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# The swan effect in midwifery talk and practice: a tension between normality and the language of risk

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**Abstract** Midwifery activity in the labour room coalesces around routine surveillance practices. When engaging in such practice, midwives have to cope with attempting to instil a sense of confidence in the mother's embodied ability to birth her baby spontaneously while concurrently attending to an array of risk-focused tests and measurements. Midwives are vigilant about the potential harm that may come to mother and baby while at the same time they are responsible for facilitating a normal birth. This article sets out to explore the tension between these two tasks and shows how routine midwifery practice during labour can communicate certain **ontological** understandings about birth. Using empirical evidence taken from an ethnographic study of midwifery talk and practice, attention is given to how midwifery activity during labour and birth implicitly introduces a sense of danger, an imagined risk that confines **practice** and operates to unsettle normality. The article starts from the proposition that the unsettling of normality and the needless introduction of medicalisation through the language of risk is problematic.

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**Keywords:** risk, normality, health surveillance, birth, midwifery

## Introduction

During a recent conversation I had with a midwife about my current research interests, I was told

Us midwives: we are like swans swimming across a lake. On the top we look all serene and tranquil but under the water our little feet are flapping about like mad.

This midwife was describing how she endeavours to give an air of professional calm, a sense of confidence in normality, while caring for women in labour; when in fact, in the back of her mind, she is battling with the constant concern: 'What if things go wrong?'; her imagined risk object. Empirical data taken from an ethnographic discourse analysis (Gwyn 2002) of midwifery talk and practice is presented here to explore the idea of the swan effect in relation to midwifery communication and normality in childbirth. **!**

The article draws selectively from a wider ethnographic study carried out in south-east England over a 13-month period from 2009 to 2010. The research, funded by the Economic and Social Research Council, was intended to explore how midwives make sense of risk and how this impacts on their clinical practice. The discussion to follow represents a recurring theme that came out of this work and falls into three distinct parts: a background section, where a brief introduction to the theoretical framework of the article is set out; a discussion

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that explores how midwifery understandings of normality are represented in the professional literature and a description of the study from which this article draws its empirical evidence. Finally, in the findings section, observation and interview data are used to illustrate how risk and normality interface in midwifery talk and practice. Using the theoretical framework outlined, the midwifery position vis-à-vis normality will be reconceptualised and evidence presented to show how midwife–client<sup>2</sup> communication in the labour room setting is not simply about what is said. In keeping with Goffman’s observations (1969), it will be argued that strategic interaction is as much about meaningful action as it is about the words that are spoken, it is as much to do with what goes on under the water, the latent worries that lurk in the back of the midwife’s mind and drive her practice, as it is to do with what she actually says to her clients. It is the contention of this article that through routine surveillance practices, midwives implicitly introduce uncertainty, amplify risk and thereby disturb and restrict the possibility that women can achieve a normal birth. Furthermore, this process is conceptualised as being a major driver in the medicalisation of birth performance in the UK.

## **Background**

There are two strands of the literature that have helped inform the analysis presented in this article. The first comes from the academic debate surrounding risk, the second from the health surveillance literature. Both of these areas of scholarly activity have been prolific and the descriptions of them here will be, by necessity, selective. In particular, this article considers and integrates the work produced by Heyman (2010, 1998) and Armstrong (1995, 1983).

### *Theoretical strand one*

Heyman’s work examines the way in which the increasing sensitivity to risk in the west, which is said to be characteristic of our late modernity (Beck 1992, Zinn 2006), operates in health care. According to this thesis, ‘risk thinking provides only one, historically recent, approach to visualizing alternative futures’ (Heyman 2010: 22). This peculiarly modern way to looking at the world centres in part, around what Heyman calls the ‘risk virtual object’ (Heyman 2010: 22). What he means by this is how current preoccupations with possible futures, where the worst possible scenario could happen, function to shape health-care practice in the present. Developing Giddens’ (1991) notion of the late modern desire to ‘colonise the future’, Heyman argues:

the lens of risk provides one particularly modern way of thinking about contingency. A contingency is invoked whenever an observer considers that one outcome out of a number of envisaged alternatives might occur . . . once their presence has been recognized by a social group, contingencies generate substantive responses. (Heyman 2010: 24)

Building upon the social theory of risk, Heyman shows how preoccupations with one possible future where things go wrong, no matter how remote or unlikely that future may be, take on a life of their own, occupying the present in shaping the way in which health care can be delivered.

### *Theoretical strand two*

Armstrong’s Foucauldian analysis of the rise of surveillance medicine, which he describes as ‘a new medicine based on the surveillance of normal populations’ (Armstrong 1983: 95), provides a second dimension to the analytical approach adopted in this article. Although Armstrong’s work does not lie within the risk literature, where the interest in Foucault has been most concentrated in the analysis of self-surveillance in public health as a mechanism of subjugation (Lupton 1993, Petersen and Lupton 1996), I link it in this article to Heyman’s work

outlined above, because I believe that together they offer a comprehensive framework through which the swan effect can be understood.

According to Armstrong, the intrusion of the medical gaze into the lives of the well blurs the boundaries between health and illness, between the normal and the pathological (Armstrong 1995). Through the language of health surveillance, with its implicit message that there is a chance; 'a small chance of a great misfortune', the boundaries of normality have been eroded (Olin Lauritzen and Sachs 2001: 498). Moreover, it has been argued that it is the magnitude of the possible hazard rather than the probability of the normal that is heard most clearly by health professionals and clients alike (Alaszewski 2007, Pidgeon *et al.* 2003).

#### *Risk in birth*

Given this background, it is hardly surprising that the language of risk permeates the delivery of maternity care and underpins the development of maternity services. Evidence of this in the UK can be seen through the intensification of clinical governance, through things like the implementation of the Clinical Negligence Scheme for Trusts and the proliferation of local and national guidelines with their associated intensification of the surveillance of even normal groups of birthing women. According to the National Institute for Health and Clinical Excellence guidelines, for example, caring for a healthy mother in normal spontaneous labour should involve surveillance that includes the following instructions:

Every 15 min after a contraction: check FHR

Every 30 min: document frequency of contractions

Every hour: check pulse

Every 4 hours: check BP, temperature and offer vaginal exam

Regularly: check frequency of bladder emptying. (National Institute for Health and Clinical Excellence 2007: 7)

In maternity care, therefore, under a guise of benign concerns with the safety of the mother and her fetus, mothers are subject to continual surveillance and a battery of risk assessments and intrusive tests (Lane 1995, Reissman 1983). In the UK, as soon as a woman becomes aware that she is pregnant she is expected to actively pursue a regime of health surveillance (DeVries *et al.* 2001). Pregnancy and birth might be described as being a point where health surveillance, as described by Armstrong, is at its most powerful, in that every woman, simply by virtue of being an expectant mother, comes under the close scrutiny of the medical gaze (Arney 1982). Through this intensification, discrete elements of symptoms and signs of pathology are subsumed under a more general discourse of risk (Armstrong 1995) where a woman may be normal but at the same time she cannot be said to be truly healthy: she is pregnant and as such is in a new and potentially dangerous category of a 'not-yet-patient' (De Swaan 1990: 12): she and her unborn child are both at risk.

It is important to understand that the intensification of surveillance of the normal in childbirth coincided with a reduction in the hazards associated with birth and improvements in its safety. This is not to suggest that there a causal relationship between the two. Although it is tempting to assume that current, medicalised birth performances have improved safety outcomes, epidemiological evidence suggests that other wider social and environmental factors are likely to have had a more significant impact (Tew 1990, Wagner 1994). Furthermore, as the medicalisation of birth has intensified so has both national and international concern regarding the iatrogenic

risks associated with this intensification (Johanson *et al.* 2002, Mander 2008, NHS Institute for Innovation and Improvement 2007, World Health Organization 2009).<sup>3</sup>

What this means is, as Possamai-Inesedy (2006) points out, that safety in childbirth and perceptions of risk in childbirth are positively, rather than negatively, correlated. As the former has increased the latter has intensified. As the dangers associated with pregnancy and birth decreased, they both became more densely associated with a climate of fear (Reiger 2006). This means that childbirth is performed upon a tension of what Taylor-Gooby (2002) has called 'the paradox of timid prosperity'. By this, he refers to the accompaniment of ever-increasing levels of material security in the west by an intensification of societal anxiety; a process particularly pertinent to the body and health (Alaszewski 2007). Despite the fact that childbirth in the UK is safer now than it has ever been in human history, policy drivers in the maternity care service coalesce around patient safety, risk avoidance and health surveillance (NHS Litigation Authority 2008). These laudable initiatives aimed at protecting the public crystallise in a discourse of risk avoidance (Skinner 2003). Although midwives and women know that the probability of highly adverse outcomes are now very low,

pregnant women are nevertheless still fearful and anxious about pregnancy and childbirth. These fears do not stem from lived experience but rather from the speculation of risks that women must contend with. (Possamai-Inesedy 2006:407)

#### *Midwifery and normality*

The implications of the language of risk and problematisation of the normal is particularly pertinent to midwifery practice since, not only are midwives the most senior practitioner in 66 per cent of births in the UK (NHS Information Centre 2009); according to much of the professional literature midwives should be and are defined as the experts of normality (Hatem *et al.* 2008, Walsh 2001, Walsh and Newburn 2002). That is to say, the rhetoric suggests that midwifery philosophy lies within the zones of normal physiology or, as Gould puts it, 'Midwives practice within the normal childbirth paradigm' (Gould 2000). According to the professional literature, midwifery and normality are symbiotically linked. Such rhetoric sits rather awkwardly with the health surveillance thesis, as it is described above. While on the one hand, midwifery practice can be described as coalescing around health surveillance, with its amplification of risk and marginalisation of subjective narratives of health (Gabe *et al.* 2004), on the other hand the profession espouses a commitment to normality that privileges women's individual, embodied experience of pregnancy and birth and woman-centred care (Davis and Walker 2008).

All midwifery practice in the UK, regardless of where it takes place, is constrained by the Nursing and Midwifery Council (NMC), which aims to standardise care, protect the public from harm and to ensure that all risks are identified and avoided (NMC 2004a, 2004b). This, in conjunction with clinical governance initiatives which, according to Power (2004), now saturate the cultural landscape of health care, means that most midwifery practice centres on health surveillance, as it is described by Armstrong (1995). Such statutory obligations operate to increase sensitivity to risk, creating somewhat of a disconnection between how midwifery is represented in much of literature and what many actually do in their day-to-day working lives. On the surface the swan may look calm and serene, suggesting her confident belief that everything is fine, everything is normal; but only inches under the water (which is a transparent liquid making visibility easy), the swan's feet tell quite a different story. It is a story of risk amplification and a story of risk avoidance driven by the so-called risk society (Beck 1992).

In their practice, midwives deal with the tensions engendered by this disconnection every day, but such embodied experience and embedded practice, paradoxically, is not often as evident to those involved as you might

expect. As Schutz and Natanson (1990) argue, such taken-for-granted ways of being tend to form part of the common sense that rarely is explicitly defined or explained. It is only through the scrutiny of everyday practice and talk, therefore, that we can gain insight into the ways in which this tension impinges upon midwifery performance during childbirth.

### **Description of the study: approach and methods**

#### *Methods*

The aim of the study was to explore how midwives make sense of risk and how this sense-making affects clinical practice. This demanded a methodological tool sensitive enough to make explicit midwives' tacit knowledge about risk and normality. An ethnographic research design that privileged participant observation, was therefore deemed to be appropriate. It is important to note that this researcher did not employ this design in its early anthropological, positivist sense (as an attempt to capture what was 'really out there') but instead a deeply reflexive approach was adopted where the researcher's identity was understood to be implicitly woven into each stage of the process, not only impacting on the data collection in terms of research relationships but also on the analysis and the production of the ethnographic text.<sup>4</sup> This design provided an invaluable opportunity to observe midwifery talk and practice in four settings:

- A large obstetric, high-risk care environment (3361 births per year)
- A midwifery-led low-risk unit situated in the hospital environment, where a full obstetric, anaesthetic and paediatric facility is on hand (606 births per year)
- A free-standing midwifery-led birthing unit, where high-risk care is a 40-min transfer journey away (378 births per year)
- At the home of the mother (224 births per year)<sup>5</sup>

In the study ethnography was understood in its broadest sense, not so much as a set of research methods or analysis techniques, but as a 'concern with the meaning of actions and events to the people we seek to understand' (Spradley 1980). As such, the methods used were those deemed to be the most conducive to the task of understanding situated meaning-making. As this task unfolded during the research process, with analysis being a concurrent part of the methodology, so the use of various research tools was adapted, adopted or, in some cases, suspended through an ongoing process of reflexivity (Denzin 2002). The emphasis and prioritisation of approaches, therefore, changed over time depending on the issues raised by the data and included a combination of

- participant and non-participant observation (Malinowski 1932, Spradley 1980) of both midwifery labour care (a total of 42 deliveries, of which four were done at home, 15 in the high-risk unit and 23 at two different midwifery-led units) and of behind-the-scenes meetings and study days at the Trust and the local level (a total of 15, which were not used to inform this article) to gain direct access to the meaning-making process.
- ethnographic interviews (Spradley 1979) with 10 midwifery managers, 10 midwives, two student midwives, two independent midwives and three maternity and midwifery pressure group members (a total of 25 interviews), which allowed for the testing of hypotheses and the scrutiny of incidents arising out of the observations to test validity.
- textual analysis (Fairclough 2001) of protocols, policy documents and key professional texts to give a broader social and cultural contextualisation to the observation and interview data. (These were also not the primary data source for this article)

### *Analysis*

A rudimentary thematic content and narrative analysis (Graneheim and Lundman 2004, Reissman 1993) of the data set was carried out throughout the research and helped to facilitate reflexivity and to direct the research process, while a closer scrutiny of the texts produced in the study (including interview transcripts, field notes, institutional protocols and staff memos) using conversational and discourse analysis techniques (Fairclough 2001, Gwyn 2002, Silverman 1988) provided further rigour to the analysis, revealing both ideological and political operations at work in the data. This initial thematic analysis was checked and corroborated through the project supervision process and was then intensified towards the end of the research, using ATLAS ti to check the reliability and validity of the analysis, and codes were networked and checked for density to ensure groundedness. ‘Normal birth’ and ‘risk’ were both densely populated codes, although ‘normal birth’ was a code that was both denser and networked with greater complexity.

### *Access and ethics*

The initial sample was accessed through a process of self-selection following a recruitment and information campaign targeted at all midwives working in the selected sites. Subsequent recruitment was achieved through an opportunistic, snowball technique (Bryman 2004), paying some attention to purposeful structuring to maximise diversity ( $N = 33$ ). While this approach presents an obvious sample bias it is consistent with usual ethnographic procedure. Written consent and consequently verbal consent was gained from all those involved in the study and all transcripts and field notes were cleaned by removing identifying features prior to analysis. Ethical approval was sought through both national (08/H1110172) and local NHS ethics boards (2008/obst/02) and full approval for the study was granted in February 2009. The project protocol was reviewed and approved, prior to the commencement of data collection, by the NHS Trust’s Research and Development governance team, the Head of Risk, Assurance and Legal Services and the Head of Midwifery. The researcher had a NHS licence to practice for the duration of the data collection.<sup>6</sup> All data used in this article have been cleaned to remove identifying features and all names have been changed. The observations from which I draw took place in both a midwifery-run and obstetric-run unit; however, these details have been removed in order to protect anonymity.

## **Findings**

### *Measuring normality and the implicit introduction of threats*

Measuring the vital signs of both the mother and baby, along with what is described as ‘progress’ in labour – meaning uterine contraction and cervical dilatation pattern – is a key to routine midwifery during labour and birth. At the point when labour is diagnosed, intensive surveillance and record keeping usually commences. Such intensive monitoring is applied to the normal and abnormal delivery alike, bringing all women in labour into visibility. Moreover, it was introduced in a taken-for-granted manner by the midwives involved in this study, rarely making the precise purpose of the monitoring explicit to the woman. Rather, each intervention was introduced as part of the customary care plan that demanded no explanation. Midwives commonly introduced monitoring activities with comments like:

‘I’m just going to have a listen in again now, just to make sure the baby is okay’. This preceded exposing the woman’s abdomen to auscultate the foetal heart. (Field notes GT 20)

Or ‘Can I have your arm a minute; I need to check your blood pressure’. (Field notes RS1). There seemed to be an implicit understanding in these mother–midwife interactions that repeated checking, rechecking and recording of

things like the foetal heart beat and maternal blood pressure was a good thing. Once the measurements were taken they were plotted in the partogram<sup>7</sup> or written into the labour care section of the maternal notes, or both. The midwives' talk following these measurements was generally quite cheerful. However, this approach did not always allay the fears that this surveillance seemed to introduce, as the following extract from the field notes suggests. Sarah, a first-time mother, is having a routine vaginal examination to measure the dilatation of the cervix and descent of the baby's head:

During the examination the room went very quiet. Sarah is lying flat on the bed as instructed by the midwife. No explanation is given to explain why this is necessary and no attempt is made to perform the examination in a position that might be comfortable for Sarah. It is as if any concerns for Sarah's physical or emotional comfort seem to be temporarily suspended given the seriousness of the task of finding out what is going on. The findings of the exam are not mentioned during the procedure, Sarah and her partner are left wondering and waiting; there is a palpable sense of tension. Afterwards Pauline (the midwife) explains what she found. Both parents look anxious and although the VE [vaginal examination] shows progress of the labour was normal, both Sarah and her partner needed to repeatedly have this confirmed. Pauline did not seem surprised by this reaction, she smiled and reiterated that 'everything was fine' at least three times. She then left the room to record her finding in the notes and on the board. (Field notes PS 14).

In this case Sarah's labour followed the partogram's trajectory and she had progressed according to the parameters set by the chart. However, although normality was confirmed, the actual confirmation process itself introduced a sense of uncertainty. Whereas before the exam both Sarah and her partner had been managing the labour process effectively and pretty much independently, when the time came to monitor the progress, to check for normality or, more precisely, to hunt for abnormality, their confidence in the process and their understanding of the active role they could play in that process seemed to dissipate. Indeed, although Pauline stressed that the progress was good, Sarah responded by asking 'Is there anything else I should be doing? Am I doing it right?' (Field notes PS14). Even when a woman's labour fits into the partogram trajectory, the very process of monitoring progress simultaneously confirms and disturbs normality.

Through the action of routine surveillance midwifery activity appears to be not so much about confirming normality as it is about searching for an absence of abnormality. This is a subtly but significantly different task that tends to privilege imagined possibilities such as 'What if things go wrong?' and thereby operates to unsettle a woman's confidence in her body's ability to give birth to her baby successfully. Although midwives may have the objective of reassuring mothers in their intra-partum communications, in order to give the impression of the swan gliding gently across the water, their actions expose the unstable base on which understandings of normality rest. Importantly, the labouring woman and her birthing partner are far from oblivious to this instability. The swan's frantically paddling feet are not invisible; water is, after all, transparent. As Sarah's need for professional reassurance suggests, parents can and easily do recognise the midwife's concern with the ever-present 'virtual risk object' (Heyman *et al.* 2010).

The midwives' understandings of birth appeared to be so confined by a preoccupation with surveillance that, in the interview context, they often found it difficult to imagine that normal birth existed without explicit reference to monitoring practices designed to hunt for the abnormal. Such ontological privileging of surveillance meant that the precise nature of normality, and how its boundaries should be defended, became obscured, so much so that these midwives felt that they should never presume that normality had any substance beyond that which is verified

through observation and recording. For example, when Mary, a senior midwife, was talking to me about birth, she explained:

But I always have here, in the back of mind, that things can go wrong so, that's how, that's how I practice as a midwife. That, you know, it can be wonderful, but it's wonderful when it is finished. You must be alert to things that can happen. Because I watch very carefully and unpick things and I check everything and, erm, because things happen. I would put her [the mother] in the bracket of 'at risk' of any risk until, until it is over.

Susan, another senior midwife expressed a similar sentiment when describing how she felt about a fellow midwife's practice:

There is two things in this monitoring and surveillance. They [midwives] don't seem to understand, just because you [the mother's labour] are normal, low risk, that you are not assessing what's, and monitoring what is happening. . . . Checking all the time. How does she [the midwife] know? She doesn't know it is going to be normal: how can she tell it is all going to be okay without checking everything and, of course, writing it down? She might have an opinion, you know, even if things are going to be okay, you have to monitor the progress all the time, don't you.

For Harriet, a student midwife, normality could be defined only via the visual aid of the partogram's trajectory:

Well, you know, when everything is in the normal parameters; making sure, erm, like keep the woman and baby safe by making sure, you know, you are listening in every 15 minutes and that they don't come out the brackets thing, the chart thing . . . partogram.

These three interview extracts represent a key theme present in much of the data set. They assume that good midwifery practice is recognisable through the practice of intensive surveillance, which is carried out to check that the birth is following the expected, population-based trajectory as it is depicted in the partogram. It is only when all such surveillance is charted on the partogram that normality can be confirmed. Normality is evident then only with abnormality lurking. Normality is constituted through actions that mark the presence of 'a virtual risk object' (Heyman *et al.* 2010), an imagined hazard that might happen at some point in the future.

#### *Deviant trajectories*

When, as happened in the above case, normality is confirmed by the surveillance techniques introduced by the midwife, the unsettling of normality can be, and often was, temporary. As the demands of labour are attended to by the woman and her birthing partner, focus on the here and now is regained and concern for what may or may not happen in the future is diluted. When, however, deviation from the norm, as it is delineated by the observation chart, is discovered, a different kind of pressure is introduced.

Finding such deviations places specific demands on the midwife. When plotted on the partogram they become visible to three groups of people: parents, the midwife and the multidisciplinary team. The moment a deviation from the expected norm is recorded it crystallises into action involving a further intensification of surveillance and medical intervention (which can include major abdominal surgery), or both. In some cases the midwife remained cheerful in an attempt to contain the severity of what her recordings implied. She would say things like, 'your progress isn't quite what we hoped' or 'you have done well but . . .'.

For example, a vaginal examination on Kerry, another first-time mother, revealed that her cervix had dilated 2 cm in 4 hours which, when plotted onto the partogram, fell well below the expected progress line. Instead of

drawing attention to the shortfall, Miranda, the midwife responsible for her care, emphasised how well she had done:

Miranda sat beside Kerry on the bed after the examination and said to her, 'I am so proud of you. You are doing so well. All those contractions are working really well and we are getting closer all the time to meeting this baby'. She then explained that she had to go out of the room for just a minute to write up the notes and let the doctors know that although she had progressed, which was good, the progress was a little bit slower than she had hoped. This is all explained with an apologetic look on her face. (Field notes ML 28)

What can be seen in this communication is an attempt to downplay the implications of the deviant measurement, an under-communication of the risk (Olin *et al.* 2001) or perhaps even an attempt to deny the deviation. Miranda is in the business of comforting the couple. She does this by drawing their attention away from the likely outcomes of the examination findings. Instead, she chooses to emphasise the progress made, even though this progress fell significantly short of the partogram's trajectory. Miranda seems to be aware of the effect that her surveillance would have on the couple's morale and is keen to minimise the negative impact this might have on the mother's confidence. Although Miranda knows that the charting of her monitoring was an invitation for proactive medical intervention, she tries to preserve a space for normality by under-communicating the risk that her actions had introduced.

This under-communicating of risk is precisely what the midwife meant when she used the metaphor of the swan to describe midwifery practice. It is a feature of midwifery that all the midwives involved in this study recognised, as Diana (a midwife) explained to me:

That is why we all have to be actresses before we become midwives! [Laughs] You're sitting there, feeling utterly dismayed by something . . . I don't know . . . hear a dip in the fetal heart . . . you know in your heart that actually it is just second stage of labour and it is just fine, but at the same time you have that, you have that little sort of 'Oh goodness, what is that?' but I think if you let the client see that, or the family see that, they start to worry and I do believe that worry and anxiety prevent the progress of a labour. Well, I think we all know that.

What the midwives did not seem to appreciate, however, was the multi-modality of their communication. While they hoped that their concern with the imagined risk object was obscured by what they said to parents, observations of midwife–client interactions revealed that midwifery communication is as much about meaningful action as it is about the use of language. It is as much to do with what goes on under the water, the latent worries that lurk in the back of the midwife's mind and drive her practice, as it is to do with what she actually says to her clients.

Through routine surveillance practices, midwives implicitly introduce uncertainty, amplify risk and unsettle normality. Once the deviant results are charted, the risks, in the sense of dangers and abnormalities, take on a life of their own (Heyman 1998). At that moment physiology is redefined as pathophysiology (Mander 2004). The medical gaze tends to widen and more intrusively multidisciplinary, technocratic surveillance invades both the woman's physical body and the space where normality had previously, albeit tentatively, existed. It is precisely this momentum of risk, or what has been described in the literature as the 'cascade of intervention' (cf. Inch 1989), which drives midwives to under-communicate risk in the context of midwife–client interactions. This represents the basis of the swan effect in midwifery.

### *Symbolic spatial boundaries and normality talk*

Until this point, risk existed as an imagined possibility, expressed through midwifery action rather than talk, but once pathology was detected and recorded the midwife had to work much harder to maintain a sense of normality in the words she used to her clients. Recording pathology in the notes meant that risk took on a concrete form that brought about a chain of events, invading the mother's protected space as well as her body. In their concern to stave off this chain of events, midwives tried to suspend the language of risk in their conversations with their clients. At the point at which unobserved, inter-professional communication commenced, however, all attempts at such suspension evaporated. Taking the maternal case notes away from the care setting commonly opened an opportunity for more candid professional-to-professional discussions of risk. Once outside the room the midwifery engagement with risk became more explicit and the swan effect was no longer considered to be appropriate, making a boundary clearly visible. Who was involved in the communication and where that communication took place therefore, had a significant impact on how midwives chose to talk about risk. Leaving the room with the notes involved symbolically crossing a boundary. The transgression of this boundary seemed to dismantle any attempts at risk insulation that had been, up to that point, carefully, albeit ineffectively, maintained by the midwife during midwife–client interaction. As the extract above demonstrates, risks and the associated fragility of normality were often downplayed in midwife–client contact. However, this was not the case when midwives entered into staff spaces, as further excerpts from the same observation episode demonstrate:

The first thing Miranda wanted to share when we left the room was her sense of disappointment and exasperation. She felt that the possibility for a normal birth was dissipating, it was 'slipping through her fingers'. I got the impression that she was feeling frustrated. This was very different from the things she had said to the couple. It was almost as if when she shut the door a whole other narrative could be released; a narrative where her lack of confidence in normality could be aired. When I asked her to explain why she felt like that she told me, 'Well, what am I going to say to them? I know exactly what they are going to say . . . so here goes'. The 'they' she referred to was a mixture of more senior midwives and obstetricians. (Field notes ML 28)

### **Discussion**

There is a substantial body of empirical evidence that suggests that pregnancy and birth engage with the language of risk in a very particular way (Davis-Floyd 2003, Henley-Einion 2003, Johanson *et al.* 2002, Lupton 1999, Reissman 1983, Rothman 1982, Tew 1990). It has been argued that being pregnant invades a woman's own embodied experience of health through the omnipotent presence of latent risk (Marshall and Woollett 2000, Oakley 1984, Weir 2006). Her personal narrative of wellbeing is eroded; she can no longer be trusted to be normal (Arney 1982, Marshall and Woollett 2000, Scully 1980); she and her baby are at risk; furthermore, this risk demands intensive and regular health surveillance. This intensity of risk surveillance culminates in the hours that mark the end of pregnancy. Thus, many have suggested that the process of birth cannot be trusted (Grosz 1994, Martin 2001) and, as a consequence, becomes a locus for risk anxiety (Marshall and Woollett 2000, Reiger 2006).

This article offers a new dimension to this observation. In much of the literature midwifery models of care are juxtaposed against medical models of care (Annandale and Clark 1996, Walsh and Newburn 2002); moreover, it is the medical models that are presumed to coalesce around a sensitivity to risk. By using a method that allowed the researcher to scrutinise the precise nature of midwifery understandings of birth and risk, revealed not only through

their talk but also through their practice, a data set was assembled that goes some way towards explaining how midwives are active agents in the medicalisation of childbirth performance. The data presented in this article suggest that routine practice implicitly introduces uncertainty even in those situations where no deviation from the normal exists. Routine midwifery care during labour and birth is not so much about facilitating the normal as about hunting out the abnormal.

This means that while midwives may purport to work within the paradigm of normality (Gould 2000), they have few resources or practical skills to police the boundaries of normality. Arguably, this would depend on the working environment in which the midwife finds herself. The London-based Albany midwifery practice, for example, has been held up as a showcase worldwide for imagining how midwifery practice could work in ways that resist risk amplification (Reed and Walton 2009, Rosser 2003). Other pre-eminent midwives in the UK have used the independent sector in order to facilitate less risk-adverse forms of practice (Scamell 2010). However, the recent and shocking suspension of the Albany's services, along with the disproportionate number of independent midwives who have been investigated and struck off the register by the NMC (Jowitt and Kargar 2009) suggests that such an approach is of dubious value in our risk society. Moreover, the working environment had much less of an impact upon the care observed during this study than the author had anticipated.

Midwifery knowledge and its skill base, observed in all four working environments, borrowed so heavily from the health surveillance repertoire, designed to seek out pathology in a healthy group (Armstrong 1995) that midwives themselves were left with few resources with which to police the boundaries of the very thing they define themselves by – normality. What is more, despite all their efforts, these midwives failed to disguise this fact from their clients. Midwives may describe themselves as actors or serene swans but their attempts to cover up the fact that they centre all their activity on an imagined pathology are at the very best transparent. The data presented in this article suggest that service users are likely to be conscious of the tension created through midwifery talk and midwifery practice and the impact this has on normality, that is, they can see both the serene swan and their madly flapping feet.

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### **Notes**

- 1 Normality here is understood to mean 'spontaneous labour and delivery, where an infant is born without medical or technological help, such as by caesarean section or induction.
- 2 This term is used to refer to the midwife's interactions with both women and their birth partners and supporters, in contrast to midwife–mother interactions that do not include these other service users.

- 3 Ironically, as has been the case with many industrial technologies, the cascade of the very interventions that were originally introduced to manage risk has itself generated new risks and new hazards through a dynamic process.
- 4 This section is a description of methods only. The methodological implications of the research design, such as in terms of author impact and construction of identity, translation of culture, and sequential consent, have been discussed elsewhere (Scamell 2010).
- 5 Home births involving independent midwifery care are not included in these statistics. The Trust has an overall home birth rate of just over 5 per cent but this is slightly higher if independent midwifery statistics for the area are included.
- 6 The author is a registered midwife but, for the purposes of the study, was licensed to practice as a Maternity Care Assistant. This meant I could be a hands-on participant observer while, in theory at least, minimising my impact upon care.
- 7 The partogram, or picture of labour, is a universal chart designed in the 1970s for recording observations of mother and baby, contraction pattern – including its rate and strength and cervical dilatation.
- 8 Op refers to occiput posterior, meaning that the baby's head had gone into the pelvis facing the wrong way round.

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