

The Drama of Childbirth

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In 1999, the organization *Cuidiu-Irish Childbirth Trust* published the third edition of its “Consumer Guide” to maternity services, with the assistance of the Department of Health and Children. One of the principal trends *Cuidiu* identified was an increase in the percentage of births by caesarean section. In this respect, Ireland appears to be ‘catching up’ with many other European states. Some commentators suggested that patient preference has contributed to the increasing number of caesarean sections in Ireland. In the personal view of *Cuidiu’s* President, Sue Jameson, women’s expectations for a “perfect, pain-free birth” had increased the likelihood of intervention. The Master of the Rotunda, Dr. Peter McKenna stated in his Annual Clinical Report for 1997 that: “There seems little doubt to me that, part of the rise in our caesarean section rate is meeting the patient request and, against a background of good results and proven safety procedure, it is difficult not to accede to these requests.” The Master of the National Maternity Hospital, Dr. Declan Keane, claimed that the “close alliance” between a country’s GNP and its caesarean section rate indicated “a direct relationship with patient demand and expectations.”¹

In this representation of Irish maternity care, obstetricians respond to the actions and choices of childbearing women who are identified as consumers. However, the image of women as active participants in the growth of medical intervention does not stand up to minimal scrutiny. In this chapter, I argue that childbirth in Ireland continues to be structured by the exercise of power in ways that limit the extent to which women can take an active part in their own labour and delivery. The pattern of increased surgical intervention has thus emerged in the context of institutional practices that deny women choice and agency.

Ireland’s Childbirth Regime

To give birth in an Irish maternity hospital is to be transformed from an active, childbearing person, into the appendage of a recalcitrant body from which a child is delivered by medical technology and personnel. This is because childbirth in Ireland is

governed by an institutionalized set of formal and informal practices and ideas that serve to perpetuate what I will call the Irish Childbirth Regime (ICR). I use the term ‘regime’ to emphasize the extent to which these practices and ideas appear to be uncontested within certain boundaries of time and space – that is, they have a character peculiar to modern Ireland. Of course the medicalization of childbirth is not unique to Irish maternity hospitals. However, the absence of any significant public challenge to the process is extraordinary. In this chapter I will suggest three reasons why the ICR is so powerful:

- The status of ‘active management of labour’ as an Irish modernization project
 - The relative – and paradoxical - success of the Home Birth Movement in Ireland
 - The reproduction of the regime in the everyday drama of hospital-based maternity care
- In my view the ICR seriously disempowers women by ensuring that childbirth is experienced as something that happens to their bodies, rather than as an active individual accomplishment. However, in that case, why is there so little public resistance to the regime?

James C. Scott has argued that, under oppressive regimes, the appearance of consent is accomplished by public displays of compliance, agreement and deference. Most of the time childbearing women, and other subordinate players in the ICR, especially midwives, have a strategic interest in observing its rules, and thus appear to affirm the values of its dominant players, mainly obstetricians. As Scott observed, this does not mean that what women say and do “offstage” is necessarily more truthful than their “onstage” performance in the consulting room.² It is possible that if Irish women had real choices about how they wanted to give birth, most of them would opt for a medicalized experience anyway. The important point is that, under the current regime, which denies choice, it is illegitimate to infer that the trend towards more medical intervention is a reflection of women’s preferences. Later in this chapter I describe the routine practices and displays that reproduce the ICR with each pregnancy and birth. Finally, I argue that things could be different.

Active management of labour as a modernization project

The package of maternity care known as “active management of labour” was introduced in the National Maternity Hospital (NMH) at Holles Street in the late 1960s, under the direction of the then Master, Dr. Kieran O’Driscoll. By employing strict

diagnostic criteria for “true” labour, and by the routine use of amniotomy (breaking of the waters) and synthetic oxytocin (the hormone that stimulates labour), practitioners of active management ensure that no labour lasts longer than 12 hours. The NMH also includes “continuous professional support” as an essential component. A chart called a “partogram” is used to monitor progress in labour by plotting the rate of cervical dilation. Under active management, “normal” labour is depicted as a straight line, because a woman’s cervix is supposed to dilate at the rate of 1cm. per hour.³

The purpose of active management, according to O’Driscoll, was to “enhance the experience of childbirth for mothers, particularly first-time mothers.” In the article that introduced active management to the medical community, O’ Driscoll and Meagher notoriously described prolonged labour as a “harrowing experience” liable to cause “permanent revulsion” to childbirth on women’s part. Prolonged labour in first-time mothers is not unusual, however, according to the criteria of the NMH, which reported that 50% had their labour accelerated in 1998. More recently, active management has been promoted on the grounds that it reduces the rate of caesarean sections. The best evidence for this claim is the low (but increasing) rate of caesarean sections at the NMH. However, systematic research does not support the contention that active management reduces the risk of caesarean section.⁴

Active management has been enthusiastically adopted by obstetricians throughout the English speaking world. According to Thornton and Lilford: “An important factor in this process was the personality, and vigorous prose style, of active management’s foremost advocate, Kieran O’Driscoll of Dublin, who managed to convince even the most cautious clinicians.” The British Medical Journal’s reviewer of O’Driscoll and Meagher’s (1980) first book-length publication on active management wrote that: “Our era will be seen as one in which there occurred a revolution in intrapartum care centring on Dublin.” For a post-colonial country still mired in socio-economic underdevelopment, this represented an extraordinary achievement of modernization. In his history of the National Maternity Hospital, Tony Farmar explicitly invoked the Irish modernization project by linking O’Driscoll’s name to those of Whitaker and Lemass in the first sentence of his chapter on active management. Eoin O’Malley has argued that, with respect to industrialization, Ireland suffers from the problems of a “latecomer.” With respect to maternity care, Ireland clearly suffers from the problems of an “innovator.” Because they achieve extraordinary initial

success, innovators invest heavily (both materially and psychologically) in the techniques they have pioneered. This makes it difficult for them to adapt to new information or changing circumstances.⁵

It is difficult to obtain precise information on just how routinely Irish maternity units other than the NMH practice active management. Cuidiu's report tells us only that: "Many hospitals set time limits for each stage of labour (Active Management of Labour)." Of the eight hospitals that reported the percentage of first time mothers who had their labour accelerated, four, including the NMH, gave a figure of 35% or more. If those hospitals that did not distinguish between first time mothers and all others are included, seven out of fourteen reported average acceleration rates that matched or exceeded that of the NMH (30.5%). Seven hospitals did not provide any information. These data are obviously unsatisfactory, but it is reasonable to infer that the practice of active management is widespread. More importantly, however, the cultural salience of active management means that the woman-centred idea of active birth is alien to Irish obstetrical thinking. It is an integral part of the "assembly-line" model of maternity care that I describe below.⁶

The Paradoxical Success of the Irish Home Birth Movement

It may seem perverse to argue that the home birth movement has been 'successful' in Ireland, given the vehemence of opposition to it, especially on the part of general practitioners, and the difficulties women continue to experience in obtaining state funding for the services of domiciliary midwives. However, my contention is that the high public profile of the home birth debate has deflected attention from the problem of medical intervention in childbirth. It has done so by establishing the perception that women who want to give birth actively are also women who want home births, and that therefore such women are a small and eccentric minority. This argument is not intended as a criticism of home birth advocates, whose courageous efforts to increase the choices available to Irish women must be applauded. Rather, my point is that if the Irish Childbirth Regime is to be transformed, the challenge must go further than a demand for home births.

According to Maire O'Regan, the successful centralization of Irish births in hospital maternity units by the 1970s created a 'greenfield scenario' for home births in the 1980s. "The opportunity to establish truly autonomous woman-centred midwifery care, from first principles, uninfluenced by the prevailing straitjacket of Irish labour management protocols,

existed for one relatively short window of time.” The problem was that such care was only available to women who could afford to pay for the services of an independent midwife. In 1994, the Maternity and Infant Care Scheme Review Group acknowledged that under the 1970 Health Act women who chose to give birth at home were entitled to free maternity care. The publication of their report in 1997 resulted in the introduction of domiciliary pilot schemes based at University College Hospital, Galway and at the National Maternity Hospital in Dublin. Home birth advocates are already concerned that these projects represent the medicalisation of home births – their incorporation into the Irish Childbirth Regime – as they include strict criteria for ‘admission’ to the schemes, and for when transfer to hospital is deemed necessary.⁷

Childbirth as a Respectable Performance

Above, I have suggested two reasons why the Irish Childbirth Regime is so powerful. However – as the demand for home births showed – no regime is ever entirely uncontested. Scott argued that any system of domination requires daily maintenance by means of small, routine dramatizations of power. These displays serve to conceal the true character of the relationship between dominant and subordinate groups, and to affirm the authority of those in power. The success of the drama depends on the appearance of unanimity and consent, so that it is essential to marginalize those who do not conform. In this section, I argue that a pregnant woman who seeks care at one of Ireland’s maternity hospitals is swept up in a scripted performance that reproduces both the dominant model of childbirth, and her own subordination within the regime. If she steps outside the script, she is marginalized, and made to feel like a troublemaker. The performance ‘works’ by inducing – and reinforcing – feelings of isolation, fear and helplessness in childbearing women. It is important to note that my argument does not imply an active conspiracy on the part of the obstetrical establishment to demean women. Indeed, as Scott observed, in dramatizations of power, the leading actors form a more important part of the audience than the bit players do.⁸

In the absence of much research, most of the argument below is necessarily based on my own experience. I cannot claim that other women experience the ICR in the same way, or that my experience would not have been different had I attended other maternity units. However, the Maternity...Review Group reported that according to submissions it received,

“the mother’s voice is sometimes lost in the organised hospital situation.” This is why I think mothers’ voices are not so much lost as silenced.

When I tried to “choose” where to give birth to my first child, I was astounded by how difficult it was to obtain information on which to base a choice. Irish maternity hospitals simply do not make public any policies about the ways of giving birth they support or allow. The publication of successive editions of the Consumer Guide to Maternity Services in Ireland has clearly led to greater openness about such subjects as rates of caesarean sections, assisted deliveries and so on. Just by asking questions about whether birth plans are facilitated, or if women are free to choose their own position during delivery, *Cuidiu* and their predecessors in the Irish Association for Improvements in Maternity Services (IAIMS) have made vital dents in the armour of the ICR. However, much of the information in the Consumer Guide remains singularly uninformative. For example, 21 out of 24 hospitals report that birth plans are ‘facilitated.’ But what does that mean? How will the obstetricians in charge react if your birth plan includes practices they disapprove of, or refuses interventions they consider necessary? Thus while *Cuidiu* aims to “provide information which will assist [women] to make choices about childbirth,” there is a very limited sense in which their publication can succeed in this goal, since the ICR is premised on women not making choices.

The concealment of this effective denial of choice is a delicate business since, if it were openly stated as a policy, it would risk violating the principle of informed consent. The Maternity...Review Group recommended that “there should be an acceptance by professionals of the right of a woman to refuse an intervention.”⁹ However, most of the time, the routine practices surrounding ante-natal care and childbirth ensure that there is very little danger of a woman refusing an intervention in the delivery suite. When you attend an ante-natal clinic in an Irish hospital, you find that you are expected to play your part as the object of an assembly-line of routinized tests, examinations and, in the delivery room, interventions. To stretch the dramaturgical analogy, the script is so ‘taken-for-granted’ that you are never even given your lines! You get extremely restricted opportunities to ask questions, and the staff never volunteer information about why a particular test or intervention is being carried out. Moreover, the routines dramatize the hierarchy of authority as you proceed upwards from lowly receptionist to nurse, midwife and doctor. If

you are a public patient you will probably rarely encounter the obstetrician, whose absent power thus inspires even greater awe than it does in the private clinic.

Given the large numbers of women who must be cared for, it is understandable that the system is somewhat impersonal. However, in my view the assembly-line model of care serves purposes other than mere efficiency. Most importantly, it dramatizes the process of childbirth as a set of standardized practices carried out by professionals on inter-changeable women. It functions as a display that continuously reaffirms both the power of obstetricians and the apparent acquiescence of pregnant women within the childbirth regime. The parade of buzzing medical personnel and mass of anonymous, undifferentiated pregnant bodies in the waiting room are both actors and audience in this drama. As an individual woman caught up in it you feel strangely at a disadvantage, since your participation is never invited, it is simply taken for granted. If you are secretly a confused or unwilling performer you feel isolated, since everybody else appears to play their part unquestioningly. As Scott observed, such displays of power also serve to “demonstrate” that, for subordinates, the only significant relationships in the drama are vertical, with those above them in the hierarchy.¹⁰ Midwives sometimes openly ‘enlist’ pregnant women as fellow subordinates within the structure of command – for example, by referring to the obstetrician as ‘the boss.’

The assembly-line script guarantees the appearance of consent because it places the onus on each individual woman to object, instead of including her in the decision-making process from the beginning. A woman is unlikely to object very strenuously, as she has an obvious incentive to retain the good will of her caregivers, especially if she is a first-time mother with a natural fear of the unknown. If she does voice an objection (or an unacceptable preference), it does not take much to induce a feeling of marginalization that will almost certainly bring her back into line. Feigned amazement at her desire to adopt a position other than semi-reclining for delivery, a soft sneer at her wish to cope without painkillers or to avoid an episiotomy and, if all else fails, the suggestion that she might be putting her baby at risk – all of these stratagems undermine a woman’s confidence in her ability to give birth actively, and increase her fear. Moreover, a woman becomes more vulnerable as the birth approaches, and her ability to resist diminishes progressively. Who wants the delivery room to be a battlefield?

When a woman is fighting for or against, she is not free to attend to herself. Nor, despite the information she absorbs, can she ever foresee all of the possibilities that

may arise. Encouraged to develop offensive or defensive strategies, or a combination of both, mothers find themselves in the insupportable position of having to depend on the people they are strategizing against. A woman seeking a “natural” birth feels tense, because she is under assault, having to prove herself, to produce a perfect experience out of the choices she has made. Often she has to give up her autonomy bit by bit. No wonder that she gives in to the imperatives of the medical machine. No wonder that, her thoughts teeming with “should haves,” she blames herself when she “fails.”¹¹

It is so much easier to follow the script.

But things could be different. An alternative model of care would be less like an assembly line, and more like a branching tree, in which every encounter between a woman and her professional caregivers represented an opportunity for both parties to come to an agreement about which branch to follow. Instead of a system in which women can exercise choice only through ‘refusal,’ we could have one in which women participated in the decision-making process throughout. It is important to emphasize that the idea of woman-centred maternity care does not necessarily imply that every woman will choose so-called ‘natural’ childbirth – it means only that women’s part is active and central throughout. Midwives and obstetricians could be our partners in helping us to achieve the kinds of births that we want. If we were confident that our goals were understood and respected, we could accept those births that did not work out as we had hoped, knowing that we, and our professional partners, had done our best.

Conclusion

I have been very critical in this chapter of the system of maternity care in Ireland, describing it as a power regime with obstetricians as the leading players. Any sociologist will tell you that people with power do not give it up voluntarily. It is thus encouraging to hear from the Chairman of the Institute of Obstetricians and Gynaecologists that: “I don’t want to see different camps – one for home confinement one for a midwifery-led unit and for a specialist service. We should all be working together and agreeing the principles... Clearly the voice of women has to be listened to. We can’t go on telling them what they ought to be doing.”¹² It is essential, however, that the integration of services envisioned by Professor

Bonnar does not mean their incorporation to a power regime in which the parameters for giving birth are dictated by a small, medical elite.

In this chapter I have identified a number of reasons to be sceptical that the Irish Childbirth Regime will topple of its own accord. These include: (1) institutional and psychological rigidity arising from the modernization project of active management; (2) the marginalization of women's desire for active birth through its association with home birth; (3) the reproduction of women's subordination in the everyday performance of antenatal care and birth. Women's voices remain largely unheard because the drama of childbirth continues to be performed within a script that disempowers and isolates them, while reassuring obstetricians that – with the exception of a small and eccentric minority – most women are content with the service they provide. Women themselves must therefore ensure that they are included as active partners in the dismantling of the Irish Childbirth Regime, and its replacement with woman-centred ways of giving birth. In order to break the 'charmed circle' of obstetrical power we must have the courage to speak more openly about the fear, anger and dreams that make up women's hidden experience of the drama of childbirth.

Notes

1. Cuidiu-Irish Childbirth Trust, Preparing Together for Birth and Beyond: A Consumer Guide to the Maternity Services in Ireland, Dublin: Health Promotion Unit, 1999; Sylvia Thompson, "The rise of the 'perfect, pain-free' childbirth," The Irish Times, 31 January 2000; Rotunda Hospital Dublin, 1997 Annual Clinical Report, <http://www.rotunda.ie/publications/report97.html>; Colin Kerr, "Management of first labour can reduce the need for C sections," Irish Medical Times, Vol. 34, No. 42, 2000, <http://www.imt.ie/news/vol161/11909.php3>.

² James C. Scott, Domination and the Arts of Resistance: Hidden Transcripts, Yale: Yale University Press, 1990, p. 5.

³ See Kieran O'Driscoll, Declan Meagher and Peter Boylan, Active Management of Labour: The Dublin Experience, London: Mosby, 1993.

⁴ Kieran O'Driscoll, "Active management of labour," British Medical Journal 309, 1994, <http://www.bmj.com/cgi/content/full/309/6960/1015>; Kieran O' Driscoll et al. "Prevention of prolonged labour," British Medical Journal 2, 1969, pp. 477-480; Cuidiu, Preparing Together, p. 30; W. Fraser et al. "Effects of early augmentation of labour with amniotomy and oxytocin in nulliparous women: a meta-analysis," British Journal of Obstetrics and Gynaecology, 105, 1998, pp. 189-94; J. G. Thornton and R. J. Lilford, "Active management of labour: current knowledge and research issues," British Medical Journal 309, 1994, pp. 366-369, <http://www.bmj.com/cgi/content/full/309/6951/366>.

⁵ Quoted in Thornton and Lilford, "Active management." Tony Farmar, Holles Street: The National Maternity Hospital 1894-1994, Dublin: A & A Farmar, 1994, p. 150, Eoin O'Malley, Industry and Economic Development: The Challenge for the Latecomer, Dublin: Gill and Macmillan.

⁶ Cuidiu, Preparing Together, p. 9 and *passim*.

⁷ Maire O'Regan, "The Ann Kelly Case: the Final Regulation of Irish Midwives," AIMS Journal, Summer 1999, <http://www.aims.org.uk/jnlsum.99b.htm>; Department of Health, Report of the Maternity and Infant Care Scheme Review Group, Dublin, 1997, pp. 20-23; Marie O'Connor, "Fundamental rights the issue at stake," The Irish Times, April 11, 2000.

⁸ Scott, Domination, pp. 45-69.

⁹ Department of Health, Report, p. 65. Marie O'Connor has recently highlighted the extent to which "the concept of informed consent to medical treatment appears to be less well established in obstetrics than in other medical specialities." See "Forced labour: how we manage women in childbirth," The Irish Times, 13 August, 2001.

¹⁰ Scott, Domination, p. 62.

¹¹ Jane Pincus, "Childbirth Advice Literature As It Relates to Two Childbearing Ideologies," Birth 27, 2000, pp 209-213, p. 211.

¹² Niamh Connolly, "All midwifery services should be integrated including home births," Irish Medical Times, 33, 1999, http://www.imt.ie/news/imt_old/news/1999/vol33no40/feature/4.php3.