AIMS For a better birth...

Between Agency and Structure

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Sociologist Julie Trottier shows how difficult it can be for women to confront maternity services

In her talk, published in AIMS Journal Vol.1 17, No. 3 (2005),1 Ruth Weston, a liberation theologian and mother of four, argued that those facing an oppressive system could only resort to three options: avoidance, subversion or confrontation. She concluded that we had no choice but to resort to confrontation if we wanted to develop better maternity services that will be less damaging to women. She received a standing ovation.

In AIMS journal Vol.17, No. 4 (2005)2 Alice Charlwood related the enormous difficulty an educated woman faces when confronting midwives, no matter how courteous and well informed she is. She said she felt utterly diminished, even though she had only been role playing. How can we proceed with successful confrontation as advocated by Ruth Weston? Is the fate Alice Charlwood describes simply unavoidable? As the mother of a little girl, I agree with Ruth that we need to improve the situation because I don't want my daughter to suffer the same appaling antenatal care and birth I experienced. However, I am very aware that Alice's account is very realistic and that confrontation carries a huge cost to us. My concern, then, is how can we proceed with a confrontation that will empower, not damage us.

This article is an analysis of the structural violence we face within modern maternity ser vices from a political science angle, looking at how oppression and resistance work. It examines how science and technology are constructed because the seeds of the structural violence within maternity services lie in the building of western medicine. It then turns to theories from Peace Studies to help us understand violence. Finally, it turns to theories exploring the interaction between agency and structure and how our actions are reproducing the structures we operate in, and how our degree of freedom, no matter how limited, allows us to change these structures.

Science and technology are a political and social construct. Theories and techniques never become dominant because they are objectively the most logical or the most accurate. They dominate when the social groups that promote them become dominant.3 Scientific evidence is not a concrete, permanent entity. It is the product of a process that is largely affected by the persistence of an opinion system which functions in relative isolation.4 Scientific evidence becomes a 'fact' if it is adopted by the scientific community for reasons that vary from personality struggles to the market dynamics of scientific publications or the circumstances that cause some investments to be more profitable than others5

As western medicine developed, it appropriated a domain that had been traditionally the preserve of

women and renamed it obstetrics. This happened within a society which is patriarchal, empowering men, and capitalist, where pharmaceutical companies largely fund medical schools. The technologies and practices that were to emerge as the dominant ones within maternity services, technologies that maximised the use of drugs and equipment, were promoted by commercial interests. Practices that treated women as objects rather than subjects were promoted by the views of a patriarchal society. These values shaped the 'scientific evidence' that is presented as 'fact'[6]

The history of science and technology is not a grand march from ignorance to knowledge, from inefficiency to efficiency. In fact, any scientific or technological debate comes to a closure only when enough resources have been invested for the cost of opposing them to become intolerable for their opponents.[7]

One mechanism within the evolution of modern medicine was the legitimisation of some forms of knowledge and the de-legitimisation of others. On 5th April 2006, the Guardian quoted Prof. Maria Fitzgerald from University College London saying, 'Anyone working with pre-term babies would feel intuitively that they're likely to feel pain - but before now we didn't know.'[8] She was referring to brain scans, taken while premature babies were having blood tests, registering a surge of blood and oxygen in the area of the brain known to be linked to pain sensation in adults. Most mothers can tell whether their baby's cry or scrunched up face indicates pain, cold, or hunger, but this was only rated as 'feeling' and therefore disqualified as 'knowledge'. Babies suffering when pricked by needles became a visible reality only when this was observed by expensive equipment and quantitative measurements through machines. This debasement of female knowledge as mere feelings is typical of the manner western medicine has approached maternity.[9] It could have approached it differently, but the mechanisms that were driving it led it to discredit women's knowledge.

Johan Galtung distinguished direct violence, where the author is easily identifiable, from structural violence. The latter leads to the same results as the former, but the complex mechanisms that carry it out usually remain faceless.[10] The social and economic mechanisms that maintain part of a population in poverty and contribute to a decreased life expectancy for that social group constitute a typical example of structural violence. Alice Charlwood's account of her role-playing shows structural violence embedded within midwives' practice.

Staff shor tages that mean home births 'cannot' be attended, birthing pools where we cannot give birth because no midwife has been trained in water births, partial information given to women that prevents them from being able to exert informed consent, invasive and mutilating practices all constitute examples of structural violence against women within maternity services. The important point about structural violence is that there is no single author. It is faceless. It is the result of economic circumstances, of procedure, or of 'scientific knowledge', yet, its results are the same as that of direct violence. Women and babies are wounded within maternity services exactly as if they had been assaulted in a case of direct violence.

Birth is sexual. Women in western society may be free to choose their sexual par tners, but they

definitely are not free to choose their birth. Patriarchal society relies in great part on the control of women's sexuality. As women increasingly acquired freedom in their choice of sexual partner, they progressively lost the freedom of their birth. It seems that women have no more control over their sexuality now than they did three hundred years ago. The manner in which society controls their sexuality has simply changed; it hasn't disappeared.

Cultural violence arises when a production of meaning contributes to justify a form of structural or direct violence.11 The idea evoked earlier, where babies' pain is recognised only when measured constitutes a form of cultural violence. The obstetrician por traying himself as defending the interest of the baby against the mother because 'her emotions are clouding her sense of judgement' is perpetuating cultural violence.

The ideas that a safe bir th is a hospital birth, or that a woman doesn't care what is done to her body if the doctor says it is for the best interest of her child, or that a woman who does care is necessarily an abnormal mother are distortions of reality. Those ideas constitute forms of cultural violence.

While peace studies allowed us to understand the forms of violence better, they were criticised because they didn't make any room for individuals in shaping this reality. With every action, an individual reproduces their social structure, however, their degree of freedom, no matter how limited, allows them to change the structure they operate in. For example, paying for my bread at the bakery contributes to perpetuating a capitalist economy. My daughter going to school contributes to perpetuating the system of legitimacy propagated by that school. So, how can I exert my agency? First and foremost, this is possible through challenging.

Giddens argued that the structural proper ties of social systems, their rules, perpetuate the structure of domination within it and determine the degree of freedom of the actors, their capacity to act and even to think and be aware of their condition.

Within the maternity services in the UK, normative sanctions do not prevent a woman from having a home birth, the production of meaning through interpretative schemes takes care of that. It is embedded in the language of medical practitioners but is also widespread elsewhere. The books available, the videos shown in antenatal classes trap the women in a position where they are stripped of all power over their own decisions. This specific use of language limits the very definition of the pregnancy and its problems. By determining the definition of the problems, the medical professionals control the definition of the possible solutions.

Medical practitioners use a very specific language that allows them to manipulate women into submitting to practices they would otherwise refuse. Any mother who faced British practitioners will undoubtedly have heard the following phrases: 'We want to discuss your options', 'We want to give you support', 'We will allow' 'We will not allow', 'Keep an open mind', 'Keep your options open', 'He/she has delivered hundreds of babies', 'At the end of the day ...' These phrases are systematically used by the medical professionals who refer to such efforts as 'communication'. All of these words are interpretative schemes

because they shape what is legitimate. They place the professional in a better position than the woman to decide on the course of action. This reinforces a structure of domination where women are not subjects, they are objects.

A woman entering her GP's practice to have her first antenatal visit is unwittingly entering this mechanism of social reproduction. If she complies, she will reproduce the structure she is embedded in. If she doesn't comply, a variety of sanctions will be applied to her, most of them informal. The crucial question, to come back to Ruth Weston's point about resistance, is how can this woman who does not wish to comply exert a resistance in a meaningful way, ultimately achieving success? The first step according to this theoretical framework is to spot what she is facing. This is extremely difficult for a woman in her first pregnancy as she is one step behind the practitioner. The professional is used to manipulating this discourse. She will be taken aback, not know how to react quickly enough, will eventually comply and therefore reproduce the structure of domination she is embedded in, reproduce a structural violence she does not believe in, that harms her and her baby.

The first step, therefore, should be for a woman to acquire information. The second step should be for her to understand the structure. Providing she succeeds in these first two steps, she should then proceed to the third step: challenging the structure that is being imposed on her and expressing an alternative one. Very, very few women will be able to come this far, but this exertion will allow them to alter the structure slightly.

We want to discuss your options

When a doctor tells a woman he wants to discuss her options, the first thing she should bear in mind is that there will be no discussion. Discussion means a two-way dialogue whereas the doctor's understanding here is that he will detail the interventions he wishes to carry out in a manner that will show his favourite one in the best light. Whatever options the woman has considered for herself are utterly irrelevant here. A correct translation from the doctor-speak would be 'I want to tell you what I will do to you in a way that will lead you not to oppose'. When a woman agrees to see a doctor who 'wants to discuss her options', she is locked in an unequal relationship for he will use rationalisations she cannot verify. If she opposes the 'options' he wants for her, he will immediately portray her as a 'bad mother' and himself as acting in defence of the baby. This is enough for most women to collapse, no matter how strongly they feel.

If the woman read extensively before her meeting and is actually capable of responding to his rationalisations, he can resort to threat. In 2003, my obstetrician ran out of arguments against me. I quoted Marjorie Tew's research when he claimed home births were not safe. I had written a clear birth plan refusing all interventions, adding that I realised that I could change my mind if I chose to do so. I referred to the research about the cascade of intervention when he claimed that doing interventions early allowed them to avoid interventions later on. He wanted to 'offer' me a medically unnecessary caesarean section in order to circumvent the medical violence I wanted to avoid with a non-interventionist home birth. When he realised he could not dominate me with a medical rationalisation

that would seem authoritative to me and would 'shut me up', he said he could challenge me legally about my birth plan and impose the interventions on me. I was taken aback because I had read about obstetrics, not about law! The only argument I could think of was that Jehovah's witnesses' wishes not to have blood transfusions were respected even when this threatened the life of the mother or baby. He responded that their reasons were religious and not emotional, which is why their wishes were respected. He was actually in full contradiction of English law.

If a doctor tells you he wants to discuss your options, the best individual course of action is simply to say, 'No.' Do not attempt to justify yourself. There are no options to discuss in any case. It is better to corner the doctor into spelling out that he wants to carry out an intervention. This dispels some of the manipulation as it allows you to force him to justify himself. You are always free not to want to discuss options.

We want to give you support

When any medical practitioner says he 'wants to give you support', your best option is also to walk away immediately. 'Support', like 'discuss' are very positive concepts in our culture. How can we turn down someone who wants to give us support? Once again, this is harnessing a concept that is perceived as positive in order to hide a coercive attitude. A medical professional has no wish to 'discuss' anything when he 'communicates' because he 'knows' what is best for the woman. Similarly, he or she has no wish to give any 'support' because that is not his or her job. 'Support' has a variety of meanings. It can mean the medical practitioner wants the woman to be monitored closely by social workers who can ultimately take away her child. It can mean they want her to take drugs so that she will be more obedient to them. The rationalisation here is that, if her 'options' for herself differ from those of the medical profession, it means that she is depressed, irrational or not in her right mind.

If a medical professional offers you 'support', your best option is to walk away because you are trapped. If you accept the 'support', you enter a coercive relationship which will leave you wounded. If you refuse, you appear irrational because no one would want to refuse support.

This does not mean that all midwives and doctors are uncaring and do not wish to offer support. Indeed, a wonderful midwife actually volunteered two of the phrases analysed in this article when I told her I was looking for frequently used manipulative phrases. But you will notice that caring doctors and midwives never tell you that they want to 'offer you support'. They just do it!

We will allow... if...; We will not allow... if...

This is an amazingly widespread phrase. It is amazing because it is technically illegal. 'We will allow a home birth only if you live within twenty minutes of the hospital', 'We will allow you not to have this intervention if ...' English law allows home birth. The same English law forbids intervention without consent. Surely, midwives and doctors know English law concerning their practices? Yet thousands of women hear this phrase during their pregnancy. It is very manipulative because women want good

relations with their midwives so don't challenge it.

Books for pregnant women are great proponents of this phrase. The book What to expect when you are expecting12 is rife with statements such as 'If you are overdue, the medical professional may decide to induce, but he may also allow you a few more days.' The medical professional does not decide anything, he can only advise. If the woman decides against his advice, she is exerting her right under English law. Usually, activist groups seek to change the law because they see it as wrong. In this case, women who are simply asking for the application of English law have to organise as activists. Such phraseology has led the public to believe that medical practitioners have the decision making power.

Keep an open mind

Pregnant mothers are told to keep an open mind by midwives and medical professionals. This is an insidious manipulation, no one would respond saying 'no, I want to keep an obtuse mind'. The manipulation arises as when he says you should keep an open mind, he means that you will have to accept inter ventions you don't want. Obedience to the medical professional's will is therefore portrayed as a positive sign of intelligence and rationality. It is an extremely manipulative phrase that leaves the woman with no alternative but to feel a diminished sense of self. If she persists in using her own mind, then she is portrayed as not having an open mind. If she gives up perceiving herself as the subject and becomes an obedient object, then she is congratulated as having an open mind. No matter which course of action she chooses, she loses. Walking away is the best course of action if 'discussing your options' or the chance to 'receive support' is offered. A copy of English law is the best tool if you are told that you will or will not be allowed this or that. Probably offering a copy of Foucault's and Gramsci's complete works are the best course of action when you are told to keep an open mind.

Keep your options open

This phrase is very similar to 'keep an open mind' and is used in the same way. The options, of course, are only supposed to be the ones chosen by the medical practitioner, not by the woman. The best course of action for a woman who is told this might be to pack up to go home. Indeed, if all options should remain open, then going home is one of them. This should be enough to prevent the practitioner from repeating it, but practitioners using such phrases will probably repeat it all the same.

He /she has delivered hundreds of babies

This is a technical impossibility. As a wonderful midwife once told me, 'The milkman delivers milk and a woman delivers a baby. The doctor cannot deliver any baby.' Of course, a female doctor can, but only after a few months of pregnancy at the very least and hundreds would be impossible. This phrase expresses the complete appropriation of birth by the medical profession. Women no longer deliver babies, they do. In her research, Nadine Edwards explores the paternalistic perception of the female body as weak and as an obstacle to the birth. Using this representation, the doctor sees himself as the hero who wrestles the baby from the body of the mother. It removes all possible sense of achievement a

woman could have in giving birth. This is a deep instinct, and depriving a woman of the satisfaction of bringing a life into the world amounts to maiming her emotionally and spiritually.

Our society is rife with this form of cultural violence. Everyday television series portray heroic doctors saving babies from the weak and screaming bodies of hapless mothers. Making the doctor a hero who does no wrong legitimises his intervention in real life.

At the end of the day...

This phrase is so widespread that the end is often not even enunciated as it is taken for granted (at the end of the day, all we care about is a healthy baby). Every pregnant mother has been bombarded by this phrase. So much so that she often justifies her attempts to have a healthy and empowering birth along this line. Home births are safer than hospital births after all. Research is unequivocal on this point. So, if all we care about is a healthy baby, then maybe respecting mothers' wishes for an empowering bir th is coherent with the only permissible goal.

This phrase is pernicious and violent. It denies women their right as human beings to be subjects instead of objects. No, at the end of the day, we do not only care about a healthy baby. Of course, we do care about the baby, but we also care about ourselves and about our whole families. That is actually the only attitude a healthy human being can adopt. The baby's health is part and parcel of our family's health. This is directly linked with our health. Maiming a woman is not helping a baby.

Maiming a woman satisfies the patriarchal need to have power over women's bodies. This is legitimised in the name of the baby's health.

So, how can a woman confront the oppressive system successfully? A clear contradiction emerges here, between her immediate, short-term individual interest and her long term collective interest as a female. Clearly from an individual point of view, the best course of action should be to refuse the dialogue as soon as one spots oppression. From an individual point of view, avoidance is the best course of action. However, this will not change the structure of domination. So, if we choose avoidance, we may help ourselves but we will not help our daughters. The problem is, if we choose to confront the medical profession, we are performing Ghandian resistance. How many heavily pregnant women want to, or can be, as heroic as Mahatma Ghandi? I know, after having suffered appaling antenatal care and birth, after having faced violence from both the NHS and the independent midwives I thought would be a solution, that I cannot contemplate another pregnancy unless I do it without meeting a single health care professional.

There should be a manner for us to solve this dilemma collectively. We could set up a system whereby the pregnant women never have to enter in contact directly with the health care professionals, or never be alone with them. We could mediate and point out these mechanisms as the woman encounters them. This is the solution promoted within conflict and conflict resolution theories in the case of abusive situations where some interaction must be retained with the abuser, but is this a solution? Is this

practically achievable? Imagination has to be in power here. Simply telling women they need to be more assertive when they face health care professionals is useless. The mechanisms these women face extend far beyond the mere expression of assertiveness

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