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## Introduction

In the first part of this editorial we reflect on some of the recent articles published in *Health Risk & Society* that contribute to our understanding of the ways in which the risks associated with pregnancy and childbirth are constructed. In the second part, we identify specific issues that would benefit from further study and which we would like to address in a forthcoming *Health Risk & Society* special issue.

## Reflections on risk in pregnancy and childbirth

As Lee *et al.* (2010) argued in the *Health, Risk & Society* special issue on 'Risk, health and parenting culture', individual and collective anxieties about the safety of babies and children underpin a system of surveillance designed to ensure that parents and others effectively identify and manage the hazards associated with procreation and child rearing. They noted that pregnancy and childhood are constructed as periods of dangers during which vulnerable babies and children are exposed to danger and that:

the parent is represented as central to the evolution and development of danger. In other words, the imperative at the individual level to become a risk manager weighs especially heavily when the message is communicated that the child is at risk. The drive to protect children 'at risk' and to increase the safety of children in general is, for these reasons, among the most powerful of contemporary cultural and policy norms (Lee *et al.* 2010, 299)

While both pregnancy and child rearing are potential sources of danger, child birth as the nexus and the point at which the potential of the foetus is realised as the baby and future child, has become a time of particular danger with the need for heightened surveillance and expert advice and guidance. In their article in the *Health, Risk & Society* special issue on risk categorisation, Scamell and Alaszewski (2012) noted that midwives were so concerned about possible negative outcomes of childbirth that normality and safety only existed as a negative, as the absence of danger. As midwives were unable 'to describe, talk about and measure normality and low risk, they effectively created an imagined future colonised by potential high risk that could at any moment be made visible through their continual surveillance'. (Scamell and Alaszewski 2012, 218).

The anxiety about the dangerousness of childbirth might be understood as an example of timid or anxious prosperity (Taylor-Gooby 2000). In general though, the concept of 'timid prosperity' is largely absent from the prevailing biomedical approach to childbirth, and instead an ethic which valorises 'prudent risk aversion' prevails. Since the eighteenth century, childbirth in the UK has become safer and more manageable yet at the same time it has become a locus of risk and expert surveillance, and women at special risk are categorised as having high-risk pregnancies and have been subjected to additional expert surveillance and intervention. In this issue, Lee *et al.* (2012) review the evidence on how such categorisation impacts on pregnant women. They note that women whose pregnancies are categorised by health professionals as high risk often do see themselves and their pregnancies as being in danger though they do not necessarily agree with medical practitioners about the extent or imminence of this danger. Women's perceptions of pregnancy as 'high risk' were associated with increased anxiety about the outcome of pregnancy. Lee and her colleagues draw on Enkin *et al.* (2000) to suggest that when women were classified as high risk and this categorisation was grounded in factors that were intrinsic to the woman's situation (such as social class), then such categorisation tended to increase women's anxiety without improving outcomes.

In late pregnancy, the main focus of concern, or in Van Loon's (2002) terms the 'virtual risk object' is self-evident – risk categorisations are intended to result in the safe birth of the baby. In high-income countries, where maternal mortality is rare and perinatal mortality is low, attention has shifted to different outcomes, including women's experience of birth, and rates of intervention which are practiced in both 'normal' and complex labours. Interventions such as operative birth (ventouse, forceps or caesarean) impact upon women's physical and emotional health following the current birth (Lydon-Rochelle *et al.* 2001), and also on future pregnancies and births; this means that the events of one labour and birth can significantly impact upon a woman's 'childbearing career' (Thomas 2003). Women expecting their first babies carry a higher burden of intervention than those expecting second or subsequent baby (Downe *et al.* 2001; Bragg *et al.* 2010) with little evidence of improvement in outcomes for babies. Yet the strong social consensus in favour of 'risk managing' birth make it difficult to tackle what is meant by the 'necessity' or otherwise of birth interventions, or to ascertain the extent to which decisions made in labour (when the outcome remains uncertain) constitute informed choices, are

negotiable, or are effectively delegated to staff in the midst of complex clinical scenarios. Unpacking these concepts from a social science perspective will enhance understanding of why interventions become characterised in moral terms (e.g. 'good', 'clinical' and 'necessary' caesareans, undertaken appropriately to save lives, versus the 'bad', 'social' or consumer-driven 'unnecessary' caesareans, which might include those conducted at the woman's 'request' (without 'clinical indication') or to fit in with the obstetricians' working weeks (Murray and Elston 2005).

Interventions during birth are widely considered to be instigated by medical practitioners, although interventions such as 'cervical sweeps' (to bring about post-term labour), rupture of membranes (to 'speed up' labour) and internal vaginal examinations to ascertain cervical dilation are also part of UK midwives' autonomous practice. Such interventions are undertaken either to hasten birth, or to measure 'progress' of labour, which is then plotted on a graph ('partogram', or 'Friedman curve') against time. The influence of 'clock time' upon the modern world has been documented by McCourt and Dykes (2010, p. 18), who link medical management of birth with industrialisation and creation of 'production line[s]' (see also Martin 1987). Undoubtedly, the time-centred medical management approach has been very influential within high-tech maternity healthcare systems and is routine practice amongst obstetricians, obstetric nurses and midwives. Sometimes however, small groups of these professionals, working with women and campaign groups representing women's rights in childbirth, oppose or seek to minimise interventions, especially those undertaken on the basis of length of time passed, rather than in response to a deteriorating clinical situation. In doing so, these coalitions effectively challenge the logic of 'clock time' in labour, and advance a counter-argument in favour of 'expectant' ('wait and see') management. However, it is virtually impossible to design or undertake clinical trials of expectant management of labour, and so evidence for providing professional care during 'normal' labour without routinely employing time-based protocols of labour management is weak. Expectant management remains controversial, and is effectively outlawed in the sense that clinicians practising this way may find that they have to argue litigation cases unsupported by their employers, although their professional organisations may defend them. These approaches are at the very least viewed with scepticism by more medically orientated members of both midwifery and obstetrician professionals.

In early pregnancy there is a different decision context, because other outcomes than the safe birth of the baby situation are possible in countries such as the UK which legally sanction the termination of pregnancies. In early pregnancy the social context of the pregnancy can bring into focus different outcomes grounded in different value systems creating competitive virtual risk objects. In this issue, Hoggart (2012) notes the ways in which teenage pregnancy has in UK government policy been categorised as undesirable and something to prevent. Although the termination of a teenage pregnancy is also considered undesirable it can be seen as the lesser of two evils. Thus for teenage mothers there are two possible outcomes, a termination of their pregnancy and the birth and subsequent care of a baby. Hoggart (2012) explores how these mothers considered these alternatives and the consequences of the choices they made. She argues that values underpinned the choices that these young women made; their own values and those of significant others. Where the values of key participants in the decision making were congruent, for example that the desirability of the continuing the pregnancy outweighed the undesirability of a termination or vice versa then the choice was relatively straightforward. However, where key participants held different values and advocated different courses of action then the choice was both more difficult and complex. Those young mothers who had made choices not grounded in their own values felt a sense of regret about the choices they had made. In some cases participants in the study whose preference was to complete their pregnancy but agreed to have a termination after a relatively short period of time became pregnant again and did not terminate this subsequent pregnancy.

## Potential themes of the special issue

### Overall approach of the issue

Editorials and articles already published in *Health, Risk & Society* indicate that pregnancy and child birth have become important sites of risk in late modern societies, and we believe that there is scope to enhance current understanding of risk contraction in pregnancy and birth. The initiations of many current publications on risk, pregnancy and childbirth is that these treat risk as self-evident clinical or demographic factors and fail to critically engage with the politics of risk. In the area of pregnancy and childbirth this is surprising, as expert groups have long competed over the control of the process and the definition of risk. In the nineteenth century the disputes tended to be between midwives who relied on childbirth as the major source

of their income and general practitioners who saw childbirth as way of accessing middle-class families and providing for all their health needs (see for example Donnison 1988). In the twentieth century, the tensions were between community doctors and midwives, and hospital-based obstetricians. These inter-professional debates have been characterised as focused upon the nature and location of childbirth with the relative risks of home birth, or birth in midwife or GP-led settings, versus birth in specialist obstetrician-led units, and natural (or 'normal' birth) versus medicalised birth being the key bones of contention. A polarised division between 'medics' *or* 'midwives', and 'natural' *or* 'interventive' birth continues to be perpetuated, although these tired either/or scenarios seem increasingly diminished if their central pretexts are examined. Medical practitioners as well as midwives and women have historically challenged the necessity for intervention and advanced the case for sensitive, woman-centred maternity care, whilst women, midwives and medics have equally argued that interventions are essential, valuable and a central basis for safe, high-quality maternity care with good maternal and infant outcomes. As Scamell and Alaszewski (2012) also note, midwives find it difficult to keep 'normal' in the foreground once they are attending labour, regardless of setting, because they feel equally bound by clinical protocols wherever they are situated, whatever personal, ideological stances they may adopt. This gives rise to a form of 'benign paternalism' where maternity health professionals reach conclusions they believe to be in the best interests of women, sometimes without exploring women's views, beliefs and values, and advise accordingly either by proposing particular courses of action, or neglecting to discuss alternatives. The interests that inform these positions are manifold but these include avoidance of litigation; fear of negative outcomes (from one perspective, infant death and from another, the loss of a 'normal' or 'natural' birth), and the cultural pressures of 'how things are done here'.

A major feature of these debates are arguments about risk and safety, though many protagonists' claims are based more on how evidence is interpreted and adopted, than objective presentation of risk and benefit in given scenarios. Risk is a key element in the conflict over hegemony and autonomy in maternity care and as Jamous and Peloille (1970) noted in their study of French teaching hospitals, claim that there was indeterminacy and uncertainty in human body and ways of managing these were used to justify the autonomy and hegemony of biomedically oriented practitioners. Given the on-going debates about the nature and location of childbirth, we would be

interested in articles that explore the relationship between the claims, evidence and objectives of particular protagonists. For example, new prospective, observational data about planned place of birth in England (BPiE Collaborative Group 2011) suggest that, for healthy women with low-risk pregnancies and straightforward obstetric histories who were expecting their second or subsequent babies, birth was safe (for both women and babies) in hospital and non-hospital settings. Birth was also safe for healthy women expecting their first baby in all settings, except that there was a higher incidence of poor outcomes (including birth injury, brain damage following oxygen deprivation and stillbirth) amongst women who planned to give birth to their first babies at home, and between 36 and 45% were transferred into hospital settings during labour (compared to 9–13% per cent of women expecting their second or subsequent babies). Intervention rates were lower for women in all non-hospital settings. This research has given rise to a range of position statements, media coverage and interpretations, and we would be interested in papers that examine the influence of claims-makers on maternity policy and practice. Brown's study of claims making and mental health policy would provide an interesting point of reference for such papers (Brown 2008).

We would also like to invite articles which examine how the debates about nature, location and 'management' of birth are changing in the twenty-first century. There is some evidence that supporters of medical models or natural birth have begun to expropriate each other's arguments, with aspirations towards clinical 'natural' births (such as Edwards' (2005) account of midwives introducing 'hospital birth' into women's homes) or caesarean sections positioned as clean, safe and normal (Bryant *et al.* 2007).

#### **Risk and the everyday experience of pregnancy and childbirth**

While risk and uncertainty are potentially interesting topics for academic research, they are also an important part of everyday life, as we have noted in two special issues of *Health, Risk & Society* (Alaszewski and Coxon 2009, 2010). As Hoggart (2012) notes, women, especially teenagers, in the early stages of their pregnancy may be faced with difficult choices and decisions. Scamell and Alaszewski (2012) argued that:

Childbirth can be seen as a fateful moment in which life is changed irreversibly. If all goes well, then a healthy baby is born. But if things go wrong then the mother and/or

her baby can be seriously harmed or even die. All those involved in a birth of baby *‘must launch out into something new, knowing that a decision made, or a specific course of action followed, has an irreversible quality, or at least that it will be difficult thereafter to revert to the old paths.’* (Giddens 1999, p. 114)

If childbirth is fateful, this affects not only the woman and her immediate family but also the professionals and organisations involved in providing her with care and support. If things go wrong they can and will be blamed and this may have important repercussions of their lives. As Hood *et al.* (2010) showed, midwives involved in a state government inquiry into midwifery practice felt they were under scrutiny and exposed to fear and responded by using strategies that minimised their personal risk such as ‘covering your back’.

We would like to include articles that explore the ways in which those involved in pregnancy and childbirth construct and manage risk and how this influences their choices and decision making. It would be helpful if these articles considered the broader social context of pregnancy and childbirth in late modern society by considering, for example, is there evidence to suggest that the development of internet access to information and knowledge has made it easier for women and partners to participate in decisions made during pregnancy and childbirth, or exploring the ways in which such access can alter women’s relationships with health professionals or provider organisations in significant ways. It would be interesting to consider whether access to internet fora has altered discourses around birth and maternity care.

The issues facing maternity health professionals also appear to be changing. In some high-income countries, where public health data suggest birth is safe for healthy women with low-risk pregnancies, maternity care professionals are being encouraged to support ‘low tech’ birth (for example, to resist ‘continuous electronic foetal monitoring’), but we would be interested in accounts of how practitioners and health systems justify ‘not’ using technology, once it has been introduced, as this must incur some risk (from medical management perspective), and may lead to unintended consequences, and hence might be considered counter-intuitive.

#### **Risk and the representation of pregnancy and childbirth: The media, accountability and blame**

In most contemporary societies, individuals reflect on mass and electronic media in the course of making sense of the everyday world. These sources are not just

‘factual’, they do not just provide representations of everyday life, but also provide one possible space within which for the expression of opinions and judgements. In particular when things go wrong the media can and does allocate blame, and pregnancy and childbirth have become part of this blame culture. As both pregnancy and childbirth are subject to expert surveillance and intervention they cannot be considered ‘natural’ process in which the outcomes are the product of chance and adverse outcomes are unpreventable ‘accidents’. Adverse outcomes are therefore evidence of failures, either of the systems or of individuals and someone must be at fault (see Green 1999 for an analysis of ways in which risk has eroded the concept of the accident). In other fields of health, there are interesting analyses of media representation of particular events (such as disasters), groups in society (such as people who are mentally ill) and impact on both policy and practice (see for example Alaszewski and Brown 2012, 210–233). However little has been published on the media representation of pregnancy and birth and the impact of the media on the construction of risk in pregnancy and childbirth.

We are therefore keen to include in the special issues articles which consider the mediated representation of pregnancy and childbirth. It would be interesting to explore how apparent failures to manage adverse outcomes are presented in the media and in particular if iconic inquiry reports are frequently used to frame and anchor the reporting of new incidents as in child abuse cases (Kitzinger 2004). Similarly it would be interesting to explore the impact of mediated representations on maternity care professionals and whether they see themselves as working in a blame culture in which their actions will be subject not just to internal management review but also to external media investigation.

#### **Choice and decision making: who controls the pregnant body**

In some areas of health care, there has been a movement away from the paternalist model of care (doctor knows best) towards a more consumer-based approach grounded in informed consent empowering patients to use the information supplied by the doctors to decide who can do what to their bodies (Alaszewski and Brown 2007). This is increasingly a feature of complex treatment decisions, such as those following a diagnosis of cancer, but it is less clear whether this occurs during pregnancy and birth. Certain difficulties present themselves; the woman is the focus of care, but the foetus/future infant (and sometimes her partner or family) are also constructed as

recipients of care, or at least as profoundly affected by the decisions made. Although the legal and ethical basis for this is contested (see for example Ruhl 1999, Kingma 2011), there is an undeniable social consensus in favour of the woman *and* foetus as recipients of care during pregnancy, labour and birth. The paternalistic model involves an agency relationship, where the professional acts as an agent and the woman has to trust that her agent has the skill and knowledge to protect her interests. The consumer model, on the other hand, is based on the assumption that the woman has the skill and ability to judge her own interests, (and that these are congruent with the baby's interests), to ask the 'right' (approved) questions and make the 'right' (sanctioned) decisions.

In pregnancy and child birth there may be societal limitations placed upon the right to self-determination and it is of interest to explore who controls the pregnant body.

Whilst women maybe encouraged to plan the sort of birth they would like, they may do this in the midst of uncertainty, unable to predict how 'this' birth will proceed, anxious that something will 'go wrong' or an important problem will be missed or mishandled, even if they are healthy and their pregnancies 'low risk'. Conversely, they may feel certain that they feel safe, that everything will go well, and that interventions are misplaced, even when there are clinical indications that the birth may be potentially problematic.

## Conclusion

In the contexts of the debates outlined here, we invite papers for a special issue of *Health, Risk & Society*. The theme of the call is pregnancy, childbirth and risk, and we particularly welcome empirical papers which focus on the ways that risk is constructed during pregnancy and birth, where the intended outcome is live birth of a viable infant; that is, in this special issue, we do not propose to focus on risks in relation to birth technologies such as IVF, genetic screening, or antenatal screening for congenital abnormalities. Rather, we welcome contributions to the debate on risk and safety in birth, in the management of birth, and on different proponent positions in relation to this. Each paper should be informed by risk theory, and the contribution to social understandings of risk knowledge made clear.

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