

Delivering Obstetric Hegemony: an analysis of the Maternity Services Review

Monica Campo
Kerreen Reiger
School of Social Sciences

Maternity policy in Australia

Context:

medical dominance over childbirth policy
since early C20th

1989s- 2000s: several state reviews and
process of social contestation

Who is defining the 'policy problem'
(Bacchi 2002)?

And in whose interests?



The Maternity Services Review (MSR)

- Auspiced by the Rudd Labor Government under health minister Nicola Roxon
- Midwives and childbirth advocacy groups concerned with escalating intervention rates, decline of access in rural areas, lack of access to continuity of care with a midwife, and continuing obstetric dominance



the Review involved

- a discussion paper, consultation sessions and received 900 submissions
- Report recommended legislative changes to facilitate greater provision of midwifery care but
- excluded independent (homebirth) midwives from eligibility to government sponsored indemnity insurance




Senate Committee - 2000 submissions

- Final report released yesterday allowed the legislation through unchanged despite raising concerns over the future of homebirth access.
- Continuing tensions though within medical circles and with midwives and consumer groups



Theoretical Framework and Methodology

Critical Discourse Analysis 'CDA'

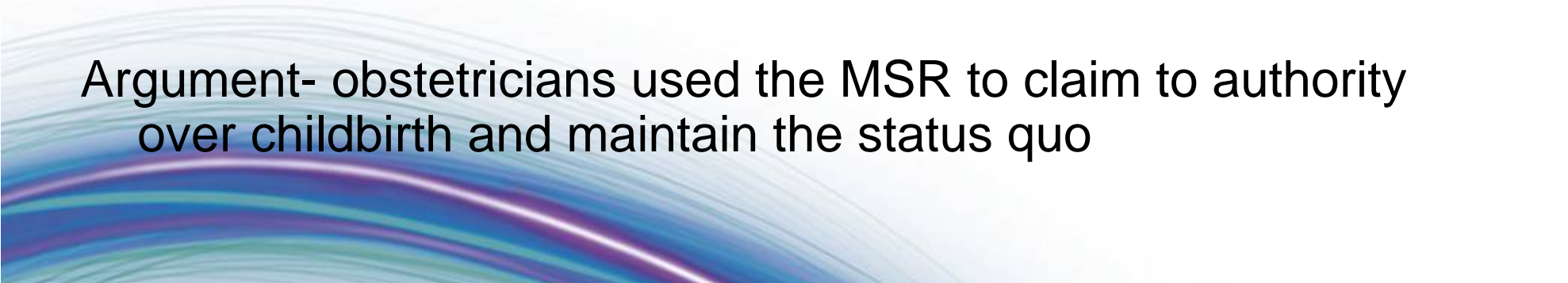
- Focus on the role of discourse in '(re)production and challenge of dominance' (van Dijk 1993)
 - 'Power elites' have more access to discourse including the popular media
 - Obstetricians have *symbolic* power linked to privileged position in society, historical dominance of maternity care as well as *institutional* power
 - All deeply *gendered* historically
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Analysis

- submissions received from medical or obstetric organizations, individual doctors/obstetricians or anaesthetists
- Represent only a small minority yet had the most influence- wielded the most power
- strategic use of research to support their positions

several key themes and ideologies identified

Argument- obstetricians used the MSR to claim to authority over childbirth and maintain the status quo




Key themes

1. Risk as necessitating obstetric care
2. 'Collaborative' care in obstetric hierarchy
3. Explaining intervention rates
4. Defensive obstetrics
5. Co-opting 'choice' discourse



1. 'Birth is never risk free'

- Majority of medical submissions countered claims that birth was 'natural'
 - instead it's risky, dangerous and unpredictable
 - therefore *always* a process that obstetricians should oversee
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'The assessment of risk throughout pregnancy is problematic. While pregnancy and birth are clearly natural processes, so too are death and disability. Intervention in these natural processes can help to deliver the very low levels of maternal and perinatal morbidity and mortality that Australia currently enjoys'
(RANZCOG 2008)



‘Again and again it is touted that birth is a ‘natural process’ and that most women should be able to deliver without medical support... [but] there is currently no effective means of determining who is likely to deliver normally before the event. The absence of ‘risk factors’ in no way ensures or even predicts the ability of a first time mother to deliver normally.’

(Dr Peter Kell, private obstetrician, WA)



[It is] an inescapable fact that in every model, no matter how 'low risk' it may be perceived to be, the unpredictable nature of pregnancy, childbirth and postnatal care requires the involvement of an obstetrician'

(Dr Vijay Roach, private obstetrician, NSW)



- Ideological construction of birth as risky was expected however it was also strategic
- Dismissal of 'high' and 'low' risk categories
- Assessing of women as low risk exempts them from obstetric care

'Labelling women as 'low risk' or 'high risk' may have the consequence of determining the care model as either 'midwifery' or 'medical'- thereby denying women the benefits of both professions'.

RANZCOG



2. 'Collaborative' care endorsed:

the solution or disguised obstetric dominance?

- Midwifery-led care and independent midwifery directly opposed. No one should 'work alone'
- Obstetricians, midwives and GPs to 'work together'

'the current proposals that are being flagged in the Review of Maternity Services in Australia will actually compromise the high standards and confidence that we have...this would mean a worsening of morbidity and mortality, and that means mothers and babies being harmed or dying'.

(AMA)

‘But midwives should NOT be the lead managers in maternity care; they should work collaboratively with us under our supervision’

Dr Kell, WA



3.Explaining intervention rates

obstetricians dismissed any suggestion that interventions were anything but necessary and safe:

- C-sections linked to ageing maternal population, obesity and maternal request
i.e. women are too old, too fat and asking for it!



4. Defensive obstetrics

Highly emotive-

- Obstetricians are hard-working
- produce 'excellent' outcomes- safety

'we are ..collectively good at what we do'

Dr Gannon, W.A



- *‘Australia already offers women and their babies safe, effective maternity care. We would be distressed to be part of a system that offers less’*

RANZCOG SA & NT Committee



5. Co-opting 'choice' discourse

'Women's rights' discourse co-opted

- High levels of reported satisfaction with private obstetric care
- Safety the only consideration
- Obs say midwifery models of care 'limit women's choice'



Conclusions and policy implications

The MSR process

- opened up a public discursive site
- midwives achieved access to Medicare and prescribing rights
- New systems of publicly funded care emerging

But....



the Review was

- not thought out, a 'quick fix'
- marginalised independent midwifery practice and homebirthing women
- did not change the underlying power structures
- exacerbated inter-professional tensions and probably reinforced the status quo

Implications-such reviews require better understanding of the *politics* of a field

