Childbirth within the risk society

Abstract

Despite the fact that the speciality of obstetrics is considered to be a high risk area, indeed it is estimated that in the UK maternity services account for massive 60% of all the NHS litigation claims burden, scholarly activity in childbirth performance as part of the risk society is relatively underdeveloped when compared to other areas of health. It is the extent of the influence of risk upon the maternity services that makes this underdevelopment especially striking. In an effort to present childbirth as a worthwhile site for empirical investigation and theoretical discussion, this paper attempts to review the sociology of childbirth and to consolidate some of the multidisciplinary contributions made to date on *childbirth within the risk society*.

Introduction and the case for concern

This paper sets out to engage with a range of sociological themes that have been used to investigate childbirth practice in developed, high-income countries. A common thread underpinning the work to be explored gives centrality to the social construction of risk. In particular, this paper speaks to an emerging interest in the analysis of the risk lens, said to dominate maternity care practice in developed, high-income countries (MacKenzie Bryers & van Teijlingen 2010, Symon 2006, Scamell & Alaszewski 2012, Coxen, Scamell et al. 2012, Ruhl 1999, Weir 2006, Reiger 2006).

The paper will unfold in two parts and will give particular emphasis to childbirth performance in the UK. Starting with a brief introduction to the discursive links between childbirth and risk, the first part will go onto visit the principle sociological account of the 20th century transformation of childbirth in developed, high-income countries - the

medicalization critique. The second section of the paper takes medicalization as a point for departure, providing a discussion of its limitations along with an account of certain more recent contributions made through the application of the sociology of the risk society. By way of a conclusion, a summary of the main arguments will be offered.

Childbirth as a site of risk

It is generally accepted that a link between childbirth and fear of potential harm has long since been established within the cultural imagination of the UK and beyond (Brubaker & Dillaway 2009, Van Teijlingen, Lowis et al. 2004, Cahill 2001, Rothman 1982, Michaelson 1988, Lomas 1978). The fact that the majority of women living in the UK choose to birth their offspring within the apparent safety of the acute hospital environment (NHS Information Centre 2009a) can be seen as testimony of the discursive links between childbirth and fear of risk. Contemporary choices around where to perform birth appear to rest upon a risk-averse logic that goes something like this:

> Birth is too hazardous, too risk laden to be managed without the support of intensive surveillance and intervention technology which is exclusively available in the acute hospital environment. Birth therefore should take place in this acute setting *just in case something goes wrong*.

In other words, choices around childbirth appear to be driven by what has been called the precautionary principle, described by Alaszewski & Burgess (2007) as being 'future oriented… cast[ing] the future principally in negative, potentially catastrophic terms' (p 349). On the face of it, such discursive logic appears to be benign or laudable. The battery of intensive surveillance techniques and technological invention offered within the hospital environment are, after all designed to ensure the safety of both mother and baby. What parent, or practitioner, would want to jeopardise the wellbeing of an unborn child or its

mother? This moral discourse aside, it is important to stress that when birth is constructed as being inherently dangerous, demanding acute hospital management, it is constructed as a site of risk (Reiger 2006, Murphy Lawless 1998). Within such risk-averse logic birth can only be legitimately managed under the shadow of what has been called the *virtual risk object* (Heyman, Shaw et al. 2010, Scamell 2011), where fears about disasters which might happen in the future have a normative function on the present by confining legitimate decision making. This is not to say that mothers across the country are being duped into conceding to a risk-averse discourse, far from it. The proposition being made here is that by making the decision to go into an acute hospital setting to give birth, women position themselves as active agents in the constitution of this risk-averse discourse.

What is particularly interesting in the UK context is that while maternity health policy up until the 1970s officially endorsed the link between birth and fear of potential harm, the ground-breaking Winterton Report (House of Commons 1992) published in 1992 marked a departure from such explicit governmental validation. Furthermore, it has been suggested that maternity health policy since that time has privileged a concordant and potentially subverting discourse (Walton & Hamilton 1995), where childbirth need no longer need to be seen as particularly hazardous. In 1992, the House of Commons Health Select Committee on Maternity Services reported that:

> 'This Committee must draw the conclusion that the policy of encouraging all women to give birth in hospital cannot be justified on grounds of safety' (House of Commons 1992 pp XII).

Furthermore, the report goes on to state:

> 'There is no convincing or compelling evidence that hospitals give a better guarantee of the safety of the majority of mothers and babies. It is possible, but not proven, that the contrary may be the case' (ibid. p. XII).

These conclusions represent a radical departure from previous maternity policy. In particular, they position women's birthing bodies in relation to safety and risk in a new and novel way.

Previous to this 1992 report, policy recommendations coalesced around the understanding that birth is inherently unreliable, unpredictable and risky. Women's bodies, when birthing, were represented as posing a nebulous threat to the well-being of both the mother herself but perhaps more importantly, to her unborn child. Due to these perceived risks, government recommendation was that **all** births should take place within the hospital environment (Department of Health and Social Security 1970), where all the necessary technology and expertise are close at hand *just in case*. The Winterton report by contrast, refused to accept that the majority of births posed a physical threat to the mother and baby (House of Commons 1992 pp V point 4). Despite these drivers however, hospital birth rates in the UK, and the associated interventions such as surgical birth rates, remain stubbornly high (Hospital Episode Statistics 2010).

Within the UK context, the picture is further confounded by the fact that midwives are the most senior health professional present at the majority of births (NHS Information Centre 2009b). This is important because midwives purportedly position themselves with respect to birth technology and medical intervention and surveillance in a very particular way (Cahill 2001, Walsh & Steen 2007, Gould 2000, Leap 2000, Downe 1997). As the most recent Cochrane review (2008) confirms, midwifery practice is built upon a professional identity which privileges

> 'normality, continuity of care and being cared for by a known and trusted midwife during labour. [Furthermore,] There is an emphasis on the **natural ability** of women to experience birth with **minimum intervention**.' (Hatem, Sandall et al. 2008 p2) [emphasis added].

It should be stressed that this interpretation of midwifery is prevalent within the UK, with one of the principle professional stakeholders, the Royal College of Midwives (RCM), describing midwives as having

> 'an underpinning philosophy of pregnancy and birth as **normal physiological processes**, with a commitment to positive **reduction in unnecessary medicalisation** of normal pregnancy

and birth.' (RCM 2000) [emphasis added]

In other words, midwifery might be best understood as being antipathetic to the precautionary, *just in case* mentality so prevalent in the contemporary cultural landscape of birth performance. That is, according to quintessential midwifery philosophy, midwifery practice operates to defend mothers' interests by resisting the discourse of risk where childbirth is perceived as an accident waiting to happen.

In sum, childbirth means different things in different discursive contexts, furthermore, the relationship childbirth has to risk is, and has been, much contested over the past 20 years. Despite the potential created by this controversy, current performances within developed high-income countries appear to remain firmly entrenched within a risk sensitive paradigm. The question is, what has sociology offered by way of explanation for the apparent resilience of the birth-risk discourse in high-income, developed countries?

Sociology of childbirth - medicalization

Having briefly examined the discursive links between childbirth and risk, and the apparent tensions underpinning those links within the UK, in the second part of this section, I want to go onto look at some of the social science accounts which have been put forward by way of explanation for these apparent tensions.

Prevalent in the social scientific analysis of childbirth has been the medicalization thesis (Rothman 1982, Lomas 1978, Haire 1973, Budin 2007, Reissman 1983, Reissman 1987, Graham & Oakley 1981, Oakley 1984). Drawing from the 1970s sociological critique of the development of medicine (1975, Zola 1972, Freidson 2006), voices, largely from the second wave feminist academic movement, suggested that the 20th century transformation of childbirth has been both culturally and socially iatrogenic for women (arguably it has also been clinically iatrogenic but this more epidemiological focussed critique was a later

development in the literature). According to this critique, with the development of obstetrics and the technologies of obstetrics, came a redefinition of reproduction where birthing women were conceived as being essentially 'uncontrollable, uncontained, unbounded, unruly, leaky and wayward' (Carter 2010 p993). Not surprisingly, within this discursive context birth physiology could no longer be trusted to take its course (Grosz 1993). Or as Brubaker and Dillaway (2009) have put it

> 'Over time, men's control of the practice of science, their development of technology and their establishment of modern medicine caused women's (health, normal natural [sic]) reproductive processes to be socially constructed as 'pathological', 'abnormal' and 'unnatural' or at least in need of continual monitoring. (Brubaker and Dillaway 2009 p34)

Crucially, this literature positions the medicalization of childbirth as something that ought to be resisted. A principle presupposition therefore is that women's social and political welfare can be furthered by their regaining autonomy over childbirth, an autonomy which was lost through the process of medicalization (Wertz & Wertz 1989). Furthermore, midwives are recurrently positioned as pivotal activists in this resistance in this literature (Oakley & Graham 1981, Walton & Hamilton 1995).

Notwithstanding the fact that the medicalization thesis has much to offer in relation to explaining why and how childbirth came to be seen as being potentially pathological, problems emerge with this perspective. Implicit in the medicalization critique is the tendency to juxtapose two mutually exclusive ideological positions championed by two very different social groups. On one side are doctors, in particular male doctors, who are busy pursuing the medicalization agenda under the auspices of scientific advancement (Cahill 2001, Wertz & Wertz 1989, Fox Keller 1990). The reason behind this pursuit varies in the account; however there is general consensus of opinion that it has done little to further women's position in the world. Diametrically opposed to these doctors are women, represented by both birthing mothers and midwives caring for these mothers (Graham & Oakley 1981, Faulkner & Arnold

1985, Fox Keller 1992, Oakley 2004, Oakley 1992). These women (mothers and midwives) are generally assumed to take a very different position, instead of seeing childbirth as medical crisis or as a state of potential disease, they are represented seeing this physiological process as being a normal social event (Bryar 1995, Downe & McCourt 2008, Edwards 2006, Kirkham 2002, Leap 2000, Misago & Murphy-Lawless 2000, Newburn 2006, Rooks 1999, Rosser 1998, Walsh & Newman 2000). An event moreover, that can be managed in most cases within the context of normal family life.

What this two dimensional analytical framework fails to capture is why, despite the fact that midwives continue to be the most senior practitioner present in the majority of births in the UK, does the medical model of birth continue to hold its grip upon birth performance. Moreover, far from contemporary birth practice being characterised by exclusive medical control, current trends indicate that a process of women centred care has been privileged (Bourgeault & Declercq et al 2001, DH 1993, 2007, Mander 2004), where user/consumer involvement is embedded within every level of service delivery, from policy making to quality assurance (Alaszewski 2007). According to the medicalization critique of the late 20th century, such a shift in power would logically operate to unsettle the current trends towards the intensification of the medicalization of birth. However, maternity statistics tell quite a different story where a common-sense precautionary principle of *just in case* (Johanson & Newburn et al 2002, Mander 2008) still prevails, dominating choices made by doctors, midwives and women alike. It is not the intension here to argue that such apparent shifts in the power relations necessarily negate the case put forward by the writers previously mentioned, it does nonetheless suggest that other more recent theoretical perspectives, namely the social theory of the risk society with its interest in individualised reflexivity, may have much to offer in explaining contemporary birth performance.

From medicalization to the risk society

Having explored childbirth performance as a site of risk and briefly visited the medicalization critique, the discussion will now move on to look at the contribution made through the application of the social theory of risk to the analysis of childbirth practices in developed, high-income countries. In this section of the paper two themes will be introduced. The first can be broadly thought of as the risk society theme, while the second, the intensification of parenting theme. In is not the intension here to suggest that this literature falls neatly into these themes. On the contrary, in contrast to the configurations suggested by Lupton (1999), Zinn & Taylor-Gooby (2006) and Mythen (2008), the literature under review in this section of the paper draws indiscriminately from various aspects of the risk debate ranging from social, cultural and governmentality perspective of the risk society. The purpose of this section of the paper is not to develop a typology rather it has the much less ambitious aim of engaging with the emerging interest in the analysis of childbirth from the risk theory (however that theory is categorised) perspective.

Theme 1, the risk society

Pre-eminent in the risk society debate, or at least in its beginnings, has been the work of Beck (1992). Although Beck's thesis has been much contested (Mythen 2007, Elliott 2002), his theoretical conceptualisation has been increasingly applied to the sociological analysis of childbirth performance in developed, high-income countries. It is Beck's interest in how the inevitable dangers of life have been selectively amplified and translated into risks in the current post-industrial epoch and how these translations of hazards into risk technologies and expertise operate to heighten social anxiety, facilitating reflexive modernisation that makes his work so appealing for this analysis. As Cartwright and Thomas (2001) point out:

> 'Danger has always attended childbirth… Danger was transformed into biomedically constructed and sanctioned notions of risk. This was more than a semantic shift: Dangers

> implies a fatalistic outlook on birth, risk implies an activist stance' (Cartwright and Thomas 2001 p. 218).

Taking a social-cultural view of risk, these authors point out that risk articulation in contemporary childbirth practice is a peculiarly modern social activity, echoing wider societal dynamics of the risk society. As such childbirth risks should never be conceived as being self-evident and impartial, scientific calculations of potential hazard. In their analysis of professional activity in relation to risk, Cartwright and Thomas argue that once sensitivity to a particular risk has been established, regardless of the links to probability which can often be quite tenuous, health practitioners are professionally bound to persuade the women in their care that these risks not only warrant concern, they demand technological surveillance and management. A good example of this might be the resilient commitment to the hospitalization of childbirth. Despite ever increasing epidemiological evidence that home birth and midwifery-lead birthing units are equitable to acute hospital settings on safety grounds, and that the latter is associated with significantly more clinical iatrogenic risk to mothers (Brocklehurst & Kwee 2011, Beech 2000), the vast majority of births in the UK, and else-where, continue to take place within the acute hospital setting (Hospital Episode Statistics 2010). As such risk in the context of contemporary childbirth operates as much as a moral discipline as it is does a scientific calculation of probability.

Using Beck's thesis as a framework for explaining childbirth practices in high-income countries, Lane (1995) observes that despite ever increasing safety, in terms of both mortality and morbidly outcomes, childbirth continues to be framed within a discourse of risk. She points out

> 'It is the case that debates about childbirth will most likely continue to pivot around the notion of risk despite the low rates of mortality and morbidity relative to pre-war figures in advanced Western economies.' (Lane 1995 p56)

Sensitivity to the possibility of harm and statistical probability of harm do not seem to be

much related in that as the probability has decreased, so sensitivity has tended to increase. Or put another way, there appears to be an irony underpinning contemporary birth performance, where maternity care is delivered under the mantra of evidence based practice, whilst at the same time is increasingly divorced from the impartial logic of statistical probability calculation. Scientific reason appears to have been subsumed by an aspiration to prevent, manage and mitigate all possible harms. Or as Murphy Lawless (1998) puts it:

> 'The tendency has… increasingly been to define every aspect of pregnancy and birth in terms of risk in a mistaken attempt to cover all possible eventualities. In this sense, the entire female body has become risk-laden' (Murphy Lawless 1998 p. 21).

Taking a more governmentality approach to risk analysis and using interview data with pregnant women close to birthing, Lupton (1999b) has explored the subjugating affects of these contemporary preoccupations with risk in pregnancy and birth. According to this analysis, the reflexive individualisation characteristic of the risk society, can be seen as an apparatus of self discipline where women choose to police their own bodies by seeking constant affirmation from professional expertise and surveillance. Lupton argues that the technologies of pregnancy and birth management have disentangled the unborn baby from its mother, moving the baby 'from the realm of private experience, the sensations and emotions felt by the pregnant mother, to the status of 'public foetus', the object of externalised mechanisms of surveillance and regulation.' (Lupton 1999b, p62).

In a description of midwifery in New Zealand, Skinner (2003) draws more explicitly from Beck, arguing that current practice is symptomatic of the wider risk society which she says is suspended within a paradox of loss of faith and intense dependency upon expert knowledge and technology. This precarious positioning operates to manifest professional anxiety and amplify risk sensitivity. Importantly for Skinner, such anxiety and hyper-sensitivity unsettles midwives' and women's commitments to the spontaneous physiology of birth which in turn

entrenches the risk-averse birth performance.

Possamia-Indesedy (2006) presents empirical evidence taken from 45 interviews with women living in New South Wales, Australia. Through this research she found that not only did the women's narratives about childbirth coalesce around fear and anxiety, the placing of the health of the unborn child above that of the mother was universal. She argues that

> 'the pregnant body has been constructed as doubly at risk and doubly responsible where blame for risk befalling the pregnant woman and the unborn child is predominantly projected toward the woman.' (Possamai-Inesedy 2006 p 409)

What is significant about these findings is that all the respondents talked about their experiences of pregnancy and childbirth through a discourse of risk. That is, these women made sense of their birthing experience within the context of a risk society. Furthermore, this sensitivity to risk did not come out off any tangible experience, i.e. a probability based risk assessment, rather they originated from a fear of possible of risk that lay dormant in their pregnant forms. Probabilistic risk appears to be relatively inconsequential in this context, being disturbed and even substituted by what Furedi (2009) has called possibilistic risk.

In a study of twenty one planned homebirths in Finland, Viisainen (2000) looks at how parents' choices on where to birth their babies, even those that choose home, are driven out of a heightened sensitivity to risk. The evidence from this investigation suggests that just as the decision to birth in an acute hospital environment is driven out of a hyper-sensitivity to risk so is the decision to birth at home. What distinguishes homebirth mothers is their sensitivity to second-order risks, the clinical, social and cultural iatrogenic risks inherent in the hospital birthing environment. While a decision to birth in hospital coalesces around sensitivity to the first-order risks, that is those risks which are assumed to be inherent in the inadequacies of the female form, the decision to birth at home relocates the focus of risk sensitivity away from the birthing body, towards the very technologies designed to negate the physiological

risks threatening mother and baby. 'In the parents' view, Viivsainen argues, 'not crossing the boundary between hospital and home birth made the birth process and perceived uncertainties involved more controllable: in their hands' (Viisainen 2000p 810). She concludes that these mothers can be described as being what Giddens calls reflexive individuals, challenging the accepted practice of hospital birth by assessing the validity of the medical risk discourse (Giddens 1991), demonstrating that paradoxically, sensitivity to risk can operate to both intensify and unsettle the medicalization of birth project.

Weir's (2006) work on the midwifery and the biopolitics of risk in pregnancy in North America takes a similar governmentality perspective to risk as Lupton's (1999b) work described above. Using interview data with midwives and archival sources, Weir argues that risk should be seen as both a security, at the level of population, and a discipline, at the level of the individual. With the shifting of attention away from the safety of mother towards safety of the unborn child, pregnancy has become governed and made visible through risk technologies. Taking exception to the Beck's thesis, Weir is keen to point out that the articulation of risk is incomplete and that by exploring the views of the risk assessors, namely midwives, she is able to examine the lines of fissure in risk governance. That is to say, while Weir recognises the centrality of risk governance in pregnancy management in the US, she suggests that resistance is always lurking and made visible through midwifery activity.

In line with this picture of complexity, a UK based empirical study investigating the midwife's role in childbirth suggests that professional preoccupations with risk, as revealed through midwifery activity during labour, at once unsettle parents' confidence in the birthing process (Scamell, Alaszewski 2012, Scamell 2011) while simultaneously, in some instances, fracturing institutionalised risk-technologies (Scamell 2011). Far from adopting a universally antithetical position to the pathologicalisation of childbirth, as much of the medicalization critique suggests, through their meticulous attention to institutionally defined risk

management with its preconceived trajectories and constant recourse to technological surveillance and record keeping, midwives, Scamell argues, implicitly introduce a sense of danger, an imagined risk (Scamell 2011). Through this activity midwives position birth performance within a framework of risk where fear of a negative outcome obscures the possibility for normality. The midwives taking part in this study were unable 'to describe, talk about and measure normality and low risk, they effectively created an imagined future colonised by potential high risk that could at any moment be made visible through their continual surveillance' (Scamell and Alaszewski 2012 p218).

Despite the ubiquity of midwifery activity that coalesced around risk management technologies, the same midwives engaged in activities that might be described as unsettling these technologies. Through a variety of social mechanisms, including peer support, personal charisma, and creative documentation, the midwives taking part in this research developed ingenious techniques to subjugate the limitations and restrictions imposed by their organisation's risk governance agenda (Scamell 2011). These findings, whilst reminiscent of Weir's work, differ in that the midwives' activity is not seen as resistance to the risk society. Rather, in much the same way as in Viivainen's analysis, Scamell suggests that by unsettling the institutional risk management technologies these midwives are not choosing to ignore risk as such but are simply in the business of amplifying and avoiding a different set of risk priorities - the iatrogenic risks implicit in hospital regimes as well as risks to themselves.

All of the material described in this section of the paper so far, gives centrality to the complexities involved in the social articulation of risk in contemporary childbirth practice. Importantly, through this theoretical centring, midwives and pregnant mothers no longer need to be aligned to a single, unshifting ideological position but can be seen a moving between concordant and often contradictory discursive positions stemming from the complexities and tensities of the risk society as it is depicted by Beck (Beck 1992, Beck 1998). Thus the late

modern transformations of childbirth practice need not be seen as a conspiracy of one group of self interested professionals over birthing mothers and midwives. Rather these transformations can be understood as being part of a wider societal gravitation towards selective risk amplification and sensitivity where, despite the ever increasing levels of safety (and sophistication in the knowledge and technology for measuring and calculating that safety) preoccupations with and fear of certain risks intensify (Taylor-Gooby 2000).

When located within the wider context of the risk society, all the actors involved in the performance of birth – doctors, mothers, their families and midwives - can be implicated in the perpetuation of the *just in case* precautionary principle (Alaszewski & Burgess 2008), regardless of how this principle manifests. Whether this principle is made evident through a hyper-sensitivity to the perceived iatrogenic risks of institutionalised birth, as in Viisvainen's work, or a hyper-sensitivity to the perceived physical risks inherent in the act of birth, as in Skinners and Possamia-Indesedy analysis, is not really the point. After all, as much of this research shows, actors can and do shift effortlessly from one position to another through a perpetual process of reflexive individualisation. Importantly, by making sense of birth performance through the risk society, this performance no longer need be analysed as something that is done **to** women, but instead by considering more recent social theory women can be cast as being active agents within contemporary birth practice.

Theme 2, the intensification of parenthood

The academic interest in the performance of childbirth in context of the risk society arguably sits in a body of work concerned with the intensification of parenting (Douglas & Michaels 2005, Lee, Macvarish et al. 2010, Furedi 2001). Within this literature, individual and collective anxiety about the safety of babies and children drives parents to seek out expert advice, both formally and informally, on how best to effectively identify and manage the

hazards associated with procreation and child rearing. Contemporary risk society parents do not envisaged themselves as being able to care for their offspring without recourse to expert knowledge and opinion (Furedi 2001).

Within the context of the late modern society, it is claimed that becoming and being a parent involves an on-going identity project (Douglas & Michaels 2005) where individuals cautiously choose to reinvent themselves and through the reflective consumption of expert opinion, carefully and arguably with an edge of paranoia, building personalised parenting biographies. According to this body of literature parenting has been remodelled into something which demands the assiduous consideration from both the parent themselves and the parenting expert, something that involves the on-going and precarious negotiation of risks and moreover, something defined by personal uncertainty (Lee, Macvarish et al. 2010). This scholarship, presents a credible case for the relation between risk society (in particular a heighten precautionary principle to risk) and contemporary parenting which can be understood in terms of what Beck's reflexive modernisation (Beck, Giddens et al. 1994), where a hypersensitivity to risk and individualism deepened their hold on the global North's imagination and where, through the emergence of reflexivity, people take on responsibility for building their own personal autobiographies, carefully considering how to negotiate the risks inherent in their family lives (Giddens 1991, Beck, Giddens et al. 1994).

Although the intensification of parenthood thesis assuredly identifies childhood as a nexus of risk where infancy is constructed as period of immense vulnerability, the act of childbirth itself tends to be conspicuous in its absence from this account. Such discrepancy suggests that interest in childbirth in the risk society can be seen to be, at once, speaking directly to this literature whilst failing to be fully aligned with it. One of the thorny obstacles impeding the alignment is the positioning of spontaneous physiology. As outlined above, pivotal to the academic critique of 20th century birth performance has been the antagonistic midwife agent,

guarding women's interests by stubbornly maintaining a professional faith in women's ability to birth and nurture their offspring without recourse to technology (Rothman 1982, Graham, Oakley 1981, Faulkner 1985). In the parenting literature such professional commitments to infant feeding are regarded with suspicion. Here quintessential midwifery activity, that is activity driven out of a nebulous belief in the adequacy of the mother's ability to spontaneously nourish her own child, operates as a moral discourse for subjugation (Faircloth 2010). According to this account, the professional pressure that accompanies the interest to facilitate what might be described as natural mothering, is not only based upon a fragile evidence base, it undermines women's confidence in their mothering skills (Lee 2011).

I would like to argue that this ambivalent positioning of spontaneous reproductive physiology could be where the theoretical underpinnings of the intensification of parenting literature might make its most valid contribution to the childbirth risk society debate. The idea that ideological commitments to the normal physiology of birth can operate as both a discourse for gender liberation and discipline, offers a sophisticated pathway through which to negotiate the theoretical impasses set up by earlier sociological critiques.

Concluding remarks

In this paper it has been suggested, contrary to the earlier medicalization critique, more recently developed theoretical perspectives which give centrality to the risk society, offer a more complete and dynamic description of childbirth performance in developed, high-income countries. Most notable in the risk literature explored above, has been the representations of the discursive complexity and multiplicity of meaning involved with childbirth in the risk society.

Cartwright and Thomas' work reveals the rupture between risk articulation within the context of contemporary birthing performance and the impartial probability calculations assumed to

underpin maternity risk technologies. Skinner adds to this by arguing that an intensification of distrust, accompanied by increased dependency on the technologies of risk within the risk society operates to sharpen anxieties about childbirth. Both show how the articulation of risk should not be assumed to be straightforward or as self evident as it appears at face value. Lupton and Weir's work reveals a political dimension of risk which is at once powerful and incomplete. In Viisainen's and Scamell's work, the contrary positioning of risk in relation to the medicalization project can be seen. From this material it is evident that late modern articulations of risk both heighten and resist the medicalization of childbirth, revealing the complexity and multiplicity of the meaning making involved. Finally, the intensification of parenting literature offers insight into how expert knowledge which promotes normality in reproduction, along with the professional peddling this knowledge, can be analysed as a form social subjugation and as such a site for political concern.

In conclusion then, through the application of risk theory to the analysis of birth some of the unhelpful confines of previous sociological critiques can be surpassed leaving the conclusion that not one of those involved in the performance of childbirth, be they male or female, are simply passive or active, reflexive or unwitting, powerful or subjugated, dependent or independent, risk sensitive or risk immune rather each player is a complex and dynamic mix of all these things.

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