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## **Chapter 9**

### **Social Policy for Midwives**

**Mandie Scamell**

**Andy Aleszewski**

The aim of this chapter is to examine the nature of social policy-making in contemporary government and its impact on midwifery practice

Learning outcomes:

By the end of this chapter the reader will be able to:

- Identify some of the key maternity policy reforms
- Discuss the ways policy shapes maternity services and current midwifery practice
- Understand the importance of the critical analysis of social policy
- Begin to critical evaluation of contemporary maternity policy
- Explain how your own practice is influenced by social policy

### **Introduction**

This chapter provides student midwives with the opportunity to engage with some of the key debates within the policy literature related to the practice of midwifery. Through description and analysis of the expansion of the state's interest in pregnancy and childbirth, the current health policy context of the maternity services and the centrality risk within contemporary health policy, readers are encouraged to critically evaluate their role in contemporary birth management practices in the UK. The chapter begins with a description of the origins of health policy within the wider political framework of liberal reform.

An analysis of maternity policy in relation to the medicalization of childbirth project follows this description. Finally, the chapter moves on to critically evaluate the impact of the contemporary policy emphasis on informed choice and risk management.

### **What is health policy?**

Among the diverse and disparate definitions of social/health policy that can be found in the literature, some are quite complex and others simple (Howlett et al 1995). Despite this apparent struggle to pin down what is meant by social/health policy, or perhaps because of it, the everyday meaning of policy, that is how policy is understood by practitioners in their everyday practice is generally taken as a given (Alaszewski & Brown 2012). This means that those of us tasked with enacting upon policy publications in our everyday care of women and their families, are more concerned with the practical tasks of 'making it happen' rather than the pondering upon what it actually is. This approach to social policy, though pragmatic, tends to provoke compliance without enquiry, critique or question. This chapter aims to provide students training to work within the maternity policy context, with the opportunity to reflect more abstractly upon what social policy is and how it shapes the way we deliver maternity care services. By capturing the key components of the current academic critique of social policy and policy-making this chapter aims to engender a more reflective and analytical approach to policy interpretation.

### **The development of policy making**

Broadly speaking, policy can be understood as the bureaucratic means through which governments in contemporary society seek to protect citizens

from misfortunes such as disease and poverty. In this chapter we focus on the ways in which ideas about what governments should do, provide the context for midwifery practice. Readers who want a more detailed analysis of the policy making processes that connect ideas to action can find these in texts which focus on policy making (see for example Hill, 2013 and Alaszewski and Brown, 2012).

The roots of social policy can be traced back to the 19th century when social reformers identified social problems which the state could and should deal with. For example Jeremy Bentham (1748-1832), the utilitarian philosopher developed plans for the rational management of poverty and crime based on model workhouses and prisons. During this period reformers and their various campaigns had some success in persuading a reluctant state to take on responsibility for the well-being of vulnerable individuals. The emerging social reforms of this period were generally seen as progressive reforms that lay the foundation for the development of the welfare state in the mid-20<sup>th</sup> century (see table \*.1). However, there were some aspects of the reforms that are now seen as less benign. It is this more discerning approach to policy that offers the reflective practitioner the tools necessary to critically evaluate their own role in relation to current health policy agendas.

### **Key points for historic development of health policy**

1. At the start of the 19<sup>th</sup> century the role of the state was limited mainly to the defense of the realm and the maintenance of law and order
2. In the 19<sup>th</sup> Century there was a reluctant expansion of the scope of the state as reformers identified social problems which the state could and should address
3. In the early 20<sup>th</sup> Century there was a rapid and relatively enthusiastic expansion of state activities that culminated in the formation of the Welfare State

Table \*.1. State expansion and the development of social policy

### **Health policy and childbearing**

Health policy emerged as a distinct area of public policy-making activity as the government involvement in health care provision intensified in the middle of the last century (Alaszewski & Brown 2012). With the post war formation of the National Health Service in 1948, health policy became both a well-defined and integral part of the government's efforts to invest in, and plan public services.

Until the end of the 19<sup>th</sup> century, the expansion of state involvement had limited impact on childbirth and midwifery but this changed with the Liberal reforms of the early 20<sup>th</sup> century. As child rearing, pregnancy and childbirth became a focus of health policy so the state needed experts who would be willing and able to manage the problem on its behalf. For the supervision of pregnancy and childbirth the state reshaped an established occupation, midwifery. The Midwives Act (1902) established a national regulatory authority, the Central Midwives Board, consisting mainly of male physicians and surgeons. The Act specified that from 1905 'No woman shall habitually and for gain attend women in childbirth unless she be certified under this Act' (Clause 1 Section 1).

### **Trigger 1 finding out about the regulation of student midwives**

Locate the Nurses and Midwives Council website.

From the landing page explore how to find professional regulation documents.

Identify which of the regulation documents apply to your practice as a student midwife.

While state registration can be seen as a benevolent development, ensuring the safety of mothers and their children through the provision of qualified and supervised midwives, it can also be seen as representing a major shift in the nature of childbirth. Women were no longer free to choose their own birth attendant but had to have one who was trained within and supervised by medical experts. For Katz Rothman this marks a shift from birth as a process that the pregnant woman controlled to birth as a medical event in which pregnancy is defined as 'a problem of medical management, into a site of screening and diagnosis at all time for all purposes' (2014, p. 2).

#### *Comment*

Whether or not midwives are aware of it, what we do, how we do it and why we do it is shaped by social policy. Thus the 1902 Midwives Act recast midwives as agents of the state who had to apply medical knowledge to a medicalised process and report the outcomes to medical authorities. As Katz Rothman (2014) notes this medicalisation of both midwifery and childbirth endures but many fail to notice it as it is so taken-for-granted and engrained into midwifery practice.

#### **Maternity policy in context**

Maternity care policy is not made in isolation. Instead it should be understood as being part of a wider political and policy context. The maternity health policy agenda over the last 25 years echoes a wider and unprecedented shift towards centering the patient in both health care provision and health policy (Giddens 1998). Public/patient consultation and verification has not only been sought in issues of direct care, but also in the policy making process itself,

privileging both patient choice and expert patient initiatives (Alaszewski 2007b, 1-10).

A central component of contemporary maternity policy is user involvement and women's informed choice. For example the Department of Health's policy document Maternity Matters (2007) set out a **national choice guarantee** 'as a way to drive the essential improvements in the quality, safety and accessibility of service' (DH 2010: 2).

### Trigger 2 Engaging with key maternity policy documents

Maternity Matters is an important Maternal Health Policy Document.

Locate this document from the National Archives.

Identify the National Choice guarantee

Do you think the Trust you currently work in complies with this policy document?

The active endorsement of women centered care and informed choice in contemporary maternity policy encourages women to reflect upon their pregnant bodies, adjust their lifestyle, optimise the health of their unborn child and purposefully design or plan their birth experience (Lupton 1999, 59-85). Evidence of this self-regulation and planning in pregnancy is evident in the plethora of pregnancy and birth texts available. See for example Marshall's critique of pregnancy texts in *Fit to Reproduce? The Regulative Role of*

*Pregnancy Texts.* With the emphasis on informed choice, every pregnant woman is seen as being responsible for ensuring that they give birth to and nurture a healthy baby. Thus mothers have to demonstrate to midwives, health visitors and others that they are, 'good mothers' who are both healthy and competent of making sensible decisions. The term - good mother - is highlighted here in inverted commas because as the academic analysis of motherhood has demonstrated, the meaning of what it is to be a good mother should never be taken as a given. What constitutes a good mother changes over time and place. In other words, how mothers should behave is in part at least, socially constructed. Furthermore, the term good mother is never neutral. Ideas around good mothering which drive midwifery public health interventions such as smoking cessation and breast feeding promotion, can and do instill feelings of inadequacy, guilt and even shame in women fail to live up to expectations set down by midwives (this idea is explored is something we revisit below in relation to pregnant drug takers).

### **Trigger 3 Further reading**

To strengthen understanding of the concept of good motherhood students are advised to read the following:

- *Being a 'good mother': Managing breastfeeding and merging identities* by Marshal et al (??date)
- *'The best thing for the baby': Mothers' concepts and experiences*



## Application to practice (1)

*We recommend that you consider this practice exercise before reading the rest of the chapter to enhance your understanding.*

Read the scenario below and consider the numbered points listed at the bottom of this box.

Emma is attending your antenatal clinic at 28 weeks gestation and is expecting her second baby. At booking Emma informed you that she was smoking around 20 cigarettes a day. You offered to refer Emma to the Cessation of Smoking Support Programme as per local protocol but Emma assured you that she managed to give up smoking easily last time she was pregnant and that she did not need any extra support.

As Emma reclines on the examination couch you notice that she smells of cigarette smoke. Emma requests that you listen into the baby's heart rate and as you do you observe foetal tachycardia consistent with maternal smoking.

When you offer to discuss with Emma the benefits of giving up smoking she responds:

"Oh that's okay, you went through all that before. Besides I've stopped now anyway just like I said."

1. Why do you think that Emma has lied about her smoking?
2. Examine how you feel about Emma's decision to continue smoking while pregnant.
3. Do your feelings reflect a partnership model of care supporting informed choice?
4. Do you think that your approach to Emma's care has encouraged her to feel like a good mother?

From the perspective of women centered care which is based upon informed choice, women are encouraged to not only be actively involved in their care but also take responsibility for their own wellbeing. Within this policy context responsibility for pregnancy and birth is not exclusively the domain of a midwife or doctor. Instead pregnancy and birth experts provide advice, leaving the pregnant woman faced with the responsibility of having to make up her own mind about her wellbeing. On the face of it informed choice appears to enhance personal freedom and individual development. In practice this policy agenda expects pregnant women to place ever-tighter restrictions on their life styles during pregnancy. Ironically mothers have no choice but to choose, provided that is if those choices comply with the list of recommendations set out by the midwife.

### **The moral loading of choice**

The moral underpinning of midwifery practice is explicit in midwives response to choices which they judge threaten the well-being of the unborn foetus, such as mothers' choosing to smoke, drink alcohol, take illicit drugs or even eat without censure during pregnancy. In such cases midwives seek to change these behaviours and in extreme cases instigate action that results in babies being removed from their mother's care after birth. For example in Stengel's (2014) study of 13 pregnant women with a drug taking history, 9 of them feared that their baby would be taken away and in five cases this happened. This form of 'policing' does not fit comfortably with midwives preferred role as the mother's trusted adviser. Public health activity here appears to cultivate a relationship of mutual distrust, a far cry from a partnership model of women

centered care. Within such a public health policy context it is not surprising that the women involved in Stengel's (2014) study sought to control information about their lives to reduce midwives' surveillance and the risk of the loss of their baby.

While some women resist the medical risk discourse of pregnancy and associated moral judgments of their behaviour, most accept and internalise it. Choice of place of birth is a graphic example of this. Despite 20 years health policy that encourages choice in where to birth, the majority of women continue to choose to give birth within the medicalised environment of an acute care setting. Home birth rates in England for example have remained virtually static at 2.5%. By way of explanation for the resilience of the medical risk discourse that surrounds birth in our country Coxon and her colleagues draw on empirical narrative research with pregnant women in England to examine the ways in which women's choices about where to give birth was shaped by what they considered safe and normal:

When women planned hospital birth, they often conceptualised birth as medically risky, and did not raise concerns about overuse of birth interventions; instead, these were considered an essential form of rescue from the uncertainties of birth. Those who planned birth in alternative settings also emphasised their intention, and obligation, to seek medical care if necessary. (Coxon, Sandall and Fulop, 2014, p.51)

Similarly when women reflected on their life style choices during pregnancy they also tended to accept the medical risk discourse. Hammer and Inglin

(2014) examined the ways in which pregnancy affect 50 white well-educated Swiss women's smoking and drinking and perception of risk. While all the women in the study tended to reduce or stop these behaviours and see them as risky they differentiated the risks:

The pregnant women in our study saw smoking during pregnancy as a risk-taking behaviour and a failure to act in the best interest of the foetus. In contrast, under certain conditions, they saw moderate drinking of alcohol during pregnancy as acceptable and responsible behaviour (Hammer and Inglin, 2014, p.22).

Pregnant women's internalisation of the dominant medical discourse to risk can be seen as a form of self-policing where women are encouraged to not only be actively involved in their care but also take responsibility for their own wellbeing, a form of subordination through the act of self-surveillance. By drawing from broad appeal notions of self-help, collaboration, empowerment and participation and so on, contemporary health policy has achieved both public endorsement and co-operation (Petersen 1996). Thus

Personal autonomy...is not antithetical to political power, but rather is part of its exercise since power operates most effectively when subjects actively participate in the process of governance. (Petersen, 1996, p 11)

According to this critique, the policy priorities of informed choice and women centered care do not represent a shift away from the medical, technocratic discourse of childbirth. On the contrary, this policy agenda represents a voluntary, even self-congratulatory move towards a more subtle but none the

less more intense medicalisation. Through self-scrutiny pregnant women actively participate in the medicalised regulation of their own bodies and lifestyles.

### **Key points for Women's choice in pregnancy and childbirth**

1. The women's rhetoric of choice is central to current social policy and finds expression in concepts such as self-help, collaboration
2. Women are free to choose as long as their choice is considered to be safe and responsible for the foetus and therefore fits with expert risk assessments
3. Client autonomy in the form of woman centered care, operates

### **Risk and maternity health policy**

Central to contemporary maternity health policy is the issue of risk and risk management. In the next part of this chapter we will examine this issue of risk, in particular the technologies of risk management within the maternity care services, to ascertain what insight this can offer in the quest for understanding maternity care provision in the UK.

Health policy experts concur that the influence of risk in health care and health policy has expanded to unprecedented levels in the past 20 or so years (Heyman et al. 2010; Gabe 1995; Alaszewski 2007, 1-10; Alaszewski 2001). Nowhere is this hypersensitivity to risk and interest in risk management more apparent than in maternity care, which is considered to be one of the highest risk areas of care in the NHS (NHS Litigation Authority 2012). With the introduction of National Service Framework policy guidelines, audit through the Care Quality Commission, establishment of the Litigation Authority with its Clinical Negligence for Scheme for Trusts (CNST) and best practice standards of the National Institute for Health and Care Excellence, the maternity services have become firmly entrenched within clinical governance. The policy reforms of the 1990s involved replacing clinical autonomy, practitioner's use of their clinical judgment based on their clinical knowledge and experience, with collectively agreed clinical guidelines, based on the systematic review of available evidences. Within this policy context clinical decision-making follows set algorithmic rules where care pathways are predetermined. Through the institutional standardisation of clinical practice professional discretion is confined to what has been termed 'scientific-bureaucratic knowledge (Harrison & Doswell 2002) based on encoded knowledge (Lam, 2000).

An example of how such algorithmic rules circumscribe clinical decision-making can be seen in the current management of pregnancies that run beyond 40 weeks of gestation. Whereas historically midwives viewed pregnancy length, as something that was individual to the woman allowing for

differentiation from one pregnancy to the other, all practitioners now expect pregnancy to be terminated within a set timeframe. That timeframe is set out in the NICE guidelines, which are reduced down to a clinical decision making pathway.

Clinical governance gave primacy to publically available and verifiable knowledge over more personal types of knowledge such as intuition or custom and practice. While clinical governance reduces the autonomy of individual practitioners, it increased the collective power of the medical profession over childbirth. Acceptable ways of managing birth must now be supported by evidence based practice where knowledge is collected using predominantly the medical gold standard of randomised controlled trials or even better a systematic review of a range of random controlled trials.

## **Application to practice (2)**

*We recommend that you consider this practice exercise before reading the rest of the chapter to enhance your understanding.*

Read the scenario below and consider the numbered points listed at the bottom of this box.

Sandra is expecting her second baby following a straightforward pregnancy. Sandra's previous labour was induced for post term. Sandra has already disclosed to you, her midwife, that she finds the memories of her first labour traumatic and that she believes that this is because she was induced. Sandra comes to see you at 40 weeks gestation and you offer her a stretch and sweep and to refer her to obstetric care for post term.

At this point Sandra breaks down in tears and refuses to accept either of your suggestions. You point out to her that this is recommended pathway for this point in her pregnancy and she leaves the clinic without making any further appointments to see you.

1. Why do you think that Sandra has chosen to reject your advice?
2. Why did you as the midwife feel obliged to refer Sandra to a service that she was likely to find distressing?
3. What would Sandra's options be now?
4. Does Sandra have the right to refuse this referral even if it puts her unborn child's life at risk?

The Department of Health led the process of systematically coding knowledge. The first set of guidelines known as National Service Frameworks were for cancer treatment and the process was led by the English and Welsh Chief Medical Officers (Sir Kenneth Calman and Dame Deidre Hine). Subsequently clinical directors (so called Clinical Tsars) have played a key role in developing and ensuring the implementation of guidelines. At the same time, the government established a new 'arms-length' body, independent but government funded, to systematically review evidence about specific treatment, initially known as the National Institute for Health and Care Clinical Excellence (NICE).

To ensure the public could trust the system as dependable and that 'bad apples' (such as Harold Shipman) did not escape detection for long, the reforms specified that both the risks and outcomes of clinical decision-making should be systematically reviewed. At local level this involved the establishment of clinical governance committees to systematically monitor clinical outcomes and to identify risks and take action to mitigate them. This involved investigating not only adverse events, that is an event in which patients were harmed but also 'near misses', events in which things went wrong and patients could have been harmed. This local system was overseen by a new body, the Commission for Health Improvement whose role was to investigate if they identified unusual patterns of clinical outcomes where there was public concern about the performance of practitioners or hospitals. Although midwives might like to think of themselves as autonomous practitioners delivering individualised care to women and their families within the contemporary policy context they become agents of clinical governance

responsible for delivering standardised care which excludes professional discretion or creative thinking.

### **The shift from uncertainty to risk**

Clinical governance health policy, where the standardisation of decision making is valued over and above professional discretion, has significantly changed the way birth can be managed. Whereas once the potential hazards that always come with childbirth, might be thought of in terms of the inevitable uncertainties inherent in the process of reproduction, these hazards have now been recast. The hazards of childbirth can no longer be thought of as chance misfortunes, instead they are understood in terms of risk. This means that poor outcomes tend to be investigated through the risk management system. Within this working environment there is no place for chance, uncertainty or accidents instead there are only risks that need to be anticipated, planned for and mitigated. Every parent expects a perfect baby and if this does not happen then it is assumed that someone is culpable and should be held to account.

### Application to practice (3)

*We recommend that you consider this practice exercise before reading the rest of the chapter to enhance your understanding.*

Read the scenario below and consider the numbered points listed at the bottom of this box.

Laura is birthing her baby at home in a birthing pool. She is progressing well and you judge by her behaviour that she reached full dilatation. As Laura begins to push spontaneously her membranes rupture. You notice that there is thick meconium staining of the fluid.

You ring for an ambulance and advise Laura to leave the pool. On auscultation you observe a foetal heart rate below 110 bpm. When the ambulance arrives the heart rate remains at around 90 bpm. You attend Laura in the ambulance listening to the foetal heart at regular intervals. The baby is delivered by emergency cesarean section but fails to respond to resuscitation.

Post mortem results – cause of death unknown.

1. Examine how you feel about this scenario.
2. Are you wondering about cause of this stillbirth? Could it be the place of birth? Or perhaps the use of water during second stage of labour?
3. Did you find yourself looking for evidence of poor midwifery care?
4. Does there have to be cause? If so why?

The distinction between uncertainty and risk is an important one on two counts. Firstly, uncertainty denotes a future that cannot be predicted, an unknown. By contrast, thinking in terms of risk is a process of mitigating those unknowns, minimising the unpredictability of the future in an attempt to improve outcome. Risk implies activities of security (Giddens 1991). Or put another way, risk thinking is all about 'colonising the future' (Giddens 1991:133).

Once birth was reconceptualised in terms of risk, technologies of risk management must be employed. In this context childbirth has to be managed through a standardisation of care through strict obstetric observation and intervention. Importantly there is no room for accidents in the imagined future dominated by risk (Adams 2003, 1-11; Green 1999, 25-39). Furthermore, individuals, midwives and obstetricians (as well as the mothers themselves), must be held accountable for any failures in birth and the battery of technologies used to manage birth.

Ironically the shift from uncertainty towards risk in the conceptualization of childbirth has been accompanied by a statistical decrease in the probability of harms associated with reproduction. The current hypersensitivity to the risk in the maternity services has developed in conjunction with an ever-increasing level of safety. As Cartwright and Thomas (2011, 161-166) point out:

'Danger has always attended childbirth... Danger was transformed into biomedically constructed and sanctioned notions of risk. This was more than a semantic shift: Dangers implies a fatalistic outlook on birth, risk implies an activist stance' (Cartwright & Thomas 2001 :218).

Due to the risk centered policy climate in which contemporary maternity services are delivered

‘It is the case that debates about childbirth will most likely continue to pivot around the notion of risk despite the low rates of mortality and morbidity relative to pre-war figures in advanced Western economies.’  
(Lane 1995: 56)

As undesirable outcomes have become less likely, preoccupations with these unlikely outcomes has intensified. Furthermore, this intensification shapes how midwives can practice and the manner in which women give birth (Scamell 2011; Cartwright and Thomas 2001, 218; Annandale and Clark 1996, 17-44; Skinner 2003, 4-7; Walsh 2006, 89-99; Kirkham 2009, 7-9). The shift from uncertainty to risk, apports a sense of responsibility accountability and ultimately blame for those involved in managing risk.

### *Comment*

The role of the state in the provision of health care expanded in the 20<sup>th</sup> century. It has created a large-scale system of surveillance that seeks to ensure that clinician’s decisions are structured by nationally agreed protocols and guidelines. Within this structured working environment routine midwifery care operates to strengthen the medicalisation of childbirth.

#### Key points in risk theory of social policy

1. The influence of risk in health and health policy is ubiquitous
2. Risk has replaced uncertainty
3. Risk management sets out to control uncertainties in the future
4. Risk underpins risk management technologies, accountability, responsibility and blame

#### Conclusion

In this chapter we have examined the impact in the UK of policy on the delivery of midwifery care. Through the analysis of the policy reforms that have helped shape midwifery practice over the past 100 years and more it has been possible to critically evaluate and reflect upon contemporary maternity services in this country.

While most midwives would like to see themselves as autonomous practitioners who enable the women in their care to have safe births, midwifery practice is in fact shaped by the exercises of state power and public policy. Within the current policy climate preoccupations with clinical governance and risk dominate meaning that routine midwifery care operates to strengthen the standardisation of childbirth through the strict implementation of risk management. In this chapter it has been possible to show how even the midwifery commitments to women centered care and informed choice operate as mechanism of subordination. Power is exercised most effectively when subjects actively participate in the process of governance compliance and midwives are active agents in the expression of this power.

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