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Reconcilable differences? Portuguese obstetricians' and midwives' contrasting perspectives on childbirth, and women's birthing experiences

Joanna White and Filipa Queirós

This paper examines the contrasting perspectives of doctors and midwives in Portugal regarding their roles in childbirth, the institutional contexts in which these divergent perspectives are enacted and sustained, and the inter-related experiences of birthing women. The ethnographic research presented found obstetricians' rhetoric to focus on potential risk; interventions were often explicated through a perception of childbirth as a risk-laden, and potential emergency, situation. Within this discourse, hospital-based birth was presented as a triumph of progress. Technical measures were justified using institutional rationales, such as the use of anaesthetic pain relief during labour ensuring tranquillity within maternity units, and labour induction guaranteeing "throughput" and freeing up hospital beds. Midwives, contrastingly, described a philosophy of care focused on offering women presence, guidance, and informed choices during birthing, professing their commitment to minimal intervention, except in cases of clinical necessity. Both professional groups expressed mutual respect for each other's skills and respective roles. Yet the co-existence of different professional rationales within the same hospital setting resulted in tensions which were exacerbated by historical power dynamics and the present spatial and organisational separation of the two groups. The ramifications of the current situation for the provision of effective maternity care are discussed, and the conceptualisation of women as autonomous consumers of services is challenged. Extracts from Portuguese women's birth narratives from the same study are utilised to elucidate the highly variegated experiences of women.

KEYWORDS: childbirth, doctors, midwives, care philosophy, Portugal, medicalization.

Diferenças reconciliáveis? Perspetivas contrastantes de obstetras e enfermeiras parteiras portuguesas sobre o parto e as experiências de parto das mulheres ♦ Este artigo analisa as perspetivas contrastantes de médicos e enfermeiras parteiras em Portugal relativamente aos seus papéis durante o parto e aos contextos institucionais, interrelacionando as experiências das parturientes. O trabalho etnográfico realizado revela uma retórica dos obstetras sobre o parto focada nos potenciais riscos; revela também que várias intervenções médicas são realizadas com base numa perceção do parto enquanto situação de emergência e riscos. Dentro destas lógicas, o nascimento hospitalar surge enquanto triunfo do progresso. As racionalidades institucionais surgem mencionadas para justificar a

utilização de determinadas medidas técnicas, tais como o uso de anestesia para o alívio da dor durante o parto, garantindo maior tranquilidade na maternidade, e a indução do parto, permitindo um maior rendimento e libertação de camas hospitalares. Contrariamente, as parteiras descrevem uma filosofia de cuidado focada na sua presença, orientação junto das mulheres e na forma como apresentam escolhas informadas na gestão do nascimento. Assim, afirmam o seu compromisso com um modelo de parto normal fundado na intervenção mínima, exceto em casos de necessidade clínica. Ambos os grupos profissionais expressam respeito mútuo tanto nas suas áreas de especialidade como nos respetivos papéis. No entanto, a coexistência destas racionalidades no mesmo ambiente hospitalar acentua tensões de poder históricas que sempre caracterizaram estes grupos. Discutem-me e desafiam-se as perceções das mulheres enquanto consumidoras autónomas de serviços. São utilizados extratos de entrevistas conduzidas a mulheres portuguesas com o objetivo de elucidar a grande variedade de narrativas existentes.

PALAVRAS-CHAVE: parto, médicos, parteiras, filosofia de cuidado, Portugal, medicalização.

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INTRODUCTION:

CHILDBIRTH AS A PROFESSIONAL AND CULTURAL ARENA

The history of birthing in Western Europe since the 19th century has been characterised by the emerging patriarchal dominance of professional obstetrics and associated application of the medical model (Donnison 1977). This transformation, it has been argued, occurred at the expense of female autonomy (Davis-Floyd 1990; Pascall 1997; Cahill 2001; Henley-Einion 2003; Reiger 2008). Comparative studies suggest differentiated cultural production of the biomedical model within various settings over time, with ideas and practices becoming embedded within broader social and institutional forms (Helman 2000; Van der Geest and Finkler 2004). Both the historical integration of and challenges posed to biomedicine have been instrumental in the distinct approaches to childbirth which emerged, hence neighbouring countries may have starkly contrasting approaches to the support offered to parturients (Christiaens and Bracke 2009; Akrich *et al.* 2014). A four-country sociological study, for example, identified maternity service structures and practices as identifiable outcomes of factors varying by location, which included professional boundary struggles and changing consumer interests surrounding pregnancy and childbirth (Benoit *et al.* 2005).

The different philosophies of maternal care espoused by obstetricians and midwives, their distinct relationships with biomedicine, and the historical professional tensions – the so-called “turf wars” – which emerged from the disparities between the two groups have been well documented (Schumann and Marteau 1993; Pascall 1997; Cahill 2001; Reiger 2008); their impacts on women less so. Primary research conducted in England in the 1990s identified how clinicians were more likely to view pregnancy and birth as states of risk and midwives tended to view them as normal processes; significantly, women’s perspectives were found to lie between the two positions (Schuman and Marteau 1993). Birthing women may therefore find themselves caught between different knowledge forms associated with birth, or what has been defined as “authoritative knowledge” (Jordan 1993 [1978]), and associated professional and institutional practice, although obstetric discourse on risk and technical salvation are known to have had a dominating impact on popular attitudes (Campbell and Porter 1997). Research has also identified how differing professional attitudes and approaches reduce effectiveness of care by hindering coherent communication, decision-making and support, and preventing parturients’ autonomy being respected and their overall needs met (Schuman and Marteau 1993; Hyde and Roche-Reid 2004; Reiger 2008; Keating and Fleming 2009). Moreover, fragmented organizational structures associated with the two professional groups of obstetrics and midwifery have been found to adversely affect coordination and care provision (Schölmerlich *et al.* 2014).

This paper explores contrasting perspectives of obstetricians and midwives in Portugal regarding childbirth, and the ways in which these are elaborated and intersect within maternity units, and their real and potential impacts on birthing women. Drawing on ethnographic research which aimed to investigate cultural aspects of childbirth care in Portugal, the findings presented exemplify how the historical power enjoyed by doctors and the privileging of medical technocratic approaches to birth are articulated in care settings, creating some tensions in relation to midwifery, which is becoming increasingly professionalized.¹ The pre-dominance of the medicalized model of birth and associated authoritative knowledge can be seen to influence women’s experiences of birth and their acceptance of intervention, which renders the notion of women as autonomous “clients,” expressing agency, more complex.

THE RISE AND CONTEXT OF THE MODEL OF HOSPITAL BIRTH IN PORTUGAL

The historical integration of biomedicine and childbirth within hospitals in Portugal established the current dominant mode of birth, whereby labour and

1 Project DFRH/WIHA/22/2011. The full project took place in two countries: Portugal and England.

parturition are managed by doctors. Traditionally, until the 1980s, however, birthing was predominantly a low-technology event occurring at home. Following the revolution in 1974, a process of health service restructuring began, resulting in the establishment in 1979 of a system modelled on the British National Health Service (NHS), partly operationalised through the construction of a comprehensive hospital network. Childbirth thereby became largely obstetrician-led over a period which also saw a dramatic improvement in perinatal mortality rates from the extremely high levels of 31.8 per 1000 births at the end of the Salazar dictatorship in 1975 to 4.2 per 1000 births in 2012 (White and Schouten 2014); current rates are widely celebrated as amongst the best in Europe. This displacement of birthing from home to institution has become uncritically synonymised – both by representatives of the medical profession and the wider public – with enhanced health outcomes, and is thereby employed as a justification for and validation of the mode of birth which now pre-dominates. Indeed, this historical understanding can be seen to represent an essential element of the authoritative knowledge which prevails in Portugal, which simultaneously legitimises medicalized hospital birth and celebrates it as a symbol of modernity and progress. Yet this association is debatable. As elsewhere, quantifiable improvements in women’s health status over time were equally determined by the wider context of more comprehensive ante-natal care, new public health measures and other concurrent changes (McKeown 1976; Pascall 1997).

The number of physicians per population in Portugal currently stands above the EU27 average, while that of nurses is well below (WHO 2010; OECD/EU 2016). This nurse/physician ratio holds obvious implications for the culture of care in hospital settings. Birth centres managed by midwives, which have evolved in other country settings (both within and outside hospitals), with positive maternal and newborn outcomes (BECG 2011), do not exist in Portugal. Further, homebirth is not supported by the state nor legally recognised (see Fedele, this volume). Research in hospitals has highlighted the long-standing domination of doctors (Carapinheiro 1993), with medical staff guided by the professional codes and values of their peers, rather than the management system of their employing institution.² This creates what have been deemed “imperfectly connected systems,” whereby staff with advanced levels of medical training identify themselves as individuals rather than as part of a team, and are often able to rebuff institutional control (Monteiro 1999).

A WHO assessment observation that information to assess clinical practice guidelines in Portugal was limited (WHO 2010) may, in part, reflect the continuing autonomy of doctors, and, indeed, their employing institutions.³

2 The “Order of Doctors” (*Ordem dos Médicos*), for example, exerts considerable power.

3 Obtaining guiding protocols for maternity unit practice was a major challenge for the lead researcher during her hospital fieldwork, though these were requested many times.

Specifically in relation to childbirth services, a recent review posited that the steep increase in caesarean section birth (C-section) from the 1990s onwards stemmed from a combination of the generalized perception of the increasing safety of caesareans and the “commodity” of a planned birth, as well as financial benefits for the health team (Ayres-de-Campos *et al.* 2015).⁴ This analysis underscores the pivotal role of doctors as well as structural factors influencing the management of birth in Portugal, all of which may operate extraneously to medical indications and women’s own preferences. The term “generalized perception” is suggestive of how (authoritative) knowledge and understanding may percolate from one powerful group (doctors) to the wider population, contributing to public perceptions of what is acceptable practice.

It is unclear whether the term “commodity” refers to planned birth as a consumer product or as a convenient entity – both interpretations resonate within the current Portuguese maternal healthcare context, begging the question: a commodity, or commodious according to whom? Ethnographic or other qualitative research examining women’s experiences of and expressed preferences in relation to childbirth in Portugal is scarce. A recent quantitative study identified how C-section rates were higher amongst women of a particular cultural background, whom, it was assumed, preferred this option (Teixeira, Correia and Barros 2013). Regardless of women’s declared (or assumed) “preferences” as consumers, it is nonetheless doctors who can be seen to enable the current prevalence of planned C-sections, a controversial practice which is contrary to ethical and medical recommendations (Bergeron 2007; Mylonas and Friese 2015).

Although doctors continue to dominate the childbirth arena, recent decades have seen increasing professionalization of the role of the specialist nurse in maternal health, obstetrics and gynaecology (*enfermeira especialista em enfermagem de saúde materna, obstétrica e ginecológica*) who supports birthing in hospitals. More advanced training programmes and qualifications have been established (Carneiro 2003), although this cadre of staff has historically held limited status in maternity units compared with doctors. These professionals are henceforth referred to in this article as “midwives,” for simplification in English, but it should be noted that their training, institutional roles and responsibilities and status are not equivalent to those held by midwives within other national health systems such as in the UK or the Netherlands. However, many of these specialist nurses in fact refer to themselves as midwives (*parteiras*), imbuing the term with the particular philosophy and sense of vocation associated with the profession of midwifery, and also evoking a historical tradition. Similar to English, the Portuguese term *parteira* is also applicable to the women with no

4 As noted in the introduction to this dossier (Fedele and White, this volume), C-section rates in Portugal currently stand amongst the highest in Europe.

medical training who traditionally governed homebirth. It is problematic to compare midwives in Portugal with those in other settings, however. For example, unlike those formally trained in some countries, it is not accepted practice for midwives in contemporary Portugal to take full responsibility for managing births without regular surveillance from obstetricians, even in low risk cases. The rare exception is at the few hospitals in the country which have explicit policies regarding “normal,” or physiological, birth.⁵ Perhaps unsurprisingly, a recent study of midwives in Portugal found that their perceived level of professional empowerment is low (Henriques, Catarino and Franco 2012).

The present health system constitutes a mix of public and private services. The public sector provides the bulk of care, while public and private insurance schemes are widespread amongst certain employees and income groups (Barros, Machado and Simões 2011). The desire amongst women receiving private ante-natal care to have the same obstetrician in attendance at their birth lends itself to a particularly medicalized approach, resulting in the “booking in” of delivery, and C-section rates at private hospitals are estimated to be double those of public hospitals. Human resources are shared by both sectors, however, and the impacts of this overlap are un-transparent and unreported (Conceição *et al.* 2000). The “booking in” phenomenon is a clear example affecting the nature of public healthcare provision, as private clinicians who provide ante-natal care can arrange to provide birthing support to their clients in the public hospital which also employs them (see Challinor, this volume).

WOMEN AND CHILDBIRTH

As already noted, academic study of women’s experiences of birthing in Portugal has been limited, as has analysis of the institutional structures, decision-making practices and care processes influencing childbirth. Overall, patient satisfaction with health services in Portugal has been extremely low, although this is seen to be improving, and greater involvement of patients in assuring and improving the quality of care provided has been identified as a strategic priority (OECD 2015). Specifically in relation to childbirth care, existing reports suggest that women’s satisfaction is extremely variable (Correia 2014; APDMGP 2015), and inordinately dependent on the individual staff who attend them (Correia 2014). Moreover, the type of birth experienced has been found to influence new mothers’ perceptions, with women who had a vaginal birth having a more positive perception of a variety of postpartum events than those who had C-sections (Conde *et al.* 2008).⁶ One of the aims of the current

5 See NCT/RCM/RCOG (2007) for definitions of normal birth.

6 In the current context normal birth without epidural is the exception rather than the rule. It is not a standard choice and has not been promoted.

study was to provide deeper insight into the experiences of Portuguese women, including what these may tell us about the present dynamics of care provision.

METHODOLOGY

Conducting social science research in hospitals in Portugal is notoriously challenging, and securing access to doctors is particularly difficult (Padilla, Rodrigues and Ortiz 2014). The ethnographic study on which this paper is based,⁷ which took place between July 2012 and January 2015, was no exception, and faced considerable barriers and constraints. A detailed methodology is provided to elucidate the obstacles encountered and the flexible approach which had to be pursued. On receiving ethical permission for the study at a central Lisbon hospital, the principal researcher (lead author) interviewed one midwife and made observations at childbirth education classes, but after several months of failed attempts at interviewing obstetricians was forced to secure an alternative fieldwork base. She identified a hospital situated within commuting distance of Lisbon whose maternity unit had promulgated normal birth since 2010 (a rare approach), and was more open to the study. Ethical approval for research at this site granted her permission to both conduct interviews with staff and carry out observations in all “public” areas of the unit. However, despite the authorization and full support of unit management, recruiting doctors for interview was again problematic. Reasons given for declining to be interviewed included lack of faith in the confidentiality of the informed consent agreement, fear that the information imparted would find its way to the media, the (false) understanding that public sector staff contracts prohibit sharing of information, and “not being bothered” to participate. These responses suggest misunderstanding and/or mistrust of social science research, as well as a lack of interest. All midwives approached agreed to be interviewed.⁸ Interviews were finally completed with two obstetricians (one female, one male) and five midwives (four female, one male), including the managers of the two professional teams responsible for assisting in childbirth; all of these individuals were responsible for supporting women through childbirth and some also provided private ante-natal care outside of the public hospital where they were interviewed. Observations were conducted over the same period as the interviews. Given the dearth of doctor respondents, however, ethical permission was also secured for supplementary interviews with three (female) doctors responsible for ante-natal care at a government Health

7 The research undertaken was made possible by the Portuguese Foundation for Science and Technology (FCT) through UID/ANT/04038/2013 support.

8 Participation in the study was, of course, voluntary. To put this outcome in perspective, at the hospital in England where the study was conducted, following NHS ethical approval seven interviews were completed with obstetricians, and seven with midwives.

Centre in central Lisbon; while one of these was also a qualified obstetrician and had experience of providing support during childbirth, two of these interviewees were solely responsible for ante-natal care within the public health system. In a separate element to the study, eight Portuguese women were interviewed throughout pregnancy and seven of these following birth, whereby they detailed their personal experiences, resulting in a total of eight detailed birth narratives.⁹ All but two were first-time mothers. These individuals were recruited through advertisements in a magazine aimed at mothers and at local health centres, and through snowball sampling. All interviewees provided informed consent. Interviews were conducted in Portuguese and recorded, transcribed and translated into English, with the support of the co-researcher (second author) and analysed using a content analysis approach. Observation notes were transcribed and integrated within the analysis.

FINDINGS: PERSPECTIVES FROM THE TWO PROFESSIONS

Midwife respondents provided a consistent view of their role during childbirth: to support women and their partners, including offering a range of choices in the experience and management of labour. In the words of one respondent: “we work with the wishes of the couple.” Certain midwives highlighted an explicitly ethical dimension to their work, whereby good practice included explaining procedures before they are carried out, as part of a respectful, individually supported birth. As one interviewee detailed:

“I need to understand what is happening, identify things, offer suggestions which help the passage of labour... suggest what is appropriate for each couple at each moment... I can say of my team [of midwives], that there are people here who are really successful at... supporting couples continuously throughout labour... This really results in a massive transformation in people; it’s the priority... There are births which make me cry... because I manage to establish a very personal relationship with a woman and with a couple” [Clara].¹⁰

As well as a desire to provide overall support potentialising women’s (and couples’) choice, an underlying motivation to promote a physiological (sometimes termed “natural” or “normal”) birth was also expressed, based on the midwife’s own knowledge and understanding that this is a healthy outcome:

9 One woman dropped out of the study during pregnancy; one provided narratives for the two hospital births she had experienced.

10 All names have been changed to protect identities.

“The WHO says that we should intervene as little as possible in physiological birth... There are situations when we need to intervene, that’s logical... But it’s beneficial for women to have a physiological birth, with the minimum of intervention possible... so midwives do not intervene, or at least our objective is to have as few interventions as possible, and allow things to run along in the best way possible without interventions” [Marta].

“We are guiding and empowering every one towards what is natural... it’s healthier for the mother and the baby” [Clara].

The authoritative knowledge informing the midwives’ approach was founded on an approach to birth aspiring to minimal intervention. However, the reference to the WHO in the first citation, rather than to the policies of the hospital employing the midwife, may reflect the ambiguous status of physiological birth within the Portuguese institutional context. Indeed, a lack of consensus between doctors’ and midwives’ representatives has led to epidural anaesthetic being included as an element of normal birth as defined in the Portuguese context, for example (OE/APEO 2012; White and Schouten 2014), which is contrary to conventional international understanding. At the same time, as noted, the hospital under study was unusual in its official promotion of this locally-defined normal birth approach. All midwife interviewees expressed their support of this relatively recent development, highlighting how observable progress had been made:

“The most important changes I have seen include a great evolution in terms of the ‘verticalization’¹¹ of women, in introducing an active phase to labour. It’s completely different from what was happening... The professional attitude towards rupturing the membrane¹² is completely different... The extensive training carried out in 2010 made a big difference to the staff in terms of normal birth... I have really noticed that women are less touched [*tocadas*]¹³ [Clara].

“There was a time when caesareans were taking place all day long... now it has calmed down and we have seen a big drop in the rate of caesareans at

11 Here the midwife refers to women being allowed to stand and move around rather than being made to lie down during labour.

12 Referring to amniotomy, a procedure locally known as the *toque* (“the touch”), whereby physical manipulation is used to separate the amniotic sac membranes from the cervix – which can be very painful. It is extremely popular amongst some obstetricians in Portugal, although its use is increasingly controversial (White 2016). The term can also be used for a vaginal examination to assess dilation. For further information and clinical guidelines on the use of amniotomy, see RCM (2012) and NICE (2014).

13 Here the respondent is referring again to the *toque*.

this hospital... 'Risks' are not always risks. We midwives, we know perfectly well what we are doing. And we started to demonstrate to the medical team what can be achieved through change... And we started to get good results" [Marta].

Yet, while midwives celebrated this evolution and both doctors and some midwives emphasised an apparently uncomplicated distinction between the two professional groups, a closer examination of their reported perspectives presented a more complex picture. In obstetricians' descriptions, the risk of complications was a background presence in every birth, and part of their pride for and passion in their work was their ability to respond to emergency situations. As described by one professional who had been working for more than 22 years in the unit:

"I think most births run beautifully. Sometimes there is a cataclysmic haemorrhage... women who have already given birth. It's lovely, and then what? Blood running like this [makes sound of a running tap]... We evolved to hospital medicine... To me giving birth at home is going backwards, to how it was" [Paulo].

Within the conceptual framework posited by this doctor, birth in hospital represents linear progress towards modernity, whereas a scenario outside of this framework, homebirth, is retrogressive. No distinction is made between the potential individual needs or wishes of women, or parturients of known high risk or low risk. Moreover, doctors described an apparently coherent, complementary model, whereby midwives cared for women throughout labour, freeing obstetricians to carry out urgent and emergency work, up until the point when intervention, in certain cases, became necessary. As one doctor stated, "In my opinion there should not be a conflict because they [midwives] have their [skill] level and I have mine." This depiction echoes Reiger's (2008) analysis of doctors' descriptions of midwives' less technical work during birth as "invisible background to their foreground" (citing Plumwood 1993: 4), understating doctors' dependence on and regular interactions with midwives for the practical management of pain and numerous other aspects of birthing. This selective representation also disguises grey areas in obstetricians and midwives' shared work supporting the same women whereby (particularly in low risk and non-emergency cases) the two professional groups might not agree on the optimal approach. The earlier citation of a midwife's statement that "'Risks' are not always risks," for example, underscores a potential point of tension concerning the knowledge and evidence which inform the two different professions. Similarly, another midwife's comment, "a caesarean is a surgery, with all the risks that involves, for her [the parturient] and the baby..."

we need to weigh everything up,” emphasizes the problematic differences in how the two professional groups may perceive risk in relation to technical intervention.

Another key point of difference identified was in relation to the understanding of labour pain. Midwives were more likely to present labour pain as a unique physiological phenomenon which certain women can be supported to bear without medical intervention. They flagged the importance of women being well prepared during their pregnancy for “confronting” or “facing” pain, highlighting their role of assisting women in developing strategies and exploring natural means of coping with pain, based on their understanding of current evidence regarding the positive outcomes of normal birth for mother and child. Doctors, however, considered the employment of the technology available to reduce women’s pain part of their clinical responsibility, focusing on positive aspects of epidural anaesthesia; indeed, one described epidural as the “salvation” of women. Certain doctors equated the rejection of epidural anaesthesia to refusing pain relief during a tooth extraction, an analogy evoking an earlier historical period of more primitive medicine – anaesthetic thereby being associated with progress (see De Luca, this volume). Such an analogy is also often employed in popular discourse in Portugal¹⁴ to pose a logical argument for accepting epidural during birth, exemplifying perhaps how authoritative knowledge functions in sustaining beliefs and associated behaviour in relation to birth.¹⁵ In this discourse, labour pain is equated with other forms of chronic pain, and is presented as something to be avoided and technologically “managed.” A further, institutional logic for the use of epidural was also presented by one obstetrician, who contrasted several women under anaesthetic “quietly and peacefully dilating” in the unit, with the “shouting in the room down the hall” by a woman labouring without epidural, a depiction which suggests the disruption and disturbance which un-anaesthetised labour may cause. Obstetricians, further, described institutional pressures which precipitate other forms of intervention, such as induction of labour to hasten deliveries late at night in order to ensure colleagues arriving for the morning shift would not find all unit beds occupied.¹⁶ This frank admission underlines the attraction

14 Indeed, during fieldwork the lead researcher saw a comedy sketch on a Portuguese TV show which included a long-haired woman dressed as a hippy, chanting and extolling the virtues of birthing without epidural, then subsequently attempting to subject her son to a DIY tooth extraction without anaesthetic!

15 A key issue here is the role of childbirth education classes in preparing women for labour pain. Childbirth education in Portugal is very patchy. While some hospital and private entities offer courses for women in late pregnancy, not all hospitals offer classes to orientate women to their services. During observations at one course of classes provided by a large Lisbon hospital, much of the information and discussions about labour focused on epidural anaesthesia, with modes of birth largely presented as a choice between a vaginal birth with epidural, or a C-section with epidural.

16 Induction of labour is the process whereby artificial hormones are used to precipitate labour.

and acceptability of clinical interventions amongst certain doctors and under particular resource(-scarce) conditions.

During her observations at the unit, the lead researcher noted how several women were often being induced at any one time for “lack of labour progress.” When these cases were probed, she was informed that in some cases doctors on duty were private obstetricians to the women in question and had pre-arranged for these individuals to give birth on that particular day. Doctors may therefore pay particular attention to the pace of labour of those arriving in public maternity units who are also their private ante-natal care patients seeking the care of their *médico particular* (private doctor), and intervene accordingly. This “booking in” procedure is known to be particularly common amongst obstetricians within private maternity units (White 2016) and has been criticised from a multitude of perspectives, including that of mother and baby’s health, women’s informed autonomy and also on ethical grounds (Lothian 2006; Bergeron 2007). This phenomenon adds considerable complexity to the patient-midwife-doctor triad of care provision.

INTER-PROFESSIONAL TENSIONS

The doctor who was unit director expressed her support of the normal birth approach officially promulgated by the unit, explicitly echoing the views of midwives: “Above all, we health professionals should be sufficiently open-minded to offer the widest range of options possible to people [for childbirth]” [Andrea].

Yet, in contrast with her own personal and professional position, she concisely captured the historical – and continuing – autonomous practice of doctors, and their resistance to change:

“There’s a friction between doctors and nurses. Do you know why? When obstetric services were first set up, doctors had a long tradition of having all the necessary specialised knowledge for taking care of pregnant women and managing their labour... This changed radically some years ago when nursing schools offered a higher level of training and a specialisation... But the thing is the obstetricians had been, so to speak, the ‘kings’ of the maternity units... Doctors have to accept this evolutionary change [increasing responsibility of midwives]... It’s something I stand up for here, but not all my colleagues accept it...”

There are always those who, because they are more insecure,¹⁷ or because they are tired or because they are very interventionist, or they are more

17 The lead author’s observations at a conference of the Portuguese Society of Obstetric and Maternal-Fetal Medicine (SPOMFF) on C-section rates in April 2013 appear to confirm this [continues]

radical, they are more likely to resort to surgical delivery than others... There are obstetricians who carry out their work as if they were working in a private clinic. In other words, they come... see a patient, operate... do whatever, then go away... This is one thing I tried to change... even getting doctors to meet together was difficult, let alone arranging meetings between doctors and nurses. This is one of the biggest problems facing our service" [Andrea].

Here the unit director reveals a vision of progress and evolution of maternity services according to which midwives are taking on increasing responsibility for the care of women, which presumably includes promoting a normal birth approach, as in the hospital included in the study. Yet a senior colleague of hers, cited earlier, considered hospital medicine *per se* to represent an evolution. Hence while "progress" may be a critical concept and aspiration in relation to childbirth support, views on what this means can clearly be quite distinct. The different perspectives identified concerning the nature of modern and progressive care reveal how different forms of authoritative knowledge may co-exist, reflecting contested and sometime shifting power relations and cultural values (Jordan 1992; Sargent and Davis-Floyd 1996); and while some doctors may be accepting change, some may be actively resisting it.

The director describes the continuing individualism of doctors as well as their overall autonomy in the unit through her explication of why some might resort to "surgical delivery" (strikingly, none of the reasons she provided related to the particular circumstances of the birthing women in question). This individualism was also observable in the way doctors described how they worked. Midwives, contrastingly, often referred to working within a team of peers, a distinction which mirrors findings from previous hospital research in Portugal (Monteiro 1999). Indeed, some midwives observed how certain doctors failed to recognise the importance of working together as a team ("we all need each other").

Observations made in the unit as part of fieldwork for the study elucidated a lack of professional integration between doctors and midwives. Although sometimes caring for the very same women, the two groups were organized separately within the hospital space, with different shifts and separate doctors' and midwives' rooms on opposite sides of the unit for resting and conducting hand-overs. No joint meetings of obstetricians and midwives ever took place. Workplace tensions between the two groups were, moreover, openly described in interviews. Both groups described the challenges involved in navigating

observation regarding doctors' insecurity. During a plenary discussion a number of obstetricians confessed that they no longer knew how to manage a vaginal birth.

professional entry points and different care philosophies. One obstetrician exemplified the tensions in his description of a recent interaction:

“A while ago a nurse was helping with a parturient. And I said, ‘Nurse, insert an IV cannula for this lady’... The lady was about to give birth... The midwife said to me ‘Doctor, women have been giving birth for millions of years without needing an IV cannula.’ And do you know what I replied? I said, ‘Look, I was also born in the same way, but you are very young and you have never seen a woman give birth and then haemorrhage like an open tap.’ What’s the catheter there for? With a line we can also give blood. We can save lives” [Paulo].

Here the midwife disputed the intervention based on her knowledge and understanding.¹⁸ The doctor pulled rank, emphasising the youth and inexperience of the midwife, associating a non-interventionist approach with an earlier historic period (“I was also born in the same way”) and introducing the concept of risk and a rare, potentially catastrophic event to justify his approach. In this interaction the obstetrician can be seen to have been performing “identity work,” establishing a professional boundary with the midwife, while at the same time highlighting the uniqueness of his professional expertise (Hunter and Segrott 2014).

The parturient whose body they are debating is conspicuously absent, apparently playing no role in the decision.¹⁹ Indeed, a number of the women interviewed for the study, reflecting on their hospital experiences, pondered retrospectively as to why particular procedures – ranging from the insertion of an IV line (as in the example described above), the use of the *toque*, induction, and a C-section – took place. In each case, the women described not being given information to explain the reasons for the intervention.

In the above example, the power relationship between the doctor and the midwife is evident in how he instructed her. Indeed, much of the midwives’ commentary indicated a wary relationship with doctors, who, they felt, asserted their power:

“They [the doctors] think they have control and often they, effectively, impose themselves, but it shouldn’t be like that” [Clara].

“All of us have our role and we all have to respect each other’s specialist field of work... Every group has its knowledge and skills and if people can adjust themselves to their skill areas, then this is better for everyone...”

18 The situation was low risk and the birth was proceeding normally.

19 It was not clear whether the woman in question was privy to the discussion described.

especially for women, who are what interests us here. Sometimes people find it hard to assert their expertise... due to their fear of biomedicine, basically. '*Senhor doutor* knows'; '*Senhor doutor* says do this.' That's what it's like. It's power... I think all of them [doctors] believe in us, just that some are a bit scared... They are afraid of losing some power over women. This is the kind of thing we [midwives] discuss. But of course we don't say anything... they always have their role of '*Senhor doutor*': 'I am *Senhor doutor*, you are just nurses.' But there are some doctors who hold a lot of respect for nurses and we have a good relationship, and this is good for everyone. For us and for women: there isn't a conflictual power relationship" [Marta].

To contextualise this description, in Portuguese the term *senhor doutor*, or *senhora doutora* in the feminine form (literally meaning Mr. Doctor or Mrs. Doctor) is used in social interactions to mark the professional status of those who have a medical qualification (or a PhD), and is a term of formal and polite respect denoting superior status. It can be applied very formally, obsequiously and also even ironically. The midwife's reference to the role and behaviour associated with this term underscores the entrenched power relationships which are often at play – both within the institutional setting and wider society – and the privileged status of medical doctors and the biomedicine of which they are “guardians,” which affects interactions. Again, the individual nature of this behaviour is apparent in the midwives' positive appraisal of some doctors.

Recalling that the hospital studied was relatively progressive in its formal promotion of normal birth and the reduced rates of intervention reported by respondents, a general picture nonetheless emerges of two professional groups with distinct knowledge bases and codes of practice – forms of authoritative knowledge – offering birth care to women in the same institutional setting. The reference to women as the ostensible focus of interest in the final citation raises a critical question: how do birthing women relate to the contrasting discourses, and how do the professional separation and tensions amongst obstetricians and midwives impact upon them?

WOMEN'S EXPERIENCES AND ROLE(S) IN BIRTH

The eight women interviewed for the study were all white, educated professionals. The eight birth narratives ranged from four cases of C-section (following induction of labour),²⁰ two in a private and two in a public hospital, and four vaginal births, three of which included epidural anaesthetic (and one also an episiotomy), two of which took place in a public hospital, one in a private hospital and one at home. The hospital births occurred in different settings

20 In one of the cases the parturient was classified as high-risk ante-natally.

in and around Lisbon – it was not methodologically possible to triangulate by only recruiting women from the hospital where interviews and observations were conducted. Nonetheless, the experiences detailed reveal patterns and relationships which can be associated with the hospital study findings, while informal conversations and anecdotal evidence exchanged publically at various academic and non-academic events in Portugal²¹ as well as new survey work (APDMGP 2015) suggest that the experiences of women uncovered are illustrative of the wider childbirth landscape in the country.

Booking in: whose choice?

Inês attended private childbirth education classes led by both doctors and midwives, but the principal guidance she received was from her private obstetrician, funded through her employment insurance scheme. During interviews through the course of her pregnancy, the question of ensuring that her personal obstetrician was present for the birth regularly emerged, until the prospect of induction was introduced by this doctor:

“The problem with not being induced is that I could end up with any doctor and not mine, you see. I’d like to be with my doctor... She told me that she normally makes an appointment to book in an induction at the end of the pregnancy... She said, ‘Let’s see if dilation takes place. If it starts, we can induce the rest...’ So her idea is this: she doesn’t like to be surprised, right? She wants to be here and work carefully with time to deal with everything. So the idea of a Monday is I get here in the morning, go with the induction and they contact her during the day if there’s some development, then after 4 pm she is here doing her appointments and then, between appointments, she will do my delivery” [Inês].

The exchange described by Inês represents a normalizing of induction, adapted to the doctor’s planned schedule. As a result, Inês followed the path recommended, going into the private hospital to be induced.²² Significantly, in one of her earlier interviews during pregnancy she had already highlighted how her resistance to experiencing pain was at odds with her professed desire for a physiological birth:

“I want a natural birth. But I want an epidural [laughs]. It’s not a question of fear [of pain]. It’s a question of it not being necessary. I think a person needn’t suffer... It’s like saying, ‘Let’s extract one of your teeth. Do you

21 The current lack of collection of systematic data means such fora are an important means of exchanging evidence on childbirth practices in Portugal.

22 Eventually she was given an emergency C-section due to non-evolution of her labour.

want anaesthetic or not?' [laughs]. Obviously I'd say I want anaesthetic. Nowadays we have the option of not suffering. It's not necessary, is it? It [epidural] doesn't do any harm to me, or my baby. I want to take advantage of it... I don't want to be a heroine and say I don't want pain relief... it's not worth it" [Inês].

Here, again, the rejection of epidural is questioned as irrational using the dentistry analogy referred to earlier; pain is presented as an unnecessary aspect of childbirth. While declaring she was not afraid of pain, Inês's desire to avoid it was so intense that in one interview she reflected on how at least during a C-section, as opposed to vaginal birth, an epidural would be guaranteed. Inês, therefore, completely accepted an obstetrician-led, medicalized approach to birth, unquestionably embracing epidural as logical necessity (apparently oblivious to the risks involved in this procedure) and willingly booked in the induction of her labour.

In contrast, another respondent who was also cared for by a private obstetrician throughout pregnancy described being advised to book an appointment for a delivery date at around 38 weeks of pregnancy. Surprised and taken aback by this proposition, she detailed her resistance to this approach:

"And she [the private obstetrician] said: 'Look, it's like this, Sofia, you know... the baby isn't doing anything, it's already fully developed, it's ready. Of course you can go into labour and come to the hospital and deliver... then it could be with any doctor. If you want me to be with you, then it is better to do it this way...' I resisted a bit and then she said: 'OK, let's wait one more week, but after 40 weeks I will not be responsible...' I ended up going in because I thought it was better, you know?... Afterwards I talked to my friends and they said, 'Oh, nowadays this [booking the delivery] is normal. You can't put your baby at risk'" [Sofia].

As has been analysed elsewhere (White 2016), Sofia was presented with a one-sided and ethically questionable presentation of the situation. In contrast with Inês, she resisted her obstetrician's recommendation and only finally relented when the issue of risk was introduced. The description of her friends, reproducing the discourse presented to them by doctors, represents the active, seemingly uncritical reinforcement and legitimisation of an interventionist practice. The concept of risk transmitted to women can be considered an important element of the vocabulary of authoritative knowledge.

Doctors are clearly not a homogenous group, however. One obstetrician respondent highlighted and criticised this known trend of "booking in," for example, situating it as an historical outcome of the early successes of the hospitalization of birth and the emergence of "social myths" which facilitate current practice:

“I think we vest a lot in the reduction in mortality because... mortality was very high in Portugal, perinatal, neonatal, and there’s no doubt that this evolution [drop in mortality rates] was very positive. It resulted in the extreme opposite where we have... a glut of appointments and of measures and medication etc., and so now it’s difficult for us, as doctors, to put a brake on this because we run the risk of being criticized... Nowadays birth doesn’t take place at its natural time, but when it’s convenient. When it suits the woman, when it suits the doctor, the hospital... I think that various social myths have evolved which also influence doctors... a total myth that from 38 weeks onwards the baby isn’t doing anything inside the mother’s belly... We don’t know during these two weeks of maturation what is being done and what might be lost... the baby is definitely growing” [Susana].

Again, the popular conflation of hospital birth with improved indicators is highlighted. Yet the outcome of the perceived successes of medicalized hospital birth – untrammelled intervention – is criticised. While the doctor is sceptical of the current state of affairs, it is notable how the phenomenon of booking in delivery is first referred to as a convenience strategy for the perceived client-consumers of services (“... when it suits the woman, when it suits the doctor”). Similarly, a pregnant woman participant in the study, who had a vaginal birth, described her perception of other service users:

“I think women here [Portugal] ask for a caesarean really quickly because they’re frightened of pain... They’re crazy. It’s the first thing they talk about. The doctor looking after me... She said to me, ‘Look, if your son keeps on growing and you go past term I’m going to do a caesarean because I don’t want to you to suffer with a natural birth...’ But I mean, life’s like this, it involves pain” [Patrícia].

Given that there is a dominant system in which pain is simultaneously presented as unnecessary and therefore to be resisted (one recalls Inês’s studied avoidance), a sense of fear amongst women is perhaps not surprising; experiencing and successfully overcoming pain is not something which is normalized in popular discourse on childbirth. Patrícia’s emphasis on women seeking C-section is ironic, however, given her own experience, whereby, similar to all of the cases encountered in the study, it was her doctor, in fact, who first introduced the idea of pre-arranging a C-section. Hence what is often presented as women’s agency, or at least “co-production” in medicalised birth, due to their perceived fear of pain or quest for convenience, for example, needs to be understood as a much more complex issue and outcome of their exposure to a ubiquitous form of authoritative knowledge. Lee and Kirkman (2008)

scrutinised differing interpretations of high C-section rates and the ways in which this phenomenon is discursively constructed, finding that medical explanations were structured by discourses which presented women consumers as responsible for the rising rates of intervention. Is this, perhaps, another “social myth” which has emerged, and whose interests does it serve?

Several midwives similarly referred to how they understood women being “formatted” and “brain washed” in line with the medical model. There is an implied criticism here, an associated onus on women to be better informed, to fit within the understanding of birth promulgated by midwives. Yet it was also suggested that medical staff do not provide all the required information for women to make an independent choice. Indeed, one midwife’s description reveals the role of power and selective information and their impact:

“We still come across a lot of women who are not well informed... they accept everything: ‘Ah, *senhor doutor* said it should be like this, so it’s better like that.’ And it’s not always the best thing. ‘Oh let’s do a caesarean now at 11 pm at night...’ He doesn’t say he wants to rest for the rest of the night, that it’s better for him to have a quiet time... Maybe it would be better to wait until tomorrow... And see if it [the birth] happens or not. But when the baby’s born, well we forget everything, don’t we? We always say, ‘Well, it’s all over. The baby’s arrived’ We’re not interested in the rest” [Clara].

It is perhaps not surprising that women are not “well informed” from the midwife’s perspective, given that many of them are dependent on doctors’ advice throughout pregnancy and also in hospital. Are women who “accept everything,” in other words, agreeing to interventions firmly presented to them by doctors (and in some cases their peers) as a correct and responsible choice, practicing autonomy, or are they bound within a dominant authoritative knowledge which is difficult – indeed for many, impossible – to resist? Cultural parallels can perhaps be drawn here with the management of birth by private obstetricians in Brazil, which has been critiqued for the dependency it creates amongst women on their “semi-god” doctors, who can manipulate the situation and exert pressure by failing to inform clients about the options available, and the possible side-effects of the procedures recommended (McCallum 2005). Similar, ethically dubious, behaviour has also been observed in other settings (Torres and De Vries 2009).

Contrasting approaches: individual “windows of care”

A number of women respondents in the study highlighted the starkly dissimilar approaches to care they experienced while giving birth in hospital, which deeply affected them in different ways. One interviewee for example, reported extremely negative interactions with a doctor whom she had never met before,

soon after her arrival in a public hospital, whereby her membranes were ruptured without prior discussion and she was given an epidural:

“They gave me a *toque*. No one told me what they would do. The doctor asked me to lie down and just did it. It was excruciatingly painful... I think they don’t tell you beforehand so you can’t escape [laughs]... It’s part of the protocol apparently... I didn’t know anything could be so painful... I then agreed to have the epidural because it was so painful and I couldn’t cope, so I even begged for the epidural... What happened was very painful and invasive” [Lídia].

In Lídia’s case, she did not accept the decisions made on her behalf because she was “formatted” (she had, in fact, received ante-natal care guidance from a doula and wanted a normal birth) but she described how negotiation in the hospital setting felt too challenging, impossible even. While she was struggling with her accelerated labour, a new professional arrived whose manner was in vivid contrast to the cold and intrusive style she experienced previously. This meant that her final phase of labour was a more positive experience:

“This midwife who came on duty was very calm, completely different from the others. She was very maternal and said ‘Look me in the eyes. We are going to be just the two of us talking to each other and doing this work together.’ It was much more intimate – I trusted her completely... She tried as far as possible... to make the delivery as respectful as she could” [Lídia].

In another case, a respondent described distinct approaches to care from different midwives, which led her to feel criticized:

“The first midwife said ‘Patrícia, if you’re in pain and want an epidural we can give it to you... you’re no less of a woman for having an epidural...’ I felt comforted... But the other midwife, when I told her I wanted an epidural, well... She didn’t want to give me an epidural because she said that with 5 cm I still had a lot of dilating to do, it was really early... I think it was really unprofessional. She shouldn’t talk like this to her patients or make them feel so bad. If someone wants it, they should say ‘of course, you’re right, let’s do it.’ She put me in a bad mood” [Patrícia].

This example emphasizes how in some contexts health professionals, even those from within the same professional group, may behave quite distinctly as individuals with their own views of optimal birth. While the first midwife facilitated pain relief, the second midwife subjected Patrícia to veiled disapproval

regarding the use of epidural rather than fully supporting her in her choice. The heterogeneity in midwife responses described may, at least in part, reflect the lack of status of midwifery and an associated lack of coherent philosophy and protocols related to childbirth support during labour in hospital settings. Importantly, it has long been determined by international professional bodies that maternity services should take women's individual needs into account, to the extent of staff even interrogating their own values and beliefs about coping with pain in labour, for example, to ensure the care provided fully supports the woman's choice (WHO 2005).

The scenarios described all highlight the extremely unpredictable and individual nature of care which prevails. In the words of another woman respondent: "It's a bit of a lottery there [at the hospital] in terms of who you get." The isolated phases of attention women received from each different professional can be considered "windows of care," each with their own potentiality, rooted in particular forms of authoritative knowledge and associated practice, rather than a coherent philosophy or approach, resulting in positive or negative experiences for women in each case.

In an extreme illustration of the lack of cooperation between the two professional groups responsible for childbirth care, another respondent described how the invasive monitoring procedure of the *toque* was applied both by a doctor and a midwife sequentially with apparently no communication between them:

"I had the *toque*²³ loads of times, because the midwives did it, and then the young doctor, when she arrived, did it too... The doctor and the midwife didn't talk to each other... there was not much dialogue... and I noticed there was some tension between them... I sensed, even in the labour room, that there was a tension, or some kind of dispute between the two of them" [Sofia].

The parturient sensed a power struggle between the older and younger professional, which was played out on her body, resulting in multiple vaginal examinations, rather than unified care.²⁴ In this and many of the narratives it was more common for women to feel acted upon rather than being invited to be decision-makers and active participants in birthing. The two women participants in the study who achieved an unmedicalized birth had to research this option, and persistently pursue it, in the face of resistance from certain health professionals. Study findings therefore reveal the rather precarious

23 In this instance, Sofia is largely referring to vaginal examinations, although one of the *toques* described in her narrative, was, in fact, amniotomy, the active rupture of the membranes.

24 Sofia eventually had a normal birth.

position of women in the current care system in which no standardised, coherent approach to birth support is promoted and choice is extremely limited.

CONCLUSIONS

The current high levels of technical intervention in childbirth in Portugal can be explicated through the historically elevated status of doctors which emerged as a result of the different evolutions of the obstetrics and midwifery professions, and the associated authoritative knowledge which celebrates hospital birth as an important symbol of modernity and progress (cf. De Luca, this volume). The continuing dominance of doctors within professional boundary struggles with midwives, resistance to change, the relationship (individual doctor “bridge”) between private and public service provision, and technological and institutional drivers of behaviour, can all be seen to be contributing to the current situation. Many women’s acceptance, and even selection of, a technocratic model of birth, from the use of epidural to the booking in of a C-section, cannot be understood outside of their relationship and interactions with doctors, or wider popular notions of acceptable practice, transmitted through a comprehensive, entrenched system of authoritative knowledge. These identifiable phenomena problematize the notion of women as autonomous, self-determining “clients.” Indeed, a dominant stereotype of women actively seeking C-sections for their own convenience or out of fear is challenged by the findings of our study. The new insights on women’s perspectives provided by this ethnographic work suggest that more comprehensive research is essential to bridge current gaps in knowledge and understanding, and to allow women a more prominent place in current discourses on childbirth.

Although the hospital-based research reported in this paper was only conducted at one setting, it nonetheless is revelatory of how doctors and midwives may care for the same women in the same physical space, yet lack a unified vision of optimal birth and coordinated approach to inform their joint work. While the centrality of women and women’s choices within their professional enterprise was articulated more clearly by midwives than obstetricians, women’s reported experiences were highly variable and access to information, the eliciting of consent and participation in decision-making, were often conspicuously absent in their narratives, suggesting that women’s informed choice and agency is, in many cases, being suppressed. At the same time, the inter-professional differences, power dynamics and tensions described by doctors and midwives as a critical issue in their daily work, and the evident continuing autonomy of doctors appears to confirm findings from previous studies elsewhere, that differing professional attitudes and approaches and fragmented organizational structures associated with the two professional groupings

reduce effectiveness of care. However, the situation of midwives revealed in the study can be considered specific to the cultural history of childbirth in Portugal and may not be directly comparable to other settings. As noted by Davis-Floyd (2008), any sense-making of the role of midwives is intrinsically linked to national and cultural definitions.

Finally, while the reticence of doctors to participate in the study was unfortunate, this outcome and the contrasting willing participation of midwives can, in fact, be considered constitutive of data or findings, which are worthy of further exploration (Inhorn 2012). The lack of engagement on the part of clinicians may symbolise poor current acceptance or mistrust of social science scholarship, for example, while midwives' willing engagement may reflect their limited "voice" in the childbirth arena, and their desire for their perspectives to reach a wider audience. In order for a greater body of meaningful social science scholarship based in medical settings in Portugal to be realised, clinicians' reticence is a particular challenge which will need to be addressed and overcome.

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