

***Lack of Voice or Conspiracy of Silence:***

***midwives, power and speaking out***

*Submitted by Heather Giannaros  
R.N., R.M., B.App.Sc.(Nursing)*

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*Tasmanian School of Nursing  
University of Tasmania  
Launceston, Tasmania, 7250  
Australia*

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## *Summary*

Through my own personal journey of midwifery practice it seems that because we have a lack of voice, and this is indeed how most of us know our worlds of practice, we *unconsciously* engage in a conspiracy of silence. In this instance I use the word “conspiracy” to metaphorically describe a kind of ‘*togetherness*’. This kind of ‘togetherness’ is not wholly desirable, but to me, it has the potential to conjure up a site of struggle, perhaps a site of resistance. If, in *togetherness*, we can keep and maintain our silence, I suggest then, by coming to understand how we may have lost our voices, perhaps in togetherness there is a chance for speech.

This thesis is written from a critical feminist post structuralist perspective calling into question the gendered discursive practices of medicine which have effectively marginalised and silenced midwives and birthing women. For this, and many other reasons, I believe feminist participatory research, its methodology and methods were appropriate for this project. Through sharing our stories (those of women midwives, including myself), actively participating in ‘analysis-in-action’, and the deeper analysis afforded by critical feminist post structuralism, we were not only able to question medicine’s role in our voicelessness, but to expose tensions between ourselves as midwives, and midwifery and feminism.

Throughout this thesis I wonder ‘who I am ?’, and ‘where am I ?’ in an effort to critique the relationships between the subject positions we occupy as women and midwives. By discussing location of the ‘self’ in feminist frameworks, I have endeavoured to raise new meanings for our lack of voice, and bring forth the tensions which surround our silence, and what this might mean for birthing women.

**Statement of Authorship**

This thesis contains no material published elsewhere, except where reference is made in the text of this thesis. Nor has material been extracted whole, or in part from a thesis or project presented by me for another degree or diploma.

In the main text of this thesis no other person's work has been reproduced without acknowledgment.

This thesis has not been submitted for the award of any other degree or diploma in another tertiary institution.

A handwritten signature in black ink, appearing to read 'H. Giannaros', written in a cursive style.

Heather Giannaros

September 1997.

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***Chapter One***  
***Women and Midwives:***  
***subject(s) of silence***

***Becoming a Midwife: is there any more to this ?***

I applied for enrollment into a midwifery course whilst overseas on holiday. I had spent eight months overseas with my husband after having resigned my position as a registered general nurse. I resigned for many reasons, the major reason being a continual feeling of being stifled and silenced by the hierarchies in which I had worked as a nurse in both the public and private sectors.

I was lucky I guess, that I had not been strictly socialised as a child to blindly accept the notions, beliefs and power of others, and while I was taught to be polite and display good manners, (no differently from my brother) I was also brought up to speak out. I was led to believe by my parents and family, that nothing was impossible if you set your mind to it, girl, woman or otherwise. I yearned to find out how I became so disenchanted as a nurse, so I sat myself down on a hot Cairo night and applied for entry into the midwifery course in my home town. Why midwifery ? In my naiveté I thought that by immersing myself in women's work, working with midwives and birthing women, I could feel happy with my work, learning about women, and weren't midwives autonomous in practice (certainly I thought midwives were from a legal perspective)? And it was mainly because of this, I thought, midwives *must* have a voice.

When I started the midwifery course we learnt how to set up delivery trays; which observations to do; how to help the anaesthetist; and what to do with the woman *for* the anaesthetist; when to make the woman and her partner a drink; the importance of cleaning up properly and the implementation of universal infection control precautions; how to deliver babies; what to do in obstetric emergencies; how to scrub

for a caesarean section; how to monitor the fetus; how to deliver more babies; and we also learnt that there were 'alternate women' who wanted to have their babies *naturally*. We learnt all this, *including*, (and despite how some doctors were talked about, often in a negative vein) that obedience to the medical staff and midwifery hierarchy were very important, we also learnt what this might mean in regard to our future employment.

Yes, all of this, but I kept feeling that there was something *missing*, something profoundly wrong. I mean there were the usual problems where the theory learnt in the class room did not meet with the culture of the maternity wards (Clare 1992), and the usual problems, for me at any rate, where no-one seemed to *speak* up about anything. So it was with little wonder that I quickly despaired with midwifery and myself even faster than I had as a general nurse. It was the *something* that was missing that was behind it I was sure, but I couldn't put my finger on it. I was disillusioned that midwives working in an institution seemed to be as enveloped in hierarchy as the rest of the hospital. This drove me to start baccalaureate studies even before completing my midwifery course because I felt there was so much missing from our education when practicing in such a sensitive area of life and death (Barnes 1995).

For me, if midwifery was supposed to be moving on why did I feel such despair over it? I guess I was coming face to face with my 'self' as a midwife who worked within a profoundly patriarchal institution, and my 'self' as a woman who outside of work was used to speaking up, being friendly and having a chat. And for me these two 'selves' are fairly incompatible. Yes, I did curb my speaking 'self' whilst general nursing (there is a certain need in most of us to 'fit' in (Street 1992a, 1995) but I thought that to become a midwife, working in an area which dealt primarily with women, I could become more of the 'self' I am outside of the 'job'. It was such a culture shock - the violence in the place (between doctors and midwives, midwives

and student midwives, and midwives themselves), our apparent lack of voice, and the discreet and overt practices of controlling the speech of others (again between doctors and midwives, and midwives themselves).

***What's in This For Birthing Women?: caught in the 'birth machine'***

It was my own experience of becoming a mother that led me on my journey of many questions. The journey from midwife to pregnant woman is a fascinating one. For me it was also fraught with frustration and confusion as I battled being caught up in the 'birth machine'. The 'birth machine', in this instance as Wagner (1994) defines it, is a 'machine' of technology, science and the power relations structured within it, where the obstetricians sit unopposed in the 'driver's' seat (Young 1995; Gamble 1993; Husband 1993; Chapman 1992). This is when I realised that as a pregnant woman and qualified midwife, as students we were taught no such thing as *women's* issues. I found that my invisibility as a *woman* became more evident as I headed toward the role of 'patient' and became enmeshed further in the 'birth machine'. .

There was no such subject as women's issues in the midwifery course I attended, and as some schools of midwifery are based on teaching within the social boundaries of the midwife/doctor relationship, it was unrealistic of me to expect to learn about women's issues within such a framework. However, women were mentioned continuously, on the wards and in the classroom by midwives and doctors, either in the capacity of the 'patient' or as midwife, but we were never encouraged to critically inquire into the issues of birthing as they appeared to women in the community. Nor were we encouraged to look to our 'selves' as women and what we might have to offer in light of this. Subjects such as postnatal depression were taught to us but these were often referred to as an outcome of the woman's inability or unwillingness to accept her changed social role. It was never suggested that a woman could be tormented for a major part of her life because of the way in which she was treated or regarded throughout her pregnancy, labour or birth. To do that would be seen as



discrediting the 'birth machine', questioning the practice of those who are deemed to 'know' (Young 1995).

What is in maternity care then for birthing women, when the focus seems to be predominately on the systems in which some of us work, rather than on the person it concerns most ? How easily the focus moves from the birthing woman to the doctor when the doctor is in attendance, and where the midwife seems to be complicit in the struggle to keep birthing women silent (Husband 1993). Is it because we keep this silent counsel ourselves, that midwives expect birthing women should also be quiet and just accept their 'place' in the 'birth machine' ?

As part of my trying to understand how 'woman' has all but disappeared from midwifery practice, I became fascinated and engrossed with the emphasis placed on 'experience' by fellow midwives. It appeared on the one hand to be something that one could learn by, and on the other hand it seemed to be some kind of power/knowledge tool (Foucault 1980) that only some could have which is not readily shared.

This was brought to my attention one day at work:

"I was racing out of a labour room to get something, when a midwife of many years experience was passing by, and she commented on the noise the labouring woman I was caring for was making, to the effect of... 'sounds like she'll be having her baby soon, *listen* to her...' and shortly after this the woman did indeed have her baby. I approached this midwife later, (who incidentally has become a good friend and mentor of sorts) and I asked her how she knew what was going on in the room I was working in, when she wasn't even in there? With that she replied, "...there are many things we learn as midwives, and these are never written down but stored away in our mind, lots of practices learnt from experience, but for some reason 'these days' no-one wants to share their experiences anymore."...experience has become a tool for control and power."

(Giannaros, Personal Journal, 1995).

Writing down this conversation helped me to begin to realise that as midwives, we have become detrimental to our own practice, instead of reflecting with and learning from each other.

When I completed my Bachelor Degree of Applied Science (Nursing), I felt my journey of inquiry into our silence and lack of voice was escalating, and that somehow these were interlinked with midwives' and women's experiences. It was during this stage of my search of where midwives' voices might be (if anywhere), I changed my place of work from a labour ward to a birth centre. This particular birth centre came under the auspices of the hospital and offered an alternative to a traditional antenatal clinic and labour ward. In a birth centre, pregnant women are encouraged to be involved in the decision-making processes concerning their pregnancy, labour and birth, and the immediate postnatal period. While I quickly learned the limitations of this type of care (such as those guidelines put in place by *doctors* for the midwives working there to practice within), it did provide time and a space for birthing women to speak. Because of this, I enjoyed caring for women and their families in such a setting, despite the fact that the midwives' hands here were still relatively tied.

We promoted informed choice to the women who chose, and were able to have their baby in a birth centre, and because of this we effectively became cultural and professional pariahs among not only some doctors, but among some fellow midwives too. This was the hardest thing to swallow - are birth centre midwives perceived as 'giving' voice, power and knowledge to others (ie the pregnant woman)? Or do we challenge the way some midwives have come to know their worlds? It was at this point in my career that I started to give more thought to the notion of horizontal violence (Street: 1992a) and how this was coming between my 'self' and my practice, and how it might be used as a means of silencing fellow midwives. It was also at this point that I was beginning to think about further study and the possibility of bringing my journey to some sort of destination.

### *I Am Not Alone: my search for the speaking self*

At this point in my career, I decided to make enquiries about doing a Master of Nursing Degree. I wondered if it might help me to find some answers. I was surprised to find how confronting to my own practice and outlook the contents of the course were. Needless to say I battled the first year, not so much with the workload (I am certainly not suggesting it was easy, quite the contrary, there were many theoretical challenges!), but more with myself, coming to terms with how I and other midwives might be socially constructed, not just in our profession, but as women. However, the path that led me to the writing of this thesis was during one of our many discussions of feminism(s), and what this might mean in practice. I vividly recall my lecturer suggesting to me that...“although there are many feminisms, *you* need to decide and recognise where *you* are coming from in all of this, if one is talking about locating the ‘self’.” (Giannaros, Personal Journal:1995).

In class, whilst learning about philosophers, positivism, post-positivism, feminism and many concepts that were new to most of us, my peers and lecturers shared and discussed stories about being nurses and midwives in practice. For me personally, it was reassuring to know that I was not alone in my feelings of powerlessness and voicelessness, and at last I felt there was a ‘venue’ in which we had a place to speak. This led me to ask, that if in a class room we are able to speak about our stories in practice and find mutual concerns when discussing work-related issues, then surely ‘out there’ (the workplace of midwives), there must be a myriad of voices wishing for a place from which to speak in a supportive environment?

As I continue this journey I find that the knowledge of midwives does not necessarily generate change in the institutions in which we work. But through conversations I discover that despite the numerous problems which may stem from our inability to speak, I am not alone in my quest. I also discover that we keep and maintain our own silence, making it all the more difficult to speak out.

Emerging from our lack of voice and silence is the confusion over how we might define the boundaries of our practice. Here appears to be discrepancies between the legal boundaries of a midwife's practice and the boundaries set on a socio-cultural /professional basis within health care institutions. What I am suggesting here, is that some midwives who work in institutions are not able to practice *to* the limits of their practice. This is because our practice has been usurped by medical practitioners where the role of the midwife is often reduced to that of the handmaiden (Dalmiya and Alcott:1993). Because of our inability to speak, some of us have been forced to learn not how to be 'with woman', but rather how to be 'with doctor' (Gamble:1993; Young:1995). It is little wonder I feel that *woman* has all but disappeared from *midwifery* practice. Worse still, it appears that because of our 'handmaiden' role, midwives have been complicit in disregarding the needs and desires of birthing women. As a friend of mine (the same midwife mentioned earlier in this chapter), suggested not long ago, "Until midwives start caring for and supporting each other, birthing women will continue to be disadvantaged. What we need to do is to sit back and (critically) think about how we treat each other and what makes us like we are" (as cited in Giannaros, Personal Journal:1995). It is on these premises that I have based this thesis.

Throughout the following chapters I take you on a journey which in parts is quite tortuous, and for some may even be confrontational, as I endeavour to expose and explore the tensions related to our silence in practice as midwives and women.

## ***Chapter 2***

### ***Speaking From Experience...***

“A clinical midwife and a student midwife emerged out of a labour ward. The midwife, who has at least fifteen years experience, exclaimed in an exasperated manner, “He (the obstetrician) is responsible for causing the baby to have low APGAR scores,” (a scoring mechanism to assess the baby’s well-being at one and five minutes after birth). I asked her what had happened, and she replied, “He (the obstetrician) asked me to deep suction the baby after she was born, so I did, causing the baby to have a vaso-vagal (a prolonged episode of a slow heart rate and an inability to draw breath triggered by hyper stimulation of the vaso-vagal nerve) and she took a good six or seven minutes to pick up...” I asked then why did she do it when she was aware of the implications. The midwife replied, “I had to, I didn’t want to ruin the woman’s birth experience by arguing. You can never win. It’s all his fault.” The student midwife who had been standing near us, and who had been in the labour ward with the midwife, then interjected, “Yeah, it was really bizarre what a strange.....” She was cut off by the midwife involved who said to the student, “There you are, now you’ve had your Doctor ‘experience’, and no we don’t bother to comment on what’s happened, its not worth it...”

(Giannaros, Personal Journal:1996).

This scenario brings to the fore several tensions revolving in and around midwifery practice. It demonstrates the problematics of midwives being coerced into a conspiracy of silence. These tensions and problems include a lack of willingness to take responsibility for their practice, and robbing women of a birth experience they deserve. By enticing others, by indirect or overt means, we have actively encouraged and participated in our own unique brand of silence, not being able or not knowing how to change this.

It is not the intent of this project to ‘prove’ (as this is antithetical to the philosophical standpoint I have taken in this project) whether it be a lack of voice *or* a conspiracy of silence, but an exercise in examining and exploring how midwives have become silent. Why midwives have succumbed to using silence as a means of engaging in our

worlds will be discussed in terms of power and power relations present in health care institutions. It appears that regardless of where midwives work within institutions, whether it be in labour wards, birth centres or other midwifery based schemes, we are restricted in our practice by the power and language exercised by medical science.

Husband (1993) suggests:

“The midwife is frequently obliged to enter into ‘management by crisis’ where midwife and mother become victims of bureaucracy and the midwife is relegated to the status of ‘silent conspirator’. The midwife is still seen as fulfilling a supportive role for the medical practitioner.”

(Husband 1993:14).

The status of medicine has allowed doctors to dictate the terms and control the boundaries of midwifery practice. Medicine exercises power and control over our practice to a point where we have, in many instances, become the handmaiden (Street 1992b; Young 1995). Weedon (1987) believes that it is a “fundamental patriarchal assumption that women’s biological difference fits them for different tasks” (Weedon 1987: 2). Hence the expectation that midwives are present mainly for the benefit of the doctors. It is because midwives work in a traditionally defined job, that we are subjugated on the basis of our gender, and allowed no place from which to speak. In Australia, maternity services continue to be largely controlled by a biomedical model, one which is enthusiastically and strongly defended by the medical profession (Young 1995). Young (1995) states that:

“Australian midwives have not been allowed to do what they do best: ensure to the greatest extent possible the normality of pregnancy and childbirth. Their role as principal primary care-giver has been steadily eroded over time until, in some places, they are glorified doctor’s assistants.”

(Young 1995:11).

### *Historically Speaking...*

It does appear historically however, that there was a time when midwives could speak clearly and were autonomous in their practice. It was prior to the ‘enlightenment’, before the ‘medicalising’ of birth, when traditional women’s roles were valued as

important contributions to local communities. According to Dalmiya and Alcott (1993) prior to the nineteenth century in the Western world, midwives were women who were 'widely respected members of the community' (Dalmiya and Alcott 1993:222), it was before the effects of the 'Enlightenment' were felt by women. It was the men of modernity, born of the 'Enlightenment', the scientists, the philosophers, the men of religion, who by either direct or indirect means, reduced traditional women's practices to invisibility, as we know them today. The knowledge and skills of midwives were widely renowned and they were often considered 'wise women'. Their range of knowledge was immense, from turning babies in the uterus, thus preventing breech births, to performing abortions and providing practical guidance on 'women's issues', and problems ranging from conception to lactation. The midwives' knowledge of herbal medicine was also vast and included concoctions to 'hasten a protracted labour, reduce the pain of childbirth and inhibit the chances of miscarriage' (Dalmiya and Alcott 1993:222). Midwives were respected by physicians, but by the nineteenth century this was beginning to fade. The midwife's training prior to the nineteenth century consisted of the sharing of personal experiences, including sharing information about difficult births, and attending births from a young age. Some midwives instructed on midwifery in a classroom. Midwives, like most women, were mostly illiterate and information was largely passed on via the spoken word (Dalmiya and Alcott 1993). Dalmiya and Alcott (1993) continue to say:

"Their skill was based on a combination of direct empirical sources, practices, experience and a reliance on a body of beliefs...so it is not at all obvious why they should be so easily discredited...midwifery knowledge was rarely if ever, written down...it was oral, practical and experiential."

(Dalmiya and Alcott 1993:223-224)

With the discoveries of science and medicine gaining importance, the great men of modernity were becoming increasingly respected and recognised via their written words. Meanwhile women's *knowledge*, which was based on hearsay and experience,

became overshadowed and made invisible. Because of this, physicians were eventually able to wrest midwifery from midwives, and develop the 'science' of obstetrics, thereby medicalising the birth process. "It was a triumph of propositional knowledge over practical knowledge" (Dalmiya and Alcott 1993:223).

Gender relations between midwifery and medicine have been understood as representative of the social relations between men and women (Street 1992a). As Dalmiya and Alcott (1993) suggest, midwife's knowledge was based on experience and hearsay, which in scientific (therefore men's) terms are considered unreliable. Because women were not considered eligible for enrolment at universities in the nineteenth and early twentieth centuries, there was no other way, apart from entry into hospitals, in which they could gain what was considered 'reputable' knowledge. Midwives in these times were mostly illiterate, their culture was, as midwifery is today, predominantly an oral culture. Therefore midwifery knowledge and practice was, and still is, rarely ever written down (Street 1992a; Dalmiya and Alcott 1993).

Midwives remained 'unqualified' because of their relative illiteracy and their gender. Historians, who were mostly men, were either disdainful of women's knowledge or ignorant of it, and did nothing to improve the midwives' plight - their practices were omitted from the historian's written accounts. This ultimately led to the situation where surgeons and physicians, with little practical experience, were considered 'experts' over midwives who had an abundance of 'gender specific experiential knowledge' (Dalmiya and Alcott 1993). This situation still exists in labour wards today. In an effort to be sanctioned as having 'proper' knowledge, women who wished to become midwives were forced to undertake institutional training. This 'training' gave (and still gives) no regard for gender specific experiential knowledge, which in other words, can be explained as 'what it is like to be' or 'knowing from the inside' (Dalmiya and Alcott 1993; Hunt and Symonds 1995). According to Street (1995) midwives who are trained in institutions are taught to disregard our gender specific experiential knowledge and our connectedness to women. We are led to



believe that we must care for patients *and* their doctors in predetermined ways (that is, via hospital education and administration) and that *real* midwives are *busy* midwives.

By hospitalising and medicalising childbirth, midwives skills and practices were constrained and confined to the hospital system which fully supported (and still does) the medical model on which obstetrics is based. Midwives were then required to be trained nurses first (therefore already incarcerated into a small sphere of practice) and then to be trained as midwives based on the medical obstetric model (Barnes 1995; Hunt and Symonds 1995). But as Barnes (1995) and Chapman (1992) ask: “Whose interests are being served and what options has this left for birthing women ?” How can midwives, as Shaw (1993) inquires, think “midwifery’ in such a small sphere of practice or space, when one considers our history ? What has happened to midwives skills? Is it as Dalmiya and Alcoff (1993:223) suggest, “...not at all obvious why they could be so easily discredited...”

Men throughout history, have been given the ‘right to be sure’(Dalmiya and Alcoff 1993), a legitimisation of their knowledge and superiority by society. Unfortunately this has been at women’s expense - it has led to the delegitimation of traditional knowledges as scientific knowledge has been pushed to the fore as the only way of knowing (Dalmiya and Alcoff 1993). Dalmiya and Alcoff also believe that this usurpation of our knowledge is, “...not only politically disturbing but epistemologically specious...” (Dalmiya and Alcoff 1993:217). That is, the medicalising of birth has appeared outwardly to be in the best interests of everyone, but in fact lacks real merit. Science has arguably contributed to improvements in maternal and infant well-being, but it has become so pervasive that now it dictates without question ,what *will be*, without regard to sexual difference, or to the well-being of the ‘whole’ person. If midwives continue to serve the medical model instead of the women who enter maternity services, then as Lumby (1991) suggests, the constraints on our practice will remain the lived experience of midwives who work in

institutions. So how can we enable our 'selves' to speak up, to break out of our conspiracy of silence?

### ***Disciplining Midwives...***

It is the dominant discourses of our patriarchal society, such as medical science, which act on midwives, constraining our practice, limiting our access to knowledge and therefore often succeeding to coerce us into 'docile' bodies. (Street 1992a).

Annette Street (1992a) in her critical ethnography of clinical nurses in practice in institutions, suggests that nurses, and in this case midwives, can be considered 'docile bodies' as:

“...disciplining power provides a docile workforce which not only responds to the wishes of others, but responds with speed, efficiency and technical mastery.”

(Street 1992a: 14).

And it seems, as demonstrated by my journal entry below, that medical practitioners do expect midwives to be just that, 'docile bodies':

“...you midwives are here for the doctors, to do as you are told, not to do as you like, endangering women's lives..” (An obstetrician addressing a group of midwives and doctors at a clinical meeting to discuss best practice issues)

(Giannaros, Personal Journal: 1996).

The 'disciplining power' to which midwives are subject in health care institutions can be explained by Michel Foucault's theory of discipline and punishment. According to Sandra Bartky (1990), by placing passive bodies (which in this case are midwives'), under rigid control and surveillance (medical control over midwife's practice) 'docile bodies' become the product of the hegemonic discourses at play. Foucault's commentators, such as Sheridan (1986) and McHoul and Grace (1993) suggest that by repeatedly 'punishing' subjects for veering away from what has been defined as the 'norm' (by dominant others), docile bodies become the outcome of such stringent surveillance. As Spinks (1995) strongly suggests, midwives are often made to pay a

price for speaking up, for example, in the withdrawal of medical, and unfortunately at times, peer support. As Gamble claims in her essay, “The Politics of Childbirth” (1993), midwives who pursue independent practice and speak up about such issues, are often threatened by medical practitioners, and their affiliated groups, with either the withdrawal of support, or are met with blatant refusals of support. This is because of the *myths* created and supported by the discourse of medicine, which strongly suggest that the doctor *knows* best. It is ‘believed’ that midwives who do not follow doctors orders are either dangerous or unqualified in their behaviour (Gamble 1993; Young 1995). This perpetuates the situation, according to Barnes (1995), and despite our rhetoric that we offer ‘choices’ in childbirth, it remains medically controlled and defined, which effectively silences and constrains midwives in practice.

Belenky, Clinchy and Goldberger (1986) believe that “...silent women’s acceptance reflects the powerlessness they have experienced...” (Belenky et al 1986). Thereby, through our silence and lack of willingness to speak up, midwives offer to medicine, an apparent acceptance of their definition and role expectations of what a midwife might be. We appear, according to Robinson (1995), unashamedly to put aside the needs and wants of birthing women in favour of pleasing medicine despite how we really might feel. In her critique of traumas suffered by women birthing in health care institutions in England, Robinson (1995) believes that midwives disempower birthing women by being caught up in hospital practices as set down by the dominant discourse of medicine, by putting the doctor or rules of administration first over the needs of the woman it concerns most, the birthing woman.

### ***Language, Voice and Silence: the essential woman/midwife***

For midwives, trying to find a place from which to speak proves a most difficult and often impossible task. We have been socialised into believing we are ‘essential’ women, who according to Gunew (1990) are the stereotypical, western societal version of what a woman should be: obedient, dutiful and quiet, all subject to the

hegemonic domain of men. In a world which recognises medical science as the dominant discourse, women with their 'lesser' knowledges such as those based on experience and intuitiveness, have little or no place in the hierarchy of health care, and are therefore not acknowledged. Walker (1993) in his discursive ethnography, "On What it Might Mean to be a Nurse", suggests that science as ideology produces a discourse of exclusion and exclusivity which results in silencing Others.

Women's lack of voice, according to Probyn (1993) may exist because we have been coerced into believing we are 'cultural dupes' and therefore have no entitlement to speak. Street (1992a) purports that while we are not 'cultural dopes' we have indeed been enculturated into silence. Spinks (1995) talks of actually having our "spirits broken", which can force us to take refuge in our silence. As mentioned earlier, Spinks strongly suggests there is a price to pay for breaking the 'code' or speaking up.

bell hooks, a black feminist writer, considers that language can be the tool with which power might be exercised, particularly when used in the context of voice and silence (hooks 1986). Cultures rely on the symbols of language to provide meaning for their world where people share specific interests and truths. Language therefore provides a system that shapes the social relations upon which we are reliant if midwives are to have meaningful dialogue with each other (Doering 1992; Street 1992a). Because language shapes social relations, it is part of the power relations within a culture. As Weedon suggests: "language is the place where possible forms of social are defined and constructed"(Weedon 1987: 21).

This is particularly evident in societies and cultures where there are groups who are constrained and restricted in their practices and behaviours. Historically, language (which is arguably *man's* language (Violi 1992)) has been considered rational, based on objectivity and preciseness. Should women want to be considered rational linguistically, if indeed we are able to speak, we are expected to put aside irrational

thought and speech, based on subjectivity and our everydayness, and adapt to using the language of men. For example, midwives must use the language of medicine if we want to be heard (Violi 1992):

“...midwives were asked to present “case studies” at best practice meetings where both doctors and midwives were in attendance. When discussing the actual presentation of such “case studies” midwives were confused and concerned as to how they should make their presentations. The debate was: should they make their presentations the same way as the doctor’s did, or should they base their presentations on what the role of the midwife was in any given “case study” ? The discussion revolved around appearing foolish, and not being listened to if midwives *did* present their “case-studies” in terms of what a midwife does...”

(Giannaros, Personal Journal 1996).

Margaret Barnes, in her critical essay on midwifery education in Australia (1995), states that because of the position midwives are placed in within the hospital hierarchy, silence has become a way of practice, “there has always been a reluctance to raise the issues in an overt way” (Barnes 1995: 20). In view of this, Barnes (1995) argues, midwives need to become more aware of the power and gender issues involved in midwifery care and practice if we want to be able to provide women with the care that they wish for and demand.

bell hooks supports the notion that language is gender situated. In her essay, “Talking Back” (1986), she writes that silence is the sign that women have become submissive to patriarchy, and if it isn’t silence then it is certainly lack of voice because women’s words are often ‘the talking into thin air, the talking to ears that do not hear you - the talk that is simply not listened to...” (hooks 1986: 124). According to Crane (1991) midwives who are unsupported in their actions and interactions usually elect to become silent. It is suggested that silence becomes a woman’s way of knowing within the constraints of her world (Belenky, Clinchy, Goldberger and Tarule 1986). Somer Brodribb believes that for women to break this silence is not only difficult but culturally taboo in western society. She tells us that:

Talking, writing, telling stories out of school: this is what we are forbidden...For us then to speak is difficult, and it seems we must shift from amnesia to aphasia as parts of consciousness appear unreal to us...Being conscious is dangerous, women's memory, women's language, women's body and sexuality have been annulled in the patriarchal tradition

(Brodrribb 1992: xviii-xix).

For some, these words resonate loudly, for others they may seem radical, despite the way in which they are written, for most, these words must have degrees of familiarity, and it would not be very difficult not to recognise, at one level, these tensions and anxieties of loss of speech, or as Brodrribb (1992) puts it: 'aphasia'.

"I've noticed recently, time and time again, when midwives have been sharing stories of practice, (this seems to occur naturally when the labour ward is quiet) or who are talking about issues in practice where they've had a 'gut feeling' (that is, nothing scientific on which to base their thoughts) about a particular woman or baby, as soon as a doctor arrives the conversation either ceases, or takes a scientific and technological turn. Its as if we, the midwives, have no thoughts, knowledge or words of our own which can be made public."

(Giannaros, Personal Journal: 1995)

This journal entry demonstrates indeed how we become aphasic and amnesic in the presence of medicine, and what we *do* and *know* as midwives is made unreal to us as we quickly hide it within our silence.

Further to our 'aphasia and amnesia', is the very real concern of horizontal violence. As many midwives *appear* to value medical knowledge over midwifery knowledge, by overtly speaking of science rather than midwifery, or by maintaining our silence, we outwardly seem to be complicit in the facilitation of 'medical processes' (Street 1992b). We are therefore not often seen actively supporting those who choose to speak of, or carry out midwifery practices, such as birth centre midwives as described by me in the first chapter. Because of this, according to Street (1995; 1992b) our silence, inaction or non-support of peers can lead to low self-esteem among midwives where ultimately we may unconsciously engage in 'victim blaming'. Victim blaming can manifest itself in different ways, including lashing out in frustration, deskilling

and undermining fellow midwives, unfortunately blaming each other for the way we are situated.

Irigaray (1993), a feminist writer who suggests that the gendering of language is no accident, states that until societies recognise that we stem from two genealogies (man *and* woman) and not one (man), cultural injustice towards women cannot be resolved. In her essay, “How She Became Not-He” (1993), Irigaray, along with Brodribb (1992), discusses that sexual difference in language, is non-existent, and this is certainly not by accident. The feminine in language, to use Irigaray’s own words, has become ‘the non-masculine, that is to say an abstract non-existent reality’ (Irigaray 1993:20). Therefore our subjectiveness, our reality and our descriptions of the worlds in which we engage disappear:

...subjective expression and vocabulary associated with women often consists of slightly denigrating, if not insulting terms which define her as an object in relation to the male subject. This accounts for the fact that women find it so difficult to speak and be heard as women. They are excluded and denied by the patriarchal linguistic order. They cannot be women and speak in a sensible coherent manner.

(Irigaray 1993:20).

It could be suggested then, that midwives have been disciplined into silence, and to maintain our lack of voice, there are certain conditions in place. Allen, Maeda and Powers (1991) suggest that language, including the discourse of silence, has become enslaving for midwifery practice.

### ***Based on Experience...***

Lorraine Code (1988) suggests that knowledge based on experience in our society is considered second class compared to *real* knowledge. She provides an example of this in her essay, “Credibility: a Double Standard” by describing a court case where both doctors and nurses were questioned on the witness stand. When lawyers, who were mostly men, questioned doctors, the questions were phrased in terms of what they *knew*. When nurses were called to the witness stand, the questions were phrased

in terms of their *experiences*. It can be assumed then that midwives and nurses should not and are expected to not *know* (Code 1988). Brodribb (1992) believes, along with Code (1988), that experiential knowledge is often put aside in preference to male knowledge and theory. But Probyn (1993) suggests that, in fact: "...experience can nonetheless give us something to speak from" (Probyn 1993:26), thereby suggesting that experience has the potential to create spaces from which to speak.

If experience can give us such a place from which women can speak, then why haven't I been able to speak ? How can I speak? Do I want to speak ? How has it become such a cultural taboo for women to speak (Irigaray 1993)? For most of us: we sit on fences (margin), we copy other people and do exactly as we are told (docile bodies), we don't have proper knowledge (intuition and experience), we are irrational (women), and we don't ask questions (silent). Acting out these myths of patriarchy, how can we possibly find ourselves as women, as midwives, and come to know what we really might be ? Somewhere out there is my self, is your self, but how might we get there if we want to?

The understanding of experience as such in feminist theory "presupposes a subject who can be presumed to know" (Elam 1994:64), thereby recognising that women can be legitimated to know. Some feminists believe theories, particularly those borne of humanist beliefs, which can include feminist theory to be elitist, presuming to tell women how or what their experiences ought to be, and that experience alone should account for knowledge drawn from women's lives (Yeatman 1994). However, Harding (1993) and Weedon (1987) both support the notion that to dismiss theory, for example feminist theory or post-structuralism, out of hand would be to deny women access to various ways of coming to know our lives. "Theory must be able to address women's experience by showing where it comes from and how it relates to material social practices and the relations which structure them"(Weedon 1987:8).



Historically, experience has been important to midwives. As Dalmiya and Alcott (1993) suggest, midwives before the Enlightenment relied on their experiences as women and midwives, to assist women throughout the childbirth process, and were often considered 'wise women' among their communities. They used the knowledges gained from such experiences to generate better practice techniques and in giving improved advice to novice midwives and childbearing women, it was commonplace for women and midwives to sit around together discussing such issues. The experiences of these midwives therefore were the source of knowledge for others, including those of the medical profession, and these knowledges (borne of experiences) were to be *shared* as such (Dalmiya and Alcott 1993).

However, knowledge, it seems, is territorial and it can only belong to certain groups. If a person is a doctor, then that person has legitimate knowledge (irregardless of years of practice), if however a person is a midwife, then that person (who is usually a woman) must follow and accept that doctor's knowledge and all the discourses it represents. These discourses include those of silence and exclusion, as discussed earlier, where we (the midwives), are expected to be 'essential' women, and that we should know our 'place' as such in western society (Gunew: 1990; Street:1992a; Walker:1993). It comes back to the 'modern' view that power and knowledge are commodities that only some can have. Born from the 'modern' notion of the knowledge/power nexus, is the liberal humanist belief that there is only one way of knowing the 'truth', and that is from science, which is representative of man's world. It is through these sets of conventions that most of us have come to identify and understand our positions in the world (Gunew:1990).

Experiential knowledge is important to midwives, but it is not without its tensions. Writers such as Elam (1994), Harding (1993), Street (1995) and Weedon (1987) suggest for knowledges based on experience to be useful and acknowledged they must be disseminated, critically appraised, used in practice, and they must be *talked* about.

In the face of medical science where experiential knowledge is often dismissed, for midwives to talk about it openly and critically proves to be very difficult indeed.

I have articulated in this chapter issues such as our lack of voice in terms of silence, language, the 'essential' woman, and some of the tensions surrounding the values of experience in relation to many midwife's social/professional positioning as Other in health care institutions. The word 'Other' in this sense, is being used to describe the asymmetrical positioning of women in traditionally defined roles, such as midwifery, where our practices are mostly influenced by dominant discourses such as medicine (Walker 1994; Street 1995; A. Robinson 1995).

In the methodological chapter which ensues, I introduce and discuss how feminist research, in the form of participatory research, offers the possibilities of providing a space from which a midwife, like myself and fellow participants can speak if we choose. This chapter discusses the methodology and method of feminist participatory research and how they are intertwined through the underlying theories and epistemologies.

### ***Chapter 3***

#### ***Methodology and Method Intertwined: feminist participatory research***

##### ***Locating the Self***

Feminist participatory research is a methodology which aims to raise our consciousness by analysing critically the experiences of women in an effort to understand how we are socially situated. These experiences, *our stories*, have been made invisible by the dominant discourses that operate in health care institutions. Yes, I believe we are lost in our silence, and in our practice, therefore we are not able to care for birthing women in a way that *they* need and demand. We've lost or never had the opportunity to use or know about our unique knowledges or skills. To look to our experiences, recognizing commonalities and respecting our differences then perhaps one day there could be the possibility of the *midwife's* stories, becoming *her* stories, stories of our own, providing a place from which to speak. Elam (1994) believes: "His-story is but one story, her-story is not one story, as one narrative would make it incomplete" (Elam 1994:38).

Very simply, to do feminist research is to put the social construction of gender at the centre of one's inquiry...Through the questions that feminism poses and the absences it locates, feminism argues the centrality of gender in the shaping of our consciousness, skills and institutions as well as the distribution of power and privilege  
(Lather 1991:71).

One of the main reasons I have pursued feminist participatory research is to explore the assumption that regardless of where midwives work within health care institutions, we are restricted by the language and power relations present in the work place. Our subject position(s) as women and midwives are shaped by our gender and how we are affected by the notions of 'power and privilege'. Within institutions it seems that, on the whole, because of the power relations that are in place, midwife's voices are absent. Lather (1991), suggests that by pursuing a feminist approach to research we

may be able to locate absences such as midwife's lack of voice and the related issues surrounding our relative silence.

The data for this thesis has been drawn from the experiences of the midwives in this project. Knowledge drawn from women's experiences in their daily lives such as the work lives of midwives, is said to be one of the main staples of feminism as it recognises women's 'knowledges' (Yeatman 1994). Therefore by using a methodology such as feminist participatory research in our project, it acknowledges that midwives in institutions can "know". It seems according to the data collected in this project, however, that we, the midwives, who take refuge in silence, have been denied the right to 'know' not only by medicine, but also by each other and our 'selves'. As we understand women's, and therefore midwives' position in our society, we have been led to believe that the concept of women's knowledge is as Walker (1994) states, "trivial, local and naive". In order to find a place from which to speak, it seems then, that first we need to 'uncover' and accept our 'knowledges', that is, our midwifery knowledges. Consciousness raising, through feminist participatory research can offer such a possibility.

### ***Methodology: an integral partner with method***

Methodology and method should be integral *partners* in the feminist participatory research process, if one is to develop meanings and knowledges about women and their lived experiences. Methodology and method enforce the projects' validity, and demonstrate how women can benefit from such a process. Henderson (1995) believes, methodology and method should be as intertwined as theory and practice.

By way of introducing the methodology of this project, and to distinguish it from method, feminist research writers, such as Campbell and Bunting (1991), Stanley and Wise (1990), Cook and Fonow (1990), Henderson (1995) and others, find Sandra Harding's definitions of methodology and method useful:

*Methodology*: provides us with the underlying theory of the proposed research. It prescribes how the research should or does proceed, and its basic principles.

*Method*: is the way in which we gather data, the tools or technique used to 'do' the research. Method in positivistic research is often given precedence over methodology. Consciousness raising, which can be achieved through story-telling and critical analysis between women, according to Henderson (1995), is an example of method in feminist participatory research practices.

As midwives, we have been socialised and educated to think and inquire in terms of positivistic scientific methodologies (King:1993), hence the 'notion of a feminist methodology is an elusive concept' (Cook and Fonow 1990: 70). It is important therefore, when undertaking feminist research, that we, according to Cook and Fonow (1990), acknowledge and take into consideration the concepts of feminist methodology "both its practice in actual research and its underlying assumptions" (Cook and Fonow 1990: 71).

The movement of woman to a speaking position cannot be brought about through discourse alone nor will simply privileging experience provide women with something to say, together, however, they give us insights into how we might say something.

(Probyn 1993:86)

Elsbeth Probyn's (1993) thoughts remind us that our experiences alone are not immune from the influences of the discourses that surround us. These discourses include those that leave us (women/midwives) relatively voiceless, with little or no place from which to speak, for example the social situation of midwives compared to doctors. However, if we critique these dominant discourses in relation to women's experiences, then we may find ways in which to speak up. For me, these thoughts underpin the thrust of feminist research. Positivistic research and technique as I have come to understand them, cannot possibly begin to provide us with an adequate methodology or method for exploring complex issues, such as the subject positions

and experiences of women, and in this project, of midwives. They are not issues which can be measured, interpreted and predicted as such. They are issues which need to be explored, critiqued, and analysed through a reciprocal interaction between the researcher and the participants, where the participants *speak* to the research process (Henderson 1995; Doering 1992; Cook and Fonow 1990). As Cook and Fonow (1990:80) suggest: “Feminist research is not only research about women but research for women to be used in transforming their sexist society.”

In feminist participatory research it is the researched, the participants, who actively assist the research process, often providing data, rich with women’s perspectives on the world. This can be critiqued and analysed by both the researcher and participant(s) so that understandings can be generated from and for the worlds in which they engage (Henderson 1995; Cook and Fonow 1990; Stanley and Wise 1990; Mies 1991; De Marco, Campbell and Wuest 1993). Feminist research, according to Harding (1991), Cook and Fonow (1990), Campbell and Bunting (1991), Mies (1991) and Acker, Barry and Esseveld (1991), must operate from feminist principles for it to be validated as feminist research. These principles are derived largely from feminist and critical theories, and more recently, those labeled post-structuralist. Harding (1991) and Henderson (1995), believe that those theories which had ‘emerged’ from the German Frankfurt School of critical social theories provide the basis for feminist emancipatory inquiry. Acker et al (1991) have outlined three major principles of feminist research, which bring to the fore the methodological issues, concerns and contradictions, in particular, between the researcher and the participants. It is necessary that the researcher attempts to address these concerns. Feminist research should:

1. contribute to women's liberation through producing knowledge that can be used by women themselves.
2. use methods of gaining knowledge that are not oppressive
3. continually develop a feminist critique perspective that questions dominant intellectual traditions, and can reflect on its own development.

(Acker et al 1991: 133)

By developing feminist research along these principles, I believe, that feminist research commits itself politically, emphasising and exploring the issues related to women's subjugated position in society. This position for many women, active feminist or not, is in one way or another untenable (Stanley and Wise 1990; Yeatman 1994). According to Acker, Barry and Esseveld (1991) and Henderson (1995), and as suggested by Probyn (1993), it is essential that, what happens to women in everyday life and how it is experienced, should be the thrust of feminist research, particularly for the type of research whose intent is to call for emancipatory inquiry. These principles of feminist research are required if we wish to...

"locate women's experiences in society and history, embedded within a set of social relations which produce both the possibilities and limitations of that experience. What is at issue here is not just everyday experience, but the relations which underlie it, and the connections between the two."

(Acker et al 1991: 135).

Feminist participatory research, as I have come to understand it, has 'borrowed' and 'taken elements' epistemologically from 'elsewhere'. As I 'work' through this particular process, and compare it to other researchers' projects and literature, I have come to realise that the epistemological and theoretical 'construction' of feminist participatory research is multi-dimensional. The epistemology in my version of feminist participatory research is post-structuralism, where post-structural theory aims to problematise and call into question the discourses of historical forms of knowledges (Friedman 1995). Butler in Friedman, (1995) states that:

“Post-structuralism is not strictly speaking ‘a position’ but rather a critical interrogation of the exclusionary operations by which ‘positions’ (including feminist positions) are established.”

(Butler in Friedman 1995:22)

Feminist participatory research in this instance does not necessarily seek to transform practice or produce emancipatory action, but, as mentioned earlier in this chapter, has the possibility of encouraging midwives to question and inquire into their relationships within the health care terrain. According to De Marco, Campbell and Wuest (1993), critique is not necessarily aligned with a particular paradigm, but provides an agent for change, as critical inquiry into lived experiences provides the site for change.

***Method: feminist research/women’s research, partners in methodology***

The group involved in my project, comprised four midwives, including myself, with mixed experience in midwifery practice. The three other participants invited to take part were women who had voiced concerns about how midwives were situated, and who had often discussed their lived experiences as midwives at informal meetings. After explaining this ‘project of possibility’ to Yoko, Lola and Eliza, and what it might come to mean to midwifery practice, (and to these women), we agreed to meet as soon as possible. I suggested that we would probably meet four or five times, but this would depend on the needs of the group. I offered, as I had the literary resources, to provide any information that participants might need in regard to feminist participatory research.

There was a general desire within our group to talk about and discuss the issues and concerns in relation to our lack of voice and ‘conspiracy of silence’. This was regarded by all of the participants as a result of our subjugation to medicine. When we started to meet, the stories poured out thick and fast from each of us about our position in relation to the medical staff. As the sessions progressed the stories began to change from those of oppression by medicine’s dominance and how midwives as a



collective were situated, into critiques about our own, and other midwives' behaviour. It could even be suggested that this was a start to locating the midwife, the 'self', in practice. Such a process is not unlike one of the underlying philosophies of feminist participatory research, which Henderson (1995) suggests, is based on the work of Paolo Friere. He expounded that liberation may happen as a result of educating the 'masses' who are oppressed by hegemonic forces. The masses, who, after having their consciousness raised, in order to see 'through' or have the ability to 'disbelieve' or 'refuse' the ideologies of the dominant group, were able to take political action that works toward emancipatory strategies (Henderson:1995; Hastie:1995; Street:1992a; Hooks:1984). This particular attribute of feminist participatory research was brought to the forefront by one of the participants, which is suggestive of the basic tenets of deconstruction. Yoko, a participant, suggested that if midwives, such as ourselves 'picked away at the bricks and mortar' of those midwives who wanted change and improved services, then surely a site for change could at least be 'prepared'. Although emancipatory action was not necessarily intentional in my research project, consciousness raising was.

At the first meeting, group members had the opportunity to ask questions, state their opinions and to discuss how this research would benefit them in their practice. We discussed issues such as 'exposing' our inner selves to one another, how that might make us feel, and we agreed that no-one would be put in a position to disclose any thoughts, feelings or experiences that we as individuals, felt too uncomfortable with. We also discussed what are we to do after the project ? - do we go back to where we were previously situated, or do we move on to other "spaces"? It was important to acknowledge this, as many feminists, including Probyn (1993), believe that liberation can be a painful process, and to have some thoughts about whether the outcome would be of benefit. It was felt that in order for consent to be informed in relation to this project, these issues needed to be given careful thought and deliberation, and that we as a group should understand the possible implications. Throughout the project we

attempted to 'work' in and around the feminist principles of research as outlined in the methodology, as well as we could.

We met regularly, about every two weeks over a two month period. Each meeting was audiotaped, and all members by mutual agreement chose pseudonyms for the purpose of anonymity. These pseudonyms were used for the transcripts and the documentation of this thesis. They were not used in the meetings as both myself and the participants felt that using pseudonyms for our 'speak-talk' (hooks 1986) might cause confusion, and more importantly, interrupt the 'flow' of conversation. Prior to each meeting, when possible, the audiotapes of the past meeting were transcribed, and given to each participant. Doing this often provided a starting point for the next meeting. It also provided participants with the opportunity to (re)discuss any issues which they felt needed further analysis by the group, reinforced the principles of equity amongst the group, and emphasised that we all had something to learn from the speech and experiences of others. Aside from this, to further encourage and 'allow' speech from all involved, a space was provided on every transcript for each member to write down any questions or proposed aims for the next meeting. This was entirely optional, but necessary in a feminist participatory project.

A major methodological concern, when using feminist participatory research, as with any type of research, is that of the relationship/partnership between the participants and the researcher. It is important for the researcher to acknowledge and understand the relationship between the researcher and the participants in order not to reproduce the oppressive relationship between *observer* and *subjects* which characterises positivistic scientific methods (Acker, Barry and Esseveld 1991; Harding:1993). Ideally the relationship between the researcher and participants, in feminist participatory research, should be one of reciprocity, where the participants are not only encouraged to speak, but where it is vital that they *talk back* (Cook and Fonow 1990). This ensures, according to Acker, Barry and Esseveld (1991), that the process is

interactive and reflective, and importantly, a partnership is formed. In my project, the interaction of the participants and participant researcher, owed its success not only to the participants, but the to method and methodology for its appropriateness and its underlying principles outlined earlier in this chapter. Because the underlying methodology was combined with the method in this instance, it encouraged and ‘allowed’ speech from *all* participants.

The data which issued from the participants was never-ending, rich stories from their lived experiences as midwives. As the information unfurled (with our help), not unlike a very large flag, it appeared the problems and concerns of our midwifery practice were many, varied, complex and ran very deep. As each meeting unfolded, commonalities, such as being exposed to horizontal violence and being silenced in practice, were disclosed as well as our differences. These differences included the ways we *each* experienced and reacted to the ‘common’ problems. Although at a macro level it appeared that we all ‘shared’ the same problems, and whilst mutuality existed, all the participants differed in their interpretations and what these issues meant to them at micro level. To cast these concerns and varying interpretations into a basket of “common oppression”, without taking regard of these differences at micro level, would, according to Elam (1994) deny that ‘difference’ exists therefore negating the method and methodology of this version of feminist research.

When writing from a critical feminist post-structuralist viewpoint, there is always the risk of minor contradictions that may become apparent as I endeavour to illuminate and discuss the issues and concerns of midwives practicing in institutions.

Throughout the data chapters, I seem at times, to be stressing an essentialist view point, whether it be the ‘birthing woman’, ‘midwife as woman’ or the ‘dominance of medicine’, which is contradictory to the tenets of post- structuralism. This is not deliberate, but there is, however, difficulty in discussing feminism and patriarchy, (particularly when my intentions are to expose our *differences* and *invisibility*) and not

to position one as Other or to reduce the midwife down to a 'victim', or midwifery to a 'traditional role'.

***Question(s) of Analysis: from narrative to text***

The first questions I found myself encountering as I attempted to grapple with the data was, where to begin ? How does one 'choose' from the data, when the data is comprised of stories heavily laden with midwives' experiences as they occurred in clinical practice? How does one 'choose' which story is more important when each provides us valuable insights into our role(s) of servitude as women ?

At times I was overwhelmed by the responsibility invested in me when (con)textualising and choosing these stories. Each story, in its own unique way, represented the thoughts, emotions and concerns of the midwives involved. Due to the word constraint placed on a thesis such as this, all too soon I felt my research relationship with fellow participants take on the 'role of the person with the power to define' (Acker, Barry and Esseveld 1991:142), when I had to select which stories and discussions would best benefit *my* arguments, *my* perspectives, which includes critical feminist post-structuralism. How this 'sat' with my fellow participants will be discussed in the last chapter as I briefly re-visit and reflect the issues presented in this thesis.

When I first began transcribing the dialogue into text, I realised this tension and took it to fellow participants at our second meeting. As a group, this dilemma was recognised as an inherent tension when 'doing' research for my Master of Nursing thesis. Therefore it was agreed by the group, that as all participants were to be given copies of transcripts, these transcripts would also serve to ensure that any data reproduced in this thesis was correct and used in proper context. In an effort to maintain validity of this research project, which alludes to a post structural critical feminist perspective, I endeavoured throughout the analysing of the data, to maintain

this self-reflexive position. Walker (1993) suggests that reflexivity enables a position of self-critique which contests many of the assumptions of the researcher, therefore allowing the researcher to engage more fully with the text or dialogue *as it is*, rather than as the researcher might *like it to be*. And as Kamarovsky (1991) suggests “...if illuminating and resonant theory grounded in trustworthy data is desired, we must formulate self-corrective techniques that check the credibility of the data and minimize the distorting effects of personal bias upon the logic of evidence” (as cited in Lather 1991:66).

The initial analysis of the data took the form of analysis-in-action, where Lola, Eliza and Yoko and I discussed and debated the issues surrounding our stories as we told them. These discussions largely revolved around our lived experiences as midwives and how these experiences affected our midwifery practice. And, as mentioned previously, after each meeting, I transcribed the tape-recorded data into a crude form of text. In feminist participatory research, as in any feminist research, when transcribing narratives into text, it is important that a politics of transcription is recognised. There is difficulty in transcribing voices into written words, as some of the words and inflections are invariably lost in the translation, which consequently meant that voices were lost when the group reflected back on prior meetings. But more importantly, whilst “the translator (may) earn permission to transgress from the trace of the other”, (Spivak 1995:180) this does not however, imply a permit to *speak* for another. Rather, the transcription of narrative to text in this research, offered a medium by which the relationships between the lived experiences of midwives and their social situation(s) could be explored. With this in mind I endeavoured to ‘tamper’ with the data as little as possible. As I read (and re-read) these stories, the midwives’ words spoke powerfully of the profound difficulties of belonging to a predominantly *silenced, largely voiceless* culture. Our stories questioned our relationship(s) with the dominant order of medicine, and what this meant to not only

to our professional practices, but how our social relations with each other were affected.

As I re-read our stories, and after listening to what they had to say at a macro level, that is, what our stories spoke of during the initial analysis-in-action, I came to 'listen' to them differently. As I am committed to practices of a critical feminist nature, in particular post-structuralism, our words begged for a deeper analysis from this perspective in order to provide more than a superficial understanding of our social position(s) as women and midwives. Grosz (1995) suggests in her essay "Sexual Signatures: Feminism After the Death of the Author", that for a text to be considered a feminist post structural piece of work, it must call into question and challenge the dominance of patriarchy and its gendered discursive practices. Critical feminist post structuralist theory, according to Walker (1994), suggests that it has the potential to challenge the 'tyrannical grip' that medical science has over the defining and production of knowledges, which serves to "...disenfranchise others; those in the centre define what passes for 'real' knowledge, and those on the margins are silenced" (Walker 1994: 164). As the data in this thesis largely speaks for *itself* when talking about the dominance of medicine and midwives relations within it, post structuralism can offer the possibilities of 'critical interrogation' (Butler in Friedman 1995) by exploring the nature of the relationships between not only that of doctors and midwives, but that of midwives and midwives. For all intents and purposes, to represent the local data through the theoretical frameworks of critical feminist post structuralism, seemed to me, most appropriate.

As I 'pitched' local data (Probyn 1993) (the stories of the research participants) against that of the literature of feminist and nurse writers (the global data), I came across many parallels and commonalities which served not only to illuminate the stories of myself and fellow midwives. I also came to recognise that there were tensions between feminism and midwifery and therefore it became necessary to

examine these in themselves. Spivak (1993:121) suggests that “deconstruction can make founded political programs more useful by making their in-built problems more visible”. Therefore if we were to make visible the problems between midwifery and feminism, then surely one could benefit from the other. Also *not* to critique feminism in such a context, I face the potential danger of replacing one grand narrative, such as those that have issued from patriarchy, and in the case of this thesis medical science and its gendered division of labour (Weedon 1987), with another, such as feminist theory (Gunew 1990; Elam 1994).

I now invite you to listen to the stories of Lola, Yoko, Eliza and myself as we travel the ‘uncharted waters’ of the data analysis chapters. As I have mentioned above, the stories you will read will largely ‘speak’ for themselves, but will be interpreted and discussed from a critical feminist post structuralist perspective. I write from this perspective, not only because of personal practices and commitments, but also in recognition of its appropriateness for myself, and other midwives, if we wish to find a place from which to speak relatively unencumbered.

## ***Chapter 4***

### ***Gendered Roles and the Importance of Experience***

As a way of introducing the data from our project, I feel it is important to briefly recapitulate the issues discussed in the literature/theoretical chapter. It is necessary to do this as these issues and ideas will be (re)presented in and through the data in a more local sense. It is my intention to pitch this 'local' data against the more global literature, as mentioned in previous chapters, in an effort to confer, challenge and contradict the dominant narratives which often take us over, producing our speech for us, forcing us to find refuge in silence. The importance of this as Probyn in Spinks, (1995) suggests, is that the local or the 'locale' places us in a context of a specific 'setting', and 'this place can be taken as both a discursive or non-discursive arrangement which holds a gendered event' (Spinks 1995:74). It is within the 'locale', our site of struggle (and resistance) for voice and recognition, that we may find ways of (re)discovering and developing knowledges that are appropriate for midwives and birthing women (Probyn:1993, Street:1992(b), Spinks:1995). The major issues that were brought to the forefront earlier and in a global sense were: gender; experience in relation to women and to midwives who practice in institutions; lack of voice and the discourses of silence and its relationships to midwives and medicine, and between midwives themselves.

#### ***Women as Woman and Midwife***

At our first meeting we were busy discussing how the dominance of medicine in midwifery affected the way we were as midwives, and how it influenced our practice. Lola felt that as a part of critique-ing medical dominance we needed to look to ourselves if we were indeed going to be able to make any progress in finding out why



we didn't have a voice in practice, and she suggests that in general we have a very limited voice, if it all, in life as women.

*Lola: What I'm going to say here could be really damning to women.*

*I just look at the women at work, the midwives at work, and it just appears to me that they just come to work, do their work and then they go home again, it's as if work is an intrusion, I mean, I don't know if this happens in other professions or whether it's just women midwives, like they won't join for example, our professional affiliated body because it costs, and er, they question, 'whats it going to do for me', they can't seem to relate work and home life...*

*Yoko: Yes you hope they um, might want to contribute to the betterment of what they are doing*

*Lola: I guess for some, [it would be] be an element of their social life, [coming to] work I mean.*

Lola is questioning what midwifery might mean to some women. It might well be that for some midwives, “[it would be] *an element of their social life...*”, where their work creates a diversion from their home life and/or where they might have friends who feel the same as they do. Or as Lola states, midwifery to some might be treated “...*as if work is an intrusion...*”, and what Lola is suggesting by this comment is that she feels these midwives are working only because they have to. Perhaps they are only coming to work for financial gain, and nothing more, or maybe it is because these women feel they *have* to go to work, believing that this what is expected from them. The questions, to posit here, I believe are; is it because midwifery has been seen to be traditionally a woman's job, that some midwives feel they can treat their profession as a means of social interaction. Or do some midwives view coming to work simply as a source of income; or a way to fulfill role expectations as set by our society? Also, is it problematic to work as a midwife for these reasons ?

In the earlier stages of our data collection, I felt that part of my role as participant researcher was to theorise and flesh out some of the themes picked up by the participants (including myself). This was done for the purpose of initiating consciousness raising amongst the group. This type of consciousness raising, we soon discovered, led us into the first stages of analysing the issues that were being discussed at the time. It allowed participants a place from which to speak, and to expand on our ideas and thoughts. In the data fragment below, I picked up on the issues brought forward by Lola in the above conversation, in particular her comments about women as midwives. By (re)raising these issues, it brought to our attention that the statements made by Lola were significant, and required further discussion if we were to try and make sense of the worlds in which we worked as midwives. This also enabled Lola the opportunity to expand and speak further on the issues that surround women who are midwives, as the data below demonstrates. As the sessions progressed, and particularly in the final session, all four participants, actively initiated and took part in analysis and consciousness raising, each in our own way.

(At the next session)

*Heather: Lola you talked about how some midwives come to work, they do their job, then go home. Well I've thought about that, and um I just wondered if it gets back to what their idea of a woman is, and because we do traditional women's work...I wonder when they come to work, they regard what we do as a trivial, local, naive, little job. But also do you think they might consider what their partners do as more important than their job [as women, as midwives] ? [Do they feel they are] just a contributor to the real breadwinner [who is the 'man'].*

*Lola: um yes, the woman [who is a midwife] sees herself as assisting the man [the breadwinner], it's as if his job is more important and that's how they see themselves as midwives, assisting the important*

*role of the doctor. She also sees herself within the family in a subservient role, and not a true partner.*

It seems then from what Lola and Yoko tell us, that the midwife sees herself as subservient and not a partner in a family or in the home, and she brings this sense of herself with her to the work place where her position is maintained at a subordinate level. In this way there is no disparity between what she may be at home and at work. This midwife is representative of what the 'essential woman', the essential Other, is in western society (Probyn:1993; Weedon:1987; Gunew:1990). The 'essential woman' is man's version of woman, she is quiet, gentle and obedient. Unfortunately this 'essential woman' pervades our very subjectivity(s) as women. 'She' is the type of woman that women have been socialised into understanding as the 'right' sort of woman in our society. Because of this, most women have grown up believing that we should live the lives that 'man' has set down for us. It is this myth that we act out in the workplace as midwives. It is where midwives (mostly women) work in a sphere of practice set down by doctors (mostly men). Because we live out this myth, our position as midwives in relation to doctors, is that of Other (we become and are referred to as Other when we are dominated by discourses of patriarchy, and in the case of the midwife we are dominated by medicine). It is because of our position as Other that women who are midwives find it very difficult to speak out against the dominance of medicine.

It is a woman's subject positions, her *subjectivities*, which influence and maintain how she participates in her world (Weedon 1987). From the time women are born, we are socialised and our subjectivities are formed by virtue of our gender, providing us a 'place' within our culture, and as midwives, "From the moment we enter the health care institution...we 'learn our place' in relation to doctors" (Spinks:1995 p.63). The 'self' is not a stationary, permanently fixed position, as the liberal humanists of patriarchy would have us believe (Weedon 1987). Women have a multiplicity of

subjectivities, such as midwife, woman, housewife, mother, where the 'self' is often changing and redeveloping depending on the power relations at a given point in time. The 'self' is therefore, always contextually situated (Probyn:1993; Spinks:1995).

For most of us in western society, we are led to believe the myth that we are indeed 'essential women' (Street 1995; Gunew 1990) as Lola suggests in her description of a midwife's social position. Rather than being a partner in midwifery and obstetric care, midwives, through acting out the myth of the 'essential woman' and not resisting it, along with the medical profession enforcing the sexual division of labour, largely remain coerced into a position of silence and relative voicelessness. The question to be asked at this point in time then, with the myth of the 'essential woman' alive and well, what is the nature of the relationship between feminism and midwives? In the conversation below between Eliza, Lola and myself, we disclose that there are tensions between feminism and midwifery practice:

*Heather: do you think feminism has er...a place in any of this [midwifery practice], like not being able to speak up and that sort of thing ?*

*Eliza: this is a really naughty thing to say, but I apologise for saying it, but really I do think midwifery is a woman's job.*

*Lola and Heather: Yeah*

*Heather: men and women are different, they can never be equal in the things we do, um O.K., we did need equal pay and those kind of things, but I think also we need to recognise things that women only can do*

*Eliza: Yeah, men do things they can only do too [and] there are roles we do better than others*

*Heather: Now just because you choose to stay at home and bring up your children it does not mean you are any less a person than the woman who ... chooses to have a career instead. But unfortunately*

*that's not how it is often perceived, so it puts a lot of people off feminism. It's also why I'm not sure if male midwives have a place [in our profession].*

*Eliza: It's [midwifery practice] woman with woman really, not man with woman. I think men have a role to be there, and I don't mean for punishment [as punishment for impregnating a woman], but as a support who loves the woman most of all, to care for her, but er.. no its a woman who can do it [care for a labouring woman] better...women support people are a lot better often than the partner.*

As our conversation above unfurled, it seems that one can have feminist values *and* do 'feminine' work. We can indeed appropriately care for women, *knowing* what women might like, and *how* they like to be cared for. Along with equal rights in the 1960's and 1970's came the right that women 'won' to have their partners by their side during labour and birth. While it seemed a great idea at the time, rather than it remaining an *option* for women to have their partners present, it has now become an expected social norm that men be present. Whilst in every respect for some women it is the best thing for their partners to be there, this option has become an 'obligation', and as midwives we see this often. In all fairness, some men too, have no wish to be there, to be present at the birth of their child, but they go through the motions, often giving little or no support. They are there only because it is expected of them. The majority of women do not recognise or consider whether having their partner with them during labour or birth is right for them or not. What the data in this study suggests however, by virtue of our sex, our gender, and our very subjectivities, women midwives and women support people are suited to care for and support birthing women. As Eliza suggests: "...men do things they can only do too". Why is it then, if midwives can offer appropriate care to women having babies, that we are so tightly bound to practice under the rules set down by medicine (therefore man)?

Almost at the beginning of this excerpt, Eliza apologises for calling midwifery *women's* work, it's a *woman's* job. 'Why apologise?' you might ask, but some midwives like Eliza, feel they must apologise to feminism for continuing on in a traditional woman's job in this day and age. They seem confused about the issues of equal rights for women, equating them with, 'work like a man, get pay like like a man', and midwives at the 'bedside' cannot possibly do that. The term 'feminism' has become a problematic issue for many women, such as midwives and nurses. It is as if it forces the notion upon them unfortunately, that one should no longer be *feminine*, and by supposedly demystifying the 'essential woman', one must take on *masculine* qualities and flee traditional roles (Street:1995). Also unfortunately, this had led to some feminists scorning or ignoring those who have maintained traditional roles, making these women feel uncomfortable about what they do, for example, Eliza apologising for believing midwifery is a woman's job, a gendered role.

In the following excerpts the gendered role debate enlivens these issues further.

*Eliza: Its beyond my knowledge, I can't understand why they [midwives]can't love what they do. That's what I'm doing it for [midwifery], because I love what I do. I'm appalled how it appears that nobody cares in the health field any more. I remember in 1980 something, there's a photo of me with this t-shirt saying, "Who Cares ? Nurses, Caring is our Business". I was proud of that, but it seems that caring isn't our business anymore, it is gone, too many people go to work and do the job, they're not putting in the effort, the love, any longer.*

*Heather: well when you think about feminism, you know Eliza...what it might mean now...I was just wondering how much of that is contributing to our 'need' to get away from the traditional women's*

*work bit, um you know like going after technology, or er getting into the economic side of things, to some midwives it's [these roles are] seen as more important than rubbing the woman's back*

*Eliza: yes I believe midwives, like some nurses are trying to escape the traditional label...*

It is interesting to hear, in these data fragments, Eliza's language. She tends in some instances to use what has been considered *feminine* language, like the word 'love', for example. It is used in the context of her work as a midwife, where language is usually dominated by the use of medical (therefore *masculine*) language. This is the language that most midwives adopt, or 'slip easily into' in the presence of a doctor, particularly when discussing a 'patient'. Medical language is also the language which predominates midwife's 'handover'. When a midwife gives report to other midwives who are taking over a new shift, a non medical person would be forgiven if she/he thought they were listening to a language from another country, as the talk of midwives is overtaken by medical jargon - I would argue that there is very little, if any, midwifery jargon in the institutional setting.

It has come to my attention lately however, that midwives who work in midwife based schemes, such as Eliza, and those belonging to homebirth groups, are tending to use less medical terms (and some of these midwives have been using these 'terms' for some time). For example, I am hearing terms such as, 'birthing' woman, 'birth' (instead of the term 'delivery'), 'womb' (instead of 'uterus'), 'baby' (instead of 'fetus') more frequently. These midwives are using words that are more familiar to the woman and her family who are having the baby, discussing the pregnancy, birth and care of the mother and baby in a way which *includes* everyone.

My point here is this: the dominance of medicine over midwifery has pervaded and restricted not only our practice, but has produced our language for us, giving us no

space to speak for ourselves. As discussed in the literature chapter, by taking on another's language (such as midwives taking on the language of medicine), one also takes on all the social values that go with it, including the prestige and authority with which medicine speaks. So although the language of medicine may not always be silencing for some midwives as such, in its entirety however, it may be silencing for women as it can take the focus of birth from the childbearing woman, through the use of jargon, and place it on the significance of science.

Feminism, in some instances, has created its own set of tensions within the practice of midwifery, particularly if we take on liberal feminism, for example, as some nurses and midwives have to 'get ahead' in their own 'territory' (Street 1995). Liberal feminism according to Speedy (1987) and Chinn and Wheeler (1985) seeks equality between woman and man, economically and politically without critically examining the social differences between the two. For liberal feminists who might be midwives, to use the language of medicine or/and to turn to technological pursuits, possibly at the cost of good service delivery to birthing women, is to actually reinforce the asymmetrical positioning of midwives'. To follow this path is to deny us (midwives) our traditional caring role. Street (1995) purports that some midwives who have gone into independent practice have probably benefited from this. However, for those of us working in institutions, adopting a liberal feminist viewpoint becomes problematic, as it strengthens the binary opposites of us/them and doctor/midwife, which brings us back to the myth of the 'essential' woman. Taking on liberal feminist beliefs is *not* necessarily to question the dominance of medicine, but is to acknowledge and accept its position. By virtue of this, the liberal feminist stance reinforces the position of the 'essential' woman and where we midwives remain, not as 'selves', but as medicine's 'Other' (Speedy:1987; Chinn and Wheeler:1985; Gunew:1990).

The implications of such actions as Eliza suggests, can be that "...caring is gone...", where we can become accustomed to being with machines instead of women, or



putting money and budgets above the needs of birthing women. Of course caring changes within context of time and place, but we can certainly become misguided unintentionally, *unconsciously*, in our actions when we are looking for a place from which to speak. As women and midwives we need to recognise and accept that women and men are different, we are borne of *different* genealogies (Irigaray 1993), we are borne from man *and* woman, not just man. If one considers this, that men and women are *different*, we *must* have different subject positions, and therefore we could be suited to different occupations, jobs and so on. If we accept this, then as women and midwives, we must be prepared to define and take on our occupations under the terms decided by us and childbearing women, and not by doctors alone (Di Stefano:1990). Perhaps then, women who are childbearing may receive care and treatment that is appropriate for them. This could also suggest, as well as midwives considering what feminism might mean to us, we may certainly have something to offer feminism (Benner in Speedy 1987; Street 1995).

### ***The Power(lessness) of the Gendered Role***

For midwives, to overcome the lived reality of the power(lessness) of the gendered role proves very difficult. To do this, we are trying to overcome centuries of oppression and repression by the medical profession, and how women have been 'expected' to behave in the context of the times in which they live(d) and work(ed). Power has traditionally been considered as 'something' you can own or have as a possession, and it is how patriarchal societies have come to know what power is. To have power under patriarchal terms means you have been recognised as having gained it through either social position, legitimated knowledge such as science and medicine, and by virtue of your sex. According to Foucault (in Street, 1995) power is exercised through hierarchies, therefore it is exercised in this manner throughout the health care institutions in which most midwives work. Whilst the patriarchal view of power is not helpful for midwives, according to Street (1995) it can be made useful when critique-ing and exposing the *myths* that are inherent in such structures of power.

The following data fragment comes from a session where we attempted to examine why doctors made us, as midwives, feel the way we do about ourselves, and about our power relations with them:

*Lola: do you feel uptight when a doctor is in the room with you?*

*Eliza: I don't, but I understand others do.*

*Lola: Hopefully I'm getting better, but I have noticed myself change when a doctor walks into the room, and I try not to, its not quite as bad if they um just come in for stitches, but er if a doctor walks in the room the atmosphere changes and I change because I'm not devoted wholly to the woman any more, and as much as I know what I'm doing, I try not to give the doctor too much attention, and keep with the woman, but I know I still change. They [the doctors] don't realise it should be the woman who has control of the room, they see it as us [midwives vying with the doctors for 'control' of a labour room], yes, that's why doctors are scared of letting midwives have anything to do with women before they do. It is also I think that we are there to be their handmaiden. This was really brought to my attention one night when an anaesthetist doctor came in, and a home birth midwife who was called in to work was caring for this particular woman who needed an epidural. He [the doctor] came in and um started tearing strips off her because she didn't have the epidural trolley set up, I mean big deal, she was 'with' [Lola's emphasis in her speech] the woman, and I was carrying on about it a couple of nights later saying we should not have to set up trolleys, but I was told we were there for such reasons by some fellow midwives. You might be seen to be efficient but who are you there for?*

*Yoko: in most people's eyes you would be seen to be very efficient, and good at practice, you know, "look she's got that tray already set up etc."*

*Lola: Yeah, that's a silent hard working woman.*

*Yoko: what really upsets me is the way in which these doctors carry on, its [putting midwives down] done open slather in front of the women and their support people, its so demoralising, and er it makes us look like we are inept handmaidens and that we haven't actually carried out our jobs properly.*

This conversation mostly between Lola and Yoko talks to us about how difficult and confusing it is for us as midwives to try and change our role in terms of the power relations with the medical staff. It causes conflicts of emotions, confusion as to whose interests we should be serving, and outright confrontation (which often shows the midwife in a bad light). For example, as Yoko states, “...it makes us look like we are inept handmaidens” (as if that’s the totality of our job!). This creates a conflict of tradition, and also a conflict of our (historically constituted) subject position(s) as women. The data fragment above demonstrates this, by suggesting that where you have the midwife being *with the woman*, and not the midwife assisting the doctor (*the man*), you may have a situation of confrontation as described by Lola, “....he [the doctor] came in and started tearing strips off her [the midwife] because she didn't have the epidural trolley set up...she was with the woman...”. The midwife was carrying out her practice in relation to the needs of the woman, and did not prevent herself from doing so in the presence of a doctor. It appears though, that the expectation of most doctors, by virtue of our history of tradition, is that we (the midwives) are there to serve them first, irrespective of the needs of childbearing woman, and when we don't and/or can't assist them, it is not only where conflict arises, but for midwives it is also a potential site for resistance, a site which could be taken up to speak from. Unfortunately this potential site for resistance will remain

overlooked while we continue to carry out the myth of the doctor's handmaiden, being *with* doctor and not *with* woman, as Lola discovered, "...*I was told I was there for such reasons by some fellow midwives, you might be seen to be efficient but who are you there for...*". Indeed, who are we there for ?

It does appear though that the 'tradition' of midwifery is changing. For some of us, instead of being the 'traditional' nurse or midwife in the patriarchal sense, setting up the trays, helping the doctor, putting his or her interests first, acting the *myth* we have been led to believe, we are opting for caring for women over assisting doctors, trying not to change when they come into a labouring room, ward or wherever. However, as Lola suggests, it should be the birthing woman who generates the power in a room, not the doctor.

"Foucault led the way to re-examine notions of modern power and understand power not as a commodity but a relationship -not what someone else has but what is exercised in a particular context. This is not to suggest that our opportunities to exercise power are the same."  
(Street 1995:43).

Street (1995) suggests we should ask how are we using power, for instance in a labour ward. Instead of just assuming who has it and who has not, "power relations can be discovered within the intricate webs of human social relations where power is produced" (Street 1995 p. 43). Perhaps then, if midwives understand and accept that power and power relations can be generated and not owned, birthing women might be recognised as the real 'power-brokers' in the politics of birth, and given the opportunity to speak. Unfortunately because of our socialisation, and the myths created by modern medicine, which are enforced by the hierarchy in which most of us work, the issue of power as a commodity is very difficult to overcome when all around you continue to act and re-enact this myth. This is when, according to Foucault (in Street:1995:45) we must "refuse what we are" and reconstruct our roles as midwives. If only it were so easy !

Street (1995) suggests that the myths operating within health care institutions represent dominant discourses which send specific messages to nurses. The same could be said for midwives, the discourses of silence and exclusion, sent in the guise of medicine, ring loud and clear to us, they tell us that we are to listen, we are not to speak and we are certainly are not to question. It is little wonder then for most of us we have no choice but to view power the way medicine views it, negating whatever we may believe, feel or know. The opportunities for exercising power are *not* the same for doctors and midwives, but if we refuse what we are perceived to be by the dominant order in health care, we may create for ourselves a space from which to speak. This in turn may provide a space from which midwifery knowledges could be generated. Our knowledge based on experience is excluded in the face of science. But how can that be when experience is, and has been, so important to us ?

### ***The Importance of Experience***

Experience today remains important to midwives. How many times have we heard, from ourselves and others, “In my experience...” or “Remember when...?”, when we are talking amongst ourselves or discussing stories of practice. But in a lot of instances our ‘talk’ of experiences, and therefore our knowledges, has become ‘restricted’, even between midwives. Because we have no substantial place from which to speak, generating our experiences into knowledges has been quashed and excluded by the hegemony of science over midwifery, and therefore, the midwife’s emphasis on experience also seems to have changed over time as Yoko next suggests:

*Yoko: ....er it seems that if you have grey hair you have wisdom and credibility, and you have power by virtue of the fact that you’ve been around for some length of time. I mean take some senior midwives, ... I think they believe they are so right, they have got the conviction that they ‘know’ [Yoko makes the sign of inverted commas with her hands] because they’ve been there for 15 years, they ‘know’ and that’s it, we*

[midwives with less than 15 years experience] *are not to ask questions.*  
*And unfortunately...professional judgment can be too readily replaced*  
*by valued judgment and this can cause all sorts of problems.*

Yoko's statement here, suggests that experience (used in the context as a category of knowledge), when dealing with other people's lives, needs to be aligned to some type of theory. It is also interesting to note Yoko's use of the word 'power', demonstrating how hard it is not to perceive 'power' as a commodity, particularly when power is being used as a way to control people. When midwives rely on their 'experience' alone, it is not generative of knowledge, particularly if the person who has that 'experience' is the only one allowed to 'have' it. It is not knowledge that is shared readily, and it is certainly not up for debate. For experience to be generative of knowledge it has to be critically analysed and shared, particularly if midwives are wanting other midwives and those who are not midwives to listen. Therefore as Harding (1993) and Weedon (1987) suggest, midwives need to align their experiences in practice with theory, theory that is *appropriate* to our practice, and 'marry' them together. This would allow 'space' for critique and analysis, and for power to be generated in the form of knowledges, rather than as a commodity to be used for 'controlling' others. 'Experience' has the potential to provide a place from which we could speak about 'our knowledges', that is, midwives' knowledges.

Whilst amongst midwives, experience is respected and revered, we often *whisper* among ourselves, "we told him (the doctor) so, but would he listen ?", when something has happened. As demonstrated by Yoko, when practice is removed too far from theory and vice versa, experience can become a double edged sword for midwives. On the one hand it can be used as a form of power in the traditional patriarchal sense, and on the other hand, we do as Elam (1994) cautions us not to do, we reduce experience down to a subject. As suggested by Yoko in the above data

fragment, “...*they have got the conviction that they ‘know’ and that’s it, we are not to ask questions...*”.

In patriarchal societies such as ours, and because midwives have been excluded as ‘knowers’ by medicine, in our Otherness we have come to understand that the knowledge of doctors means ‘power’. A common situation that arises from midwives’ behaviour, borne from our oppression, can be where a midwife with many years experience of midwifery practice may keep her knowledges ‘secret’, over a midwife with less practical experience (but who might have tertiary education qualifications), and she may use this as a method of ‘controlling’ the other midwives she works alongside. As well as power being misunderstood as something which can be ‘owned’, *knowledge* is also often misunderstood as belonging to a privileged few, and usually to those who have had formal scientific training. I am not rejecting here science per se, but the overqualification and intervention of science in midwifery. It has affected us by its stance on gender, and therefore has affected our subject positions which can lead us to misjudge our fellow women.

Because of the pervasive nature and influence science has over midwifery practice, midwives reduce childbearing women’s experiences down to a set of observations and interventions, and in the labour ward midwife’s case, the woman’s childbirth experience can be reduced down to hours and minutes rather than what has transpired as a ‘whole’ over the woman’s labour and childbearing experience. It seems that midwives want recognition for the knowledges that their experiences might bring. However, because of our modern ‘training’, which is borne of scientific method and inquiry, we are not encouraged to refer to our experiential knowledges. Nor it seems are we encouraged to, or accept the childbearing woman’s version of her birth experience and how it really is for *her*. Lola speaks to us powerfully on the subject:

*Lola: [discussing the implications of midwives relying on the totality of their experience with very little reference to the birthing woman's experience] If you don't get through your labour acceptably for yourself, if the outcome is something that you [the birthing woman] are not happy with, and that is from the birthing woman's point of view and not the midwife's, (Lola particularly emphasised this point) then you don't start your parenting right, and so if you are not happy with your birth or labour, you um can't actually go on to parent properly as your experiences have not been resolved, often what the midwife may have thought of as a great birth experience for a particular woman, was anything but that for the woman.*

I fear this occurs because of the conflicts and contradictions about our own subject position(s) as midwives. As mentioned above, we judge a woman's birth experience from a scientific physiological point of view, based on what happened at a particular point in time, reducing the labour and birth to minutes, hours and interventions, instead of interpreting it from *her* viewpoint, the *birthing woman's* subjectivity. So rather than learning from a woman's labour and birth, and allowing it to be generative of knowledge, as midwives, we seem to think that because we are the 'expert' (haven't we, as midwives 'conducted' many births?), that we might be the best judge of *another's* experience. Isn't this a contradiction of events? It appears that because our experiences as midwives are ignored in the face of science, we have difficulty in accepting that someone else's experiences, such as that of the birthing woman, are of value either. Instead we take on the patriarchal stance of 'expert', which implies that the 'expert' knows best (Code:1991). As Lola says, we must as midwives and as women, begin to truly listen to the childbearing woman and accept her experience as *her* own, and not just from what empirical evidence showed, or what *we thought* was her lived reality. Therefore brushing aside the childbearing woman's experience is not generative of knowledge, is not always in her best interests, and can be



unintentionally destructive as suggested by Lola in the data fragment above, “...*you um, can’t actually go on to parent properly as your experiences have not be resolved...*”. This means that in order for the midwife, to assist a woman to overcome and resolve any issues relating to her pregnancy, labour or birth, there must be acceptance of the experience as it happened for that woman, and not how it was ‘seen’ through the eyes of the midwife.

A constant concern I have about myself in practice is that I might make *my* version of a childbearing woman’s experience become *her* experience, and I worry also that I might speak *for* her (and literally put words into her mouth), instead of *with* her. As women, we are faced with what Annette Street (1992a) calls the “tyranny of niceness”, (of course, the ‘essential’ woman is always nice). This is where we forsake critique and possible reconstruction of our practices so that as midwives, we do not upset anyone, or make ourselves feel uncomfortable about not being ‘nice’, (for not to be nice is not to act out the myth of the ‘essential’ woman). However, I look to my ‘self’, myself as midwife, and how I am placed in the terrain of midwifery (that is: my actual practice, my general outlook, how all this reflects on my ‘outside’ life and my pursuit of further studies). Because of where I am in terms of my ‘self’, I feel I am beginning to find a space from which to speak. I can, and do *voice* my concerns to my peers and doctors alike and to some, these are not always acceptable. But first and foremost, it is to the *childbearing woman*, I feel midwives *owe the explanations, the chance to talk about her ‘self’* but because of the spectre of the ‘essential’ woman, still we hesitate.

Our lack of voice, as I have mentioned earlier is deeply embedded in midwifery culture. The next chapter demonstrates and discusses how this is perpetuated and enforced by the dominance of medicine, and how it has come to affect our practice as midwives.

## ***Chapter Five***

### ***Lack of Voice Or Conspiracy of Silence ?***

#### ***No Place From Which to Speak ?***

*"I was trying to say something and he (the doctor) told me to be quiet a few times....Anyway it was horrible, he just wiped the floor with me and nobody got up and actually helped me, ...I was so angry someone should have said something...I didn't have any active support, not from midwives, not from the medical staff...."*

(Lola, midwife)

You would be forgiven for thinking that the above quote might have taken place in the 1890's where a woman had spoken out of place. Unfortunately it is as recent as last year, and not a whole lot has changed between then and now. Lola was speaking at an *obstetric* meeting about *midwifery* based practice.

This chapter speaks powerfully about the relative dominance of medicine and how it reduces midwives' speech to silence. It also speaks of the dominance and inferred importance of scientifically based practice over the knowledges and practices of midwives, and how we as midwives are marginalised into Otherness allowing us a limited place from which to speak in an institutional setting. A large proportion of this chapter is made up of our conversations and stories about practice, and as you read on you will find that these stories speak mostly for themselves. To break down these conversations and stories any further would be to interfere with our speech. The aim here is to demonstrate and discuss how hard and harrowing it is to speak up and talk about our practice as midwives, and how we have come to perpetuate our own continuing silence.

Through our stories, the discreet and overt ways in which medicine has come to influence midwives' ways of thinking, our practice and the working relationships between ourselves as midwives, and as carers of women are highlighted. Because of our lack of voice, and the way in which we have come to understand the worlds in

which we work, some midwives and nurses have alluded to practices where we actively encourage each other to keep quiet, and take away our own voice, and the voices of others (midwives). For most of us, who are midwives we do not always consciously think about the consequences of our maintained silence. This is because we are socialised into knowing ‘correct behaviour’ as women and midwives. We are actively *discouraged* from asking questions, by both medicine and our own profession. A lack of voice then, in the case of most midwives, turns into a ‘conspiracy’ of silence. It is where we have gone from passivity, that is our lack of voice, to action that is turned in towards ourselves in various ways including that of horizontal violence. This, I believe, demonstrates that midwives are capable of action within our oppression, if only we could redirect our ‘actions’ in a more positive light, let me explore these notions further...

### ***Our Place as Other: a silenced practice***

The conversation below involves all the participants, that is Yoko, Lola, Eliza and myself, and it here that we speak about the difficulties of speaking up, both at a professional and a personal level:

*Heather: do we not speak up at work because we are women or both?*

*Lola: I personally don't because I know that I won't get support [from other midwives], also I'm not very comfortable about how articulate I am...so often I back myself into a corner.*

*Heather: that's interesting Lola because your role [as the 'clinical' midwife in a midwife based scheme] has kind of gravitated around to you being a spokesperson*

*Lola: I don't think I do a very good job of it*

*Eliza: I think you do, but how do you feel about it ?*

*Lola: scared...like when I was discussing with the doctor issues related to our practice, I didn't have support there, midwives were*

*listening and it wasn't until after that someone [a midwife] came and agreed with me, but she didn't do it in front of the doctors.*

*Heather: do you think that they don't support you because of the fact of repercussions or do you think its the way in which we've been socialised that you just don't question authority?*

*Lola: I don't know but I feel it should be part of midwives' roles to support each other on issues that we have similar feelings about, not just sit there and say nothing or wait until it was over.*

*Eliza: it's interesting that people still feel the doctor/nurse thing. I started training when you stood with your hands behind your back in front of a doctor...thankfully things have changed enormously, but obviously they haven't changed enough, it's interesting to find that people coming through the system that they still feel the doctor is the superior person, whereas [I believe] they have different knowledge, they don't have better knowledge*

*Lola: Well they've got that "A Country Practice" back on TV, now that Terrence or whatever his name is, he is the head of society, the country doctor, which is amazing to watch, just amazing, everyone stands back for him, he's an alcoholic, he's got psyche problems and yet he's looked up to as the pillar of society and everyone looks up to him*

*Heather: in the old days it used to be the midwife*

*Eliza: yes, the wise woman. I find myself kowtowing to doctors and I'm not quite sure why, I really don't know why*

*Heather: yes well sometimes its easier, it really is*

*Yoko: it is about control and who has it.*

*Heather: do you think that we as midwives not only have a lack of voice but do not support those who choose to speak then ?*

*Yoko: ...isn't there fear of reprisal at a personal level, like if you opened up your mouth and said something, people just sit back, and*

*make you feel the perpetrator. Often its not just fear of um probably being shot down in flames or treated with a wall of silence, there is equal fear for your job, your position. But we haven't really learnt to say anything yet...*

The above conversation illustrates how we are placed socially and professionally in relation to the doctor and society. It really is all about power, and who is 'seen' and portrayed to be powerful and knowledgeable.

It appears that midwives are indeed afraid to speak out because we cannot rely on active support from doctors but our peers as well, as suggested by Lola, "*I personally don't because I know that I won't get support*". It is because of our relegation to Other, where one is dominated by another. In our case it is where we, the clinical midwives, are dominated by the socially accepted power of medicine and the hierarchical structure of health care institutions. If we speak out we are often punished (Spinks:1995).

Midwives who find it difficult to support another midwife speaking out, do so not only because of fear for themselves, but also because they may have become 'docile bodies', (previously discussed in Chapter 2). McHoul and Grace (1993) and Sheridan (1986), as commentators of Foucault, suggest that 'docile bodies' are not necessarily in a position to know that they have a place from which to speak in the first instance, as mentioned by Yoko "*..we haven't really learnt to say anything...*". 'Docile bodies' are the outcome of constant surveillance, discipline and punishment in institutions where there is a hegemonic order in place. Michel Foucault founded this notion when studying prisoner's reactions to constant surveillance, discipline and punishment in a penitentiary unit in France. He also found that these 'methods' could easily apply to, and were often present in other institution such as schools, defence forces and hospitals (McHoul and Grace:1993). Therefore our silence as midwives who work in

hospitals, is maintained, leading us to believe that we do *not* have a place from which to speak. For some, we have indeed become ‘docile bodies’ which also ensures that our Otherness is maintained. Despite Eliza’s statement that “*doctors don’t have better knowledge*”, the common myth is that they *do* have better knowledge than midwives, and this is widely accepted and overtly supported by the institution and the community. Our different knowledges as midwives, however actively supported by fellow midwives and birthing women, remains hidden, discreet and unrecognised.

It has been easier for us as midwives to ‘kowtow’ to the patriarchal structures evident in most institutions for fear of repercussions. But aside from that, it is also a myth we have been led to believe. Yoko speaks to us about fears and punishments because the few who do speak out are often punished. When other midwives hear or see this, they feel that they are not able to say anything and that they are not in a position or a place to learn to speak out, they *involuntarily* become ‘docile bodies’. We become what we know, and in our case most midwives maintain their silence because we learn we are *not* supposed to speak (after Gunew:1990; hooks:1986). As we are not supposed to have speech, knowledges borne of experience and practice are given little credence or value. The voices of experience are silenced in the presence of medicine, and the knowledge of science is given precedence (Dalmiya and Alcoff:1993). In such situations it almost seems impossible “to refuse what we are” (Foucault in Street:1995:45).

Because of our lack of voice, our forced silence, and our Otherness, the implications are many, varied and serious, particularly when one considers what it all might mean to midwives, the childbearing community and nurses training to be midwives. The next section is made up of the implications of our conspiracy of silence, including how it is used by some midwives as a form of horizontal violence, and of the research group’s last session together. As it turned out, this meeting represented to us, as a group, a ‘fitting finale’ of weeks of hard work, discussion and debate, as we all felt

that we had got down to the 'nitty-gritty' of the implications of silence in practice - a site of struggle and a site for resistance, and how our 'selves' as midwives and women could be situated.

***Conspiracy of Silence: a site of struggle, a site of resistance***

*"...it was the expectation of just um, accepting the doctor's ways, and....it was the comments and the expectations of my peers, (the midwives), for example, "oh that's just the way he (the doctor) is, and we just put up with it". Yep, put up and shut up really, just this benign sort of acceptance is what it (midwifery practice) is about."*

(Yoko, Midwife)

Yoko's words demonstrate to us one way in which we conspire amongst ourselves to keep our silence. For her, our silence is a site of struggle, and given the situation she speaks of above, most midwives would not look upon this site of struggle as a potential site of resistance. Instead, it is largely looked upon as a site of acceptance, even though as practicing midwives we may not necessarily be happy about it. This is because of our position as Other, and our feeling that we are not in a position to do anything about it. It is this position of relative helplessness that Yoko describes as, *"...this benign sort of acceptance"*. For most of us, this is how we have come to know our worlds as midwives and as women. If we are strong enough and able to 'refuse what we are' (Foucault in Street: 1992a), our site of acceptance and struggle could become that site of resistance whereby we refuse to participate in taking each other's voices away (Street:1995; hooks:1986).

Aside from conspiring to keep quiet through *"...accepting the doctor's ways"*, our research group discussed and debated many ways in which midwives participated in silencing others. However, the most common theme which repeatedly cropped up through all of our meetings, and which predominated our last meeting, was that of 'horizontal violence'. Through our exploration of what this might mean to midwives, we came to recognise that this type of silencing manifested itself in many ways. It

seemed to affect all levels of midwives from students through to clinical nurse consultants. This affects not only our practice, but how we *feel* and *think* of our 'selves' as midwives. Ultimately this must influence how we care for childbearing women.

### ***Horizontal Violence: power displaced***

The conversation below actively involves all of the participants. It involved us all, as we felt that at some stage in our midwifery and nursing careers, we have been in similar situations. Our 'speak-talk' (hooks:1986) at this final meeting also demonstrates how as a group we had gained confidence to actively raise our consciousness about what we felt as the 'nitty-gritty' of this research project. These particular data fragments speak frankly and honestly about how *each* of us has come to understand horizontal violence in the places in which we work:

*Heather: recently I had three nights where I was subjected to a continual erosion by another midwife who happened to be in charge of the area I was working in. She controlled who did what, actually displaced midwives caring for women by taking over herself, she controlled who had a break and when, went in and out of wards like they were her own rooms to do that, and on and on it went. I feel I've let myself down and others with whom I was working by um not saying any thing at the time.*

*Yoko: so many times in the last four weeks we have said, "why didn't I or why didn't we...", but by doing this, that is this research and discussion, I feel we are coming to see why didn't we say this or do that.*

*Heather: well I analyse this kind of behaviour as horizontal violence, she [the midwife] silenced us and/or excluded us... we lose our voice to these midwives by the way in which they assert themselves.*



*Eliza: yes you can be intimidated very easily...*

*Yoko: What I'm saying is, that when we all started to talk about the doctors and how they made us angry and stuff like that, we now are able to get down to these facts...*

*Eliza: Mmm..the nitty-gritty.*

*Yoko: part of the problem is within our own level, you talk of horizontal violence, you think about the horizontal part, think about the violence, which is a very strong word, there are many different forms of violence.*

*Heather: yes we have to look at what we are at work for, whose interests are being served? we've got get back to caring, being with women, not being with doctor or midwife, we are supposed to be there for the woman.*

*Eliza: yes, the woman should be the focus, not who controls whom.*

As you have read, the conversation above begins with myself speaking of an episode of horizontal violence that had occurred recently. Of course I was left wishing that I had said this or that. The truth of the matter is that when you become the 'victim' it is easier to maintain your silence in the presence of that person, rather than confronting them, particularly after what bell hooks (1984), would call a 'battering' or as I suggested in the conversation, "*a continual erosion*" where I felt I 'worn out' from that sort of violence. From this, it seems that by maintaining silence we actually support the view that control means power, power being seen in this instance as the patriarchal view of power, where it is regarded as a commodity that only some can 'have' or 'own'. This version of power is the accepted mode in most health care institutions, as stated in previous chapters. Where you have midwives whose culture is interwoven with this kind of hegemonic structure, the silencing of each other is not difficult to attain, since importance is placed on *achieving* power and control. A conspiracy of silence however, does develop a sense of struggle when midwives such

as Eliza begin to question the 'placement' of power, "*...the woman [birthing woman] should be the focus, not who controls whom*".

Chinn and Wheeler (1985) and Speedy (1987) urge women who are nurses, and in this instance, midwives, to get to know *our* 'culture' rather than trying to side-step it (thus looking to our own values, instead of taking on those of medicine). By getting to know our own (somewhat curious) culture, we may gain and develop insight into why we are and what we are. Yoko speaks to us about this, and it seems that for midwives to turn to them 'selves' to explore questions and search for answers, we need to review our 'outside' relationships first before we can get to the 'nitty-gritty' of our own particular concerns and problems with other midwives. Yoko's speech in the above conversation, "*...but by doing this, that is, this research and discussion, I feel we are coming to see why we didn't say this, or do that... What I'm saying is, that when we all started to talk about the doctors and how they made us angry and stuff like that, we are now able to get down to these facts [that is, horizontal violence].*" In doing so, midwives may begin to develop critiques about how we are situated in healthcare institutions, and the nature of the relationships involved.

These relationships include not only those between midwives and other types of health professionals, but most importantly, the relationships between midwives themselves. Because of our lack of critical reflective practice and because of how deeply horizontal violence has become embedded in our culture, midwives who carry out this form of violence do so unaware of its implications and consequences (Hastie:1995). They are unconscious of the fact that they are being *violent* to fellow workers ('fellow' in this instance refers to the sameness of profession, not gender). Yoko, brings forward this point, "*part of the problem is within our own level, you talk of horizontal violence, which is a very strong word, there are many forms of violence*", and 'essential' women do not consider themselves 'violent' because we are taught that violence is reserved for men in patriarchal societies.

As horizontal violence had become the topic of our last meeting together, we discussed the different ways in which we were affected and ‘controlled’ by it. These different forms of horizontal violence occur where its effects are felt by midwives regardless of their position within their own hierarchy. The conversation fragments below introduces this notion:

*Heather: I've been labeled 'madam' by a midwife...*

*Yoko: You see that's where you have been placed now in that midwife's eyes, you say what you think therefore you are a 'madam', rather than a forward thinking person.*

*Eliza: This is the price we pay for breaching the silence...*

*Yoko: Yes, yes!*

It is because I *do* choose to speak out in the work place, that I have been ‘labeled’. As Eliza, states, and as discussed by Spinks (1995), “*This is the price we pay for breaching the silence...*” Midwives who speak out are ‘punished’ by some of their fellow colleagues. To question and critique our practice, might threaten how some midwives have come to know their worlds, and attempts to suggest or bring about change are usually uncomfortable for all concerned (Street:1995). This is particularly difficult for those midwives who have learned that the patriarchal form of hierarchy on which midwifery is based, is acceptable in the sense that its presence is overt and has a sense of permanence.

*Lola: Yes, its like you might influence other midwives differently, its happened to me. A midwife would not let me near the student at a delivery [birth of a baby] for fear of what I might suggest differently.*

*Heather: I believe horizontal behaviour to be typical behaviour of oppressed people, lashing out at their own levels. Tall poppies must be cut down because they might speak up and change things. So*

*intimidation might be one way the horizontal violence is inflicted, can you think of others ?*

Through these conversation fragments about horizontal violence, and as shown above, I suggest that not only do some midwives ‘backstab’ and undermine each other within their own particular level, but this kind of violence is also interwoven throughout our hierarchy as stated by Caroline Hastie in her article, “Midwives Eat Their Young Don’t They?: A Story of Horizontal Violence in Midwifery” (1995). Horizontal violence I believe, is mostly an unconscious act that is used by oppressed people as a way of dealing and coping within strictly set structures, who are bound by the laws and rules of that society or culture. In midwifery, a way in which we have come to deal with our lack of voice has been by *learning* that we have little place from which to speak, and for some of us, this has become the way things should be. This could be why some midwives conspire to keep others quiet. Being silenced by our colleagues unfortunately, (and albeitly superficially in some cases) demonstrates an acceptance of our status, maintaining our place as Other.

Our silence, either forced or voluntary, impedes progress and change as Lola herself has experienced. Lola is a midwife who works in a midwife based scheme, and occasionally helps out in the labour ward, as she was in this instance, “...*A midwife would not let me near the student at a delivery [birth of a baby] for fear of what I might suggest differently.*” So, not only has Lola been excluded from her role as a preceptor (which is part of a qualified midwife’s role) because she might practice ‘differently’ (that is, Lola might have encouraged a less ‘scientific’ approach to the birth and actively include the birthing woman in the decision making), but the birthing woman and student midwife have also been excluded from a potential learning experience. Because Lola’s voice has been taken away in this instance, the opportunity to ‘know’ is lost before it could even begin for both the student midwife and most importantly, the birthing woman. This is not to suggest that Lola knows

‘best’ but she may have been able to offer another way of coming to ‘know’ and utilise *midwifery* practice, adapting her practice to the needs and well-being of the birthing woman and her unborn child.

In such circumstances, horizontal violence does indeed become power displaced. For my research colleagues, myself and many other midwives, as the data and supporting literature suggests, horizontal violence is problematic, and it affects the way our ‘selves’ as midwives and women actually feel and practice. It can, and does, affect the care we give to childbearing women and their families. Eliza speaks to us below, about another way in which horizontal violence is interwoven through the various levels within our hierarchy:

*Eliza: ... not letting the junior midwives have the opportunity to ‘be in-charge’, and letting them gain that experience, for fear of what they might say or do.*

*Heather: So, working to enforce the hierarchy then could be a way of violence in itself then?*

*Yoko: yes talk about a way of controlling, silencing, blocking progress.*

It seems that by asking a junior midwife to ‘be-in-charge’ over more senior midwives, in some institutional settings, is upsetting the balance of ‘power’. In other words, if you are ‘seen’ to be taking the ‘power and control’ from a traditionally recognised source such as that of doctor or senior midwife, and be ‘in-charge’ despite your ‘junior’ status, you will be punished, not only for challenging the traditional view of what power might mean, but for encouraging speech from Others and for speaking up yourself. Such a move by a ‘junior’ midwife is often viewed with suspicion, as it might be threatening to some midwife’s interpretation of their worlds of practice. Thus, within our own culture we may relegate some midwives to Otherness. By this, I am not just referring to the ‘junior’ midwives that Eliza speaks of, we have to be

cautious also that we do not alienate those midwives who feel strongly bound to the practices of dominant structures within health care institutions. It is important to recognise that these midwives also make valuable contributions to midwifery. To alienate them would be to perpetuate the myth that inflicting horizontal violence is alright, and we too could stand accused of conspiring to keep them quiet, complicit in taking away the voices of Others. This would resolve nothing.

Horizontal violence, for the most part, is not necessarily a *deliberate* attempt to ‘pull’ down our fellow midwife(s) or silence them. However, it has become an *unconscious* act that some midwives participate in because of how we are situated within our worlds of midwifery practice (Street:1992a). Because our subjectivities, as midwives and women, are constricted through a range of social and discursive practices, there is always a risk of creating a victim-blaming argument. It is not my intention to essentialise midwives as silent, violent women always destined to be that way. Rather, my intention is to point out that if we can critically look inward to our ‘selves’ and how we practice (including how we might treat each other), then we will come to understand how we have come to be as we are.

As our research group discussed the topic of horizontal violence and how it seems to be interwoven across and through the ways in which midwifery is structured in institutions, our talk turned to what this might mean for student midwives. The next and final section of this chapter revolves around the issue of horizontal violence and the affects it may have on student midwives. It is interesting to note here that as a group we sought not only to raise consciousness of the plight of many students, we also discussed ways in which violence against students could be better dealt with. It became a moment of recognition for myself and fellow participants that because we had become so engrossed in the ‘doom and gloom’ of who we were in practice, we almost bypassed that somehow there must be possibilities (A. Robinson 1995), ways that could contribute to the betterment of our culture, *our* midwifery culture. It was

when we were discussing the student midwives and their place as Other within the 'ranks' of midwifery that ideas of 'mentorship' were formed. We actively pursued this line of thought as a group, because we all felt that mentorship could have the possibilities of providing positive long-term implications for midwifery practice.

### ***Maintaining the Status Quo: the student as Other***

Horizontal violence by some midwives against student midwives is something that *does* happen, as you will read in the data fragment below. Carolyn Hastie (1995) supports this notion, when she tells us: "I was told about the lack of support and helpfulness shown to students, new and junior midwives by seniors..." Student midwives are registered nurses and are not without knowledge of the 'system' in which we work. Midwives in Australia are nurses certified to practice midwifery after having successfully completed an education course recognised by both the affiliated professional midwifery body (including the official nurses' registration board) *and* the professional body of obstetricians and gynaecologists (N.B.T:1997). It is a legal requirement in Australia at present, that people wishing to be midwives must first be a Registered Nurse. Because of this, student midwives bring with them to midwifery the knowledge(s) of the social strata within health care institutions, and perhaps how as 'selves' they are situated in it. Compounded with this seems to be loss of 'status'. By this I mean that because these registered nurses have elected to become *students* of midwifery, they are considered by some trained midwives and by some students themselves, as having sustained a loss of 'status' equated with a loss of knowledge as a result of the way in which we have learned what power and prestige mean. What speech they might have had as a registered nurse might unconsciously be taken away.

Some student midwives, and I stress here particularly if they are women, continue to struggle for a place from which to speak, and for this they might be penalised. They become enmeshed in the tensions of being a qualified nurse on the one hand (who should 'know' the 'system' of 'status'), and a student midwife on the other. This is

demonstrated in the data below where Yoko speaks of a student midwife who wrote a critical reflective paper on what it meant to her to be a ‘student midwife’:

*Yoko: Lola and Heather have you read the midwifery student's paper on reflective practice as a student midwife ?*

*Heather and Lola: Yes.*

*Heather: She didn't actually want anyone to read it for fear of reprisal...and some midwives from admin [administration] read it. There were reprisals for this student because she spoke out in her assignment. She hadn't written all 'bad things' [critiquing midwifery practice how she 'saw' it], but for some [midwives] these became the focus.*

*Lola: Yeah, they [some trained midwives] just missed the whole point, they just looked at it only from [their own] perspective.*

*Yoko: Yes, the student was looked at as if she was being scathing, not poor student, [and] this is how we must make them [student midwives] feel, you worry how many other students have felt this way.*

Some midwives' responded to the student midwife's paper believing it was “scathing” and that she was not in a position to critique her ‘place’ as a student midwife. This type of response can be a result of long term oppression by midwives' who have been subjected to constant surveillance and ‘punishment’ themselves, whilst working in health care institutions (Foucault in Sheridan:1986; McHoul and Grace: 1993). In the story above, the subordinate, in this instance, the student, is discouraged from calling into question the existing hierarchy and power relations, as many midwives may have been discouraged similarly before her. Because midwives have been discouraged from questioning, and made to feel that to question is to breach social and professional restraints, the word ‘critique’ has taken on the negative



connotation of 'criticism' (and senior staff are not supposed to be criticised), rather than it being a possible way of learning from another's experiences.

Because of the way midwives have been socialised, some midwives believe that they should be punished for *speaking* out about their experiences. It seems also that some midwives believe that there are those of us who will always 'learn the hard way' - learn that speaking out, or to reflect and critique will mean punishment. If this is the case, then eventually students like the one in our story, who critique-ed midwifery how she saw it, may be silenced and forced to join the ranks of 'docile bodies' which, according to Foucault, can be the outcome for subordinate people who work or belong to patriarchal institutions and who are subjected to persistent scrutiny whether it be by one's own colleagues or a dominant body (Street:1992a; McHoul and Grace:1993; Sheridan:1986; hooks:1986).

It was this account of the student midwife which suggested to us that obviously there were many more student midwives who have, in one way or another, been subjected to similar treatment in learning their 'place' as 'the student'. In the data fragment below we look for a way of dealing with horizontal violence towards students, and discuss those who might be most affected by it:

*Yoko: The students need mentors in situations like this, not preceptors.*

*Eliza: Yes, especially for those who are outspoken, who are often in the same position as some of us [trained midwives] might be at times.*

*Heather: Yes, those who seem to be outwardly eager and open about their intelligence are often cut down like 'tall poppies'.*

*Lola: It would be good for students to pick their mentor...*

*Yoko: Yes it should be strongly encouraged...*

*Eliza: ...it would really be helpful to put things into perspective when needed...*

*Lola: ...yes and then things don't seem so bad.*

*Yoko: It is terrible to see these bright keen women, like that student, who have aspirations of their own, to see them be pulled apart by virtue of another's behaviour and expectations putting these trained nurses down because they are students, and not taking them for what they might have to offer, [and] often referring to them as 'the student'.*

*Lola: Yes, [as midwifery students] you are put in your place, and are not to go above it.*

Eliza implies a kind of empathy, likening the plight of midwives who speak out with the plight of student midwives who might be victimised into being quiet, “...*who are often in the same position as some of us [trained midwives] might be at times*”. It is because of this empathy, knowing what its like to be silenced, that our suggestion of mentorship was borne - ie, all midwifery students should have the opportunity to choose for themselves a mentor. Eliza's comment also suggests that unity, students and midwives coming together to discuss such issues, could be a positive way in dealing with horizontal violence, “...*it would really be helpful to put things into perspective when needed*”.

Some might question the use of such a strong word as ‘violated’ or ‘violent’, but when it is used in the context of horizontal violence between midwives and student midwives and what this can mean, particularly when one considers the long term implications, such as the creation of Otherness and maintaining the myth of the ‘essential’ woman, I find it most appropriate.

It seems that although *all* students are relegated as Other in some way, some were likely to be mistreated more than others, such as those who might be considered “*tall poppies*” or as equally, according to Hastie (1995), the ‘quieter’ student midwife.

Yoko encapsulates what I mean by the ‘*tall poppy*’ in her statement, “*It is terrible to*

*see these keen bright women...who have aspirations of their own, to see them [the student midwives] pulled apart by virtue of others' [trained midwives] behaviour and expectations, putting these trained nurses down, because they are students, and not taking them for what they might have to offer, [and] often referring to them as 'the student'.* She also suggests in her statement, that even the way in which the words, 'the student' are spoken by some midwives, with *much emphasis*, relegates them automatically to Other, and is violent in itself.

The notion of mentorship, as discussed by our group, was not to suggest that student midwives will be spoken *for* by trained midwives, nor was it suggested that mentorship was *the* answer for all (for example, an answer for one person, should not impose that it be the answer for another) but that it may provide the *opportunity* to develop a support network, and a place from which student midwives could speak for themselves. Mentorship, I believe, could be, a positive way in which to deal with horizontal violence through unity, support and reflection. Unfortunately, because of the way horizontal violence is so deeply entrenched in our midwifery culture, the path will not be easy. But the opportunity may be there, the possibility to come together and refuse to be silent voiceless midwife (Foucault in Street:1995), where student and trained midwives alike could learn from *each other*, supporting each other in our speech.

**Chapter 6**  
***Back to the Margin:***  
***agent(s) for change or subject(s) of silence?***

How does one ‘finish’ writing a text for such an ‘unfinished’ story? It has become a task that I have found most difficult. But as I bring this thesis to a ‘close’, I feel and know that my journey within the margins of the health care arena will be ongoing, a continuum of questions and critical analysis. This is crucial if I, and any ‘traveling’ companions I meet on the way, wish to be agents for change in the workplace *with* a place from which to speak. As hooks (1984) believes, to resist critically examining theories (including feminist theory) is to “refuse to acknowledge its limitations” (hooks 1984:160). For me then, to resist critical appraisal of midwifery practice and those discourses with/in it, such as those of medical science, would be to acknowledge and accept midwife’s position(s) within that particular framework without question.

hooks (1984) suggests that women who are seeking change must accept that some will seek change sooner than others, and while change or breaking with a hegemonic system may be the only choice at that point in time, we must not alienate or try to dominate those who remain in status quo. This warning I believe should not be heeded lightly. In the case of midwives there are those of us, such as myself, who are finding a place from which to speak, and there are others who are not able to speak. To dominate these midwives would be to oppress and alienate them, and we could become guilty of producing their speech for them.

When Yoko, Eliza, Lola and I first met as a research group we discussed the possible outcomes of raising each others’ consciousness. This conversation included how, by the end of the data collection, we might not as individuals, be able to occupy the

relatively silent spaces we had occupied previously, and what this might mean (Probyn 1993) Hence we recognised not only our emancipatory potential, but had also discussed possible tensions within it. As each meeting progressed we talked at length about the consequences of speaking out, and it soon became evident that it was highly probable that none of us could seek the spaces we had previously occupied, which was that of a more silent midwife.

Equally important, as we discussed our relative voicelessness and its implications, in particular horizontal violence, we came to understand that lack of support from peers meant the silencing of Others. As Street (1995) suggests, unsupportive action amongst nursing (and in this case midwifery) staff, can actually lead to the silencing of our peers, and can be considered a form of horizontal violence in itself. From this understanding, as a group, we decided that if we could rely on each other for support when speaking out, yes, at least four of us in a sea of many, we felt that this could be a positive start. Although emancipatory action was never the intention of this project, only the raising of its potentials, our suggestions of action seemed, for us, a natural progression. Perhaps this is necessary if midwives are to have more of a voice, enabling us to reconstruct and reposition the socio/professional boundaries of our practice.

Because of the nature of this particular version of feminist participatory research and the ensuing critical analysis of the data, many tensions between midwifery and medicine, and from within midwifery itself, were exposed. As a way of concluding this thesis, I feel it necessary to end on a self-reflexive note in order to reconfirm or to problematise any contradictions that arose throughout this 'story'. An appropriate place to begin here, is to ask: how did fellow participants feel about me framing our stories within a framework of critical feminist post-structuralism?

Through discussions of how I might re-present our stories, the group as a whole recognised the need to align our stories within some type of theoretical framework to provide further meaning and understanding. We invariably discussed feminism many times throughout our meetings, and in particular at our second meeting I brought up the issue of post-structuralism as a critical type of feminism, which on the whole was accepted by the group. It was accepted providing that the outcome of this thesis was 'reader friendly', and the participant's stories were not taken out of context in order to suit the theory. This I have endeavoured to do throughout, all the while however, I felt that I was in a position of privilege as the researcher, who had decided for the group the type of framework in which this thesis rests, about which I often felt the pangs of being the one 'with the power to define' (Acker, Barry and Esseveld 1991).

The major issues which were discussed in this thesis included gender; experience in relation to women as midwives practicing in institutions; lack of voice and the discourses of silence and its relationships to midwives and medicine, and between midwives themselves. As the data analysis demonstrated, when each of these issues were exposed and explored critically, they were not without tensions or contradictions themselves, and nor was I spared these contradictions as a writer. I have attempted to theorise and analyse these issues from a viewpoint that demonstrates not only our positions as women and midwives in Western society, working in institutions, but also by critically examining the relationships between the midwife with the more dominant order of medicine, and how this has impacted on our professional and social practices. By doing this, analysing the data through our stories, I have also attempted to provide an account of our 'everydayness' (Street 1992a, 1995; Walker 1993) as midwives. I am sure there are many 'moments of recognition' for any midwives who read the testimonies of Eliza, Lola, Yoko and myself.

There are places in this thesis, however, where I, the writer, seemed to have positioned medicine as Other or reduced midwives down to 'silent violent women, always destined to be that way'. As I mentioned in earlier chapters, this certainly was not my intention, but rather to demonstrate, as clearly as I could, our position as Other, and how this has influenced our practices, our behaviours, as women and midwives. The point that I wished to make was this: by understanding our positions in the health care terrain as midwives and women, we can then look to the potentials for emancipatory actions if we choose, providing ourselves with a firmer, surer place from which to speak.

However, since I began this thesis (early 1996), in a short space of time, through the small acts of speaking out that I, and some midwives have actively participated, or as Yoko suggested, 'picking at the bricks and mortar' ( and this has not been without some cost at different times) there appears, even now, to be slowly growing 'chinks' in our silence as midwives. This has happened, I believe, through the recognition that there is support in the togetherness of our speech.

## **APPENDIX 1**

### **Statement of Informed Consent**

#### **TITLE**

**“Lack of Voice or a Conspiracy of Silence?: Midwives, Power and Speaking Up.”**

Dear Participant,

This study seeks to identify and examine the cultural issues surrounding why midwives may not feel able to articulate and confront their concerns and problems in practice. Further to this, its intent is to expose and analyse what it might mean to the way in which midwives practice in health care institutions.

You are invited to join this project along with three other midwives, including myself. The intent of this project is to be of a participatory nature, with all participants contributing to the project, which will be used as part of a thesis contributing towards a Master of Nursing, Tasmanian School of Nursing, University of Tasmania.

It is envisaged that we will meet approximately six times, depending on the needs of the group, to take part in sharing our stories as they have occurred in professional practice. We will be assuming pseudonyms and these ‘names’ will be used in the thesis and any documentation or published materials reporting study findings.

These meetings will be audiotaped and transcribed prior to each meeting to provide feedback, discussion and analysis as a group. The tapes and transcriptions will be stored in a locked cupboard to maintain confidentiality.

By agreeing to this consent form, you have also agreed to the following:

- That the information provided by you will be audiotaped for the purpose of transcription and discussion.
- That your identity will be protected at all times by the use of a pseudonym, assuring confidentiality.
- That you may withdraw from the study at any time without prejudice.

If you have read the statement above and agree to take part in the research, please sign below:



I, \_\_\_\_\_, agree to participate in the research outlined, and that the information I provide may be used as part of a thesis, which will contribute towards a Master of Nursing. I understand and accept that my input into the group discussions will be audiotaped and transcribed, and that my identity will be protected by the use of a pseudonym. I also understand that I may withdraw from the study at my own discretion at any time.

\_\_\_\_\_  
(Participant's Signature)

\_\_\_\_\_  
(Researcher's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)

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