Beyond the Birth Wars: Diverse Assemblages of Care

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Abstract

Childbirth has been transformed by increased use of life-saving medical technologies, greater understanding of the complex interplay between care environments, emotional states, complex biophysical processes and ongoing physical and mental health for babies and mothers. Maternity care has also been subject to broader changes in healthcare economies that reposition mothers as rational consumers in a health care marketplace. Drawing on empirical research we identify problems with imagining maternity care and the cared-for subject via 'choice' alone, and explore how the diverse assemblages that converge in birthing spaces could be better attended to through alternative 'logics of care' (Mol, 2008).

Keywords: childbirth, care, choice, diverse economies, healthcare, maternity care

Introduction

During the last few decades, patients in New Zealand and Australian healthcare systems have been reimagined as 'consumers' of healthcare services. Maternity care systems have followed suit. Expectant mothers have become 'consumers' of maternity care services, who are expected to survey the available options and make rational decisions based on the information available to them. Health care has been transformed: from a space where the ill, elderly and vulnerable are cared for, to a marketplace in which we are all recast as either 'providers' or 'clients' and 'consumers'. This transformation is, as we shall see, deeply problematic and has ongoing consequences for labouring and birthing women. At the same time choices around maternity

care have become wrapped up in the moral and ideological conflict of the so-called 'birth wars' (MacColl 2009). The so-called birth wars play out in media sites like Mamamia (www.mamamia.com.au)where 'natural' versus 'medical' models of maternity care are endlessly pitted against each other.

The market-based model of 'providers' and 'consumers' in maternity care calls into being mothers-to-be and women in labour as rational decision-makers, making choices about their care in competitive markets associated with private capitalist enterprise. The reimagining of mothers as 'healthcare consumers' is part of a wider pattern in (particularly Western) society whereby individuals are encouraged to think of themselves primarily as (particular kinds of) economic subjects: as entrepreneurs, workers, producers, even 'home educators' or 'home executives'. Consumption becomes central to identity (Mansvelt 2005), and that may even include what kinds of healthcare services are consumed. But the economic subject called into being by the 'provider-consumer' nexus is not just any kind of economic subject. It is the singular individuated economic subject that is both 'free' to make well-thought-out decisions and simultaneously obligated to subject themselves to a health *system* as citizen-consumer. Some might be tempted to read this as care being subsumed by the pervasive forces of neoliberal capitalism, but our research reveals the extent to which multiple other kinds of cared-for subjects are emerging in the birth space. It is these subjects who push us to rethink the premise of provider-consumer that drives the maternity-care 'marketplace' – not only for a 'postcapitalist politics' (Gibson-Graham 2006), but for the sake of the highly complex balance of bodily systems enabling the important altered state of consciousness involved in giving birth.

In our other work in diverse and community economies, we document and describe a diversity of forms of economy – capitalist, alternative capitalist, noncapitalist – that contribute to the care of others and ourselves (Morrow and Dombroski 2015, Dombroski 2015, Dombroski 2016a, Dombroski 2016b, Gibson-Graham, Cameron and Healy 2013, Healy 2008, McKinnon 2016). Diverse economies scholarship refuses the presumed hegemony of global capitalism, and opens

a conceptual space for recognising and enacting 'community economies': economic relations that foreground an ethic of interdependence. A community economy of care takes shape through forms of transaction, labour, enterprise, property and finance that help us collectively to survive well and to encounter each other with care (Gibson-Graham et al. 2013, Dombroski 2016a), for both human and more-than-human (McKinnon 2014). In this paper we extend our analysis to maternity care by considering some of the implications of extending market-based 'logic of choice' (Mol, 2008) to the area of maternity care in New Zealand and Australia. We focus in particular on the ways in which the informed citizen-consumer subjectivity could actually inhibit the material and biophysical 'flow' of birth, while isolating birthing women from the relational context in which care occurs. Working with AnneMarie Mol's idea of a 'logic of care' (Mol, 2008) we explore what a distributed relational economy – or assemblage – of care might look like as opposed to an economy of maternity care that draws primarily on the 'logic of choice'.

Making choices

We begin with three stories that highlight the way the implications of choices in maternity are deferred and individualised. Like Simmonds (2016), we see stories as having power in both complicating and transforming our understandings of maternity. In the three stories below, we also see how the potential enactment of empowerment in 'free choice' may be transformed into the opposite, in which mothers carry not only responsibility for making rational 'best' decisions, but for the lifelong implications of what may (or may not) follow on.

Story One: Choosing the hospital

Esther is an educated woman who has recently returned to New Zealand after living in Japan, where she had her first baby. For a variety of reasons, she ended up getting her antenatal care through a hospital (rather than a maternity centre). In that system, she was scanned every

week – which in Japan was thought to epitomise excellent care. Late in her pregnancy, her obstetrican expressed concern that according to her scans, her baby was in a breech position, and he would like to book her in for a caesarean. She refused, saying she would rather give it a go. The obstetrician insisted. She refused again, politely. Finally, after several rounds of polite argument, the obstetrician growled at her in frustration, saying "You did not choose to give birth in a maternity centre, you chose to give birth in a hospital. If you had wanted that kind of care and support for natural birthing, you should have gone with a maternity centre!"

Story Two: Choosing an amniocentesis

Annemarie Mol was 36 years old and pregnant with her second child in the Netherlands (Mol 2008). The health guidelines recommended that due to her age, she should have an amniocentesis to check the foetus for Down's Syndrome. She agrees, and goes in for her procedure. She lies down on the table and as the nurse is preparing the long needle that will be inserted into her womb, she says "I hope it all goes okay". She is referring to what they both know: a small percentage of women have a spontaneous abortion as a result of the procedure. The nurse snaps back: 'Well, it's your own choice'.

Story Three: Choosing a homebirth

In June 2012, the Australian media erupted with vitriolic condemnation of a South Australian homebirth midwife when a coroner ruled her responsible for three babies that had died during homebirths. While the coroner ruled that the specific decisions that *this midwife* had made had led to the deaths of these babies, media outlets reported that 'Homebirth killed three babies: It's official' (Mamamia, 2012), and the internet buzzed with commentators judging the mothers of these children for their poor choice of birthing environment and caregiver. One anonymous commentator on the parenting website Mamamia wrote: "Any woman selfish enough to have a home birth and things go tragically wrong and your baby dies, well you have the rest of your life to feel guilty over your decision."

What is happening here? While pregnant women are able to be rational, informed decision-makers about their healthcare consumption choices, there is the possibility that *after* that first choice, they are expected to comply with the ongoing institutional norms that choice implies, and lie down in the bed they have made. They may be expected to just accept the consequences of their initial choice of provider or place of birth even when the care received is inappropriate: the homebirth midwife who did not transfer to emergency services early enough; the obstetrician who insisted on booking an 'elective' caesarean; the nurse who failed to provide a caring word at a moment when a mother was nervous. Annemarie Mol, the author mentioned in Story Two, tells her story at the beginning of a book-long investigation into the logics of 'choice' and 'care'. She wonders what the nurse could have said that would have fitted with a logic of care: "I hope it goes well too", "most of the time its OK", "are you worried about it?" She might have patted her hand, or given a smile. She might have even encouraged 'good behaviour' and reminded Annemarie to take it easy that afternoon (Mol 2008). Instead, the interaction with the nurse highlighted how mobilising the logic of choice can sometimes lead to poor care. It can shift the weight of everything that goes wrong on to the shoulders of the patient-chooser.

For us these stories illustrate the way choice, developed in the context of so-called free market societies, has come to function in health and maternity care. Choice, as it has been developed in the context of neoliberal governance and free-market economics, is closely associated with competition and efficiency. As consumers express preference for goods and services that best suit their needs—in terms of quality, convenience and speed—the assumption is that the market place will reward the best providers, leading to optimality. This clearly works best when the goods and services are well defined and where the transaction between buyer and seller is temporally discreet. This vision of the patient-as-consumer has, over the last quarter century, begun to circulate in health-care as a kind of common sense (even in places where health care continues to be provided as a public good) (Glynos 2014). Even where true health care markets do not exist, patient choice finds expression in an endless series of so-called quality measures that allow patients to make informed choices. Glynos (2014), following Mol

(2008) argues that this idea of consumer-choice is a poor fit in the context of health care, where choices are not so discreet, where "service provision" requires adjustment, improvisation, and tinkering and where "consumer" and "provider" are in an ongoing relationship. In his view, the good intentions of imposing market discipline by means of "choice" serve not only to undermine these relational dynamics, they can also generate anxiety in the patient who must choose. While choice is an important part of empowering mothers within maternity care systems, we are uneasy with the particular sociality it engenders in this context. The stories we tell above seem to speak to the consequences of this understanding of choice: strained relations between patients and carers, the anxiety that comes from making far reaching decisions where full understanding of consequences is not possible, social approbation when we are judged to make the wrong choice.

At the same time we recognize that we cannot be 'against choice' if the alternative is no choice. The history of maternity care in the mid-twentieth century was by and large an era of command and control maternity, regimented and antiseptic birth in a hospital setting in which expectant mothers had little to no say in the care they received (MacColl 2009, Kedgely 1996). Women were routinely shaved, given enemas and incapacitated with drugs and/or strapped to the bed (Kedgely 1996). In the late 1950s, global campaigns, inspired in part by French obstetrician Ferdinand Lamaze's concept of 'natural birth', pushed the changes that led to pregnant and birthing women being given increasing power to make choices (Reiger 2001). Later, birthing women began to ask for fathers and other carers to be present throughout labour and delivery, to refuse to be administered drugs, and to keep their babies with them following delivery. These developments do present expectant mothers with "choices"—but these choices are not discreet consumer goods but *an assemblage of relationships.* We see tremendous potential in these ongoing developments to improve maternity care—to make it safer, more supportive, less

anxious. A fuller understanding of this potential, however, requires a better understanding of the materiality of care practices and the economy of relations that define them.

Lining Up Choices with Spaces

One of the things we have noted in both New Zealand and Australia is that when pregnant women are positioned primarily as consumers of a healthcare service, the terms of the debate become 'which service is better to choose?', and of course this brings to light the underlying question of 'what do we mean by better?' The debate can then become quite oppositional. If a pregnant mother values access to technology, the perception of safety, and the possibility of a painfree birth, she might choose to give birth in a hospital, perhaps even a private one, with an obstetrician as a lead maternity carer (LMC). If a pregnant woman is convinced that a natural birth with no intervention is less likely to happen in a hospital environment, she might choose to give birth at home where she perceives herself to have more say over what goes on. If something goes wrong with the birth – in either environment – the blame may be laid on the mother – as we saw with each of the three stories above. Making these choices thus produces a considerable amount of anxiety for those about to become parents, who progressively discover how little their research and choice matters once they are absorbed into the particular regimes and routines of the place in which birth ends up occurring. These simplistic binaries of choice often seem to then line up in oppositional 'tendencies' (Sedgwick 1994), where hospital means obstetrician means medical and where homebirth means natural means midwife, despite the diverse possible and actual combinations of these.

Instead of reproducing these forms of lining up in the area of maternity care, we ask along with Sedgwick:

> What if instead there were a practice of valuing the ways in which meanings and institutions can be at loose ends with each other? What if the richest junctures weren't the ones where *everything means the same thing*? (Sedgwick 1994, 6, her emphasis).

As geographers, we approach our analysis of maternity care in Australia and New Zealand as partial 'outsiders' to both healthcare and birth activism. We begin looking for other junctures of study beyond the 'lining up' of natural-midwife-homebirth and medical-obstetrician-hospital.[i]

This brings us to the two problems at the heart of the logic of choice in maternity care and the presumed rationality that lies behind choice. In focusing our attention on 'the choice' it blinds us to much else. It imagines birthing women primarily as 'healthcare consumers' when they are also clearly productive participants in the process, indeed they are the chief labourer. Discourses of choice fixate on the human 'actors' in the space of labour and birth, and obscure from view all that is party to the process: technological and bodily processes, verbal and nonverbal communication, and the other-than-human actors both within and beyond the birthing space.

The focus on the rational act of choosing also limits what we might notice and understand. The birthing woman may be a subject that chooses, but she is also much more. She is a body in labour with all the dangerous feminine 'leakiness' and 'irrationality' (Longhurst 2001) that goes along with that. And there are many others present who will shape labour in multiple ways. For example, the role of hormones (primarily oxytocin), the limbic system, the microbiome, and other biophysical elements are well recognised for the way they can shape labour in the unfolding birth experience (Dixon, Skinner and Foureur 2013, Douglas 2010, IsHak, Kahloon and Fakhry 2011). Hormones help to bring birthing women into a different, liminal, space of being, where our 'rational' and 'calculative' brain might take a back seat to an instinctual and embodied 'in the moment' experience, where time seems to stand still and speaking or calculating seems like too much effort. This is a normal part of giving birth, and often marks the transition to the second stage of labour where the birth actually occurs (Dixon, Skinner and

Foureur 2013). It has been documented by a variety of birth commentators, described as a 'shift in conciousness' and 'going to another planet', where the limbic system 'needs to take precedence over our neo-cortex' (Buckley 2009), a 'trance state' where the 'inner primate' emerges as part of 'optimum labour' (Gaskin 2011, p.37). .

One obstetrician we interviewed spoke about how he first became aware of changes to mother's 'thinking state' during birth:

> I just noticed how much women were in their own zone when they're labouring. They don't want to be in the cerebral zone. There's just something almost meditative about what they're going through. It's a way of coping with the pain and so you have to work with that and it's - when you - when that sort of finally hit home to me it's so strong - that zone they've got around them - it's just the way.

This theme was present in many of the stories of birth told to us by mothers, midwives, and obstetricians: the state of 'being on another planet' is a common experience. In fact, the hormones that promote this *alter*-rational state can be seen as 'intrahuman' material actors who play a pivotal role in the process of giving birth. Along with many other elements that form complex ecologies internal to the human body (including microbial populations in the gut, skin, vagina, mouth), yet not quite human in themselves, these 'intrahuman' actors are present in various combinations in diverse birth events. The work these intrahuman biophysical processes do can be interrupted by 'bright lights, conversation, and expectations of rationality' (Buckley, 2009, p 99) and they do not always obey the rational, conscious decisions made by a mother. In addition, they can render a woman in labour unable or unwilling to engage in the kind of evaluative thinking in which a rational decision-making subject is supposed to engage. In our view, the pivotal presence of not only multiple actors, but multiple intrahuman (and non-human and more-than-human) actors in birth shows how unhelpful it is to enact binaries where one must choose a side in a pre-determined arrangement of options (medical-hospital-high-intervention or natural-home-low-intervention).

The presumed subject in the logic of choice cannot capture what happens in the actual birth-event. The birthing mother is not just the mother, she is also the birth which is a coming together of biophysically and biochemically constituted intrahuman actors, the baby within and the placenta that is shared between mother and child (see Fannin 2004), plus the other humans, nonhumans and more-than-human present, and assembled tools and technologies, furniture and décor (Fahy and Parratt 2006), policies and procedures (Powell, Walker and Barrett 2015). Beyond a discourse focused on choice—rational, empowered, anxious, guilty—we would propose an approach to maternity care that in the first instance focuses on the economy or assemblage of relations that compose it. We here draw on an approach to economies well articulated in diverse economies literature, where an economy is understood to be an assemblage of diverse relationships of production and exchange, a vast network that we might notice (and amplify) through mapping.

Mapping birth stories

As we discussed birth spaces and stories with mothers, obstetricians and midwives, the relations and exchanges that emerged were diverse – and did not always 'line up' in the ways described earlier. We interviewed obstetricians that support vaginal birth after caesarean (VBAC), we interviewed mothers who had fantastic caesareans, experienced as relief after days in labour. We discovered homebirths where midwives were intrusive and demanding, and hospital births where birthing women were left to labour as they saw fit.

Given the important roles of all the intra-, non-, and more-than-human actors described previously, we decided to use a particular method of research that works to catalogue all the actors involved in a birth, not just the mothers and LMCs. Our methodology borrowed from our readings of science and technology studies (STS) literature (particularly Law 2004) and was inspired by Jane Bennett's (2009) call to attend to the presence and agency of 'things'. In our interviews ,we asked mothers to draw conceptual maps of the spaces in which they gave birth,

commenting on the objects, the people, and the other institutional presences in the room. This allowed us to map a more complex birthing 'assemblage', where socialities, spatialities, materialities and more come together (differently) to enable (different) particular outcomes. As we talked through the construction of these birth maps with our participants, we asked them to draw in not just themselves and their support people, but furniture, objects and territories. We asked them about movement, and about what ideas, beliefs and symbolic presence each person or object brought in to the room, as well as the work each did to enable or hinder birthing. We discussed the mother's own 'presence' and 'absence' – what is was like when she transitioned into a state of 'zoning out' or 'turning inward'. We discussed the baby's presence – how it communicated with the mother through subtle movements, how her intuition fought with her nervousness. We discussed the absence and presence of noise, light, objects and more. From these accounts we were able to map networks of the diverse actors engaged in the birthing space (McKinnon 2014) and begin to identify some particular assemblages that seemed to have produced good care .

In what follows, we pull out two more stories to begin this process of articulating diverse assemblages of care. We have chosen these two New Zealand based stories as examples of care 'beyond the birth wars' – care where the ideology-caregiver-space 'lining up' we have come to expect is disrupted in some way, allowing us to think more carefully about what it is that enables good care.

Story Four: A good caesarean

Linda, a New Zealand mother in a small city, had planned to homebirth both her sons, but both had ended up in caesareans. Linda was reconciled to these births — she felt she and her midwives had given homebirth a good shot both times. Linda says about her births:

> It just worked that she [midwife] gave me enough time to make my own decisions without me floundering about not making a decision so that she had to push one. Because I'm sure some people wouldn't make a decision and then they'd have to be forced to make one. Then the person

> would feel like they hadn't made the decision. So they're kind of in a no win situation. I feel that I was able to process the information, make a decision that I was happy with.

It is clear from this quote, and others in Linda's interview, that her strong rational decision-making character was evident even while labouring. She was happy with her caesareans because she felt that the decisions were made by herself. Unlike the story of Esther we began with, she was given the opportunity to explore the possibility of giving birth, despite never dilating more than one centimetre in more than three days. Linda's acceptance of her difficult births is framed in terms of decisions: 1) the fact that the baby got to 'decide' the day of the birth and experience some labour and 2) the fact that Linda was able to logically work through a progression over several days in order to explore every other alternative to caesareans. The 'working through' involved more than just Linda undertaking the required work. The work of the body, the baby, and her carers contributed to a productive labour that produced, in the end, a caesarean undertaken as the result of care and acceptance. In this interview Linda highlighted the importance of making choices while giving birth, and in her own story values the ability to process information and make a decision – an ideal rational labouring woman, in some ways.

Linda's stories suggest that she may not have reached the later stages of labour in which women often report an experience of 'turning inward' and leaving 'the cerebral zone'. Certainly she never mentions feeling like this even when we probed this area in the interview. In fact, she tells of an incident in her second birth experience where she gets 'stroppy': she changes her mind about not wanting an epidural and her mother and husband try to hold her to her original birth plan and the amount of time she had decided to trial labour. She felt that she was rational and able to make that decision herself, but her support crew inappropriately assumed she was unable to think clearly.

> I said "You are not listening to me!" Then I had a contraction, and then the contraction finished and I said "I have a right to change my mind".

Linda, by virtue of the fact that she never reached the 'more-than-rational', altered consciousness, transition stage of labour, was able to embody the rational decision-making consumer that our healthcare systems seem to prefer. In her second birth, she made a choice to take an epidural three hours earlier than she planned in light of new information: unlike her first child where she had dilated 1cm after several days,[ii] with her second her cervix had not dilated at all. Linda realised that her pattern of labour was unlikely to change, and given her previous experience and her feelings of exhaustion, decided to use an epidural for pain management.

Although we can read Linda's story as a 'logic of choice' story, since she was rational all the way through and able to make clear choices as a 'healthcare consumer' and communicate them to her human supporters, we can also begin to read in a logic of care and pay attention to the specific place and its objects assembled for the labour and birth. The specificities of Linda's situation called for an adjustment to her plan — the hormones and contractions were not progressing the birth, her walking and swiss ball and hunger and pain and previous experience and more all assembled in such a way that the target time for trialling natural labour in her second birth became to seem unreasonable to her. Her midwife was attentive to these factors, and cared for Linda within the specificities of the situation (whereas the support crew were perhaps applying a more general antenatal class advice of how to manage 'women in labour'). Linda also draws our attention to other specifics of care unrelated to decision-making that made her caesarean experience less terrifying, firstly, the presence of her midwife in the operating room (OR)[iii] and secondly, the presence of a surprising and comforting object:

> They had this big wide TV screen [in the OR] and they were playing some beautiful images of a beach and some lovely music. It was really cool…I just lay there and like chilled out for a bit because instead of like going "look at all those instruments" and stuff, it was somewhere to focus on.

Given that only five minutes of her time in OR was dedicated to getting her baby out, with 50 long minutes directly afterwards while they stitched her up, this material intervention/object certainly made a difference to Linda's experience.

Story Five: Silly questions

Martinne had homebirths for all her three children. For each birth, the most important aspect for Martinne was having whānau around. She was fearful of having to have a caesarean without her husband or children present. At each birth, she also had a younger relative present in order to give them an educational experience of birth. She mapped and discussed the objects and people present in the small room in the flat in which she gave birth to her eldest daughter. Martinne says of her first midwife:

> [she was] talking to me through everything and was emotional support and she was getting me cold cloths and doing all those things that I really appreciated. So to be honest …She was good but just – yeah, really fussy, she was – I remember getting quite annoyed with her, asking me silly things like how am I feeling. Wanting to swear at her.

Despite generally good experiences around giving birth, Martinne could also identify moments and objects and particular ways of doing things that were unwelcome. In the quote above, she mentions how annoying it was to have the midwife ask her 'silly' questions — that is, bring her rational mind into play and wasting energy on making decisions or talking. Martinne appreciated the hands on approach of her partner, who physically comforted her, and the aroha support of having whānau physically nearby in the next room as caring and quiet absent-presences. In Martinne's case the presence and/or absent-presence of whānau members was what made her feel cared for and supported, even though she preferred them to be quiet and not interrupt. The ability to carry out certain cultural rituals was also an important aspect of experiencing care or aroha, for example, she mentioned retaining the placenta for later burial and reciting karakia.

In Martinne's case, one could argue that the 'choice' to give birth at home enabled her to have the birth she 'chose', and a healthcare system should provide lots of choices so people can be happy with their own choices. But as we can see in the quote from Martinne's transcript, there is a sense that just having the 'consumer's right' to choose the place or style of birth is not the only thing involved in good care. Martinne wanted her midwife to be skilled in reading her nonverbal body language and respecting her state of mind (Martinne described it as 'in a zone' and 'not really conscious'), and in one of her births this was not the case.

Conclusion

The marketplace model of maternity care brings what Ann-Marie Mol calls 'a logic of choice' (Mol 2008) or a 'regime of choice' (Glynos and Speed 2012) into the birthing suite. The idea that mothers can choose the 'best care' for them ignores the reality of a fierce political and ideological debate about how a woman should give birth, and leads consumers to assume that a 'best choice' is indeed possible. Regardless of the choices made, or what ended up happening in a given birth, mothers carry the moral weight and emotional depth of those decisions through life.

Part of the problem is that the logic of choice, and the polemic of the birth wars, make it seem possible to make the 'right choice' (based on rational well informed decisions). Using stories from research participants we have elaborated examples of frictional encounters that produce for us insights into the diverse assemblages that shape childbirth. Through these stories we explored how the 'logic of choice' has been brought into play in maternity contexts in Australia and New Zealand, and introduces how our experimental methodology reveals a more diverse assemblage of actors than client-provider forms of health care currently envisage.

Neither Martinne or Linda's stories fit easily into the polarised debates of the 'birth wars' or the 'lining up' that accompanies the conflict. Instead, they are particular and situated 'assemblages' of the spatial, the social, the material, the economic, the political. Martinne and Linda neither fully embody nor fully reject the 'informed healthcare consumer' identity. Their particular

situations required their caregivers to read them *in context*. By context we mean this complicated, situated assemblage where differing degrees of rationality and decision-making are embodied, and, thus for the caregiver, differing degrees of pre-empting, reading nonverbal signals and providing physical support.

We should make it clear that we are not arguing for less choice in where or with whom to give birth. What we are trying to show is that care is about something *more than* choice, and this is especially important in maternity care. The kind of contextual, situated care is what we are interested in exploring as we move forward with our project in both Australia and New Zealand.

While the discourse of the rational decision-making healthcare consumer appears to empower women in making birth choices that should be respected, it does not easily highlight the complex materiality of care in the moment — especially where nonverbal, nonrational, nonhuman and intrahuman interactions are present, as they necessarily are in birthing. Choice engages only some of the key actors in the room, and even then only at certain moments. A diverse array of actors assembles during childbirth, and are engaged in an economy of relations in which the conduits of transaction and negotiation are only sometimes acessible to logics of choice.

As we advance our project, we are interested in exploring different ways of writing and talking about the instances of good care within our health systems in ways that create connection across difference, break down barriers and conflict, and contribute to even better care for mothers, babies, and their families. We seek to imagine how existing diverse assemblages of childbirth can be 'tweaked' to enable better care for more (rather than just more choice).

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Endnotes

[i] We do not mean to imply that all health professionals or even mothers necessarily subscribe to these 'lining ups'. Excellent research from health and midwifery scholars provides a plentiful evidence base for those working outside this kind of 'lining up' (for example, see the work coming out of the School of Nursing and Midwifery at Western Sydney University). The focus of much of this research, however, remains on clinical outcomes and providing the 'proof' needed via large trials for changes in practice. Our focus as geographers is on the spaces and economies and embodied habits that reproduce non-best-practice care even after proof for change is provided.

[ii] Ten centimetres is considered full dilation, ready for birthing.

[iii] This is not strictly part of the midwife's job, and she is most likely not remunerated for this.