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I confirm that this assignment is all my own work.

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The most common way people give up their power is by thinking they don't have any.

- Alice Walker

Abstract:

The aim of this work is to explore the relationship between women and maternity services as it is realised in the home birth information provided to women by a large teaching hospital in the North of England. Using Systemic Functional Linguistics (SFL) and Critical Discourse Studies (CDS) in the model set out in the socio-cognitive discourse studies, I will analyse the messages that are explicit, implicit and obscured in order to reveal how the place of birth provision is supported or withdrawn by the service provider.

1. Introduction

1.1 the context of the booklet

This study aims to conduct an analysis of the recently published antenatal information booklet which women is given when they attend a 'booking in' appointment (see definition) with a midwife when she accepts maternity care in the National Health Service (NHS) at the hospital here on anonymised as City Hospital. The booklet is designed to cover all aspects of care from booking in to labour and post-partum care. The theme of home birth extends to the first four pages of the informational booklet. Each mother is provided a copy by the midwife who conducts her 'booking in' appointment (CHS 2016).

This booklet has been chosen because there is power of the significance of the timing the booklet and each woman will receive this document alongside her 'hand held notes' or antenatal record booklet as a part of the provision for informed consent and evidence based care. CCGs across the UK produce similar material and which serves as evidence of involving women in the their care. The comprehensive nature of the booklet is a move away from providing mothers with leaflets which would be viewed in random order and which would typically be interspersed with promotional material within the appointment pack and which therefore were easily overlooked (Stapleton, et al 2002 p 640). The Care Quality Commission (CQC) requires evidence that service users of the NHS are being informed about their rights as service users and of participating in their treatment. To this effect, booklets are now being developed and shared on Trust websites representing a new genre of educational literature. In the past an assortment of commercial leaflets would be found in a 'maternity pack' of information. The number of NHS produced informational literature in these packs are few in comparison to the number of commercial literature in the maternity pack which drew criticism for their removal from patient advocacy groups as reported in the media. Other examples of booklets can be seen on the websites of various NHS Trusts across the UK (DOH 2010; SATH NHS 2014). The content of these booklets is worth investigating as the language and information represent the Trusts and the NHS and as will be discussed later communicate intentional and unintentional information to their readers. These booklets are the written version of communication with the service users

while simultaneously serving the expectations of transparency of the Trust's commitment to involve the service users in their as outlined above.

The National Maternity Review (2016) has made it clear that women are to have an active role in their care plans wherever possible. This trend of informed consent in maternity services brings with it challenges in communication which the employees NHS will reflect on their practice to fall in line with the Human Rights Act 1998 (Selinger 2009): for a person to have autonomy over her body as a part of fulfilling their duty of care to the service user. In addition to institution of the NHS has its duty of care to its employees in supporting them with the training and workplace support to enable them to perform their duties in a manner that is respectful to women and respectful to them as employees. The recent publication of this booklet, June 2016, adds salience to this review and is indicative of a move by hospitals to use the internet to provide online access to women and the public.

The focus is to the discourse fragment regarding homebirth and waterbirth. These two aspects of birth choices represent statistical minorities of births across the United Kingdom, particularly in areas with high levels of socioeconomic deprivation which this CCG represents. Sheila Ford, Supervisor of Midwives (SOM) states that homebirth must be mentioned at the booking in appointment (personal communication) but she also added, 'It [homebirth requests] depends on how it is sold [by the individual midwives].' when discussing the local figures for home birth

requests. This paper will therefore investigate how home birth is sold to mothers by the institutional power.

The decision to use this booklet was based on opportunistic reasons such as my previous experience with maternity care with this hospital, previous contact with key gatekeepers and as a large teaching hospital large urban centre making it representative of other CCGs across the UK with a similar population profile. The timing of the release of the booklet was fortuitous providing an opportunity to analyse a document that reflects the most recent objectives of the Trust.

1.2.1 The context of the City Hospital

This hospital is typical of a large urban NHS hospital providing maternity services approximately 3,500 women annually with a diverse population and a wide variety of socio-economic and health profiles. However, this city ranks high in economic deprivation, 44th in 326 local authorities in England and with a smaller than average ethnic minority and immigrant populations (CQC 2015). Every woman who registers for care at this Trust receives a hard copy of the booklet and a digital version is now online.

This hospital has a low rate of home birth, a feature shared by many hospitals that serve areas of high deprivation. Nationally, the home birth rate in the UK is 2.3% in 2014 (ONS) with regional variations ranging from near 3.2% in south west England to 1.1% in the North East (Maternity

Matters 2007). In this Trust, which manages about 3,500 births annually, approximately 20 women request home births annually and about 12 home births are realised (Ford, 2016) or 0.57% and 0.3% respectively.

1.2.2 Description of the Maternity Unit

This booklet is developed by midwives working within the Trust and therefore represents their conceptualisation of the service they aim to provide. The choice of birthplace is the first topic that is introduced in the booklet. City Hospital facilitates home births and hospital births with the homebirth rate at approximately 0.35% against a national background of 2%. There are no free-standing midwife led units (MLU) in the communities linked to the hospital nor is there an MLU attached to the obstetric unit (OU). However, six beds are allocated within the OU which, as Sheila Ford explained in personal communication, are midwife-led beds. Unless midwives request assistance from consultants, doctors will not visit them while on their shift. This practice makes these six beds function as an alongside midwifery unit (AMU). Only women who are determined to be of 'low risk' are typically permitted to use these six AMU-style beds and the birthing pool which is on site at the OU.

Home births have shown to have distinct advantages for women in multiple indicators for deprivation: minority, young age of first pregnancy, obesity, birth trauma, low income, education. The experience of Albany Midwifery Practice which served Hackney, east London and which will be discussed later is a testament to safer outcomes on multiple factors such as

prematurity, drug and alcohol dependency, low literacy, higher rates of single motherhood and teen pregnancy, statistics which are familiar in the City Hospital.

Additionally Ford stated that two unassisted or free births were supported by the hospital in the previous 12 months. The antenatal booklet therefore communicates the hospital's aims for home birth through this document through explicit and implicit messages. The language of the booklet will be analysed with the aim of understanding how it has been shaped and 'how it shapes and limits the ways that individuals and institutions think, speak, and conduct themselves'. (Hodges 2008: 571) In order to do this it is important to review the historical context of the behaviour of institutions, medical professionals and women with respect to obedience/adherence and compliance, education and autonomy.

I begin with a note about language because language matters in birth. Thereafter I speak of my personal experiences which have shaped the lens through which I can view the documents I read. Without my birth experiences, I would have a different perspective on birth.

In the historical context of birth, I aim to show the differences in approach to birth. The medicalized version of birth is one where hazards are pre-empted through statistics and technology and where birth can be measured, controlled, and contained. It is typified as rational, scientific, and empirical and in the history of birth is viewed aligned in the public psyche with obstetric, consultant led model of birth which occur in hospital settings. The physiological version of birth is as a process whereby observation, birth reveals itself to the woman and the

midwife, unfolding at its own pace if given its space and time. A type of birth which depends on patience and intuition as much as knowledge of the physiology, psychology and spirituality of birth and the trust of woman's ability to birth which has traditionally been associated with midwifery. Within this dialectic are the tensions of civilization vs nature, order vs unpredictable, male vs female, science vs mysticism, and control vs freedom the former representing obstetrics and the latter normal birth.

1.3 Notes about language

The word 'patient' is not used to describe pregnant women as this is a clinical term which implies an aspect of disease to a physiologically normal event (HOC 2003 p. 32). Pregnancy is a normal physiological state and it along with birth are normal life events. Occasionally medical complications unique to pregnancy develop or a woman may have pre-existing medical conditions alongside her pregnancy. In these occasions a pregnancy may remain physiologically normal despite a mother having conditions which may benefit from medical monitoring.

I also use the terms 'woman' and 'mother' to refer to pregnant persons though I realise that some individuals from the LGBTQ community who are pregnant do not identify with these terms. This usage is to remain concise and I would like to acknowledge that gender identity can be particularly sensitive during reproductive life events. At times 'service user' is used to denote anyone who accesses the NHS.

The word ‘deliver’ is not used to refer to the birthing process. Deliver implies that someone other than the mother and baby dyad is the primary agent in the birthing process. Hence the term, ‘birth’ and its derivatives are used instead as it puts the woman and her unborn child as agents in the process.

The word ‘risk’ is handled at length in section… as it forms a larger part of the investigation.

1.4 Personal Perspectives

The researcher possesses great power by interpreting a text as “power relations between researcher and the researched and the ethics of imposing meanings” determines that “analysts are not only readers but also producers of discourse” (Parker & Burman, 1993:159). Jager and Maier (2016: 133) also state that the researcher “has to rely on his own and his fellow researchers’ background knowledge” and should therefore seek to extend his knowledge. In order to illuminate how my experiences influences my critique I am disclosing my experiences of pregnancy and birth as a mother, as a supporter of pregnant women and new mothers, and as a user of NHS maternity services.

I gave birth two daughters in 2005 and 2008. For both pregnancies, I booked in with the maternity unit at City Hospital. My first pregnancy concluded as an induced labour and ventouse assisted birth due to acute pre-eclampsia at 38 weeks’ gestation. I experienced eclamptic seizures during labour where I now only recall incoherent fragments of the event. In the following days, my daughter and I displayed signs of trauma. In the weeks following, I

developed post-traumatic stress disorder (PTSD) and I self-diagnosed two years later but I did not seek a formal diagnosis until eight years after the birth. In the interim years, I trained as a volunteer a breastfeeding supporter with a UK charity and undertook doula training with a Doula UK accredited trainer.

During my second pregnancy, I realised that I had developed a phobia for maternity wards. For this reason, but also for my socio-cultural context I requested midwifery support for a home birth. The interactions with midwives during several appointments were marked by coercive statements which sought my acquiescence to a hospital birth. (Forster 2014) I wrote letters to the hospital to reassert my legal right (Birthrights 2013d) and I received a letter of support from the administration. However, a deep distrust in the midwives to fully support my decision precipitated my intention to have a planned 'BBA' - Born Born Arrival (of midwives) birth. A planned BBA is typically classed as a freebirth or unassisted birth (see definition). In my experience within the freebirth community this 'tactical plan' is utilised to deflect possible referrals to social services, perceived retaliatory behaviour, and other perceived coercive moves in attempts to achieve conformity with a midwife's intentions. (Birthrights 2013a; Birthrights 2013d; Feeley 2016; Plested 2016).

I was diagnosed with PTSD in 2013 and received Eye Movement Desensitization Reprocessing (EMDR) therapy on the NHS. My experiences in supporting women with birth and breastfeeding decisions centres on providing women with information to make decisions which they feel will be in their best interests. My birth and breastfeeding support training and the EMDR therapy

have provided me with opportunities to debrief my experiences with the goal to precluding the possibility that I frame another person's experience through my own.

As Foucauldian power over discourse shows "Everybody is co-producing discourse, but no single individual or group controls discourse or has precisely intended its result." (Jager & Meyer 2016, 118) As Foucault stated: 'people know what they do, they frequently know why they do what they do; but what they don't know is what what they do does' (personal communication, quoted in Dreyfus and Rabinow 1982; 187). Instead of complying with the midwives' intention, my decisions for birth was deliberately obscured in order to protect my independent birth decisions. At the heart of my decisions laid the principles of informed consent and bodily autonomy. These human rights principles form the core of this investigation.

1.5 A Summary of outcomes for Home births in the UK.

Home births have distinct advantages for women who are experiencing a normal healthy pregnancy. The Birthplace Study (2011) shows many advantages to mother and baby with additional savings to the NHS while showing that there is no increased risk for adverse outcomes in second or subsequent births and a slight increased risk for primipara mothers, an increase of 4 in 1,000 births when compared with large obstetric units. A detailed summary and table of the statistics above is provided in the Appendix 1.

The Birthplace Study also revealed that planning a home birth, regardless of whether the birth occurred at home or hospital - 45% of planned home births for first time mothers occur in hospitals - was associated with lower rates of :

- Caesarean sections
- Instrumental birth (ventouse and forceps)
- Augmentation and induction of labour
- Reduced use of pain relief including epidural and pethidine
- Severe perineal trauma to mother
- Blood transfusions
- Episiotomy

Considering that the increased rate of poor outcomes is reflected only in primipara mothers, one question that arose from the study is how being in hospital may have affected the outcome for the women who transferred to hospital as 45% of first time mothers transfer to hospital for reasons such as additional pain relief during labour and change of plans before labour has begun. Once a home birth is planned, it remains classified as a home birth irrespective of where birth takes place and being in hospital is also associated with iatrogenic injury, morbidity caused by being in a hospital (Horn 2012).

These findings are in opposition to Wax Study (2010) which found that deaths were three times more likely to occur in a home birth setting in a review of 50,000 births in 12 industrialized countries. However, criticism to this meta-analysis included the exclusion of the 65,000 Dutch

home births and their 30% home birth rate under planned midwifery care. A Dutch study drew similar conclusions to the UK, Birthplace study, that planned home births were as safe as hospital births for mothers and babies. The Wax Study has been criticised for several other major flaws which were reported in dedicated journals shortly after (Hart 2010, Cohain 2010).

Prof Soo Downe, OBE summarizes the efficacy and safety of home births when she stated that if a pill existed that could decrease the risk of late miscarriage, low birth weight, prematurity, and maternal infection, increase breastfeeding rates, and birthing without experiencing an episiotomy, caesarean section, haemorrhage, while saving the NHS money, and without excess risk to the baby except at a very low level and in very specific circumstances, that health service providers would claim it is unethical to withhold that drug. These outcomes are associated with booking for home birth during pregnancy. So, does it suddenly become less effective, less ethical as a treatment, because it is a way of doing birth, and not a drug? Surely not. (Birthplace Matters 2nd edition 2014:19, Zielinski 2015, Quigley et al 2016, Schroeder et al 2012)

Through policy revisions the NHS seeks to increase the power the service users have in shaping their health plans (National Maternity Review 2016). One way which the NHS strives to share information is through information booklets. Analysing their message can provide useful insight to design as well as an opportunity to provide data to guide future developments in the field. Particularly this paper aims to add to the data on home birth, which is a marginalized birth choice (Walsh 2015:157) though has been shown to have a number of optimal outcomes for mother and

baby. Booklets which provide unbiased, evidence based information could contribute to supporting women's decisions for their place of birth if the information is provided within the context of women's lived experiences.

2. Literature Review

2.1 Discourse analysis in antenatal literature

Cheek (2004) noted that discourse analysis has become more prominent if not better understood as a tool for health research and Hodges et al (2008: 572) concludes that discourse analysis provides "rigorous and powerful approaches to understanding complex phenomena,... on the inner workings of systems of power that construct what is 'true' about health and health care" and that while discourse analysis methods are gaining popularity within health care, much remains to be done to achieve its widespread use, funding, and publication.

In an analysis of patient leaflets, Dixon-Woods (2001) found two discourse. The first illustrated a comparatively small but increasing body of discourse in medical leaflets now include discourse of 'patient empowerment' versus the dominant discourse of patient compliance through its definition of patient education. The latter discourse has been criticized "for withholding information of uncertainty, to promote the benefits of interventions without discussing risks and to be patronising and overly prescriptive" (Dixon-Woods 2001: p14 -22). She identifies that the patient empowerment discourse can patronise the reader by withholding information that would facilitate independent decisions and assume the 'voice of the medicine' but the patient empowerment discourse also shows where it advocates for the patient decision-making without

the practical concerns of consultation costs, professional targets, and time. It also importantly sees the patient as holding the intelligence to make informed decisions given the time and professional support to do so and rejecting the idea that the patient is 'fundamentally incompetent'.

Within maternity care, Stapleton et al. (2002) investigated the use of evidence based information for women but the text of the leaflets was not the focus of their investigation. Discourse analysis was used to gain insight into the woman - care provider relationship through analysis of interactions between the parties including Feeley 2016 who focused on the narrative stories of women who chose unassisted birth. Hudson et al. (2009) investigated interactions with conversation analysis and discourse analysis techniques, saying that "there is a dearth of process studies examining prenatal genetic counseling sessions".

O'Malley-Kieghran (2016) examined evidence of woman-centeredness in the discourse of professional midwifery bodies using systemic functional linguistics and they also note that "there has been a lack of research into the discourse of midwifery texts in general (O'Malley-Keighran et al 2016: 50). No research literature seems available for the study of discourse pregnancy information booklets other than the leaflets used by Stapleton et. al. mentioned earlier.

2.2 The Relevance of Educational Healthcare Booklets

The occasion and timing that women receive the booklet confers power to the booklet however studies have shown that leaflets which are given at antenatal appointments are largely ignored

and unread (O'Caithan et al 2002, Stapleton et al, 2002) which reduces potential impact of their power. Dixon-Woods (2001) draws attention to concerns that patients may not find the booklets credible, that leaflets do not take their beliefs and concerns into consideration as well as findings that medical staff do not consider patients competent to understand medical terminology, make decisions about their care or would like to spare them of the unpleasant aspects of their illnesses and / or treatment. These concerns show that it is important to consider the ineffectiveness of patient leaflets may lie not only with patient culpabilities, real or perceived but also with the wording in the leaflet designs (Maat & Lenz 2009). The different cultural context of patients and health care providers is an important consideration in leaflet design which has been shown to influence the understanding of leaflets in Dickinson et. al. (2001) with participants responding less favourably to the regimented criteria set out by EU requirements. The general outcome from both sides seem to be that booklets are pointless as service users do not use them and professional staff do not expect them to be read or understood by the majority.

Considering that extensive financial and human resource costs of producing educational material and since informed consent is legislated for, the function to improve the quality of information provided to service users is open for critical discussion and this booklet affords the opportunity to look at a representative text to deconstruct the message and look for ways to make them relevant to the staff and to service users. In the era of explicit informed consent these booklets carry an expressed intent of information however they express the intentions of the hospital rather than the voice of the service user. Another function of this booklet is within this ritual of

bureaucracy are “promises of order and continuity... The order of belonging, status, material sustenance and the avoidance of the anxiety of chaos.” (Rosen 1985: 48). For the midwife, the mother and organization, this booklet serves a purpose to reset the balance (ibid). For the mother, it is a part of the social contract that she is accepted as a pregnant woman into the organization which will protect her from “unconceptualized, unformed chaos” (ibid) which accompanies birth in the public consciousness. It is a symbol of the organisation and its contract with the mother which provides reassurances that the contract is intact.

2.3 Informed Consent in Maternity Care

The statutes of the Human Rights Act 1998 (Hewson 2000) is illuminated in Better Births (RCM 2016) which has placed informed consent as a central theme for maternity care to 2020. It involves a personalised care plan where the woman is instrumental in making decisions regarding her care. Women must also “receive unbiased information, ... an assessment of their needs’ (RCM 2016:2). “Women are able to fully discuss the benefits and risks associated with the different options for place and type of birth.” (ibid) “CCGs make available maternity services that offer the options of birth at home, in a midwifery unit or at hospital.”(ibid) Further, it states that “Women should be informed of risks and be supported to make decisions which would keep them as safe as possible.”(RCM 2016:3).

Informed consent as a human right within maternity care which is gaining worldwide recognition (WRI 2011) along with the recognition that obstetric violence (see definition) is not an uncommon occurrence in maternity services. Maternity Services has the unique position of care

for a physiologically normal life event and one which typically involves the lives of two persons in a condition where disease or injury is not usually present. These unique circumstances and the unique attributes of the participants, ie, age, gender, vulnerabilities have colluded to make pregnancy possibly the only physiological life event that focuses surveillance by agents of the state whereby birth activists are concerned that a woman's physical and emotional beings are vulnerable to being devalued in favour of the welfare of the foetus and the interests of the state.

2.4 Research Argument

Antenatal information on home birth which is distributed by the NHS is a materialization of informed choice.

a. How the roles of the hospital, the midwife and the woman articulate within in the text Ie., explicitly, implicitly or obscured

3. Methodology

3.1 Critical Discourse Studies (CDS)

Critical Discourse Studies investigates how discourse fragments are realized from and shaped by ideologies of power and knowledge (O'Malley-Kieghran, Lohan 2016:49) and 'offers a considered theorization of the relationship between social practices and discourse structures (Lazar 2007:144). For Van Dijk, discourse practices become so naturalised over time with both

the oppressor, and the oppressed treating them as natural, acceptable and a part of the norm. Looking at power in discourse as social interaction, socio-cognitive CDS focuses on how social power between groups, classes or other social formations relate with each other rather than personal power. Social power is manifested in interaction whereby one group exercises control over another group. Because the first group has control over the second group and its members knows this cognitively, group two limits its own actions according the implicit rules that (re)produces their dominant-subordinate relationship. The first group therefore 'must have some control over the cognitive conditions' of the second group 'such as desires, wishes, plans and beliefs.' Group two accepts therefore 'to follow the laws, rules or consensus to act in the interest of the first group'. (Van Dijk 1989 pp 19-20) Social power is therefore indirect, with the first group managing the information or opinions which group two needs to act. The persuasion of the first group's argument or the fear of sanction by the second group is usually enough to achieve compliance by the group. (ibid)

The social status accorded to hospitals, the powers and resources with which it has been endowed by the state, the knowledge of its employees are powerful motivators for women and by extension the rest of society confers much privilege to the information which they possess. The value which parents and society places on the welfare of the mother, foetus, and the neonate are also powerful motivators to comply with the wishes of the institution. The institution has more access to resources in which to disseminate its opinions, knowledge, attitudes, and social representation, including prejudices which form its ideological framework is therefore more

likely to be accepted as the consensus for the wider society. Lazar (2007:148) quotes Bourdieu (1991) stating,

> "Modern power (and hegemony) is effective because it is mostly cognitive, based on an internalization of [gendered] norms and acted out routinely in the texts and talk of everyday life. This makes it an invisible power, 'misrecognized' as such and 'recognized' instead as quite legitimate and natural."

Dominated groups are seldom powerless. The Human Rights Act 1998, limits the power of obstetricians and midwives with the right to consent and decline any procedure which is offered, even when it is at odds with the recommendations of her health care professional as long as the person is 16 years or older and not incapacitated, sectioned under the Mental Health Act or infected with certain contagious diseases. Some women therefore choose to decline the standard antenatal care package offered by their hospital trust and in many instances find that they are a 'resistance', enacting a 'counterpower' (Van Dijk 1989: 21) which may result in either a change or make the suppressed group more vulnerable.

As discussed by Lazar (2007) CDS 'cannot and does not pretend to adopt a neutral stance' it makes its biases a part of its argument' (Lazar 2007: 146). While this may be problematic for other fields of studies, in CDS, giving voice to the oppressed is a cornerstone of much of CDS.

The topic of this paper is suited to utilising this technique as it features the hospital as the institutions with the midwives as its representatives representing the dominant group and the mothers as the subordinate group. However, a secondary theme to be realised to a lesser extent in the institution as the dominant group and the midwives themselves as a subordinate group who are subject to the ideological underpinnings of the institution as employer.

3.2.1 Systemic Functional Linguistics

Systemic Functional Linguistics (SFL) is frequently paired with CDS in order to explore the relationship between a discourse fragment and the socio-cultural context which produces it. SFL is a systematic method of analysing the mostly unconscious choices that a speaker or writer must make from the grammatical and lexical reservoir of options from his community discourse. (Lukin 2012) The grammatical and lexical choices are 'suited the particular needs and are appropriate for the particular social contexts' (O'Malley-Keighran 2016: 51) for which the writer in this case, hopes to achieve. As Lukin (2012) states when discussing the rationale behind Hallidayan SFL,

"Grammar gives you a choice. But you have to choose. On one hand, you have choice while on the other you are constrained by the available choices. It is this restriction that allows us to get under the information to the deeper meaning that a discourse fragment construes." Lukin (2012)

That is, in order to understand the meaning of a text it is important to understand the choices that were made and explain why those were made by the speaker at the time.

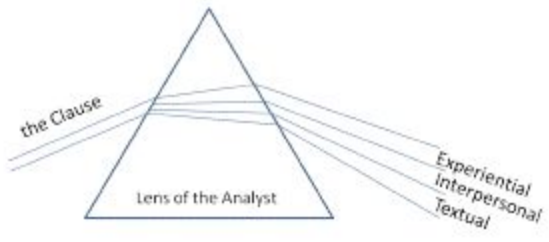
Therefore, the homebirth content of the Pregnancy Information Booklet contains multiple strands of information and it is these strands that I will attempt to make discrete.

3.2.2 Transitive Analysis

In transitive analysis, focus is placed on the choice of verbs in order to uncover the meanings and ideas which are represented within the discourse. These points may be ideologically significant to the author(s) and the institution which is represented as "each 'author' represents his experience of the more general experience of their society and its institutions." (O'Malley: 51-2)

While the experiential strand of the Pregnancy Booklet is a primary focus of this analysis, the Booklet's author is aware of her audience and this this interpersonal element is also revealed by the grammatical choices that were made. Finally, textual element reveals information with regards to its coherence and cohesion which the author was probably not consciously aware.

The graphic below gives into the 3 strands mentioned above.



(Semioticon 2016)

The table below is a summary of the processes (Lukin 2012, O'Malley-Kieghran 2016)

processes			
Material (doing)	actor	goal	Focuses on activities/what happens
Mental (sensing)	senser	phenomenon	Focuses on perceptions, emotions, cognition
Verbal (saying)	sayer	verbiage	Focuses on who says what to whom
Existential (being)	carrier	attribute	Expresses attributes, possession, equivalence

3.2.3 Analysis procedure

Using coding techniques from Saldaña (2009) a primary coding cycle of the discourse fragment was identifying key terms in a descriptive coding analysis. A second coding cycle established categories and distilled the codes that emerged from the text.

Compliance with Obstetric Norms (Theme)	
Risk / Safety (category)	Hospital's context (Category)
Liability, warnings, focus on safety (codes)	Omissions privileging hospital birth Omission that prejudice home birth
Context of mother (category)	Details that privilege obstetric led birth
Ignorance of birth and medical process	Misinformation /disinformation
Obedience to authority - instructions, modal verbs, conditional 'if'	Technocratic language

Technocratic language	Below each category are the codes which were identified in the text.

After this coding was applied, paragraphs were identified that exemplified the themes. Omissions was a theme that pervaded the whole text however, by its nature, it cannot be analysed but where it has been identified it has been highlighted. After coding the texts were deconstructed as described above.

The use of coding to identify themes assisted with controlling for subjective analysis of the themes. My declaration as a mother who has birthed within this trust and who has undergone a medically urgent and interventionist hospital birth as well as a noninterventionist, physiologically normal home birth has had a large impact on my life of which this document is a materialization. My knowledge as a birth worker who continually updates her knowledge along with the debriefing of my experiences have assisted with maintaining objectivity.

4. A brief history of midwifery

This section aims to show the historic context of tensions that have existed between the male viewpoints of birth versus the female and how these differences are still at work into the modern age. Within this review, I show how midwifery evolved from a cultural norm mostly independent of male power to one which became subordinate to obstetrics in recent centuries. The tensions of place of birth, birthing positions, birth attendants, the perceptions of risk, and the fear of

persecution are recurrent themes in birth that persist today and which are contextualized within the Pregnancy Booklet.

4.1 Pre-Christian Europe

Midwifery has always had a tense relationship with obstetrics. The earliest written evidence how the dichotomy originated comes from Aristotle (Jowitt p 26) may be viewed by how men, who came to dominate obstetrics and women who have always been the workers in the birthing rooms see the birthing woman's body. Aristotle wrote that with midwives, women "use different ways; some are delivered sitting on a midwife's stool, that is, upright positions. But, for my own part, I think that a pallet bed, girded, and placed near the fire". He goes on to describe the lithomy position, that is lying on her back.

From the British Isles the Pre-Christian image of a woman in childbirth persisted into Christendom in the stone figure of Sheelagh-na-gig. Typically, a small stone squatting and grimacing woman with her genitalia exposed from within open legs. They are found most commonly today in Ireland and a few in England in niches on outer walls of churches among other publicly accessed places today. Whatever their original intentions, a young woman could view this figure and know that one day she may adopt this position in childbirth. The normality of their locations, the majority are found on church walls, point to a time when birth was within the domain of the everyday. (Cannon 2016, Gaskin 2003:252)

4.2 The Middle Ages

Evidence from the Middle Ages show the use of the birthing stools and positional changes in upright, kneeling and squatting positions point the birthing process being a dynamic and interactive process with illustrations In Practica Maior (1446), Rosegarden for Pregnant Women and Midwives (1513) and The Byrth of Mankynde, Otherwyse Named the Woman's Booke (1545) show women on birthing stools. From the Bible, Exodus 1, 16 states: "When ye do the office of a midwife to the Hebrew women, and see them upon the stools, if it be a son, then ye shall kill him;" with the Hebrew word for a birthing apparatus translated as a birth stool in the King James Version, translated between 1604 and 1611 (Jowitt 2009).

Licensure as a doctor required university training and women were barred from universities. The domination of doctors, ie men, over nurses and midwives, ie women, is not accounted for by the rational or the scientific. Medicine was restricted by the church which was deeply anti-empiricist, dictating that treatments adhere to religious interpretation of illnesses and treatments making prayer a sanctioned cure. During centuries of witch hunts, medicine incorporated astrology, alchemy, the humours, leeches, and bleeding as medical training. Midwives and healers, who were the doctors of the peasantry, may have utilised incantations but unlike prayer this may have been as superstition and sorcery. The skills and knowledge of midwives and lay healers were acquired during long apprenticeships and digitalis, belladonna, and ergot are plant based agents that still have roles modern pharmacopoeia. According to Ehrenreich (2002:5) "The suppression of healers under the guise of witches was the creation of a

new male medical profession, under the protection and patronage of the ruling classes" and it is the start domination of obstetrics over midwifery. They were the victims of witch hunts because they were in direct competition with physicians. During the witch hunting centuries, physicians were called to give expert witness to witchcraft thereby becoming complicit even encouraged to report women for sorcery if it meant eliminating the competition. (Ehrenreich 2009)

4.3 Barber-surgeons at births

Barber-surgeons, men, attended births in order to removed dead fetuses with the antecedents of obstetric forceps. Women were therefore in a passive, reclined position receiving what was a lifesaving procedure. Men's view of birth was therefore confined to a place of tragic outcomes. As the forceps evolved into more efficient instruments, barber-surgeons, now known as 'accoucheurs', attended birthing events in order to assist live births among the upper classes, being present 'just in case' (Sheikh et al. 2013). Their training coming from the charity hospitals in cities which had mortality rates in comparison to midwife led births outside this setting (Jowitt 2014:30). The business aspect in creating this niche market cannot be overlooked as well as that men were motivated to enter this trade in direct competition with midwives selling the modern occupation of obstetrics as lifesaving with its instruments following the logic that if some births need tools then it is better to have all births occur with the presence of tools - and obstetricians. In effect, doctors apprenticed on women in the training hospitals until they had their licensure and opened their practice to wealthy women for a fee (Jowitt 2014: 31).

From the mid nineteenth century, forceps were routinely used to hasten labour and to prevent the deaths of the mothers and fetuses with one doctor in 1908 suggesting that all births be completed with forceps because women were too weak to give birth unaided (Sheikh et al 2013). The man in the birth room paved the way indiscriminate introduction of birth interventions, many which persist today (Walsh 2015:155). By the start of the 20th century, the birthing stool was no longer in widespread use while midwives were banned from using surgical tools and the forceps was classed as one. The consolidation of power to obstetrics over midwifery is evidenced in the Midwives Act 1902 (England and Wales) and 1915 (Scotland). In this Act, midwifery is subordinated to obstetrics. Obstetricians and physicians wrote midwifery textbooks. By the 1950's birth training had moved from under midwives and out of homes into the hospitals and universities, completing the cycle of moving birth out of the domain of the home and midwives and into the hospital and obstetrics.

The Peel Report was the final act of domination, moving the final 20% of homebirths into the hospitals in the decade leading up to 1980. Home birth is now seen as the deviation from the norm. To practice midwives have adapted to facilitating births in an obstetric led environment dominated by hierarchy, routines, measuring, recording data and accountable to her employer and institutions which regulate her practice.

4.4 The Peel Report

The Peel Report (1967) represents a turning point in maternity care in the last century, as important as the Midwife Act in 1903. It recommended that 100% of births take place in hospital settings. The Peel Report was quickly criticized for lack of evidence to support this position and for lack of consultation with women about their needs. In the push towards hospital births, Dugald Baird, Regius Professor of Midwifery stated that "if it is accepted that confinement in hospital is safer for certain types of patient, where the risks are high, it must also be safer for cases where the risks are less" (Tew 1998). This 'just in case' obstetrics is documented in the rhetoric of birth in the public consciousness as outlined by Jowitt (2014:141) continues to be a theme when women discuss place of birth not only with their peers but also with midwives.

The 1977 report Reducing the Risk reinforced the Peel Report, stating that 'Even if a woman is 'low risk' and likely to have a normal birth, one cannot be sure it is normal until it is over" (Davis 2013). Within a decade, more than 95% of births were occurring in hospitals. From 1948 to 1965 the figure was 66% and 20% in the 1920's. By 1985, 0.9% of births occurred at home (Zielinski 2015)

The following case studies depict an institutionally biased perception of home birth from within the NHS. The first, documents the bias against informed consent in maternity care though the case study is of the experience of an obstetrician whose philosophy of practice is in harmony

with the philosophies of midwifery and which illustrates that it is the philosophy which brings conflict between the two approaches to childbirth.

The second case documents the achievements and closure of a midwifery cooperative which existed as long as it did because it was privileged to have the sponsorship and goodwill from executives within the NHS (Jowitt, 2009) and is an example of how midwifery since the 1904 Midwife Act has allowed midwifery to exist only within the guidelines of obstetrics.

The third case illustrate how vulnerable midwives are to persecution even in the UK where more robust discrimination legislation, employment protections and a comprehensive support system for midwifery exist. If a midwife's practice deviates from outside the standards set by her employer, she may be vulnerable to charges of poor practice.

4.5 Wendy Savage

Wendy Savage, became a cause célèbre after she was suspended from her post of Honorary Chair Consultant in Obstetrics and Gynecology for Tower Hamlets Health Authority in April 1985 for alleged incompetence in 5 cases, two which resulted in neonatal deaths. A campaign to support her began and she was exonerated in February 1986 and reinstated to her post in July 1986 after a high profile public enquiry. Mrs Savage's career was marked by her commitment to providing woman centred care and involving them in a making decisions regarding their obstetric care and reproductive rights, she also credits her early training to 'view people as a whole, to understand their place in the world and the community and not just treat them as a

patient in bed' (Wellcome Library) and having people participate in their medical care. This philosophy of care is in harmony with the principles of service user autonomy and human rights that is being espoused in Better Births (2016) document of the National Maternity Review. Her training in 1958 included observing home births with midwives "where she saw big differences in women's experiences when compared to the hospital births she also observed during this period and made her reluctant to intervene in pregnancies" (Ridley 2009).

Dr Savage believed that women 'have the right and the power to see that the health services they get are the ones they want' and that 'asserting that every pregnancy should be treated as 'normal' unless there were clear contraindications.' (Davis 2013). Through these lens, births are normal and women's pregnancies are to be assessed on individual information and her care is planned with her as opposed to the hospital and obstetric practice of labelling women as high risk or low risk on the basis of statistical outcomes (Savage 2011: 217).

The BMJ editorial, Lessons from the Savage Inquiry (1986) concluded that a difference in personalities and professional philosophies lay at the heart of the charges against Dr Savage. For her part, Dr Savage's stated: "I am not a member of the 'establishment' and saw no reason to conform to the medical profession's unwritten, but well-documented, 'party line', especially if I thought this was not in the interests of patients." (Savage 2011:218). Mrs Savage also concluded that the loss of power in midwifery is due to 'loss of control by professionals and the ascending control of managers' (Ridley 2009).

4.6 The Albany Midwifery Practice

The Albany was team of 7 self-employed midwives which subcontracted its caseload from King's Healthcare Trust. It provided continuity of care for about 216 women per year in Southwark, the 14th most deprived area in England in a woman-centred care model called caseloading or continuity of care midwifery (see definition) that is recommended by the Changing Childbirth report (DOH 1993).

In the first 10 years of practice, the Albany boasted a perinatal mortality rate of 4.9 versus a national rate of 7.7 per 1,000 births and 11.4 for its local rate. Its caesarean section rate was 8-10 percentage points lower than the hospital under King's (Jowitt 2009). In addition, the practice had a homebirth rate of 40% versus a national rate of 2.4%. Breastfeeding rates were around 80% at 28 days versus a national average of 60%. "More women had vaginal births, intact perineums, used birthing pools, fewer had episiotomies, elective caesareans, inductions and fewer used pethidine and epidurals than at King's and in the other midwifery group practices." (Albany 2009; Edwards 2010).

In 2008 the practice came under investigation when in the previous year, a number of babies suffered poor outcomes and a baby died shortly after a home birth in September 2009. King's Healthcare Trust suspended its contract to the Albany Midwives and commissioned Centre for Maternal and Child Enquiries (CMACE) to carry out an independent confidential inquiry after its

own internal inquiry “did not find any problems with the midwifery care except 'in a minority of cases'” (AIMS 2010:5). The CMACE Inquiry acknowledged that its methodology was weak due to the data set. A separate analysis by Alison Macfarlane, a former advisor to CMACE, concluded that it would be ‘impossible to draw any inferences’ from the data presented (AIMS 2010:8).

The failings which CMACE identified were in management issues within the Albany and King’s and a breakdown in communication and trust between their respective staffs which could have contributed to the decisions made by Albany staff (O’Neil 2008). Despite the recommendations made by the enquiry on how to improve the service, King’s terminated its contract with the Albany on the grounds of patient safety (CMACE 2009). King’s later offered staff positions to all the midwives from the Albany Midwifery Practice.

4.7 Becky Reed and Julia Duthie

Becky Reed worked with the Albany from its inception in 1997 until it closed in 2009. After the initial internal inquiry by King’s, the hospital referred Becky to the Nursing and Midwifery Council which it recommended that Becky complete 450 hours of supervised training, which she completed at two different NHS hospitals and she was deemed fit to practice. However, the NMC drafted seven charges against her in 2012 relating to her practice at the Albany. Eventually all charges were dismissed and she was deemed fit to practice without restrictions. AIMS states that, ‘the public needs protection should there be midwives who are dangerous and

negligent. ...however, Becky is certainly not the first woman-centred, skilled and dedicated midwife to undergo bullying and victimisation. [to treat] one of the UK's most respected midwives, constitutes an attack on midwifery autonomy.' (AIMS 2014, Edwards 2010b).

The investigations by the NMC brought against Julia Duthie can be interpreted as institutionalized bullying and victimization. Her eventual exoneration six years after the original complaints for which the NMC was unable to construct a coherent case against her practice is another instance where birth activists regard the investigation as a form of bullying and victimisation. Julia had contemporaneously produced documentation of informed consent from the mother detailing the wishes of her care and her communication with the mother and the supervisor of midwives which would provide back-up services. In this case, the woman's baby died intrapartum. Though she had carefully documented evidence informed consent and had addressed all the identified hazards to the impending birth, her suspension as a midwife was cited on a single factor which was in the control of hospital staff with whom she had liaised effectively in the previous weeks. Cases like Julia's and Becky's are sometimes referred to in midwifery and birth activism circles as a 'witch hunt' Wagner (1995) when he further states,

"It is no coincidence that 90% of the accused in my sample were involved in homebirth or alternative birth centres." (Wagner, 1995)

And that,

> "70% of the accused in my sample are midwives, all in independent practice where they are not under the immediate control of doctors. Fear of being investigated by the authorities is a strong deterrent to independent midwives." (ibid)

Nadine Edwards (2014) is in harmony with Wagner (1995) when she states,

> "The NMC's role is to protect the public. Condemning committed and experienced midwives does not achieve this. If safety is genuinely the concern of the NMC, of the supervisory system and of senior midwives, they would facilitate rather than obstruct initiatives that provide greater safety for women and babies. (Edwards 2014)

Wagner (1995) interprets that the function of tribunals was "to punish deviant professional behaviour that could threaten the income, practice style, prestige, and power of mainstream doctors." Wagner (1995) It is no coincidence in this hostile atmosphere that midwives are risk averse and fearful of using professional discretion when one incident can precipitate an investigation that may last for years and which threatens to destroy many years of professional practice, family income, and mental health and penalizes professionals for practicing in accordance with their professional codes of conduct.

That home birth occurs outside the usual surveillance which accompanies a hospital birth is relevant to the discussion at hand. Birth outside the institution where the actions of mothers and

midwives are no longer easily monitored make midwives more vulnerable to accusations. The policies brought from the hospitals to the home birth context offer protection to the midwife that she has liability cover in the face of an actual adverse event. This risk mitigating tactic could explain how midwives are at pains to operate within the guidelines that are established by obstetrics even when they are outside direct surveillance. The case studies above show that midwives like women are oppressed by institutionalized birth despite change of birthplace. The Pregnancy Booklet is a materialization of obstetric control over home birth.

5. Evidence

What are professional midwifery statements really 'saying'? - Wickham (2016)

The home birth section of the document illustrates the continuing conflict of interest in midwifery between its philosophy of being 'with woman' and promoting physiological birth while being constrained by the institutional demands of obstetric led practice. I intend to show how the use of the terms 'risk' and modal verbs in the text reinforces these conflicts of interests.

Institutions have an agenda. They have preferences which best suits their outcomes which its representatives or agents promote to achieve a desired outcome which benefits the institution fore mostly. Institutions therefore steer clients both overtly and covertly down a preferred path that is usually in its own interest. One technique is to highlight factors which serves the institution's better interests while diminishing or ignoring the aspects which it perceives to be

costly or difficult to manage. In scenarios where all parties are well qualified in the subject areas it becomes difficult diminish or ignore the terms of services. Maternity care is an example where the balance of power is weighted in favour of the institution with the woman as women rely heavily on their midwives to provide the information for their care.

Within maternity care, the client is the pregnant woman who is not an expert in the field. Her ability to ask questions is therefore impeded by her lack of expertise feeling that the professional will now act as her advocate. This view is fostered by midwifery and the health services, by the media, community, and family within an expectation that power is transferred from the woman to the midwife or consultant during pregnancy because 'After all, they know best.' Individuals who step outside these societal birthing norms may be viewed with suspicion, signalled by terms that indicate qualities such as wilful, careless, frivolous, naive, aggressive, and non-compliant (personal communications), finding "themselves being talked down to, badly treated, sometimes bullied, and sometimes far worse" for deviating from the societal norm (Wickham 2016, Schiller 2016, Carpenter 2012).

Additionally, the patient - doctor/midwife relationship is based on trust that they, the expert, knows more about pregnancy and childbirth giving midwives a position of authority over the physiology of birth and of the medical institutions within which she is trained and they have the best interests of the mother-baby dyad as the focus of their professional care. Common wisdom suggests that the mother and the unborn baby are the same entity during early pregnancy -

meaning that the wellbeing of the foetus is indistinguishable from the wellbeing of the mother and that the actions of maternity services through their agents of doctors and midwives put the best interests of the pregnant woman first. However, this view as the accepted reality is not universally held or how it the view remains especially when a foetus is at or near full term. Further discussion of how this dialectic evolves is outside the scope of this paper. Unknown to the mother, the midwife therefore finds herself as an agent of an institution with divided loyalties for institution, her professionalism, the mother and possibly her foetus.

This paper will argue that the loyalty of the midwife is ambiguously placed between the mother and the hospital trust which employs her. In order to practice legally in the United Kingdom a midwife must be registered with the Royal College of Midwives and therefore uphold its professional standards. On the other hand, her ethical responsibility and the cultural history of midwifery are first to be with the mother. The etymology of the word 'midwife' is 'with woman'. At the same time, her terms of employment to her hospital trust is to adhere to the policies and protocols under which she is employed. These policies and protocols of the hospital, the professional standards of her professional body are sometimes at odds with her duties as a midwife to be 'with woman'. Midwives therefore find themselves negotiating between the needs of a woman, her personal midwifery philosophies and the demands of her employer and professional body.

5.1.1 Risk Talk

The definitions of risk and related terms as the definitions have implications for the interactions with develop when using risk in text.

The Health and Safety Executive (HSE), the independent regulatory body in the UK with responsibility for the implementation of the Health and Safety at Work Act of 1974 (HSWA), defines risk as the 'likelihood that a hazard will actually cause its adverse effects, together with a measure of the effect". It further defines hazard as "something (e.g. an object, a property of a substance, a phenomenon or an activity) that can cause adverse effects." The HSE also acknowledges that the terms hazard and risk are used interchangeably in everyday language so it goes on to make a 'conceptual distinction' between the two terms (HSE 2001:5)

For this paper, I will use the terms and definitions as set out by the HSE.

A search for how risk and hazard are used in the NHS has reflected the interchangeable usage of the term as stated above. An NHS England policy document (NHS England 2015:13-14) defines a risk with the definition that the HSE uses for a hazard and uses the term 'threat' instead of 'hazard' with a synonymous definition. A further search for definitions from City Hospital

(CHS) provided a definition for ‘adverse event’ as ‘any event which exposes the organisation to risk... which results in litigation against the Trust.’

It defines ‘risk’ as “likelihood of injury or harm occurring to the Trust’s patients, staff, stakeholders, finances or reputation.” (CHS 2014:3-4). Here, the term ‘risk’ is used in line with the HSE definition of a likelihood of ‘adverse effects’ ie injury, harm without referring to ‘hazard’ as a circumstance, behaviour, or an object with the **potential** to cause injury or harm.

This omission of the concept of a hazard as seen in the HSE definition and the focus on adverse effects may influence the interpretation of how local policies are developed. The introduction of litigation in the definition of adverse event and again with ‘finances and reputation’ hinting at litigation, is outside the scope of the definitions as set out by the HSE which raises further questions for how policies will develop in the policy documents and in the training and behaviour of midwives and ultimately within the day to day care of women. These inclusions are about the interests of the institution rather than the midwife or the woman.

These facets of a corporate policy at the executive level for the Trust may have significant impact on the writing of local policies within the Trust, the nature of induction and professional development of midwives therefore the ways which midwives conceptualise and communicate risk in discourse with expectant women. It can also influence the writing of guidelines for midwives and the literature which is distributed to expectant women. This booklet represents the

dispositive of the conceptualisation of risk within this maternity unit. I am therefore seeking to examine the culture of risk which is then reflected in the writing of the antenatal booklet.

5.1.2 Usage of 'Risk' in the Pregnancy Information Booklet

In the homebirth text, 'risk' is transposed from the technocratic and bureaucratic genre into the community, intended for all expectant mothers who choose CHS for antenatal care. Risk is also a high frequency morpheme which is defined as 'A situation involving exposure to danger' in the Oxford Dictionary. Risk has its meaning and connotations in the layperson's world where it is associated with activities and behaviours, legal and illegal, that can cause life changing injury or death and for which special insurance coverage may be advised. In the home birth context in my experiences as a childbirth supporter, frequent replies to women who express an intention to birth at home include 'Do they let you do that?' and 'If I had a homebirth my baby (and I) would have died.' and 'You are braver than me.', sometimes with accompanying eyerolls. Discourse by women who are planning home births pre-emptively reference the distance or time which it would take to transfer by ambulance to a hospital. The message that home birth a dangerous activity and one which value judgements are expected permeates discourse. As the common interactions above show, the layperson typically view home birth as an activity which is more aligned to a sport for which special insurance may be advised rather than with hospital births. It is with this background understanding that many women arrive when they presented with the home birth option in her booking in appointment where a midwife must mention the option.

5.1.3 The function of Risk in the booklet

Title	#Would there be	any indications	[[that	would prevent	me	from having a choice]]?
	process (existential)	existent	[[actor	process (material)	recipient	goal]]

[[If	your pregnancy	is	considered high risk,]]	#you	will be advised	[[to have your baby in hospital]]
conditional	carrier	process (relational)	attribute	recipient	process (verbal)	verbiage
[[as	you and your baby	will need	[[to be closely monitored]]	[[during the labour and birth process.]]]]		
conjunctive adjunct	goal	process (material)	scope	circumstance		

If	you	are	medium risk	#you	will be advised	[[to deliver your baby in hospital]]		
conditional	carrier	process (relational)	attribute	recipient	process (verbal)	verbiage		
However,	if	you	[[feel	strongly]]	[[that	you	would like	a home birth,]]
adversative (conjunctive adjunct)	conditional	carrier	process (existential)	[[Conjunction	senser	process (mental)	phenomenon	
#you	can discuss	this	with your Midwife and Consultant.					
actor	process (verbal)	verbiage	actor					

If	you	are	low risk or receiving Midwifery Led Care	#you	can opt
conditional	carrier	process (relational)	attribute	actor	process (material)
[[to deliver either at home or in the hospital.]]					

The question which forms the heading (see table above) suggests that a woman may not have a choice when she almost always does, even when it would be against her best interests in the view of the authority figures. That this question is even posed suggests that choice is an action that an authority figure endows or deprives on a mother rather than her inalienable right. The presence of the question reinforces the perception in the subordinate group that the dominant group's expertise endows it with the privilege of granting or denying a home birth. This perception causes much anxiety in women when they consider requesting any care pathway that deviates from what is on offer as Jenkinson et al (2016) found in her Australian study.

The uses of 'if clauses' which show that certain conditions must be fulfilled before a home birth can be 'granted' also underlines the perception of authority by the health care professionals. However, the passive voice in these clauses, while giving the impression that this is the professional opinions of the midwives, actually works to omit the midwife from the discourse. Her actual professional opinion is silenced by these sentences and the policy of the obstetric led unit is heard. The sentence pattern is repeated three times in this short phrase, which again reinforces the power behind the discourse fragments. In this way both the midwife's voice and the woman's voice are absent from the discourse, illustrating that the woman and the midwife are subordinates to the obstetric.

This fragment is also the first voice heard in the booklet. The semiotics of which suggests the primacy of the obstetrics in the discourse.

Jenkinson et al (2016:535) also notes some obstetricians and midwives can experience cognitive dissonance in when women request a care plan that is outside the standardised care because care is fragmented with a woman seeing multiple professionals over the course of her pregnancy, their personal beliefs about certain choices women will make, and the lack of support for employees to provide a more individualised care plan, and fearing especially if a poor outcome results from advocating a more woman centred plan, they would not be covered by the hospital's liability insurance and would then be personally liable if 'something goes wrong'.

Using the nominals ‘high /medium / low risk’ are ambiguous leaving the definitions open to interpretation. However, the definition which the obstetric model favours is aligned with that in the dominant discourse or the document would provide definitions, knowing that the conclusions which will be drawn will benefit the organisation. What it omits is what constitutes high, medium, and low ‘risk’. Or how these hazards can be managed in order that a mother can be supported with an individual care plan to mitigate the hazards and progress with the plan for a home birth.

The NICE Guidelines (2016; pp 13-18) lists 22 categories and 87 conditions which may indicate ‘increased risk suggesting planned birth in an obstetric unit’. This tally of conditions or ‘deviations from textbook norms’ suggests that having a complication in pregnancy is another type of normal. Instead of suggesting that women with these complications birth in obstetric units, the opportunity presents itself to plan a home birth while mitigating for the hazards that are uniquely present to her pregnancy. The ultimate decision on place of birth lies with the woman who depends on her antenatal team for timely, relevant information in appropriate language of what the hazards and how the risks can be mitigated to make her birth safer. The implication of omitting some information or worse distorting information can lead to coercion and denial of the right to informed consent.

5.1.4 No Risk, No problem.

What	are	the risks?
value	process (relational)	token

If	problems	arise	during labour,	#you	will require	immediate transfer
conditional	actor	process (relational)	temporal	actor	process (material)	goal
to Delivery Suite at Sunderland Royal Hospital.						
spatial						

Midwives	carry	[[some emergency equipment]],	#however	this	is	limited.
actor	process	goal	adversive adjunct	carrier (token)	process (relational)	attribute (value)

If	an emergency situation	develops	#the midwife in attendance	may not have	the necessary equipment
conditional	actor	process	actor	process (relational)	goal
to deal appropriately	with the situation.				
verbal group	nominal group				

#You	will then be advised	to transfer in	to the maternity unit.
recipient	process	verbiage	nominal group

#An emergency situation	[[which	develops	at home]]	may be	distressing	for you and your family.
actor	[[actor	Process (relational)	Nominal]]	process relational	attribute	nominal group

The theme of information provided by the fragment above is nearly identical in the fragment that follows immediately in section 5.1.5. The themes of liability, the midwife being the agent by use of the passive voice as previously discussed and its omission of agency by the woman also

occur here. These themes and will be dealt in more detail in the next section. The theme of warning is revealed by the functional grammar. There is no discussion of what would constitute a problem so the implication is that it is defined by the midwife. 'However,', the adversive adjunct of the clause in sentence two suggests an 'unconceptualized' (Rosen 1985:48) warning and loss of control, depending once more that the dominant discourse will influence the woman's perception of risk.

The 'if' clauses reinforce the sense of warning by following the same pattern, discussing 'emergency' and 'problems' that 'arise' and 'develop' when discussed in context of the main clauses. They say that home birth is risky, in the voice of an unseen authority who knows about birth.

With warnings come what will happen, what will be the penalty for not following the norm, and here the penalty is conceptualised in the main clause of the last sentence, "An emergency may be distressing for you and your family." That is, if you don't follow instructions, the responsibility of the outcome is yours in a home birth.

5.1.5 Home birth is a problem.

What	will happen	#if	a problem	#occurs	during a home birth?
goal	process material	conditional	actor	Process material	Nominal phrase

The midwife	#will notify	the Delivery Suite	at Sunderland Royal Hospital	that	[[you	require	transfer.]]
actor	process (verbal)	recipient	Nominal group	Conj.	[[recipient	process	Goal]]
					verbiage		

The midwives	will [then] arrange	[[for a paramedic ambulance]]	to take you	[[to Delivery Suite.]]
actors	process [conj] (material)	Nominal group	goal	Nominal group

Your midwife	will escort	you	in to the Delivery Suite	with the support	of a paramedic ambulance team.
actor	process (material)	goal	Nominal group	Nominal group	Nominal group

The word 'problem' is collocated with homebirth in the title paragraph about home birth in large blue and bold font, "What will happen if a problem occurs during a home birth?" (CHS 2016; p. 2). The midwife as actor is the only decision maker in the room, in control of the events with the midwife as the subject of the main clauses of sentences. The midwife 'will notify', 'will arrange' and 'will escort'. These are terms of authority that confer power to the midwife. In the only verbiage of the paragraph, 'that you will require transfer' 'you' is a recipient of a process, a passive player who is not in control. Agency by the mother, her actions by choosing a home birth, by potentially being more active during labour and by having the continuous support of her family and a midwife is excluded from this fragment as discussed in the proceeding paragraphs. 'What will go right' in her home birth is excluded, as the balance of outcome in Table 1 demonstrates overwhelmingly with a focus on what with go wrong. This position not only increases anxiety but also highlights the implications that liability by the hospital is being minimized by putting the agency of the midwife as the central theme in the discourse fragment.

The second is the question of who is in control. One oft cited reason to access home birth is that women want to feel more 'in control' of the birthing space. While this means that the bright and noisy environment of the hospital with it routines, clocks, dialogue between individuals, changing of shifts, strangers entering and leaving the birthing space without invitation are not conducive to the flow of oxytocin and are cited as elements which contribute to longer labours. There is also the control of space. The hospital is the domain of the midwife and doctors while the home is the domain of the mother. Whose space it is determines who makes the rules.

Birthing from Within (England & Horowitz 1998) emphasizes that the women's feeling of control over their birth environment is significant to the physiological and emotional outcomes of birth. Michel Odent's life work also devoted it to recreating the feelings of home in a hospital and speaks of the protected space that women must find to birth as safely as possible. As an octogenarian, he is now less diplomatic in voicing the need for the birthing woman to feel in control of the birth space. The establishment of midwife led units which copy many aspects of home such as double beds for fathers to join the mother and new baby in bed, furniture to encourage women to adopt non-supine positions during labour, fridges for food and drinks, low lighting which is in harmony with the flow of oxytocin, and restrictions on the number of staff who will attend the birth is also testament to the knowledge that home-like environment makes birth safer as evidenced in Jenkinson, et. al, (2013).

A third problem with this short paragraph is that while midwives are skilled in arranging for a transfer to hospital, this one technical detail has taken precedence over the essential midwifery

skills for assessing, monitoring, and mitigating intrapartum complications. One of the major aspects of intrapartum care in home births is the attention of one midwife to one woman. On a busy ward, a hospital midwife may be attending to up to four women which means that in real time she leaves and returns to the room many times during labour. Her attention is on observing and supporting one woman. One to one intrapartum care irrespective of birth location is credited with shorter labours, less painful labours thereby fewer use of intrapartum pain relief, and reduced incidence of iatrogenic injuries for babies and women including caesarean sections. One to one care confers benefits that are not easily quantified under maternity care such as reduced incidence of post-natal depression, post-traumatic stress disorder, and higher incidence of initiation and establishment of breastfeeding, the last which is being shown to confer physiological advantages will into adulthood for the baby and into old age for the woman.

By having one midwife attend one woman during her whole labour, called continuity of care, is shown to confer quantifiable benefits to a woman and baby. Women who investigate home birth soon find out that home birth is associated with fewer medical interventions as documented in the Birth Place Study (2011) and Homer et. all (2014). In the drive to feel safe in birth women move outside the normal narrative of hospital birth and explore what a home birth entails. A meta-analysis of midwife-led continuity of care found that women had fewer birth interventions, they felt more positive with the outcomes despite the way birth transpired which translates to lower incidences of post-partum depression and iatrogenic injuries and have fewer adverse perinatal outcomes (Sandall et al., 2015). Dahlen (2016; p.7) states that, “the evidence is now so

strong on this issue that one could consider it unethical not to offer all women this model of care". Within the setting of home births, the potential for a complication to develop is highlighted earlier giving midwives more opportunity to mitigate risk. The one to one interaction affords a midwife to develop a dialogue with the woman and her birth supporters in order to include her in making an informed decision in regard to her options, including a transfer for a hospital. Hazards with potentially serious outcomes are rare in homebirth and hospital settings. However, the Birth Place Study (2011) shows that for babies of first time mothers a homebirth has higher risk for poor outcome (NICE 2015 p 11). This risk is frequently expressed as "5.3 per 1,000 births in hospital compared with 9.3 per 1,000 home births" (BBC 2011). This increased risk pervades the talk on home birth forums when mothers begin to investigate home births which is understandable when considering the BBC 2011 article and the Daily Mail (2016) headline and article. However, the same statistic expressed as "99.07% of first babies born at home have a normal outcome compared to 99.47% in hospital" (SATH 2015 pp 2-3) may not cause the same level of anxiety among women. It is significant that the Booklet does not highlight this statistic while other booklets that were briefly surveyed articulated the statistic in similar overtones or even vague references (North Bristol; Cheshire). In 2013, the risk of C-sections for first time mothers was 25% in first time mothers and 70% likely to have a c-section in a subsequent birth and an increased risk for stillbirth (BMJ 2010) though this much larger increased risk is not articulated antenatal leaflets nor is it common knowledge unlike the increased morbidity for first time home birthing mothers. The obscuring of this fact demonstrates that hospital birth with its c-section risks occupies a privileged position in

discourse where one of its disadvantages is hidden from the public domain whereas a compatible statistic causes much anxiety for first time mothers.

Emerging research into the human microbiome and epigenetics (Schlinzig, et. al. 2009) also point to changes caused by some of the consequences of birthing in a hospital environment. They include of illnesses linked to the early colonization of babies by microbes found in hospital environments and c-sections are linked to a higher occurrence of leukemia (Amitay et al 2015) asthma, eczema and obesity (Ip, S. et. al 2007; Martin et al 2005; Kwan et al. 2004). Again, the privilege afforded hospital birth obscures this message unless a mother has the resources to inform herself outside the NHS.

Still, women are averse to information that there is any risk of stillbirth during labour or death within the first week of life and this unique difference in first time mothers causes them concern. However, the benefits which counterbalance the risk include many other benefits for mothers and babies as outlined in appendix and which also need sharing with women in antenatal literature. As also shown in appendix, homebirth is as safe as hospital births for multiparous women. One booklet in a brief internet search invited women to seek information outside the immediate care of her midwives or Trust including to ‘Chat to friends, relatives, and neighbours of their experiences’ (Lewisham and Greenwich NHS Trust, undated). The theme of a woman’s context will be discussed in the section titled: Her Context Matters.

5.2 Liability: The absence of physiological observation.

The language of risk contains the language of liability and litigation. The proceeding section discusses how normalized activities of hospital birth is normalized in the home birth setting. The place for the monitoring of birth as described below represents obstetric practices which is distant from the dynamic biological rhythms of the birth process. It places the midwife as the primary agent in birth with the woman as the disembodied receiver of actions.

"Observations

The following observations will be offered to you:

- Listening to your baby's heart rate every 15 minutes until you are fully dilated, this will be every 5 minutes once you are fully dilated
- Your vital observations will be taken as follows- Pulse rate hourly at a minimum, blood pressure four hourly at a minimum, and temperature 4 hourly at a minimum
- Vaginal examinations are usually offered at 4 hourly intervals" (CHS: 4).

Observations

The following observations	will be offered	to you.
goal	process (verbal)	recipient

Listening	to your baby's heart rate	every 15 minutes	#until	you	are	fully dilated
			adverbial temporal	carrier	process	attribute

This	will be	every 5 minutes	#once	you	are	fully dilated.
attribute	process (relational)	circumstance	adverbial	carrier	process	attribute

Your vital observations	#will be taken	as follows-	pulse rate hourly	at a minimum.
goal	process (material)	Adverbial group		

blood pressure	four hourly	at a minimum	and	temperature	four hourly	at a minimum.
			conjunction			

Vaginal examinations	#are usually offered	at four hourly intervals.
goal	process verbal	adverbial group

The word ‘offer’ is only used in the above paragraph. This word underpins all the processes which are discussed within it. It’s antonym, ‘decline’ is not used at all. In fact, decline is conspicuously absent because as discussed in the human right of bodily autonomy, everything is optional and are all only offers. Even midwifery attendance at a birth is a service that is offered and can be declined at any point, even if it is during labour. It comes to some surprise to members of the public and even birth professionals that it is not illegal to decline midwifery services. The surveillance of a woman’s body which is documented as a natural process however can have a detrimental effect on how labour progresses and an element of the multifactorial reasons which result in instrumental births, caesarean sections and mother and infant morbidity.

Mumby & Stohl: 'Power and Discourse' (1991) describes how absence is reconciled in the dialectic of control. In birth, the absence of activity or intervention by the midwife correlates

with a more physiological birth. Or more accurately a midwife whose skills and experiences are in observing and restraining her actions at previous birthing episodes gains insight in how and when to leave birth alone and how and when to intervene. Vaginal or internal examinations, listening to foetal heart tones as represented in the discourse fragment, asking a woman to move into a position to accommodate the activities of the midwife affects a woman's ability to labour undisturbed (Reed, 2015; Reed, 2013, Dixon, 2010), prolonging labour and raising the possibility of obstetric interventions. These activities are obstetric practices that are hospital based and are brought to the home birth setting to protect the obstetric interest within this domain. Measuring and logging 'progress' is creating a stream of evidence in the obstetric model that may protect the institution from liability in the risk averse culture that permeates birth in the current era. Without consensus, training, and documentation of how to assess 'progress' outside the obstetric model, a midwife may fear that she has opened herself to personal liability" as discussed in Jenkinson et al, (2016).

There is evidence that frequent monitoring can be very unwelcome in different stages of labour. These practices in the homebirth context "favours management", that is, obstetric "interests and is detrimental to worker interests", ie midwifery and the mother's (Mumby, et. al. 1991). It privileges masculine over feminine, obstetrics over midwifery, the hospital over the home, the rational over the instinctive and biological.

All midwives are bound by the Nursing and Midwifery Council's (NMC) Code, specifically

10.1, to create records contemporaneously (NMC 2015 p. 20) wherever possible. The coded fragment illustrates a series of obstetric practice which is routinely used in the hospital to record the progress of labour. These actions however have the potential to disturb birth and trigger the 'cascade of intervention' whereby physiological birth becomes increasingly medical (Tracy et. al. 2007). In theory measuring and recording her interventions during labour, a midwife has a written record to protect herself and the hospital from complaint or liability, though her actions may well have been a part of a dynamic process to create the disturbed birth.

The paradox of birth is that the less a midwife 'does' the more physiological a birth usually progresses. Midwifery done ‘best’ is when a midwife sits and does nothing as explained by Odent (2015). If she marginalizes herself in birth space, listening, observing, waiting, remaining silent, and even engaging her sense of smell instead of interacting, her absence from the role of central actor facilitates a physiological birth (Dixon, et. al 2013; Odent 2015 pp. 17 - 20). Her presence with midwifery training and experience is the manifestation of safety for women who choose to birth with a midwife. Oxytocin the hormone cited as one of the main drivers in the birthing process (Dixon et al. 2013) which is at its highest concentrations during the birthing process and its flow is inhibited by interruptions such as unexpected sounds, bright lights, unfamiliar or unwanted touch, conversations, all frequent occurrences in obstetric settings. These activities stimulate the neocortex which dampens or even stops oxytocin while raising the levels of adrenaline and noradrenaline hormones that are associated with anxiety, fear and the fight or flight instinct. “In humans, high levels of adrenaline have been associated with longer

labour and adverse foetal heart rate (FHR) patterns, which indicate that the baby is low in oxygen (hypoxic), consistent with CA-mediated reductions in uterine blood flow." (Buckley 2011) Oxytocin flows easily in warmth, dim lighting, in the presence of individuals with whom women feel a high level of trust and in spaces where women feel safe. These conditions for birth are almost identical to those for sexual intercourse, the other episodic event where oxytocin reaches very high concentrations where interruption dampens the physiological behaviour. By constraining her interaction, a midwife is present but absent, fulfilling a biological imperative for an undisturbed birth while fulfilling the socio-cultural norm that humans need birthing assistants. However, the obstetric model expects her to do, to become an agent in the birth and to document what she has 'done' following its criteria of how to facilitate a 'good' birth and by default what is the evidence that shows how she has acted to mitigate risks. Hence vaginal examinations are offered, the fetal heartbeat is monitored and women's vital signs are taken with increasing regularity as birth becomes imminent. Ironically these 'just in case' acts disturb birth and may have the effect of prolonging labour and increasing the probability of further interventions.

On the other hand, doulas, who are proscribed by UK law from acting as a midwife, have the opportunities in attend and observe the birthing process before the arrival of midwives. Through non-medical support they can actively enhance their skills on how assess the progress of labour by using their senses and intuition (Vine 2010; Shepherd et. al. 2010; Wickham 2002). The intrapartum behaviour of labouring women can be lost on midwives who are taken up with recording data of birth. These skills may represent the type of skills an apprentice midwife may

have observed before midwifery became codified by the Midwives Act 1902 and subsequent UK legislations and NHS policies circumscribed the training and assessment of who became a midwife. By accepting a list of conditions to ensure its survival, midwifery also accepted the conditions which threatens its existence as a care model.

The protocol that is outlined in the discourse fragment is an example of 'the lengths to which … the marginalized… groups will go to preserve the given hegemonic relations that are structured into the organisation" (Mumby, Stohl 1991: 327). The marginalized groups in this case is represented by midwives and the home birth mothers. The drive by the organization to minimize liability was illustrated at the Royal College of Midwives' first legal conference (RCM 2009) where it is stressed that "in emphasis on contemporaneous note-taking: 'Cases are won and lost over record-keeping'". It also provides insight into the inclusion of liability in City Hospital's definition of risk. Doing obstetric practice at home birth and record keeping are therefore paramount in the care of the mother taking primacy over waiting, observing, experience, and intuition which are not so easily quantified and controlled.

5.3 Information and Power

By degrees, compliance is built into the fabric of the Pregnancy Booklet and the following discourse fragment exemplifies this process.

"After delivery

Once the baby **is delivered** and the midwife **has finished** providing care, you **may remain** at home and **enjoy** this special time as a family. It **is** essential that at some point the baby **has** a neonatal check *performed* by a member of the neonatal team, to ***minimise*** impact on your family time the neonatal unit **have agreed** that the neonatal check **can be** completed within 48 hours providing there **are** no concerns. The neonatal check **includes** *listening* to the baby's heart, *checking* the reflexes of the eyes, hips and general appearance of the baby. You **can have** this performed within 6-48 hours **should** you wish your baby **to be seen** sooner."

CHS (2016:4)

After delivery

Once	the baby	is delivered	and	the midwife	has finished	providing care		
adverbial	goal	process	Conj.	actor	process	goal		
you	may remain	at home		and	enjoy	this special time	as	a family.
actor	process	nominal grp		Conj.	process	goal		

It	is	essential	that	at some point	the baby	has	a neonatal check
token	process	value	conj	Adverbial grp	recipient	process	goal
performed	by	a member of our neonatal team.					
verbal	preposition	actor					

[[To minimise	impact	on your family]]	#the neonatal unit		have agreed	[[that	the neonatal check	can be
Verbal group			actor		Process (verbal)	[[goal]]		
completed		within	48 hours]]	if	there	are	no concerns.	
				conditional		process	existential	

The neonatal check	includes	[[listening	to the baby's heart,	checking the reflex of eyes, hips
carrier	process	[[attribute]]		
and	general appearance of the baby]].			
[[attribute continued]]				

You	can have	this	[[performed within 6-8 hours]]	should (you) wish	your baby	to be seen	sooner.
actor	process	possessive	Verbal group	Process (senser)mental	recipient	phenomenon	adverbial

The Newborn and Infant Physical Examination (NIPE) discussed in the table above is a screening programme by the Public Health England (PHE) in which is universally offered to newborns. Its purpose is to "identify and refer all babies born with congenital abnormalities of the heart, hips, eyes or testes, where these are detectable, within 72 hours of birth" (PHE 2016:4) thereby increasing the probability of early diagnosis and treatment of abnormalities and reducing inequalities across the population (PHE 2016: 10). This screening test like all screening tests is voluntary as can be intuited from the PHE text when it states that NIPE 'will be offered' and 'should be offered' (PHE 2016:4), and that it is aimed at "the eligible population who are informed and wish to participate in the screening programme" (PHE 2016: 7) and from the National Screening Committee (NSC) which states in 5.19 that 'Evidence-based information, explaining the purpose and potential consequences of screening, investigation and preventative

intervention or treatment, should be made available to potential participants to assist them in making an informed choice." (PHE 2015a) stating that informed consent is a vital attribute of NIPE.

One to One (Parkington undated) is unequivocal that participation in the test is voluntary where it states, "Although it is recommended... you have the right to decline it, or part of it." Other attempts to find an equally clear service user friendly discussion in NHS resources was not forthcoming. The state's implicit surveillance contrasts with this contractor's information that mothers can decline.

Within the Pregnancy Information booklet, the language of the paragraph does not confer that this screening examination in optional and is an offer that can be declined. The word 'essential' connotes compulsion to the 'neonatal check' which is 'performed a member of the neonatal team'. This appealing to the authority of the team who 'has agreed' to 'minimize impact' on the newborn and mother. The introduction of technocratic terminology contrasts with the introductory sentence which is written in layperson's language and which accentuates the family friendliness of homebirth as a 'special time' to 'enjoy'. The following sentences revert to the language of hospitals, measuring, and routines with overtones of surveillance where it states, "providing there are no concerns" as if the delay for the checks are conditional of the approval of someone other than the parents. Without being specific about the concerns, the organizational power could be assumed by the mother and the midwife. The concerns of the mother and the midwife is more than rhetoric as Elizabeth Prochaska of Birthrights stated that, "the threat of

referral to social services “seems to have become a common tool used by health professionals when they are uncomfortable with women’s choices”.’ (Guardian 2016)

Stating that there is an ‘agreement’ from the ‘neonatal unit’ also implies that decisions beyond the control of the attending midwife and the woman has determined that this screening test is compulsory. The implication is that the mother must interrupt the family time and go to a hospital. Without the use of the term ‘offer’ will be interpreted as a compulsory test unless a woman received her antenatal education outside the oversight of the NHS as the online leaflet by One to One demonstrates.

The initial period of bonding after the birth is portrayed as an indulgence that families are ‘allowed’ to have with the “agreement” of the “neonatal unit” to “minimize impact on your family time”. It is in opposition to the fact that it is the mother who has the legal power to accept or decline the NIPE, even when she is unaware of it.

The fragment, ‘special time as a family’ is especially noteworthy as special in real life usually means an extra effort, a bonus, or a reward for something out of the ordinary as discussed by critical analyses in the discourse of breastfeeding where special is frequently used with other superlatives such as best and optimal. (Gribble 2007) and that ‘The mother having difficulty with breastfeeding may not seek help just to achieve a "special bonus"’ and that “Special is nice, but it is complicated, it is not an ongoing part of life.” (Wiessinger 1996). Birthing in one’s own living space is treated as an alternative, a counterculture to the norm of hospital births (Walsh 2015:157), similarly to the way artificial milk feeding is treated as the norm and breastfeeding as

the alternative in discourse as Gribble and Wiessinger argue. Home birth it can be argued is analogous to breastfeeding in that it is the historical and evolutionary norm, 'the control' (Gribble 2007) against which the alternatives ought to be analysed.

In CHS Pregnancy Information the window of screening being six to 48 hours rather than 72 hours as recommended by PHE. This representation is arguably intentional as the test is known to every midwife. The 24 hour discrepancy may provide midwives the opportunity to follow up babies who have not presented at the hospital trust within the first 48 hours thereby further reducing the optionality of the test. While PHE has set targets for hospitals to screen a minimum of 95% acceptable of neonates in 72 hours and uses 99.5% achievable expectations, it is clearly not optional as articulated by the PHE (2016:7). It states that all babies except those who die will be eligible for NIPE and any delay in meeting the 72 hour deadline must be accounted for as "as mitigations against performance thresholds" (PHE 2016:10).

Bringing a baby to hospital for a test when the decision was made to avoid hospitals so it seems counterintuitive to visit one within a day or 2 of giving birth. In response, some trusts have trained midwives to perform the NIPE with referrals for further assessment by a paediatrician only if there are concerns. However, this option is subject to a 'postcode lottery' and the language of CHS does not imply that it is a possibility to have a NIPE test at home. The atmosphere of compliance through disinformation pervades the discourse fragment rather than seeking information through consent. If the test is so important and effective at improving outcomes the information can be shared with parents in a non-judgemental, timely and sensitive

manner, opening the opportunity to provide informed consent. As displayed here there is no element of trust being conveyed in the people would best placed to have interests of their babies at heart. Parents overwhelmingly can monitor their babies in the first few days of life however the mother's natural instinct to protect her baby is being overridden by a surveillance culture that seeks compliance with the interests of the institution being the primary consideration.

The last sentence suggests and option with the use of 'wish' as the process however, the inclusion of this wish happens to align neatly with the goals of the institution.

5.4 Her Context Matters

"The knowledge of how to give birth without outside intervention lies deep within each woman. Successful childbirth depends on an acceptance of the process."
Suzanne Arms, author, birth activist

As discussed already, there is scant evidence within the document that the woman is the agent during her birth. One of the oft cited evidence that one of the reasons women chose home birth is to exercise control over her place of birth as place of birth has a psychological effect on how or if a woman exercises her power. The hospital with its protocols, timetables, shift changes, influences a woman to recreate the images that she has seen in the media or heard in her community. Pam England (1998) discusses "banishing pillows from the [antenatal] teaching room… to avoid strengthening cultural images of women lying in a hospital bed.". This

illustrates the internalization of obstetric birth within society and by removing objects that conform to the obstetric expectations women will seek out the more physiologically useful furniture, the walls, chairs (for kneeling and leaning against, not for sitting), and the floor to support them during labour.

The choice of home presents the unique opportunity to alter the discourse of birth, shifting from the institution in which the power of multimodal texts lie with the obstetrics. Home brings with it access to her own facilities on demand unlike a hospital where previous institutional experiences have normalised boundaries of space, time and hierarchies and expectations linked to permission. The physical and emotional comfort that home provides supports the psychological and physiological birth. The number of birth partners is unlimited and children sometimes pets are accommodated in a woman-centred homebirth.

Other considerations may include more practical ones such as lack of childcare for other children, distance from hospital, or a previous precipitous labour. Psychological conditions may create severe anxiety about place of birth including tokophobia, agoraphobia, and PTSD related to previous birth trauma which today affects about 10% of births at differing levels of severity. In addition, a woman's desire to have a home birth, whether based on evidence based knowledge or from a socio-cultural context are equally valuable reasons to access a home birth as they are for accessing any other place of birth.

Hastie (2008) discusses how the mental health and emotions of a pregnant woman can affect the outcomes of her pregnancy and Lipton (2005) in Hastie (2008) discusses how stress during the antenatal and perinatal period has been accounted as factors that determine gene expression in the new field of epigenetics. Additionally, through meditation and visualisations practiced in yoga and hypnobirthing, women may experience intuitive communication with their unborn baby (Lokugamage 2011) and experience connection with my ancestry and envisioning how birth would transpire. (Forster 2014). Lokugamage (2011) documents how her perception of birth changed from an evidence based, rational, medicalised process to one that is spiritual and intuitive, centred within the woman. These factors are not conveniently quantified by institutional processes so it avoids incorporating them into the birth environment and as such these factors remain within the domain of individual women. She discusses how she like all medical staff are traumatised by witnessing and partaking in births with poor outcomes and which influences their practice in other births. Debriefing as a part of the staff's continuing professional development would result in better outcomes for babies and increased staff satisfaction.

One mother stated that she was "more relaxed - just knowing a home birth is a possibility, whether or not I choose it.' England (1998:102) and midwives also recognize that most problems in labour develop slowly allowing for safe, non-emergency transfers to a hospital. Indeed, some women will arrive at hospital after a prolonged labour at home and progress quickly because, "It's reasonable that women who hold an unrecognized belief that the hospital is a safer birth

place, will have difficulty letting go at home" (England 1998:104). This phenomenon is documented in Hastie (2011a) where Newburn & Singh (2005) report that "nine out of ten women thought that the physical environment influenced how easy or difficult it was to give birth."

Psychophysiological approach to childbirth "appropriately acknowledges and integrates the woman's active, mindful agency in her birth process" (Hastie 2011a). It is therefore difficult to quantify these elements in the positivistic birth discourse and controlling for the factors mentioned above are erased from hospital births by their policies which frequently cite safety and safety of staff and service users as ways of eliminating the options.

6. Conclusion

Is it time to move beyond discussing home birth choices and discuss home birth decisions. - Emma Stromberg Armstrong, Doula and AIMS Committee Member

In response to a question about whether women had more choice today than ten years ago, Beverley Beech, Chair of AIMS replied:

"Absolutely not. Choice is an illusion. The majority of women are conned into thinking that they have a choice. What they have is a specific menu that is offered them. If they choose

within that menu, that is fine. If they choose outside that menu, they have an enormous battle to get what they want." (HOC 2003:22)

Today, sadly the illusion of choice is still real.

The discourse fragments reflect an environment where medical staff work in a stressful environment where the power that the organization exercises in maintaining the status quo supersedes the power of evidence based practice and the right of the individual to make decisions about their care. It shows that the midwifery model of care is dependent on the goodwill of its sponsor which can be withdrawn, even when the outcomes benefits the greater good for those populations which are subject to a range of social injustices, unequal maternity care being just one.

While it is expedient to bring midwives and their supporters under investigation with the emotive justification that 'the lives of mothers and babies are at risk', this paper shows that the fear pervades birth at many levels and fear is utilized to achieve compliance to the obstetric model.

Hastie & Fahy (2009) found that "the organisational culture within the 'birth territory' of a particular maternity unit seems to be predictive of the type of interactions that are likely to occur there." and "Midwives and doctors agree that positive interactions are collaborative, include the woman and her partner and are associated with the best possible outcomes and experiences possible. In contrast, they agree that negative interactions involve power struggles between the

professionals and these are associated with adverse outcomes." Consent rather than compliance is associated with positive interaction.

Odent, quoted by Williams (online) states "If we want to find safe alternatives to obstetrics we must rediscover midwifery. To rediscover midwifery is the same as giving back childbirth to women. And imagine the future if surgical teams were at the services of the midwives and the women instead of controlling them." Unfortunately, the centralisation of obstetric units, the fragmented care that are a result of staff shortages, the closures and restrictions of home birth services (Messenger 2016; Cleary 2106) point to a further decline in the provision, further marginalizing the choices for women and further pressure on midwives to either conform to the obstetric norm or find alternatives outside the system.

Vanessa Brooks (2016), Director of Da a Luz Holistic birth envisions establishing a new system of education [for midwives] outside the control of obstetrics as it 'has lost all integrity'. A system which 'cares about its midwives' in order to 'give pregnant women decent care', claiming that midwives have been deskilled with midwives practicing like 'obstetric nurses and handmaidens of doctors'. However, others such as Sheena Byrom OBE, freelance midwifery consultant would prefer changing the system from within while recognizing that maternity services requires starting again due to 'lack of insight to potential damage caused [by the current system]'(ibid).

The infrastructure of a society must invest in maternity care workers in order to begin a cascade of normal were the perspective of risk is balanced with a perspective of trust in the biological process of birth. These include policy makers in government who must seek to protect hospitals and its services from neoliberal policies of market forces, support professional independence for midwives, and the media which has a social responsibility to inform themselves and report without sensationalising stories of birth and infant feeding. Birthing outside the obstetric norm will not go away as discussed by Feeley (2016), it will resist as some women will register their resistance by making the decision to birth without surveillance and assistance whether that decision is made with informed consent or by being coerced into birth outside the institution.

Abbreviations
AIMS - Association for Improvement in Maternity Services
CCG - Clinical Commissioning Group
CHS - City Hospitals Sunderland
HOC (HC) - House of Commons Health Committee
NMC - Nursing and Midwifery Council
SATH - Shropshire and Telford Hospital
WRI - White Ribbon Alliance

Definitions:

"Booking in' appointment: This appointment lasts about an hour and it is typically conducted in the mother's home. Alongside this booklet an official 'hand held notes' is completed. It records vital statistical information on health, previous pregnancy (ies) if any, socio-economic and biographic details and birth choices. It remains a working document throughout her pregnancy and is to accompany her at her birth. The booking in appointment is typically the longest appointment a woman will have with the midwife who is typically her 'named midwife'.

Caseloading or **continuity of care midwifery** is a system a woman's antenatal care is mainly provided by the same midwife and her partner or a small team of midwives who will attend her

during labour and birth. This is in contrast to midwifery teams in obstetric-led units where a larger number of midwives whose rota is controlled by the shift patterns set by the needs of the unit which results in more fragmented care. Continuity of care has been shown to provide better outcomes for all women including those with complex needs. It has also been shown to be cost effective and safe for women of any risk and providing higher satisfaction for women and their families as well as for midwives who want to work with this midwifery model. (RCM 2014:10)

Obstetric Violence: a term coined in Venezuelan Law in 2007 to recognise the violations of human rights which occur while a woman is in labour. It constitutes verbal, emotional and physical abuse, which may materialize as coercion to accept unnecessary procedures, physical assault or battery by treatment that is forced upon a woman, and dehumanizing interactions that include threats to withdraw treatment or support, denying support or treatment, belittling a woman's lived experiences and ignoring her requests for assistance.

Precipitous labour - a labour that is shorter than 3 hours.

Unassisted birth - also called **freebirth** - A birth which is planned to be unattended by medical or midwifery agents. It is legal in the UK to birth without the assistance of doctors or midwives. Antenatal care, screening tests, and attendance to a birth are services which are offered by NHS and which a woman has the legal right to accept, decline or discontinue at any point. (Birthrights 2013a.) Frequently, laypeople and healthcare professionals believe that planned unassisted birth is illegal, conflating it with the law that prevents a person from impersonating a doctor, nurse or midwife (Beech 2007). As a fetus has no rights in law until after birth (Birthrights 2013c), the mother has complete agency over her unborn child and her decisions regarding her care, even if it contradicts the recommendations of health care professionals, are to be supported and respected (Birthrights 2013c). The only time a health care professional has agency a woman's maternity care is when she is sectioned under the Mental Health Act.

Ventouse - a suction cup that is attached to a baby's head in order to expedite birth. Ventouse may leave a swelling or bruising of the baby's head and it is associated with fewer incidences of severe trauma to the mother's vagina and perineum than the use of forceps.
http://www.nhs.uk/conditions/pregnancy-and-baby/pages/ventouse-forceps-delivery.aspx

Footnote:
In a search for comparative pregnancy information texts revealed a discourse fragment regarding birthing without a healthcare practitioner within a booklet by Shrewsbury and Thetford Hospital. In UK legislation, it is illegal to impersonate a midwife. However it does not state that the likelihood of someone impersonating a midwife is nearly nil in the UK and the law does not stop

anyone from assisting in a birth in the Samaritan's law context. The lack of clarification of this law in the home birth information may be interpreted as anyone else who is present and assisting the mother at a home birth is impersonating a midwife. This will be concerning to a woman as most women will not want to put their birth partners in a vulnerable position and therefore it works against a mother opting for a home birth. From personal experiences with health visitors and midwives in social settings I have become aware that even midwives frequently don't know that it is legal to birth without a midwife.

I shared it with a secret Facebook Group for women who have had or are considering an unassisted birth and whose membership includes some birth rights activists and academics. Within a few days of my initial discovery, a revisit to the link found that the booklet had disappeared from the website. I had already saved a copy of the booklet. However, unreported by me, and still live on the website is a digital home birth leaflet from which the text may have originated. The link to the now broken link (SATH 2014), and the homebirth leaflet from which it seemed to have been drawn are in the references (SATH 2015:4).

Summary of the Birthplace Study (2011)

The Birthplace study revealed that the most dangerous place for a low risk woman to have a baby is a large, centralised obstetric unit, as the following tables show:

The following table gives the numbers of babies who have adverse outcomes for low-risk women expecting second or subsequent babies (per 1,000 births):

Obstetric unit	3.3
Home birth	2.3
Free-standing midwifery unit	2.7
Alongside midwifery unit	2.4

The study also looked at the way these babies were born and showed higher rates of spontaneous vaginal births when babies were born outside consultant units and lower rates of caesarean births.

Spontaneous vertex (head down) birth for low-risk women per 100 births:

Obstetric unit	73.8
Home	92.0
Freestanding midwifery unit	90.7
Alongside midwifery unit	85.9

Caesarean Section for low-risk women per 100 births:

Obstetric unit	11.1
Home	2.1
Freestanding midwifery unit	3.5
Alongside midwifery unit	4.4

The Birthplace Cohort Study also published the average costs of birth in the settings available in the UK. It shows that a planned home birth is cheaper than any other option. "On average, costs per birth were highest for planned obstetric unit births and lowest for planned home births.

Average costs were as follows:

£1631 for a planned birth in an obstetric unit
£1461 for a planned birth in an alongside midwifery unit (AMU)
£1435 for a planned birth in a freestanding midwifery unit (FMU)
£1067 for a planned home birth"

Table 1

Interventions for healthy women with low risk pregnancies by their planned place of birth at start of care in labour

Intervention and planned place of birth	No of events/births	Incidence of events/100 (99% CI)*
Spontaneous vertex birth:	54 798/64 483	76.4 (73.8 to 78.7)
Obstetric unit	14 645/19 688	73.8 (71.1 to 76.4)
Home	15 590/16 825	92.8 (91.7 to 93.7)
Freestanding midwifery unit	10 150/11 280	90.7 (89.1 to 92.0)

Alongside midwifery unit	14 413/16 690	85.9 (83.7 to 87.9)
Ventouse delivery:	2953/64 483	7.3 (5.9 to 9.0)
Obstetric unit	1535/19 688	8.1 (6.4 to 10.1)
Home	342/16 825	2.0 (1.6 to 2.5)
Freestanding midwifery unit	321/11 280	2.7 (2.0 to 3.5)
Alongside midwifery unit	755/16 690	4.8 (3.6 to 6.2)
Forceps delivery:	2813/64 483	6.2 (5.1 to 7.6)
Obstetric unit	1307/19 688	6.8 (5.4 to 8.4)
Home	372/16 825	2.1 (1.8 to 2.5)
Freestanding midwifery unit	365/11 280	2.9 (2.3 to 3.7)
Alongside midwifery unit	769/16 690	4.7 (3.5 to 6.4)
Intrapartum caesarean section:	3748/64 483	9.9 (8.4 to 11.5)
Obstetric unit	2158/19 688	11.1 (9.5 to 13.0)
Home	458/16 825	2.8 (2.3 to 3.4)
Freestanding midwifery unit	405/11 280	3.5 (2.8 to 4.2)
Alongside midwifery unit	727/16 690	4.4 (3.5 to 5.5)
Third or fourth degree perineal trauma:	1737/64 354	3.1 (2.7 to 3.6)
Obstetric unit	625/19 638	3.2 (2.7 to 3.7)
Home	318/16 800	1.9 (1.6 to 2.3)
Freestanding midwifery unit	259/11 262	2.3 (1.9 to 2.9)
Alongside midwifery unit	535/16 654	3.2 (2.6 to 4.0)
Blood transfusion:	545/64 044	1.2 (0.9 to 1.4)
Obstetric unit	241/19 579	1.2 (1.0 to 1.6)
Home	101/16 687	0.6 (0.5 to 0.9)
Freestanding midwifery unit	67/11 230	0.5 (0.4 to 0.7)
Alongside midwifery unit	136/16 548	0.9 (0.7 to 1.2)
Syntocinon augmentation:	8078/64 174	20.9 (18.7 to 23.3)
Obstetric unit	4549/19 483	23.5 (21.1 to 26.2)

Home	943/16 794	5.4 (4.8 to 6.1)
Freestanding midwifery unit	878/11 238	7.1 (6.0 to 8.5)
Alongside midwifery unit	1708/16 659	10.3 (8.9 to 11.8)
Immersion in water for pain relief:	17 674/64 086	13.4 (10.5 to 16.9)
Obstetric unit	1836/19 680	9.1 (6.4 to 12.6)
Home	5523/16 443	33.3 (30.1 to 36.6)
Freestanding midwifery unit	5253/11 270	45.7 (35.6 to 56.3)
Alongside midwifery unit	5062/16 693	30.2 (23.4 to 38.1)
Epidural or spinal analgesia:	10 950/64 287	27.6 (24.6 to 30.8)
Obstetric unit	5817/19 576	30.7 (27.5 to 34.2)
Home	1418/16 799	8.3 (7.3 to 9.4)
Freestanding midwifery unit	1251/11 251	10.6 (9.1 to 12.3)
Alongside midwifery unit	2464/16 661	15.3 (13.2 to 17.7)
Episiotomy:	7806/64 312	17.8 (16.0 to 19.6)
Obstetric unit	3780/19 678	19.3 (17.4 to 21.4)
Home	933/16 670	5.4 (4.8 to 6.1)
Freestanding midwifery unit	995/11 275	8.6 (7.3 to 10.1)
Alongside midwifery unit	2098/16 689	13.1 (11.4 to 14.9)

*Weighted to reflect each unit's duration of participation and probability of being sampled; confidence intervals take account of the clustered nature of the data.

Birthplace in England Collaborative Group (2011)

If, instead of sending out two midwives to every home birth the hospital ensured that the second midwife was a student not only would the costs reduce further, but they could also begin to develop a cohort of midwives who are confident at attending home births and who will then see normal, straightforward, births Each Caesarean section costs £2,579 compared with £1,174 for a normal midwifery-led birth.

The caesarean section rate in the Queen Elizabeth Hospital (QEH), King's Lynn is 26%, whilst the World Health Organisation has pointed out that there is no health improvement for women or babies when the caesarean section rates exceed 10%. The caesarean section rate would

be reduced if the Trust establishes a freestanding midwifery unit and a community based caseload midwifery (homebirth) service (Cleary, 2016).

After 3 years of grassroots advocacy, the Ombudsman has written to the Queen Elizabeth Hospital to inform them that they must re-establish the homebirth provision (QEH 2016). Its removal of the home birth provision was against the NICE and NHS Guidelines and is indicative of the common response across hospitals to remove a homebirth service citing expense though the numbers above does not bear that out nor does the actions of the QEH. In the three years that the QEH did not have a homebirth service, it opened a new birthing suite modelled on a home birth setting at a cost of 600,000 pounds.

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