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Midwifery practice and the crisis of modernity: implications for the role of the midwife

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Abstract

Almost since its inception, the concept of modernity was found to display tensions between its emancipatory potential to liberate the human subject from the manacles of tradition, and the application of reason to co-ordinate and control the natural world through scientific knowledge. This paper presents a qualitative analysis of in-depth interviews with 12 midwives about their role in the Irish maternity services and argues that, in a period of late modernity, these tensions continue to manifest themselves in the context of the midwife's role. Although the contemporary period is marked by a loss of faith in scientific truths, widely contested obstetric knowledge and practices continue to exercise mastery over nature while undermining a central feature of the midwife's role—the liberation of the autonomous subject. Drawing on the theory of communicative action developed by the critical theorist Jurgen Habermas, it is argued that the midwife's role in facilitating the autonomous choices of women through communicative action is impeded by the colonization of the lifeworld of labour and childbirth by the technocratic system of obstetrics. Although participants reported that their role involved empowering women and facilitating choices through dialogue congruent with communicative action, data also suggested that participants used strategic communication with clients aimed at achieving particular ends. The use of strategic communication was linked to the way in which the midwife's role is determined to a large extent by the practices and protocols of obstetrics, and also to the notion of client passivity. The instrumental rationality of obstetrics is linked to an outcome orientation to power and money, and a political economy perspective of medicine. It appears that communicative action between midwives and obstetricians is important in bringing about structural changes to facilitate the conditions for communicative action between midwives and their clients.

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Keywords: Midwifery; Republic of Ireland; Childbirth; Habermas

Introduction

In spite of the prominence given to postmodern thinking over the past three decades, the conflicts and tensions that have emerged with the project of modernity continue into our present time (Delanty, 1999). This article, based on a study of midwives' perceptions of their role in the maternity services in the Republic of

Ireland, relates contemporary midwifery practice to the tensions of modernity, in particular, the way in which the autonomous subject has been undermined in the quest to control nature. Drawing on the work of the critical theorist Habermas (1971, 1984, 1987), the kind of action orientation in social relations between participants in this study and women experiencing labour and childbirth is analysed. Participants' experiences of the impact of technocratic rationality on their role in labour and childbirth is theorised in relation to Habermas' notion of the colonization of the lifeworld. Communicative action by midwives as a means of redressing the invasiveness of instrumental rationality

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and facilitating the autonomous choices of women is considered in relation to the study's empirical findings.

The article begins with an overview of the project of modernity and locates the practice of obstetric medicine in the context of late modernity. Since the analysis draws heavily on the work of Habermas (1971, 1984, 1987), an account of his theory of communicative action is presented. The study's methodology is then outlined, followed by the study findings. A discussion follows, in which impediments to communicative action in midwifery are located within a political economy perspective of obstetrics. It is argued that obstetric medicine is orientated to technically regulating nature to achieve the outcome of power and money, and that communicative action between midwives and obstetricians is necessary to enable communicative action between midwives and women in their care.

Modernity: the birth of the autonomous subject and the scientific control over nature

Modernity emerged from rapid capitalist expansion and a series of historical changes arising from the Renaissance, Reformation, the American and French revolutions and the Scottish Enlightenment. The outcome of these changes was the re-shaping of economic, political and social structures and the transformation of the traditional religious worldview to modern secularism. The ideals encapsulated in the concept of modernity promised to emancipate humans from the shackles of tradition and the unified worldview of medieval Christendom (Lyon, 1999). The fundamental notion was that humans would become autonomous from the constraining forces in society, with social order maintained by a political realm based on democratic principles (Delanty, 1999). Modernity was related to the belief in progress and the emancipatory capacity of human reason (Lyon, 1999).

In addition, the modernity project also encapsulated a drive to liberate humanity from what were perceived to be the brutal forces of nature. In early modern thinking, the capacity to dominate nature was central to the autonomy of the subject. The means to do this was through cognitive rationality in the form of scientific knowledge. This was central in the thinking of Kant who asserted that the autonomy of the subject was contingent upon the dislocation of morality from the world of nature (Delanty, 1999). In the struggle to gain mastery over nature, the notion of instrumental rationality gained momentum. As Delanty (1999, p.23) notes:

Nature is the domain of external necessity, an objectivity to be dominated by a self-legislating subjectivity, which eventually uses its newly discovered autonomy to dominate human beings. In this

way the domination of nature and social domination are mutually implicated...reality began to be seen as a human construction and no longer as a representation of a natural order.

The gap between the aspirations of modernity, and its social reality as experienced by social actors began to surface soon after its inception. The autonomy of the subject was undermined by a capitalist mode of production that required the rational and instrumental control of people. Weber ([1930] 2002) referred to this technocratic instrumental rationality as an 'iron cage'. In the *Dialectic of Enlightenment*, Adorno and Horkheimer ([1947] 1979) argue that the mastery of nature as a feature of modernity is also mastery over fear, operationalized through technocratic instrumental reason. In an era of late modernity, however, the 'masters' have come under threat; we are now experiencing a crisis of faith in progress, reason and the validity of scientific truth claims. Obstetric medicine is one area where this crisis of faith has become palpable.

The quest for mastery of science over nature in the realm of childbirth has been interpreted as the patriarchal control by male-dominated obstetrics over all childbearing women (Murphy-Lawless, 1998; Oakley, 1993). Oakley (1993, p. 71) argues that the male role in obstetrics reflects their role in society, and the manner in which they are '...socialised to be masters of their own fates, families and environments.' Obstetrics developed its power through claims of safer childbirth in hospitals under the supervision of medical men. The allying of obstetrics with science attempted to add credibility to its claims. Murphy-Lawless (1998, p.32) states that '...obstetrics is a scientific...dominant discourse which argues that it is making steady scientific progress, steadily revealing more of the 'natural facts' about the female body in pregnancy and birth'. Murphy-Lawless (1998) proposes that the 'facts' presented in obstetric discourses are socially constructed rather than discovered.

The theory of communicative action

Unlike many postmodern thinkers who abandoned modernity as a defunct project, Habermas (1984, 1987), while acknowledging the pitfalls and problems with modernity, nonetheless deemed it to be an unfinished enterprise that held promise and potential. At the heart of his optimism is the notion that a particular aspect of human reason, that based on the presentation of valid arguments through verbal communication, can rescue humanity from Weber's notion of 'the iron cage'. Indeed, Habermas' work is a development of a second kind of rationality identified by Weber, value-rational action, rooted in ethical principles and moral values rather than being success oriented (Weber, 1968). Before

exploring the issue of action orientations further, a brief synopsis of Habermas' work is necessary in order to clarify his theoretical position as it relates to the present study.

In late capitalist societies, Habermas (1984, 1987) identified an increasing sense of goal, success and outcome-orientated culture to the detriment of equality-orientated interactive discourses. He conceptualises society in relation to two perspectives, the *system* and the *lifeworld*. The system represents the aspect of society associated with technical–scientific rationality, and is mediated by power and economic matters. The system requires efficiency and strategic rationality in its operations (Habermas, 1984). Habermas' ideas about the system originate in systems theory, a theoretical perspective concerned with the functional relationship between parts of society (Parsons, 1951). Within the system, the actors' motives are egocentric insofar as they aspire to maximise the individual pursuit of utility or economic profit. Communication, communicative reflection, evaluation of relationships and mutual understanding are minimal (Andersen, 2000).

Habermas developed the notion of lifeworld from the works of Edmund Husserl and Alfred Schutz (Andersen, 2000). For Habermas, the lifeworld refers to the symbolic space where meaning, solidarity and personal identity are linguistically communicated. It is distinguished by reflexive discourse, human rights and relationships, and aims at consensus through reasoned dialogue (Habermas, 1984). Andersen (2000, pp. 332–333) succinctly abridges Habermas' notion of lifeworld as follows:

Lifeworld is the world viewed from a participant perspective, and it is structured through meaningful symbols, communicated through verbal action that is orientated toward understanding. This coordination and integration of action builds on consensus established communicatively through recognising the validity of verbal statements. Therefore content can be subjected to rational reflection and critique in dialogue. ... Action is based on implicit agreement on social interpretations, action goals, morals, and self-understanding. Consensus is based on linguistic communication, which can always, in principle, be contested and made the object of discursive, argumentative later tests.

The lifeworld, therefore, is constructed and reproduced through verbal language, and comprises culture, the social world and personality (Habermas, 1987). It represents an implicit, pre-reflexive knowledge form of taken-for-granted everyday assumptions (Habermas, 1987). It constitutes everyday life revealed in the form of a 'natural attitude' rather than a 'scientific attitude' (Mishler, 1984). It comprises the milieu of understand-

ings and assumption shared within a culture that permeate everyday interactions (Habermas, 1987).

Modelled on an unofficial adaptation of Weber's action theory, Habermas (1984) distinguishes non-social and social action situations, and relates these to two action orientations: Non-social action situations are orientated to success, he argues, and are mediated by instrumental purposive–rational action. Social action situations are of two kinds, depending on their orientation; those orientated to success are mediated by strategic action, while those orientated to reaching understanding are mediated by communicative action. Habermas (1984, pp. 285–286) differentiates these action orientations as follows:

We call an action orientated to success *instrumental* when we consider it under the aspect of following technical rules of action and assess the efficiency of an intervention into a complex of circumstances and events. We call an action orientated to success *strategic* when we consider it under the aspect of following rules of rational choice and assess the efficacy of influencing the decisions of a rational opponent. Instrumental actions can be connected with and subordinated to social actions of a different type—for example, as the 'task elements' of social roles; strategic actions are social actions by themselves. By contrast, I shall speak of *communicative* action whenever the actions of the agents involved are coordinated not through egocentric calculations of success but through acts of reaching understanding.

Success-orientated actions such as purposive–rational action and strategic action are linked to the system, and are concerned with efficiency and outcome. Communicative action, developed from Weber's notion of value rational action, is linked to the lifeworld and represents a kind of action rooted in the ethics of a behaviour, whereupon the goals of the actions are transparent and consciously determined (Weber, 1968).

While recognizing the need for purposive–rational action, Habermas was concerned with the rise of the 'technocratic consciousness,' i.e., the manner in which a range of problems in the world are being viewed in technical rather than ethical terms (Porter, 1998). Indeed, for Habermas, the key conflict in modernity was the tension between instrumental rationality and communicative rationality, 'a conflict which is worked out in the encounter between lifeworld and system' (Delanty, 1999, p. 5). He referred to the 'colonization of the lifeworld', a situation whereupon where the system, with its dysfunctional tendencies, is compelled continually to extend its purposive rationality to the detriment of the communicative rationality of the lifeworld (Andersen, 2000). Habermas (1987) contended that the

colonization of the lifeworld could be impeded by human action in the form of resistance by value-orientated social movements. In this sense, Habermas still holds out hope for the aspirations of modernity through the use of a rationality based on values, ethics and dialogue.

Scambler (1987) used the Habermasian theory outlined here to interpret physicians' and mothers' encounters in the maternity services in a re-analysis of earlier research that had been conducted by Graham and Oakley (1981). Following Mishler (1984), Scambler referred to the physician's perspective as the voice of medicine and the pregnant woman's perspectives as the voice of the lifeworld. He illustrated that physicians exercise power in their speech acts with pregnant women in order to influence a particular course of action. Scambler concluded that in obstetric practices, system rationalization in relation to medicine has led to a colonization of the lifeworld.

Situating pregnancy and childbirth within the lifeworld: a midwifery model of care

A midwifery model of care (or 'new midwifery') has a number of characteristics, namely, a recognition of the normalcy and uniqueness of pregnancy, the development of the individual through the experience of pregnancy, the woman and family as the major decision makers and the sharing of information (Bryar, 1995). The outcome aim is for a live, healthy mother and baby and satisfaction of individual needs (Bryar, 1995). Central to new midwifery are notions of choice, continuity and autonomy and it reflects notions advanced within feminism (Campbell & Porter, 1997). The midwifery model of care is also concerned with reclaiming childbirth as a normal event from its medicalized version, and there is a strong emphasis towards locating births either at home, or in low-technology midwifery units that have a 'home from home' atmosphere. Clearly, Habermas' notion of life-world (outlined above) as a realm associated with a 'natural attitude' as opposed to a 'scientific attitude', and as the domain of action rooted in linguistically negotiated consensus, would be seen as the proper location for labour and childbirth within new midwifery discourses. Indeed it may reasonably be argued that new midwifery is concerned with rescuing labour and childbirth from the technocratic system (apart from the small percentage of 'abnormal' cases) and situating them as normative components of the lifeworld.

Methodology

As indicated, the study aimed to understand midwives' perceptions of their role in the maternity services

in the Republic of Ireland. Access to a sample was negotiated formally via the Directors of Midwifery at each of three maternity hospitals in the Republic of Ireland. Four midwives were sought from the labour ward in each of these three sites. The rationale for using a number of sites was to allow for diverse thoughts and perceptions to emerge and to determine if these were peculiar to a particular site or were applicable more widely. Since a sample of experienced midwives was sought, inclusion criteria were that participants were registered midwives with at least four years postqualification experience in midwifery. In order to access midwives who were experienced in infant delivery, two of these years were to include labour ward experience. This study was focused on the labour ward experience for a number of reasons. The antenatal ward was excluded because of its focus on problems and abnormalities in pregnancy. The postnatal ward is an area where midwives have traditionally expressed the highest levels of satisfaction with their role; this has been associated with lower medical overlay in the work (Askham & Barbour, 1996; McCrea & Thompson, 1995; Robinson, 1990). The present research study aimed to determine midwives' perceptions of their role in the labour ward, an area where the midwife can execute complete autonomy but also an area where the 'medical model' of care appears to dominate in Ireland (McCrea & Thompson, 1995). Participants were required to be working in their present hospital for at least one year in order to ensure that they had experience with the practices and protocols of the unit.

Once permission was gained from the Directors of Midwifery to undertake the study, a statement about the proposed research was sent to each unit and placed on notice boards. The clinical midwifery managers then forwarded to the researcher (B R-R) the names of midwives who volunteered for the study. All participants were female and their midwifery experience ranged from 4 to 17 years. Although management levels were not deliberately sought out, midwives at Clinical Midwifery Manager 2 level were included in this study as they have a clinical caseload. A sample of 12 midwives was selected. Informed consent was obtained from participants and confidentiality assured. In-depth interviews were undertaken with each participant in May and June 2002. These interviews took place at a room in the hospital of employment. A semi-structured interview guide used, with four main issues for discussion identified. These issues included the following: (1) Participants' perceptions of their role, (2) Participants' views on: (a) the active management of labour¹ (b) the

¹Active management refers to 'a set of obstetric protocols standardizing the medicalization of first births. It comprises early amniotomy, high-dose oxytocin, and one-to-one 'nursing', the term it uses to denote midwifery' (O'Connor, 2001).

induction of labour, (3) The degree of autonomy they believed that they held in relation to their work and (4) Wider influences which they considered to impact on their role. All interviews were audio-taped and later transcribed.

Data analysis was facilitated using a grounded theory style of analysis (Glaser and Strauss, 1967; Glaser, 1978, 1992; Strauss, 1987). The central techniques of grounded theory are the constant comparative method, openness to evolving theoretical insights, and theoretical sampling where questions generated from early fieldwork were used to guide subsequent data gathering. Data were initially scrutinized for themes and concepts in a line by line analysis, and comparisons were made between items of data. Issues arising in early interviews were used to guide subsequent interviews. Constant comparative analysis of these themes led to the emergence of categories of data.

Findings

For analytical purposes, midwives' perceptions of their role in the health services have been conceptualized under three categories, namely, the 'autonomy and centrality of the subject', 'the mastery of science over nature' and 'the colonization of the lifeworld.'

Autonomy and centrality of the subject

When asked about the most central feature of their role, along with the primacy accorded to the safe delivery of the infant, virtually all participants presented a version of midwifery where the woman giving birth was the central player. The kind of language used by participants was underpinned by democratic principles and the autonomy of the subject. A number of participants alluded to the concept of informed choice:

Well the ultimate aim is to provide a positive experience with a good outcome ... so again I mean informed choice comes in and explaining everything to them. (No. 7)

...a lot of women will come in and they won't have a clue and that's, you know, quite the way that they want it, you know, but I just feel that from our point of view it's up to us to sort of say to them, 'Look it! you can have this choice, that choice', and give the

(footnote continued)

Feminist sociologists argue that 'active management' of labour facilitates the efficient running of labour wards with its basis that women deliver within 12 h or less, echoing a factory-like efficiency and eliminating individuality (Murphy-Lawless, 1998).

advantages and disadvantages of the whole thing and let them have some information. (No. 6)

Facilitating empowerment and control through partnership was also noted by participants as being an important aspect of their role:

To allow her to feel that her birthing experience is the most ... is positive no matter what happens. That she feels empowered and that it's been good for her. I see my role as being with the woman in labour ... very much a partnership with the woman... trying to facilitate the woman's wishes really. (No. 8)

Just giving them [women] confidence in their own ability to be in charge of what they do. (No. 2)

It's to allow them have some choice and some control over what they want and how to get the best out of their experience. (No. 6)

A number of participants referred to the importance of communication in enabling women's autonomous choices based on the expressed needs of women

...occasionally the women come in with kind of an idea of what they want ... and then that sort of becomes their care because you know what they want and you speak about it ...determine what care you are going to give them ...along with the woman. (No. 10)

However, there was also a sense in participants' accounts that they retained a degree of power over the situation because of their expert knowledge and experience vis-à-vis the women. In this respect, participants informed women about the care they were receiving, and attempted to get the women on their side, with decisions appearing to emanate from the midwife rather than the client.

...to build up her confidence in what you are doing or I suppose the main thing is ...communicating to her what you are doing and getting her trust. (No. 10)

Some participants felt that women handed over their trust to the midwife, which to an extent undermined notions of choice, autonomy and so forth.

...I suppose overall it is probably the midwife, even when you are giving informed choice to women and you tell them about ... available they often will say, 'What do you think?' I suppose ultimately it can be very much influenced by the midwife who is looking after them. (No. 8)

They will be looking to you for advice and obviously that you are doing the right thing for them and that you would be there to fulfil their needs and requirements throughout labour. (No.1)

One midwife who had experienced working in Britain suggested that Irish women may be more passive than their British counterparts:

[Clients] ...were a little bit passive you know— 'I come in here in labour and you do what you have to do with me!' (No. 6).

As the next two sections will suggest, midwives' role in facilitating the choices of women was restricted by policies and procedures set out by consultants, invariably limiting the choices that they could offer women.

The mastery of science over nature

Nowhere in medicine is the modernist notion of the mastery of science over nature more evident than in obstetrics, with routine use of technological and pharmacological interventions. The majority of midwives reported that 'active management of labour' was used in regulating childbirth, though its use reportedly varied among consultants. Participants suggested that consultants used active management more frequently on private patients. Although there were some midwives who defended the moderate use of technology in childbirth, it was clear from most that they were conscious that many interventions occurred literally to manipulate nature for reasons other than the health and well-being of the mother or baby.

Some midwives noted that interventions were specific to the particular preferences of obstetricians, rather than being based on evidence-based medicine:

... and there is various controversies between one consultant here... thinks that the minute the woman is actively contracting, regardless of her parity and her dilatation that she should be on a partograph. (No. 12)

Policies and protocols for the induction of labour were reported to be ad-hoc. Induction occurred for postmaturity anytime around 10 days over the expected date of delivery. This very much depended, not only on fetal well-being on scan, but also on individual obstetrician preferences—'whoever is in the clinic'. (No. 8)

Labour was also accelerated for industrial reasons so as to process as many women as possible in the shortest possible time. In the micro-setting of the labour ward, midwives themselves were caught up in the system of pushing women through.

I know it goes on sometimes because it is a lack of staff and it's easier to put a woman on the monitor if you are short midwives. (No. 11)

... I think you see it used more during the day when there is a big work load ... If you've three inductions

done and you've only two staff after five, you are under pressure to try and get a couple of them ... you are gonna push synto [hormone to accelerate labour] to get..., which isn't the right thing to do, but it does happen. (No. 7)

Interventions were also determined by the civil status of the women in terms of whether she was a public or a private patient. Private patients were subjected to a greater level of interventions because medical consultants were called to attend all private deliveries whether there was a problem at the time of delivery or not, whereas midwives had greater freedom to practise midwifery on public patients

If a private patient comes in ... if they are 1 cm the consultant may come in and do an ARM [artificial rupturing of membranes] on them, where if it is a public patient, you admit, assess and let them do their own thing. (No. 9)

Data in this category suggest that midwives in the study worked in a context where nature was routinely controlled and regulated by technological interventions. This arose, not because a body of scientific knowledge proposed that such interventions were necessary for the health of the woman or baby, but rather because of individual preferences of obstetricians, for convenience, because of staff shortages, or because the woman was a private patient.

The colonization of the lifeworld

A striking, though perhaps not unsurprising finding was the limits to the midwives' role arising from the high use of what they acknowledged to be unnecessary technological interventions in childbirth. In this sense, the 'natural' experience of childbirth viewed in relation to the lifeworld, which participants felt could have been managed without technological interventions was colonized by an over-extended technocratic rationality:

I think that technology has really, I think it has trapped us ... to the degree that we feel if we are not doing something, scanning and I think we do too many scans instead of using our clinical judgements, I mean I am for technology, it has an important place but I think we over use it ... we are in shackles I think and hemmed in by the environment we work in ... if you have a look around the labour ward you will see what I mean the technology, the level of technology staring you in the eye the whole temptation there to use it all the time. (No. 12)

Well in hospital ... basically my understanding is that every woman that comes through the front door automatically goes under the care of a consultant ... so really the midwife, although we try to be the lead

1 professional sometimes we are not able to because of
2 the legal atmosphere. (No. 11)

3 Formal efforts to redress the colonization of the
4 lifeworld were limited in the face of medical dominance.
5 Even the two participants who were most articulate and
6 most forthright in their criticism of medicalization felt
7 that they were restricted within the context of medical
8 power:

9 I am very much aware of the power basis and the
10 politics and I have to work within that ...
11 Obstetricians have a huge influence because of their
12 power and they are still the medical model and it is
13 very hard to get them to change. (No. 11)

14 When you have a dominant obstetrician, he tends to
15 undermine our confidence in our midwifery skills.
16 (No. 12)

17 Both of these midwives found greatest freedom to
18 practise their midwifery skills without interference by
19 indirectly and informally circumventing obstetric inter-
20 ference rather than directly confronting and challenging
21 obstetricians about the rationale for their practices

22 [Attempt to] ... to keep everything as normal and
23 natural as possible and to keep the medical people
24 and obstetric people on the other side of the door...
25 (No. 11)

26 The best times I enjoy is night duty when you have a
27 client, when you have a one to one with minimum
28 intervention. There's nobody popping in to see
29 what's happening and why isn't she making more
30 progress and putting subtle pressure on you. (No. 12)

31 It appeared that some midwives believed that they
32 were able to exert a greater degree of influence over
33 doctors' decisions than others

34 If there was somebody I suppose less experienced or
35 less able to speak with Dr. [name] ... the way I do, he
36 mightn't have been as open to do that ... (No. 2)

37 Nonetheless, the same participant acknowledged that
38 historical dominance was still a major impediment to the
39 midwife's role.

40 [Maternity care as a system] ...where the doctor's
41 role is enhanced and that a lot of their decisions are
42 based on history and because we always did it like
43 that ... I mean for the most part ... our consultants
44 are here for years and ... there's nothing much new
45 with them they, you know they don't really like
46 change all that much. (No. 2)

47 One participant reported that midwifery managers
48 were limited in their capacity to alter clinical practices
49 because of obstetric resistance

50 I think they have the notion they are managers who,
51 like, would give great time to midwifery practice but I
52 feel they are pressurised all the time by the
53 consultants ... I mean they give good lip service to
54 something and they try in their way but I don't feel
55 totally supported. (No. 12)

56 It was noted that obstetric medicine was reluctant to
57 cede ground over normal labour because it was driven
58 by monetary gain:

59 ...doctors should be saying at every opportunity,
60 'The midwives are the people that know about
61 normal labour and midwifery practice...they're the
62 best ones to give you the care' ...but why would they
63 do that ... so they're not going to give over what is
64 easy money for them really. (No. 2)

65 Data in this category highlight the way in which the
66 midwife's role in assisting women in 'normal' labour and
67 childbirth, ideally a component of the socio-cultural
68 lifeworld, is impeded by the expansion of an instru-
69 mental purposive rationality of the system with its
70 outcome orientation based on power and money.

71 Discussion

72 Data presented above suggest that the central tensions
73 at the heart of modernity dominate and delimit the
74 midwife's role, namely, the way in which the quest to
75 control nature inhibits the autonomy of the subject.
76 Drawing on the work of Jurgen Habermas, it is argued
77 here that instrumental action of obstetric medicine
78 orientated towards success, power and money impacts
79 upon midwifery practice, which is primarily concerned
80 with communicative action orientated towards under-
81 standing. In this sense, the lifeworld of childbirth is
82 colonized by the technocratic system, concurring with
83 Scambler's (1987) earlier arguments regarding obstetric
84 practice. It is further argued that while participants
85 constructed modernist notions of empowerment, con-
86 trol, partnership and choice as central features of their
87 social relations with clients, data suggest that these
88 social relations demonstrated features of strategic rather
89 than communicative action.

90 As indicated in the first category 'autonomy and
91 centrality of the subject,' participants' notions on the
92 central features of their role were consistent with
93 contemporary midwifery discourses about choice and
94 control for women during childbirth, and the midwife's
95 facilitative role in this regard. Since Habermas' (1984)
96 concept of communicative action refers to speech
97 actions aimed at reaching understanding between
98 parties, this type of social action situation constitutes
99 communicative action since it is not orientated to
100 calculations of success. As Habermas (1984) notes, an
101

essential feature of communicative action is that definitions of the situation are negotiated between the social actors. However, it is clear from participants' accounts that not all interactions were of this kind. There were also interactions with women that were, to some extent at least, orientated towards achieving specific ends. These ends included gaining the midwife's trust, or merely communicating to women what the midwife was doing, without inviting alternative 'validity claims' (Habermas 1984, p. 287) from women. These resemble Habermas' other type of social action—strategic action. With active management of labour strategies and medical hegemony, the choices that midwives could really offer to women were clearly limited by the dominance of instrumental rationality. In the world of practising midwifery in the labour ward, the level of instrumental rationality in the form of technical protocols controlled by obstetricians would appear to severely limit the extent to which midwives could engage in communicative action.

Biomedical hegemony does not appear to be the only impediment to communicative action. A number of participants alluded to the issue of client passivity, which is at variance with the notion of communicative action. As Habermas (1984, p. 287) notes

A communicatively achieved agreement has a rational basis; it cannot be imposed by either party, whether instrumentally through intervention in the situation directly or strategically through influencing the decisions of opponents... Agreement rests on common *convictions* [original italics]. The speech act of one person succeeds only if the other accepts the offer contained in it by taking (however implicitly) a 'yes' or 'no' position on a validity claim that is in principle criticizable. Both ego, who raises a validity claim with his utterance, and alter, who recognises or rejects it, base their decisions on potential grounds or reasons.

The primacy accorded to reason in Habermas theorization problematizes the potential of communicative action in midwifery practice, because it demands that both parties can negotiate and argue positions using the power of reason. If, as data here suggest, women appear satisfied to allow midwives to take the lead, and do not have the knowledge or skills to propose a course of action, communicative action becomes problematic. Campbell and Porter (1987, p. 353) draw on Steven Lukes' theory of power to explain the uncritical belief that many women hold in relation to in obstetric expertise, in which both obstetrician and patient 'adopt the voice of medicine' (Campbell & Porter, 1997). Lukes proposed that people's perceptions, expectations and so forth are shaped by dominant discourses of powerful groups; this serves to obscure an adequate under-

standing of power—people then simply accept the existing social order (Lukes, 1974). The kind of consciousness-raising required to re-socialise women would appear to be an enormous challenge for midwives, as it is very time-consuming, and in Ireland at least there is a serious shortage of midwives. Since midwives in the Irish health care system are more restricted in practising midwifery with private patients whose labours are controlled to a greater degree by obstetricians, they have greater potential to enlighten less-well educated women about their choices. However, for these the learning curve is likely to be sharper and their socialization into passive roles more established.

The second category of data, 'the mastery of science over nature' depicted participants descriptions of the routine use of technology in the process of childbirth. Participants were aware that technical interventions were used for reasons other than to enhance the health of the mother or the baby. These reasons included consultant preferences, the acceleration of deliveries in times of staff shortages, and whether the patient was attending on a public or private basis, with private patients being exposed to greater interventions by virtue of the fact that their deliveries were attended by an obstetrician. This amount to the control over nature in the extreme, since such interventions are clearly not undertaken on 'medical' grounds, and the spurious claims of obstetric science are exposed. Participants' accounts suggested that they were aware that many routine interventions amounted to pseudoscience.

Participants' accounts lend some empirical support to the construction of the modern maternity hospital as a factory, with reproduction being treated as a form of production (Begley, 1997; Martin, 1989). The physician acts as the supervisor who regulates the worker (mothers) whose machines produce babies. Begley summarizes the 'active management of labour' plan as follows: All patients are processed through the plan regardless of their preferences or physiology. It involves the artificial rupturing of membranes after one hour since the diagnosis of labour, and IV oxytocin at a standard rate if dilation has not accelerated meanwhile. The (unresearched) plan according to its instigator, has since its introduction, reduced the 'unit cost of production' and permitted staff to be deployed in the labour ward, demonstrating economic motives for its use (O'Driscoll & Meagher, 1980, cited in Begley, 1997). Begley (1997) argues that this amounts to an industrial or economic model of care, a notion supported by data in this study.

Begley's (1997) review of medical research relating to labour and childbirth indicates that many technological interventions and routine practices are not even supported by conventional obstetric research as scientifically sound. This suggests that neither obstetricians nor midwives are implementing evidence-based findings.

Because midwives' role is to a large extent controlled by obstetric practice, they occupy an intermediary role of 'piggy in the middle' (Murphy-Lawless, 1991). There was evidence in this study that midwives increased pharmacological interventions to accelerate labour ('you are gonna push synton') at times of staff shortages, and therefore have a role in sustaining the economic or industrial model of care.

The third category, 'colonization of the lifeworld' described the manner in which the midwife's role is controlled and regulated by what participants deemed to be unnecessarily high interventions in childbirth. The technical-scientific rationality of the system encroaches and penetrates the lifeworld and constructs labour and childbirth as technical problems. Participants who recognized the pervasion of the lifeworld by the obstetric system tended to resort to informal and indirect measures to give space to the lifeworld. These included attempting to exclude doctors from the birthing room if possible, or to enjoy their skills on the night shift while obstetricians slept. These findings echo those of Hunt and Symonds (1995). Participants were aware of their limited power base relative to obstetricians and there was a tendency not to challenge the system directly.

Technical-scientific rationality is mediated by the quest for power and money (Habermas, 1987). Habermas (1987, p. 323) links expert practice with technical rationality and the self-serving quest for monetary gain rather than human service or even personal fulfilment

Technically intelligent adaptation to the objectified milieu of large organizations is combined with a utilitarian calculation of the actor's own interests. The life conduct of specialists is dominated by cognitive-instrumental attitudes towards themselves and others. Ethical obligations to one's calling give way to instrumental attitudes toward an occupational role that offers the opportunity for income and advancement, but no longer for ascertaining one's personal salvation or for fulfilling oneself in a secular sense.

In Ireland obstetrics is a lucrative business where state employed midwives care for obstetricians' private patients (O'Connor, 2001). Public policy in Ireland has been an important factor in supporting the medicalization of childbirth and concomitant demise of autonomous midwifery. That state-employed midwives care for private patients who are 'controlled' by the obstetrician places midwives firmly in the 'obstetric nurse' role. The political economy perspective, linking medical practice to state-sponsored capitalism (Navarro, 1976, 1986) has some support in relation to Irish obstetric practice. The high mortality rate in childbirth in the 1940s in Ireland, unfoundedly attributed to 'home births' and unskilled birth attendants, resulted in changes in public policy

that lead to the setting up of maternity units and hospitals around the country (Murphy-Lawless, 1998). The trend towards hospitalized births increased steadily thereafter; in 1955, a third of births in Ireland took place at home whereas by 1999, the figure had fallen to 0.5% (Kennedy, 2002). The Maternity and Child Health Services (Amendment) Regulations (1956) politically endorsed the basing of maternity care in hospitals by allowing, in many cases, free hospitalization (Robins, 2000). This gave obstetricians access to what was to become the predominant form of maternity care in Ireland, obstetric led maternity services, in hospital units assisted by midwives. This situation contrasts with that in the Netherlands, where healthy women may only avail of free maternity care through the midwife (De Vires & Barroso, 1997).

In Irish maternity units, intervention rates have risen steadily over the past 20 years. The caesarean section rate rose from 7.4% in 1984 to 20.6% in 1999 (Kennedy, 2002). However, the rate tends to vary across maternity units, with a 14.2% caesarean section rate at the National Maternity Hospital to 25.5% at the Rotunda Hospital, with no differences in maternal or perinatal mortality outcomes. The use of epidural anaesthetics has also been arising steadily in the last two decades. By 2000, epidural anaesthetics were used in approximately half of all labours at the three largest maternity hospitals (Kennedy, 2002).

Active management of labour, used in 73% of maternity units in Ireland (Irish Association for the Improvement of Maternity Services, 1995), epitomizes a technical rationality oriented to processing as many women as possible in the shortest possible time. Obstetrics claims that active management is a system to 'produce normality' (Murphy-Lawless, 1998). Murphy-Lawless (1998) argues that a system that 'produces normality' and epitomises efficiency makes a good case for state approval. Obstetricians argue that childbirth can only be seen as normal in retrospect, creating 'patients' out of all pregnant women, and widening their market to the whole of the childbearing population. The use of instrumental reason in matters of childbirth is related to the notion of 'risk', so that every possible 'adverse' development may be addressed with a technical 'fix'. Murphy-Lawless (1998) notes that, throughout its development, the obstetric profession has used claims of safety and the notion of 'risk' to retain control over both women and midwives. Obstetricians have defined 'every aspect of pregnancy and birth in terms of risk in a mistaken attempt to cover all possible eventualities.... and in this sense the entire female body has become risk-laden as the possibilities for something going wrong proliferate' (Murphy-Lawless, 1998, p. 21–22). This 'risk' notion, she argues, has helped obstetricians maintain their monopoly of control over the maternity services and over midwives (Murphy-Lawless, 1998).

Funding necessary for midwife-led units must be sought from the state, whose leaders are influenced by the 'what if' theory of obstetrics (Murphy-Lawless, 1998).

In this study, communicative action as a counter-measure for an over-extended instrumental rationality at the micro-level of the labour ward was found to be limited by the structural obstacles of medical dominance and client passivity. The extent to which the system is sustained by the socialisation of midwives as 'obstetric nurses,' (Begley, 1997, 1999a-c, 2001) also requires further investigation. The ability of midwives to engage in communicative action with clients would appear to depend to a large degree on the ability of midwives to engage in communicative action with obstetricians. Midwives have a greater chance of having the power of their arguments and validity claims heard at the macro-level of the new midwifery movement, yet this social movement depends for its very existence on the agency of individual midwives to engage with it. Campbell and Porter (1997) note that internationally, midwifery care has had only moderate success because it takes time and effort to change existing structures. They do note, nonetheless the levelling off of caesarean rates in the US and the reduction in rates of induced labours in the late-1970s. Recent changes in midwifery education in Ireland, locating it within the higher education sector is likely to equip midwifery graduates with a scepticism of truth claims of science and the ability to develop powers of persuasion and reason required for communicative action.

8. Uncited reference

Lukes (1973)

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