater Dublin Area (KPMG 2008) confirmed that primary care in Ireland was still underdeveloped and under resourced, with the lowest rate of GPs per 1000 population in any of Organisation for Economic Co-operation and Development (OECD) countries (McDaid et al 2009). Disappointingly, there was no mention of the midwife's role in this document, nor was the midwife included as part of the multidisciplinary primary care team outlined in the document.

Given that the primary care model is evidenced based, cost effective, safe, appropriate for and desired by healthy childbearing women who are considered 'eligible' according to the obstetric-led guidelines (EHB 1997, Brenner 2003), the failure of governments to adequately resource primary care is a very real concern when advocating change in the maternity services, as it affects both midwives' work and choices available to women. The impact of the first Midwifery-Led Units (MLUs) on change in maternity provision in Ireland is now discussed.

9.6. The first Midwifery-Led Units (MLUs)

It was only on publication of the Kinder Report (2001), that for the first time, the blueprint for an integrated woman-centred model of maternity care was translated into practice in the Irish context. The setting up of the MLUs in Dundalk and Monaghan North-eastern Health Board (NEHB)) in February 2001 reflected genuine political action that disrupted the existing power-relations. This was triggered by the withdrawal of hospital indemnity insurance cover by the Irish Public Bodies Mutual Insurances in February 2001, on the bequest of the obstetricians, on the grounds that the smaller maternity units could not support 24/7 obstetric and paediatric cover. This is in accordance with government policy that advocates 100% consultant-led

hospital birth and the closure of smaller maternity units out of safety concerns. The decision to close the units was justified and consistent with government policy and the recommendations of the standards and requirements of the Institute of Obstetricians and Gynaecologists (Robinson 2002) and appeared to be the only logical solution to the withdrawal of indemnity insurance.

The threat to close the units led to a state of uncertainty and instability in a maternity system that is normally in a state of 'static equilibrium'. This state of flux presented an opportunity to reconsider the nature of maternity services provision in rural areas, where it was no longer feasible for all women to birth both close to home and in a consultant-led maternity unit (Kinder 2001, Robinson 2002). In practical terms, women in labour would now have to travel long distances to urban maternity hospitals to birth. This was at best inconvenient and at worst unworkable, with well publicised media reports of some women birthing their babies on the motorway on route to the larger maternity hospital. This led to widespread public protests backed by a political campaign to save the units, with 43,000 people signing a petition demanding that the Cavan and Dundalk maternity units be retained (Kennedy 2012, O'Connor 2001). Political pressure made it a campaign issue, as it became a real possibility that some politicians would lose their seats in an upcoming by-election, for the ruling Fianna Fail Party (O'Connor 2001). Considering demographic factors of predicted rising birth rates, rising demand for maternity services in the region, and the cross-party and trade-union support for the campaign, compelling arguments for preserving the smaller local maternity units were offered to the NEHB. Conflict between the wishes of women to birth close to home and the wishes of obstetricians for all women to birth in a consultant-led maternity unit ensued. Despite media and political attention and rising popular demands, the Maternity Services Review Group (Condon Report 2000), commissioned by the NEHB to consider the options for the provision of maternity care in the region and made up primarily of obstetricians, found in favour of closing the smaller, consultant-led maternity services at Monaghan and Dundalk (Condon 2000). The salience of the biomedical model and active management of labour doctrine was such that anything other than 24-hour consultant-led care was inconceivable. Those elites charged with deciding the future shape of maternity care in the NEHB, were the same elites who informed government maternity care policy advocating 100% consultant-led hospital births.

Following publication of the Condon Report, the Monaghan hospital Board requested financial approval from the DOHC to fund the appointment of the necessary consultant obstetricians and paediatricians to allow services to be maintained at both sites (Robinson 2002). The chief executive officer (CEO) of the NEHB Hospital at the time, Paul Robinson, reported that Comhairle na nOspideal, who handled consultant appointments, refused to support the appointments (ibid).

Traditionally in patriarchal Ireland, that would have been the end of the matter and government policy of 100% consultant-led births would have prevailed. But Paul Robinson, the CEO of the NEHB, influenced by public opinion and party-political pressure, rejected the Condon Report and commissioned a second report, entitled the Report of the Maternity Services Review Group (The Kinder Report 2001) (Robinson, 2003). Kinder, the chairperson heading up the report, was from Northern Ireland, where MLUs were well established and well integrated into the national maternity services. Obstetric knowledge, that prior to this would have been accepted unconditionally, was for the first time subjected to rigorous debate from fellow obstetricians from the UK who did not share their views and could conceive of autonomous midwives running a low-risk service. The opening up of the discussion to other ways of knowing is evident in Mr Richard Porter's address to the Kinder Committee. A consultant obstetrician at the Royal United Hospital at Bath, England, Mr Richard Porter posited that, "maternity care is not an illness - it is a wellness service. The disease model must be discarded, and the switch made to the social model" (Kinder Report 2001:19). In contrast to Irish obstetric thinking that saw closing the maternity units as the only option open to the government, Porter suggested that closing the maternity units was only one of many options open to the committee.

For the first time, the Kinder Committee had women at the centre of the decision-making process about where, how and with whom they should birth their babies (Kinder Report 2001). In contrast to the Condon Committee that was almost exclusively obstetricians, the committee members were diverse, with representatives from all professional groups and the wider community, including Councillors from the different localities, nominees from consumer representatives, Patient Focus, the Irish Countrywomen's Association, the National Woman's Council of Ireland, and the Faculty of Nursing and Midwifery (Kinder Report 2001). A total of 170 written submissions were received in response to advertisements in the local press and on local radio stations" (Kinder Report 2001:10). The committee member's remit was not to dictate to the population, as was the tradition in hierarchical Ireland, but to address their needs. Local submissions about service provision were genuinely sought. "This shift from a technocratic to a democratic form of negotiation represented democracy in action.

The Kinder report, that recommended the establishment of the two midwife-led units in the NERB, not only emphasised the need to provide "a woman-centred, quality service which is safe, accessible and sustainable" but found a meaningful way to incorporate the views of women in the planning, development, and delivery of the service. A woman-centred model of maternity care was for the first time enacted, embedded and integrated into the Irish maternity service. The MLUs also introduced a new governance structure that did not include obstetricians in their traditional authoritative role, but instead appointed a clinical directorate, led by Dr Alan Finan, a consultant paediatrician, whose role was to address the integration of a programme of care for women and children within the region (Murphy-Lawless 2010

unpublished). Traditional power-relations enshrined in the MICS and operationalised in the combined-care model were for the first time being challenged with the establishment of the MLUs. The opening of the MLUs led to cultural changes that disrupted the status quo and involved a loss of gained entitlements where rights and privileges are no longer automatic (Kaufman, 2011). These losses included losses in terms of custom and practice, access and control of beds, admission rights, financial gains, clinical autonomy, status, authority and identity for GPs and obstetricians in the NEHB. This represented real political change in practice. Changes that disrupt the power balance of an institution, until they become fully embedded and normalised, are vulnerable to resource cuts and closure to restore the status quo.

9.7. The HSE National Homebirth Service

Birth activists and midwives united to campaign for the development of a national protocol on domiciliary births and a proposal that domiciliary birth was now to be state supported, albeit in limited circumstances, and was to be governed and policed by the HSE, quickly followed the reconvening of the National Expert Group on Domiciliary Birth in Feb 2003. Pressure on the government from the Ombudsman, to provide for women's statutory entitlement for home birth (EHB 1997) also drove the change. The withdrawal of insurance cover, however, was again central to creating the state of flux in an otherwise static system (Loman 1998), that made reconsidering the homebirth service currently being provided possible. Originally, independent midwives (IM) obtained affordable insurance through their union subscriptions with the Irish Nurses Association (INO). In 2007, in a letter sent by the INO to the 19 independent midwives working in the state, The IMs were informed that it was "not sustainable" for it as a union to continue providing cover for them and it was to be withdrawn (McGreevy 2007). "A request by the INO's underwriter, Lloyds, that the union pay €1,000 towards the insurance of each of the independent community midwives was rejected by the INO executive" (McGreevy 2007). Independent midwives, willing to pay the 1000 euros themselves, were denied the option by the INO. With litigation in obstetrics on the increase, and the costs of indemnity insurance for midwives aligned with obstetric costs and based on 'obstetric defined safety' which in and of itself is not necessarily safe (Edwards et al 2011), the cost of indemnity insurance for midwives wishing to work independently of the HSE is prohibitive.

The uncertainty that arose out of this insurance crisis was an opportunity to reconsider the role of the state-run maternity services in the provision of domiciliary birth, which became policy in 2008. Following negotiation, the state agreed that independent midwives could avail of the state clinical indemnity scheme, following the signing of a Memorandum of Understanding (MOU) with the HSE (Oboyle 2009). Independent midwives (now re-named self-employed community midwives (SECM), who sign a memorandum of understanding (MOU) agreed to

adhere to a strict and very narrow definition of what constituted low-risk and therefore suitable candidates for domiciliary birth. These domiciliary guidelines are obstetric driven and use best available evidence selectively, to suit their risk averse agenda (Oboyle 2009). So, while the development of state-run homebirth service was welcome, control of this service and the opportunity to qualify for this service rest with the obstetric elite and HSE managers. Eligible for homebirth depends on the woman's circumstances following the risk averse biomedical guidelines, which many midwives find too restrictive (ibid).

Women eligible for the universally free combined-care scheme, should also be able to avail of the HSE Home Birth Scheme, free of charge. Women availing of a SECM under the HSE Home Birth Scheme are entitled to 11 appointments throughout the continuum of care and their insurance covers the continuum of antenatal, intranatal and postnatal care at home. However, many GP's indemnity insurance does not cover woman wishing to have a homebirth. If they want to avail of free antenatal care, these women's only options are to alternate care between the SECM and the consultant team in the hospital setting or opt to have all their care with the SECM, on the payment of an added fee.

It is also worth noting that due to the mix of state-run and voluntary maternity hospitals in the Irish healthcare system, the midwife's contract with the HSE does not automatically extend to the Voluntary hospitals. In case of hospital transfer being required, while accompanying the woman during hospital transfer, maintaining continuity of carer at this most vulnerable time is covered by the HSE hospital groups but is not automatically covered by the three Dublin voluntary maternity hospitals, affecting continuity of carer for those women.

So, while the re-introduction of state supported domiciliary birth is welcome, it is not fully integrated into the health service, it is not freely available to all women and is not a workable option for childbearing women who do not conform to the very restrictive low-risk obstetric criteria. These eligibility restrictions also impact midwives' work, restricting SECMs' scope of practice and the midwife-woman relationship, because if midwives care for women outside of the 'agreed framework' in support of the woman's wishes, they now risk prosecution and criminalisation. Resorting to criminal prosecution of midwives for practicing midwifery is a recurrent theme in the Irish jurisdiction having been enacted following the 1918 Health Act and again in relation to not being properly indemnified prior to being placed on the midwifery register. Both the escalating cost of and restrictions placed on practice by indemnity insurance cover is also curtailing autonomous midwifery practice and women's access to free public domiciliary birth service. Another HSE restriction is the non-evidence-based requirement of having to work three out of the preceding five years in an acute hospital setting, to be eligible to apply for HSE indemnity insurance in the first instance. This requirement severely curtails midwifery access to becoming SECM and is completely out of step with international best practice. Consequently, the numbers of SECMs are small. In 2016 there were 19 SECM (Ní

Chríodáin 2016) and in 2020 there are 21 SECM registered with the HSE (HSE online National Homebirth Services 2020). In 2019, 254 women booked with the SECM (CMA 2019). In addition to all these controls and limitations imposed on midwives working within the HSE Homebirth Service, the SECMs are also vulnerable to the withdrawing of HSE indemnity cover with little notice, with devastating personal, financial, and professional consequences for the midwife concerned and the women in her care (Murphy-Lawless 2019).

So, while the HSE homebirth service appears to be moving in the right direction, much of the control around accessing and eligibility for the service still rests with obstetric dominated HSE guidelines, policies and protocols. Again, instead of supporting easy access to the HSE homebirth service for both midwives wishing to work in the service and women wishing to avail of the service, every effort appears to have been made on the part of the HSE to limit access to the service, on grounds of improving safety and minimising risk. Here again, we can see how best evidence supporting the safety of homebirth, women's choices and midwife's autonomy are subjugated by the risk averse, highly litigious culture of the HSE. After the seemingly endless crisis and scandals that have faced women's health services in recent years, this patronising approach by policy makers must be reserved for the history books.

9.8. Strategies and tactics for resisting and supporting change initiatives

When considering change management one has to keep in mind the strategic and tactical use of power to undermine change initiatives. The key rationale for closing Cavan MLU was that it was not in demand and was working below capacity. In Cavan, only 6 per cent (90 births) out of 1,555 births that took place in the first 9 months of 2011 were accommodated in the MLU, compared to Drogheda's MLU, that is only 80 Km away, where more than 10 per cent (303 births) out the 2,892 births were accommodated (Wayman 2011). Again, the 2014 figures, 288 and 121 births were recorded in Drogheda and Cavan respectively (DOH 2016: 15). A review of the service carried out by former NHS executive David Flory in 2015, reported the MLU birth rate accounts for only 130 births out of a total of 1,800, in a culture where the "the doctors are very much in charge," and where there is evidence the most senior midwife, an assistant director of nursing, is professionally isolated and unsupported (Cullen 2015).

Feedback conducted by AIMS, from women wishing to attend the MLU in Cavan supports the view that there is a general lack of support among doctors for the MLU. According to an agreed protocol, women wishing to avail of the MLU birth must book in by 20 weeks' gestation. Women reported that MLU bookings, made by the GP on behalf of the pregnant woman, were left too late to avail of birth in the MLU, that MLU booking appointment were often delayed making it too late for the consultant to 'sign off' for MLU" (AIMS 2013). This is an example of how power works in institutions. The powerful first create the problem of underutilisation by inhibiting

access to a service, then use the underutilised of the service to argue that there is no demand for the service among the public, justifying closure of the service.

Another strategy used by the HSE, directed by the obstetric elite, is the policy to suspend a rival fledgling public service as a first as opposed to last resort, should an adverse incident occur in that service. Power in this instance works by applying the double standards, where the penalties for the ruled far outweigh those of the rulers. When an adverse incident occurs in the hospital setting, services are suspended only as a last resort, following a full investigation and once every other avenue is exhausted, unless the practice is thought to be based on unsound evidence or new evidence comes to light questioning the merits of the practice. The suspension of birthing in water in Cavan MLU in 2014, following an adverse incident, occurred prior to launching an investigation, as a first resort. When it comes to HSE policy of early suspension of services, there appears to be a double standard between midwife-led and consultant-led services. This policy of suspension of services as a first resort only appears to apply to midwife-led services. For example, in the case of a HSE commissioned investigation into 30 babies' deaths in Portlaoise and 18 babies' deaths in Portluncula in March 2014, (DOH 2013, HIQA 2013, Holohan 2014), no services were suspended, as a first or as a last resort. Instead, recommendations to improve and safeguard the services in question were introduced following the investigation.

This HSE Homebirth service is also vulnerable to the double standard strategy of using suspension of services as a first as opposed to last resort. Again, on Wednesday 4th November 2020, birthing in water at home was suspended, pending the outcome of an investigation and not based on the findings of an investigation. Given the evidence and the safety record of the HSE Homebirth Service since its introduction (NPS), and the negative impact such a decision to suspend a service would have on public confidence in the service and childbearing women's autonomy who are booked to use the service, how such a decision could be defended on moral, ethical, legal, litigious or evidence grounds is questionable. Is the problem here simply that midwife-led services are not consultant-led services. The process of arriving at a decision to suspend one service and not another following a critical incident needs to be made transparent. Also, the recommended timeline for any investigation and publication of results of the investigation need to be upheld, swift and automatic.

Key factors that influenced the success of the MLU project included the Committees tenacity in the face of scepticism and their unfaltering determination to see the project through to its conclusion, good leadership and negotiation skills including the ability to persuade others of a different disposition to come on side and support the project and having the patients to wait for this to happen.

The decision to conduct a RCT to compare the traditional service with the MLU service was a powerful one as it produced competing authoritative knowledge claims that could not be easily

disputed by the hegemonic group. Integrating research into the implementation process is crucial to supporting change management, although vested interest groups are often selective in the research that they promote. A RCT that was conducted to compare care in the MLU with traditional consultant-led care, found that this model of care was safe and associated with less intervention, with no difference in maternal and fetal outcomes (Begley et al 2009). Like the midwife-led initiatives of the 1990s, the researchers recommended that it should be made available to all healthy low risk women in the Irish jurisdiction. A follow-up study of the first six years of operation after the end of the trial period continued to show favourable results (Dencker et al 2016). But, like the other midwifery pilot projects that were evaluated favourably, no further MLUs have since been established in the Irish context (O'Connor 2003, Begley et al. 2007, Kennedy 2012). In contrast Scotland, with a population of 5.4 million, a similar population to Ireland has 17 midwifery-led units (HSCD 2017) and Northern Ireland, with a population of 1.8 million has 8 midwifery-led units (DHSSPS 2012).

To sustain midwife-led innovations so that they do not succumb to threats of closure but instead become integral to an organisation's culture, inter-professional alliance must be forged (Antwi and Kale 2014). Baker et al. (2012) argue that barriers in achieving sustainable reform in complex systems tend to be relational, not technical. The successful implementation of the MLUs in Cavan and Drogheda was very much dependent on the support of the GPs, who acting as gatekeepers of the service, remained in a powerful position to control access to the MLUs. This was especially the case for GPs who were not in favour of the MLUs or were not covered by indemnity insurance to care for women antenatally who intended to birth in an MLU. Local resistance in the form of the Cavan MLU getting noticeably less interprofessional support compared to the Drogheda MLU, among GPs and obstetricians, became evident early in the implementation process. Since then, there have been repeated attempts to close Cavan's MLU: in 2011 and 2013 and again in 2020 (AIMSI 2013), on grounds that the unit 'was functioning below capacity' (AIMSI 2013). Yet the RCT conducted during the implementation process reported that the MLUs were cost effective, associated with less intervention, safe and highly valued by childbearing women (Begley et al 2009, 2011).

Exploring how power works in institutions must never be taken off the agenda when considering change in complex systems. If repeated efforts to close Cavan MLU are not made on economic or safety grounds or because childbearing women are dissatisfied with the service, it raises important questions of what is motivating efforts to close the MLU and who benefits if this service is closed. Even when whole systems change is implemented in maternity care it is subjected to resistance by vested interested groups who hold much of the power in the traditional model of care and have most to lose. It also suggests that repeated attempts to close a competing service that flies in the face of good practice, justifies a government commissioned investigation.

Not all obstetricians are threatened by midwife-led services. Policy makers and medical authorities in Ireland need to re-examine their entrenched commitment to consultant-led care for all women and to place women's demands genuinely at the centre of policy making in maternity care. Murphy-Lawless (2010) suggests that involvement of obstetric and paediatric colleagues in the future development of midwife-led services is crucial, to ensure the availability of an effectively integrated, seamless referral pathway between medical and midwifery staff should referral be required. Clearly in Ireland, some obstetricians are still threatened by what they view as their professional rivals, a sentiment evident in the 1950s Health Act, where attempts were made to replace the title 'midwife' with the title 'maternity nurse' (Browne 1995). Those obstetricians who support childbearing women's and midwives' autonomy need to speak up and make themselves known as true collaboration is dependent on close co-operation, respect and mutual trust between all professionals involved (HSE 2008). Likeminded midwives, women and obstetricians need to unite to confront this oppression of women's rights.

9.9. Legislative changes to midwives' education and professional status

It was not until 2006 that the first four-year BSc direct-entry midwifery programme began, even though the BSc in nursing (general, mental health and intellectual disability strands) had been introduced nationwide in 2002. The move of midwifery education into universities increased the professionalisation of midwifery by providing increased educational and research opportunities at graduate and post graduate level (O'Connell and Bradshaw 2016, Vermeulen et al 2019). This led to an accumulation of an alternative authoritative knowledge regime to that advocating biomedicine in maternity care. Third level education empowers midwives to adequately represent their vested interests and influence the political agenda. It took another five years before the Health Act of 2011 replaced An Bord Altranais (The Nursing Board), with the Nursing and Midwifery Board of Ireland (NMBI 2011) reinstating the midwife once again. Again, without collective action and concerted pressure being applied by midwives and birth activists, change was not forthcoming. Changes in the Act eventually became a legal requirement when the first direct-entry midwives were due to register. Another development came in the 2018 Health Act when midwifery was granted a separate division on the NMBI register (NMBI 2011). The new Rules put in place for the first time a midwife tutors' division, a midwife prescribers' division and an advanced midwife practitioners' division (O'Connell 2019).

9.9.1. Mandatory clinical indemnity insurance

The Health Care and Associated Professions (Indemnity Arrangements) Order 2014 made clinical indemnity insurance for all healthcare professionals mandatory across Europe. Medical Malpractice Insurance (MMI) became mandatory in Ireland through the enactment of the 2013

(amendments) to the Irish Medical Practitioners Act (2007). This was informed by an EU passed Directive 2011/24/EU and the Finlay Scott Report (NHS 2010), an independent review of the requirements which recommended making MMI a statutory condition of registering as a healthcare professional including midwives. This new legislation was enshrined in the Nursing and Midwives Act (DOH 2011), where midwives now had to have 'adequate' medical malpractice insurance; that is 'sufficient' to cover the level of claims made (NMBI 2019). Not having 'adequate' insurance will from here on in be considered a criminal offence (NMBI 2019). This is reminiscent of the 1918 act that criminalised lay midwives and threatened them with incarceration for practicing.

The legal requirement for mandatory medical malpractice insurance does not impact state employed midwives and hospital doctors, as they are already covered through the principle of vicarious liability; the principle that an employer [in this case the State] is legally responsible and therefore liable for the acts and omissions of employees during their employment (National Treasury Management Agency (NTMA) 2018). As state employees, hospital midwives' insurance is covered by the State Claims Agency (SCA) under the Clinical Indemnity Scheme (CIS) established in 2002, whereby the state bears the financial risk associated with the costs of clinical negligence claims (NTMA 2018). Midwives providing community midwifery outreach services, including homebirth supported from the National Maternity Hospital and Waterford Regional Hospital, are also covered by the hospitals' own indemnity insurance. Following the new legislation on Indemnity Insurance enshrined in the Nursing and Midwives Act (2011), midwives who have successfully completed a designated third level education programme, but who cannot access affordable insurance, cannot register as midwives. This confines them to working in the hospital sector. This severely limits the options for midwives to be self-employed. It could be argued that a midwife's work is defined more by doctors and insurers than by the midwives' professional body.

9.10. Conclusion

The purpose of the chapter was to explore the drivers of change and change processes in the Irish maternity services. I argue that change in complex systems is not linear or rational but may have multiple drivers and its effect is unpredictable with often unintended consequences. Meaningful change in institutional culture requires disruption of the established power-relations embedded in institutions and this results in a loss of previously accepted privileges and status and a shift in taken for granted social norms. Most of the changes introduced since the 1990s have not been whole systems changes, nor have they disrupted the existing power relations. The role of the midwife as subservient to the doctor has not changed. I demonstrate that in many instances doctors are still required to give midwives 'permission' to practice as midwives, in a culture where midwives are still not legally recognised as autonomous practitioners. These

initiatives represent changes *in* the system and not *of* the system, they are tokenistic in nature, less likely to be successfully integrated into the established system and vulnerable to withdrawal by those whose privileged positions are challenged by their introduction. More often than not, changes introduced were unpredictable in nature resulting from unintended consequences of government maternity care policy and the withdrawal of indemnity insurance by multinational conglomerates, both influenced by risk and safety discourses defined by obstetric vested interests. The hiatus that results during these periods of instability in a maternity system that is normally a static equilibrium, creates a transient opportunity to challenge the status quo and introduce changes that would otherwise have been vehemently opposed by the hegemonic elite. I demonstrate that any meaningful change involves a change in the power-relations embedded in the organisation. The only one to date is the introduction of the MLUs in 2003. The need for a joined-up whole-systems approach to change, that fully understands the complex system nature of the maternity services is acknowledged. Without these in-depth understandings change will continue to be implemented on a local, ad hoc, piecemeal basis, and be vulnerable to withdrawal of resources, without much notice, should competition for resources dictate it. Various strategies used to discredit these fledgling innovations were identified. So, despite the midwifery-led initiatives starting in the 1990s, access to midwife-led care and genuine choice for women remained patchy at best and the provision of maternity care at national level remained broadly unchanged. While acknowledging these limitations and persistent efforts to discredit or suspend some of these newly fledged initiatives, the normalisation of these services for women and healthcare professionals has led to changes in practice and attitudinal changes among women using the services, midwives providing the services, and some of the obstetric elite. To conclude, the midwifery profession, because of its unequal hierarchical relationship to the obstetric profession, is always going to be under threat and this is particularly so when new initiatives have been introduced but are not yet embedded in the system. While the first primary care initiative was less than successful and not fully implemented, 2011 saw universal healthcare back on the agenda in the development of a framework known as Sláintecare (Houses of the Oireachtas 2017b). Its impact on change and entrenchment of the maternity services will now be explored.

10. Chapter Ten Universal healthcare back on the agenda

10.1. Introduction

The public-private mix continued to be official government healthcare policy right up until 2006 and beyond, despite it being an area of contention in Irish health debate. This led to allegations of ‘creeping Americanisation’ of the system” (Harvey 2007: 14). The purpose of the chapter is

to explore the potentially dramatic changing shape of Irish health care services following an All-Party Oireachtas Committee and the development of a framework known as Sláintecare (Houses of the Oireachtas 2017b). This committee was committed to ending the heavily criticised two-tier public-private system and to developing universal healthcare. The impact of the Sláintecare Report on maternity services will also be explored. I argue that excluding maternity care from the Sláintecare Report is a major concern, represents more of the same and as it signals a continuation of obstetric dominated government maternity care policy seen as distinct from healthcare policy generally and might lead to poorer healthcare for women. It also suggests that the power and authority of the obstetric regimes in maintaining private practice may have been under-estimated.

10.2. Challenges to the two tiered private-public system

The economic crash in 2008 challenged the ongoing existence of private/public partnerships in healthcare (ibid.). It was not until 2016, following an All-Party Oireachtas Committee on the Future of Healthcare, that the centralised, means tested, public-private mix of healthcare, which became entrenched in policy after the failure of the two white papers in 1947-9 and following the 1953 Health Act, was back on the government policy agenda. The resulting health policy framework, known as Sláintecare, outlined a commitment to the development of a universal, single-tier health service, as a priority for future healthcare reform over the next 10 years (Houses of the Oireachtas 2017b).

Universal healthcare was a key principle in the development of the National Health Service (HSE) in the UK in 1947 and underpinned the development of European healthcare systems in the 1950s. Today, the benefits of universal healthcare are widely recognised, being acknowledged as a precondition for economic prosperity (European Commission, 2013) and “a powerful social equalizer ... [that] contributes to social cohesion and stability” (WHO 2015b: iv). Sláintecare marks a re-alignment of Irish healthcare policy with the egalitarian ideologies that informed the development of European healthcare systems since the 1950s (Smith and Normand, 2011). Underpinned by the European principle of social solidarity: “access will be according to need and payment will be according to ability to pay and would be partly funded by Universal Health Insurance” (UHI). (Wren and Connolly 2016). In order to achieve universal healthcare, the two tiered private-public system, recognised as the cause of sustained inequalities in health service provision (Burke 2008), would have to be dismantled.

Sláintecare recommends separation of the public and private elements of the system, where private consultant activity would be progressively removed from public hospitals (Houses of the Oireachtas 2017b). Expansion of primary care that would be better value-for-money, facilitate healthcare closer to home and maintain a strong focus on health promotion and public health delivery is another fundamental reform recommended in Sláintecare (Houses of the

Oireachtas 2017b)? The Report also recognised that mechanisms for implementation are vitally important and that although the reforms have cross-party support, that resistance among vested interest groups must be expected and planned for.

10.3. The feasibility of separating the public and private spheres

In order to evaluate the feasibility of separating the public and private elements of the system, an Independent Review Group, commissioned by the Minister for Health and chaired by Dr Donal de Buitléir, chairman of the Low Pay Commission and former HSE Board member, conducted a comprehensive examination of private activity in public hospitals. This examination included how removal of private practice from public hospitals might be achieved, the cost, the timeframe involved and the impact on health insurance of removal of private care from public hospitals (Department of Health 2019). The conclusion was that while the move would be costly to begin with, at a cost of €1bn to the exchequer, with commitment from all stakeholders and phased out over a ten-year period, it was eminently doable. Changes to the consultant contracts and legislation to ensure that public hospitals are exclusively used for the treatment of public patients would be required for successful implementation. By that time private maternity care was well entrenched and the private/public divide was well established. The Sláintecare Health Act was proposed to provide the legislative basis for this radical reform, including provision for universal healthcare, change of governance structures, funding mechanism and organisational realignments, all to be achieved through political and stakeholder consensus.

10.4. The impact of Sláintecare on the maternity services

These key recommendations of Sláintecare are consistent with maternity services urgently needed reforms. A worrying aspect of Sláintecare is that it fails to include the maternity services in its report. An explanation for this may be that the first ever National Maternity Strategy was already underway prior to the Cross-Party Oireachtas Committee on the Future of Healthcare and the National Maternity Strategy was published in January 2017, the same year that Sláintecare was launched. Alternatively, it may be that because there is already universally free access to the maternity services, policy makers and politicians may erroneously think that all is well with the maternity services and little reform is required. While universally free access to maternity care services is already a feature of the current service, it should be noted that non-means testing was only removed with the 1991 Health Act. All the recommendations contained in the Sláintecare report are consistent with and will support the expansion of community midwifery services that promote a wellness approach to pregnancy and birth. Some argue that currently, the private sector plays an essential role in supplementing the work of the public sector, while others argue that the private sector undermines state policies to

provide free maternal services while benefiting the wealthy (Parkhurst et al 2004). Fahey (2013) suggests that the public maternity hospitals rely on much needed resources from private patients. Not surprisingly, leaders in obstetrics argue that removing private consultant beds from our maternity hospitals will have a seriously negative impact on maternity services (Larkin 2018). Murphy-Lawless argues that the reverse is actually true, that public monies and state-employed midwives are resourcing private practice in public hospitals (Murphy-Lawless 2020). She goes on to say that the private/public divide and the lack of transparency regarding how the private sector is resourced using public monies 'actively precludes the development of relevant publicly-funded midwifery-led services' (2020: 6). Removal of private practice from public maternity hospitals will significantly impact care provision and governance structures in those institutions.

In June 2019, a private member's bill presented in the Dáil by Fianna Fáil's health spokesperson Stephen Donnelly "called for a guarantee from the Government that the new [maternity] hospital, to be constructed on the site of St Vincent's Hospital in Dublin, would not have separate facilities for private patients" (Brennan 2019). This motion was passed unanimously. Yet in July 2019, the Minister for Health Simon Harris, stated that due to their pre-existing contracts "some consultants are entitled to engage in private outpatient practice outside of their public commitment and that this "commitment must be conducted on site". He added that "there is an obligation to provide such facilities for consultants holding such contracts" (Brennan C. Irish Examiner. September 11th, 2019).

10.5. Conclusion

Government commitment to the development of a universal, single-tier health service as a priority for future healthcare reform over the next 10 years is very welcome. It has taken over 60 years to correct the policy decision not to go with universal healthcare as proposed in the 1947 Health Bill. Mounting evidence since then confirmed that universal healthcare has many advantages, including being a precondition for economic prosperity, social equality and social stability. A worrying aspect of Sláintecare is that it fails to include the maternity services in its report. The lack of private maternity hospitals in the Irish jurisdiction presents a challenge to those wanting to continue private practice on a separate site. Despite this Cross-Party Dáil motion and recommendations from the Independent Review Group (Department of Health 2019), I fear that excluding the maternity services from the Sláintecare Report is further evidence of obstetric hegemony and the role of elite obstetricians in government maternity care policy and might lead to poorer healthcare for women. Ireland's newest maternity hospital that is currently under construction, will continue to conduct private healthcare business on its premises (Brennan 2019). This signals a worrying trend of continued entrenchment of biomedicine and the private/public divide in Irish maternity care.

11. Chapter Eleven The First National Maternity Strategy

11.1. Introduction

The first National Maternity Strategy 2016-2026, *Creating a Better Future Together* (DOH 2016) was long awaited, urgently needed and very welcome. Given the previous legacy of government policies that were never implemented but continue to gather dust on government shelves, one must approach the National Maternity Strategy's (The Strategy) promises, with a healthy degree of scepticism. Exploring the Analysing the Strategy affords an opportunity to make explicit the institutional and organizational processes, power-relations, ideologies, and values that underpin Irish maternity services in the 21st century. Biomedical obstetric thinking has three principle imperatives; the first is the obstetric imperative, the belief that all births are risky, and birth is only normal in retrospect, the second, emerging from the first, the risk imperative, is a risk averse approach where risk minimisation is prioritised, the third, the technological imperative, the solution to the second imperative, is the unconditional belief in the use of ever increasing technological interventions over the more humanistic alternative (socioeconomic and psychological) as the rational solution to preventing future 'imagined' risk, because the technological 'fix' is 'more scientific' and therefore fits with the dominant technocratic biomedical paradigm. All three imperatives work to mitigate the role of the midwife in maternity care. The purpose of this chapter is to utilise the biomedical imperatives as heuristic tools to analyze the principles underpinning the Strategy. Also, given that meaningful change requires genuine political action that is aimed at whole system change, I will explore whether the proposed changes in the Strategy constitute moments of genuine political action or not (see chapter 9 for more on political action). A fundamental overhaul of the maternity system, as promised in the Strategy, requires those in positions of power to be willing to share that power, resulting in a more egalitarian, democratic structure. A critical exploration of whether changes to the ruling relations are likely to result from the proposals embedded in the Strategy will be examined. First, the driving forces that lead to the development of the Strategy will be explored. Second, the emergence of dissenting voices from some members of the obstetric profession will be examined. Third, the ruling relations and discourses embedded in the Strategy will be explicated. Finally, whether the Strategy results in a true overhaul of the services evidenced in a shifting of power-relations or is merely used to perpetuate the current hegemonic system will be explored.

11.2. Background to the strategy

The development of the first National Maternity Strategy was not driven by the government's considered response to consumer demands and/or lobbying for reform by birth activists. It was not a planned and managed change initiative led by visionary leaders in maternity care. The Strategy came about as a response to recurrent crisis and scandals within our fragmented,

dehumanising, biomedically dominated maternity services⁷³. Several investigations into safety, quality and standards of services provided by the health service, commissioned by the Government of Ireland and carried out by the HSE, HIQA⁷⁴, the Department of Health and the Chief Medical Officer, repeatedly highlighted significant shortcomings in the Irish maternity services (Harding Clarke 2006, HSE 2008, HSE 2013, Holohan 2014, HIQA 2015)⁷⁵. The maternity services were dysfunctional; quality protocols and guidelines were not being adhered to, communication between overworked staff who had enormous workloads was left wanting, because of which operational risks increased and mistakes happened (HSE 2013). The death of Savita Halappanavar in particular, a 31-year-old woman who died of sepsis one week after she was admitted to the hospital when she was 17 weeks pregnant and miscarrying, triggered widespread outrage, received damning national and international media coverage, and resulted in legal action against the HSE and a large financial pay out (BBC News 2013, BBC World news 2013, O'Brien 2013). The HIQA Reports into Savita's death (HIQA 2013, 2015) found system failures, with many missed opportunities that, if acted on, might have saved Savita's life. Similarities between the circumstances surrounding Savita's death and the findings of an HSE inquiry into the death of Tania McCabe and her son Zach, in 2007, at Our Lady of Lourdes Hospital in Drogheda, County Louth, were found. Adding to this was the shocking confirmation that recommendations from that inquiry in 2007 were never implemented across the 19 maternity units in Ireland. If they had been, Savita may not have died. The jury at Savita's inquest returned a unanimous verdict of medical misadventure (O'Brien 2013). Following the investigations HIQA made 34 recommendations on improving the care of clinically deteriorating pregnant women. It also called for a national maternity strategy to be developed as a matter of urgency to ensure women receive safe, high quality, reliable and nationally standardised care (HIQA 2013). The uncertainty and instability created by this crisis in the maternity services and the ensuing lack of consumer confidence was a warning that the maternity services, as it were currently organised and coordinated, was not working. Again, similar to previous instabilities in what is normally a static system, the crisis in the maternity services offered an opportunity to reconsider the nature of maternity provision in

⁷³ Scandals such as routinised practices of symphysiotomy and pubiotomy (O'Connor 2011) and routinised intrapartum hysterectomies carried out by De Neary over a 25-year period when 188 women were operated on for hysterectomies without their consent and without any sound clinical rationale (Matthews and Scott 2008) were just two high-profile issues which cast a long shadow alongside the more recent scandals of baby deaths in Portlaoise and Portlinculla Hospitals.

⁷⁴ "The Health Information and Quality Authority (HIQA) is the independent Authority established to drive high-quality and safe care for people using our health and social care services" (HIQA 2015:1).

⁷⁵ Avoidable maternal and perinatal deaths occurred in the Irish maternity services between 2008 and 2014; of eight maternal deaths which did receive a public inquest, the deaths of Tania McCabe, Evelyn Flanagan, Jennifer Crean, Bimbo Onanuga, Dhara Kivlehan, Nora Hyland, Savita Halappanavar and Sally Rowlette all concluded with verdicts of medical misadventure.

Ireland and what other models might work. For this to happen, diverse interests needed to come together in a meaningful dialogue to address common concerns.

11.3. Dissenting voices

From the very beginning, dissenting voices emerged from some members of the obstetric profession, who were quick to contest any challenge to their influence and authority when it comes to maternity care policy. When the steering group for the maternity strategy was being set up, the chairperson of the Institute of Obstetricians and Gynaecologists, Professor Robert Harrison, protested that obstetricians were under-represented on the 28 members steering group, given that there were three obstetricians compared to nine current or former midwives (Cullen 2015). In the controversial letter sent to the Health Minister, Leo Varadkar and leaked to the media, the chairperson of the IOG, along with other obstetric colleagues, raised the issue of being under-represented and raised objections to the appointment of two service-users to the steering group on the grounds that the service-users remaining objective, in their opinion, would be impossible, given that both their new-born babies have died due to medical misadventure (Cullen 2015)⁷⁶. This view was contrary to the HSE's comprehensive guide to planning and implementing change, that advocated meaningful participation of service users as best practice (HSE 2008).

“The process of listening to and acting upon the grounded sense of reality that emerges from meaningful participation and involvement of service users is paramount for change to be successful” (HSE 2008: 4).

Likewise, the Patients for Patient Safety (PFPS) Ireland Organisation, a World Health Organisation (WHO) initiative aimed at improving patient safety states that it is essential that engagement with patients takes place in the initial stages of planning and development of services (HSE 2013).

In the outrage that followed, the letter was swiftly withdrawn, and the chairman forced to resign. Professor Boylan who replaced Professor Harrison, was quick to issue a rhetorical statement insisting that the institute was committed to continuing to work closely with midwifery colleagues in a partnership model of care in the best interests of patients (Cullen 2015). In this instance the obstetric elites clearly felt their power and influence was being threatened and power only becomes visible when it is challenged or resisted (Foucault 1980). I wondered whether similar letters were received by previous Ministers for Health over the years but were never open to public scrutiny. In this instance, it was left up to the newly appointed obstetric leaders to regain their authority and in doing so, to avert any long-term harm to their reputations.

⁷⁶ Both women's babies had died during birth in suspicious circumstances at HSE Midland Regional Hospital, Portlaoise. With several more newborn deaths being reported, the workings of Portlaoise maternity unit became the subject of an external inquiry into the unprecedented number of perinatal deaths occurring at the hospital. The report found that many of the deaths were preventable (Holohan 2014).

The end result was a National Maternity Steering Group, set up to oversee the development of the Strategy, that consisted of 31 members including Ms Sylva Langford the independent chair, 7 midwifery academic and clinical leaders, 9 doctors and 2 user representatives, Ms Shauna Keyes, and Ms Roisin Molloy. The chair of the Birth Activists Group, AIMS Ireland, Dr Krysia Lynch, was also invited to attend alongside other senior representatives from the Department of Health and HSE (DOH 2013: 128 Appendix B). A public consultation involving 1019 service-users, 202 health-care professionals, and 73 organisations (Keilthy et al 2015) (DOH 2016) and an international literature review (Hanafin and O'Reilly 2015) preceded the Strategy and were intended to inform the development of a Strategy that should reflect best available evidence (DOH 2016).

11.4. Upholding dominant governance structures

The National Maternity Strategy presented a unique opportunity to reform the patriarchal Mastership system of governance that exists in the three voluntary Dublin maternity hospitals (see section 8.3). In modern day institutions, the roles of manager and professional are separate domains with distinct roles and responsibilities, thus avoiding any conflict of interest. The Mastership combines both roles into one person (CEO and clinical lead) who, along with the Board of Governors, traditionally made up of doctors and clergy (Browne 1995), continue to have overall corporate and clinical responsibility at local and national level (DOH 2016: 102). Yet, the Strategy states that there are 'no plans to change the Mastership system' (DOH 2016:102). In fact, they propose to roll it out nationally. At a joint Oireachtas Health committee following the Strategy in 2017, Peter Boylan, a former Master of the National Maternity Hospital and the chairperson of the Institute of Obstetricians and Gynaecologists asserted that

'We wish to see the Mastership model of governance applied nationwide [...] this model has been in operation in the three Dublin maternity hospitals for more than 200 years. It is a tried and tested model that works.' (Oireachtas 2017).

Support for the Mastership was again reiterated at a joint Oireachtas Health Committee in 2018. In the Rotunda Strategic Plan 2017-2021, the Master, Professor Fergal Malone also acknowledged his commitment to maintaining the values of Voluntarism" (Rotunda Strategic Plan, 2017). The three Dublin maternity hospitals still remain independent, Voluntary organisations operating under Charter with a Board of Governors and the Mastership System. Real change in the system requires that midwives have governance over their own practice in a community midwifery setting, while still being fully integrated with both primary and secondary services. The fact that the Mastership governance structure exists virtually unchanged today, is testament to obstetrics unassailable control and influence on all levels of maternity care, "from the individual women to hospital policies to national policy making" (Murphy-Lawless 2011:3). This form of patriarchal and hierarchical entrenchment gives those

who benefit from these organisational structures a sense of embedded power (Bleakley et al 2012) that continues to remain largely unchallenged (Murphy-Lawless 2011). If a true overhaul of the system is to be achieved, the Mastership system of governance needs to be replaced with a more egalitarian governance structure that allows for true collaboration between professional groups who are in the business of sharing power.

11.5. Biomedical thinking underpins the Strategy

On first reading of the Strategy, many aspects appear hopeful. It begins by acknowledging that maternity care in Ireland is largely consultant-led and hospital-based and suggests that the model of care proposed, informed by a view of pregnancy and birth as a normal, physiological process represents ‘a fundamental overhaul of services’ (DOH 2016). If the Strategy is truly informed by the view of pregnancy and birth as a normal, physiological process, a wellness approach to practice should be adopted. In other countries where a wellness approach to maternity care is adopted, all women have access to a midwife as first point of contact in pregnancy. This is the case in England, Scotland, Wales and Northern Ireland, New Zealand, and Canada (Hanafin and O’Reilly 2015). For example, The Scottish 2017 Five Year Forward Plan, The Best Start (Government of Scotland 2017) states that ‘all women will have continuity of midwifery carer from a primary midwife’. The Northern Ireland 2012-2018 Framework Document also promotes an ‘early direct contact of the woman with her local midwife’ (DHSSPSNI 2018). Not problematising the GPs role as gatekeeper of the maternity services in the Strategy is problematic, as it does not reflect a wellness approach to maternity care. Instead, the position of GPs, as gatekeeper of the Irish maternity services, enshrined in the MICS, is not challenged in the Strategy, or opened up for meaningful discussion, but is presented as an uncontested norm in the Strategy.

“All women booking for antenatal care should be encouraged to register with a GP” (DOH 2016:84. Strategy Priority 3)

“All pathways of care [...] will lend themselves to a shared model of care with the GP, as provided for by the Maternity and Infant Care Scheme” (DOH 2016: bullet point number 16: 6).

The Strategy, as the excerpt above shows, continues to support the shared model of care with the GP, as provided for by the Maternity and Infant Care Scheme and underpinned by the idea that all pregnancies and births are potentially risky.

Another key tension at the heart of the maternity services and key to obstetrics thinking is the need to constitute, what is essentially normal pregnancy and birth for the majority, as risky, justifying their dominant role in maternity care. Power works by first constituting ‘the problem’ and second offering themselves up as the only legitimate solution to the problem that they have engineered in the first place. In obstetric thinking therefore, the solution precedes the

problem. The solution looks for issues for which the biomedical paradigm is the answer. Constituting 'the problem' through risk averse partial truth claims, are the means by which the potential and need for obstetric intervention is conceived, discussed, and enacted by obstetricians, and becomes understood and internalised by childbearing women, government policy makers, the media, and the public at large. This need to overemphasise co-morbidities among childbearing women in the Strategy is an attempt to construct the current cohort of pregnant women as high risk. The only legitimate solution to 'the problem' is that they must be under medical jurisdiction and management.

Obstetrics is a risk averse culture and a risk-based practice (see chapter 4 for more on risk). Risk discourse in obstetrics pathologized the social through issuing risk averse, partial truth claims. Those in positions of power tend to overstate the role of the powerful while simultaneously understate the role of the powerless; Obstetric thinking overstates the role of obstetricians in high-risk pregnancies, while understates the role of midwives in normal pregnancies. If midwives, women and the general public accept obstetric authoritative knowledge claims as representing reality, they unwittingly maintain the status quo, because "accepting a disciplines' knowledge claims has the effect of increasing the power of that discipline" (Fahy 2002:11). This is how the subjugated become part of their own subjugation. Contesting the power of the obstetric elites "is about outing the hegemony within which claims of 'absolute truth' operate" (Foucault 1977). Foucault refers to this as 'regimes of truth' that are thoroughly imbued with relations of power and therefore accepted unconditionally, as a mechanism by which knowledge is power and power is knowledge (Foucault 1977:23). In regimes of power, partial truths become constituted as whole truths; the idea of pregnant women with comorbidities, only a partial truth, becomes internalised as constituting all women in 21st century Ireland, the whole truth. Service-users and providers are effectively socialised into a tacit acceptance of medical involvement in *all* pregnancy and childbirth as legitimate, necessary, inevitable and for the benefit of all.

The risk imperative is also evident in the three care pathways based on risk assessment; supported, assisted and specialist care pathways (DOH 2016). In the Supported Care Pathway, intended for 'normal-risk' mothers and babies, the woman does not have a specifically named midwife but what is stressed is that she provides care within a multidisciplinary framework. The Assisted Care Pathway is intended for women of medium risk who will be cared for by a named obstetrician as part of a multidisciplinary team. The Specialised Care Pathway is intended for women with high risk categorisation who again will have a named obstetrician and will be cared for by the multidisciplinary team. The assumption here is that all pregnancies and births are potentially risky. Also, this obstetric reach into normal pregnancies and births is not sufficiently challenged in the Strategy. Childbearing women in both the assisted and specialist care pathways, and in the 'normal risk' pathway, upon request,

it is proposed, will be assigned to a named obstetrician (DOH 2016:5). This suggestion clearly safeguards private medical practice for low as well as high risk women. Using the obstetric and risk imperative to underpin the Strategy, has a dual effect of implying that all women's care requires supervision by an obstetrician and that midwifery care is somehow inferior to obstetric care, legitimising obstetrician's control of pregnant women's care and midwives' work.

What is missing from the Strategy is a critical insight into 'why things are the way they are'. What is missing is an acknowledgement that the current maternity system is a product of obstetric dominated government policy; obstetricians are the architects of the system; they designed it, they control it, they govern it, they perpetuate it. What is needed is an acceptance that this current risk averse, overly medicalised, fragmented, and depersonalised hospital system is not working for many women, as the most recent investigations demonstrate. The real problem with the current system will not be solved by more of the same. The technological imperative (Fuchs 1972) in obstetrics is the tendency among obstetricians to adopt the technical aspects of any intervention over the more humanistic alternative. This tendency is evident in the Strategy. Reform is needed and it is only with a better understanding of the root cause of the crisis in our maternity services, that an appropriate solution will be found and meaningful change happen. The impact of the biomedical obstetric imperatives on subjugating the role of the midwife in maternity care is further discussed in the following section.

11.6. Perpetuating the subjugation of midwives

If midwives are not viewed as distinct professionals and autonomous practitioners, they will never have full control over their work. The fact that there is no place for autonomous midwives in Irish obstetric thinking is evident in Doctor Peter Boylan's response as chairperson of the Institute of Obstetricians and Gynaecologists, to the Oireachtas Health Committee Review of the National Maternity Strategy 2016-2026, when he said that.

"We do not want to repeat the mistakes of separating out midwifery and obstetric care. They are both the same. All obstetricians are midwives and are proud to be midwives, but they are also looking after more complicated cases". (Oireachtas Debate 2018: 15-16).

The view that all obstetricians are midwives is also evident internationally, as a submission made to the South Australian Government on a Proposal to Protect Midwifery Practice in 2013 exemplifies. Australian obstetricians said that they objected to any legislation that would lead to separately defined midwifery and obstetric care.

"Maternity care" cannot be subdivided into "Midwifery care" and "Obstetric care" ... there is no portion of that care that can be partitioned off and described as 'midwifery care' (Professional Medical Organisation) (Rigg et al 2015:124).

Propagating this hegemonic obstetric discourse safeguards the vested interests of obstetricians with all births and leaves no space of autonomous midwifery practice, thus it subjugates and de-values the midwives role, while simultaneously legitimises obstetrician's control of midwives' work. This approach also leaves no space for true collaboration between obstetricians and midwives because true collaboration requires professional groupings to recognise and respect each other's distinct, yet complementary roles. In fact, what is missing from the Strategy is an acknowledgment of the evidence supporting the safety benefit having access to a midwife during pregnancy and birth confers to women and their babies (Brocklehurst et al. 2011, Buekens and Keirse 2012, Sutcliffe 2012, Sandall et al 2013, Renfrew 2014, Sandall et al 2015, WHO 2018). Also, the evidence presented by Hanafin and O'Reilly (2015) that is meant to inform the Strategy, relaying that all women should have access to a midwife, as lead-care providers for healthy well women and as part of the multidisciplinary team for those with known or developing complications during pregnancy, is not acknowledged in the Strategy. The refusal among the institutional elites to recognise midwifery's philosophy of care as distinct from obstetricians and of proven benefit to women is telling and represents a perpetuation of midwives subjugation in the Irish context.

Another attempt to de-value the role of the midwife in the Strategy is the juxtaposing of woman-centeredness and professional-centredness.

" At the centre of this Strategy is the mother. We have therefore avoided, as far as possible, profession-centric terms such as 'consultant led' and 'midwifery led,' as they incorrectly place an emphasis on the profession" (Langford [Chair of the Strategy] DOH 2016: 3).

'Midwife-led care' is an internationally accepted term used to describe the valued role played by midwives in the maternity services worldwide (Tucker et al 1995, Hildingsson et al 2002, Hatem et al 2008, Sutcliffe et al 2012, Walsh 1999, Begley 2011, Brocklehurst et al. 2011, Buekens and Keirse 2012, Sutcliffe 2012, Sandall et al 2013, Renfrew 2014, Sandall et al 2015, WHO 2018). The juxtaposing of 'women-centredness' with 'professional-centredness' such as 'consultant-led' and 'midwifery-led' is used in the Strategy to downplay the role of the midwife and justify omitting the 'midwife' in the newly named proposed care pathways. So, instead of a clear and unambiguous 'midwife-led care pathway', a vague and non-descript 'supported care pathway' is adopted in the Strategy, followed by the equally ambiguous 'assisted care pathway'. The title midwife-Led Units (MLUs), well established in Ireland since the first units were open in 2003, is referred to in the Strategy as Alongside Birth Centres, and Midwife-Led Homebirth Services is referred to as HSE Homebirth Services. This decision to omit highlighting the midwife's role in the new care pathways is justified in terms of it being 'rational' and 'woman-centred' as opposed to professional-centred and its success is dependent on midwifery acquiescence. But this move should be viewed as a hegemonic tactic

that safeguards the vested interests of obstetricians while simultaneously subjugating the role of the midwife. As Bauman (1989:142) succinctly puts it “the rationality of the ruled is always the weapon of the rulers.” It is a strategic obfuscation⁷⁷ on the part of the hegemonic elites; in order to obscure the role of the midwife. By gaining midwifery approval, the rulers continue to rule without any obvious use of coercion. While more subtle than the public campaign to discredit domiciliary midwives in the 1930s, the intention is the same.

To imply the term midwife-led care would de-centre the childbearing woman from her rightful place at the centre of care, is to deny the historical legacy from which the concept emerged as a contingency to counter and resist the biomedical paradigm and reclaim control of normal birth for women and midwives (Association of Radical Midwives 1986). Woman-centred care epitomises the midwifery philosophy of ‘being with woman’, which is at the heart of midwifery care (Guilliland and Pairman 2010). Juxtaposing women-centredness with midwife-led care is an example of how the powerful re-appropriate, re-interpret and re-write history to promote their own vested interests and current agenda. In this instance “the subject of history is but the product of apparatuses of power/knowledge” (Foucault in Balbus 1987: 117) and is an example of what Foucault refers to as ‘a micro-physics of power, that is “constituted by a power that is rhetoric, strategic and tactical rather than acquired, preserved or possessed” (1977: 55). Rhetorical is used to persuade and influence beliefs and practices of the ruled, by those doing the ruling. The result is effectively to side-line midwives by ensuring their subordination. Here again, we see the constant need of obstetricians to safeguard their role and supremacy by subjugating midwives by influencing them to be part of their own subjugation.

Another key component of the Strategy that perpetuates the subjugation of midwives is that the community midwife’s role is framed as part of the hospital ‘outreach service’ only as not as part of primary care (DOH 2016:12). The possibility of moving most of maternity care out of the HSE’s Acute Hospital Services Directorate and into the Primary Care Directorate, is not given thoughtful consideration in the Strategy. Yet, the current governance arrangements have major implications for the nature of midwifery work. Under the Mastership governance structure, within the current budgetary constraints, monies allocated to develop community maternity services is likely to be spent on developing acute services. This is reflected in the subsequent HSE National Service Plans (HSE 2016c, HSE 2019c). The need for separate governance structures and separate budgets to develop the community midwifery services, that is ring fenced, centred around women’s needs, and controlled by midwives, as part of the primary care team that deliver these services, is critical to successfully implementing these new services.

⁷⁷ The obscuring of the intended meaning of communication by making the message difficult to understand (Oxford English Dictionary 2020).

If obstetricians truly wish to work in partnership with their midwifery colleagues, as Doctor Boylan, in his capacity as Chair of the Institute of Obstetrics and Gynaecology said in 2016, they need to abandon their tendency to subjugate midwives' identities to assert their own.

11.7. Locating the problem; with institution or with individual

Another tension at the heart of modern-day maternity care is the tension exercised between the institutions and the individual. Predilection to escalating interventions is part and parcel of the biomedical culture of childbirth. Risk escalation in the Strategy, however, is explained exclusively in terms of demographic and epidemiological changes, and not in terms of the predilection to escalating interventions. Rather than focus on whole system improvement to promote a health and wellbeing approach, the focus is almost exclusively on lifestyle choices and conditions that could negatively affect the woman's health and wellbeing. The problem and solution to the maternity care 'crises are framed in terms of a women's individual freedom to choose positive lifestyle choices, where success and blame centres on the choices the woman makes and on the medical profession's ability to manage the defective bodily conditions that arise from these choices. The concept 'individual lifestyle choices' shift attention away from socioeconomic disparities and inequalities that exist within the system (Marmot Review 2010, 2020); as if pregnant women living in precarious circumstances have actually made a choice to do so, with no mention of the stratification of health in line with our national statistics on socioeconomic status and on how socioeconomic inequalities cut across maternal and perinatal health outcomes (Renfrew et al 2014).

The current crisis in maternity care is embodied in the image of the woman's body as obese (McKeating et al 2015), older (Bell 2001, Carolan and Nelson 2007, 2009, ESRI, 2013a), and with more co-morbidities (Knight et al 2015). This is reminiscent of how puerperal sepsis, rife in institutional settings in the latter half of the 18th century and associated with high maternal mortality rates, was similarly explained by a previous master of the Rotunda in terms of arising from "the [poor, unmarried lying-in] women themselves and not from the men midwives spreading infection" (Murphy-Lawless 1988a: 297).

This emphasis on individual pathophysiology and 'defective bodily conditions' exemplifies Foucault's idea of the 'medical gaze' (1976), that by nature is partial, fragmenting and dominating. Risk averse partial truths are always "contextualized in a framework which makes it intelligible" (Foucault 1977: 26-27). While it is true that the average age of mothers giving birth in Ireland is increasing, with almost one-third of women giving birth aged 35 years or older (ESRI, 2013a), this means that 2/3 are aged 35 years or younger⁷⁸. It is also true that the percentage of childbearing women who are categorised as obese has increased (Lay and

⁷⁸ The average maternal age for women giving birth nationally ranged from 31 to 32 years over the period 2010-2015 (CSO 2016).

Turner 2013, McKeating et al 2015), but whether the increased risks of caesarean section associated with these women's maternity care is justified, or more a reflection of obstetric thinking, in the risk averse, high interventionist culture of the Irish maternity services, calls for further investigation. It is widely reported that the high rates of intervention in Ireland are 'not fully accounted for by medical or obstetric risk differences' (Murphy et al. 2013: 1). Also in the Irish context, high rates of intervention are also associated with private practice, regardless of risk factors (Lutowski et al. 2014). This is because obstetricians' interventionist imperatives are very often unwarranted and to the detriment of women's well-being (Murphy-Lawless 2013a).

By focusing the current crisis in our maternity services on individual unhealthy lifestyle choice and defective bodily conditions instead of on the structural issues, we fail to address the over-medicalised, highly interventionist, risk averse culture of the organisation (Edwards and Murphy-Lawless 2014), or the grievous socio-economic inequalities which place women at a disadvantage when they become pregnant. Attempting to do so blatantly ignores the fact that the Strategy was triggered by the numerous government sponsored reports of systemic systems failures. These included failure to follow up blood tests; failure to make adequate assessment and monitoring; failure to offer all management options to the patient; failure to adhere to clinical guidelines and best practice, and poor communication at shift changes (DOH 2013, Cullen 2013). This over-emphasis on individual risks and complexities generates shame, guilt and blame among birthing women and diverts attention from the fact that most women are healthy and well at the onset of labour (KPMG 2008); they are better nourished, have fewer babies and longer intervals between births, compared to their earlier counterparts⁷⁹. Not seeking medical expertise is cast as deviant and/or irrational and immoral and not acting in the best interests of the baby. This spread of misinformation or half-truths, is not alone oppressive and coercive, it also denies both social and reproductive justice to women (Bridges 2011, Luna and Luker 2013).

11.8. Alongside Birth Centres and 'the get out clause'

The long-awaited government commitment to develop Alongside Birth Centres (ABCs) more commonly referred to as MLUs, is included in the Strategy. Women in the supportive care pathway will now have a national choice to birth at home or in an Alongside Birth Centre (ABC).

"Each maternity network will be required to prepare a plan to provide Alongside Birth Centres across their network. In determining the priority for implementation, each maternity network will have regard to the need to ensure a reasonable geographic spread of such birth centres across the network" (DOH 2016: 6).

⁷⁹ In the 1960s Coombe hospital annual report, "Coombe Grand-Multipara" were referred to as the 'dangerous multipara' (Coombe Hospital Report 1960:7).

Despite it appearing to be counter-intuitive, evidence now proves that proximity to obstetric-led maternity units for women experiencing a healthy pregnancy increases the likelihood of an interventionist birth (Downie et al 2001, Jomeen 2010, Brocklehurst et al 2011, de Jonge et al 2013). That women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions and more 'normal births' than women who planned birth in an obstetric unit, with no adverse impact on perinatal outcome (Brocklehurst et al 2011)⁸⁰. In a survey of women's experiences of maternity care conducted by AIMS in 2014 among 2,836 women, 58.5 per cent said they would opt for a freestanding birth centre, if the service was available (AIMS 2014). While making no reference to Freestanding Midwifery Units (FMU), the Strategy does advocate for the development of ABCs (MLUs). Yet, on closer inspection the Strategy includes a 'get out clause', that when not feasible, the substitution of alongside birth centres (ABCs) with homely, non-clinical rooms within the smaller obstetric unit, as an alternative to ABCs was recommended.

"An Alongside Birth Centre should ideally be situated immediately alongside and contiguous [meaning adjoining, touching, attached, connected] to a Specialised Birth Centre" (current labour ward) (DOH 2016 pg.6)... [and] ... "where it is determined that, given the small size of a maternity unit, a discrete Alongside Birth Centre cannot be justified, it recommended that a designated space is established within a Specialised Birth Centre, with an appropriate environment and processes to ensure that, as far as possible, the normal risk woman will be provided with a natural childbirth experience" (DOH 2016: 7).

The 'get out clause' contained in the Strategy means that introducing an ABC depends on if having one can be 'justified.' That final decision becomes the prerogative of the ruling elite, embodied in the Mastership system, who can use their embedded authoritative power to unilaterally veto a legitimate decision made through democratic processes, if they feel its justified. This is difficult if introducing them would not suit their vested interests. In change theory this is referred to as 'the pocket veto' (De Caluwe et al 2003:16-17).⁸¹ The pocket veto is the principle behind agreeing one thing in principle and doing another in practice and is a

⁸⁰ The Birthplace in England, national prospective cohort study (Brocklehurst et al 2011) exploring perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies, involving over 64,000 low risk births including 28,000 planned low risk midwifery units (freestanding and alongside) and 20,000 planned low risk obstetric units, found that women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions and more 'normal births' than women who planned birth in an obstetric unit, with no adverse impact on perinatal outcome. For women having a second or subsequent baby, the proportion of women transferring to an obstetric unit during labour or immediately after the birth was 9% for planned FMU births and 13% for planned AMU births.

⁸¹ This term originated in Political Science where the president of the United States can decide not to approve a bill that has already been passed by Congress, by simply doing nothing until the time to approve the bill has expired (De Caluwe et al 2003:16-17).

means by which those in positions of power and influence, can sabotage decisions agreed by stakeholders, by blocking the executive from making those decisions, at the final hurdle and without a public mandate. It is not what powerful elites say they will do that counts, but what they actually do. Promises and compromises made by the powerful elite are later 'vetoed' through inaction or simply not allocating adequate resources. Whoever controls the budget, controls government maternity policy, and by examining budget allocation, the values that underlie it are laid bare. The use of unilateral vetoes in hierarchical institutions arise from "too great a recourse to hierarchy, from serious differences of opinion, or from too little discussion, respect and acceptance" (de Caluwe et al 2003:17) and where those in positions of authority feel they know best and thus feel morally obliged to act.

When negotiating for change that is contentious and challenges the status quo, it is imperative that monies for the proposed change are ring-fenced and agreed in an open forum. Who has the final say on how budgets are allocated and under whose mandate, needs to be pinned down? Finally, change agents need to keep track of the execution of these decisions by lobbying those in attendance and holding the elected members of parliament to deliver on the promises embedded in the Strategy. To date, four years on, no ABCs appear to have been deemed necessary.

The alternative to ABCs is a home-from-home room on the labour ward that facilitates a natural childbirth experience. A pilot project aimed at facilitating a "home environment in a maternity hospital" recommended in 1997, as part of the 1990s midwife-led initiatives (DOH 1997), gave as its rationale that this atmosphere would prove desirable to women "who would wish to have a delivery in a homely atmosphere but who would be afraid for whatever reason not to be close to hospital services" and that "hospital support would be available for any emergencies that might arise" (EHB 1997: 5). The assumption was that proximity to obstetrics units confer safety. Yet, attempts to create a home-from-home environment in maternity units in the UK, as far back as the 1980s, was overly simplistic, ignored the impact of the biomedical interventionist culture on the care being offered and proved futile precisely because of its proximity to the obstetric-led unit (Oakley 1980).

The assumption that hospital birth is the safest option for all women has underpinned obstetric dominated government maternity policy since the MICS and continues to be the case in Ireland's first National Maternity Strategy over 60 years later. The following account appears to confirm this.

HD2: I do not buy this idea of [...] two separate labour wards, to me that's a non-starter because what you'll have is a situation where you'll have territorialism, you also have division and you also have, if you are very busy, an inability to run the service, so, what I argue for, okay, I said this to the HSE [...] if you're building a labour ward that every room in the labour ward should be capable of delivering

every model of care, that no patient should be sent to another part of the hospital to access another level of care, you want your birthing pool, you want your resuscitaire behind the wall, you want your bouncy ball, [...] that if the low risk woman goes in there and she develops severe pre-eclampsia in labour that she does not move outside that room and that room then becomes a high risk room [...] midwives and obstetricians need to be able to work across.

Underpinned by a risk averse approach, obstetric authoritative knowledge appears eminently rational. If you believe that all births are potentially risky, it makes sense that all women have access to an obstetrician and appropriate birth technology. But the evidence contradicts this view. The central critique of the biomedical paradigm, that authoritative knowledge rests with the professionals and not with the childbearing woman is evident here. Not only is this doctor's 'expert' knowledge, not evidence-based, it is oftentimes counter to women's needs and desires. Authoritative knowledge from this positivistic perspective is presented as 'the truth' and as merely standing *for* reality. This is consistent with Smith's argument that there is a clear link between the standpoint of men [who are in these authoritative positions], their claims of objectivity and rationality and relations of ruling (Smith 2012). Men who do the ruling are the beneficiaries of objectified, scientific knowledge (ibid.). Many of those in positions of authority and influence hold no official mandate. While wanting to be seen as progressive, they continue to uphold the principles of the biomedical paradigm; advocating women-centred care while simultaneously thinking that they know best and continuing to promote a bureaucratic centralised system. Despite claiming to be woman centred, which suggests that women's views have some sway, proponents of the biomedical model appear to have held the dominant decision-making powers in the maternity strategy steering group. Contested authoritative knowledge/power claims of obstetric elites, that are not evidence-based and not in women's best interest, may be a useful strategy in reducing medical dominance.

11.9. The vision and immediate impact of the Strategy

The national Maternity Strategy appears to be 'all things to all people' and by trying to please everyone it is left wanting. Ambiguity in the form of conflicting goals and ideologies is at the heart of the Strategy. No matter what perspective you approach the Strategy from, you could argue, using a few well-chosen quotes, that your views are well represented and legitimated. If your concern is about managing and categorising risks in childbirth, or alternatively, about promoting normal physiological birth, both reflecting competing ideologies of reproduction (Graham and Oakley 1981, Garcia et al 1990), you will find a suitable quote to support your

argument. Numerous government reports on the scandals in our maternity services over the last decade have demonstrated that our overly medicalised maternity service is out of step with current best practice models. Yet, the Strategy does not grasp the nettle, it does not offer clear and unambiguous statements about what cultural changes are needed and how these might be achieved in practice. The common shared vision and overarching goals between policy makers, the public and professionals, so important in system-wide reform at a cultural level is missing from the Strategy. Effective communication of goals “can be clear only if we are aware of our own as well as other people’s paradigms” (De Caluwe et al 2003:7). With no shared vision in terms of the cultural changes needed, it is doubtful that meaningful and sustained reform is even possible. This is reflected in the title of the Strategy, that does not reflect the urgent need for change in the maternity services. No advertising campaigns or marketing accompanied the launching of the Strategy. It also does not take cognisance of the political, social, and historical contingencies within which the Irish maternity services are embedded, beginning with the MICS.

By way of comparison, the impact of *Changing Childbirth* in England and Wales (DOH England and Wales 1993), now 28 years old, left a lasting legacy on how policy makers and healthcare workers ‘think about’ the maternity services, not just in the UK, but worldwide. Although not successful in changing practice, it was the first time that a government policy document acknowledged women’s experiences of maternity care and challenged the culture of non-participation of childbearing women in decision-making (McIntosh and Hunter 2014). As is evident in its title, it made clear and unambiguous recommendations for change that were contentious, revolutionary and resonated deeply with large sections of the community (McIntosh and Hunter 2014). The need for a humanised approach to care was widely recognised. It is also accredited with reversing official government policy that hospital was always the safest place to give birth and emphasized the psychological as well as the physical impact of childbearing on women (McIntosh and Hunter 2014). The take home message, the three C’s, choice, control and continuity, though contentious, were powerfully simplistic. The new vision for the maternity services was easily communicated and understood by policy makers, service-users and providers alike. It effectively put maternity care on the international agenda, opened up honest engagement with and provoked a mature conversation about the nature of the maternity services and issues of concern. This was a powerful example of genuine political action, “a powerful example of proactive communication and collaboration, if not always agreement” (McIntosh and Hunter 2014: 280). Sadly, this cannot be said for Ireland’s first national maternity Strategy.” The difficulty of translating rhetoric into action as experienced by *Changing Childbirth* has and continues to be a feature of maternity care” (McIntosh and Hunter 2014:281).

11.10. Conclusion

The purpose of this chapter was to utilize the biomedical imperatives as heuristic tools to analyze the principles underpinning the Strategy. An exploration of whether the proposed changes in the Strategy constitute moments of genuine political action or not were also examined (see chapter 9 for more on political action). Finally, whether changes to the ruling relations are likely to result from the proposals embedded in the Strategy were examined. The Strategy in trying to appease everyone reflects the inability of the steering group to reconcile their differences. The end result is an ambiguous coexistence of conflicting goals and ideologies of reproduction. Despite the apparent compromises, the Strategy appears to be a calculated tactic aimed at supporting obstetric control more than a true engagement in a democratic process. The end result is that the cultural hegemony of the maternity services is not challenged or disrupted. The power-relations underpinning the MICS (1954), operationalised as the combined-care scheme, continues to dictate the terms upon which maternity care is practiced unabated and constitutes 'the way things have always been done' and 'the only way of doing maternity care' in Ireland. This reflects the historical discordance at the heart of the Irish maternity services that still resonates today. It means that a shared and easily communicated vision of the Strategy is missing.

The power of the biomedical paradigm is its ability to reproduce the social structures and established processes that support it, without appearing coercive. A rhetorical strategic and tactical use of power rather than a coercive use of power is shown in the Strategy. Yet cracks are appearing in the biomedical arsenal. Out of the apparent weakness of the Strategy comes possibilities. It is the ambiguous coexistence of contradictions and conflicting ideologies embedded in the Strategy that makes change a possibility. Whether the first National Maternity Strategy constitutes a moment of genuine political action or not depends, not so much on what policy makers and leaders in obstetrics say they are going to do, but what they actually do that counts. What is needed now is for midwives to engage in collective solidarity and unite behind their professional body, the MAI, to make their collective voices heard and to challenge and hold the government to account to deliver on the promises embedded in the Strategy.

12. Chapter Twelve Micro-analysis: bureaucratisation and the biomedical model

12.1. Introduction

From the 1950s onwards, with the introduction of the Maternity and Infant Care Scheme (MICS) in 1954, antenatal care has been shared between GPs and obstetricians or hospital doctors in training, with midwives in an assistant's role. Midwife clinics were introduced for

women considered low risk from the late 1990s onwards. At the time of data collection (2013-2015), hospital clinics were generally scheduled from 8am to 4pm, Monday to Friday, with most clinics occurring in the morning. Midwife-led hospital clinics were introduced to run alongside the traditional clinics on one or two days a week. Outreach community midwife clinics took place in health centres and primary care centres at various locations across Dublin. The timing of these clinics depended on room availability and were more likely to occur from 5 to 8 pm, after day surgeries had finished.

Currently, there are between 50,000-54,000 antenatal care appointments per year in each of the three Dublin maternity hospitals (CWIUH Annual Report 2019, Rotunda Annual Report 2019). Despite these changes, childbearing women accessing the maternity services for the first time in 2021 are still directed via the HSE (Health Service Executive) website to attend a GP once pregnant, and not the midwife, so visiting the GPs tend to be the woman's first contact with the maternity services.

The aim of this chapter is to explore and make explicit how the organisation and coordination of antenatal care at local level is shaped by broader institutional forces and power-relations. Data used is generated from interviews with participants (women, GPs, midwives, obstetricians) and participant observations of the antenatal encounters (see chapter 3).

Focusing on the individual does not offer much help in effectively challenging or changing the workings of the institution (Smith 2005). When exploring the dominance of the biomedical model in practice, we need to go beyond the individual and particular professional groups and think of it as the property of institutions, where practices are informed by the dominant culture of the institution (Cox et al 2012). The encounters summarized here illustrate typical patterns in the sampled interactions.

For theoretical analysis this chapter using a feminist lens, draws upon the work of Michel Foucault, and his conception of the medical gaze, disciplining power and power/knowledge and Dorothy Smith's work on relations of ruling to analyse the mechanisms of social control and surveillance in the antenatal encounter.

12.1.1. Bureaucracy and biomedicine

The aim of this section is to describe how antenatal care is organised and coordinated using a bureaucratic institutional model of maternity care. Findings suggest that the development of obstetrics necessitated the institutionalisation and bureaucratisation of pregnancy and birth in Ireland, making mass processing of pregnant women possible. With increased centralisation of biomedicine, the need to process increasing numbers of pregnant women within a smaller number of urban hospital services has led to the increasing bureaucratisation of the service, where the focus is on keeping everything manageable, and where the emphasis is on

efficiency, maximising throughput, and appropriate use of dwindling resources (Bourgeault 2000, Kirkham 2004, Finley and Sandall 2003). Findings suggest that the biomedical model and the bureaucratic institutional management system are interdependent and co-constituted and that one way of identifying entrenchment of the biomedical model at local level is to identify the extent of the bureaucratic management system currently in operation. That is because bureaucratic management systems focus on maintaining uniformity and conformity by steering individuals to follow strictly designated rules and regulations. This is the mechanism by which bureaucratisation has acculturated service-users and providers into the institutional norm of the medical model of childbirth (Davis-Floyd 2008).

12.1.2. *Bureaucratisation and maternity care*

James Deeny, the chief medical officer to the government during the period from 1944 to 1950, noted that the defeat of the original 1950 Health Act 'opened up the way to the centralised, bureaucratic, politicised and authoritarian government' (Deeny 1989: 178). Bureaucracy means the

"objective discharge of business [...] according to calculable rules and 'without regard for people. Bureaucracy develops the more perfectly, the more it is 'dehumanised,' the more completely it succeeds in eliminating from official business love, hatred, and all purely personal irrational and emotional elements which escape calculation' (Weber quoted in Allen 2004:144).

Both bureaucracy and medicalisation are instruments of rationalisation where objective reasoning based on rules, regulations, and norms, guide how the organisation is administered (Bauman 1994). Bauman (1994: 6 & 10) refers to this as 'procedural rationality'; the constructive principle of organisations' that underlies bureaucratic systems (Bauman 1994:6). Central to bureaucratic administration and governing structures is the role played by technical knowledge where 'bureaucratic administration means fundamentally the exercise of control on the basis of knowledge [...] and this is the feature of it which makes it specifically rational' (Weber quoted in Gouldner 1964: 21). Also, central to Weber's notion of bureaucracy are the roles played by discipline and obedience. This involves unconditional obedience and acceptance of the rules 'for its own sake' (Gouldner 1964: 22) and is required for the system to achieve uniformity and function rationally. As the findings of the micro analysis demonstrated, it is through this process of cooperation and acceptance of the system as given, that the system is reproduced without resistance. Just as Descartes believed in universal laws, bureaucratic and biomedical systems are universalising systems that subjugate individual needs.

12.1.3. *Fragmentation and de-humanised care*

Fragmentation and task orientation under strict time constraints, thought to improve efficiency, are central tenets of bureaucratisation. In this context, care is broken down into manageable tasks, and the woman is moved along in an orderly fashion, from one task to another, and from one person to another, where each task is allocated to a different person. For "a 'problem', to become a 'task', it is first cut out from a tangle of its multiple connections with other realities" (Bauman 1993:194). It is in the nature of fragmentation and task orientation to objectify the subject, by separating the task from the person. This has a dehumanising and de-personalising effect on the interaction, which impacts the formation of therapeutic relationships (Kirkham 1999, Stach 2020). For example, the number system used for organising antenatal clinic appointments is a manifestation of this.

Researcher and woman interview 5

W: I am number 72. Once you check in and they give you your file, they give you a number.

R: So does that mean that there are 71 women ahead of you?

W: Yes, but there are one, two, three, possibly four doctors, so you divide that among four doctors, that's 10 minutes each.

The number system, used for mass processing of women attending the clinic, reduces the woman to an inanimate object that can move through the system unhindered by individual characteristics. It is the universalising nature of the system, the focus on technological protocols as opposed to the person's unique circumstances that renders the system efficient and rational. But many hospital clinics do not appear to cope with the numbers of women attending the maternity services.

The following excerpt demonstrates that the procedural, task orientated, nature of hospital antenatal care is not confined to the hospital setting but is also routinely practised in the community GP/woman encounter.

GP4: "We've seen this lady at an earlier stage say and now we want to do a follow up antenatal visit, the workflow is determined to some extent by the Health 1. Pro-formulas [referring to computer programme] that we have where we simply record the date, we calculated the duration of the pregnancy from the information that we got previously, we do the weight, urine, blood pressure, and then we examine the abdomen and listen to the foetal heart and then we'll ask them if there is any worries or questions that they want to put to us. Now it could be improved and amended. It could be changed but it's a bit like the antenatal chart in the hospital where you just tick the boxes right across and just sign it. That is our equivalent. Most of us feel what we're doing is pretty similar to what

the hospital's doctors are doing. If they see somebody, we record what we are doing and give it [the electronic printout] to the women”.

Fragmentation of the antenatal encounter into multiple tasks performed by different professionals is also evident in some GP practices, where antenatal encounters are shared between the practice nurse and the GP.

GP2: “Some GPs might have different systems where they might see the lady, [pause] the nurse might do all the checks [BP, urine} and they [the GP] might quickly see the lady and check the checks. Sometimes the nurse might do the entire check-up”.

In the former situation, the nurse completes the mothers observations, while the GP does the abdominal examination and listens to the fetal heart. There is now the added complication that practice nurses are no longer required to be midwives, so nurses who have not a midwifery qualification would be working outside of their scope of practice if they conducted antenatal care. Another woman’s account, who is attending a different maternity hospital, and is on her first pregnancy, echoes these findings.

(W & GP Observed Encounter 1)

Woman: “Yeah, I had an appointment yesterday, [pause] in all I saw two midwives and one doctor [clearly irritated about this] [...] although the visit with the doctor was very brief, I had been waiting for two hours in-between seeing the midwife and the doctor [pause] it was chaotic, I got no clear instructions, I had been waiting for two hours to be called when I should have gone back to the other midwife with my urine sample. So firstly, I was seen by one midwife and after two hours by a second midwife and then only saw the doctor for a few minutes”.

The suggestion here is that the woman did not have a quality encounter with the doctor and did not see it as a positive pregnancy experience. Again, in the following account, childbearing women appear to spend much of their time in the antenatal clinic queueing, and very little time in consultation with the doctor or midwife.

C2: We would have huge numbers, we would have traffic jams of people queueing up to try to get into the hospital, queueing up to get parking and then queueing up to be seen by a consultation that may last five minutes. So, the best part of the morning was gone for a very short consultation.

As one doctor noted, the way the current system is organised, women are ‘left behind and forgotten about’ and ‘they [the doctors] are far more likely to miss something’.

C1: (um) and you know people are kind of left behind and forgotten about a little bit and (um) I think that’s (um) far from ideal you know. [...] You have doctors in such a rush to get people in and out of the room, they’re far more

likely to miss something because they're so intent in just getting those one hundred and twenty patients through in two hours and you, kind of just treat everybody the same and it's easy to just say come in, how are you doing? Fine.

Here's your scan, off you pop and let's get the next patient in.

The clinical midwifery manager also emphasised the need to 'keep the system moving'. Again, she juxtaposes this need for throughput, with the patient's needs being left behind.

CMM= clinical midwifery manager 002

CMM: [...] I think it's [antenatal clinic] more kind of system centred, in that it's [pause] run to, kind of keep the system moving you know, as opposed to being there to kind of look after the individual needs of the patients. [...] The system has to keep moving, even though the patient's needs are maybe left behind a little bit.

The fact that the individual is left behind in bureaucratic systems should not come as a surprise. Bureaucratic systems do not attempt to distinguish between one person and the other. It is in the nature of bureaucratic systems to subordinate the needs of the individual, both service-users and providers, to the needs of the institution. De-personalising the system is the mechanism by which the system is rendered rational and efficient. This has a dehumanising effect.

"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).

Because individualism violates the norms of universalising systems, antenatal bureaucratic management systems are barriers to individualised care and are found to be incompatible with facilitating woman-centred care and inhibits the formation of therapeutic relationships.

12.1.4. *Relational continuity or lack of*

Relational continuity models are not facilitated in the traditional bureaucratic, combined-care scheme, where attending multiple care providers is the norm. Yet, continuity models and the development of a personal relationship between service-user and provider are inextricably linked and are associated with a quality and safe maternity services (Renfrew et al 2014). See chapter 5, section 6.9 for more on relational continuity.

C 1: You know, you're not going to meet them on the labour ward, the likelihood [is] you know you only scratch the surface of things [...] that's definitely lacking, you don't get to [...] you don't get to know them. You don't understand what their (um) what their feelings are, what their wishes are for the delivery (um)".

This seriously impairs the development of therapeutic relationships.

Woman 7: "I don't know if I can choose to go to a particular person, but I know you must go to the hospital. I meet different midwives every time. The last time I met two midwives. First [midwife] asked lots of questions, 2nd none. When you're meeting a new person you don't know how much they know about you".

Both service-users and providers recognised the enormous advantages conferred by relational continuity models of care. The advantage afforded to women who book privately or semi-privately in terms of relational continuity models is recognised.

Doctor 1: "Private patients are seen almost exclusively by their obstetrician, so unless they express a specific desire to see their general practitioner, then they would be seen regularly over the course of the pregnancy by their obstetrician and not by anyone else. [compared to public] There tends to be a lot more continuity in semi-private. (um) Obviously, people have holidays and cover and all this kind of stuff (um) but people tend to take the same semi-private session all the time".

This is compared to the public clinic where

"You could see everybody during your pregnancy, [pregnant women] are getting past around from one person to another (D1).

The probability that high risk women will be afforded more continuity is also remarked on.

C 1; "the junior doctor population is broken up all the time, and it could be a different person all the time. (um) The consultants are continuous in that they take the same clinic on the same day (um), they obviously can't see everybody all the time (um) but there're certain patients, say high risk patients, that end up seeing the consultants all the time"

In the account above, low-risk women who attend the traditional biomedical clinics in the hospital setting are particularly disadvantaged in terms of continuity. Referring to the value of relational continuity that is not facilitated within the current organisational structures, one doctor suggests that it is especially important for the most vulnerable women. Here, the consultant associates continuity with 'being looked after'.

Doctor 1: "But you know, in the system we work in, I think it's more important that people who are that little more vulnerable, who need a little more looking after, seeing a familiar face on a regular basis instead of just a different person all the time [is important]. I think a lot of the time someone who is maybe a little more vulnerable like that, just needs to be made to feel that, (um) that they're in the right hands, and they're going to be looked after. Even if you do categorise this person's risk as being low (um), it would be quite important to make that girl feel like she's going to be looked after over the course of the pregnancy"

Midwife-led continuity models for low-risk women is the evidenced based solution to this inequitable situation and is linked to providing a quality and safe maternity services (Renfrew et al 2014).

Midwife 8: "[continuity] is a good idea because we were trying to get a bit of continuity of care that maybe then, sometimes, some of the women in labour might meet the midwife you know, that she'd seen downstairs on a Tuesday. Last time I looked, seventy-six percent of the time, (um) I would facilitate the clinics so I would know the women and they would (um)...they love coming back and seeing you again cause they know...I remember I might have written down, going to Poland on her holidays, so I'll go oh yeah how did you get on on your holidays you know at Christmas, or whatever, so little things like that, or also, I would have seen them with their last baby and they're back then straight away into you. (um) So there's that little continuity of care".

Continuity was also provided for childbearing women attending 'specialist clinic', where women attended the same consultant and midwives worked as part of the multidisciplinary team. When women get the opportunity to know their health care provider, when the healthcare provider has time to listen and when the woman gets the opportunity to ask questions, this positively impacts the quality and safety of the antenatal encounter.

Women 7: "She [the GP] has time to listen to my stories - even if it is not physical but mental – you're not afraid to tell her. [...] I can tell her one hundred small things. She will tell me what is important and what is not important. [...] I feel calm now. All questions I had were answered. I had 3 questions. She looked in my file and went through it with me and explained everything to me. It's like when you don't have any more questions, it's good."

The opportunity to develop a therapeutic relationship is also highly valued by healthcare providers.

Doctor 1: "Its quite a nice aspect of your job, but you have to get to know them personally and you have to [...] make them feel that [...] you're tied to them a little bit you know. You kind of get to know people's quirks a little bit as well, and that's kind of important you know. And (um) I think (um) you know how people will respond towards the end of the pregnancy and I think that's [...] look, that would be far more desirable but I think we're a long way away from that unfortunately. I think it's far more preferable to just seeing a different random face all the time. "

By keeping the woman and healthcare professional separate from each other, fragmentation limits communication and meaningful interaction, and limits strong advocacy for the woman, on the part of the healthcare provider. This leaves the woman

in an inherently weakened position, where she comes to feel that she must negotiate the maternity services on her own.

12.1.5. *Bureaucratic systems are dysfunctional systems*

There is a general agreement among participating healthcare providers in this research that the hospital outpatient antenatal system is dysfunctional and does not meet the woman's needs.

C1: But I think that everyone in that clinic is run off their feet you know, that (um) whether it's the midwife trying to put people through, or the blood pressure, giving urine or taking the pulse, or you know, all this kind of stuff, that there is first of all too much work for the number of people who are assigned to the clinic. And the facility is also just inappropriate [...] So, as a result, the place is absolute mayhem.

The dysfunctionality of the system is not located in the centralized bureaucratic administration system itself, but in the outdated hospital infrastructure that is not fit for purpose, poor staffing levels and the service that is completely overstretched. Despite this acknowledgement, the consultant still thinks that the way forward is to be more efficient.

C 1: But I think the model of the clinic is kind of clumsy. I don't think it's as efficient as McDonald's. I don't know. I think it could be a lot more efficient. I think those clinics are completely dysfunctional. I think they bring very little benefit to anybody. I think there is, look, absolutely, the way the system is designed (um) There are big discrepancies in what should happen and what does happen.

The discordance created by the discrepancies between the ideal way of practising and their practical reality suggest that there is an acknowledgement that change is necessary as well as an openness to change. In the following accounts, again there is an acceptance that the hospital outpatient system is 'far from perfect'. Viewing the system as 'a necessary evil' suggests a reluctant acceptance of the way things are, and a powerlessness to change it, given the demands on the service.

Clinical Midwife Manager = CMM 002

CMM 2: "I think it's more system centred in that it's, [...] I think it's probably a necessary evil at the moment, (um) but (um) I think (um) that it's, [...] it's far from perfect you know. It's more so, that the system is this enormous juggernaut that has to continue and deliver, you know, sixty thousand women a year nationwide, or whatever it is, and (um) as a result of that (um) the (um) [...] as a result of that the (um) the system has to keep moving".

Here the 'system' is presented as an objective entity, something that is fixed and exists independently from social context and social relations; the 'system' is unstoppable and presented as a structural barrier to addressing individual 'patient's' needs. Internalising the

unstoppable, bureaucratic nature of institutionalised antenatal clinics as necessary and inevitable, impedes individual agency and makes any meaningful change inconceivable. The abdication of wider responsibility for the dysfunctional services to government policy, and lack of funding for what is an outdated infrastructure, gives weight to the belief that both service-users and providers are victims, and as such, are at the mercy of wider government policies that fails to provide adequate public funding for our failing maternity services. Internalising this view also supports the idea of benevolent healthcare providers who are doing their best under these structurally constraining circumstances. In this context, both service-user and provider are constituted as powerless to effect change. Individual agency is subverted and replaced with the docile, compliant body (Foucault 1976), where people's belief in their capacity to effect change is stifled.

What is not explicit in the wider public consciousness, is that the current overly bureaucratic, overstretched institutional model of antenatal care is the product of an alliance between the obstetric elite and politicians who make up the 'relations of ruling' (Smith 1980) in the first instance, and dates from the MICS. The current system, that is now considered unfit for purpose, is the legacy of obstetric dominated government maternity policy that chose an exclusive, consultant-led, centralised bureaucratic model over a combination of consultant and midwife-led services in both hospital and community settings. Developing community services and moving the care of low-risk pregnant women to the community setting, would address some of these issues, freeing up the hospital outpatient department for women who require it. Obstetric elites, along with politicians, must be held to account for the decisions they make 'on our behalf'. Obstetricians are not victims of the system but, along with elite politicians, are the architects of it.

12.1.6. No time for questions: objectifying the subject

The time constrained nature of the services, alongside the self-disciplining, compliant pregnant woman attending the service, meant that women were reluctant to ask questions regarding their own needs, which were subjugated to the needs of the overworked healthcare providers.

Woman 7: "I was not bothered to say too much – instead I would use Google to find things out. When you see the person is busy you choose what you're going to ask and not going to ask. [...] I know she [the midwife] had a queue [of women waiting]. [...] The midwife is passing you to the doctor. I didn't feel I could share my feelings with her".

A midwife account resonates with the pregnant woman's view.

Researcher /midwife interview 003

Midwife 8: "Like, there's two or three women in that little alcove behind, and like, if you [referring to pregnant woman] had a problem or concern, it's hard to discuss it you know, when there's a woman sitting here and another midwife and everyone having their urine [check] [...] Just to make it a bit more personal you know, [...] so you know they might kind-of whisper or whatever [...] and I suppose they presume then they're going to wait until they go into the doctor and maybe ask the doctor".

When seeking clarification regarding where the encounter between the woman and the midwife takes place in another hospital outpatient setting, the following conversation ensued.

Researcher and Women

R: [interrupts] and where does that take place, does that happen in a room?

W: No behind a curtain near the nurses' station and in around to the left as well.

R: [...] I just want to get some clarity in relation to where the midwife sees you, because I gather that it is in the corridor or is it in a room?

W: No, it is in the corridor, but you are separated off by a curtain.

R: And is that adequate do you think?

W: [pause] Like you can't ask... like if you are asking questions people are two feet away from you and they can hear you.

R: So, it is not conducive to asking any intimate questions anyway I suppose?

W: Not really, it depends on how much you want to know the answer to your question and something [...] I should say sometimes there is the doctor, and it depends on who the doctor is, and like I said this is my fourth pregnancy, and I would be very willing to ask questions, but sometimes the doctors can be a little bit abrupt.

Not having the opportunity to ask questions or make sense of the information given to her during the hospital doctor/woman encounter, left the following woman feeling worried unnecessarily.

(W & GP Observed Encounter 1)

W: So firstly, I was seen by one midwife and after two hours by a second midwife and then I only saw the doctor for a few minutes. The doctor did a quick ultrasound, and he mentioned something about seeing water on the scan [pause] [anxious expression] [pause] I presume this must be a problem? What does it mean?

GP: Did you ask the doctor what it meant?

W: The hospital doctor was just too busy, and everything was so rushed. I wasn't able to find out what it really meant.

Similarly, in the following account, a busy hospital outpatient clinic, feeling rushed and knowing that there is a queue of women waiting to be seen acts as a barrier to asking questions of the healthcare professional.

Interview 16 Researcher and Woman

Woman: I felt a bit rushed in the [names hospital] because you're aware there is so many people behind you like, yeah! yeah!

The development of personal relationships requires time, yet the constant aim in bureaucratic systems is to manage time more efficiently (Kirkham 2018). An investment in time is considered an unaffordable luxury in bureaucratic managed systems. The reduction of antenatal care to a series of tasks which must be completed within a defined timeframe squeezes out care (ibid.). In the next excerpt, lack of time was associated with poor quality of care.

Women 7: "Staff are very nice everywhere, but time is lacking – no time for staff, no time for small details, no time for personal attachments, then just paperwork"

One consultant, who said that he supported women having a birth plan, recounts how time constraints in the antenatal clinic and a focus on throughput inhibits quality interactions with the woman.

C1: When you're confronted with a birth plan, do you have twenty minutes to sit down and go through it, you know with the other one hundred and odd patients you know outside the door you know? It's difficult.

If we do not provide the time or opportunity for women to ask questions, we ignore the unique presence and experiences of women's lives, and we objectify the interaction. Situated within the scientific technocratic paradigm, the objectifying version of the world is from the male standpoint, that has traditionally excluded women's subjective experiences (Smith 1980). The pregnant woman's unique, social context or experiential knowledge is not sought after or valued in the dominant bureaucratic, biomedical model of pregnancy. In the above account, the environment does not enable and encourage the woman to ask questions or raise confidential issues of concern with the midwife. The lack of confidentiality, respect and dignity afforded to the woman here, indicates that her experiential knowledge is not valued or prioritised. In this biomedical paradigm, the woman's embodied contribution to the antenatal clinic is not seen as essential and can be dispensed with. The woman's voice is not listened to. In the biomedical paradigm there is lack of conceptual foundations for the value of understanding women's needs (Davis-Floyd et al. 2009). instead, the knowledge that matters is authoritative objective knowledge, obtained through scientific inquiry, involving precise controls, universal testing, measurements, and monitoring, recording, examining, and documenting.

12.1.7. *Women's low expectations*

The bureaucratic, fragmented, time constrained nature of maternity care institutions also shapes women's expectations of the service, and how maternity care was experienced. Not surprisingly, according to one midwife, many women have very low expectations of the hospital antenatal services, and only complain when the extended antenatal clinic waiting time encroaches on family or work commitments.

Researcher/midwife interview 6

Midwife: "I think you know most women are just happy with that [how the system works], once they get in, get the bit of care, the baby's okay, get back to work, they're not waiting two hours, they're okay, they're happy like. [...] They don't ask for much, do you know what I mean, and if they do complain, usually in fairness they'll say look I'm here since nine o'clock, what is the story, it's half eleven. I'm exhausted, [and I have] to pick up the child, you know, so that's understandable.

Women's low expectation of service provision is corroborated in the following account, where being well organised; getting a seat and getting in and out of the clinic in the shortest time frame possible, is considered the best that can be expected.

Researcher Woman Interview 6

R: What is the public clinic like at the hospital?

W: Yeah! I found it grand. It was very efficient. They had a number system. [pause] I had heard so many horror stories that you'd be waiting for 4 hours, and you won't get a seat, and [pause] I thought it was absolutely fine. [pause] 45 minutes to an hour 'in and out' and it was very well organised.

Rr: What was the waiting area like?

W: It was basic, very, VERY basic [pause] It was jam packed all the time, **but I always got a seat. That was my main concern.** I always go by myself, so there is only one bum to squeeze down on a seat. [...] It was busy, and some days it was probably a struggle for some people to get seats, but [in a quieter tone] people bring a lot of people with them. [**my emphasis**]

A quality encounter is not expected, so the woman is not disappointed when she does not get one. Low expectations of service provision are associated with higher reported satisfaction rates (Bjertnaes et al 2012, Gaile et al 2015), hence the need to be cautious with interpreting service user's satisfaction surveys.

12.1.8. *Disciplining power enacted and embodied*

Foucault argues that disciplinary power, a key feature in modern day institutions, works by creating 'docile bodies' that are self-disciplining, obedient, and unconditionally conform to

institutional rules, regulations and norms (Foucault 1977). This makes the individual adopt a passive, rather than an active role, when attending the maternity care, which makes them more malleable, and easier to control. Also bureaucratic administration systems require the co-operation of the governed to work efficiently. Whether service-users attending the maternity services fit this description will now be explored. A critical exploration of how women learn to negotiate the system is revealing. In the following excerpt, a woman who has a previous experience of the maternity services, knowing how to navigate the system to avoid delays, becomes self-regulating and self-disciplined.

Interview No.6: Researcher & Woman

Researcher: What did you do when you knew you were pregnant?

Woman: I rang the hospital first, the later you contact the hospital the later your first appointment.

Researcher: [interrupts] So you didn't even go to the GP?

Woman: No. I rang the hospital first. I got an appointment for I think it was 12 weeks. I didn't go to the GP then until 8 weeks [...]. I rang the hospital when I was four weeks and two days or something, straight away.

Most childbearing women who attend the GP have already confirmed the pregnancy with a positive pregnancy test. Despite having, in some cases, numerous positive results, women still attend the GP looking for confirmation that they are indeed pregnant. In the following excerpt, women defer their subjective reality of 'being pregnant' to medical expert's authoritative knowledge and objective truth claims, which comes to define what is normal, acceptable, and real.

GP2: "Most women have done two or at least three of the tests in the local pharmacy, well, depending. The majority of cases, they are very excited to be honest, they just want to come in and for you to confirm that they're pregnant. Okay, they are very excited, they'll often want you to repeat the pregnancy test, just to show them that they really are [...]. They just don't feel it's real until they come to the doctor. I think that is one of the main reasons the women are coming, [...] they want the pregnancy to feel real, and they will feel that when they see a doctor".

and

GP4: [...] "We look for confirmation of pregnancy, the record here is this woman did seven checks herself, but she still wanted another one done here because she didn't believe it".

By accepting the doctor's knowledge claims, childbearing women effectively increase their authority and power. In the following excerpts, women appear to have accepted their role as passive recipients when it comes to attending the maternity services. This passive role is

evident in women's responses to questions regarding what thoughts or plans they have, for the upcoming birth.

Woman 1: "I don't want to have too much of a plan, as plans change. Whatever happens, happens".

and

Woman 5: "I thought I would just go with the flow"

Instead of taking an active role, in what will be one of the most memorable days in their lives, they take a back seat, leaving all the decisions up to the professionals. According to Dil Wickremasinghe, a social justice and mental health campaigner, and broadcaster of Global Village on Newstalk 106-108fm, most pregnant women in Ireland 'don't play an active part in their care, but instead, completely surrender their birth experience to the medical professionals' (Wickremasinghe 2015). The influence of family on influencing decision making in terms of type of birth imagined, is evident in the following transcript.

MW 8: "Straight away it could be something I usually open up with, well, have you thought about this birth, and they'll say what do you mean? and I'll say [...] so do you have any plans? [...] or else some of them will come in and nothing is said and they'll say no, don't want to do classes, I'm having an epidural because my two sisters had epidurals, and said it was brilliant."

Whether this reflects women's social positioning and subordinate role in a highly gendered stratified society more generally, or whether women are already socialised to adopt the role of the passive recipient when it comes to attending the maternity services, is unclear.

12.1.9. Prior knowledge: accessing information and choices

Given that it is the norm for midwives to be the lead maternity care provider in many high-income countries across Europe (KPMG 2009), the question of how GPs in Ireland came to be centrally involved in antenatal care was raised with the participants. Yet, when asked about the history of GPs involvement in antenatal care, most GPs had not heard of the MICS and had limited knowledge of its significance in the organisation and coordination of their working lives.

GP4 That is a historical question, I couldn't give you a full answer. [...] I don't know, it's been around for a long time [...] 28 years we've been providing antenatal care services, and it has always been the combined care scheme, so I don't know.

As one GP put it,

GP3: "GPs have always been involved in antenatal care, that is just the way things are in Ireland".

The combined care scheme is normalised as a taken for granted and inevitable part of GPs everyday practice. The very first Report of the Maternity and Infant Care Scheme Review Group (1994 published in 1997), highlighted confusion among both GPs and pregnant women regarding the range and level of service that is included in the MICS (DOH 1997). Not much appears to have changed in the current study. Many GPs reported being inadequately informed and unsure of the midwife-led service on offer in their locality.

GP4: "It is only evolving, and I must say I don't think I have had much notification about it. The information that I got would be simply from women, who told me they were going, and I didn't get much information before it started, and I don't know a lot about it".

and

GP 2: "The midwife system; I have no formal arrangement with them, but I pick up a sense from other patients who go through the system, chatting to them, I hear what happens. But again, I haven't formally been informed about it for a long time, so a bit of information would be nice. [...] I think there are some satellite clinics, as far as I know. I think they are doing some booking checks in local clinics. Here again, I don't know about that, but I think that's all booked through the [...] hospital".

Similarly, many of the women attending antenatal care for the first time, do not appear to have prior knowledge of midwife-led clinics or the home birth service.

GP4: [regarding women raising possibility of attending midwife-led services] "That usually doesn't come up, it doesn't come up as a routine"

When asked whether she had considered having a home birth one woman remarked

W 7: [shakes head] "I know nothing about this service. I thought that this was a private thing. I never thought that there was any chance to do it. [...] I imagined it would be more expensive. It is just the money. Is it possible?"

Much of the knowledge about the running of the maternity services was obtained from family and friends. When asked about how they understood their role as gatekeepers of the service, GPs presented themselves as apolitical, neutral facilitators of the maternity services. The power-relations embedded in the GP/woman encounters and their influence over women's access to information and choice of care provision, identified in the literature (KPMG 2008) was not recognised or acknowledged.

GP2 "We're primary care, so we're the first port of call and refer to secondary care. I don't think we're exactly the gatekeeper for maternity services. Women do not need a referral from GPs to go to antenatal care or to attend the maternity hospital.

As far as I know they can just ring up and book an appointment".

The mandatory requirement for childbearing women to register with a GP to avail of the free state sponsored combined care scheme was not acknowledged. Another thing not

acknowledged was the right of the GP to refuse to accept a woman on the Scheme, if she expresses a desire for a home birth (this has now been amended). GPs also play a role in determining the scope of the practice nurse. Variations between GP practices and restrictions imposed by the GPs' indemnity insurance cover, on the role of the practice nurse in antenatal care provision, has resulted in confusion over the role of the practice nurse.

GP2: "We do have a practice nurse [...] we have 4 GPs and 1 PN (Practice Nurse). She works 2.5 days a week. She does do antenatal checks, yeah! she does yeah! or let me just remember now, does she do the antenatal checks? I'll have to check that. No, [...] she works specific days, but she doesn't do a clinic. No, she certainly doesn't do antenatal clinics, no. I'm just wondering if she does the checks. Some nurses don't, and I have a funny feeling she doesn't do them. She is midwife trained but I think we do them all. [...]. It is a grey area".

and

GP2: "It seems to have been down to the individual practice to decide [on the role of the PN] in that sense. Some GPs might have different systems where they might see the lady. [pause] The nurse might do all the checks [BP, urine, FH] and they [the GP] might quickly see the lady and check the checks. Sometimes the nurse might do the entire check-up".

The PNs' role is also determined by the needs of her employer (the GP). Whether the practice nurse does the antenatal clinics depends on the preferences of the GPs, many of whom reported that they really enjoyed this aspect of their work as the following excerpt exemplifies.

GP2: Personally, I just like doing the antenatal checks, it is an area that interests me, so I always wanted to kind of do my own [antenatal clinics] and the nurse is always busy doing other jobs as well you know [...] [laughs] I really enjoy doing antenatal checks myself [...] I don't do specific days women come in anytime.

GPs are the main source of information on maternity care options (AIMSI 2014). This survey revealed that GPs did not inform childbearing women on choices about midwife-led care models, instead focusing on the choice between public, semi-private and private care (AIMSI 2014). As the following findings reveal, little has changed in this regard. When asked to expand on discussions regarding choices available to women, all GPs confirmed that they always asked the woman whether she was 'going private or public'. The private/public option took center stage in the discussion on the organisation and coordination of antenatal care. Offering information on the combined-care scheme and the choice of public/private care occurred in tandem, often as part of the same sentence.

GP4: "We tell them that they can do combined care with the hospital, we tell them that they can go privately, semi-privately or publicly, they tell us what they want".

and

GP2: "There is another thing. You would explain to them about the maternity services, you would explain to them about combined-care, about the difference between private care, semi-private, public clinics, midwife-led clinics".

Whether private or semi-private care was chosen depended on whether the woman had private medical insurance (known in Ireland as Voluntary Health Insurance VHI). Government tax incentivisation for private medical insurance at source, and the woman or her partner's ability to afford private medical insurance, impacted the woman's choice of public, private, or semi-private care. Women without medical insurance had no option but to accept what was on offer in the public sector. The presumption in the following excerpt is that private or semi-private care involves less time waiting and is therefore considered to be more convenient.

Interview No.4 Researcher and Woman

Woman 4: "Just I was [...] I had heard that public is very, very, busy and you can be waiting a long time for it and I am covered by VHI [private medical insurance] so I thought uhm because it's my first baby, I don't know [laughs] I just thought that [pause] I've got semi-private, I have the cover, that it might, it might be easier".

Along with the woman's preferences, GPs note that the obstetrician's preferences are also considered when it comes to the woman availing of combined-care in combination with private obstetric care.

GP4: "We tell them that they can do combined care with the hospital. We tell them that they can go privately, semi-privately or publicly, they tell us what they want. We often say, check with your insurance, see what they covered. [...] Some of the consultants see them privately, but they also do combined as well, that suits them, [the women] because they don't have to pay for combined care. So, when they come for their first visit, we tell them that it's free, just sign the form. [...] Some of the consultants **will allow** the patient to do some visits here [GP surgery]. That doesn't happen very often. Sometimes, the women want to get their money's worth, but again it's the woman's choice, if she wants to do antenatal care here, we do it, whether she is going publicly, semi-privately or privately".

For most GPs, choice of place of birth was limited to which hospital, as opposed to home versus hospital birth. Some GPs expressed severe reservations about the home birth possibility, and did not offer this choice to women routinely, but only discussed this possibility

if it was first raised by the woman. Again here indemnity insurance was a factor. One GP recounted that

GP1“Even if I wanted to participate in homebirth, which I don't, GP indemnity insurance does not cover it”

Choice of home birth appeared to be more to do with the GPs philosophical assumptions and indemnity insurance restrictions, rather than the woman's wishes. Without an informed and unbiased discussion about all the choices available to her, a woman who is well educated, but sees herself as inexperienced in terms of maternity, is unlikely to choose a service that is perceived by her as not mainstream, despite having reviewed the services on the hospital website.

Researcher : Did you consider attending the midwives clinic?

Woman 4: No, but I was very interested in that, but I just wasn't [...] uhm [...] sure with it being my first baby, or [pause] you know whether you should do that unless you're sort of a more experienced mother. [pause] I looked on the website [hospital website] and all the parts were [pause] explained very well. I thought [pause] I did think that it sounded very good, so I was torn.

There is an urgent need for GPs to reflect on the asymmetrical power-relations embedded in the organisation and provision of antenatal care, as an understanding of this is crucial if they are to recognise and challenge their own role in women's subjugation.

12.1.10. The business model of antenatal care

How the capitalist mode of production and the business model of antenatal care came to shape antenatal care provision in practice was explored. The private/public mix appears to be a central organisational feature of the business model of the Irish maternity services. One GP spoke of the need to 'break even' (GP1).

GP1: it is a business and as such I need to be making a profit [...] now we are no longer allowed to charge for the first visit, and this makes thing very difficult.

The GP in question above, felt that HSE remuneration offered to GPs to supply the public maternity care package under the combined-care scheme was woefully inadequate and was not worth the time involved in administration. This attitude appeared to contrast with that expressed by most GPs, who were financially incentivised to join the Scheme. For further discussion on the role of government financial incentives on change and entrenchment in maternity service provision and whether withdrawal of financial incentives triggers change in service provision see chapter 8.

Evidence of the business model of antenatal care was exemplified in 1998, when the privately employed practice nurse/midwife was introduced as an employee of the GP, who received a state subsidy towards her salary. Given that most midwives are state employees, what wider

social processes and power relations underpinned the introduction of privately employed practice nurses required further investigation (see chapter 8). Also, whether it was the need to safeguard private practice that motivated the government in the 1970s Health Act to designate all GPs as self-employed, emerged as a key area of inquiry (see chapter 5). The role of multinational insurance companies, which exist beyond the state, also emerged as broader social forces that controlled the conduct and scope of the practice nurses' work. Restrictions imposed by the GPs' indemnity insurance cover, specified what a practice nurse could and could not do when it came to the provision of antenatal care.

GP2: "As far as I know, our nurse wasn't happy to do them. It's different in different practices, and definitely there seems to be an indemnity issue now as well, so I don't know".

As is demonstrated here, the private/public mix of maternity care, that is central to maternity care provision in Ireland, is a key institutional arrangement that shapes the organisation and coordination of antenatal care (for macro-analysis see chapter 5).

12.1.11. Technological imperative

The 'technology imperative' (Fuchs 1972) is a central tenet of the biomedical paradigm and bureaucratisation and is key to their perpetuation. In obstetrics, there is the tendency among obstetricians to adopt the technical aspects of any intervention over the more humanistic alternative (socioeconomic and psychological). Technology use is viewed as progressive and modern and is reserved for medical experts use. Many strategies are used in the biomedical paradigm to justify routine technological intervention. In the following account, the association of technology with efficiency is offered as a rationale for routinising medical surveillance using reproductive technology, despite the doctor considering it to be unnecessary.

C 1: "You are involved in a clinic where there might be one hundred and fifty patients. An ultrasound scan takes twenty to thirty seconds as opposed to a five-minute discussion with somebody about why they don't need an ultrasound scan. A lot of the time it's quicker and more efficient to do an ultrasound scan than it is to explain why it's not necessary to perform one".

The doctor also recognises that many junior doctors are not sufficiently trained to carry out ultrasound.

C 1: "I'm very aware that a lot of people doing antenatal clinics have very limited ultrasound experience, and probably shouldn't be put in charge of an ultrasound machine".

The doctor appropriates the modernist, consumer choice agenda, using the women's expectations of having a routine ultrasound scan in the hospital outpatient antenatal clinic, to justify its continued use.

C 1: "They have a clinical exam and what has become almost standard now is that they also have an ultrasound scan. And that has become a little contentious in that they're unnecessary, but patients equally probably wouldn't like to come to the hospital and not have a scan, so it's difficult to tell them that scanning isn't necessary at every visit. I think you get to a point where the vast majority of women will be dissatisfied by not having a scan. Patients want to see their baby and they want to see pictures on the screen and as a result people are kind of under pressure to perform an ultrasound".

Yet women attending the midwife's clinic appear to readily accept not having routine ultrasound scans during the antenatal encounter.

Midwife 8: "I'll say I'm a midwife, I always say I'm a midwife I'm not a doctor, and they'll go oh! right, and you can see some of them, a little bit hmm and then. But sure once we have her visit, then there's not another mention of scans or doctors or whatever".

Midwives also invoke the technocratic imperative. In the following example medical surveillance, technology and fetal safety are linked.

MW & W Encounter 6

MW: Okay? then at 40 weeks, at term, 9 months, you'll be back into the hospital we'll sent you into the docs and they'll do a little ultrasound scan

W: oh!

MW: And make sure the placenta is functioning and everything is going Okay.

W: Grand

MW: From then on in you stay with your visits in the hospital until you deliver your baby.

The propensity for technological innovation is a central tenet of the biomedical paradigm and the bureaucratic management system. The technological imperative is tautological in its effect, being both facilitated by and required for the continual perpetuation of the biomedical paradigm. The midwife, likewise, associates technology with medical expertise and safety. The continuing interplay between the biomedical model and bureaucratic institutionalisation in perpetuating the status quo is further evident here.

The continued use of technology, despite some reservations expressed by the consultant above, is justified in terms of improving efficiency and offering consumer choice. In the current bureaucratic system, where there is no time to talk to the patient, an ultrasound scan that takes 'twenty to thirty seconds' is seen 'as quicker and more efficient' than 'a five-minute discussion with somebody about why they don't need an ultrasound scan' (C. 1). Another rationale that performing ultrasound scans is that it is what 'patients' want and expect. Doctors appropriate the individual choice discourse to justify routine intervention, as a reasonable clinical response

to women's requests. Also, there is a failure among obstetricians to acknowledge that it was proponents of the biomedical model that routinely used ultrasound scan as an indispensable part of medicalised antenatal care in the first instance (Oakley 1986). With advances and more widespread availability of antenatal diagnostics in the late 80s, women began to internalise this view, linking the availability of antenatal diagnostic technologies with medical expertise, safety, and a modern progressive maternity service (Hildingsson et al 2002). Availing of routine ultrasound scans was considered rational and a moral imperative, given that any sensible and caring woman would want what is perceived as best for her unborn child (ibid.). So, while doctors created the demand, and women bought into this demand, doctors now used women's demands to justify this routine technological intervention and so, it became a self-confirming process.

These reasons for perpetuating technological interventions may appear reasonable and relatively harmless in their effect. Foucault warns that while oftentimes people know what they do, and know why they do what they do, they do not know the impact of what they do (Foucault 1976). The underlying assumption here is that the priority afforded to the use of routine screening tests, like ultrasound, is value-free and neutral in its effect. However, we know this not to be the case and this draws our attention to the perils of dichotomous thinking in maternity care. Routine ultrasound practice shifts the emphasis from surveillance of the pregnant woman's body to surveillance of fetus development in the womb (Oakley 1986). Routine repetitive technocratic practices perpetuates the medicalised gaze and reinforces the idea of the medical expert as indispensable in antenatal care. As well as normalising women's subordination, internalisation of the medical gaze also normalises patriarchal inequalities in the gendered power-relations, that are at the heart of the biomedical system of maternity care. This shifts control of the pregnancy in general, and the foetus, from the woman who embodies the pregnancy experience to the experts: the technicians who use these modern technologies. The woman's and healthcare professionals' belief in the woman's ability to birth without medical technology is undermined, as is confidence in the physiological process.

When one examines the impact of routine medical intervention, one must not only explore the impact of an intervention per se, but also what is omitted as a result of prioritising that intervention. During the medical encounter, the technological imperative supersedes the humane imperative (Stach 2020). Yet, according to women's views, technological interventions are not high on the list of their priorities during antenatal care (see chapter 6, section 6.2).

This apparent rational demand for a 'technological fix', which allows only for a technological action once the technical "problem" is identified, makes it extremely resistant to challenge (Bauman 1993: 187-8). As Bauman observes, "the more 'problems' technology spawns, the more technology is needed as only technology can 'improve on' technology" (Bauman 1993:186). So paradoxically, policymakers, service users and providers, seek technological

intervention as the 'logical solution' to problems that originated in the inappropriate use of technology, to the neglect of a more humanistic model of care, and so the cycle continues.

*12.1.12. Praxis: change in
practice triggered change in
attitudes*

A survey conducted in 2014 revealed that only 5.5% of the 2,836 respondents reported that antenatal midwife clinics were available to them (AIMSI 2014). Despite the failure of the government to make midwife-led clinics available nationally, change in attitude did result from a change in practice, where clinics were available. Change in this context happens *in* and *through* practice. Once the 'word got out' the midwife-led services did not take long to become routinised, integrated and normalised.

Midwife 8: "I think we've gotten a little bit better now [at promoting midwifery led care] because you know more women, they're more aware as well of the clinics which is great, and maybe their last baby, [...] they would have gone [to the midwife's clinic] and want to come back so (um) [...] I'd say the external clinics do well, really, [...] the women like it, they're out around home and they're not coming in and parking the car and queueing up downstairs. So, they do well, [...] they like that they know they'll see the midwife after the baby is born if they [...] you know, for the early transfer home, if the mum and the baby are well".

Change happened in and through practice, where change in practice led to change in normalising judgement and behaviour. Once introduced, community midwife clinics came to define what is normal and routine, and they began to be seen as the rational and most convenient choice for pregnant women when availing of antenatal care. Midwifery power is embodied and enacted through the local clinics and has a conditioning effect on childbearing women's expectations, attitudes, judgement, and conduct. Childbearing women became socialised into the tacit acceptance of attending community antenatal clinics as mere common sense. So, instead of focusing on changing attitudes leading to a change in behaviour, we see the opposite can also be true. A change of attitude to midwife-led services among GPs was triggered by experiencing the services, either personally by attending a midwife-led service, or vicariously, by listening to the testimonies of their client's experiences of midwife-led services. GPs became very open to discussing midwife-led options with women antenatally, despite feeling the need to qualify women's experiential information as anecdotal.

Researcher: What do the women tell you about midwife-led care, about the midwives' system?

GP2: Excellent, really, really, really, good. They love it. When I'm giving somebody [childbearing woman] their basic information at the beginning, I would always tell them, and it's always *anecdotal*, I would tell them that my patients love the system,

but again that's *anecdotal*. You do tend to refer patients to a service that you found other patients to be happy with, though.

and

GP6: One of the other things that has changed is the outreach antenatal clinic in [Dublin suburb]. Women do like to go to that, so we possibly do that with them.

The setting up of midwife-led services, regardless of intentions or motivations, triggered praxis, a change in action which in turn triggered a change in attitude and conduct of both service-users and providers. Drawing on Foucault's work, midwifery power became embodied and enacted through the routinisation of community midwife-clinics. Once the clinics became normalised, they again have a conditioning effect on individuals, who become socialised into a tacit acceptance of how things are.

Obstetricians' traditional role in antenatal clinics, is reflected in government policy contained in the Comhairle na nOspideal report 1992:

"Antenatal clinics should be conducted regularly, by consultants from the main maternity unit [and that] ... it is of the greatest importance that the holding of such consultant clinics should be a prominent feature of a re-organised system of obstetric care" (Comhairle na nOspideal 1992:13).

and

"In present day practice one consultant would see four first visits or ten to twelve follow up visits in one hour" (Comhairle na nOspideal 1992: 26).

Government policy here is promoting consultant-led hospital antenatal clinics as central to the provision of antenatal care. The midwife's role is given no mention in this document. Over 20 years later, Peter Boylan's extraordinary response as chairperson of the Institute of Obstetricians and Gynaecologists, to the Oireachtas Health Committee Review of the National Maternity Strategy 2016-2026, regarding the role of obstetrician's in Ireland, also reflects the view that they have a key role in looking after all pregnant women, regardless of risk.

"All obstetricians are midwives and are proud to be midwives', but they are also looking after more complicated cases". (Oireachtas Debate 2018: 15-16).

Here, the role of midwives is subsumed into the role of obstetricians, which leaves little room for the autonomous role of the midwife in normal pregnancy and birth. It also leaves no space for true collaboration between professionals that recognise their distinct, yet complementary roles. The legacy of obstetric dominated government policy reiterated above, meant that midwives played the role of assistant to doctors in antenatal care, doing blood pressures and checking urine, while doctors ran the majority of the antenatal clinics. Like the Comhairle na nOspideal directive, this statement by Doctor Boylan supports the view that doctors have legitimate jurisdiction over all pregnancies. While exclusive consultant antenatal clinics are

viewed as ideal according to the obstetric elite, the reality of conducting ten to twelve antenatal visits in one hour, where many of them are low risk, is seen as far from ideal, when it comes to doctors on the front line.

C1.: "It's an extra inconvenience is what people see it as you know, and that's not a great way to look at an important part of your job, but unfortunately it probably is the way a lot of people see it you know. [pause] I think, as you become a more senior doctor, (um) you do feel a bit more rewarded by seeing people who are a bit more complicated, you know. You know you haven't trained for years to kind of bring people in, normal blood pressure and then say off you go. You know it's not exactly the most exciting stuff in the world. Doctors just see the antenatal clinics, as kind of, it's not your most exciting session of the week. Most people would prefer to be in the operating theatre, something else like that, and as a result they don't, they don't necessarily need to be, they don't feel like they, you know, want to be putting all their energy into the antenatal clinic".

While theoretically, re-inventing pregnancy as potentially high risk justifies obstetric involvement in antenatal care, where the aim of the medical encounter is to elicit "the problem" in terms of a medical diagnosis, what happens if obstetricians on the front line do not encounter any 'problems' in the majority of the women they see antenatally. In other words, most of the women are low-risk. Because of the narrow definition of medical risk in the biomedical paradigm, the 'medical gaze' afforded little or no attention to broader social problems that may be of concern to women. By inference, if no medical problem can be elicited, then the role of the doctor in antenatal care appears to be redundant. As the above excerpt confirms, some, perhaps more recently qualified doctors, do not view routine antenatal clinics with women who are low risk as a valuable use of their time and expertise, given their extended specialist training in pathology. In this study there was evidence of a recognition that the belief that all pregnancies are potentially risky was not born out in practice. One obstetrician confirmed categorically that 'the vast majority of people who attend an antenatal appointment are low risk' (C1). This belief makes room for midwives' role in normal low risk pregnancies and reflects a change in attitudes among obstetricians regarding their role in antenatal clinics, compared to the 1990s. Similar to the example with GPs, midwifery power becomes embodied and enacted through repetitive practices and discourses involved in running an antenatal clinic in the hospital setting. As midwife-led clinics began to be seen as routine, it triggered a change of attitude among obstetricians. One midwife, running a midwife's clinic alongside an obstetric colleague, referred to the changing attitudes of the consultant towards midwife-led clinics.

Midwife 8: [...] "One of the consultants is (um), I mean fantastic, supportive, but she'd have a habit of saying oh! look send those charts over to the midwives cause

they're low risk women, but my clinic is full [...] So, I felt that we were getting extras, overbooking, and that we were getting more....Consultants are definitely starting to say midwife, midwife, midwife. I suppose they feel, well we're overbooked as well".

Obstetric support of midwife-led clinics may also be motivated by the doctors perceived excessive workload when compared to their midwifery colleagues and is rationalised in terms of midwives needing to take an equal share of the workload in antenatal clinics. It may also be motivated by the institutional need to free up the overcrowded outpatient departments for those women who need to attend the obstetrician (KPMG 2008). Finally, obstetricians focusing on high risk women may be perceived as a better use of their time and expertise.

The limitations of Lean⁸² a change management project which focused on making 'the system more efficient in terms of getting people through' (C 1), are exemplified by one midwife's reflections on the implementation and impact of the Lean Project in her organisation. This project was introduced by the then newly appointed Master, with support and funding from the HSE, including the appointment of a project officer.

Midwife 8: "We had to go to meetings and you'd see the pathways and why are women waiting, why is there an hour wait here and half an hour wait there, you know, what's the story, so it was all about organising. I'd say they're (service-users) not waiting as long. So they might still get ten or fifteen minutes (antenatal visit) but they're not...maybe they're only waiting an hour instead of waiting two and a half hours you know, and I think you know most women are just happy with that".

While the Lean Project may have reduced waiting times it did little to improve the time allocated to or the quality of the antenatal encounter. One doctor raised the idea that modifying the system may not be enough and that there was a need to replace the system entirely.

Consultant 1. "I think it's [continuity of care models] far more preferable to just seeing a different random face all the time. But if... you know...I suppose what everyone will tell you is like, these cultural changes, they're not easy to implement. (um) But equally, you'd never know unless you try. You know, I don't think anyone has tried to modify antenatal care for years. [...] Do we need to modify the system we have or do we need to get a new system entirely you know? And I think before you go one direction you need to decide what's the more appropriate option".

⁸² Lean is a universal management tool aimed at continuous improvement in production processes, purposes and people that has been applied to healthcare. Originally derived from the Toyota production model, Lean trusts the people who are doing the job to say how it should be done. It aims to achieve significant improvements in productivity through employing various efficiencies and optimising resources. It emphasizes the consideration of the patient's needs by reducing waste and waits, employee involvement and continuous improvement (Lawal et al. 2014).

12.1.13. *The midwives personal qualities and philosophy of care*

When it comes to individual midwifery empowerment and role as drivers of change, much depends on the midwives personal qualities, her understanding of the philosophy of midwifery, her attitude and commitment to midwife-led care, her status within the organisation and the support she receives from her peers and the leaders of the organisation. One midwife, who had a clear understanding of her role as a midwife, and a strong commitment to midwife-led clinics for low risk women, found a pragmatic solution to overbooking and rising demand to attend the midwife-led antenatal clinic.

Interview midwife 8

Midwife 8 “So, I felt that we were getting extras, overbooking [...] but that’s ok because they (obstetricians) should not be seeing low risk anyway because that’s my job you know [...] So, I went down to the medical records to the admin and I just said look, can we just start the clinic [...] we’ll see twenty-two women but just stagger them a little bit. Start a little bit earlier and finish a little bit later”.

Promoting midwife-led services at every opportunity is very much down to the midwives themselves.

Midwife 8: “We do try and encourage them [midwives doing booking visits] when the women are [being] booked, the midwife would say, look. listen Patricia you’re low-risk, you’re very healthy, you’re uncomplicated, you know you can see the midwives”.

Not all women automatically embraced midwife-led services when first offered to them, but once they attend the midwife clinic, they tend to want to come back in subsequent pregnancies.

Midwife 8: “Some women will still say ‘ah, I wouldn’t mind seeing the doctor, is that ok? or, god I saw the doctors the last time, why am I seeing the midwives this time? But I actually think, women will have no problem [...]. If they knew what they were missing out on you know. Because then they come and say ‘oh, I didn’t know the system was this, or this is great so, (um) and they’ll come back for their third baby, or whatever, so I think it’s actually the women being aware and midwives encouraging it”.

It has already been identified that key concepts that underpin the philosophy underpinning midwifery closely resemble the key tenets of the social model of care. Both the philosophy underpinning midwifery and the key tenets of the social model of care in turn, closely resemble the qualities reportedly valued by childbearing women and found in the literature as necessary for providing a safe and quality maternity services (Renfrew et al 2014, Downe et al 2019).

12.2. Conclusion

The complex and multiple interconnections between macro and micro processes in shaping maternity care in general, and antenatal care in particular, are demonstrated here. How antenatal care is organised and coordinated, using the key tenets of bureaucratic management systems: universalisation, rationalisation, fragmentation, and the technological imperative is explored and made explicit. Also, the interconnection between capitalism, private practice and private/public government maternity care policy is illuminated. The co-dependence of the biomedical model and the bureaucratic institutional management system, in maintaining and reproducing the dominant paradigm is revealed. The current way of organising and coordinating the maternity services has resulted in objectifying and dehumanising women attending the service, who should be the focus of care. It is clear from this analysis that woman-centred, individualised care is incompatible with the current system of care. How some midwives involved in providing midwife clinics, inadvertently support and reproduce the asymmetrical power-relations embedded in the biomedical model is demonstrated. An in-depth knowledge and understanding of the biomedical paradigm, and how it looks in practice, is urgently needed so that stakeholders can recognise their role in perpetuating the dominant model of care and perpetuating their own subordination. It is only by knowing how the broader social process and power relations work to shape local practices, that change in a complex system becomes possible.

13. Chapter Thirteen Micro analysis: power-relations and the midwife/woman antenatal encounter

13.1. Introduction

The WHO acknowledges that antenatal care provides a platform from which to support women, families, and communities at this pivotal time in the course of their lives (WHO 2016a). Antenatal care is worthwhile when it is transformative for both the woman and healthcare provider and this begins with the antenatal encounter, the essential building block of the maternity services. All encounters are socially and culturally marked and shaped by the core values and ideologies held in the wider society. What the woman and the healthcare provider say and do during the antenatal encounter reflects and reinforces her/his ideological standpoint on pregnancy and childbirth.

Modern healthcare espoused values of dialogic, egalitarian, patient-centred care which suggests a sharing of power equally in service-user and provider interactions and an avoidance of the paternalistic approach to care (Kon 2010). In the biomedical model, doctor-patient power-relations have traditionally been represented as at the very least unequal if not altogether oppressive (*ibid.*). This inherent power imbalance in the doctor-patient dyad is due to the doctor possessing legitimised expert knowledge which the patient may depend on for survival. Midwives, who are associated with a more holistic, social model of care, have typically been represented as less authoritarian in their dealings with women, in their idealized role as caring and compassionate healthcare professionals (Kirkham 2000). Crucial here are the different philosophical perspectives. The essence of the philosophy of midwifery is 'being with' women, is where a partnership approach is espoused, which implies a sharing of power (Guilliland and Pairman 2010).

In order to understand what impacts change and entrenchment in any system, we need to understand how the current maternity system is perpetuated and resisted, at both macro and micro level. The purpose of this chapter is to explore change and entrenchment in Irish maternity services in terms of the power-relations, practices and discourses embedded in the antenatal encounter. Drawing on Foucault, I take the view that power is omnipresent in every social encounter. Achieving social change through healthcare professionals reflective use of power during the antenatal encounter is at the heart of this micro-level stage of inquiry. Transactional and interactional approaches to encounters

As power is socially constructed, power-relations are constantly being negotiated, enacted, and resisted during the antenatal encounter. The nature of the conversations that take place during an antenatal encounter appeared to be on a continuum between a transaction and an interaction approach, with most leaning more one way than the other. Extrapolating from transactional leadership, where a leader is defined as someone who values order and structure and focuses on rules and regulations to complete objectives on time or move people and supplies in an organized way (Oxford English Dictionary 2020), those who utilise transactional approaches to encounters tend to use closed-ended questions, that are more of a structured conversation with clear objectives, that focus on communicating and seeking conformity to the

workings of the institution. They tend to stick to the institutional script, almost verbatim, and recount the woman's story back to her using the woman's maternity records, prioritising objective knowledge over subjective experience. Asymmetrical power-relations are imbued in the traditional biomedical, transactional approach. Service-providers that focus on the disease aspect and/or the bureaucratic procedural aspect of the encounter and exclude the patient's socio-economic context and wider life experiences, favour a more transactional, closed-ended questions approach to the antenatal encounter. The person who sets the agenda and asks the questions is generally the person with the higher institutional status in this highly hierarchical system. Biomedical models of health care similarly assume an expert provider imparting information to a receptive, passive patient (Dixon-Woods 2001).

An interactional approach uses open-ended questions, is more of a semi-structured reciprocal two-way conversation which takes the form of a dialogue between two people and sets out to inform and maintain relationships. Interactional approaches utilise open ended questions which elicit the patients key concern (Waitzkin 1985). Healthcare providers who take a broader definition of health, one that includes the biomedical world of medicine and the everyday world of the patient, and who are willing to share power by working in partnership, favour a more interactional, open-ended questions approach to the antenatal encounter that goes beyond the information and disease aspect to include a combination of information and emotional support.

Power is also constructed verbally and non-verbally through the use of questions, orders, advice, interruptions, instructions, expectations, the use of pronouns and the use of professional language. Timing of questions, the context in which the questions are asked, what you already know and what you want to know determines which questions you will ask, and how and where you will ask them (Leech 2002). If you want a specific answer, ask a specific question. In terms of non-verbal communication, power is constructed through physical positioning of the subject/object dyad and the possession and control of technology including woman's maternity record (MR), urine dip sticks, blood pressure apparatus and fetal monitoring equipment.

13.2. Transactional and interactional approaches to encounters

How power can be enacted through the use of closed-ended questions is evident in the following excerpt.

MW & W Encounter 006

MW: Do you have loads of fetal movement at the moment?

W: Yeah!

MW: And do you have any swelling of the hands and feet?

W: No.

MW: Do you smoke at all?

W: No.

MW: Do you feel generally well in yourself?

W: Yeah!

As the above transcripts demonstrate, when highly structured question and answer sessions are employed during the encounter, the dialogue tends to be one-sided, with the bulk of the conversation weighted in the midwife's favour. The midwife asks a disproportionate number of questions and employs a disproportionate number of directives compared to the woman. In a transactional, structured encounter the questions are direct and directed, where the monosyllabic yes and no responses are not only expected but deemed sufficient in a culture that favours above all else, efficiency and effectiveness. This format is similar to quantitative statistical public interest surveys. The conversation is like a flowchart, one-directional, time constrained, focusing on throughput and risk assessment. You can almost see the healthcare provider mentally ticking off the enquiries in a form of a tick box exercise. It appears to be more a question of pinning down the 'facts' in as short a time as possible as opposed to making any meaningful connection with the woman.

This question and answer transactional approach to antenatal encounters can lead to much repetition for the service-users, who are seeing multiple service-providers, all of whom ask the same questions and can be experienced as distressing for the woman. In the following excerpt, the woman was subjected to repeated enquiries regarding recreational cannabis use, documented in the woman's maternity records during the booking visit.

Interview between researcher and woman 0012

Woman: "oh I so regret having mentioned that I tried cannabis during my booking visit. Since then, I have been asked whether I am still using it on every visit. I feel like a junky. The laugh is I tried it once at a party when I was sixteen, and that's it".

The sequencing of questions, whether adequate time is given for the woman to answer the question, as well as non-verbal communication are all factors that impact the quality of the interaction. Here, the midwife leaves an important enquiry to the very end of the encounter, and raises it almost as an afterthought, just as the woman is about to leave the room.

Midwife and Women Encounter

MW & W Encounter 006

MW: Okay. [The midwife talks to the woman while her head and eyes are facing downwards and while she continues writing in the woman's maternity records]. Any concerns, worries or questions that you have before I let you go? [still no eye contact]

W: No. that's everything, yeah.

MW: [looks up from the woman's records for an instant] And you have a contact number there?

W: Yeah!

MW: [Continues to write in the woman's maternity records while talking quietly to herself]. Perfect. Okay. We'll see you next time. [talking aloud now while continuing to write in the maternity records] ...to come if reduced fetal movement, bleeding or your waters go. Okay. Perfect. Lovely to meet you [name]. [closes the woman's records and stands, hands them to her while walking to open the door].

W: You too. Thanks a million for that.

Leaving such an important enquiry until last says much about the procedural nature of the encounter. Along with the timing of such an important question, the midwife's body language and multi-tasking; non-verbal communication and non-directed utterances, talking while continuing to write in the woman's maternity records, head down, no eye contact, all communicates that the midwife is not actively listening or actively present in the encounter. The presumption here is that there is in fact nothing more to discuss. Closing the woman's records effectively closing down the conversation. In addition, adding the repetitive refrain 'to come if reduced fetal movement, bleeding or your waters go' is not directed at the woman *per se* but more a question of documentation in terms of 'if it is not written it is not done', a common mantra used in litigation cases (Roth 2020). I suspect that the importance attributed to documenting these directives is a much to do with protecting the midwife from accusations of misconduct, should an adverse incident occur, as discussing these risks with the woman. In a risk averse litigious culture where defensive practice is commonplace, this may be a question of 'covering your back' while managing throughput.

13.3. Seeking compliance with hospital policies and protocols

When the primary aim of the antenatal encounter is to seek compliance, the nature of the conversation is again transactional as opposed to interactional. In this opening conversation during an antenatal encounter, the focus of the healthcare provider is to explain the workings of the institution in terms of institutional protocols, policies, and practices, as operationalised within the combined-care scheme.

MW & W Encounter 006

MW: Have you attended the midwife clinic before?

W: No.

MW: I'm just going to explain it to you: you will have shared care with the GP and us, before you leave every visit, we are going to make an appointment for you with the GP

W: Okay

MW: that will probably be two weeks from today, two weeks after that you come back here.

W: Okay

MW: So you'll probably see us on average every four weeks up to 36 weeks Okay?

W: Grand

MW: Then you will be seeing us and the GP every week.

W: Grand

MW: Okay? then at 40 weeks, at term, 9 months, you'll be back in the hospital. We'll send you into the docs and they'll do a little ultrasound scan

W: oh!

MW: And make sure the placenta is functioning and everything is going Okay.

W: Grand

MW: From then on in you stay with your visits in the hospital until you deliver your baby,

W: grand perfect .

MW: After you deliver your baby you will probably be going to the postnatal ward, just let them know you are with the DOMINO scheme

W: uhm

MW: And we can discharge you a little bit earlier if you want to go home, if not that's fine. Once you go home, the day after, we come out to see ye.

W: Okay that's grand

The information imparted by the midwife focuses on the workings of the combined-care and DOMINO schemes, including the schedule and location of visits. Closed-ended questions or statements are used to confirm 'informed compliance' (Kirkham 2018) as opposed to seeking the woman's perspective. This is because optimised antenatal care is seen in terms of service-user compliance to hospital regimes. Not only does the woman know what she can expect of the service, but also what is expected of her. No attempt is made to ascertain the woman's unique circumstances. The priority is not about how the institution will meet the needs of the woman, but rather how the woman complies with the workings of the institution. As the encounter unfolds, we learn that as a mother of two, she is already familiar with the workings of the combined-care scheme.

When analysing questions asked in an encounter, one can gain insight from omissions as well as inclusions. With this exclusive focus on the Working of the Institution, the vital opportunity to promote and disseminate the unique role of the midwife and to discuss how antenatal midwives' clinics differ from the standard medical-led clinics, given their different philosophical underpinnings, is missed. Ascertaining the women's philosophical leanings and where she positions herself on the continuum between the biomedical and biopsychosocial model of care is also not ascertained. The lens through which the encounter is enacted clearly influences, if not determines what is excluded as much as included in the interaction.

In the conclusion of the transcript above, the women's preferences for birth are not sought and possible options available to her at term are not discussed. The woman's embodied experiences of fetal movement, growth and overall wellbeing are not referred to. As opposed to adopting a wellness, optimistic approach to the upcoming birth, where the woman's ability to know her own body cues and her baby's needs are optimised, the midwife adopts a biomedical approach where the woman is subjected to the medical gaze and is left in no doubt about what is expected of her at term. Central to the medical gaze is the use of medical

technologies which reveal the workings of the body through a particular lens. The medical gaze is also central to the operation of disciplinary power. The presumption is that the use of medical technologies will reveal the 'truth' about the working of the body and this objective truth will take precedence when it comes to informing medical decision-making regarding further management. The fragmenting nature of the 'medical gaze,' effectively diverts attention from the person, as a human being, instead focusing on the problematic bodily condition, in this case the pregnant uterus and the fetus, as representing the sum of a person. Availing of an ultrasound scan at term is not presented as an option, but a rational and moral imperative. The partial visualisations of the body that are revealed by the ultrasound act as a tool of governing bodies as opposed to providing a complete and holistic picture of the body. The use of these technologies has enabled a shift of power away from the childbearing woman towards the medical profession and perhaps increasingly to technical processes. The idea that pregnancy is a 'condition' requiring expert knowledge and medical management is effectively perpetuated. The woman is socialised into a tacit acceptance of the regulatory regime (medical gaze), seeing it as inevitable, and the safest option. This has a conditioning effect on the woman. She comes to know what to expect and what is expected of her. Women eventually internalise the medical gaze which undermines their subjective experiences of pregnancy and confidence in their own ability to birth without medical expertise. The woman is further alienated from her embodied pregnancy experiences while the doctor's authoritative knowledge is promoted as essential to confirm fetal wellbeing. The link between medical expertise, antenatal diagnostic technologies and safety is evident here and the biomedical model is perpetuated. Because the dominant gaze is internalised the power-relations underpinning it are not visible.

13.4. The universalising nature of transactional encounters

The standardisation of information offered to women during the antenatal encounter is evidence of the universalising nature of transactional encounters.

Encounter 006 MW & W.

MW: [...]:if your choice is breast feeding, **we** can help you, if your choice is formula feeding [then] **we** can help you, there are always new protocols, things like that, we can give you advice and **we** weigh your baby. Okay? alright.?

W: Grand.

As a mother of two her views on how she intends to feed her third baby is known to the woman, and is available on request by the midwife, but the midwife disregards this fact, she does not enquire how she previously feed her babies, but instead gives routinised de-personalised information as standard.

Feminist inquiry has traditionally politicised women's subjective experiences of inequality and oppression in patriarchal dominated society by exposing the gender assumptions that shape them (Davis and Craven 2011). They do this by challenging the valorisation of objectivism; knowledge/truth claims that are represented as value-neutral, inevitable, and merely reflections of reality (Davis and Craven 2011). Offering information which bears little or no relevance to

the woman's circumstances objectifies the woman and rendering her needs and unique social context superfluous to the encounter. A Cochrane qualitative evidence synthesis on the provision and uptake of routine antenatal services concluded that initial or continued use of ANC depends on 'a perception by women that doing so will be a positive experience' (Downe et al 2019: 2). If the woman's experience is that her individual circumstances are surplus to requirements in the antenatal encounter, she is unlikely to rate it as a positive experience.

13.5. Sticking to the script: text, objective knowledge, and biomedical power

In transactional conversations, the midwife sticks to the standardised institutional script as much as possible and sticking to the script appears to take precedence over the unique issues confronting the woman during her pregnancy. If side-tracked, the midwife endeavours to return to that standardised text as soon as the opportunity presents itself, affording little or no attention to the woman's individual circumstances.

Encounter 007 MW & W.

MW: So did you have your last baby in the [name of hospital]?

W: Yeah!

MW: You did [pause] Okay.[pause] And were you with the community midwives when you had your last baby? Did you come to this clinic before?

W: Yeah!

MW: So you know kinda how it works?

W: But I was here only one time because later I was going to the hospital, they were looking after me in the hospital.

MW: And why did you go back into the hospital?

W: They thought that my baby is too small.

MW: Too small, okay, and what was your baby's weight? [Midwife doesn't wait for the woman to answer but proceeds to check the woman's maternity records (MR)] so your baby was at 2.95 kilos?

W: yeah!

MW: [reading from the woman's MR] Okay, and it was a little girl?

W: yeah!

MW: And was she fine after she was born?

W: Yeah! Yeah, she was fine.

MW: [Reading aloud from woman's MR as if to confirm what the woman had said.] She was born at 39 and 3, IUGR noted at 34 [reading reduces at a whisper and then becomes inaudible for a time] okay, and you have an allergy to [name drug] Okay, and that's all there [referring to the information documented in the MR] [...] So, you're going to be coming to us every 4 weeks or so, in between that you will be going to see your GP

W: Okay.

MW: At 36 weeks you will be going between the GP and us each week up to 40 weeks which is term and then you'll be going back into the hospital and you'll see

the doctor in there and they'll do a little scan and they make sure that the placenta is functioning and the baby is Okay?

The midwife is initially side tracked from her original script; imparting information on the working of the institution, by the woman's discussion of her previous baby having suspected intrauterine growth restriction (IUGR). Given that this is the woman's story, one would expect her to be the best person to tell it. Yet, in the conversation that follows, the midwife recounts events of the previous pregnancy and birth by reading aloud from the woman's maternity records, rather than waiting for the woman to give her own account. The midwife does not hand over control of the exchange to the woman.

This practice of recounting the woman's story back to her, while reading from the woman's maternity records, as opposed to asking the woman to recount her own medical and social history, is a strategy used by midwives throughout the antenatal encounter. Viewing the woman's maternity records appears to be a routine part of the welcome and introduction, as the following excerpts demonstrates. In these examples, the lack of continuity of carer is linked to the need to 'go through' or 'just check' the woman's maternity records. There was no evidence that the woman's records were reviewed prior to the encounter, as is recommended by the antenatal NICE Guidelines (2014).

MW & W Encounter 006 (community outreach clinic)

MW: **So I'll just go through your chart** ... This is the first time I've seen yea [Opens Woman's medical records situated on the table in front of her and reading aloud from it]. You have a little boy and girl at home?

and

MW & W Encounter 009 (community outreach clinic)

MW: Congrats as I say my name is [state her name] nice to meet you and this is your third pregnancy. **I am just going to have a quick scan of your chart** as it is the first time that I've met you just to make sure [reads in a whispered tone from woman's medical records - not addressing it directly to the woman] two spontaneous [pause] okay. So [reading from woman's maternity records] folic acid, hypertension, I'm checking your booking bloods, perfect, your rubella is all perfect, it's fine, you're immune, okay, its grand, your haemoglobin is 141, which is good

According to Smith (Smith 1990b: 62) texts (here in the form of maternity records) are coordinated by and embedded in a prevailing set of social or 'ruling' relations". Given that the ruling relations in maternity care are embedded in a patriarchal, hierarchical system, the woman's records "constitute the dominant gender subtext of the rational and impersonal 'male' discourses" (Smith 1990b: 61). The 'ruling concept' or simply, what ideology underpins the biomedical model, is the prioritising of objective knowledge over subjective experience.

Maternity records follow a nationally agreed, standard format for maternity care documentation. There is little or no sense of dialogue or disagreement in the documented account. The woman's voice is largely absent and the woman's subjective experience is reduced to a fixed and simplistic medical condition, IUGR (Encounter 007). Text is "an objective form of knowledge" (Smith 1990b:61). Having the information documented in the woman's record adds

legitimacy and objectivity to the midwife's account. It is almost as if the midwife does not put trust in the woman's own version of events but instead needs to confirm 'the facts' using the woman's records. Instead of prioritising the personal account reiterated by the woman herself, she prioritises 'expert knowledge' contained in the woman's records.

Power is also constructed through the midwife's keeping possession and control of the woman's record. Much of the time the midwife's eyes are diverted downwards as she reads oftentimes inaudibly from the notes. Raising her voice appears to coincide with raising her head on occasion, in order to make eye contact with the woman, to confirm some fact or other. This 'just checking' maternal records also detracts from active listening and being actively present during the antenatal encounter, as her attention is directed elsewhere and the woman does not have her undivided attention. The midwife in this excerpt uses the woman's maternity records as the formal account of events and in effect, keeps the woman's story in check. The local and particular become generalized into objective forms (Smith 2005). According to Smith, institutional ethnography treats such texts as "virtual realities" (Smith 1990b: 62).

This, in effect, trivialises further woman's embodied experiential knowledge, which renders her views and opinions superfluous to any decision-making process regarding this current pregnancy. Treating the woman as absent when she is physically present, denies the existence of the human subject and denies her active participation as an equal partner in the antenatal encounter. Inappropriate use of the woman's maternity records acts to perpetuate unequal power relations and reinforces the object/subject dyad of the medical encounter. An opportunity to support the childbearing woman, as central and in equal partnership and primary decision-maker in her care is lost. Whether intentionally or otherwise, the woman is subjugated and 'put in her place' as the passive recipient of care.

As soon as midwife has finished with recounting the woman's past pregnancy experience in Encounter 007, she returns to the designated script, and gets back on track so to speak, while the important issue of IUGR reoccurring, or how it might be prevented in the current pregnancy, is not discussed.

In the second part of the same encounter that follows, the woman realises that the standardised schedule of appointments, imparted by the midwife, does not fit with her subjective experience of antenatal care thus far. Asserting her agency and authoritative knowledge over her own pregnancy, the woman shifts the discussion away from the standardised scripts and towards her unique scheduling of serial scan during the current pregnancy.

Encounter 007 MW & W.

W: Actually, I have a scan appointment already for this, after 4 or 5 weeks

MW: Okay

W: I've already had 3 scans

MW: Ah alright, you've had a few scans Okay. We'll have a look at that now [opening scan results in the woman's maternity records (MR)] and I see.

W: It was on Monday.

MW: Why were you having scans? [the previous discussion appears to have been lost on the MW]

W: They were looking after me, it's the same like, [pause] for the size, the baby's size.

MW: Okay.

Midwife: So let us start from the beginning [referring to the woman's records then reading aloud] so your due date is [date mentioned].

W: Yeah!

MW: And you're happy with that?

W: Yeah!

MW: [continues reading from woman's MR] Your first scan was 8th April, your placenta was fine, your gestation age was 15 weeks which you were measured for, and it says size was appropriate for gestational age, Okay, but they wanted to see you again then?

W: Yeah!

MW: [continues reading from woman's MR] 20th May then. Size equals dates, the baby was breech, but they couldn't see the heart structure at that ultrasound scan [MW reads scan result aloud]. Okay. And another one on the 3rd of June. [MW reads scan results aloud]. So you had your scan then [pause] the last one on Monday?

W: I had it on Monday.

MW: And what did they say to you?

W: Everything is going fine, she is growing, I will have another appointment on 13th of August again.

MW: Okay. For another scan?

W: Yeah!

MW: Okay. And did you tell them you were coming to see us in the community?

W: Yeah!

MW: And they [meaning hospital consultant] were happy for you to do that?

W: Yeah!

MW: Sorry what was the date again for your next ultrasound scan?

W: 13th of August

MW: Okay. [Refers to woman by name] Alright. **So** what we're going to do is [pause] have you got a urine sample for me?

W: Yeah!

MW: Yeah! I'll take that and then I'll do your blood pressure and **we'll** have a little feel of your tummy and **we'll** listen to the baby then, as well , I want to grab a pair of gloves for a moment. What age is your other baby now?

The woman's dialogue about her differing scan schedule from the routine schedule, side-tracks the midwife once again from her designated de-personalised, uncontextualized script, forcing her to return to a more meaningful reciprocal interaction. But as soon as the opportunity presents, as denoted by the word **So**, which seemed to indicate a return to the transactional nature of the encounter, the midwife is back on script once more, focusing again on the procedural, task oriented nature of the encounter. The use of the plural pronoun **we**

instead of the singular pronoun **I**, is a common strategy that is used to add weight and the backing of the institution. It shifts the onus away from the individual midwife and onto the organization. Continuity of carer from an individual midwife is clearly not an option, otherwise the midwife would not be inclined to resort to the plural pronoun **we**. This excerpt ends with the procedural, fragmented, task oriented nature of the hospital encounter being further outlined by the midwife.

13.6. Power only becomes visible when it is resisted

In the following excerpt, the midwife attempts to persuade a woman, deemed to be non-compliant regarding the workings of the institution and combined-care scheme, to abide by the rules of the institution. In this example, power becomes visible when it is perceived to be resisted. Note how the midwife refers to what is documented in the woman's maternity records as objective fact. Also note the impact of replacing the pronoun **I**, the first-person singular with a plural pronoun **we**.

Encounter 083 MW & W

MW: You're going to your GP as well aren't you?

W: No.

MW: Do you have an appointment with your GP?

W: No.

MW: No? Have you not been going to your GP at all? [Rising inflection at end of sentence].

W: No, I haven't.

MW: No? How come? [Refers to women's maternity records] **It's down here that you're going to your GP.** Do you have a GP?

W: Yes.

MW: And did you ever go to him or her for your visits?

W: Yes, for the first visit just.

MW: And how come you didn't go back after that? [doesn't wait for an answer] You just came here for all of them? [Rising inflection at end of sentence].

W: I don't know. I just had these dates and I kept on coming.

MW: I know that's for here but in between you need to go to your GP.

W: ooh!

MW: In between these visits. You haven't been doing that?

W: No.

MW: **We** wouldn't give you an appointment for your GP 'cause **we** wouldn't know. You'd normally ring up your GP yourself. So that would be something that you might need to [pause] So would it be possible for you to go next week and see your GP?

W: [reluctantly] yeah!

MW: And then come back to us in two weeks -time otherwise **we** would have to see you every week for the next four weeks or maybe five weeks and then it means **we** would be able to see so many less people so you make an appointment with your GP in a weeks- time. Okay?

W: yeah

MW: [pause] You see we wouldn't give you an appointment for the GP because we'd expect you to ring up for a visit.

Questions are employed here as coercive tools in order to enact power on the part of the midwife over the woman. Replacing the pronoun I, the first-person singular with a plural pronoun we, shifts the onus away from the midwife as an individual and onto the organization, which adds weight to the midwives' authority and persuasive powers. The midwife's request is now presented as having the backing of the institution.

What the midwife fails to do is to establish why the woman does not attend the GP. In an interactional encounter this would have been elicited. It may be that she is not eligible for the combined-care scheme, as to be eligible one must be ordinarily resident in the country for a period of 1 year prior to the birth (HSE 2020). Perhaps the only available GP is male and it is not culturally acceptable to her. It may be that the hospital clinic is more convenient. It may be that the woman genuinely did not know to attend the GP or it may be for some other reason unknown to us. At the end of this encounter the woman is left in no doubt that she has not abided with the workings of the institution and she is left in no doubt as to what is expected of her. Non-conformity goes against the efficient workings of the institution.

The conflict between meeting the woman's needs for weekly appointments in the last four weeks of pregnancy and meeting the needs of the institution is evident in this excerpt, where limited availability of appointment times within the time constrained hospital setting pits the woman's demands for weekly as opposed to two weekly appointments in competition with the needs of other women attending the midwife's clinic, by usurping their appointment times. Midwives face dilemmas in attempting to fulfil these competing demands. Discordance between idealised woman-centred care and the midwife's lived reality in a time constrained protocol-driven clinic is evident here. The needs of the individual are in conflict with the needs of the institution.

13.7. Conclusion

Midwife-woman encounters should differ from doctor-woman encounters because theoretically midwives view pregnancy as a state of health and not an illness. Despite the current rhetoric of partnership approaches to care and a sharing of power, many midwives espousing the biopsychosocial paradigm continue to perpetuate the asymmetrical power-relations in practice, where the power rests with the healthcare professional. Community clinics are for the most part hospital outreach clinic and not originally primary care clinics, hence the biomedical institutional model of care, already internalised by many of the midwives who have worked in the hospital settings, is transported to the community clinics, knowingly or unknowingly. While you can take the midwife out of the Institution, it is a much more complex issue to take the institution out of the midwife. As these excerpts demonstrate, midwives, through their discourses and practices, often unknowingly perpetuate traditional views of power embedded in the biomedical model. Making these powerful processes visible can be emancipatory and makes change possible. With in-depth reflection on how power is constituted and how the hegemonic model is perpetuated in the antenatal encounters, positive change is possible. Changes in the power-relations embodied and enacted during the antenatal encounter, inform

the woman-midwife relationship, and ultimately may lead to changes in the whole systems of care, at both micro and macro level.

14. Chapter Fourteen Conclusion and Recommendations

14.1. Introduction

An urgent need to understand why the Irish maternity services appeared to be so resistant to change was the starting point for this doctoral thesis. The persistence of the highly centralised biomedical model was deeply worrying (HIQA 2013), given its association with a risk averse, highly interventionist and dehumanised service (O'Connell & Downe 2009, Healy 2017). The expected changes to service provision, following increasing demands for reform from birth activists (AIMSI 2010, 2012, Cuidiú, 2011), and sociologists (Murphy-Lawless 1998, Kennedy 2012) and despite mounting evidence supporting alternative models of care (Begley 2011, Brocklehurst et al 2011, Sutcliffe et al 2012, Sandall et al 2013, Sandall et al 2016), was not forthcoming. The study's aim was to explore change and entrenchment in Irish maternity care policies and practices, using institutional ethnography, which is committed to discovering how things actually work in practice. Of particular interest was how ways of doing and thinking about the maternity services, embedded in power-relations and social processes, are recognised, perpetuated, and challenged. It is intended that by making explicit what change agents are at play and how power works in institutions, that resistance and change become possible. To date, there has been a dearth of research exploring maternity care using institutional ethnography in the Irish context. My intention is that this study will make a unique contribution to this body of knowledge. While local contexts will always have their own particularities, the modern biomedical model of maternity care, found in the Irish context, is similar to that found in most income rich countries, to some degree or other (Wagner 1995). Having a better understanding of how hegemonic power relations in institutions work to perpetuate the status quo will be of interest to all stakeholders who want to negotiate changes in modern maternity services.

Drawing on the macro and micro analysis and using historical data and empirical evidence gathered from the participant observations and interviews, the multiple interconnections in complex maternity systems are explored and made explicit. For a summary of the multiple interconnections in the maternity services see table 14-1. These will be referred to throughout this chapter. This chapter will begin by exploring and making explicit the link between modernity, modern ways of thinking, the biomedical model and its insatiable ability to perpetuate and dominate maternity services. Secondly, the need to unpack and reconstruct the biomedical model into the three imperatives of biomedicine is outlined, in order to make its pervasiveness and influence in everyday social interactions more visible in practice and more accessible to scientific inquiry. Thirdly, I explore the link between bureaucratisation, institutionalisation, and biomedicine and I outline its role in the perpetuation of the biomedical model in maternity care. I argue that bureaucratisation and biomedicine are mutually

codependent and perpetuating. Fourthly, against the background of the entrenchment of the biomedical model and the reluctance or failure to introduce alternative model of care, I outline the interrelationship between the rise of the obstetric profession, the introduction of state-run maternity services and the subjugation and side-lining of the midwifery profession.

This is followed by an examination of change processes, change agents, how change is resisted and how change is brought about through praxis. How power works in Irish institutions is unmasked. The need for and success of whole systems changes **of** the system, as opposed to changes that are meant to fit **into** the current system is discussed. Finally, I explore the current situation that we find ourselves in, including the continued entrenchment of the biomedical model despite acknowledgement by some healthcare professionals and academics that the medicalisation of maternity has gone too far (Johanson et al 2002). The failure of much of the establishment to acknowledge the current crisis in the maternity services and locate the problem in individual women's bodies and individual lifestyle choices and not in the problematic biomedical model and the bureaucratic institutional structures is outlined. Despite these serious challenges facing the Irish maternity services, I suggest that the midwifery profession is in a stronger place now than it has been historically. I follow this by signalling a way forward and offer some suggestions as to how the hegemony of the biomedical model may be challenged and how appropriate and sustainable changes may be achieved. I argue that midwives, in collaboration with other stakeholders, must take a leadership role in the campaign for reform in the maternity services. I conclude this chapter with recommendations and implications for future practice and research.

Table 14-1 Multiple Interconnections in a Complex Maternity System

- The complex interconnections between:
- modernity, rationality, objectivity, dichotomous thinking, the capitalist mode of production and the medicalisation of the social is made explicit.
- modern institutions, bureaucratic administration systems and the biomedical model of maternity care as a method of social control and surveillance is examined.
- the rise of the profession of obstetrics, the introduction of state-run maternity services and the subjugation and side-lining of the midwifery profession is explored.
- uncertainty-risk-intervention-safety paradigms that are shown to underpin the biomedical model are explored and made explicit.
- future (imagined) uncertainty, the link between risk, distrust in the natural process and the inappropriate use of interventions and the emergence of real risk with iatrogenic effect are also made explicit.

- the rise and maintenance of the hegemonic elite, the profession of obstetrics and the workings of power in institutions are explored.

14.2. Linking modern ways of thinking with the biomedical paradigm

In the following section the link between modern ways of thinking and the biomedical paradigm are explored and made explicit. There appears to be a superficial understanding of the social processes and power-relations that underpin the biomedical paradigm among many healthcare professionals, politicians, and other change agents. Analysis of modernity at macro-level revealed the tenets that underpin modern ways of thinking in terms of universalities, rationality, dichotomous thinking, and the search for scientific certainty through predicting and controlling the probability of future events (see chapter 4). Part of the modern cultural revolution was the prioritising of science over nature and the objectification of the social using scientific rationality. This involved the medicalisation of every aspect of the human life cycle, including birth, childhood and adolescent states, reproduction, the menopause, and death. This study explored and made explicit the interconnections between modernity, the capitalist mode of production, the mechanistic, technocratic world view, and the biomedical paradigm. These interconnections, although important, were not enough to explain why the biomedical paradigm was so omnipresent in everyday social interactions and resistant to change in modern maternity care. In order to make the diffuse, embodied, and discursive power of the biomedical paradigm more visible in practice and more accessible to scientific inquiry, a deconstruction and reconstruction of the biomedical paradigm into more bite size, recognisable and user friendly component parts became necessary.

14.3. Unpacking the biomedical paradigm: the three imperatives of biomedicine

Through a detailed critique and analysis of the processes and power relations embedded in the history of the maternity services and the ethnographic data, and supported by the literature, the components of the biomedical paradigm were made explicit in terms of the three biomedical imperatives: the risk imperative, the technocratic imperative, and the obstetric imperative (for summary of these terms see table 14-2).

Table 14-2 The Biomedical Imperatives

- The obstetric imperative: is the need to construct all births as risky. The belief that all births are risky, and birth is only normal in retrospect (Percival 1970, Savage 1986 vxi, Gould 2000), is well embedded in obstetric thinking. Given

that obstetrics does not deal with true pathology in the majority of the women it treats, the obstetric imperative is the constant need for obstetricians to re-imagine what is a normal pregnancy and birth for the majority, as potentially risky. In this instance, the solution, which is medical surveillance and obstetric intervention, precedes the problem, as the solution seeks out 'the problem' that can be solved using the biomedical paradigm. The 'obstetric imperative' is not only the power to re-imagine pregnancy and birth as potentially risky, but to constitute it as 'the truth' and internalise it as merely reflecting reality.

Obstetric authoritative knowledge claims are linked to power and, drawing on Foucault (1977) "Knowledge linked with power, not only assumes the authority of 'the truth' but has the power to make itself true" (ibid.:27). That childbearing women are potentially at risk comes to dominate public discourse and justifies the maintenance of the obstetric dominated centralised bureaucratic system at macro and micro levels.

- The risk imperative in obstetrics has negative connotations and is about predicting and controlling the probability of future uncertainties in the present, in the pursuit of scientific certainty. Obstetrics is a risk averse culture and a risk-based practice. Removing future uncertainty is synonymous with removing risk and improving on safety, so preventing risk is seen as rational and logical. Intervention is the default for biomedicine in terms of preventing real and imagined risk. This is about maintaining population norms and reducing the possibility of outliers/risks and uncertainties. The risk imperative is tautological in its effect and this is how it comes to dominate and control with unquestioned ease the practices, decision-making and discourses in pregnancy and childbirth, at the macro level of the institution and the micro level of the individual interactions.
- The 'technocratic imperative' (Fuchs 1972) in obstetrics is the tendency among obstetricians to adopt the technical aspects of any intervention over the more humanistic alternative (socioeconomic and psychological), because technology use is viewed as progressive and modern and is reserved for

medical experts use. Because technology use is perceived as objective and measurable, it is viewed as 'more scientific' and therefore fits with the dominant technocratic biomedical paradigm. Ever increasing technological interventions are seen as beneficial to humanity and therefore the rational solution to preventing real or what may be imagined risk; that is possible future risk that does not actually exist in the present. This justifies the unwarranted use of routine, non-medically indicated interventions. Inappropriate use of technological interventions may have iatrogenic effects, resulting in 'real risk,' that originated in the inappropriate use of technology in the first instance. This real risk requires further obstetric intervention and so the cycle continues. The 'technological imperative' (Fuchs 1972) or 'technological fix'" (Bauman 1993) is tautological and becomes "a closed system" consisting of "self-corroborating beliefs" (Bauman 1993: 187). This is how the technological imperative in obstetrics comes to dominate and control practices, decision-making and discourses in pregnancy and childbirth at the macro level of the institution and the micro level of the individual interactions.

As this study demonstrates, the three biomedical imperatives underpin the workings of institutions at both macro level, where they inform government maternity care policies and decision making, and at micro level, where they shape and coordinate service-users' and providers' local realities. The biomedical imperatives, due to their tautological nature, are the mechanisms by which the biomedical model is maintained and perpetuated in practice. They emerged as heuristic tools that aid in the recognition of the workings of the biomedical model to perpetuate itself in practice. They also offer a means to unmask hegemonic power relations that underpin maternity care policy and practice, by outing the hegemony of obstetric authoritative knowledge claims. An understanding of these imperatives by healthcare professionals means that they can be utilized by individuals to reflect and make explicit the philosophy that underpins their everyday practices and interactions, regardless of their espoused ideology or affiliation. It is hoped that this will make the dissonance between practitioners' espoused philosophy and philosophy in action evident and the practitioner's role in perpetuating the biomedical model visible. It is only by recognising the role practitioners play in perpetuating the biomedical model, that they can begin to change their practice, and

resistance and change become possible. The biomedical imperatives can also be utilised in research to analyse the philosophical assumptions that underpin government policy and organisational decision-making.

Against a background of capitalist development, state collaboration with the obstetric elite was shown to be central to the development of the modern maternity services as we know it today. The biomedical model was institutionalised as part of the introduction of state-run maternity services in 1954 and was integral to the development of welfare regimes and the capitalist mode of production in the newly emerging modern nation state (see chapter 5). A detailed analysis of government maternity care policies since then, revealed that medical hegemony was such that Irish obstetrics not alone remained a traditionally unchallenged site of power from the foundation of the state onwards, but right up through the 1970s and beyond. Throughout this time, obstetric authoritative knowledge and expertise continued to single-handedly drive maternity care policy, resulting in the biomedical model becoming more and more entrenched and resistant to change in the Irish context (HIQA 2013). I demonstrate that the complex interconnections between uncertainty-risk-intervention-safety, which is central to modern and biomedical ways of thinking and the undermining of and distrust in the natural biological processes which ensues from this way of thinking, are powerfully persuasive and compelling discourses that informed policy and clinical decision making at macro and micro level.

As is evident from the in-depth analysis of government policies and legislation, the state acted in collaboration with obstetric elites to safeguard capitalist development and private practice, and in doing so, perpetuated a two tiered private/public maternity service and an ideology that is patriarchal and hierarchical in nature. The safeguarding of private practice was evident with the introduction of private medical insurance (VHI) in 1957 supported by government tax incentives, significant government remuneration packages for GPs and obstetricians as part of the combined care scheme, following the 1970s Health Act, access by private patients to public maternity hospital resources, including state-employed midwives and following the 1990 Health Act, the sanctioning of private wings in public hospitals (see chapter 5). The power and influence of multinational insurance companies in shaping the maternity services is also discussed.

When it came to analysing the National Maternity Strategy, the utility of the biomedical imperatives in helping to make the philosophy that underpins the Strategy explicit was revealed (see chapter 10). Amid the discursive rhetoric of woman-centredness and the promotion of wellness and birth as a normal, physiological birth, thinking in terms of the obstetric imperative re-emerges and it becomes clear that the Strategy actually adopts a risk averse approach to

maternity care where it focuses on the comorbidities located in the individual childbearing woman's body, in an attempt to constitute pregnant women as high risk. These obstetric authoritative knowledge claims that constitute childbearing women as high risk are based on the risk versus safety agenda and are accepted unconditionally by the establishment, the judiciary and by multinational insurance companies. This is because the obstetric imperative of biomedicine is grounded in partial truths that are credible and rational and therefore justifiable. For example, it is true that the average age of mothers giving birth in Ireland is increasing (ESRI, 2013a). The issue here is not about denying real risk but is about contesting the power of obstetric elites to construct 'reality' using 'absolute truth' claims (Foucault 1977). Obstetric knowledge that constitute 'regimes of truth' are thoroughly imbued with relations of power and therefore come to constitute reality. Therefore, according to obstetric authoritative knowledge claims, all pregnancies and births are constituted as risky. While it is true that almost one-third of women giving birth are aged 35 years or older (ESRI, 2013a), it is also true that two-thirds of childbearing women are aged 35 years or younger. Yet, in the popular imagination, the potentially high risk, ageing maternity population becomes constituted as the "whole truth." The need to overemphasise the risk aspect of childbearing women while underemphasise the wellness aspect, where the possibility of morbidities are internalised and accepted unconditionally, as constituting the whole truth, is evidence of the workings of the obstetric imperative in the National Maternity Strategy. Service-users and providers are effectively socialised into a tacit acceptance of medical technological involvement in *all* pregnancy and childbirth as legitimate, necessary, inevitable and for the benefit of all. These "whole truths" become internalised by the subjugated; midwives and childbearing women, who become part of their own subjugation. Similarly, in the National Maternity Strategy, the obstetric imperative is evident by the need to overemphasise the role of the obstetrician in what are considered high-risk pregnancies while underestimating and trivialising the role of the midwife in what are constituted as normal pregnancies. The continued failure to delineate the role of the midwife in successive government maternity policies (see chapter 5 & 7) is also evident in the Strategy. This results in the perpetuation of obstetric hegemony while simultaneously perpetuating the historic subjugation of midwives, whose role is not seen or named. This in turn results in a lack of midwives in leadership positions and midwives' voices being excluded or ignored in policy decision-making.

The power and persuasiveness of the technological imperative, where the use of constantly updated technology is valued over the non-use of technology, also meant that the increase in obstetric litigation cases in the 1990s, instead of challenging the biomedical model, led to its further entrenchment. This is because litigation for medical negligence is associated with the underuse of medical intervention as opposed to its overuse (Davies-Floyd 2004). Adopting a

'wait and see' approach, advocated by proponents of the social model of care, is viewed by some as a sign of 'inaction' and can be construed in a court of law as negligent. So, far from challenging medical hegemony, the litigious culture of our maternity services increases defensive practice and the rise in non-medically indicated intervention rates (Davies-Floyd 2004, Miller et al 2016). I argue that like risk discourses and evidence-based discourses, technocratic discourses are appropriated by those in positions of power and presented as inevitable and essential in order to protect life, and this again reinforces their authority and strengthens their professional status. It is only by deconstructing the biomedical paradigm and unpacking the hegemony of the risk, technocratic and obstetric imperatives, that we might better understand how it came to dominate pregnancy and childbirth and how practitioners sometimes unknowingly, play a part in its perpetuation. The interconnections between modern institutions such as maternity hospitals, bureaucratic administration systems and the expansion and entrenchment of the biomedical model of maternity care also emerged as key factors that shape and influence how maternity care is organised, coordinated, and maintained at local level (see chapter 11 micro analysis).

14.4. Linking bureaucratisation, institutionalisation, and biomedicine

The link between bureaucratisation, institutionalisation and biomedicine is made explicit in this study. Key principles underlying bureaucratisation and biomedicine, used in the process of social control are rationalisation, universalisation, disciplining power, and fragmentation. Both bureaucracy and medicalisation are universalising systems and tools of rationalisation designed to maintain uniformity and control (Lipsky 2010). Universalising systems are grounded in Descartes' mechanistic view of an ordered world, governed by universal laws and are systems used to maintain order and social control of service-users and providers of maternity care.

I argue that bureaucratisation and biomedicine are mutually codependent and perpetuating. The development of modern nation state systems was dependent on the development of industrial economies by state facilitation of capital accumulation, and this required a far more intensive management of populations than earlier modes of production. The control of populations necessary for industrial expansion were facilitated by the expansion of the state apparatus and institutional bureaucracies; workhouses, hospitals, asylums, prisons, schools, and factories, with their central emphasis on rules and regulations and maintaining order. According to Foucault, institutions are modern systems of social control (Foucault 1977). With parallels to the panopticon, a metaphor used by Foucault to explain the relationship between systems of social control and people in a disciplinary situation, disciplinary power involved the

expansion of disciplinary institutions (Foucault 1977). I argue that the development of obstetrics necessitated the institutionalisation and bureaucratisation of pregnancy and birth, which made mass processing, medical control, and surveillance of pregnant women possible. Just as Foucault argues that the shift from torture to incarceration was as much if not more to do with 'disciplining power' than a benevolent act, ostensibly done in the name of humanitarianism (Foucault 1977), the same can be said for the move of pregnancy and childbirth from the home to the hospital. These macro processes are co-dependent and interconnected aspects of modern maternity systems and the capitalist mode of production. I demonstrate that patriarchal and hierarchical infrastructural power, embedded in the biomedical paradigm dominating modern maternity care institutions, not only facilitates but requires a bureaucratic management system to perpetuate its traditional power base.

It is in the nature of bureaucratic systems to subordinate the needs of the individual, both service-users and providers, to the needs of the institution, because de-personalising the system is the mechanism by which the system is rendered rational and efficient. This is achieved through the disciplining power of the institution and a process of fragmentation. As a process of social control in bureaucratic systems, disciplining power and fragmentation are used in maternity care institutions to regulate the conduct of others, maintaining uniformity and conformity without the use of coercive, through time constrained, repetitive daily practices.

Bureaucratic systems are task oriented, time constrained and standardised, where the emphasis is on efficiency through the appropriate use of dwindling resources and maximising throughput. All these characteristics are modelled on the capitalist factory system. Disciplining power, through repetitive practices, steer individuals to follow strictly designated rules and regulation that eventually become internalised and individuals become self-disciplined. This is the mechanism by which bureaucratisation enculturates service-users and providers into the institutional norm of the medical model of pregnancy. As this study demonstrates, individual practitioners are so taken up with the daily need to process increasing numbers of pregnant women attending antenatal clinics, that it does not allow time to consider new ways of working. Meaningful action to change practices is habitually postponed and the status quo is maintained (see chapter 12). This focus on getting through the tasks at hand means that the individual practitioner co-operates, accepts the order, setting aside judgments either of its rationality or morality" (Gouldner 1964: 22). Disciplinary power requires the cooperation of the subjugated subjects in order to work (Fahy 2002). Individuals cannot find the time in their busy schedules for resistance.

Because individualism violates the norms of universalising systems, childbearing women's active role in antenatal care is discouraged and the woman's voice is silenced. Antenatal

bureaucratic management systems do not facilitate or encourage childbearing women to ask questions or share their experiential knowledge with the healthcare provider; instead individual experiential accounts are often considered superfluous to requirements (see chapter 11). The systematic removal of women's individual circumstances and experiences from the industrial, streamlining process of antenatal care, objectifies the subject and renders their subjective experiences non-essential to the business at hand. The fragmenting, partial and dominating nature of the 'medical gaze' (Foucault 1976), embodied in both the doctor/woman encounter and the midwife/woman encounter is discussed in chapter 11. Just as the medical gaze separates the patient's body from the patient's person, the obstetric gaze, using Cartesian-like thinking and available birth technologies such as ultrasonography, separates mother and baby, as distinct, if not competing, entities. These technologies, linked to scientific discoveries, are thought to reveal the 'objective truth' about the fetus in utero, resulting in little or no need for direct input from the woman. Grounded in modern, dichotomous thinking, objective 'expert' knowledge is valued, while subjective 'experiential' knowledge is subjugated (see chapter 11).

Silencing has been especially important as a mode of control in Irish society (Murphy-Lawless and Oaks in press). On the silencing of individuals in fragmented bureaucratic institutions, Foucault suggests that "the suffering of men must never be a silent residue of policy. It grounds an absolute right to stand up and speak to those who hold power" (Foucault 2000: 475).

Fragmentation, as a mode of control in silencing individuals, also works by preventing the formation of meaningful relationships between the woman and the healthcare provider, and among and between professional groups. As the micro analysis in chapter 12 demonstrates, care of the woman is broken down into manageable tasks, where the task is separated from the woman. Similarly, midwives' and doctors' work is also fragmented, task orientated and arranged around shift work, which prevents them from attending to the same woman throughout her childbirth continuum. By keeping the woman and healthcare professional separate from each other, fragmentation limits communication and meaningful interaction, and limits strong advocacy for the woman, on the part of the healthcare provider. This leaves the woman in an inherently weakened position, where she comes to feel that she must negotiate the maternity services on her own. Just as women are left alone to negotiate the institution, so too, healthcare professionals have had to act alone when challenging the hegemonic system and risk being scapegoated, victimised, or blamed if they raise issues of concern (INMO 2021). Resistance is severely curtailed and childbearing women and healthcare professionals are effectively silenced. If resistance is not possible, low morale leads to a rise in attrition rates (Smith & Dixon 2008). Staff who experience burnout often feel alienated or conflicted due to being unable to give the care they consider appropriate, and this may result in them leaving the profession (ibid.). Murphy-Lawless and Oaks (in press) commenting on the phrase – a

'silent residue of power' - in the context of midwifery practice in Ireland, suggest that it is that which "breaks the hearts of our new midwives, and too often deadens the hearts of older midwives". Certainly, in this study, that is also true for doctors working in fragmented, de-personalised, efficiency driven, hospital antenatal clinics (see chapter 12). As this analysis demonstrates, bureaucratic institutions of biomedicine, with their norms of universalism, are incompatible with a woman-centred philosophy of care.

The far-reaching consequences of fragmentation impacts both service-users and providers at all levels of the analysis. This is achieved either through diverting their attention to managing throughput within strict time constraints leaving little time for anything else, encouraging conformity and modifying behaviour through surveillance and repetitive practices, through the threat of disciplining for individual staff and fear for women of retribution, if they raise concerns that upset the system, and through limiting political capacity for collective solidarity and the silencing of individuals by keeping individuals separate. The strategic and tactical use of power by hegemonic groups work to maintain the status quo and perpetuate further entrenchment of the biomedical model in the maternity services.

14.5. The obstetric profession, the state, and the subjugation midwives

The undermining of midwifery by obstetricians who "sought to outlaw midwives in order to gain a monopoly over this potentially lucrative field of practice" (Ehrenreich & English 2010:34) is not a new idea. It was originally raised with the exploration of the professionalisation of obstetricians in the United States (Salinger 2019) and Britain (Oakley 1984, Tew 1995). It was not my intention to focus on the subordination of midwives when I undertook this study. But as this study demonstrates, it is difficult not to come back to this assertion when examining change and entrenchment in maternity services in Ireland. What emerges in this analysis is the involvement of the state, in collusion with the hegemonic obstetric elite, in the systematic undermining of the midwifery profession (see chapter 5). For example, the establishment of state regulation of midwives through the regulatory body (Central Midwives Board (CMB) in 1918, along with the medical and nursing control of midwives' training, education and practice occurred in tandem (see chapter 5). The midwife's unique role was blatantly ignored and not delineated in state legislation when setting up the state-run maternity services (MICS 1954), which ultimately led to the demise of the autonomous role of the district midwife. Using divisions of labour based on gendered power relations, midwives were later confined to the role of assistant to the doctor on duty in the hospital setting (Wagner 1994). As midwives' identity became blurred with that of nursing, a midwife became a person on the Midwives' Division of the Nursing Registrar and midwifery was designated as a branch of nursing (O'Connell 2019). As the midwives' scope of practice contracted, correspondingly the doctors'

scope of practice expanded to include what was traditionally exclusively midwives' work, caring for healthy well women. Yet, over 40 years later, in 1998, when it benefited private general practice, midwives were reintroduced into 'the district' under the General Medical Services Payment Board as practice nurses, privately employed by general practitioners, who were in receipt of a government subsidy towards the cost of their salaries (DOH (Department of Health) Circular 5/89) (see chapter 8).

As the historical analysis of government legislation demonstrates, the use of legislation to undermine the role of the midwife was often most effectively enacted through inaction, by not recognising their role in maternity care and not giving the role any statutory weight, as with the MICS (see chapter 5). But also, legislation is used in a more coercive, punitive way, by threatening criminal prosecution for practising midwifery outside of the restrictive, obstetric driven HSE guidelines, despite these restrictive practices often being non-evidenced based (Oboyle 2015). Professional indemnity insurance (PII) is also used as a coercive tool to control the autonomous scope of practice of midwives, where instead of focusing on ensuring affordable PII for practitioners working independently, the government focuses on legislation that threatens criminal prosecution, if working without having adequate insurance cover. This is despite the high cost of midwifery PII being linked to obstetrician's often non-evidenced based interpretation of risk. Most significantly, as the example of Philomena Canning, Self Employed Community Midwife (SECM) demonstrates, even midwives with HSE sponsored indemnity cover are vulnerable to it being withdrawn with little justification or notice, with devastating personal, financial, and professional consequences for the midwife concerned and the women in her care (see chapter 8). Limiting access to becoming a SECM due to a HSE mandatory requirement of having to work three out of the preceding five years in an acute hospital setting, unique to Ireland, and the disparity of direct entry midwives' ineligibility for the payment of the practice nurse subsidy (PQ 630 Question Reference(s):5089/21) is more concrete evidence of continued state prejudicing of midwives in the healthcare system. These government-imposed restrictions on the role of the midwife in the Irish context are out of step with international best practice, where evidence demonstrates that strong midwifery involvement in maternity care is linked to a safe and quality maternity service which improves choices for women and is a service that safeguards physiological birth and ultimately saves mothers' and babies' lives (Wagner 2001, WHO 2020, ICM 2021). By contrast, what Ireland has amounts to little more than ongoing state discrimination against midwives. It could be argued that a midwife's role in Ireland is defined more by doctors and multinational insurers, with the collusion of the state, than by the midwives' professional body or best available evidence. This is not surprising, given that government maternity policy is obstetrically driven and that an understanding and valuing of the distinct role and philosophy of the midwife, that is different to obstetricians and what the evidence suggests is proven to be of benefit to women,

is blatantly missing from obstetric thinking. A statement from the chairperson of the Institute of Obstetrics and Gynaecology (IOG) exemplifies this when he said that 'all obstetricians are midwives and proud of it' (Oireachtas Debate 2018: 15-16).

Far from being altruistic, this can be viewed as another strategy to undermine the social location of midwives in Irish society and ensures that the midwife's unique role remains unseen and surplus to requirements in the Irish context. Yet, according to Michel Odent, the French obstetrician and advocate of natural birth, to rediscover midwifery is the same as giving back childbirth to women (Oden 2015). What distinguishes a midwife from other clinicians who care for pregnant women emerged as an important question when conducting this study (see chapter 7). The complex interrelationship between the social model of care, the philosophy underpinning midwifery and what women value in antenatal care provision is made explicit in the literature (Downe 2010, Renfrew et al 2014). What this analysis identified was that obstetricians were not alone in their misinterpretation of what midwifery is and is not. The unique role of the midwife, as distinct from a doctor, was not always apparent in the midwife-woman antenatal encounters. What emerged from the micro analysis in chapter 11 and 12 was that while many midwives espoused the social model of care, their practice did not always reflect this. Midwives' involvement did not guarantee that their practices and discourses embodied the social model of care. Many midwives were historically socialised into the biomedical model and knowingly or unknowingly, perpetuated the biomedical model of reproduction as normal and inevitable and just the way things are done (see micro analysis chapter 11). Others felt coerced, due to institutional constraints, to conform to the hegemony of the biomedical model (see micro analysis chapter 12). Despite the context, much still depended on the attributes and philosophical commitment of the healthcare provider in question (see chapter 11).

So, just as an in-depth understanding of the key tenets of the biomedical model proved necessary for service-users and providers in order to better recognise their role in its perpetuation, so too, the key tenet of the social paradigm also emerged as a necessary topic of inquiry when it came to change and entrenchment in the maternity services. This was especially relevant in terms of recognising the social model of care, what the social model of care looks like in practice, and how it is linked to the philosophy underpinning midwifery practice.

In summary, the historical erosion of midwives' identity, both within the legislation, at institutional level, in practice and among the public, hindered the development of midwifery as a profession in the latter half of the 20th century, and led to the midwifery professional being underdeveloped, marginalised, and excluded from public policy decision making. As choice of service provision in maternity care is linked to midwife-led services, the strategy to subjugate the midwife and undervalue her/his role in the provision of maternity care in Ireland has

severely limited the introduction of changes to the maternity services and choices to women using these services. It is clear from this analysis, that the gendered unequal hierarchical relationship between the midwifery and obstetric professions, in a society that remains doggedly patriarchal, means that the survival of the midwifery profession is always under threat.

14.6.Change processes: unmasking how power works in institutions

A complex system is one in which there are many components and high interrelatedness between the large numbers of components (Kannampallil et al 2010). Maternity institutions fit this definition of a complex system. Successful change management in complex systems requires a ‘whole-system-change’ approach (Datée and Barlow, 2010, Barry and Norton 2018). The view that organisations are complex systems that are multi-layered and inter-relational is at odds with Descartes’ mechanistic view of the world as orderly and governed by universal laws. In this perspective, institutions are thought to work as rationally designed machines, where all parts of the organisation are interconnected and work unproblematically to achieve one predominant goal. Instead, I concur with others that complex systems are messy, and changes in complex systems are not linear, rational, or always pre-planned processes, but are often irrational, contingent, and unpredictable, and the result of unintended and unforeseen consequences of one's actions. Change agents must also be aware of the tension between intentional versus unintentional effects of change. For summary of strategies used for unmasking obstetric power see table14-3.

Table 14-3 Unmasking Obstetric Power

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| <ul style="list-style-type: none"> • The tautological nature of the biomedical imperatives • The power and persuasiveness of the biomedical imperatives in being the sole influencer in Irish government maternity care policy • The obstetric imperative and the strategic use of power and influence using obstetric authoritative knowledge ‘truth’ claims in constituting reality. This body of legitimate knowledge comes to define what is normal, acceptable, and deviant (Foucault 1980). This is achieved by constituting ‘the problem’ through risk averse partial truth claims and presenting the biomedical model as the obvious and only solution. The |
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discursive power of risk averse, partial truth claims comes from the fact that they are always contextualised and appear rational and comprehensible. This is the means by which the potential and need for obstetric intervention is conceived, discussed, disseminated, and enacted by obstetricians and becomes understood and internalised by childbearing women, government policy makers, and the public.

- The obstetric imperative is to overstate risk and the role of the powerful while understate wellness and the role of the powerless; it overstates the role of obstetrics in what is constituted by them as high-risk pregnancies, while it understates the role of midwifery in normal pregnancies, thus safeguarding obstetric practice while maintaining the historical subjugation of midwives.
- The side-lining of the competition: The obstetric elite strategy is to side-line and subjugate midwives' identity in order to assert their own. This is achieved by disseminating misinformation that scapegoats or undermines the role of the midwife, by not naming the midwife in legislation and government policy documentation, by a policy of holding midwife-led services to a higher standard than consultant-led services (double standards) and suspending midwife-led services as a first rather than last resort.
- Individual blaming instead of system blaming: Constituting 'the problem' in the first instance and then locating 'the problem' within women's defective bodies or lifestyle choices and not the biomedical, bureaucratic risk averse system. This means that the solution is misdirected to the individual and shifts attention from the risk averse culture with a predilection to escalating interventions and

socioeconomic disparities that are at the heart of the crisis in the Irish maternity services.

- The use of fragmentation as a process of social control: in terms of bureaucratic fragmentation, the medical gaze, objectification of the person and reducing political capacity for collective action.
- Strategies of resistance in the change process: The use of the 'get out clause' in government policy documents to initially feign compromise and later justify inaction on the part of the powerful elite. This facilitates the use of the pocket vetoes as a means by which those in positions of power and influence can sabotage decisions agreed by stakeholders by blocking the executive of those decisions, at the final hurdle and without a public mandate.

14.7. The appropriation of change discourses

Many discourses emerged in the 1970s and beyond to challenge the biomedical model and drive reform in the maternity services, such as the natural childbirth movement, the need for women's choice and woman-centred care, and continuity of care models (see chapter 6 & 7). Whether these are useful concepts to drive the change agenda was explored. I raised the question of who controls and defines these concepts and how their meanings have changed over the years. I argue that when these discourses enter the mainstream, their meanings are often ambiguous, open to different interpretations and they are subject to appropriation by the hegemonic elite, to strengthen their professional status and support the status quo. I also raise the question of the power-relations that underpin the change process.

The discourse of protecting normal birth, synonymous with birthing women's empowerment and midwifery autonomy, was the first major challenge to the hegemony of the biomedical reproductive paradigm with the 1970s Natural Childbirth Campaign in the United States (Davis-Floyd 1992, Hardy 2011) and the work of Sheila Kitzinger in the UK (Kitzinger 1980). The emergence of the discourse that the normal process of birth needed protection indicates that the normal process was no longer valued in the dominant discourse. What normality meant was open to multiple interpretations and gradually changed over time (see chapter 6). Normality linked to statistical analysis of populations and embedded in the biomedical paradigm, replaced physiological normal, embedded in the biosocial paradigm, as the

dominant maternity care discourse. These contesting notions of what constitutes 'normal' are also evident in the National Maternity Strategy, where they emerge as competing ideologies of reproduction (see chapter 10) and in the micro analysis in this study, where they are evident in the childbearing women's varying perspectives on what type of childbirth they want or expect (see chapter 11). Even within the midwifery profession itself and evident in this study, promoting normal birth has moved from the essentialist 'natural' childbirth to mean an approach that supports women's ability to give birth without routine medical interventions (see chapter 8). This latter meaning of promoting normality in terms of non-interventionist birth suggests that midwives have renegotiated its meaning in order to remove any ambiguity. Perhaps every woman's human right to a non-interventionist birth should replace protecting normal birth in the campaign for a better maternity services.

In the 1990s, woman-centred care in terms of choice, control and continuity, representing an alternative to the over-medicalised, over-interventionist fragmented, risk averse approach to maternity care, replaced normal birth as the dominant rhetoric used to challenge the biomedical model and drive reform in England and Wales (DoH UK 1992) and elsewhere (DOH NZ 1989, Wagner 1994, Davis-Floyd et al 2009, Guilliland & Pairman 2010). But, as with the discourse of protecting normality that preceded it, these later concepts also proved problematic (Edwards 2005).

The appropriation of women-centredness to support hegemonic vested interests is evident in the National Maternity Strategy where woman-centeredness and profession-centric terms such as 'consultant-led' and 'midwifery-led,' are seen as mutually exclusive and in opposition to one another (see chapter 10). Given that the term woman-centred care in maternity care is historically linked to the campaign for reform of the maternity services in terms of midwifery autonomy and childbearing women's empowerment, this move is disingenuous and may be viewed as an attempt by the hegemonic elite to reappropriate woman-centredness for their own vested interests. This strategy of reappropriation was used to justify not 'naming' the midwife in the alternative care pathways. The Strategy offered ambiguous, nondescript titles such as supported, assisted and specialist care pathways, instead of the clear and unambiguous midwifery-led and consultant-led pathways. This proposal was not going to impact on the existing dominant, consultant-led service, which is already well ingrained in the popular imagination. It does, however, reflect a continuation of the pattern to not name or fully acknowledge the role of the midwife in Irish maternity care, a familiar strategy used by those who want to undermine the competition.

Similar to the natural childbirth discourse and woman-centred discourse, I concur with others that the need to over-emphasise individual choice in maternity care is again a tacit acknowledgement that individual autonomy is under threat and incompatible in a system that operates in accordance with institutional bureaucratic universalising values. As the literature

review demonstrated, childbearing women's choices are severely restricted in the often disempowering, risk averse culture of the maternity setting (Kirkham 2004, Jomeen 2012). The discourse of choice as an idealised norm can also prove to be counterproductive and can be utilised by those in authoritative positions as a coercive tool to encourage conformity with the status quo. Thinking that you have made a choice is not always the same as making the choice. Women who are disempowered by their experience of the biomedical model tend to leave the decision making up to the perceived experts as is evident by the childbearing women's accounts (see chapter 11).

While childbearing women, 'appeared' to have a statutory right to a domiciliary birth in the 1970s Health Act, in practice the choice did not rest with the pregnant woman and her family as autonomous subjects, but with the 'medical experts' (see chapter 7). The fact that medical expertise, grounded in objective scientific rationality, is accepted unconditionally over women's subjective experiences and preferences/choices by the Irish establishment, was more recently revealed when reviewing maternity cases heard in the High Court in 2013. The case to have a home birth following a previous caesarean section (HBAC) was rejected by Ms Justice Iseult O'Malley on the grounds that it would be "manifest irrationality" for the courts to change the criteria for home births as set out by the HSE (McGreevy 2013) (see chapter 7, section 7.6). Paul Anthony McDermott, for the HSE, also defended the HSE decision not to permit Ms. Teehan, the plaintiff, to have a HBAC on the grounds that "the policy was rational and based on medical evidence" (McGreevy 2013). The limitations of the legislative process to drive reform in the Irish maternity services, when it does not have the support of the dominant hegemonic groups is evident here, and can be costly for those involved, both in monetary and emotional terms (McGreevy 2013). This refusal to acknowledge women's everyday realities amounts to 'gender politics of knowledge and expertise' (Gavaghan & Kulawik 2020:647), where women's voices continue to be silenced or trivialised. It is worth noting that the view that HBAC is irrational is by no means universal or unanimous among the scientific community. HBAC is facilitated in the United States (MacDorman et al 2012) and the UK (Chamberlain et al 1993). Also, how doctors use the choice agenda and women's expectations of routine ultrasound to justify its continued use in terms of addressing consumer demand is demonstrated. What the doctor fails to do is to recognise or acknowledge doctors' decisive role in creating the consumer demand in the first place, by disseminating the idea that an ultrasound scan, linked to obstetric safety and progress, was a 'must have' at every antenatal visit. Similarly, the association of private-practice with higher, non-medically indicated intervention rates demonstrates that the choice agenda has been appropriated by private practitioners to justify non-medically indicated interventions on the grounds of supporting consumer demand (Murphy and Fahey 2013, Lutomski et al 2014). In Ireland, with no extensive community midwifery, the choice discourse came to be interpreted to mean that the choice of private or

semi-private care under a consultant obstetrician, is the only choice that gives women who can afford to do so, the best chance of getting what they want, and recourse to private obstetric care remains high (Pope 2017). The appropriation of the same discourses used by the ruled to challenge the hegemony of the rulers is well elucidated in this study.

Facilitating women's choice is also the sentiment underpinning childbearing women's satisfaction surveys. I argue that these surveys can be used as strategic tools to justify the maintenance of the status quo and so should be used with caution when planning the future of maternity services. Research has shown that women tend to favour whatever system of care they have experienced (Porter & Macintyre 1984), be that routine ultrasound scans or the combined-care scheme, thus supporting the status quo over changes of which they have no experience (see chapter 6). As this study demonstrates, women who have had the opportunity to attend the alternative, midwife-led clinic, appear to readily accept not having scans routinely during the antenatal visit (see chapter 11). So, without a comparative analysis, I have cautioned about using women's satisfaction surveys to plan the future provision of maternity services. The report on the findings of the first-ever 2020 National Maternity Experience Survey (HIQA (Health Information and Quality Authority) 2020) was published in 2020. The survey showed that among 3204 women out of a possible 6357, 85 percent of participants had either a good or a very good experience of the maternity services (HIQA 2020). Teijlingen et al (2003) suggest that because satisfaction surveys are flawed, it makes the distinction between "very satisfied," and "satisfied" especially important for all studies in maternity care. The above figure needs to be broken down accordingly. Anything below 'very satisfied' or very good in the above survey, implied deficient care with significant room for improvement. Those reporting very good experiences in the above study numbered 52 per cent (HIQA 2020), just over half, suggesting there is substantial scope for improvement. It may be useful to juxtapose this statistic with another, using a similar sample size. In a survey of women's experiences of maternity care conducted by AIMS in 2014 among 2,836 women, 58.5 per cent said they would opt for a freestanding birth centre, if the service was available (AIMS 2014). While satisfaction surveys are heavily used to support the status quo, other survey results that do not support the dominant agenda are ignored. Clearly choice and satisfaction discourses are open to appropriation by the obstetric elite to support the biomedical model and maintain the status quo. Focusing a campaign for a better maternity services around discourses that are open to multiple meanings and being appropriated by the hegemonic elite, hinders effective communication of clear unequivocal statements and a clear vision of the purposes and rationale of the changes being proposed, both necessary for an effective marketing and implementation strategy. This may account for the link between rhetorical discourse and actual practice remaining underdeveloped in maternity care.

14.8. Discourse versus practice

Although discourses about reform, using terms of reference familiar to service-users and campaigners, have become mainstream in government maternity care policies, the high-level rhetoric and policy statements from the 1970s through to the 1990s, most often failed to be translated into daily working practices (see chapter 7). Even into the 1990s and beyond, when government healthcare strategies focused on woman-centred care as an ideal and a small number of midwife-led initiatives were introduced, government and institutions neglected to focus on what changes and implementation processes would be required for the successful integration of these new initiatives into practice.⁸³ For example, the continued recommendation for 100% consultant-led care, along with the continued, widespread adoption of the active management of labour protocols at this time, meant that what woman-centred care would look like in practice was given little attention and was in fact alien to Irish obstetrical and governmental thinking. The fact that these government recommendations and protocols that require childbearing women to conform to institutional norms are blatantly at odds with woman-centred models of care was not given serious consideration. The need for the current system to change was not considered. Most midwife-led and woman-centred initiatives introduced in the 1990s involved changes introduced *in* the current system as opposed to changes *of* the system, where the changes are meant to ‘fit in’ to the current dysfunctional system instead of replacing it. As the Irish and international evidence has demonstrated, attempts to introduce continuity models into existing bureaucratic biomedical systems has proven problematic. We see from the UK literature that the first continuity of care initiatives ended up prioritising continuity between antenatal and intrapartum episodes of care (Green et al 2000). This priority was driven by the bureaucratic imperative to measure the delivery of continuity, defined as having a known caregiver in labour (DOH, England and Wales 1993), as an outcome, rather than as a process, which would involve measuring the subjective reality of the midwife/woman relationship. By adopting this ‘scientific-bureaucratic’ approach, the emphasis is on performance targets that are measurable, and in which personal relationships are invisible. In the Irish context, attempts to integrate midwife-led DOMINO schemes, underpinned by the social paradigm, within the constraints of the current bureaucratic biomedical system proved unworkable and failed in their attempt to offer continuity with a known midwife in labour, precisely because the philosophy underpinning them was incompatible with the existing hegemonic system (see chapter 8). Because change processes are unpredictable and because reform discourses are open to appropriation by hegemonic groups, changes intended to offer alternatives to the dominant model of maternity care, may unintentionally lead to further

⁸³ It took a leader in healthcare, from outside of the Irish jurisdiction, before woman-centred care became a reality in practice, with the introduction of the MLUs (Midwifery Led Units) in 2001, in the North-Eastern Health Board (NEHB).

entrenchment of the very model that the change strategy was meant to challenge. A review of maternity and gynaecology services in the Dublin area as late as 2004 revealed that 'no participant [neither service-users nor providers] thought that the maternity services were women-centred at the time' (Women's Health Council, 2007 quoted in KPMG Report 2008).

14.9. Power-relations underpinning the change process

An analysis of the power-relations underpinning the change processes is also revealing. While the introduction of the HSE homebirth service is welcome and appears to be moving in the right direction, offering women alternatives to the biomedical model, and proven to be successful at achieving caseload continuity, much of the control around accessing and eligibility for the service still rests with restrictive obstetric- dominated HSE guidelines, policies, and protocols. Also, it took a healthcare leader from outside of the Irish jurisdiction to approve the setting up of the first MLUs, following recommendations of the Kinder Report (2001), that was the unintended consequence of government blanket policy to close down all small maternity care units. However, because these midwife-led initiatives challenge existing power relations and vested interests, they are still vulnerable to the hegemonic strategy of double-standard when it comes to midwife-led services, as was the case with suspension of waterbirth in Cavan MLU in 2014 and in the National Home Birth Service in 2020 (CMS 2020), as a first resort and before carrying out an investigation, completely undermining confidence in the service and with a devastating impact on the women using the service (see chapter 8). Autonomous midwife-led services are also vulnerable to being withdrawn due to feigning underutilisation or a lack of resources, as evidenced in Cavan MLU, which has been under constant threat of closure since it opened in 2001 (Kennedy 2012, O'Connor 2001).

There is also the question of what drives changes in the maternity services. As this historical analysis of change in the maternity services has demonstrated, change agents in the maternity services are multiple and pervasive and occur at all levels of the institution (see Table 14-5). Also a single change or innovation may have multiple change agents and therefore conflicting motivations. The more motivations for change presented by change agents, the better the chances of the change being implemented, despite the rationale justifying the change coming from different philosophical persuasions. As evident from this study, the development of midwife-led community, antenatal clinics may not be motivated by pure altruism on the part of healthcare providers and politicians to meet the needs of childbearing women, but may also have been introduced to address the needs of the institution in terms of addressing the problem of not fit for purpose, overcrowded hospital clinics and to relieve the heavy workload of junior doctors due to the reduction of doctors' hours as per the European Working Time Directive (EWTD 2009), as suggested in the government commissioned report of the maternity services

in the greater Dublin area (KPMG 2008). This means that the introduction of innovations that appear to challenge the dominant model of maternity care may not signify a willingness by the hegemonic elite to share power, or a change of power relations at the heart of the institution. Also, just because changes are legislated for does not mean that they will be acted upon or facilitated, as was the case with entitlement to domiciliary birth in the 1970s. If the proposed changes are contentious, and do not have the backing of the hegemonic elites, despite apparent government backing, such as the government recommendation in the National Maternity Strategy to introduce MLUs nationwide, they tend to be blocked at the final hurdle, by the hegemonic elite who occupy positions of power and authority and influence budget allocations, or simply do nothing to drive the change forward. Implementation plans for proposed changes are often left under-developed, under-resourced, not facilitated or deliberately blocked by vested interest groups.

Despite their limitations, midwife-led community initiatives were favourably evaluated, yet were never rolled out nationally, and access to a midwife and genuine choice for women remained patchy at best. In contrast, in England, Scotland, Wales and Northern Ireland, New Zealand, and Canada, for example, early direct contact with a local midwife is recommended, and all women have access to a primary care midwife (Hanafin and O'Reilly 2015). There is no such proposal in Ireland's first National Maternity Strategy, where the role of the GP as gatekeeper of the maternity services remains unchallenged. In the 2020 National Maternity Experience Survey 87.4% (n=2,797) of women saw a GP first and only 3.7% (n=120) saw a midwife first (HIQA 2020). In 2014, only 5.5% of the 2,836 respondents of an AIMS (Association for Improvement of Maternity Services in Ireland) Survey reported that antenatal midwife clinics were available to them (AIMS 2014). It can be argued therefore that maternity care remained broadly unchanged at national level.

14.10. Hegemony, obstetric authoritative knowledge and resistance to change

The limitations and potential of the National Maternity Strategy (DoH 2016) have already been discussed in Chapter 10. The continued government support of the voluntary status of the Dublin maternity hospitals and the Mastership system of governance for these hospitals, evidenced in the Strategy. Fergal Malone, Master of Rotunda Hospital also reflects the importance of maintaining the values of Voluntarism in the Rotunda Strategic Plan 2017-2021 (Rotunda Strategic Plan 2017-2021:9). Government support of this patriarchal governance structure is also evident in the National Women and Infants Health Programme (NWIHP), set up to implement the 2016 National Maternity Strategy, where the first director appointed is himself a former Master.

Despite its promise to overhaul the maternity services completely, four years on no substantive changes have materialised. In February 2020, HIQA published an overview of its inspections

of Ireland's 19 maternity units and hospitals, with a particular focus on obstetric emergencies, considering the NMS implementation plan (HIQA 2020). Mary Dunnion, HIQA's Director of Regulation, reported that the HSE has made limited progress in advancing this Strategy since it was approved four years ago, that there is a lack of clarity and national leadership within the HSE regarding the responsibility for its implementation. HIQA found that maternity networks to ensure equal access to the same level of care and support across the country, fundamental to the workings of the Strategy, still need to be implemented. The Strategy had promised that all development funding for maternity services would be ring-fenced. Only 11 percent of the money originally promised to implement the maternity strategy has been provided by Government (ibid.). Of an estimated cost of €75 million for the 10-year strategy, only €8.5 million was provided in its first three years, and part of this was spent on setting up a national ultrasound service. HIQA concluded that there was a "need for a more comprehensive, time-bound and costed implementation plan," and "the development of a comprehensive plan to fully implement both the National Standards for Safer Better Maternity Services and the National Maternity Strategy (HIQA 2020). In June 2021, Micheal Martin TD and Taoiseach, in response to questioning in the Dáil from Alan Kelly Labour TD, sums up the government's deference to medical authoritative knowledge on all matters to do with health and 'the world of medicine'. "The question is often asked [as to] who is in charge. In health and in the world of medicine, politicians do not dictate - and have never done so - to medics in terms of clinical guidance". (Houses of the Oireachtas June 16th, 2021).

The belief that hospital birth is safest still dominates obstetric discourse in the Irish context, is internalised by healthcare providers, politicians, and the public, and underpins the National Maternity Strategy. Attitudes to consultant-led hospital births are still very much entrenched. This entrenchment is not reflected internationally. In 2013, a statement issued by the Royal College of Obstetrics and Gynaecology, UK, Dr Tony Falconer, President of the RCOG, acknowledged that home birth was safe for low risk women and associated with less interventions was said:

"The RCOG supports the choice of a home birth for low-risk women expecting a second or third baby. This large study reiterates the findings from the Birthplace study (Brocklehurst et al 2000) which showed good outcomes for some low-risk women and their babies who delivered in either midwife-led units or at home".

A similar statement, in support of home birth and written jointly by midwives and obstetricians in response to the evidence on place of birth, was issued by the Journal of Obstetrics and Gynaecology Canada (JOGC 2016). In Ireland, no such statement supporting home birth has been forthcoming from the Institute of Obstetrics and Gynaecology (IOG). As one Irish obstetrician in this study put it 'most obstetricians would not be philosophically well disposed to home birth' (C2 see chapter 7: 144). Irish obstetricians appear to actively resist new

evidence that challenges deeply held beliefs about hospital safety and risks of home birth at an intellectual and intuitive level. However, the government-funded website, Citizens Information, does carry an entry on home birth and how to go about accessing this care as does the HSE with a section on its National Home Birth Service. The HSE website states that

“Home birth can be a safe option for low-risk healthy women. Research shows that a planned home birth is an acceptable and safe alternative to a planned hospital birth for some pregnant women” (HSE website 2020).

While consultants’ surveillance during all pregnancies has given way to midwife-led clinics for women deemed low risk, the belief that hospital birth is safest still dominates obstetric discourse in the Irish context, still dominates obstetric thinking, and underlies the National Maternity Strategy. While perhaps not a deliberate conspiracy per se, it is difficult not to see elite obstetrician’s persistence that childbearing women should attend an obstetric unit during birth, just in case ‘something goes wrong’ as not only untrue but untenable. This over-emphasis on medical risk and obstetric safety is linked to current very significant shortcomings in maternity care (Harding Clarke 2006, HSE 2008, HSE 2013, Holohan 2014, HIQA 2015).

Five years on, and with the official timeline expired, a network of alongside birth centres (ABCs), a key recommendation of the Strategy, has not been delivered. This is considered an absolute economic and social priority by the Midwives Association of Ireland (MAI 2020). At the National Perinatal Epidemiology Centre (NPEC) study day on ‘Birth Choices’ on 22nd January 2021, when asked to confirm current plans for future MLUs (referred to as ABCs in strategy), as proposed in the maternity strategy, Angela Dunne, Midwifery lead in the NWIHP, confirmed that there are currently no plans to deliver on its commitment to make MLUs available nationally (NPEC 2021). Also, the new National Maternity Hospital currently under construction, with a projected 10,000-births-a-year and extensive facilities for private medical practice, does not include plans for a MLU (Canning 2017). Astonishingly, despite the promises made in the National Maternity Strategy, the evidence of the safety of MLUs (Midwifery Matters DoH 2007, Brocklehurst et al. 2011, Begley et al 2009, 2011, Downe et al 2001, Jomeen 2010, Kenny et al 2017) and established consumer demand for MLUs (AIMSI 2014), the government continues to stall on implementation. This is in stark contrast to Northern Ireland, where government policy firmly supports the provision of MLUs ((DHSSPS 2012, 2020). Healy & Gillen (2015) report that in an effort to normalise birth, there has been a steady increase in the provision of MLUs since the first unit opened in 2001. The consultant’s take that ‘having two separate labour wards [is] a non-starter’ (for full quote see chapter 10 pg. 186), suggests that current government policy may reflect the historical legacy of obstetric dominated government maternity policy. While the obstetrician’s rational bureaucratic perspective for not supporting ‘having two separate labour wards,’ may appear eminently reasonable and logical to the obstetrician in question, it is in fact anecdotal and crucially, it is

not evidence-based. The central critique of the biomedical paradigm, that authoritative knowledge rests with the professionals and not the childbearing woman is again clear here. Authoritative knowledge produced in this conceptual framework is far from neutral in its effect (Harding 1991). Not only is it not women’s knowledge, but worse, it is counter to women’s needs and desires. Those in authoritative positions, do not appear to reflect on how authoritative knowledge and power relations work and coalesce and are imposed within the scientific community. This is consistent with Smith’s argument that there is a clear link between the standpoint of men [who tended to be in these authoritative positions], their claims of objectivity and rationality and relations of ruling (Smith 2012). As Bauman (1989) succinctly puts it “the rationality of the ruled is always the weapon of the rulers” (ibid. :142). While wanting to be seen as progressive, and earlier in the interview this consultant claimed to be an advocate of woman-centred care, he simultaneously and perhaps unknowingly denies women-centred care, thinking instead that, given his authority and expertise, he can decide what is best for women. Whether this obstetrician recognises and is willing to acknowledge openly that he and his fellow obstetricians are the beneficiaries of this objectified, scientific knowledge on the infeasibility of MLUs, and childbearing women and midwives are the losers, is unclear. For a summary of drivers for entrenchment see table 14-4.

Table 14-4 Drivers for Entrenchment in Irish Maternity Services

• The power and persuasiveness of hegemonic authoritative knowledge claims as the deciding influence on Irish government maternity care policy that led to a 100% consultant-led, hospital based maternity care system. • Government support for private practice through legislative changes and government financial incentives, consultants’ private/public contracts, tax incentivised private medical insurance, commissioning of private wards in public hospitals • Government’s collusion with the obstetric elite and nursing and midwifery regulatory bodies to effectively undermine the competition by their systematic and historic undermining of the midwifery profession. • Neoliberalism and the impact of multinational insurance companies and government clinical indemnity arrangements on practice. • Support for bureaucratic management systems that maintain the entrenchment of the biomedical model through repetitive, fragmented, time constrained practices.
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14.11 Power embodied and enacted: change in and through practice

Attitudes to midwife-led clinics have changed dramatically between the 1992 (Comhairle na nOspideal 1992) which advocated 100% consultant-led hospital clinics and the National

Maternity Strategy (2016) where midwife-led community antenatal clinics for women of low risk were advocated as part of the supported care pathway. Consultants' surveillance during all pregnancies has given way to midwife-led clinics for women considered low risk. Despite the failure to implement midwife-led services nationally, and regardless of what possibly motivated the initiatives, in the localities where community midwife clinics were introduced, they come to define what is normal and routine, and they began to be seen as the rational and most convenient choice for pregnant women when availing of antenatal care (see chapter 11). Midwifery power is embodied and enacted through the local clinics and has a conditioning effect on childbearing women's expectations, attitudes, judgement, and conduct. Childbearing women became socialised into the tacit acceptance of attending community antenatal clinics as mere common sense. So instead of focusing on changing attitudes leading to a change in behaviour, we see the opposite can also be true. As my research findings demonstrate, this change in experience and practice among midwives and pregnant women, triggered a change in judgement and conduct of GPs and obstetricians (see chapter 11). Obstetric support of the clinics was not always rationalised in terms of midwifery autonomy or being part of the midwives' role. Instead, in keeping with their dominant paradigm, midwife clinics were supported in terms of the need for midwives to take an equal share of the workload, to benefit the institution in terms of reducing overcrowded and better use of doctors time and skills. Exposing midwives and obstetricians to homebirth as part of their training may impact the likelihood of them recommending and supporting homebirth in practice.

Since the HIQA overview of the implementation of the Strategy, the Minister for Health, Micheal Martin reported that a request for the drawdown of new development funding made by NWIHP, was approved on 10th June 2020, and will help the further development of community midwifery services around the country and finance the development of advanced midwifery practice (AMP) leadership positions.

Cracks were beginning to appear in the normally unquestioned alliance between obstetricians and politicians when there was another attempt to suspend services in Cavan MLU in 2020. This triggered an active campaign of service-users (AIMSI 2020), midwives (MAI 2020) the IMNO and local Cavan/Monaghan TD Niamh Smyth (Bowers 2020), who put Parliamentary Questions to the Minister for Health, Simon Harris on the proposed closure. A review of the MLU Cavan General Hospital (CGH) commissioned by the Minister for Health, following the attempted closure, reported that the MLU was to remain fully operational, and no restrictions were to be placed on eligible women accessing this service (Houses of the Oireachtas 2020). When it came to the governance structure and professional control of the midwife-led services, the decision that "all sites currently support the concept of having a lead midwife as being the named lead healthcare professional for normal-risk obstetric patients." (Houses of the

Oireachtas 2020) represented a decisive change in the power-relations within the organisation and the status afforded to midwives. Self-governing is a key first step in professional autonomy. This also demonstrates that sustained and collective campaigning from multiple sources and with government backing can be effective when midwifery-led services come under threat of closure.

Change in attitudes to women's rights in maternity care among legislators is also evident in more recent court rulings. In November 2016, Judge Michael Twomey refused the HSE request to order a woman to undergo CS against her will as it was a 'step too far' (Carolan 2016). Although the discourse was still framed in terms of rationality and risk versus safety, this time the judge did not defer unconditionally to the medical authoritative knowledge when making his judgement. The woman sought to wait to see if she could deliver naturally after her three previous CS deliveries. The obstetric evidence was that natural delivery after CS carries a risk of uterine rupture, which her obstetrician was not willing to take. Even though the judge "could not see why she would choose to increase the risk of death or injury to herself or her child," he still concluded that to perform a surgical procedure without consent would constitute a "grievous assault" if done on a woman who was not pregnant (ibid.), and he found on the side of the defendant. Following the birth of the child via CS, that was later conducted with the woman's consent, the mother's request that the legal case be made public was blocked by the HSE on the grounds that it was not in the child's best interest (Carolan 2016). Again, the judge found in favour of the mother, concluding that what was in the best interest of the child was for the mother, and not the HSE, to decide (ibid.). Given that the Eighth Amendment on the rights of the unborn child was not repealed until 2018, following a referendum that passed the amendment by 67% voting in favour to 33% voting against (no author, The Irish Times 2018), this verdict was significant for supporting women's reproductive rights. Nonetheless this remains an ambiguous space. In a more recent hearing, the HSE obtained a court order allowing doctors to perform a caesarean section on a woman who is incarcerated, against a woman's wishes, to avoid the risk of serious injuries or death, on the grounds that the woman has mental health issues and lacks capacity to decide on her health (O'Faolain 2021) without that issue of mental capacity being properly explored (Murphy-Lawless 2021).

One important move in the right direction occurred on April 24th, 2021, when the Citizens' Assembly on Gender Equality made among other recommendations the ground-breaking recommendation to replace the paternalistic and controversial "woman in the home" provision of the 1937 Constitution Article 41.2) with a clause that would obliged the state to provide a reasonable level of support for carers in the home (Cahillane 2021). It remains for the government to enact this recommendation. The framework known as Sláintecare, following an All-Party Oireachtas Committee (Houses of the Oireachtas 2017b) is also a significant

development. Sláintecare has the potential to challenge the current obstetric hegemony in the maternity services as it supports a universal healthcare structure and recommends the progressive removal of private consultant activity from public hospitals, over the next 10 years. After 60 years, the means tested, public-private mix of healthcare, which became entrenched in policy after the failure of the two white papers in 1947-9 and following the 1953 Health Act, was again being challenged. I argue that excluding maternity care from the Sláintecare Report is a major concern, as it signals a continuation of obstetric dominated government maternity care policy, as being dealt with separately to healthcare policy generally and might lead to poorer healthcare for women.

14.12. The medicalisation of maternity: too far is never far enough

The complex interconnections between uncertainty-risk-intervention-safety have been internalised and is central to sustaining the biomedical model in practice, yet the complex interconnection between future uncertainty-imagined risk-distrust in the natural process-and inappropriate use of routine interventions-resulting in real risk with iatrogenic effects, that is central to an over-medicalised and de-humanised maternity service, is not immediately apparent. Initially, the public embraced medical involvement in pregnancy and birth technologies as signs of modernity and progress, linked to safety. It was widely believed that the shift from home to hospital birth following the 1953 Health Act was an altruistic move on the part of the establishment to safeguard women and their babies, given the widespread confidence in modern medicine that abounded at the time. However, with the benefit of hindsight, it became clear that the biomedical model did not live up to its promise on safety (Wagner 1994, 2001, Brocklehurst, et al. 2011). The move also meant that women lost control of the pregnancy and birth experience to the medical profession, and midwives' status in the division of labour, already curtailed since the 1950s Health Act, was further eroded. Regardless of safety promises, maternal mortality rates are increasing in high income countries, despite, or perhaps because of the availability of reproductive technologies and high intervention rates (Newnham et al 2018). Similarly, despite the availability of a high-tech interventionist environments, preterm births and low birth weight babies are on the increase in high-income countries (Healthcare Pricing Office 2014). The WHO's review of international literature showed that when the population caesarean section (CS) rate rises above 10-15 per cent, it does not positively impact morbidity or mortality rates (WHO 1985, 2015), and so, may be considered excessive. Yet, CS rates have doubled globally over the past 15 years to 21% (Boerma et al 2018). If this is partly related to increasing age of pregnant women (Maeruf 2020) and increasing obesity as some obstetricians argue (Layte and Turner 2013, McKeating et al 2015), and increasing choice of childbearing women (Osis et al. 2001), the question is, why is there no comprehensive public health initiative to help support women in these circumstances.

The link here would be community midwifery such as the Albany Practice in London (Moulla and Walton 2000, Sandall et al 2001, Rosser 2003, Reed and Walton 2009). Is this rising CS rate more likely to be associated with the evidence that the practice of conducting caesarean section without a clinical indication is increasing (Ribeiro et al. 2007). The finding that CS rates for non-medical reasons are rising is corroborated in the Cochrane Database of Systematic Reviews (Lavender et al 2012) and also concurs with a global trend in reducing normality of childbirth (Soltani & Sandall 2012).

The extent of medicalisation in Ireland is reflected in some of the highest caesarean section rates in Europe, with induction rates of 32.5% and caesarean section rates of 34.3% as per Irish Maternity Indicator System National Report 2019 (NWHIP and CPOG 2020). More recent studies corroborate this finding, demonstrating how the high rates of intervention in Ireland are 'not fully accounted for by medical or obstetric risk differences' (Murphy and Fahey 2013: 8) and they are associated with private practice, regardless of risk factors (Lutomski et al. 2014, Moran et al. 2020). The history of denial and concealment of extensive evidence that obstetric intervention only rarely improved the natural process is now undeniable (Tew 1995).

There are sufficient reasons for stakeholders of maternity care to be alarmed, given the high rates of intervention signifying the over-medicalisation of childbirth in Ireland but where is the outrage. One would suppose that risk categorisation in maternity care cannot expand any further into normal pregnancy and birth and that the biomedical model cannot become even more entrenched than it already is. However, without collective action and concerted pressure being applied to curtail the 'obstetric imperative'; the power to re-invent and re-imagine pregnancy as high risk, that is exactly what will happen. Alarming, the worldwide trend in obstetrics to conduct non-medically indicated induction of labour studies at earlier and earlier gestations is emerging (Middleton et al. 2020). Regarding conducting scientific research in general, Wagner (1994) suggests that just because it is possible to measure something using scientific methods, does not make it right.

Efficacy and risk about appropriate technologies in birth are probabilities that can be measured. The acceptance or not of those probabilities, based on the benefits and safety comprises a value judgement. Furthermore, such value judgements 'must be assessed by those on whom it is used' (Wagner 1994: 37).

But with the continued advancements in technology, it is the nature of the obstetric imperative to find more ways to justify obstetric interventions, even if it is without any clinical indication and full ethical considerations. So, despite the National Maternity Strategy (DoH 2016) advocating the safeguarding of physiological pregnancy and birth and the minimum use of intervention and only when medically indicated, the HOME Induction of Labour Trial 2021 signifies how far we have come from promoting physiological birth in the Irish context. The Trial is currently being conducted in the Rotunda Hospital in Dublin, where induction of Labour

in primigravid women, before their due date and with no medical indication is being advocated, by virtue of the fact that the study is being conducted in the first place. The potential of this study to damage confidence in physiological birth is considerable. Again, it is an example where a secure structure for community midwifery could make a difference to the care of individual women, over and above unnecessary interventions. Once knowledge about the supposed benefits of 39 week gestation, non-medically indicated IOL assumes the authority of 'the truth' and is accepted as representing reality, it has the potential to be used to control and regulate the conduct and decision making of pregnant women before term. It does this by claiming that IOL before term is safer for the unborn child and moralising that any responsible mother would want the best for her baby, and by undermining the woman's confidence in her ability to birth without medical intervention. Adding to its impact are the current demographics that women are now having on average only 1.7 children (ESRI (Economic and Social Research Institute), 2019). What motives or self-interests underpin the HOME Induction of Labour Trial 2021 and whether the study is morally defensible must be open to scrutiny. A recent study on non-medically indicated IOL conducted in Australia and including 69,397 participants, found that it was associated with higher birth interventions and more adverse maternal and neonatal outcomes (Dahlen et al 2021). Collective action and concerted pressure being applied on the part of change agents is urgently required to curtail the 'obstetric imperative' and the rise in non-medically indicated intervention rates with its associated iatrogenic effects.

14.13. Acknowledging and locating 'the problem' in Irish maternity care

The systemic, endemic failure to listen to women's voices, in what is a highly patriarchal culture, is evident in the numerous reproaches that have besieged women's healthcare in Ireland in recent years. Vicky Phelan, an activist, and survivor of cervical cancer argued that the patronising nature of healthcare professionals towards women contributed significantly to the delayed disclosure of misdiagnosis. Following the publication of a report into the Cervical Check scandal in 2018, the chairperson leading the publication, David Scally, referred to consultants' attitudes towards women as "verging on misogyny" (Gabriel Scally, quoted in Loughlin and McEnroe 2018) Carrying out procedures without the woman's consent and the patronising treatment of women at the hands of service-providers was again highlighted in April 2019, when women's voices exploded onto the airwaves in the Joe Duffy's RTÉ Liveline show. Over 1,000 calls and emails were received from women recounting uncaring, unconsented medical practices and patronising experiences while attending the Irish maternity services. The radio presenter accounted for the avalanche of calls received as evidence that "once again women are not being believed" (Joe Duffy: quoted by Lynott 2019). In a private member's bill on the National Maternity Services, by Deputy Stephen Donnelly (Dáil Éireann debate -

Wednesday, 19 Jun 2019 Vol. 983 No. 8), following the broadcast, the need for women to be listened to and respected was again emphasised. The National Maternity Strategy is no exception in this regard. While the “public consultation” process accompanying the Strategy invited women to contribute and women’s suggestions from the consultation process are quoted in the Strategy, they are not actually reflected in the body of the Strategy. This suggests that the consultation process was tokenistic at best (Stach 2020). Given that “what matters to women is also what is likely to generate the safest and most humanised maternity care provision” (Downe et al. 2018: 14), a maternity system that ignores and diminishes women’s views and concerns is seriously problematic.

There have been many health system failures since the introduction of state-run maternity services. It is evident in the successive investigations into safety, quality and standards of services provided by the health service, commissioned by the Government of Ireland, and carried out by the HSE, HIQA, the DoH and the Chief Medical Officer. They reported significant shortcomings in the Irish maternity services (Harding Clarke 2006, HSE 2008, HSE 2013, Holohan 2014, HIQA 2015). Despite the findings, many politicians and government legislators have still not made the connection between modernist, obstetric scientific thinking, the bureaucratic centralised approach, the biomedical imperatives, and the current problems in maternity care. The rhetoric espoused by lead obstetricians and successive Ministers for Health is that Ireland is one of the safest places to give birth (Duffy 2014, Hennessy 2014). The 2014 report from the United Nations Population Fund (UNFPA) showed that 25 countries in Europe have a lower maternal mortality rate than Ireland (Duffy 2014). Similarly, in the State of the World’s Mothers report (Save the Children 2015) Ireland was ranked 22 out of 179 countries, leaving substantial room for improvement. This persistent refusal to listen to women and the denial of a crisis in our maternity services by the establishment, undermines the need for urgent reform.

Change requires acknowledgment that there is a problem in the first instance, and then identification that the defective system that is risk averse, highly interventionist and over-medicalised is the ‘real problem,’ and not defective women’s bodies. Only then can appropriate solutions be found and meaningful change implemented. An acceptance that the current maternity system is a product of obstetric dominated government policy is essential, and a recognition that obstetricians are the architects of the system; they designed it, they control it, they govern it, they perpetuate it, and they must take responsibility for it. If we acknowledge that the system is the problem, working harder using the same system is not the solution, rather, the solution is to change the system.

14.14. Irish midwives: in a stronger position

Despite ongoing challenges, the midwifery profession is in a stronger position today than in 1954, when the Irish maternity services were first established, as considerable progress in midwifery education and research has taken place (Connell and Bradshaw 2016, Vermeulen et al 2019). However, the continued limitations imposed on the autonomous role of the midwife in practice and a lack of sufficient midwifery leadership and influence in maternity policies and politics are matters of concern. The re-establishment of the Midwives Association of Ireland is a promising development. So too is the commitment of the government, following recommendations of the national maternity strategy, to follow through on its promise to fund community midwifery development. For the first time, there is an opportunity for midwives to develop community continuity models on a national level. If successfully implemented, removing maternity care from bureaucratic biomedical institutions would act as the launching pad for changing the culture of the maternity services as a whole. The year 2020 was designated the “International Year of the Nurse and the Midwife,” by the World Health Organization (WHO), in recognition of the significant role played by a strong midwifery profession, that is well integrated into the system, in providing a quality and safe maternity services worldwide (WHO 2020). On the International Day of the Midwife (IDM) on 5th May 2021, The International Confederation of Midwives (ICM) launched a 10 year campaign to advocate for promoting quality midwifery care around the world entitled “Follow the Data: Invest in Midwives” to coincide with the launch of the 2021 State of the World's Midwifery (SoWMy) Report, co-led by UNFPA, WHO and ICM (ICM 2021:5). Midwives can no longer be silenced or stay silenced. There has never been a better time for grassroot midwives, leaders in midwifery, better maternity care activists and advocacy groups including obstetricians, politicians, and legislators, to act in solidarity to effect meaningful change in maternity care. We must now hold the government accountable to deliver on all its promises embedded in the Strategy, including the development of ABCs (more commonly referred to as MLUs). To review the summary of drivers for change see table 14-5.

Table 14-5 Drivers for Change in the Irish Maternity Services

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| <ul style="list-style-type: none">• Midwifery solidarity: having a strong, educated, midwifery profession and a strong, integrated midwifery presence in practice, in policy decision making and leadership positions. Having an agreed message to disseminate and disseminate it repeatedly and at every opportunity. |
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- Authoritative knowledge claims are only powerful as long as they are believed. Disseminating truth claims and clear unequivocal statements that challenge traditional authoritative knowledge claims, by making evidence for midwife-led services and out of hospital, non-interventionist birth accessible to all through repetitive messaging using the traditional media, social media through active lobbying of the National Women and Infant Health Programme, (NWIHP), lobbying of politicians at constituency office, Department of Health, as well as insurance brokers and other influencers. This required the need to be consistently proactive and ever ready to be reactive, when required.
- Strategies to challenge the current hegemony include the use of Freedom of Information requests and parliamentary questions to get to the heart of government decision making.
- Collaborate and build relationships with other likeminded individuals and vested interest groups such as professional bodies, employee unions, maternity rights campaigner, human rights lawyers, politicians, journalists, philanthropists to influence grassroots populist movements and policy decision making.
- Utilise Irish Human Rights and Equality Commission Act 2014 mandates and European legislation, women's statutory entitlements as citizens and pressure from the Ombudsman.

14.15 Conclusion

An urgent need to understand why the Irish maternity services appeared to be so resistant to change was the starting point for this doctoral thesis. The detailed analyses of government maternity care policies revealed that medical hegemony was such that Irish obstetrics, not alone remained a 'traditionally' unchallenged site of power from the foundation of the state onwards, but single-handedly drove maternity care policy right up through the 1970s and beyond. I concur with others that, like other jurisdictions, the subjugation and side-lining of the midwifery profession was integral to the rise of the profession of obstetrics in Ireland and without a viable alternative, has played a major role in their entrenchment. As the empirical evidence demonstrates, state collusion with the obstetric elites, either through state inaction

and/or coercion through the legislative process, has led to state discrimination against midwives. I argue that it is only by truly understanding the biomedical paradigm, its origins, its components, and its interconnections, that we can know it and resist it, and meaningful change in institutions becomes possible. The power of the institutional processes is that they can remain unknown to the individual, who may unknowingly participate in its reproduction. Contesting the power of the obstetric elites is about making explicit the hegemony within which claims of 'absolute truth' operate.

There is now accumulating evidence that the medicalisation of pregnancy and childbirth has gone too far, but this is set to continue unless stopped through collective action. Despite recurrent crises in the maternity services, there is still a reluctance on the part of the establishment to acknowledge that there is a problem. Many politicians and government legislators have still not made the connection between obstetric thinking, the bureaucratic centralised approach, the biomedical model, the technocratic imperative and the current problems in maternity care. This persistent denial of a crisis in our maternity services by the establishment, undermines the need for urgent reform.

Maternity care fits the definition of a complex system. Successful change management requires a 'whole-system-change' approach. This approach has not been evident in the Irish maternity system. As a result, many of the midwife-led initiatives have never been fully integrated into the already well-established hegemonic system as both are incompatible. This makes the changes introduced vulnerable to resource cuts and closure, in an attempt to restore the status quo.

There has never been a better time for grassroot midwives, birth activists including likeminded obstetricians and politicians, to act in solidarity to effect meaningful change in maternity care, to make their collective voices heard and to hold the government to account to deliver on its promises embedded in the Strategy. It is time for midwives to become political, to truly embody the midwifery philosophy of woman-centred care, to take a seat at the table and a lead role in negotiating and driving maternity care reform, in order to safeguard the midwifery profession, and to support the delivery of a quality and safe maternity service that truly meets the needs of childbearing women. Making the strategies and social processes through which hegemonic power is collectively constituted in institutional settings visible, can be emancipatory, and makes resistance and whole-system gender policy changes become possible. If we recognise relations of ruling and acknowledge their pervasiveness, we may also agree that a more coordinated, strategic, and nuanced campaign for change in the maternity services is needed, that acknowledges the complexities of institutional systems.

Table 14-6 Unequivocal Message for Campaign Dissemination

- Childbearing women have a fundamental human right to have access to non-interventionist pregnancy and birth care
- The World Health Organization's (WHO 2016) guidelines on antenatal care state that "midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well-functioning midwifery programmes" (WHO 2016: 89).
- The WHO (2017) also suggests that when it comes to antenatal care there is "an urgent need to expand the agenda to go beyond survival, with a view to maximising the health and the well-being of women, families and communities" (Tuncalp et al 2017:860–862).
- Radical, whole system changes from the bureaucratic biomedical model to a community-based, relational caseload model, that is organised around community midwifery hubs and the needs of the woman, are supported by best evidence.
- Caseload midwifery, throughout the continuum of pregnancy, birth and early parenthood represents a radical departure from the traditional bureaucratic, industrial model of care. For caseload to be achievable and sustainable, it must be woman-centred and not institutional-centred.
- To support an autonomous midwifery profession, midwives need to be self-governing.
- Moving most of maternity care out of the HSE's Acute Hospital Services Directorate and into the Primary Care Directorate, where midwives have a separate governance structure and separate budget to develop community services is recommended.
- A strong, well-educated midwifery profession and a strong, integrated, midwifery presence in practice, is proven to be associated with providing a safe and quality, low interventionist maternity services, giving woman choice of care pathway, safeguards the physiological process and saving maternal and babies lives (ICM 2021).
- Key concepts that underpin the philosophy of midwifery closely resemble the key tenets of the social model of care and both closely resemble the qualities reportedly valued by childbearing women and found in the literature as necessary for providing a safe and quality maternity services (Renfrew et al 2014, Downe et al 2019).
- The assumption that proximity to obstetric units automatically confers safety for all childbearing women is not evidenced based (Brocklehurst et al 2011).

- Proximity to obstetric-led maternity units for women experiencing a healthy pregnancy increases the likelihood of an interventionist birth (Downe et al 2001, Jomeen 2010, Brocklehurst et al 2011, de Jonge et al 2013, Zielinski et al 2015).
- Women who planned home birth or birth in a midwifery unit (AMU or FMU) have lower rates of severe acute maternal morbidity, significantly fewer interventions and more 'normal births' than women who planned birth in an obstetric unit, with no adverse impact on outcomes such as episiotomy, instrumental vaginal birth, and caesarean birth compared to those with planned hospital birth (Downie et al 2001, Jomeen 2010, Brocklehurst et al 2011, de Jonge et al 2013, Zielinski et al 2015).
- Results of satisfaction surveys are misleading if taken at face value, and therefore should be evaluated critically, when used to plan the future provision of maternity services (Sullivan and Beeman 1982, Fitzpatrick 1991, van Teijlingen et al 2003).

14.16 Recommendations and implications for practice

The findings of this study build on previous studies exploring the meaning, workings of and pervasive impact of the bureaucratic, technocratic, biomedical paradigm. These findings have implications for service-users and providers, policy-makers, politicians, obstetricians, midwives, maternity care activists, and educators at individual, organisation, and policy development levels.

14.16.1. Recommendation for all maternity care stakeholders

- To facilitate a more nuanced understanding among policy-makers and healthcare providers, of how change processes and power-relations work in complex systems. This will be of interest to all stakeholders who want to negotiate changes in modern maternity services and may help stakeholders to be more effective change agents.
- To better recognise and challenge strategies used by hegemonic groups, both explicitly and implicitly, to resist, block or prevent reform.
- To make more explicit the role stakeholders play, perhaps unknowingly, in supporting the status quo. This will put them in a better position to resist the dominant discourses and may make meaningful changes in practice possible.
- To understand that meaningful change in complex systems requires disruption of current power-relations and the hegemony of the established system.
- To acknowledge that successful change management is not a question of trying harder. Trying harder with a system that is already broken will not work. Changing the systems overall will.
- To utilise the imperatives of the biomedical paradigm as a heuristic tool to ascertain whether the changes proposed are *in* or *of* the system, whether they are non-integrated and fragmented or integrated whole-systems changes. This will increase the likelihood of successfully implementing whole systems change.
- To expect that changes that challenge the hegemony of the established system will be strongly resisted by those whose professional status and authority are threatened by these new initiatives, so resistance should not only be expected but strategies to deal with resistance planned for. Be proactive instead of always reactive.
- To acknowledge the limitations of childbearing women satisfaction surveys in informing healthcare reform.
- To use knowledge that the biomedical model of care and the bureaucratic institutional management system are interdependent and co-constituted to investigate entrenchment of the biomedical model at local level by exploring the extent of the bureaucratic management system currently in operation.

14.16.2 Deconstructing the biomedical model

- Interrogating assumptions underpinning the biomedical model by stakeholders elucidates its impact in the organisation, coordination, and perpetuation of the hegemonic system of maternity care.
- Identifying and making explicit the three biomedical imperatives makes the biomedical model more visible in practice. The biomedical imperatives can be utilized by

healthcare providers to reflect and make explicit the philosophy that underpins their everyday practices, regardless of their professional affiliations. This will make the dissonance between practitioners' espoused philosophy and philosophy in action evident and the practitioners' role in perpetuating the biomedical model visible.

- Utilisation of the three biomedical imperatives in research makes exploration of the biomedical model more accessible to scientific inquiry.
- Utilisation of the three biomedical imperatives in analysing policy decision making, especially to make explicit the philosophical assumptions that underpin decision making at government maternity care policy and organisational level.
- Increased exposure to the theory of the biomedical paradigms, including an in-depth understanding of how it translates into practice, and exposure to the theory and practice of the social model of care, particularly homebirth, should be a requirement for all healthcare professionals and should be part of their professional undergraduate training programmes.
- Encourage healthcare professionals to reflect on power relations embedded in the antenatal encounter and how power is constituted during the interaction is emphasised in this study. It is hoped that by encouraging a questioning attitude and consciousness-raising through reflection on the use of power in the antenatal encounter, that healthcare providers will first acknowledge the asymmetrical power relations embedded in the encounter and, second, through conscious-raising will prompt a more woman-centred and power-sharing approach to care.
- Facilitate unmasking of the hegemonic power-relations that underpin maternity care policy, by outing the hegemony of obstetric authoritative knowledge claims.
- Understanding that meaningful changes to the current system, involving a social paradigm must be situated in community based settings under a midwifery governance structure.
- Contesting authoritative knowledge/power claims that are not evidence-based and not in women's best interest, as a strategy to reduce the over-medicalisation of childbirth is every stakeholder's responsibility. This can be achieved by raising awareness of the evidence supporting midwifery practice and the explicit benefits associated with midwife-led models of maternity care with a similar level of safety.
- Forging alliances with childbearing women, maternity care activists, politicians, healthcare professionals, lawyers, and other stakeholders to drive the message of reform and influence maternity policy decision making.
- Find innovative and accessible ways of giving women, healthcare providers and the public balanced information on the pros and cons of the biomedical model, because

moving away from a technocratic biomedical model appears to be counterintuitive to most people.

14.16.3. Recommendations for midwives

- All midwives must become politically active. They can do this by:
- standing in solidarity with their professional body, the MAI, and launching a national, well organised, strategic, and sustained campaign of collective action for reform of the maternity services.
- developing and disseminating a system of power/knowledge as a form of resistance, by gathering various forms of knowledge and evidence into sound argument to aid effective communication with childbearing women, other healthcare providers, politicians, and policy makers.
- lobbying for access to leadership roles and be prepared to challenge and assert their political will, professional midwifery solidarity and representation in government maternity care policy decision making, negotiations over the future of the midwifery profession and the nature of midwifery's work, including the way maternity care is organised.
- disseminate user-friendly, accessible, and evidenced-based information to childbearing women, policy decision makers, elective representatives, other healthcare providers and the public using every means available.
- giving women access to evidenced-based information, midwives can help to open up spaces for self-determination and for meaningful discussion with professionals.
- Forging an alliance with childbearing women is mutually beneficial, as women can safeguard the midwifery profession by advocating for a choice of care pathways and legitimizing midwifery's philosophical approach to care, and midwives can facilitate choice of care pathways for women and support woman-centred care.
- arriving at a consensus on key campaign messages to be disseminated. These should be consistently and clearly communicated at every opportunity and using various platforms. For examples of what these messages might be, given best available evidence, see table 14-6.
- campaigning for the establishment of MLUs. Without collective action and concerted pressure being applied from midwives and maternity care activists, implementation of MLUs will not be forthcoming from the Irish government.

In conclusion, the aim of this study was to explore change and entrenchment in the Irish maternity services. The complex and multiple interconnected nature of the maternity services were made explicit. A failure to understand that maternity systems are complex systems will lead to an overly simplistic approach to change strategies that will not be successfully

implemented. Also, an in-depth knowledge and understanding of the omnipresence of the biomedical model and its tautological nature is essential for all stakeholders, in order to affect meaningful change in the services. There is an urgent need for all stakeholders to reflect on the asymmetrical power-relations embedded in the organisation and provision of antenatal care, as an understanding of this is crucial if they are to recognise and challenge their own role in women's subjugation.

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16. Appendix 1 – PIL Service-user (Pregnant women)

Title of study: An exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers in the Greater Dublin Area

1. Who am I?

My name is Margaret Dunlea, and I am a midwife and lecturer in Midwifery in the School of Nursing and Midwifery, Trinity College Dublin. As a practicing midwife involved in antenatal care, I am governed by a Code of Professional Conduct which includes patient confidentiality. I would like to invite you to take part in a research study that I am undertaking for PhD studies. It is important that you fully understand what this research is about and what you will be asked to do before you decide to take part in the research. It is important that you read the following information in order to make an informed decision, and if you have any questions about any aspects of the study that are not clear to you, please do not hesitate to ask me. Thank you for giving your time to read and consider this participant information leaflet.

2. What the study is about?

In Ireland, 80% of pregnant women using the public maternity service avail of free antenatal care under the Maternity and Infant Care Scheme; this is known as combined care. Combined care means sharing care during your pregnancy and after birth between your General Practitioner (GP) and a team of doctors in your chosen maternity hospital. More recently, specifically for healthy women, care can be shared between the GP and a team of midwives in your chosen maternity hospital. Combined care involves many service-providers; therefore, collaboration among all health care providers is essential to ensure a quality maternity service. If and how this is achieved is not known at present. Many demands have been placed on this service in recent years. Ireland has the highest birth rate in the EU and 30% of births take place in the three Dublin Maternity Hospitals. Also, as a result of the current economic downturn, staffing levels are at a minimum. A combination of these factors has stretched the current service. The purpose of this research study is to explore the nature and impact of the combined-care model in pregnancy during the antenatal visit, from the perspective of service-users and providers, in the Greater Dublin Area.

This proposed study is needed because evidence suggests that the physical and psychological outcomes of pregnancy and childbirth are directly related to the type of maternity care the woman and her family receives. One of the key strengths of this study is that it recognises the importance of true collaboration among all health care providers, with a commitment to exploring the experiences of those directly involved in providing and availing of maternity services for childbearing women in Ireland. Until now, no research exists on this model in the Irish context.

3. Who can take part? /What does the study involve?

If you are newly pregnant, are over 18 years, will be attending both your GP and a maternity hospital for your pregnancy, and can speak English comfortably, I would like to invite you to take part in this important study. This will involve the researcher (Margaret Dunlea) sitting in/observing three of your antenatal visits between you and your various healthcare providers, at the beginning of your pregnancy, the booking visit and again at the 36-38 week's visit and digitally recording the interaction that takes place. A digitally recorded interview with me, face-to-face or by telephone, depending on your preference, will follow, at a time and place that is convenient to you. I will also review your antenatal records with your permission to seek clarification on related issues where appropriate.

4. Location of research:

The observation will take place in the antenatal clinic or location where your antenatal visit takes place; that may be the GP surgery, community clinic or hospital outpatient department. The interview will take place at a location of your choice that is convenient for you, for example, a private room in the antenatal clinic, your home if you so wish, in a room in Trinity College Dublin, or a quiet public place.

5. What will happen to the results of the study?

All digital recordings of antenatal visits and interviews will be transcribed, that is written or printed for you to read. Following transcription, the recordings will be deleted. A copy of the transcripts will be available to you on request. This will give you the opportunity to agree that the writing represents your views about what has occurred and to offer feedback if you desire. The information you and other women involved in the study provide will be of interest to all those concerned with the health and wellbeing of women during pregnancy and after birth, including women and health professionals. For this reason, the findings from the research study will be discussed in public forums, sent to policy makers at local and national level, presented at relevant conferences and published in medical and midwifery journals. It is important to say that you will be given a code number to protect your identity. It will not be possible to identify any individual participant or research site in any presentation or publication.

6. Benefits:

Your views and experiences of care offered in pregnancy are important because they inform service provision that best meets your needs. While the research study is unlikely to benefit you individually, it is hoped that you are happy to share your views and experiences of the combined-care model and the antenatal encounters more specifically. It is envisaged that the

findings of this study could potentially influence policy development about how antenatal care is organised in the future.

7. Risks:

There are no physical risks to you should you decide to take part in this important study. However, should you become distressed or upset during the interview I will help you in any way I can and on request will direct you to the appropriate healthcare professional. Also, I wish to inform you that should issues be raised during the interview – for example child protection issues, as a healthcare professional I am obliged to report matters of concern.

8. Exclusion from participation:

You cannot participate in this study if any of the following are true: If you are not pregnant, under 18 years old and cannot speak English fluently without the use of an interpreter.

9. Confidentiality:

Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group. A code number instead of your name will be used and your personal details will be stored securely and separately from the interview recordings and transcripts. The recordings will be transcribed at once after the interview. After the study has been completed the transcripts of the recordings will be kept securely for 5 years in keeping with best practice recommendations and then destroyed permanently. In addition, all information collected will always be stored securely (in a locked cabinet or secured hard disk) that is accessible only by me.

10. Compensation:

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

11. Voluntary Participation:

Taking part in this research study is entirely up to you and if you decide to volunteer to participate in this study, you will be required to sign a consent form. However, if you do not wish to take part and if you change your mind at any time you may withdraw from the research without giving a reason and without penalty. You will not give up any benefits that you had before entering the study.

12. Stopping the study:

The investigators may withdraw your participation in the study at any time without your consent.

13. Permission:

Ethical approval for conducting this study has been granted by the Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin, the Irish College of General Practitioners Ethics Committee (ICGP), and the Research and Ethics Committees of the Dublin Maternity Hospitals.

14. Further information**14. Further information:**

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from the researcher, Assistant Professor Margaret Dunlea, Lecturer in Trinity who can be contacted at 0872261798 or e-mail dunleama@tcd.ie

17. Appendix 2 – PIL Service-providers (GP, practice nurse, midwife, obstetrician)

Title of study: An Exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers, in the Greater Dublin Area

1. Who am I?

My name is Margaret Dunlea, and I am a midwife and lecturer in Midwifery in the School of Nursing and Midwifery in Trinity College Dublin. As a practicing midwife involved in antenatal care, I am governed by a Code of Professional Conduct which includes patient confidentiality. I would like to invite you to take part in a research study that I am undertaking for PhD studies. It is important that you fully understand what this research is about and what you will be asked to do before you decide to take part in the research. It is important that you read the following information to make an informed decision, and if you have any questions about any aspects of the study that are not clear to you, please do not hesitate to ask me. Thank you for your time to read and consider this participant information leaflet.

2. What the study is about?

In Ireland, 80% of pregnant women using the public maternity service avail of free antenatal care under the Maternity and Infant Care Scheme; this is known as combined care. Combined care means sharing care during pregnancy and after birth between the General Practitioner (GP) and a team of doctors in the chosen maternity hospital. More recently, specifically for healthy women, care can be shared between the GP and a team of midwives in the chosen maternity hospital. Combined-care involves many service-providers; therefore, collaboration among all health care providers is essential to ensure a quality maternity service. If and how this is achieved is not known at present. Many demands have been placed on this service in recent years. Ireland has the highest birth rate in the EU and 30% of births take place in the three Dublin Maternity Hospitals. As a result of the current economic downturn, staffing levels are at a minimum. A combination of these factors has stretched the current service. The purpose of this research study is to explore the nature and impact of the combined-care model in pregnancy during the antenatal visit, from the perspective of service-users and providers, in the Greater Dublin Area.

This proposed study is needed because evidence suggests that the physical and psychological outcomes of pregnancy and childbirth are directly related to the type of maternity care the woman and her family receives. One of the key strengths of this study is that it recognises the importance of collaboration between all health care providers, with a commitment to exploring

the experiences of those directly involved in providing and availing of maternity services for childbearing women in Ireland. Until now, no research exists on this model in the Irish context.

3. Who can take part? /What does the study involve?

If you are offering antenatal care to a woman consented to participate in the study and will be seeing her at one or more of the designated times mentioned above (first trimester, booking visit, 36–38-week visit), I would like to invite you to take part in this important study. The researcher seeks your permission to observe these antenatal encounters between the pregnant woman and yourself. This may mean observing one or more encounters involving the same pregnant woman participant and digitally recording the interaction that takes place. These non-participant observations will be followed by one-to-one digital-recorded interviews or telephone conversations with the researcher, at a time and place convenient to you. The woman's antenatal records will also be reviewed by the researcher.

4. Location of research:

The observation will take place in the antenatal clinic or location where the antenatal visit takes place; that may be the GP surgery, community clinic or hospital outpatient department. The interview will take place at a location of your choice that is convenient for you, for example, a private room in the antenatal clinic, your home if you so wish, in a room in Trinity College Dublin, or a quiet public place.

5. What will happen to the results of the study:

Digital recordings of antenatal visits and interviews will be transcribed. A copy of the transcripts will be available to you on request. This will afford you the opportunity to agree that the writing represents your views about what has occurred and to offer feedback if you desire. The information you and your colleagues provide will be of interest to all those concerned with the health and wellbeing of women during pregnancy and after the birth of the baby, including women and health professionals. For this reason, the findings from the research study will be discussed in public forums, sent to policy makers at local and national level, presented at relevant conferences and published in medical and midwifery journals. It is important to say that you will be given a code number to protect your identity. It will not be possible to identify any individual participant or research site in any presentation or publication.

6. Benefits:

While participants have no immediate benefit from participating in the research, it is hoped that they will be happy to collaborate, to share their views and experiences of the combined-care

model generally, and the antenatal encounters more specifically. It is envisaged that the findings of this study could potentially influence policy development about how antenatal care is organised in the future.

7. Risks:

There are no risks to you should you decide to take part in this important study. I am obliged to tell you, however, should I observe issues of suspected bad practice I will first discuss my concern with the clinician involved and if, following this I am still concerned, I will follow the appropriate structures and reporting mechanism as laid down by the relevant institution, following the guidelines on *Good Research Practice* which is informed by the Declaration of Helsinki and my Professional Code of Practice.

8. Exclusion from participation:

You cannot participate in this study if you are not offering care to a woman participating in the study.

9. Confidentiality:

Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group. A number instead of your name will be used and your personal details will be stored securely and separately from the interview recordings and transcripts. The recordings will be transcribed at once after the interviews and deleted. After the study has been completed the transcripts of the recordings will be kept securely for 5 years and then destroyed permanently. In addition, all information collected will always be stored securely (in a locked cabinet or secured hard disk) only accessible to the researcher.

10. Compensation:

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

11. Voluntary Participation:

Taking part in this research study is entirely up to you and if you decide to volunteer to participate in this study, you will be required to sign a consent form. However, if you do not wish to take part and if you change your mind at any time you may withdraw without giving a reason and without penalty. You will not give up any benefits that you had before entering the study.

12. Stopping the study:

You understand that the investigators may withdraw your participation in the study at any time without your consent.

13. Permission:

Ethical approval for conducting this study has been granted by the Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin, the Irish College of General Practitioners Ethics Committee (ICGP), and the Research and Ethics Committees of the Dublin Maternity Hospitals.

14. Further information:

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from the researcher, Assistant Professor Margaret Dunlea, Lecturer in Trinity who can be contacted at 0872261798 or e-mail dunleama@tcd.ie

18. Appendix 3: PIL Leadership Role

Title of study: An exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers, in the Greater Dublin Area

1. Who am I?

My name is Margaret Dunlea, and I am a practicing midwife and lecturer in Midwifery in the School of Nursing and Midwifery in Trinity College Dublin. As a practicing midwife involved in antenatal care, I am governed by a Code of Professional Conduct which includes patient confidentiality. I would like to invite you to take part in a research study that I am undertaking for PhD studies. It is important that you fully understand what this research is about and what you will be asked to do before you decide to take part in the research. Please read the following information in order to make an informed decision, and if you have any questions about any aspects of the study that are not clear to you, please do not hesitate to ask me. Thank you for taking the time to read and consider this participant information leaflet.

2. What the study is about?

In Ireland, 80% of pregnant women using the public maternity service avail of free antenatal care under the Maternity and Infant Care Scheme; this is known as combined care. Combined-care means sharing care during your pregnancy and after birth between your General Practitioner (GP) and a team of doctors in your chosen maternity hospital. More recently, specifically for healthy women, care can be shared between the GP and a team of midwives in your chosen maternity hospital. Combined-care involves many service-providers; therefore, collaboration between all health care providers is essential to ensure a quality maternity service. If and how this is achieved is not known at present. Many demands have been placed on this service in recent years. Ireland has the highest birth rate in the EU and 30% of births take place in the three Dublin Maternity Hospitals. As a result of the current economic downturn, staffing levels are at a minimum. A combination of these factors has stretched the current service. The purpose of this research study is to explore the nature and impact of the combined-care model in pregnancy during the antenatal visit, from the perspective of service-users and providers, in the Greater Dublin Area.

This proposed study is needed because evidence suggests that the physical and psychological outcomes of pregnancy and childbirth are directly related to the type of maternity care the woman and her family receives. One of the key strengths of this study is that it recognises the importance of collaboration between all health care providers, with a commitment to exploring the experiences of those directly involved in providing and availing of maternity services for childbearing women in Ireland. Another key strength of this study is its ethnographic approach. Until now, no research exists on this model in the Irish context.

3. Who can take part? /What does the study involve?

If you have been or are currently involved in some way at a strategic level about antenatal care provision, such as a leader in healthcare or at policy level where you are involved in decision-making about care provided, I would like to invite you to participate in this study. This would involve one or two digitally recorded interviews to explore issues arising relating to the combined-care model. Examples of these would be Directors of Midwifery, Masters in Obstetrics, Professional Development Coordinators, National Lead in Midwifery and others whose opinions may be looked to inform the ongoing development, findings and analysis of this study.

4. Location of research:

The interview will take place at a location of your choice that is convenient for you, for example, a private room in the antenatal clinic, your home if you so wish, in a room in Trinity College Dublin, or a quiet public place.

5. What will happen to the results of the study:

All digital recordings of interviews will be transcribed. The recordings will then be deleted. A copy of the transcripts will be available to you on request. This will allow participants to agree that the writing represents their views about what has occurred and to offer feedback if you desire.

The information you and your colleagues provide will be of interest to all those concerned with the health and wellbeing of women during pregnancy and after the birth of the baby, including women and health professionals. For this reason, the findings from the research study will be discussed in public forums, sent to policy makers at local and national level, presented at relevant conferences and published in medical and midwifery journals. It is important to say that you will be given a code number to protect your identity. It will not be possible to identify any individual participant or research site in any presentation or publication.

6. Benefits:

While participants have no immediate benefit from participating in the research, it is hoped that they will be happy to collaborate, to share their views and experiences of the combined-care model generally, and the antenatal encounters more specifically. It is envisaged that the findings of this study could potentially influence policy development about how antenatal care is organised in the future.

7. Risks:

There are no risks to you should you decide to take part in this important study. I am obliged to tell you, however, should I observe issues of suspected bad practice I will first discuss my concern with the clinician involved and if, following this I am still concerned, I will then follow this up with the appropriate person, for example the Director of Midwifery, The Master (Similar role to that of CEO of the hospital, usually an obstetrician) or Irish College of General Practitioners.

8. Exclusion from participation:

You cannot participate in this study if you are not offering care to a woman participating in the study or are not involved in the provision of maternity services at a strategic level.

9. Confidentiality:

Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group. A number instead of your name will be used and your personal details will be stored securely and separately from the interview recordings and transcripts. The recordings will be transcribed at once after the interviews and deleted. After the study has been completed the transcripts of the recordings will be kept securely for 5 years and then destroyed permanently. In addition, all information collected will always be stored securely (in a locked cabinet or secured hard disk) only accessible to the researcher.

10. Compensation:

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

11. Voluntary Participation:

Taking part in this research study is entirely up to you and if you decide to volunteer to participate in this study, you will be required to sign a consent form. However, if you do not wish to take part and if you change your mind at any time you may withdraw without giving a reason and without penalty. You will not give up any benefits that you had before entering the study.

12. Stopping the study:

You understand that the investigators may withdraw your participation in the study at any time without your consent.

13. Permission:

Ethical approval to carry out this study has been granted by the Faculty of Health Science Research Ethics Committee, Trinity College Dublin, the Irish College of General Practitioners Ethics Committee (ICGP), and the Ethics Committees of the Dublin Maternity Hospitals.

14: Further information:

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from the researcher, Assistant Professor Margaret Dunlea, Lecturer in Trinity who can be contacted at 0872261798 or e-mail dunleama@tcd.ie

19. Appendix 4: Informed Consent Form (service-users)

Title of research proposal

Title: An Exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers, in the Greater Dublin Area

Principle Investigator: Margaret Dunlea, Assistant Professor Trinity College Dublin

Contacted at 0872261798 or e-mail dunleama@tcd.ie

(Circle as appropriate)

1. I confirm that I have read and fully understood all the information provided in the accompanying Participant Information Sheet and each of my enquiries about the study has been answered.
Yes / No
2. I consent to observation of 3 antenatal visits and recording of same.
Yes / No
3. I consent to participate in interviews following each antenatal visit.
Yes / No
4. I agree that my maternal antenatal records will be accessible to the researcher.
Yes / No
5. I confirm that I have read and fully understood all the information provided in the accompanying Participant Information Sheet and I consent to the participation of GP, hospital doctor and midwife who provide care during the observed antenatal visit to be interviewed and to discuss my antenatal care for the purpose of the research.
Yes / No
6. I fully understand that my participation is completely voluntary and that I am free to withdraw at any given time (prior to publication / anonymisation) without providing a reason and it will not affect my care in any way.
Yes / No
7. I understand that the researchers involved in this study will hold in confidence and securely all collected data and other relevant information. Additionally, I understand that I will not be identified as a participant in this study (unless a legal requirement) and that the researchers may hold my personal information for a five-year duration.
Yes / No
8. Additionally, I understand that the researcher will transfer recorded data onto the researcher's personal computer which will be encrypted, and password protected as

soon as possible after the observation and interview and thereafter the tapes will be deleted.

Yes / No

9. I agree to participate in the above research study.

Yes / No

10. I consent to being contacted in the future for follow-up studies. For example, the researcher may consider doing a post birth interview.

Yes / No

Participant name

Date

Signature

Researcher name

Date

Signature

20. Appendix 5: Informed Consent Form (service-providers)

Title of research proposal

Title: An Exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers, in the Greater Dublin Area

Principle Investigator: Margaret Dunlea, Assistant Professor Trinity College Dublin

Contacted at 0872261798 or e-mail dunleama@tcd.ie

(Circle as appropriate)

1. I confirm that I have read and fully understood all the information provided in the accompanying Participant Information Sheet and each of my enquiries about the study has been answered. **Yes / No**
2. I consent to observation of the antenatal visit and recording of the same. **Yes / No**
3. I consent to participate in interviews following the antenatal visit. **Yes / No**
4. I fully understand that my participation is completely voluntary and that I am free to withdraw at any given time (prior to publication / anonymisation) without providing a reason and it will not affect my care/my babies care in any way. **Yes / No**
5. I understand that the researchers involved in this study will hold in confidence and securely collect all collected data and other relevant information. Additionally, I understand that I will not be identified as a participant in this study (unless a legal requirement) and that the researchers may hold my personal information for a five-year duration. **Yes / No**
6. Additionally, I understand that the researcher will transfer recorded data onto the researcher's personal computer which will be encrypted, and password protected as soon as possible after the observation and interview and thereafter the tapes will be deleted. **Yes / No**
7. I agree to participate in the above research study. **Yes / No**

_____ Participant name	_____ Date	_____ Signature
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_____ Researcher name	_____ Date	_____ Signature
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21. Appendix 6: Informed Consent Form (leadership roles)

Title of research proposal

Title: An Exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers, in the Greater Dublin Area

Principle Investigator: Margaret Dunlea, Assistant Professor Trinity College Dublin

Contacted at 0872261798 or e-mail dunleama@tcd.ie

(Circle as appropriate)

1. I confirm that I have read and fully understood all the information provided in the accompanying Participant Information Sheet and each of my enquiries about the study has been answered. **Yes / No**

2. I consent to participate in interviews about the provision of antenatal care in the Irish context. **Yes / No**

3. I fully understand that my participation is completely voluntary and that I am free to withdraw at any given time (prior to publication / anonymisation) without providing a reason and it will not affect my care/my babies care in any way. **Yes / No**

4. I understand that the researchers involved in this study will hold in confidence and securely collect all collected data and other relevant information. Additionally, I understand that I will not be identified as a participant in this study (unless a legal requirement) and that the researchers may hold my personal information for a five-year duration. **Yes / No**

5. Additionally, I understand that the researcher will transfer recorded data onto the researcher's personal computer which will be encrypted, and password protected as soon as possible after the observation and interview and thereafter the tapes will be deleted. **Yes / No**

6. I agree to participate in the above research study. **Yes / No**

Participant name

Date

Signature

Researcher name

Date

Signature

22. Appendix 7: Letter Seeking Access

School of Nursing and Midwifery
Trinity College Dublin

Dear Director of Midwifery and Master (Named),

My name is Margaret Dunlea, and I am a practicing midwife and lecturer in Midwifery in the School of Nursing and Midwifery in Trinity College Dublin. As a practicing midwife involved in antenatal care, I am governed by a Code of Professional Conduct which includes patient confidentiality. I am undertaking research to fulfil the requirements of a PhD with the School of Nursing and Midwifery, Trinity College, Dublin.

I write seeking permission to access clinicians who provide antenatal care using the combined-care model to pregnant women who have consented to participate in this study and who attend GP practices that have also consented to participate in the proposed study. The purpose of this research, the first of its kind in Ireland, is to follow 10-15 women through their pregnancy, observing three antenatal visits between the pregnant woman and different healthcare providers, and digitally recording the interaction that takes place. The visits in question include a first trimester visit, the booking visit and the 36–38-week visit. Digitally recorded individual interviews of service-users and providers will follow each antenatal encounter observed at a time and place convenient to them. The recordings will be transcribed at once after the interviews and deleted. A copy of the transcripts will be available to participants on request. This will allow participants to agree that it represents their views of what occurred and offer feedback if desired. The woman's antenatal records will also be reviewed by the researcher.

Recruitment of Hospital Staff:

Prior to the study beginning and pending approval from your Research and Ethics Committee, I seek permission to display posters outlining the details of the study in the hospital staff canteen and antenatal clinics. I would also like to present a general information session on the proposed research to hospital staff. On commencement of the study, a GP referral will be made to the chosen maternity hospital and the woman will receive confirmation of her booking visit. Once the woman participant informs me of the details of the booking visit, I will contact a nominated gatekeeper for the midwives or team of doctors providing care for the woman at that next visit, to offer a Letter of Introduction and a Participant Information Leaflet (Appendix 4b and 1c), and invitation to participate in the study. Participation is entirely voluntary. Should the service-user choose not to participate, the woman participant would continue in the study, and be

interviewed after the antenatal encounter in question. The same recruitment procedure will precede the 36–38-week visit.

Ethical approval to carry out this study has been granted by the Faculty of Health Science Research Ethics Committee, Trinity College Dublin, the Irish College of General Practitioners Ethics Committee (ICGP), and the Ethics Committees of the Dublin Maternity Hospitals.

While participants have no immediate benefit from participating in the research, it is hoped that they will be happy to collaborate, to share their views and experiences of the combined-care model generally, and the antenatal encounters more specifically. It is envisaged that the findings of this study could potentially influence policy development about how antenatal care is organised in the future.

This proposed study is needed given that it is widely reported that the physical and psychological outcomes of pregnancy and childbirth are directly related to the type of maternity care the woman and her family receives. Currently 80% of pregnant women in Ireland avail of the combined-care model. A key strength of this study is recognition of the importance of inter-professional collaboration and service-user involvement in providing a quality maternity service with a commitment to exploring the experiences of those directly involved in providing and availing of maternity services for childbearing women in Ireland. Until now, no empirical research exists on this model in the Irish context.

Should you have any queries or questions about the study please do not hesitate to contact me at the above address or by telephone or email provided below.

Yours sincerely

Margaret Dunlea (Assistant Professor in Midwifery, TCD)

dunleama@tcd.ie

087-2261798

23. Appendix 8: Letter of Introduction to Woman participants

School of Nursing and Midwifery
Trinity College Dublin
'The Gas Building',
24 D'Olier Street,
Dublin 2.

Dear,

My name is Margaret Dunlea, and I am a practicing midwife and lecturer in Midwifery in the School of Nursing and Midwifery in Trinity College Dublin. As a practicing midwife involved in antenatal care, I am governed by a Code of Professional Conduct which includes patient confidentiality. I would like to invite you to take part in a research study that I am undertaking for PhD studies.

The study is entitled 'An exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers, in the Greater Dublin Area'. This will involve the researcher sitting in and observing three of your antenatal visits between you and your various healthcare providers, at the beginning of your pregnancy, the booking visit and again at the 36-38 week's visit and digitally recording the interaction that takes place. An interview with the researcher, either face-to-face or by telephone will follow, at a time and place convenient to you, in order to clarify issues arising during the visit and explore how you felt about the antenatal visit. The recordings will be transcribed at once after the interviews and deleted. A copy of the transcript will be available to you on request. This will give you the opportunity to agree that it represents your views of what occurred and offer feedback if desired. The researcher will also review your antenatal records.

Ethical approval to carry out this study has been granted by the Faculty of Health Science Research Ethics Committee, Trinity College Dublin, the Irish College of General Practitioners Ethics Committee (ICGP), and the Ethics Committees of the Dublin Maternity Hospitals.

This proposed study is needed because evidence suggests that the physical and psychological outcomes of pregnancy and childbirth are directly related to the type of maternity care the woman and her family receives. One of the key strengths of this study is that it recognises the

importance of collaboration between all health care providers, with a commitment to exploring the experiences of those directly involved in providing and availing of maternity services for childbearing women in Ireland. Until now, no such research exists on this model in the Irish

While you will have no immediate benefit from participating in this study, it is hoped that you will appreciate being consulted about your views and experiences of the current model of antenatal care. Also, it is hoped that the finding of this study could potentially influence policy development about how antenatal care is organised in the future.

Participation is voluntary so you are not obliged to take part and may withdraw at any time.

Confidentiality is assured. Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group.

If you are interested in taking part or you have any queries or questions about the study you can contact me directly at the above address or by telephone number or email address provided below. Alternatively, you can fill in the form below indicating a willingness to be contacted by the researcher and return it to the receptionist at your GP surgery or to the researcher directly.

Yours sincerely

Margaret Dunlea (Assistant Professor and Midwifery Lecturer, TCD)

mdunlea@tcd.ie

01-8964080 / 087-2261798

.....

Willingness to Participate Form

I confirm that I am happy to be contacted by the researcher regarding the above proposed study.

Signature.....

Mobile Phone Number.....

House Phone Number.....

Please return this form to the receptionist at your GP surgery.

24. Appendix 9: LETTER OF INTRODUCTION TO HEALTHCARE PROVIDERS

School of Nursing and Midwifery
Trinity College Dublin
'The Gas Building',
24 D'Olier Street,
Dublin 2.

Dear,

My name is Margaret Dunlea, and I am a practicing midwife and lecturer in Midwifery in the School of Nursing and Midwifery in Trinity College Dublin. As a practicing midwife involved in antenatal care, I am governed by a Code of Professional Conduct which includes patient confidentiality. I would like to invite you to take part in a research study that I am undertaking for PhD studies.

The study is entitled 'An exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers, in the Greater Dublin Area'. This will involve the researcher sitting in and observing and digital recording the antenatal visit (early visit to confirm pregnancy, the booking visit and again at the 36-38 week's visit) between you and the pregnant woman who has consented to participate, and interviewing you afterwards either face-to-face or by telephone, at a time and place convenient to you, in order to clarify issues arising during the encounter. The recordings will be transcribed at once after the interviews and deleted. A copy of the transcript will be available to you on request. This will give you the opportunity to agree that it represents your views/what occurred and offer feedback if desired. The researcher will also review the woman's antenatal records.

Ethical approval to carry out this study has been granted by the Faculty of Health Science Research Ethics Committee, Trinity College Dublin, the Irish College of General Practitioners Ethics Committee (ICGP), and the Ethics Committees of the Dublin Maternity Hospitals.

This proposed study is needed because evidence suggests that the physical and psychological outcomes of pregnancy and childbirth are directly related to the type of maternity care the woman and her family receives. One of the key strengths of this study is that it recognises the importance of collaboration between all health care providers, with a commitment to exploring the experiences of those directly involved in providing and availing of maternity services for

childbearing women in Ireland. Until now, no empirical research exists on this model in the Irish context.

While you will have no immediate benefit from participating in this study, it is hoped that you will appreciate being consulted regarding your views and experiences of the current model of antenatal care. Also, it is hoped that the finding of this study could potentially influence policy development regarding how antenatal care is organised in the future.

Participation is voluntary so you are not obliged to take part and may withdraw at any time. Confidentiality is assured. Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group.

If you are interested in participating, you can contact me directly at the above address or by telephone number or email address provided below.

Alternatively, this letter of invitation will be followed up by a visit next week from the researcher to offer an informal information session and research overview with details of how to participate and to answer any questions or address any concerns raised. You can also refer to the Participant Information Leaflet Included.

Yours sincerely

Margaret Dunlea (Assistant Professor and Midwifery Lecturer, TCD)

dunleama@tcd.ie

087-2261798

25. Appendix 10: OBSERVATION & INTERVIEW SCHEDULE

Observation Schedule

A detailed recording of the interaction that takes place between the service user and provider paying particular attention to:

Duration of encounter

Introduction sequence:

- Greeting
- Referring to woman and partner by name
- Introducing oneself and other in the room

Nature and meaning of content of encounters

- Enquiries addressing physical wellbeing/examination
- Enquiries addressing psychological wellbeing
- Enquiries addressing sociological wellbeing
- Health promotion needs addressed

Needs being met:

- Whether the woman's needs are elicited
- Are questions raised answered adequately
- Are her verbal and non-verbal cues picked up on
- Note non-verbal cues of service provider

Nature and meaning of relationship between service user and provider

Language use to denote:

- Philosophy underpinning practice

Interviewing Schedule for woman participants following:

- First trimester encounter with the GP or practice midwife
- Booking visit with the midwife
- Third trimester encounter with one or other health service provider

Each interview will have the potential to provide data on:

- Meanings, feelings and insights attributed to their interactions with the service provider during the antenatal encounter.
- Philosophical perspectives/knowledge schemas on pregnancy and childbirth which may have already been demonstrated during the conversational activities of the encounter.
- Prior expectations and if their experience of the encounter met with their expectations

- Notions of self-efficacy and agency as how this was played out during the encounter
- Prior knowledge and understanding of care options in maternity services and issues relating to general wellbeing during pregnancy.
- How their prior knowledge and understanding was affected by the encounter
- What aspects of the encounter that bothered or delighted them?
- Participants' suggestions on what would improve the encounter
- Aspects of the encounter that appeared contradictory or confusing to the researcher

Interviewing the service providers:

Each interview will have the potential to provide data on:

- Meanings, feelings and insights attributed to their interactions with the service provider during the antenatal encounter.
- Philosophical perspectives/knowledge schemas on pregnancy and childbirth held by participants which may have already been demonstrated during the conversational activities of the encounter.
- Aspects of the encounter that they particularly valued or disliked
- Participant suggestions on what would improve the encounter
- Aspects of the encounter that appeared contradictory or confusing to the researcher
- How information is communicated between different healthcare providers, both formally and informally, using examples from the encounters
- What differentiates the roles of multiple service providers?
How the content of each encounter is decided

26. Appendix 11: ICGP Check List for Research Ethics Committee Applications

The ICGP, 4-5 Lincoln Place, Dublin 2, three weeks prior to the meeting, i.e., deadline submission date as indicated below. In addition, please email a copy of the full application to sallyanne.o'neill@icgp.ie

documents required: PLEASE RETURN THIS PAGE WITH YOUR APPLICATION

Documents Required: <i>All documentation to be presented in typescript and in single bound form</i>	Number of Copies Required:	Please indicate: Yes / No / N/A	It not included, give reason.
Local Checklist i.e., this page	13	yes	
Common Application Form	13	yes	
Local Declaration and Signatory Page <i>(which must be signed by all co-investigators and the academic supervisor if relevant)</i>	13	yes	
Participant consent form	13	yes	
Research Participant Information Leaflet(s)	13	yes	
GP/Patient letter of invitation	13	yes	
Questionnaires	13	N/A	No questionnaire being used
Protocol <i>(must be appended to all application forms)</i>	13	N/A	Included in research design
Curriculum vitae of PI (including previous research) MAX 2 pages	13	yes	
Principal Investigator MDU/Medical Insurance Details	13	N/A	Covered by the Clinical Indemnity Scheme
Agent Nomination Form (for each participating practice)	13	N/A	To be submitted following recruitment of GPs following ethical approval being granted

Short Curriculum Vitae of all co-investigators and researchers MAX 1 page	13	N/A	To be submitted following recruitment of GPs following ethical approval being granted
List of all participating general practitioners	13	N/A	To be submitted following recruitment of GPs following ethical approval being granted

If all relevant documentation is not included at the time of submission, the application will not be considered. In exceptional circumstances, where minimal documentation

27. Appendix 12: Ethical Approval 3rd Level Institution



COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH

Dámh na nEolaíochtaí Sláinte,
Foirgneamh na Ceimice
Colaiste na Tríonóide,
Baile Átha Cliath 2, Éire.

Ms. Margaret Dunlea,
School of Nursing,
D'Olier Street
Trinity College Dublin.
Dublin 2.

11th February 2014

Re: An exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers, in the Greater Dublin Area

Dear Applicant (s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in February 2013, we are pleased to inform you that the above project (as amended) has been approved without further audit.

Yours sincerely,

pp. Sonya McConnon

[Redacted signature block]

Chairperson
Faculty Research Ethics Committee

Appendix 13: Ethical Approval ICGP

11th February 2014

Ms. Margaret Dunlea,
School of Nursing and Midwifery,
24 D'Olier Street,
Trinity College,
Dublin 2

An exploration of the nature and impact of the combined-care model in pregnancy at the operational level of the antenatal encounter, from the perspective of service-users and providers, in the Greater Dublin area

Dear Ms Dunlea,

I wish to confirm that on review of your amendments, I am now happy to approve the above-named study.

Yours Sincerely


Chair- Research Ethics Committee

28. Appendix 14: ETHICAL APPROVAL DECLINED SITE NO. 3.

M. Margaret Dunlea
School of Nursing & Midwifery
24 D'Olier Street
Trinity College
Dublin 2

**Re: An exploring of the nature and impact of the combined - care
model in pregnancy at the operational level of the antenatal
encounter, from the perspective of service - users and providers,
in the Greater Dublin Area**

Dear Ms Dunlea,

The above paper has been rejected by the Ethics Committee.

Our impression was that there was lack of clarity in exactly what was being undertaken. As far as we can gather it is to look at the combined care model in pregnancy at operational level. The aspect that concerns the Ethics Committee is that the investigator wishes to observe the operators in action. Then then in the last stage the investigator may get involved in reporting the individual midwife or doctor. This is a potential for confusion. The hospital has a clearly laid out structures and reporting mechanisms for all its clinical activities. An outside research worker involved in the day today operation of clinical matters would be a cause of concern both at midwifery and medical levels.

Kind Regards

Yours sincerely




Chairman Ethics Committee

29. Appendix 15: Professional Indemnity Liability Form

TO WHOM IT MAY CONCERN

Our Ref AMM/EXT.6403

Your Ref

Date 24 October 2012

Dear Sirs,

Re: Our Client - Trinity College Dublin

We act as Insurance Brokers to Trinity College and confirm details of their Professional Indemnity insurance cover as follows: -

- Insured Title The University of Dublin Trinity College and Ghala Ltd. and TCD Ethics Committee and Trinity FM
- Business Description University
- Renewal Date 1 st October 2013
- Insurer RSA Insurance Ireland Ltd.
- Limit of Indemnity €12,000,000 in the aggregate
- Territorial Limits Worldwide
- Jurisdiction Worldwide (subject to special conditions for North American claims)
- Excess €25,000 each and every claim
- Principal Exclusions Cover for Clinical Trials Medical Malpractice

The policy provides an indemnity against legal liability for claims arising from all of the Insured's activities as a University.

Cover is subject to the terms, conditions and exceptions of the policy.

Yours sincerely

ANN MARIE MURPHY

Client Service Executive, Corporate Risks

DD: +353 (0) 1 639 6403

F: + 353 (0) 1 669 4475

E: annmarie.murphy@willis.ie

WILLIS

GRAND MILL QUAY, BARROW ST

DUBLIN 4

T: +353 1 661 6211

F: +353 1 661 4369

E: info@willis.ie W: www.willis.com/Ireland

30. Appendix 16: Public Employers Indemnity Letter

TO WHOM IT MAY CONCERN

Our Ref AMM/EXT.6403

Your Ref

Date 17 October 2012

Dear Sirs,

Re: Our Client - Trinity College Dublin

We act as Insurance Brokers to the above-named Client, and confirm details of their insurance cover as follows: -

- Insured Title Provost, Fellows, Foundation Scholars and other members of the Board of the College of the Holy and Undivided Trinity of Queen Elizabeth near Dublin
- Business Description University
- Renewal Date 1 st October 2013
- Insurer(s) RSA Insurance Ireland Ltd. (and Chartis Europe Ltd. on excess loss layer)
- Limits (of Indemnity) · Public Liability: €30 million any one event.
- Employers Liability: €32.5 million any one event (incl. of costs and expenses).

Subject otherwise to the terms, conditions and exceptions of the policies.

Should you have any queries please contact the undersigned.

Yours sincerely

ANN MARIE MURPHY

Client Service Executive, Corporate Risks

DD: +353 (0) 1 639 6403

F: + 353 (0) 1 669 4475

E: annmarie.murphy@willis.ie

WILLIS

GRAND MILL QUAY, BARROW ST

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T: +353 1 661 6211

F: +353 1 661 4369

E: info@willis.ie

W: www.willis.com/Ireland

31. Appendix 17: Demographics: Service-providers and leaders in healthcare

Note: Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group. A number instead of your name will be used and your personal details will be stored securely and separately from the interview recordings and transcripts.

Please tick which best describes your current position

- General practitioner ☐
- Practice Nurse/Midwife ☐
- Consultant Obstetrician ☐
- Obstetric Registrar ☐
- Senior House Officer ☐
- Hospital Midwife ☐
- Community midwife ☐
- Leader in Health Care ☐

Please specify:

.....
.....

Name:

.....

.....

Contact Details:

E-

mail.....

.

Mobile

number.....

Age:

Level of Education:

- Diploma ☐
- Degree ☐
- Masters ☐

Certificate ☐

Other ☐

If other, please specify:

.....
.....

How many years of experience (excluding your training) do you have in your current profession?

.....
.....

Place of Training:

Ireland ☐

UK ☐

Other ☐

If other, please specify:

.....
.....

Demographics: Service-user (Pregnant woman)

Note: Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group. A number instead of your name will be used and your personal details will be stored securely and separately from the interview recordings and transcripts.

Name:

.....

Marital Status:

Single ☐

Married ☐

☐

Cohabiting

Other

☐

Contact Details:

E-mail

Mobile number.....

Age:

Level of Education

Secondary School ☐

Certificate ☐

Diploma ☐

Degree ☐

Masters ☐

Other ☐

If other, please specify:

.....

Currently Employed

Yes

☐

No

☐

Type of Employment

.....

.....

32. Appendix 18: PhD Poster/Flyer

ANTENATAL CARE STUDY



Have you just found out you are pregnant?
If so congratulations!!
The care you receive is important.
If you are:

- Over 18 years old
- Will attend your GP as part of your care in pregnancy
- Can speak English comfortably
- I would like to invite you to take part in this study

Interested? For more information talk to the receptionist.



MARGARET DUNLEA: RGN, RM, BSC ANTHROPOLOGY, MA EDUCATION
MIDWIFE LECTURER SCHOOL OF NURSING AND MIDWIFERY TRINITY
COLLEGE DUBLIN DUNLEAMA@TCD.ie 0872261798