CHAPTER XX CHOICE, RISK AND MORAL JUDGEMENTS: USING DISCOURSE ANALYSIS TO IDENTIFY THE MORAL COMPONENT OF MIDWIVES DISCOURSE

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1. Introduction

In this chapter we examine midwives' discourses in relationship to risk and place of birth. We analyse the ways in which these discourses take place at the intersection of two discrete imperatives: to provide pregnant women with choice over where and how they give birth; and to protect mothers and babies from harm. When midwives assessment of risk of harm during birth is aligned with their assessment of the riskiness of a woman's preferred place of birth then there is little need or purpose in scrutinising this choice. However where there is a misalignment then midwives feel obliged to interrogate the choice, especially when midwives categorise a mother as high risk and they want to restrict the range of choices. In this chapter we focus on the discursive methods that midwives use to shape mothers decisions when pregnant women are unwilling to accept midwives' risk categorisation and/or the recommend place and method of birth. We examine the ways in which implicit moral judgements underpin and are evident in such discourses.

2. Using ethnography for discourse analysis

Discourse analysis at the micro level, examines texts (written, spoken and/or visual) to examine the ways in which language both creates meaning and constitutes relations of power. Through detailed analysis of text (using wide and in some cases disparate range of approaches) the intentional, and arguably more superficial, process of communication can be penetrated to expose discourse as an instrument of power (Fairclough 1992, Weedon 2004). Detailed discourse analysis seeks to move beyond the overt and obvious meaning of the texts, the words and utterance, to the underlying socio-political purpose of the text. Thus discourse analysts are interested in what lies behind the text such as 'participants' role-relationships and their motives/accountability as well as wider institutional/professional and socio-political underpinnings' (Sarangi and Candlin, 2003, 116).

Such methodological approaches focus on the internal structures of language, but can be criticised for their inward and dislocated focus. Through the detailed analysis of text there can be a tendency to overlook the importance of the context from which the texts emerge, especially the conditions under which they are produced and how this shapes their meaning (Sarangi and Candlin, 2003, 116). Analysis of such contextual elements is often limited with little consideration of the context and the ways in which these contribute to purpose and function of the text. Ethnographic discourse analysis seeks to combine the interest in discourse as a form of social action with an analytical sensitivity to the social context from which utterances emerge. From this perspective the finer details of language can be examined not as a dislocated and isolated text but an embedded process of meaning making (Sarangi and Roberts 1999).

The texts we use in this chapter are derived from an ethnographic discourse analysis of midwifery and childbirth that Mandie Scamell undertook in four clinical settings in England in 2009 and 2010. This approach combines a textual analysis of policy documents with the analysis of the ways in which midwives talk and act in their everyday practice. The texts include national policy documents, local clinical practice protocols, interview transcripts and ethnographic field notes and memos. The four clinical settings accessed in the study represent the major settings for birthing and midwifery practice in the UK: doctor-led obstetric units with all the medical facilities for high risk births; midwife-led units, located in a hospital with access to back-up medical facilities if and when a birth shifted from low to high risk category and free standing units where the reclassification of a birth into the high risk category involves an ambulance transfer journey; and the woman's own home.

In this chapter we focus on the texts that specifically relate to midwifes interaction with mothers in the context of choice and safety. We focus on the social context and use textual material from the ethnographic discourse analysis to explore not only the ways in which midwives made sense and defined their work but also the ways in which moral judgement permeated and was expressed through texts. We examine the use of texts as a way of defining the situation and exercising power and explore how midwives, sought to impose their own definitions of the situation. We show how this exercise of power involved them in remaining relatively silent and neutral in some situations but assertive and judgemental in others.

3 The national discourse: Empowering pregnant women through choice while ensuring they are safe

Midwives' discourse are shaped by national discourses on the nature of childbirth and the role and rights of pregnant women. As in most areas of health care these discourses have been shaped by shifting notions of power, especially the shift from the paternalist notion of the individual as the passive recipient of health care to a more 'enlightened approach in which the individual is respected as an active agent exercising power and control through informed consent though as we will show in this section this is tempered by a concern with minimising harm to the pregnant women and her unborn foetus.

The dominant choice discourse

In maternal health, *Changing Childbirth* (Department of Health Report of Expert Maternity Group 1993), identified the ideal of service user autonomy and informed choice as the key element of maternity policy.

Subsequent government policy statement endorsed and provided more substance to the principle of choice. At the 2001 Royal College of Midwives Conference the then Secretary for Health, Alan Milburn, pledged £100 million for maternity services to 'ensure that pregnant women have more choice and access to improved maternity services' (House of Commons Health Committee 2003 p. 4); while in the 2007 *Maternity Matters* White Paper the word 'choice' dominates, appearing no less than seven times in the short preamble address written by the then Secretary of State for Health, Patricia Hewitt. In the White Paper the government gave 'choice guarantee' the Department of Health promising that by 2009 all women were to be offered a choice of birth settings.

This commitment to 'choice' permeates the midwifery discourse on birth and in the professional literature midwifery is position as a mechanism for empowering women by providing them with choice. In this literature midwives are described as politically and ethically aligning themselves with the concept of informed choice and woman-centred care (Walton and Hamilton 1995). That is to say, in their role of being 'with women', the midwives' role is to preserve their client's autonomy in order to facilitate and support woman-centred care. The Royal College of Midwives in a position statement articulates this role in the following way:

> 'Woman-centred care' is the term used for a philosophy of maternity care that gives priority to the wishes and needs of the user, and emphasises the importance of informed choice, continuity of care, user involvement, clinical effectiveness, responsiveness and accessibility (Royal College of Midwives [RCM] 2001).

There is little dissent in the midwifery literature from the view that the midwife's role is to empower women through providing them with choice. For example Crabtree notes that: 'The midwifery model of care... is grounded in supporting women's choice' (Crabtree 2008 p. 106), while Pairman (1998) uses the term 'professional friend' to describe how midwives go about supporting women to give birth in the way they have chosen and believe to be right for them and their babies.

Underlying this discourse of choice is a related discourse of normality, that is by exercising their choice women will choose the most normal or natural birth

(Edwards 2006; Graham and Oakley 1981; Newburn 2006; Walsh and Newburn 2002).

The discourse around choice and safety

The statutory body responsible for the conduct of midwifery in the UK, the Nursing and Midwifery Council (2008) in its professional code for midwifery practice endorses the key role which midwives should play in empowering women albeit the Code does not explicitly use the term choice, the nearest it gets is in the following statements that:

> You [the midwife] must listen to the people in your care and *respond to their concerns and preferences…* You [the midwife] must uphold people's rights to be *fully involved in decisions* about their care (Nursing and Midwifery Council, 2008, paras 8 and 14 emphasis added).

However the Code also placed a major emphasis on the effective use of professional expertise in ensuring safety. The Code required midwives to 'maintain the safety of those in your care', to manage risk and use the best available evidence (Nursing and Midwifery Council, 2008, paras 22, 32-34 and 35-37). In its Midwives Rules and Standards (2004 - the last Rules and Standards to provide a definition of midwifery care), the Council defined midwifery care as a means of ensuring safety and preventing harmful outcomes through:

> *preventative measures*, the *detection of abnormal* conditions in mother and child, the *procurement of medical assistance* and the *execution of emergency*

> *measures* in the absence of medical help. (emphasis added, Nursing and Midwifery Council 2004 p 36)

Thus there is within the Council's discourse a potential tension between actions justified by the scientific expertise of midwives and those based on the choices made by pregnant women. When the two are not aligned and if the midwife anticipates that the woman's choice is risky, that is could result in harm to the women and her baby, the Council makes it clear that the midwife should intervene by counselling the woman about the risks and if women persists in her choice, referring her to a superior and documenting the anticipated 'outcome'*:*

> If you judge that the type of care a woman is requesting could cause significant risk to her or her baby, then you should discuss the woman's wishes with her; providing detailed information relating to her requests, options for care, and outlining any potential risks, so that the woman may make a fully informed decision about her care. If a woman rejects your advice, you should seek further guidance from your supervisor of midwives to ensure that all possibilities have been explored and that the outcome is appropriately documented. The woman should be offered the opportunity to read what has been documented about the advice she has been given. She may sign this if she wishes (Nursing and Midwifery Council 2004 p17).

Comment

At national level the dominant policy discourse centres on choice with advocates of choice arguing that providing women choice over birthing will both empower them and lead to better outcomes. However underlying this

dominant discourse is a discourse about risk and safety that is most clearly articulated in the professional regulatory body, which seeks to qualify the freedom of choice. In this discourse midwives have a duty to intervene if a pregnant woman proposes to exercise her choice in a way which the midwife judges will expose the woman and her unborn child to excess risk. In the next section we will focus on the discourse which midwives use when they judge women's choices are creating preventable risk.

4 Midwives'discourses: choice and risk

In everyday midwifery practice there were two potential areas in which midwives assessment of risk did not align with mother's choices. Midwives' could assess a pregnant woman as low risk and therefore recommended setting in which medical intervention was unlikely such as home or a midwife-led birthing unit while the mother wanted a more medicalised birth in an obstetric unit even an elective caesarean section. In this case the midwives anticipated the risk on unnecessary and harmful medical intervention. In contrast midwives could assess a mother as high risk with an increased probability of an adverse outcome and recommend that she give birth in a more protected setting such as a consultant-led obstetric unit and the mother wanted to give birth in a birthing unit or even at home. We will start this section by considering the role which choice played in the discourse of practising midwives and then explore the ways in which they manage the tension between rhetoric of risk and choice.

Midwives' choice discourse

Choice played a central role in midwifery discourses. For example when we invited Cindy, an experienced midwife to describe her role as a midwife she

centred her description on choice and her role in enabling women to have choice: 'your *whole* role is to support women and be the women's advocate' (emphasis added).

Similarly, when another experienced midwife, Gail, reflected on the role of choice she defined her role as empowering women by providing information enabling them to make informed choices:

> I think informed choice is exactly what it says it is. That women... have the right to choose what they want to choose and believe. And if you have given them all the facts and all the information and they still choose their way of doing things. Their method of birthing or their decision, then more power to their elbows. You know.

However in practice midwives recognised there were limits to choice. As Hope, a senior midwife, put it:

> Some of the constraints... I mean there are criteria... and no matter what the woman chooses she won't be allowed, if it isn't thought to be appropriate. The midwife doesn't have any control over that or any say in that nor does the woman.

In the remainder of this section we will explore these constraints.

Low risk and high safety

Practicing midwives were aware of the harm which medical intervention could cause and sought to avoid the iatrogenic cascade of intervention which could

result it women gave birth in a medicalised environment. For example Fay an experienced midwife described this in the following way:

> You see where I've been banging on about things, like not putting women on monitors, mmm, just not going down that cascade of intervention – you know, that sort of thing, making it all abnormal – well, now all the evidence is coming out to support all that.

However while they were aware of iatrogenic harm and despite their commitment to inform pregnant women of all risks, they often chose not to highlight the danger of birthing in a medicalised environment. For example Hope described the nature of these 'man-made' risks and then noted that she did not feel it was her professional role to tell women about them:

> *Hope*: There is a risk to going to unnecessary intervention and the cascade of intervention, erm, of being in an obstetric unit when actually there is no need to be there. Or even if you have a need to be there, there is still risks of unnecessary intervention and the consequences involved in that.
>
> *Mandie (Researcher)*: And is it the midwife's role to explain those risks to the woman?
>
> *Hope*: [long pause] Mmm, it probably should be but, erm [pause], I don't know whether it is. The thing is, there is just so many risks, there is risks to everything so you have to balance it all out and make sense of it all, it is like, oh I don't know, if you think about it too deeply

[pause]. I think risk management is about more check-ups, more scans, that sort of thing.

Thus Hope did not see it as her responsibility to inform the woman about the evidence of the iatrogenic risks associated with unnecessary hospitalisation, which may include major abdominal surgery. She did not identify these as risk that she had a responsibility for mitigating. Instead she focused on the instrinsic vulnerability of the women's body and subjecting it to surveillance and control through 'more check-ups, more scans'.

All the midwives involved our research were well versed in the iatrogenic risks associated with the medicalisation of birth, and it was a topic that commonly came up in group conversations, which took place in staff spaces where only midwives were present. As Gail noted in the following interview these iatrogenic risks were discussed amongst midwives but not with pregnant women:

Gail: People can see that doctors can cause problems by over intervention, lack of communication, etc... that is, causing, introducing risk and I think everybody would accept that. Or I don't know if everybody would but I think that would be accepted [sigh]. I think, I think yeah. I don't think that idea is too marginalised... I think that amongst midwives, I think that's perhaps the predominant. No, I don't know, I don't know, mmm. You will find out [laughs]. I think it is probably a widely held view and I think that

the majority of midwives think, see that, that iatrogenic risk and they understand that.

Mandie (Researcher): Where would you hear that? Would it be expressed to the women?

Gail: Probably not. They might express it to each other in the coffee room mightn't they? Sort of [pause], you know. I think in the coffee room. They might at labour ward forums. I think that could be I think a lot of it would be unexpressed and taken as a given. Unexpressed or to colleagues really.

While midwives recognised that 'trading-up' using more technology or giving birth in a more medicalised setting exposed pregnant women to iatrogenic risks, they did not actively discourage mother from taking such risks. They were effectively silent about them. The following extract from our field notes shows the willingness of midwife to accept a mother's request for monitoring technology that was not clinically indicated and to which the woman was not legally entitled:

Fieldnotes from a high-risk, obstetric unit Pregnant women was admitted in early labour. On admission, the midwife, Miranda, explained the observation procedures she would have to carry out as part of her routine care and assessment. The mother, however, was not satisfied with the list of surveillance procedures and questioned Miranda, saying:

'What about the foetal monitor? I want to have my baby monitored just for peace of mind.'

> Miranda responded to this by reassuring the mother that continual foetal monitoring was not necessary as she was low risk.
>
> 'If anything happened and there was a clinical indication,' Miranda explained, 'then, of course, the baby would be monitored.'
>
> 'But I cannot possibly do this without the monitor. I just need to know everything is Okay... I couldn't relax otherwise,' protested the mother. Miranda acquiesced, leaving the room to discuss the request with the midwife in charge of the shift and returning with the appropriate equipment to carry out a continual electronic foetal monitoring, in line with the mother's request.

When we later discussed this situation with Miranda, she did not refer to the possibility that such monitoring could start a cascade of intervention rather she placed the responsibility for the decision on the patient and within the sphere of patient choice, arguing:

> It's not up to me, is it? I mean we live in a world where... well, women are entitled to choose, aren't they?

High risk low safety

Midwives discourse around 'high risk' women in setting suitable for 'low risk' women such as the home or birthing centres, were different. They discussed such choices as a challenge and a problem they had to manage. Every 'high-risk' pregnant woman who choose to birth away from the high-risk, obstetrically-run birthing environment, was formally talked-to by a midwife who explained the dangers of her proposed choice and identified the things that might go wrong in

either the mother's or the baby's body. The midwives stressed the importance of recording this discussion in the mother's hand-held maternity notes. Interestingly, this formalised discussion and documentation was not a professional responsibility which we could locate anywhere in the Trust's protocols or guidelines, as Mary an experienced midwife noted in her discussion of the 'advice' which was offered to such women:

> We usually write on their birth plan words to the effect: 'Aware no doctors, no epidurals, reasons for transfer'... I don't think there is any formal guidance on this and now you mention it I don't know how I know to write that!'

When midwives talked about high risk mothers who chose to birth in settings the midwives considered suitable for low risk mothers they tended to see the issues in moral terms. In the following extract Lindi highlights the 'dishonest' aspects of the woman's behaviour and her sense of professional and personal affront at being made to run round like an idiot:

> What I don't like is when, we had an incident not so long ago when somebody was, erm, wanting a home birth had had rupture of membranes, all explained to her, she decided she didn't want to go into the high-risk unit, which is fine. I have got no problem with that but then we were trying to send midwives in to check that everything was okay and she was pretending not to be at home. So she wasn't, so she didn't actually call them until she was in labour. Now I feel that woman had every right to make that decision;

> what makes me cross is that when we were running round like idiots after her.

Lindi clearly saw this as a challenge to her professional identity highlighting the moral implications of the decision, implying that the pregnant woman would be unwilling to take full responsibility for the decision including the blame if something went wrong:

> My line [to the woman] would then be: 'I am more than happy for you to have your home delivery, I am more than happy to leave you alone. If you take that decision and something happens to your baby would you ever forgive yourself?' And I think that makes somebody really think about it so that that would be my way of dealing with it.

Lindi was convinced that if things did go wrong and the outcome was not good for mother or baby, then it would be the midwife who took the blame. She said:

> They [parents who did not accept her advice] are not prepared to actually go to the bottom line and say: 'Okay, I understand that is a risk and *if anything happens I will not blame you*' (Emphasis added).

Lindi's story illustrates the unsettled ground upon which the client's right to choice is placed within the maternity care setting. Although service user autonomy has been endorsed through health policy for almost twenty years, how this is allowed to be expressed is strictly policed through routine midwifery practice, which revolves around the selective identification of risks. Those

women who choose options that are not on the presubscribed menu of choices that have been carefully set out by the midwife, create, through their choices, a site of tension where professional understanding of human rights and risk collide and where professional commitment to the possibility of normality is undermined. It is at these points of collision that the moral loading of risk crystallises into a discourse of deviance and, once loaded in this way, operates to fracture relations between the midwife and her client.

This is evident in Cindy's experience of caring for a woman who had been diagnosed as morbidly obese. Having had two normal vaginal deliveries before in a hospital setting, this woman decided, largely for personal reasons, to opt for a home birth. Following her NHS Trust protocol, which states that women with a 'body mass index at booking of greater than 35 kg/m should be excluded from delivering at either a midwifery-led birth centre or at home', Cindy tried her best to persuade this mother to have her baby at an acute, obstetrically-run site. When the mother refused to accept this advice, tensions arose within the relationship. As Cindy described the situation in the following way categorising the mother as irresponsible because she would not follow her advice as other mothers ensuring they did what was 'right for them and the baby':

> She, erm she, understood that but she was very, well [pause] very adamant that she was going to have a home birth and nothing was going to stop her. She was very challenging in that she was defensive, argumentative, rather than sort of going through the risks with me, and us making a plan together that we were both happy with. She was making clear that it was her that she was going to do exactly what she wanted to do...

> I mean usually women, if you explain to them the reason why they need to do that and the other, they, they are happy to do that because they want to do what is right for them and the baby. But for this case it was really difficult because I knew what I was suggesting according to policies and guidelines was, erm [pause] was the right thing for her, erm [pause] and she was just disagreeing with me at every moment.

Cindy was confident here that she had provided this mother with all the information she needed to make the right choice. In her professional opinion, therefore, this mother was in a position to make a fully-informed decision about where to give birth to her baby. Clearly, Cindy had fulfilled her professional duty of care as it is set out by the Nursing and Midwifery Council and the Trust's protocols in relation to the risks this mother was choosing to take. However as the woman rejected Cindy's advice, Cindy felt she was rejecting her professional expertise:

> The way she reacted made me feel like she didn't care what I thought as a professional. Erm, it almost made me feel like I didn't know why she was coming to see me! It felt like she wasn't listening to any of my advice, she didn't want any of my advice and it made me feel a bit, erm, useless, I suppose.

There was effectively a power struggle. Cindy expected to have authority over what and how risks should be understood, and these, in her professional opinion, should reflect her Trust's policies and protocols. This meant that when her client refused to accept her authority the relationship became almost

pointless in her eyes. The tension created by her deviant client's assertiveness seemed to make Cindy feel uncomfortable, vulnerable even, suggesting that professional identity and her right to authoritative knowledge heavily coincide. When her recommendations were ignored, the basis of her professional confidence fractured. At that point, her role as a midwife was severely compromised, since this role depended upon her maintaining a status gap between them, where she was placed in a position of authority. As Cindy explained:

> When you feel… that everything you're advising [is rejected], it is very hard then to be that woman's advocate because you don't understand what she, what she wants, and what she is saying. You don't understand where she is coming from and it is really hard to go to support her in her decision.

Comment

The midwives we spoke to during this research were very keen to explore the risks associated with the physical process of birth with the women in their care and actively used this information to guide women through their decision making. These were the risks which evoked notions of professional responsibility and accountability and, ultimately, fear of blame. By contrast, those iatrogenic risks associated with the hospital environment remained predominantly unvoiced. These risks seemed to have, at most, tenuous links to understanding of professional responsibility and accountability. Indeed, many of the midwives were uncomfortable talking about such matters with their clients. The moral loading of risk involved a systematic bias, with some risks being highlighted, while others were obscured through midwifery activity.

5 Discussion

Underpinning the discourse we have analysed in this chapter are two types of potential harm, one is grounded in the intrinsic uncertainty of childbirth. Even when there appear to be no warning or danger signs, that is pregnancy and childbirth appear to be normal and low risk, things can go wrong, and this likelihood is increased when there are warning signs and woman's pregnancy and birth is not categorised as low risk. However there is a low probability of things going wrong even is the 'riskiest' option, the home birth. A recent National study conducted by the National Perinatal Epidemiology Unit designed to measure birth outcome against choice of place of birth showed a small but significant increase in negative outcomes for first time mother choosing to have home birth but none for other mothers (Brocklehurst et al 2011). Importantly, if things do go wrong then the consequences can be catastrophic, serious harm even death to the baby. Therefore midwive's discourse around childbirth are grounded in the need for constant vigilance and care (Scamell and Alaszewski, 2012).

The other type of harm comes from unnecessary medical interventions, especially Caesarean section. According to the findings from the Birthplace study risk of medical intervention for all women is significantly decreased in out of hospital birth settings. Some obstetric interventions do prevent worse harm, particularly for the baby. However what the birthplace study does show is that it is difficult to estimate the level of 'life-saving' interventions. The World Health Organization (1985) has made an informed guess that on optimal caesarean section rate would be between 5 and 15 %

of all births, however rates in the UK exceed 25% (HSCIC 2013). Iatrogenic interventions associated with hospitalised births represent a relatively high probability risk compared to the complications of 'normal childbirth' in the non medicalised birthing setting of home (Brocklehurst et al 2011).

Thus in their discourses midwives are balancing two types of risk, the low probability/high consequence risk of normal childbirth versus the high probability/lower consequence risk of medical intervention. In the national discourse over the role of midwives the balance is clearly in favour of normal birth over medical intervention. A review for the Cochrane data base clearly articulates this:

> The philosophy of midwife-led care… is normality, continuity of care and being cared for by a known and trusted midwife during labour. There is an emphasis on the natural ability of women to experience birth with minimum intervention.' (Sandal et al 2013).

Yet when the midwives in our study were faced with two situations, one in which a birthing woman was requesting more intervention than the midwife judged to be appropriate and the other in which the woman was requesting less, they acquiesced without much resistance to the request for increased intervention but were upset by and resistant to the request for reduced levels of monitoring and intervention.

The differences in discourses reflect the power relations. The midwives work in a medicalised environment in which benefits of medical intervention are embedded in documents such as their employers' policies. Midwives select those risks which coincided with Trust protocol priorities, the first-order risks associated with birth,

leaving other more controversial man-made risks unvisited in their conversations with their clients or as Kirkham and Stapleton (2004) put it, just 'going with the flow' .

However the moral guiding of maternal choice through risk selection does not appear to be just a case of midwives passively submitting to protocols over which they have little control. Rather, this is a practice those involved in this study actively pursued out of a consciousness that such careful risk selection was seen as being part of their role as a responsible midwife.

Such selections reflected midwives' narratives around the fragility and untrustworthy nature of normality and their professional duty to be ever vigilant. In contrast to the certainty around medical interventions such as C-sections, which they created some harm but they ensured the safety of the mother and baby, normal childbirth could only be safe once it was over. As Mary a senior midwife put it:

> But I always have here, in the back of my mind, that things can wrong so, that's how, that's how I practice as a midwife. That you know, it can be wonderful but it's wonderful when it is finished. You must be alert to things that can happen. Because I watch very carefully and unpick things and I check everything and erm because things happen. I would put her (the mother) in the bracket of 'at risk' of any risk until, until it is over.

However the uncertainty of normality does not fully explain midwives discourse around mothers requesting less intervention than the midwives judged necessary. Their discourses articulated the mothers' actions as a personal as well as a professional challenge. Not only did they describe how these mothers were rejecting

their expert advice they were also rejecting their values and the personal relationship, for example by hiding from the midwife. As Cindy noted there was a breakdown in the relationship as she could not act as an advocate when her client wanted or what she was saying. Midwives described this rejection as hurtful. She could no longer relate to the mother as a moral and competent human being.

In such discourses the moral dimension of professional practice is visible. As Douglas (1990) has argued in contemporary societies, risk may appear as a neutral technical concept, indeed it is this neutrality that makes it so attractive, and provides legitimacy to the experts who use it. The unease which underpins midwives discourses in relationship to mothers requesting less intervention than the midwives judged necessary comes from this exposure of the moral basis of their work.

6 Conclusion

In this chapter we have analysed a range of discourses around midwifery practice, risk and place of birth. We have shown that the purpose and meaning of texts cannot be considered in isolation but only becomes evident when the relationship between different texts is considered and the creation of these texts is placed within their social contexts. Thus the discourses of mothers' choice and the normality of birth are prominent within both national and practice texts. Yet despite these discourses the proportion of birth subject to medical intervention grows and the proportion of births in the least medically controlled environment remains static. By exploring midwives' discourses around mothers who choose to have more or less intervention than the midwives judge necessary we have been able to explore the moral and

ideological underpinning of midwives' discourse. Midwives tended not to challenge those mother who wanted more medical surveillance and intervention as this tended to go with the flow of their medicalised work. In contrast mothers who wanted less were treated as both a professional and personal threat and as women who were not behaving morally or responsibly.

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