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Introduction: risk assessment and midwifery

Beck’s (1992) concept of the Risk Society encapsulates a tectonic shift from a focus on class consciousness of the ‘first modernity’ to risk consciousness and individualisation of ‘the second modernity’. Specifically, the goal to eliminate scarcity under class society is substituted for the eradication of fear and risk caused by technological change under the risk society (Scott 2002). Within the health arena, medicalisation (a focus on illness and disease) is supplanted by biomedicalisation (a focus on health and risk). Health becomes an individual life project or achievement rather than a static physical state where the role of health professionals is to assist individuals to avoid and control potential risks, typically through technological surveillance (Clark et al. 2003). Within maternity care, for example, obstetricians and midwives base their professionalism on the successful anticipation of risk before it occurs. The contentious point is that these professions employ different models of birth and the body in their understanding of the sites of risk and its avoidance. The techno-rational/scientific (biomedical) model has assumed that the body itself is inherently risky. The role of the obstetrician, therefore, is to anticipate risk before it occurs typically intervening to avoid an adverse outcome. In reverse order, holistic midwifery regards medical interventions as the major source of risk to women and babies (Lane 1995) because for midwives, birth is a normal physiological and social event (Skinner 2006: 62); midwives avoid risk by avoiding medical intervention – that is, in facilitating a normal birth through ‘woman-centred’ care. Consumerism has thus traditionally formed the corner-stone of midwifery practice and professionalisation. However, while cognisant of the relationship between risk assessment and woman-centred care and the wider project of midwifery professionalisation, this chapter focuses primarily upon a critical examination of the rise of consumerism and risk cultures and how they relate to the growing support for complementary and alternative medicine (CAM) within midwifery.
In this chapter I argue that ‘woman-centred care’ within midwifery practices is inherently compatible with CAM and focus attention upon two advantages that CAM provides midwifery. First, as a signifier of the individualisation of health care with its more recent shift towards consumerism, CAM facilitates the active participation of consumers in making decisions about their own health care. Just as CAM recognises individual idiosyncrasies in proposing appropriate treatment, so is midwifery cognisant of the active participation of the mother in defining her own care compatible with her unique biography. CAM may profitably add to the midwifery arsenal of treatment regimes in which case it would help to define midwifery as a ‘realised’ risk culture.

The second advantage for midwives using CAM is that it allows midwives to practise as primary carers effectively and autonomously in managing real and perceived risk without recourse to medical expertise. CAM promotes midwifery as primary care (rather than obstetric assistance) because CAM lies outside of the medical jurisdiction and thus facilitates midwives’ professional distance from their institutional competitors and colonisers (i.e. obstetrics). Midwifery and CAM are thus natural allies but only if CAM is adopted as part of a ‘transformative integration’ pattern of medicine (one that refuses to compromise holistic principles and is used only in consultation with the woman) (Kailin 2001; Coulter 2004).

**Risk Society thesis: the heartland of health care, obstetrics, midwifery and childbirth**

At the heart of the Risk Society thesis (Beck et al. 1994; Adam and van Loon 2002) is the proposition that modern societies are the structured outcome of advanced industrialisation, a process that has produced hazards that cannot be controlled or managed by existing safety systems. Our faith in the progressive nature of science is a casualty of the new risk society because science, in conjunction with commercial exploitation, has been a key actor in producing the very risks it now seeks to resolve. The revelation of the fallibility of science produces the first proposition of the risk society – ‘reflexive modernisation’ which refers to the self-authorisation of individuals as a consequence of their mass disenchantment of science. Individual autonomy is the outcome of negotiating contradictory discourses emanating from scientific inquiry and in finding their own resolutions for scientific and commercially produced hazards. The second proposition is that the risks manufactured by industrial technologies are dispersed globally, unevenly and often invisibly; they materialise only as symptoms perhaps some time later.

A more recent update entails a further proposition that risks are manufactured by social individuals from particular vantage points or philosophical traditions. Risks are not simply ‘out there’ but based upon context,
epistemology, political interest and power; risks are attached to situated knowledge (Haraway 1988). It follows that there are competing definitions of risk associated with competing paradigms of knowledge that produce competing solutions and, since this is a political process, not all definitions and their respective solutions will be equally credible. The political process centrally involves the media, commerce, the state, law and science—all of whom produce variable interpretations of the meaning of risks. The outcome is a pervasive sense of uncertainty apprehended by reflexive individuals in different ways that call for a reflexive disciplinarity; an opening up of knowledge claims that go beyond traditional disciplinary boundaries. This is what is inferred by ‘reflexive modernisation’ (Beck 1992) and what Adam and van Loon (2002: 10–11) call a ‘repositioning of risk’ requiring a ‘repositioning’ of the bases of social theory. The latter must necessarily relinquish an ambition to produce theory that will provide general laws and abstractions as in the Enlightenment quest for prediction and order, or determinate judgement, in favour of theory that harnesses what Lash (2002) calls ‘an aesthetic of the sublime’; a judgement based upon bodily powers of tacticity, the immediate and the sensuous.

Similarly, Scott (2002: 38) argues, Beck’s theory of the risk society anticipates risks as really ‘out there’; it is an objectivist, realist theory of risk. Scott denies an unmediated connection between risk consciousness and real risks on the grounds that this ignores the interpretation of risk by different kinds of communities with their specific conventions, norms and structures. Scott is reluctant to concede Beck’s division between the class consciousness of class societies and the risk consciousness of risk society, an argument that rests on the indivisibility between risk consciousness and class consciousness. It assumes that those who have most to lose are those who perceive higher levels of risk. The question for Scott (2002: 43) is, ‘how safe is safe enough for this particular culture?’—to answer this question we must inquire into the relative and dynamic nature of the discourses surrounding individual freedoms and collective responsibility within a particular society.

**Risk Culture**

In adopting a social constructivist paradigm, ‘Risk Culture’ is the starting point for Lash (2002: 47) who, like Douglas and Wildavsky (1983), argues that ‘real’ risks have not necessarily increased but that our perceptions of risk have escalated. Beck et al.’s (1994) objectivist notion of risk *society* assumes ‘a determinate, institutional, normative, rule bound and necessarily hierarchical ordering of individual members in regard to their utilitarian interests’ whereas:

Risk *cultures*, by contrast, presume not a determinate ordering, but a reflexive or indeterminate disordering... Their media are not procedural
norms but substantive values. Their governing figurations are not rules but symbols: they are less a hierarchical ordering than a horizontal disordering. Their fluid quasi-membership is as likely to be collective as individual, and their concern is less with utilitarian interests than the fostering of the good life . . . Risk cultures are based less in cognitive than in aesthetic reflexivity. Risk cultures are reflexive communities. (Lash 2002: 47; emphasis added)

To substantiate his departure from a positivist view of risk, Lash draws critically upon Douglas and Wildavsky's thesis in *Risk and Culture* (1983) proposing there are no increases in risk but only an increase in the perception of risk on the part of powerful social actors, mainly those attracted to environmental causes. Their radicalism and allegiance from the unreflective masses was allowed to grow, they argue, because of the 'softness' of core institutions, read the Catholic Church, in failing to condemn them. Although Lash rejects the inherent structural functionalist conservatism of Douglas and Wildavsky, he enthusiastically appropriates their idea of the sect and the subjective interpretation of risk, albeit with a positive twist, to suggest that such groups or sects are better conceptualised as anti-institutional because they are 'constructed in the context of institutional uncertainty of risk' (Lash 2002: 60) and may work to signal to others where such risks are located. Without hierarchy, sects comprise individuals who meld through mutual affection and intense commitment to common causes. Sects are possible because people join with others in their mutual incomplete and unfinished subjectivities; they define themselves in terms of lack rather than a certainty afforded through institutional traditions or rationality. As communities of affect, Lash (2002: 60) argues, sects espouse values rather than norms:

The sort of sociations that make up the critical risk cultures of reflexive modernity are not normative but value groupings that operate in the margins, in the third space, the boundary that separates private and public life. They are cultures and not institutions in the sense that they operate in the media of values not norms. But they are characteristically risk cultures . . . in that there is chronic uncertainty, a continual questioning, an openness to innovation built into them. They deal with risk, with identity-risks and ecological risks, not so much through rational calculation or normative subsumption, but through symbolic practises and especially through symbol innovation.

The significance of sects for Lash is that they represent a cultural vehicle in redefining realist interpretations of risk. In this enterprise, Lash invokes Kant's concept of reflexive judgement that emanates, not from rules of logic (determinate judgement), but from feelings. It takes place, not through under-
standing (cognitive, self-monitoring processes) of a priori rules, but through imagination and sensation. Reflexive judgement does not follow rules, it must look for rules; it is created, not logically, but 'through the approximation of “configurations” to one another' and then in synthesising or constructing new meanings (Lash 2002: 55). In a post-industrial milieu (as opposed to Beck's industrial risk society where risk is conceived as fixed, objectivist, norm-based and rationally defended) reflexive modernity comprises dynamic, anti-institutional, subjective and affective-based risk cultures.

The notion of constructed risk and risk cultures as comprising anti-institutional and critical but reflexive communities forged through affect and utilising reflexive judgement are useful propositions in attempting to unravel the complexities that surround the 'postmodernisation' of health care and the fast growing normalisation of CAM use, particularly by primary practitioners, such as general practitioners (GPs) (Eastwood 2000; Easthope et al. 2001; Rayner and Easthope 2001), nurses and midwives. The concept of risk culture promotes a more incisive understanding of the position of midwifery in appropriating CAM in primary care and in midwives repositioning themselves vis-a-vis obstetrics in the new collaborative care regime promoted by the post-welfare neoliberal state in Australia and elsewhere (Department of Human Services 2004).

The postmodernisation of health care: the emergence of risk cultures

Connor (2004) surmises from her study of residents of a small suburb in Australia that people use CAM therapies, in conjunction with other medicines, as a defensive strategy against the humanly manufactured risks of 'risk society'. Such risks include the lack of work/life balance, use of addictive substances and pollution of the natural world by the side-effects of industrialisation. Connor's study comprising 34 respondents (18 women, 14 men and 2 children) compares with other work that reports usage rates for men and women on a broader scale (Adams et al. 2003; Murray and Shepherd 1993) and an international review that found rates varied from 9% to 65% (Ernst 2000). Australian government surveys show that 42% of Australians use CAM treatments and similar findings have been made in the USA and the UK (Murray and Shepherd 1993; Eisenberg et al. 1998; Bensoussan 1999; Coulter and Willis 2004). An important next question is: why do significant numbers of people increasingly use CAM?

A somewhat surprising outcome of the rising use of CAM has been an increasing willingness on the part of allopathic practitioners (given their pronounced aversion to CAM) to at least consider the possible benefits or at least refer patients on to alternative practitioners. Many GPs have even undertaken short courses on some of the more popular options, such as
meditation, relaxation therapies, herbal medicine, nutritional medicine, acupuncture, manipulation and homeopathy and have incorporated them into their own practice (Adams 2004; Eastwood 2000). Even the Australian Medical Association (2002) has been pressured by a groundswell within their own ranks to recognise the growth of interest among GPs but also among specialties such as obstetrics, gynaecology and rheumatology and to note an increasing demand on hospitals and pharmacies to produce policies in response to patients who desire continued use of CAM during hospitalisation. Of course this may signal, not an acceptance of the verities of CAM, but more a begrudging acknowledgement of its burgeoning use and an overarching concern to contain CAM within orthodox boundaries via standardisation, research evaluation, professional accreditation, regulation of practitioners and training for members.

The individualisation of risk

We need to account for the inevitable event that all information, including CAM discourses, are culturally mediated or selectively interpreted and used. Goldner (2004) intimated this by calling CAM a social movement because users comprise loose social networks through the sharing of information to create an alternative way of life. This is a useful step forward in understanding the political tendencies of CAM users. Many users identified by Goldner (2004) seek more ‘balance’ in their lives even when disease is not present; alternatively, those afflicted seek to improve their lives ‘spiritually, emotionally, mentally and socially’ (Goldner 2004: 15). The ‘postmodernisation’ of health care goes some way in explaining the rise of CAM (i.e. that users reject the legitimate authority of science and allopathy) but we also need to account for its momentum – that is, the increased acceptance among health consumers that health is an individual responsibility. The users in Goldner’s (2004) study are a case in point. They were less concerned about the absence of scientific rationale than they were in practical efficacy; CAM empowered them to take individual responsibility for their health. Although these consumers did not believe they created the problem, they did believe that they were responsible for finding the solution.

This is where we might usefully employ Lash’s (2002) concept of ‘risk culture’ or ‘reflexive community’ to explicate the growing use of CAM because ‘risk culture’ implies the individualisation of risk as well as a rejection of realist interpretations of risk and the body. At the very least, CAM users are placing ‘a bet each way’ on CAM and orthodox medicine (Bakx 1991; Siahpush 1999; Willis and White 2004). Users are not especially concerned that CAM lacks an objective, scientific, evidence-based grounding but follow a Kantian assessment that rejects the rules of logic (determinate judgement) in favour of feelings, imagination and sensation. So long as they believe that CAM gives them ‘balance’ users are not especially
concerned with explaining how it works. Such reflexive judgement juxtaposes experiential knowledge to create new paradigms. As Goldner (2004) showed in her study of CAM users, respondents' activism began with positive results from which they embraced the foundational philosophies then projected their worldview into political campaigns whether these were individual-based or collective strategies. In rejecting the authenticity of orthodox biomedicine, CAM cultures signify via symbolic means (vital forces, energy fields, qui, chakras, spirit) where risks are located (neoliberalism, capitalism, corporatised medicine, globalised pharmaceutical industries). CAM users are often passionate about their own health and see their own micro-interactions in terms of a macro-political framework where CAM is consistent with defending and healing an increasingly fragile universe.

**The happy marriage of midwifery and CAM**

The second part of my argument is that risk cultures can be applied fruitfully to understand a close affinity between CAM and midwifery. CAM refers generally to a diversity of practices and traditions that may be categorised broadly as those that adopt vitalistic principles at the centre of the healing modality. Vitalism conveys the understanding that any form of life is energised by a life-force that is more than the sum total of chemical and physical forces (Coulter 2004). Disease is said to be an outcome of the imbalance of the body's vital force caused by the interaction between the individual and the environment, including the social environment. This Kantian dialogic relationship between nature and culture produces a different set of assumptions about the relationship between practitioner and patient and a different approach to treatment. In assuming that both are active interpreters of the social environment, CAM promotes a more egalitarian exchange between equals at the heart of the clinical encounter. Treatment regimes are similarly sympathetic to the integrity of the individual body. Homeopathic remedies, for example, treat 'like with like' or, in other words, try to match the remedy with the symptoms of the disease on the grounds that the body will produce its own antidote. The medicine is used only to prompt a 'natural' recovery towards what they believe is a natural equilibrium. Biomedicine, by contrast, explains disease by reference to material causes. Cartesian dualism between mind and body, subject versus object, practitioner versus patient produces a hierarchical relationship between expert and (passive) recipient and with it a definition of illness as a malfunction of a particular body part (Coulter and Willis 2004; Collyer 2004). It follows that CAM and at least some midwifery practitioners will share intrinsic affinities that prove fortuitous in the shift towards consumerism under neoliberal political and economic reforms and individualisation under risk society or risk cultures.
Midwifery practice has traditionally occupied a strident binary opposition to obstetrics. This traditional dichotomy between techno-rationality and holism, however, has been ameliorated in more recent times by the collective forces of marketisation, managerialism and consumerism. In the push for value-for-money alternatives, neoliberal government policies have urged greater collaboration among midwives and obstetricians (Department of Health 2004; Reiger 2006) resulting in a blurring of professional boundaries and at least a limited convergence of ideas around childbirth practices (Lane 2006). It is now more useful to consider practitioners from both professions as occupying fluid positions along a sliding scale demarcated by a reductionist model of birth, the body and risk at one end of the continuum and a holistic model at the other. Individual positioning is neither entirely predictable nor static and will depend on a range of factors including: the place of birth (private versus public sector or home); the training and expertise of the midwife and obstetrician; the educational level and express wishes of the mother; and the perceived nature of the risk. Such complexities signify a greater degree of heterogeneity of practices now than in the past within midwifery and in medicine in defining and assessing risk and in providing optimal care for women (Lane 2002; 2006).

Notwithstanding individual differences in practices, significant differences remain in the respective spheres of practice of obstetrics and midwifery and in their assessment of risk. Midwives claim that ‘woman-centred care’ (as opposed to profession- or provider-centred care) optimally delivered via continuity of care by a known midwife is the antidote to adverse outcomes principally because it recognises individual choice and intrinsically works with the idiosyncratic needs of women, especially in labour and childbirth. Midwives describe their practice as comprising skilled techniques in calming, encouraging, facilitating, listening, looking for cues, anticipating needs and strengthening women’s resolve to birth without intervention (Leap 2000). In assuming no differentiation between mind and body, this brand of holism is based upon providing a secure, peaceful and predictable environment where harmony between the woman and her social environment (and especially the carer) is the key to non-medical interventionist outcomes. Midwives claim that obstetrics, by contrast, is rule-governed and non-consumer-centric because the biomedical default position assumes that all births are potentially high-risk events. Logically, therefore, the obstetrician aligns with the baby to circumnavigate the primary risk variable that is the mother and her inherently risky body. Although many obstetricians now expect, and even welcome, women’s demands for more information and choices (Lane 2006), they nevertheless draw the line much earlier on what is deemed ‘safe’. The outcome is much higher rates of all kinds of inter-
ventions under obstetric care sometimes referred to as the 'cascade of intervention' (foetal heart monitoring, syntocinon augmentation to speed up labour, epidural, forceps extraction, episiotomy and caesarean section). Ironically, obstetricians say they use these procedures to anticipate risk before it occurs (Lane 2006).

The irony is that from a holistic, midwifery paradigm the positivist mindset, rather than the mother's inept body, represents the most potent site of risk (Lane 1995). For holistic midwifery practitioners the key to safe practise is the Kantian dialogical relationship between practitioner and patient (Collyer 2004) — that is, relations based upon mutual respect, integrity and reciprocity (Lane 2000). The commensurability between CAM and midwifery is that both require patients to extensively discuss their idiosyncratic location in the world for the optimal medicine to be prescribed. This is what midwifery means when describing its practice as 'with women' (Leap and Hunter 1993). The idea that the relationship is actually a 'partnership' (Guilliland and Pairman 1995) is now an accepted part of the lexicon of midwifery practice (Victorian Midwifery Code of Practice, Nurses Board of Victoria 1999) appearing in leading midwifery training texts:

A midwife forms a partnership with a woman as she experiences the life process of childbearing and early parenting. Midwifery care is woman-centred . . . The midwife shares knowledge, experience and wisdom reciprocally with the woman and her family. The midwife protects and promotes the dignity of each woman and accepts her culture, beliefs, values, expectations and previous experiences. The midwife and the woman make decisions together through a process of negotiation.

(Pairman et al. 2006: vii)

Holistic care, 'woman-centred' practice and 'continuity of care' constitute key features that midwives claim distinguish their practice from obstetrics. The latter is based more on a defensive style of care, a 'just in case' syndrome, that encourages a greater use of technology and thus restricts choices for women. Conversely, 'best practice' midwifery is defined as woman centred, rather than profession or institution centred. It is on this premise that one recent training manual (Tiran and Mack 2000: 6–11) promotes the use of complementary therapies (massage, relaxation, meditation, visualisation, guided imagery, play and humour, music, therapeutic touch and a healing environment in pregnancy and childbirth) as ideal modalities to achieve increased choice and control for women, a better emotional experience and a safe delivery without unwanted side-effects for the mother or her baby:

[Complementary therapies have] . . . fewer side-effects than many of the pharmaceutical options, and enable the mother to achieve not only a
safe delivery of a healthy child but also to experience a satisfying, significant episode in her life. Mothers and midwives are looking to complementary therapies to avoid the risks of drugs to the unborn baby . . . provide more natural advice for the relief of common discomforts of pregnancy and the postnatal period and [provide] . . . alternative forms of pain relief in labour.

(Tiran and Mack 2000: 10-11)

Significantly, this manual suggests CAM is to be used in consultation with the client who no longer accepts the belief that ‘doctor knows best’ or that allopathic medicine has all the answers (Tiran and Mack 2000: 3-4):

while orthodox medicine views the body in a reductionist manner, as an engine which can be dismantled, mended and reassembled, irrespective of temperament, personality, emotions or external influences, CAM is based on an understanding of the interaction between body, mind and spirit, and a recognition of each person as an individual in the wider context of the environment.

Further, CAM ‘expands choices for women and helps them to feel in control of their own wellbeing’ (Tiran and Mack 2000: 3-4). The fact that CAM therapies lack scientific support should not deter midwives from using them, it is stated, because the randomised, double-blind controlled clinical trial is ‘not always an appropriate methodology for complementary medical research’ (Tiran and Mack 2000: 5). For these authors, CAM and midwifery are perfect partners in providing optimal health care for women. Both harbour philosophies that reject biomedical reductionism and both regard individuals as reflexive subjects whose symptoms mirror their discrete interpretation of a complex environment where choice and active involvement are fundamental requisites in the healing process; both therefore are holistic and see healing as more ‘art than science’ (May and Sirur 1998). But can we regard midwifery as properly coming under a ‘CAM risk culture’?

Despite the obvious convergences between CAM and midwifery, there is little indication that midwifery political bodies or mainstream educational curricula have embraced CAM usage as a natural ally of consumer choice and continuity-of-care. The Australian College of Midwifery Inc. has posted no position statement on CAM (unlike the Australian Medical Association [AMA]) and a recent text on midwifery practice (Pairman et al. 2006) specifically avoids discussion of CAM usage by midwives except briefly to caution undergraduates that the efficacy of CAM for pain or discomfort is yet to be proven. Midwives were warned not to assume that ‘natural’ or ‘alternative’ means ‘safer, lower risk or more effective than conventional options’. Rather than promoting CAM remedies, midwives were urged to
advise their clients to adopt a healthy lifestyle, healthy diet and follow a moderate exercise regime (Grigg 2006: 366). However, Lash (2002) argues that risk cultures are by definition marginal. Building on this, we might distinguish between latent and realised risk cultures. CAM sympathisers within midwifery who are usually community-based independent midwives could be called a realised risk culture in that they espouse egalitarian, holistic values, are reflexively interpretive and judiciously anti-science. While mainstream midwifery practised in hospitals is dominated by obstetric protocols, it may still be regarded as anti-institutional in relation to the objectivist mindset of obstetrics. All midwifery practice sees risk in intervening too early in a woman's labour, in imposing standardised timeframes in which the woman must progress through labour and in undermining her confidence in her ability to give birth without drugs and surgical procedures. Thus all midwives constitute, at least notionally, a latent risk culture.

Individualisation

It is necessary at this point to take a detour to Beck and Beck-Gernsheim's (2002) concept of individualisation or, 'institutionalised individualism' which points, like the 'Risk Society' thesis (Beck 1992), to a new epoch of modernity called second modernity or reflexive modernity. Individualisation is the flip side of the Risk Society; it refers, not to the neoliberal idea of the self-sufficient individual and the disappearance of mutual obligation, but to the fundamental incompleteness of the self. In developed modernity, the central institutions protecting civil, political and economic rights, including the labour market, education and health, are geared towards the individual. Giddens (1992) called this the 'disembedding of social relations' whereas Beck and Beck-Gernsheim (2002) call it 'individualisation' meaning 'an institutionalised imbalance between the disembedded individual and global problems in a global risk society' (Beck and Beck-Gernsheim 2002: xxii). Individualisation refers not to a 'me-first' society, but an 'ideal intimacy situation' (borrowing from Habermas) that governs the construction of specific rules for intimate, reciprocally interactions. The old structures - class, gender, ethnicity and status - no longer mould the individual. Rather, the individual is shaped by an ethic of self-fulfilment and achievement. It is a search for a 'life of one's own in a runaway world' (Beck and Beck-Gernsheim 2002: 22–9); an attempt at social cohesion when the new ontologies of Western culture are formed from individualism, diversity and scepticism. Individuals are forced to be free to construct their own biographies, including their own failures, and their own traditions. They must be reflexive - to be able to process contradictory discourses within the risk society of global uncertainty.

Individualisation has transformed the concept of health and the body from the idea of having 'lucky genes' to a task, an ongoing project and a
life achievement and to this end a reflexive individual will visit a variety of
modalities and, more significantly, actively institute ways to prevent illness
via a 'proper' lifestyle, diet, exercise and life choices and probably above all
a positive mindset. Under individualisation, health infers, not the absence
of illness, but a vehicle to optimal personal performance.

**CAM and autonomous professional practice**

It is my thesis that, potentially at least, CAM provides a fortuitous crux to
the emergence of the midwife as primary carer at a time when the neoliberal
state is encouraging the dissolution of professional boundaries that may
impede economic efficiencies. The National Competency Standards for the
Midwife (ANMC 2002), for example, defines the midwife as:

> a responsible and accountable professional who works in partnership
> with women to give the necessary support, care and advice during preg­
> nancy, labour and the postpartum period, to conduct births on the
> midwife's own responsibility and to provide care for the newborn and
> the infant. This care includes preventative measures, the promotion of
> normal birth, the detection of complications in mother and child, the
> accessing of medical care or other appropriate assistance and the
> carrying out of emergency measures . . . A midwife may practise in any
> setting including the home, community, hospitals, clinics or health units.
> (ANMC 2002: 1; emphasis added)

**The history of midwifery subordination**

These internationally agreed upon dictums demand the midwife be profes­
sionally autonomous. Specifically she/he should carry out preventive treat­
ment and only as a last resort call for medical assistance. In practice, such
autonomy has been vastly undermined by legal regulations and obstetric
and hospital protocols that had been transplanted from the British medical
system and instituted within Australia at the time of early settlement
(Willis 1983).

Legal control of midwifery in Australia is now variously apportioned in
different statutes and regulations in each of the states. The Victorian and
Tasmanian statutes have been the most repressive. Tasmanian regulations
stipulated that women must attend a medical practice for maternity care
and 1985 Victorian Midwifery Regulations 601–604 propped up obstetric
dominance by requiring medical supervision of all midwifery activity,
including vaginal examinations, manipulative procedures and delivery.
Unsurprisingly, consumer and midwifery calls for the abolition of the regul­
tions were thwarted by the College of Obstetricians and Gynaecologists.
These kinds of legal constraints on autonomous midwifery gradually
diminished in light of recommendations made by government reviews of birthing services in most states in the 1990s. These recommendations included a more active role for midwives in and outside of hospitals, the public funding of community (homebirth) midwifery (only now being considered), the development of a direct entry midwifery degree (which has now eventuated fifteen years later), the recognition of overseas trained direct entry midwives (normally from the Netherlands or Britain), and the granting of hospital visiting rights for independently practising midwives (Department of Health Victoria 1990: 155–6).

Some state governments (Victoria, New South Wales and Northern Territory) have more recently recognised the cost savings to be achieved under caseload models that ensure that women receive one-on-one care throughout their maternity careers by a known midwife (Reiger 2006). This is an important shift not just in midwifery autonomy but in achieving better outcomes for women because evidence suggests that continuity of care by a known midwifery is the best assurance of lower intervention rates and lower rates of morbidity (and lower costs) (Oakley and Houd 1990).

The one remaining obstacle to full autonomy for midwifery, at least technically, has been the removal of professional indemnity insurance in the aftermath of the collapse of HIH (Heath International Holdings) although there are encouraging signs recently that one insurer is finally prepared to provide professional indemnity for all midwives regardless of where they practise. This may encourage the expansion of autonomy although residual cultural factors pose the greatest barriers. These include the consequences of decades of deskilling under labour-force deployments where midwives were assigned exclusively to one of three areas of maternity care – antenatal, delivery and postnatal units. This fragmentation effectively divided midwifery into specialties and downgraded them as obstetric assistants. The outcome has been depleted skills and a correspondingly deflated midwifery identity among the majority of midwives, but particularly those who work in hospitals. The upshot of such developments is that few midwives are currently willing to volunteer to take on the caseload mantle although this may change when graduates from current Bachelor of Midwifery (direct entry) courses in South Australia, Victoria and New South Wales make their presence felt in large enough numbers in the labour-force. There are early signs that a new professionalism is emerging – one that encourages midwives to regard themselves as fully autonomous professionals in partnership with both obstetricians and women in the delivery of maternity care (Lane 2006).

In terms of risk assessment, qualitative and quantitative studies have shown that obstetric care in hospitals has never been safer than delivery at home attended by a midwife (Tew 1990), although such claims can only be authenticated if there is an adequately skilled midwifery workforce. CAM may yet prove instrumental in promoting the caseload model as it propels
the midwife into the role of primary carer and autonomous professional. The Australian College of Holistic Nurses endorses the signal advantage of CAM interventions because it protects midwifery autonomy: ‘carried out within the scope of nursing or midwifery practice [CAM therapies] do not require a medical practitioner’s order’ (Australian College of Holistic Nurses 2002: 6–7). Of course other practitioners (complementary/alternative therapist, pharmacist, medical practitioner) may be consulted but only when circumstances dictate. Although primary health care has traditionally been the province of general practice (Dowell and Neal 2000: 9) its holistic parameters could equally describe the increasing role of one-to-one, caseload midwifery with its ‘value-for-money’ qualities (Power 1999), including the substitution of expensive obstetric care, 24-hour personal and family care and its potential to realise lower medical interventions. In short, CAM has attractive qualities in realising midwifery autonomy.

The transformative integration pattern of medicine

Collyer (2004) has argued that CAM expansionism has been driven by commercial opportunism which is slowly transforming its cottage industry status into corporatisation. Although CAM has been mainstreamed, what arises (according to CAM practitioners) through a superficial merging of treatment regimes on the basis of a short introduction, is a loss of the philosophical basis of holism and a dilution of the healing potential. Kailin (2001 in Coulter 2004) has argued that attempts to integrate biomedicine with natural medicine often fall short of the objectives of all stakeholders. Allopathic practitioners typically contain CAM by imposing a biomedical perspective on the disease and employing CAM in a limited way within their own paradigm (Adams 2004). Consumers lose because the medicine is imposed uniformly according to surface symptoms rather than applied sensitively according to their unique constitutional disposition and complex causes. Nevertheless, one option is the ‘transformative integration pattern’ (Coulter 2004). Here CAM and biomedicine mutually inform each other within a close collegial relationship. The question is whether this kind of respectful relationship between medicine and CAM is likely to emerge within maternity care.

The issue is best represented as a battle between dominant and marginal discourses. The AMA requires hard evidence from double-blind randomised controlled trials (RCTs) to ensure CAM medicines pass the three pillars test – safety, quality and efficacy (AMA 2002). The problem is that CAM remedies are not easily evaluated by randomised controlled trials (Pirotta 2006). The assumption underlying the RCT is that patients are the same – that the body is a universal, uniform mechanism (Dew 2002). However, modalities such as homeopathy are based upon the opposite
premise that one's constitution is a complex amalgam of life experiences that renders the universal body an impossible concept. In an experiment, the body cannot be kept constant so that differential outcomes test the intervention. Indeed, one of the challenges for the holistic practitioner is to ascertain exactly each patient's constitution to prescribe exactly the right medicine and this may only be achieved through a very long, in-depth interview. Even then after following such detailed inquiry, finding the right medicine is trial and error due to the complexity of individual identity.

Extrapolating a view of the body and identity as complex entities explains why midwives generally define risk in childbirth as precipitous medical intervention; their critique of obstetrics is that it pathologises the normal (Lane 2006). Normal birth may occur outside predetermined timeframes because individuals labour at different rates and treatments are determined by individual responses to their immediate social environment, medical and obstetric history and idiosyncratic choice. Midwives claim their practice is premised on birth as a normal, physiological process and significant life event (ANMC 2002) where each woman will require different types of assistance depending on how she constructs her life's narrative. The sociological adage that biography becomes biology is nowhere more evident than in childbirth. By conceptualising birth as a social event that requires idiosyncratic social support rather than medical interventions, midwives are more likely to adopt CAM within the realm of preventive care when appropriate and always in consultation with the woman. This philosophy constitutes the use of CAM within a 'transformative integration pattern' – transformative (of the old hierarchical relations) due to the refusal to compromise holistic principles and only for use in consultation with the woman.

Conclusion

I have argued in this chapter that we need to take a constructionist view of risk. Risk is anticipated by different cultures differently; risks are attached to situated knowledge (Haraway 1988). Lash (2002) proposes that we abandon the idea of risk society (a realist objectivist notion of risk) in favour of risk cultures. Risk cultures define themselves not in terms of rules of logic but in terms of reflexive judgement drawn from imagination and sensation. In a post-industrial milieu, risk is not fixed, norm-based and rationally defended, but dynamic, anti-institutional, subjective and affective-based. I have argued that CAM users and practitioners may be usefully categorised under this banner. They eschew rational scientific philosophies in favour of holism, vitalism and naturalism (Coulter 2004). Midwives may not universally advocate the use of CAM remedies. However, I argue that CAM has two distinct advantages for midwives. First, CAM allows midwives to galvanise their 'partnership' relationship with women. This is
an organic relationship because 'partnership' defines midwifery professionalism and practice and thus CAM can only strengthen such a relationship. Second, CAM is consistent with holistic midwifery practice and the quest for autonomy (from obstetrics) because both CAM and holism lie outside of medical positivism and reductionism. As such CAM and midwifery are natural allies. Finally, in line with these themes, there appears every likelihood that CAM use would be executed by midwives in a transformative way – that is, in the quest for an integrative model of care that refused to sacrifice holism or active consumer participation.

Note

1 Contracting Advantage offers two operating systems:

1 The ODCO System – Agency services to hospitals and other establishments with permanent employees.
2 Independent System – Agency services on a user pays basis for self-employed contractors.

The ODCO Pty Ltd System: This is the original contracting system set up for self-employed contractors. The system has been tested in courts several times and has been legitimised after Unions questioned the legality of the Agency. The ODCO system continues providing services for contractors, is audited and complies with the legal requirement of appropriate Licensing Boards. An example of the ODCO System working for a Private Midwifery Practice: If the company Melbourne Midwifery wanted to permanently employ full-time or part-time midwives, the ODCO system would require a 10% Administration fee; 5% paid by Melbourne Midwifery and 5% by each employed midwife. This system can be offered with cost savings to hospitals, universities and other organisations employing full- or part-time midwives. A midwife who both has private clients and is employed by a hospital system must be clear in declaring her/his client contractual arrangements from the outset.

The Independent System: In this case a user pay system provides individual access for midwives to Professional Indemnity and Public Liability Insurance for any sphere of practice – antenatal, labour and birth, postnatal, education (inside or outside hospital settings). The system is flexible – it will meet the needs of midwives who have not yet set up a business and for those who have well-established business facilities. Midwives pay a $500 per year up front fee for the Insurance Policy; there are no professional or other exclusions. The ACMI Codes and Guidelines are used for risk assessment. The back-end Administration is similar for both Systems; CAdv can deal with invoicing clients on behalf of midwives, or midwives in established businesses can choose to continue without disruption their individual accounting and payment systems.

(Broadcast email to Maternity Coalition members from R. Thompson, Director, Melbourne Midwifery Pty Ltd, 6 September 2006).
References


