FEELING THE PRESSURE - COPING WITH CHAOS: BREASTFEEDING AT THE END OF THE MEDICAL PRODUCTION LINE

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A thesis presented in fulfilment of the requirements for the degree of
Doctor of Philosophy

SCHOOL OF NURSING AND MIDWIFERY

UNIVERSITY OF SHEFFIELD
UK

FEBRUARY 2004

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ABSTRACT

This study explored the influences upon women's experiences of breastfeeding within postnatal ward settings. A critical ethnographic approach was adopted in two maternity units in the North of England, with 61 postnatal women and 39 midwives participating. Participant observations of 97 encounters between midwives and mothers, 106 focused interviews with mothers and 37 guided conversations with midwives were conducted. Basic, organising and global themes were constructed utilising thematic networks analysis.

The metaphor of the production line, with its notions of demand and efficient supply against linear time, illustrated the experiences of breastfeeding women. They conceptualised breastfeeding as a 'productive' project yet expressed deep mistrust in the efficacy of their bodies. Their emphasis centred on breast milk as nutrition rather than relationality and breastfeeding. Women referred to the demanding and unpredictable ways in which their baby breached their temporal and spatial boundaries. They sought strategies to cope with the uncertainty of this embodied experience.

Women felt 'subjected' to ideologically pervasive notions that 'breast is best' and authoritative versions of how 'best to breastfeed'. An atmosphere of surveillance was experienced in relation to the institutional regulation of breastfeeding and through conducting a private and culturally ambiguous activity in a public domain. Women felt dissonant when a 'natural' process was experienced as complicated and challenging.

The midwives were also 'productive' yet 'subjected', their work being time pressured, unpredictable and fragmented. In 'supplying' a service under 'demanding' conditions midwives engaged in institutionally orientated rituals and routines, approaching women in disconnected and directive ways. Consequently, breastfeeding women's individual needs for support were rarely met.

Recommendations are made for: a reconsideration of the way in which women's bodies are understood and experienced; a re-conceptualisation of women's time; reconfiguration of knowledge about breastfeeding; re-visioning of relationships; and relocation of the place within which women commence breastfeeding.

ACKNOWEDGEMENTS

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GLOSSARY AND ABBREVIATIONS

ABM	Association of Breastfeeding Mothers
ASA	Association of Social Anthropologists of the UK and the Commonwealth
BFHI	Baby Friendly Hospital Initiative (WHO/UNICEF - International)
BFI	Baby Friendly Initiative (UNICEF UK - National)
BfN	Breastfeeding Network
DH	Department of Health (UK Government)
GP	General Practitioner
HCA	Health Care Assistant
LLL	La Leche League
MSLC	Maternity Services Liaison Committee
MW	Midwife (participant)
NCT	National Childbirth Trust
NHS	National Health Service (UK)
P	Postnatal woman (participant)
PCT	Primary Care Trust
PPF	DH Priority and Planning Framework
RCM	Royal College of Midwives
'Ten Steps'	WHO/UNICEF BFHI 'Ten Steps to Successful Breastfeeding'.
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

CHAPTER 1
INTRODUCTION

Time
It was for us
a cycle
until you marked a return-notches on bone
later found and theorized upon
as marvels of primitive ingenuity
when it was us
you were feverishly measuring
calculating a life
carried by one of ours.
At first we were surprised
by these crude measurements
and laughed as a group
at these plottings of our body.
It seemed not to matter.
You continued with this obsession
and we dismissed it.
When the moment comes we will let you know
it seems we once said.
But you counted backwards
and now your measured fact
tells us what once
we knew beforehand.
The first mark of time
was against us
and you continue
to march your numbers
through our souls
where out of habit-
and weariness too-
we have made a place for you.
(Rachel Vigier in Forman and Sowton 1989, p.135).

Breastfeeding - everyone's business?

Breastfeeding over the past century has become increasingly ideologically pervasive with authoritative knowledges being constructed and dismantled, settling for a time, then moving on and shifting. Breastfeeding has also become institutionalised as women's (re)productive[1] experiences have been reconstituted and reconfigured within a profoundly medicalised setting, the hospital. At the same time breastfeeding is a uniquely female embodied activity that brings a woman into altered experiences of temporal and spatial dimensions and new relationships with her baby and others.

Breastfeeding is a culturally mediated bio-psychosocial activity and as such has been studied in many academic disciplines ranging from biomedicine, nutrition, midwifery, nursing, politics, sociology, anthropology, psychology and medical geography. There are now two academic journals devoted specifically to the subject and many guide books. The theoretical perspectives adopted include positivistic, interpretevist, feminist and post-structuralist. Breastfeeding has also become the focus of considerable political activity.

So, it seems, everyone is interested in breastfeeding. However, my deliberate use of the word breastfeeding as detached from those who *do it* reflects the predominant interest of many academics. This centres upon breastfeeding as a health behaviour of considerable importance to maternal and child health. It is only during the last two decades that researchers have started to ask the question, what is the experience like for *women?* How do they negotiate this

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[1] I bracket off 're' from 'production' to highlight the ambiguities in the ways in which women's reproductive activities are conceptualised and experienced.

experience and what are the constraints upon women from *their* perspectives? While these questions are slowly being understood, the research tends to be discipline-bound. For example, sociologists and feminists exercise caution with regard to the embodied nature of breastfeeding as this may be seen to cross into biological domains and risk a return to essentialism. However, the study of women's experiences of breastfeeding provides exciting and unique opportunities to cross interdisciplinary and theoretical boundaries. With the above considerations in mind, I now highlight my personal journey towards undertaking this doctoral study followed by a brief outline of each chapter.

Personal reflections

My interest in women's experiences of breastfeeding probably began when I was breast fed myself in 1960. As my mother developed mastitis at three months and was advised to stop breastfeeding I must have experienced distress and anger. I later came to understand that this advice to my mother followed two brutal birthing experiences through which she 'produced' firstly me and then my brother, Danny. Advice and prescriptions were then issued on every aspect of mothering and child-care. Wisely for her third 'time around' she opted out of the system and had a home birth. Perhaps this explains why my sister, Susan is so unconventional?

Some years later, in 1982, I became a student midwife. I don't really know why. I think partly because I was disappointed with nursing which I practised for only a year after spending three years as a student. I had gone into nursing because I liked being with and caring for others but the experience could not have differed more profoundly from my expectations. My first experiences of midwifery were not very different. I was repeatedly told that midwifery differed from nursing in that it was 'well-being' orientated. However, what I saw and heard was in complete contradiction to this notion. My first memories of midwives and breastfeeding mothers could be summed up by constructing an example of one of the many well remembered scenarios:

> The setting is a 'Nightingale' ward in a maternity unit in the South of England in 1984. Mothers are 'arranged' in two long rows, sitting up 'nicely' in neatly made beds with their quiet babies lying alongside them in perspex cots. The noisy and unruly babies are elsewhere in a nursery. One of the mothers, still sedated and shocked from a traumatic birth, calls for help with her crying baby. The midwife bustles in and purposefully looking up at the large clock asserts that it is not time for a breastfeed yet and that she will settle the baby in the nursery. The mother looking half bewildered, half-relieved sits back against her neat pillows and watches the postnatal ward 'world' go by. About an hour later the midwife returns...it is now time for a breastfed. The mother rouses herself and sits up in bed for the feed. The midwife, having enquired as to which breast the woman last fed from, grasps her other breast and pushes the baby on to it. The mother has a strangely detached look in her eyes as if this was neither a part of her nor even happening to her, hands by her side. The baby having cried for an hour in the nursery is neither interested nor energetic and eventually the midwife 'gives up' and deposits the baby unceremoniously back into the cot to sleep off her exhaustion. When the baby wakes again, the midwife again tries to 'fix' her on and after a further failed attempt, pricks the baby's heel to test her blood sugar level and then announces that the baby needs some milk and that she must give some formula. I watch her collect the ready-made, packaged and labelled bottle, screw on the teat and sit herself in the chair beside the mother. The teat is pushed into the baby's mouth and the baby duly sucks. Each time she stops sucking the midwife 'rattles' the teat in her mouth to keep the baby going. When the procedure is finished the midwife returns the stunned, but satiated baby to the cot and announces to the mother that she has taken 30 mls and will be fine. She documents the time and quantity on the chart at the end of the bed, also noting that the baby had passed urine but not meconium. She reorganises the mother's pillows and assists her to reposition herself comfortably and....neatly. Order has been restored and mother and baby are looking 'nice', quiet and tidy.

Witnessing scenarios like this started a profound questioning in me as to what had become of the fundamentally female experiences of birth and breastfeeding and *what* had happened to midwives. What would happen to *me* if I stayed in this system? A few months after qualifying as a midwife I joined a pioneer team of midwives providing continuity of carer to women. We grew to know the women and they came to trust and relate to us. However, this experience

was short lived as for family reasons I then moved to the North of England. On commencing work in a northern maternity unit I felt like I had entered a time warp and arrived into the 1960s. I moved into a local housing estate in a socially deprived area for the first few months. The deck access flats have since been condemned and demolished. They were cold, isolated, grey and seriously depressing. In the maternity unit I powerfully re-experienced the frustrations and tensions that had been building up when I was a student midwife. The combination of the aversive living conditions and the hostile maternity environment strengthened both my socialist convictions and my desire to challenge the current maternity system and the ways in which birth and breastfeeding were 'managed'.

This led to a gradual journey into the relative 'safety' of education where I felt, probably somewhat naively, that I could support 'future' midwives in questioning, challenging and changing the system. Shortly after qualifying as a midwife teacher, in 1989, I became pregnant and later had a Caesarean section due to my severely contracted pelvis. My son Colin had been lying in an unstable position at thirty-six weeks pregnant, a most unusual situation for a first pregnancy. My second and third children were also born by caesarean section. After the birth of Colin, feeling rather like a cyborg, I began to breastfeed. The experience was highly challenging for the first three months with episodes of nipple thrush and mastitis punctuating the journey, combined with considerable anxiety related to being a new mother. However, after this time I moved onto a profound relational and positive embodied phase during which the experience became increasingly transformative. Colin stopped breastfeeding at around fourteen months of his own accord when I became pregnant with Stephanie. I breastfed Stephanie for sixteen months and then Andrea for three and a half years. I can remember reflecting at various stages during this period in my life upon the experiences of other women, knowing that very few women reached the point at which, in my case, the challenges of breastfeeding were replaced by tremendous fulfilment.[2]

When I re-emerged from seven years of pregnancies and/or breastfeeding, I wanted to dedicate myself to supporting women to commence and continue to breastfeed, so that they too could experience the transformative power. This conviction was strengthened by my socialist political motivations that led me to deeply dislike the ways in which the marketing of infant formula by powerful multinational corporations had undermined women's belief in breastfeeding. This led me to joining the National Childbirth Trust (NCT) and later the Breastfeeding Network (BfN), a break-away group from the NCT. My involvement with the NCT and BfN opened up an understanding of the collective women-centred understanding of women's breastfeeding journeys that the voluntary support organisations held. I subsequently collaborated with an NCT breastfeeding counsellor and tutor and two infant feeding specialists in setting up a breastfeeding module at the University in which I was then working part-time. This centred upon facilitating midwives in gaining the knowledge and skills needed to offer support to breastfeeding women (Dykes 1995).

As part of my desire to restore breastfeeding as the 'norm', I set out in 1996 to explore the key reason why women discontinued breastfeeding in the UK - 'insufficient milk' (Foster et al 1997).[3] I adopted a hermeneutic phenomenological perspective and interviewed ten women at three points in their journey, commencing six weeks following their birthing. Seven of the ten women 'fell by the way-side', explaining their sense of isolation and lack of support, nurture and replenishment. Three women described a powerful and enjoyable experience.[4] Through this study I came to increasingly realise that during my own experiences of breastfeeding I had received an enormous amount of social support from my family and friends and that this was not the norm for many women. As women spoke with me they often reflected back on their experiences of inadequate midwifery support both in hospital and at home. I wished I had started the study from the postnatal ward experience onwards, rather than from six weeks after the birth. Secondly, I realised the need to not only hear about the hospital experience but to see it. I wanted to understand what is was like for mothers breastfeeding in hospitals at the turn of the twenty-first century and how the postnatal ward culture and midwifery practices and interactions influenced these experiences. This is the focus of my thesis.

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[2] Only 64% of women in the UK commenced breastfeeding, only 41% of women breastfed at all at six weeks and 26% at four months following their birthing (Martin and White 1988).
[3] This work was prompted by working with Jacqueline Prya Vincent who was interested in Indian women's perceptions of their breast milk, later described in her book 'Feeding Our Babies' (Vincent 1999).
[4] The study was submitted for my dissertation in part fulfilment of an MA in Health Research, in the Faculty of Social Sciences at the University of Lancaster (Dykes 1998) and subsequently published (Dykes and Williams 1999, Dykes 2002).

Introducing the chapters

In the next chapter (2), I describe the background to the study. This is presented through a 'critical' lens with the notions of ideology and power being located centrally. In line with this critical approach, I avoid presenting a detailed and linear chronology of events, but rather highlight key 'moments' that are relevant to this study. I do, however, commence with the 'Enlightenment' as this marked the way for many of the influences upon breastfeeding that I go on to discuss. I present the background through the conceptual lenses that I have become increasingly aware of as I have progressed through the thesis, including 'production', 'linear time', 'separation/space', 'authoritative knowledge', 'surveillance' and 'control'. The background therefore constitutes a very different account than the one that I might have written at the outset. While highlighting powerful and hegemonic influences upon women's experiences of infant feeding, I also focus upon breastfeeding within the fabric of women's lives, acknowledging that there are multiple and complex influences upon their infant feeding decisions and experiences.

In chapter 3, I make connections between my epistemology, theoretical perspective and methodology. I highlight my central theoretical perspective as aligned to critical anthropology with a political economy of health perspective underpinning it. I also describe the ways in which I have engaged, with caution, with some post-structuralist theory, in particular that of Foucault and feminist post-structuralists. In drawing together various theoretical perspectives in this way I highlight the ways in which they converge and diverge in relation to power, ideology, knowledge, the body and resistance, making explicit aspects that I embrace and those that I reject. With these perspectives in mind I justify my selection of a critical ethnographic approach to this research.

In chapter 4, I describe the method I adopted, to include gaining access to the two maternity units I studied, selection and recruitment of participants and the conduct of observations and interviews. I move on to reflexively discuss ethical considerations, my presence in the field and the dilemmas that this created for me, with particular emphasis upon levels of participation. Finally, I describe the processes I utilised in the concurrent and iterative analysis of the data. These included a combination of categorical and non-categorical readings of the data and development of thematic networks to illustrate global themes and their underpinning networks. Finally, I discuss theoretical sensitivity and trustworthiness.

In chapter 5, I set the scene by describing my first impressions of each site and the cultural milieu in which women commence breastfeeding and midwives work. This crucially provides the context for the ensuing chapters in that I emphasise not only the medical nature of the experience for women but the harsh working conditions for midwives. I particularly focus upon the temporal pressures upon midwives as this was central to their experience of providing support, or lack of it, to women. As midwives were the main group of people with whom women engaged while in hospital, the ways in which midwives negotiated their work, given the massive constraints upon them, was inevitably crucial to the experience of women.

In chapter 6, I focus upon the impact of the ideologically pervasive notion that 'breast is best' and the authoritative versions of how 'best to breastfeed'. I highlight the ways in which institutional regulation of infant feeding places pressures upon both women and midwives bringing into play a range of surveillances upon both groups. I illustrate the ways in which both mothers and midwives resist and/or accommodate the power of authoritative versions of breastfeeding. Not only do mothers come under surveillance through institutional regulation of breastfeeding, but they are engaging in an essentially private activity within their communities in an intensely public arena. I illustrate the ways in which women negotiate their time and spaces to minimise the inevitable feelings of discord created by their dilemmas in relation to authoritative knowledge and their desire for privacy.

In chapter 7, I extend and elaborate Martin's (1987) notion of productive labouring bodies to theorise women's perceptions of their role as breast milk producers and deliverers and the demanding nature of this role. I utilise the industrial metaphor 'supplying' to illustrate the ways in which women conceptualised and negotiated this role with all of its inherent uncertainties. I then discuss the ways in which women experienced breastfeeding as physically and emotionally 'demanding' in terms of their temporal and bodily boundaries. I move on to highlight the ways in which women, with their central preoccupation with supplying and demanding, sought ways in

which to cope with and control for the unpredictability of their bodily experience of breastfeeding and activities of their babies. I discuss women's anxieties about and lack of confidence in their breast milk 'production' in combination with their preoccupations with returning to a 'normal' life and 'productive' paid employment.

In chapter 8, I highlight the influences upon women's desire to 'carry on' and 'persevere' during the early days of breastfeeding. I discuss the concept of perseverance in its connections with confidence (self-efficacy), but also with regard to the ideologically pervasive notion that 'breast is best'. The challenges to women's sense of self and self-confidence were enormous and in some cases overwhelming, with the two most immediate and pressing concerns for breastfeeding women in hospital being nipple pain and fatigue. I describe the ways in which women described and negotiated both the positive and negative experiences during their postnatal ward stay.

In chapter 9, I focus specifically upon the nature of encounters between mothers and midwives. These encounters are contextualised within the cultural settings in which midwives are coping (or not) with 'caring'. I draw upon midwifery and nursing theory with regard to caring/uncaring encounters (Halldorsdottir 1996, Woodward 2000, Fenwick et al 2000, 2001) but also upon research that highlights the constraints upon midwives and nurses within the UK National Health Service (Kirkham 1999, Kirkham and Stapleton 2001b, Ball et al 2002). I extend this theory by producing a synthesis that reflects not only the style of encounters I witnessed and their impact upon women but also highlights some of the reasons why encounters take the form that they do within hospital settings. To support this interpretation I draw upon the recent research on emotion work of Hunter (2002).

In chapter 10, I draw together the thematic networks to highlight the multiple constraints and pressures upon both breastfeeding mothers and midwives. I relate these to the concepts of 'linear time', 'production', 'separation', 'authoritative knowledge', 'surveillance' and 'control'. I illustrate the striking parallels between the two groups and assert that both mothers and midwives are engaged in 'productive' activities under considerable emotional pressure in a highly public place, open to many observers. The project of 'doing the correct thing....in the right way', creates further tensions and turmoil. 'Supplying' for another's needs in a culture in which linear time is reified, randomised and embodied leads to both mothers and midwives constructing ways of coping and controlling. Despite the challenges most mothers and midwives persevere through the troubles and triumphs, the pain, fatigue and special moments. The nature of the encounters between mothers and midwives reflect the ways in which both groups feel the pressure and cope with chaos. Given this scenario, I make recommendations for: a reconsideration of the way in which women's bodies are understood and experienced; a re-conceptualisation of women's time; reconfiguration of knowledge about breastfeeding; re-visioning of the mother-baby and midwife-mother relationships and relocation of the place and space in which mothers commence their breastfeeding journey.

It's about time

I selected the poem above to illustrate the centrality to this thesis of the concept of linear time. As stated, throughout the thesis I highlight the relevance of the concepts of 'separation', 'control' and 'production' in addition to 'authoritative knowledge' and 'surveillance' and the power that these exert upon women. However, as I have immersed myself further in the data I have become profoundly aware that these concepts manifest themselves partially but significantly through time. As Foucault (1977) states, "time penetrates the body and with it all the meticulous controls of power" (p.152). Ironically, it was when I had a short period of 'time out' to recover from pyelonephritis that I developed a heightened awareness of the ways in which time appeared repeatedly through the data. This realisation was precipitated by an altered experience of time for me while recovering. I felt a sense of temporal dislocation from the familiar world of time pressures, constraints and deadlines. This experience and my reflections on the data assisted me in moving towards a deeper level of critical consciousness. As Peters and Lankshear (1994) assert, this relates to Freire's philosophy that:

> Human development is based upon a certain quality of awareness: awareness of our temporality, our 'situatedness' in history, and our reality as being capable of transformation through action in collaboration with others [....]. Progress from naïve to critical consciousness involves conscientization. This is the process by which we learn to perceive social, political, and economic contradictions and become involved in the

struggle to overcome them; to identify 'limit situations' for what they are and confront them with 'limit acts'. In this very process we enter history as subjects, humanizing ourselves, becoming more fully human (p.181).

My experience of undertaking this doctoral study has in itself refocused me upon time as I have negotiated for 'time-out' from a busy job and have constantly 'juggled time' in order to meet the needs of my three children. Committing to a project like this for over four years is something that I will remember for all of my time. But for now I focus upon critical historical moments that have influenced the complex and convoluted journey for breastfeeding women in the present time.

CHAPTER 2
MOMENTS OF SIGNIFICANCE

Introduction

In this chapter I focus upon key moments of historical significance through a 'critical' lens, with the notions of ideology and power being located centrally. In line with this critical approach I avoid presenting a detailed and linear chronology, but rather highlight key social, political and economic events that have relevance to this thesis. I commence with the 'Enlightenment' as this era marked the way for a profound reconfiguration of the ways in which infant feeding was conceptualised and experienced by women. I then focus upon the development and rise of the techno-medical model of medicine and its central arena, the hospital. I highlight powerful and hegemonic influences upon women's reproductive and infant feeding experiences to include the activities of powerful multinational companies and their marketing of breast milk substitutes. I also discuss some of the ways in which women engaged with and indeed contributed towards a reconfiguring of birth and breastfeeding, by relating them to the complex socio-cultural contexts of women's lives.

I move on to focus upon the growing international concerns raised in relation to the reconstruction of infant feeding practices. I refer to some of the resulting initiatives that sought to challenge aspects of the medical regimentation of infant feeding and reverse the negative effects of the era of aggressive marketing of infant formula. I highlight, in particular, aspects of these programmes that utilised the hospital as their key place for operationalisation. Finally, I focus upon existing literature that centres upon the early breastfeeding experiences of women and their stated needs. I refer to related ethnographic studies and research that focus on the culture of institutionalised midwifery in order to set the context for the study.

I present the background through the conceptual lenses that I have become increasingly aware of as I have analysed the data, including 'production', 'linear time', 'separation/space', 'authoritative knowledge', 'surveillance' and 'control'. All relate to ways in which women perceive and interpret embodied experiences, in particular breastfeeding, and their associated relationships with others.

The 'Enlightenment'

My starting place is the era referred to as the "Enlightenment". This was a major turning point in human history, a "self-proclaimed Age of Reason" that began in England in the 17th century and subsequently spread to Western Europe during the 18th century (Crotty 1998 p.18). This period was characterised by the development of rationalistic science as a supreme source of authoritative knowledge[5]. It was also the era during which there was an exponential growth in the human population and increasing industrialisation (Doyal and Pennell 1979, Pelling et al 1995).

Populations and production

The industrial revolution was well underway between the late 18th to mid 19th centuries and as Doyal and Pennell (1979) highlight, this contributed to the mass movement of people into cities. The development and growth of the capitalist economy took place concurrently with its emphasis upon productivity for profit and monitoring of efficiency and outputs (Doyal and Pennell 1979, Foucault 1977, 1981). Indeed, the growth of the population and growth of capitalism could be seen as symbiotic, as argued by Foucault (1977):

> The two processes - the accumulation of men and the accumulation of capital - cannot be separated; it would not have been possible to solve the problem of the accumulation of men without the growth of an apparatus of production capable of sustaining them and using them; conversely, the techniques that made the cumulative multiplicity of men useful accelerated the accumulation of capital (p.221).

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[5] Authoritative knowledge refers to the legitimisation of one kind of "knowing" as having power over other forms of knowledge; subordinating, devaluing, delegitimising and often dismissing them (Jordan 1997, p.56). Authoritative knowledge may define itself as having established "a certain field of empirical truth" (Gordan 1980, p.237). As Jordan (1997) states, "The power of authoritative knowledge is not that it is correct but that it counts" (p.56).

Thus capitalism was made possible by the "controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes" (Foucault 1977, p. 141). As Fairclough (1992) states, "modem societies are characterised by a tendency towards increasing control over more and more parts of peoples' lives" with technologisation playing an increasing role (p.215). Foucault (1977, 1980, 1981) argues that this expanding population and the need for controlled production contributed to the formation of the major systems that he calls "disciplines", i.e. the military, the prisons, factories, hospitals and schools. As the apparatus of production grew and became increasingly complex the growing costs required acceleration in profitability. In this context the disciplines functioned as "techniques for making useful individuals" (Foucault 1977, p.211), for example, the individual capable of mechanical work in a factory.

Rationalistic science as the supreme source of authoritative knowledge

The 'Enlightenment' was the era during which rationalistic science reached a supreme authoritative status bringing with it an epistemology of objectivism. Objectivism was underpinned by reductionism[6] and dualism[7]. The notion of dualism extended to a distinction between the mind and objects within the material universe and thus allowed the study of the universe as separate from any consideration of the human mind (Crotty 1998). The essence of objectivism, therefore, centred upon the "view that things exist as meaningful entities independently of consciousness and experience, that they have truth and meaning residing in them as objects" (Crotty 1998, p.5). This objectivist epistemology enabled the viewing of the world through a positivistic lens so that it could be explained, described, codified and quantified in order to reveal its absolute laws and principles (Doyal and Pennell 1979, Marston and Forster 1999, Crotty 1998). Therefore, during the 'Enlightenment' reason increasingly superseded revelation, rationalism suppressed and opposed the metaphysical and certainty replaced mystery and complexity.

Separating spheres - constructing dualisms

It is crucial to this thesis to view the impact of 'Enlightenment' thought upon the ways in which women were conceptualised, for as Shildrick (1997) asserts:

> In directing its attention to mastery of the natural world and given the close identification of the female with nature, the scientific project of the Enlightenment may be conceptualised as inherently hostile to women (p.26).

While, as Shildrick (1997) argues, it is simplistic to entirely attribute separation of male and female domains to post-Enlightenment (modernity), the hierarchical separation of the roles of male equals culture and female equals nature developed very clearly during this era. Martin (1987) refers to this doctrine of two spheres by firstly connecting the development of industrialised and capitalist societies with displacement of production from the home to the factory. This contributed to the construction of public and private domains. The public world of paid work, that is work involved in the production process, came to be seen as separate from the private world centred in the home. Previously, work had been located in and around the home with the extended family being seen as united in an endeavour to make provision for their own needs. The private world came to be associated with the 'natural', that is bodily functions, sexuality, intimate relationships, morality, kinship and expression of emotions. Women, who were seen as 'natural', increasingly came to be seen as located within the private world of the home, as wives and mothers. Their role was one of reproduction rather than production in the industrial and economic sense. The public world, on the other hand, was seen as related to the impersonal process of efficient, goal-orientated competitive production. It was not only seen as breaking away from nature, but indeed dominating and controlling it. This was the world of the wage-earning male who came to be seen as cultural, in contrast and in superior position to the feminine and natural (Martin 1987). Women from poor families were the exception to this public-private divide in that they were forced into the ambiguous position of juggling paid employment and home responsibilities (Doyal and Pennell 1979).

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[6] Reductionism refers to the philosophic view that complex phenomena are nothing more than the sum of their parts (Engel 1977, Marston and Forster 1999).
[7] Dualism, a concept developed by Descartes, a French philosopher relates to the view that the mind is a separate entity from the body thus paving the way for the objectification of the latter (Engel 1977, Davis-Floyd 1994).

Surveillance

The development during the 18th and 19th centuries of mechanisms and means for surveillance of the growing, mobile population described by Foucault (1977, 1980) is particularly relevant to this thesis. He argues that "this moment in time corresponds to the formation of, gradual in some respects and rapid in others, of a new mode of exercise of power" (1980, p.38), leading to the development of a "disciplinary society" (1977, p.209):

> Discipline fixes; it arrests or regulates movements; it clears up confusion; it dissipates compact groupings of individuals wandering about the country in unpredictable ways; it establishes calculated distributions (p.219).

To understand Foucault's notion of the disciplinary society it is useful to commence with his focus upon the prison and Panopticism. Panopticism was a "technological invention in the order of power, comparable to the steam engine in the order of production" (Foucault 1980, p.71). Foucault (1977) describes the transformation during the 18th and 19th centuries from the body as focus for punishment whose severity varied with the crime, to the body being subjected to the power of imprisonment with its removal of freedom. He describes in detail a building, the Panopticon designed by Bentham that was circular with a central tower. The prisoners' cells were positioned radially around the edge of the building. The central tower had a window and lighting system that allowed a supervisor to watch every prisoner in the building. Each prisoner was separated from his neighbours by a wall so visibility was one way, supervisor to prisoner. It was never lateral, thus negating disruption or communication between prisoners. The major function of the Panopticon is described:

> To induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power [....]. Bentham laid down the principle that power should be visible and unverifiable. Visible: the inmate will constantly have before his eyes the tall outline of the central tower from which he is spied upon. Unverifiable: the inmate must never know whether he is being looked at at any moment; but he must be sure that he may always be so (Foucault 1977, p.201).

This means of exerting power created "dissymmetry" between observer and observed, "disequilibrium" and "difference" (Foucault 1977, p.203). As Kendall and Wickham (1999) describe, for Foucault the prison as a form of visibility assisted in constructing the concept of criminality whilst statements related to criminality produced forms of visibility that reinforced prison. Foucault (1977, 1980) asserts that the architectural design of the Panopticon was utilised to insert this form of surveillance into other "formidable disciplinary regimes" (1980, p.58), for example factories, schools, hospitals and army barracks. These institutions with their large populations developed specific hierarchies, spatial arrangements and surveillance systems centred around the requirement to supervise activities. Thus the exercise of power through 'the gaze' was facilitated:

> The perfect disciplinary apparatus would make it possible for a single gaze to see everything constantly. A central point would be both source of light illuminating everything, and a locus of convergence for everything that must be known: a perfect eye that nothing would escape and a centre towards which all gazes would be turned (Foucault 1977, p.173).

Taking the factories that emerged at the end of the 18th century as an example, we see that individuals had to be strategically placed and monitored in relation to the spatial arrangements and operational requirements of production machinery to ensure maximum efficiency and output:

> A central aisle allowed the supervisor to walk up and carry out a supervision that was both general and individual: to observe the worker's presence and application, and the quality of his work; to compare workers with one another, to classify them according to skill and speed; to follow the successive stages of the production process (Foucault 1977 p.145).

Again, this factory surveillance links with its economic functions, maintaining the link between populations and production:

As the machinery of production became larger and more complex, as the number of workers and the division of labour increased, supervision became ever more necessary and more difficult [....]. What was now needed was an intense, continuous supervision; it ran right through the labour process; it did not bear - or not only - on production (the nature and quantity of raw materials, the type of instruments used, the dimensions and quality of the products); it also took into account the activity of the men, their skill, the way they set about their tasks, their promptness, their zeal, their behaviours' (p.174) [....]. Surveillance thus becomes a decisive economic operator both as an internal part of the production machinery and as a specific mechanism in the disciplinary power (Foucault 1977, p.175).

Foucault (1977) refers to "hierarchical observation" (p.170), the extension of surveillance within the disciplines to those supervising:

The Panopticon may even provide an apparatus for supervising its own mechanisms. In this central tower, the director may spy on all the employees that he has under his orders: nurses, doctors, foremen, teachers, warders; he will be able to judge them continuously, alter their behaviour, impose upon them the methods he thinks best; and it will even be possible to observe the director himself. An inspector arriving unexpectedly at the centre of the Panopticon will be able to judge at a glance, without anything being concealed from him, how the entire establishment is functioning (p.204).

The connections between the prison, the factory and the hospital become immediately striking, hence setting the scene here. I return to the hospital, as a site for the implementation of surveillance mechanisms, later in this chapter.

Construction of a clockwork culture

As capitalism, mechanisation and the requirement for controlled production methods developed, the need for precise timing, measurement and consistency grew (Gray 1993, Palmer 1993). The construction of the mechanical clock provided the perfect tool to connect the imperatives of industrial productivity, mathematical measurement and the monitoring and surveillance of groups of people. The desire to control time and indeed the concomitant control that clock time has over people is central to this thesis and I therefore introduce a brief history of the mechanical clock.

Cipolla (1967) traces the development of the mechanical clock within the socio-historical context of the economic and technological processes by which Europe gained power in the world. He links the clock's growing super-valuation with the growth of industrialisation and related technical machinery and with the philosophy of empiricism and utilitarianism which "infected" all branches of human knowledge (p.33). The desire for power in Europe that manifested in the combination of wars, industrialisation-later capitalism, and the growth of empirical science, paved the way for a central and growing place for the mechanical clock. Cipolla notes that many of the early clock makers were also gun founders and he asserts that this connection has major significance. "The simultaneous appearance of the gun and the mechanical clock was both a testimony to the character of European development and a forecast of things to come" (p.40).

Cipolla argues that it was during the 17th century, when the Scientific revolution "exploded" that scientists saw the clock as "the machine par excellence" (p.57). Their growing interest in the clock led to its rapid technological sophistication. This was also the era when growing numbers of relatively wealthy urban dwellers, for example merchants, lawyers and doctors, could afford watches and clocks which were being made at increasingly low costs. So demand fuelled supply and vice versa. The clock fulfilled the growing human desire to measure time and rapidly became a status symbol. As Cippolla states, people increasingly timed activities they would never have thought of timing. People became obsessed with punctuality and timing which was seen to be virtuous. Clocks were changing ways of thinking as they replaced the variable times associated with the seasons with a measured time that overrode the former. Cipolla refers to these clocks as machines which like other new machines create new needs and therefore "breed" newer machines (p.105). Each new tool then influences us deeply while we are using it. "The fascination exerted by the machine induces a rapidly growing number of people into a tragic fetishism of the machine" (Cipolla 1967, p.106-107).

In the forward to Cipolla's text, Ollard (1967) summarises the tyrannical connections between the clock and power:

> Clocks are the prototypes for all precision instruments: and once they are valued as such and not simply admired as the most delicate and enchanting of mechanical toys the age of industrial innocence is over [....]. If wrist watches and guided missiles are not obtainable at one and the same shop they still to the reflective eye disclose a recognisable cousinhood (Forward).

As Thomas (1992) states, "Any understanding of time must identify which time and whose time is involved" (p.65). What evolved during the industrial revolution was the notion of mechanical clock or linear time. This may be contrasted with cyclical or rhythmic time. Mechanical clock/linear time is commonly referred to as having over-ridden or obliterated cyclical/rhythmic time (Cipolla 1967, Kahn 1989, Adam 1992, Bellaby 1992, Helman 1992, Starkey 1992). Kahn (1989) makes the distinction between the two times particularly clear. She compares the concepts of "linear" time, also referred to as "clock time", "historical time" or "industrial time", with "cyclical time", also referred to as "organic time" or "agricultural time". She states:

> The kind of time we are most familiar with is historical or clock time, a life sequence which moves relentlessly forward. In the West we have lived in this kind of time for so long it seems almost impossible for things to be otherwise (p20).

Linear time, Kahn (1989) argues, is "pitched towards the future" (p.21) and is centred around the notion of production which in the factory not only overrides closeness to natural body rhythms and flows, but with shift work even erases day and night distinctions. It consequently exerts control over nature. In contrast, cyclical time relates to the "organic cycle of life" in which one is "living within the cycle of one's own body". It is a time that is "cyclical like the seasons, or the gyre-like motion of the generations" (p.21).

The sense of the clock having deeply penetrated society is emphasised by Simonds (2002) who refers to the perpetuating nature of the western dependence upon clock time, as the clock and technological "progress" have become mutually dependent:

> A cultural ethos (capitalist, technocratic, bureaucratic, and psychologically individualistic) makes time keeping relevant, and the more it develops such foci, the more it creates technology to assess, to measure, to control (p.569).

Linear time was fundamentally favoured and imposed by those in power, for example, the wealthy upon the less powerful in factories (Kahn 1989, Bellaby 1992, Starkey 1992). It also disadvantaged women in that, as Forman and Sowton (1989) observe, phallo-centric western epistemologies around time have reached into the lives of women. However, linear time has not simply been imposed upon women for they have increasingly embraced this form of time within the fabric of their lives. The ways in which linear time weaves in and out of women's lives will continue to constitute a central theme throughout this thesis.

Ideological ascendancy of techno-medicine

The dramatic transformation of the practice of home-based medicine to techno-medicine in Western Europe during the 'Enlightenment' is widely reported (Doyal and Pennell 1979, Lupton 1994, Illich 1995). From the middle ages to the late 18th century medicine had been practised in the home, with the doctor attending patrons, as requested by the latter or their family members. Only the wealthy could afford this service and patrons decided which doctor they would select. As it was the patrons who summoned doctors, they retained an autonomous and dominant position within the relationship. The fundamental belief system regarding health that persisted during this era could be summarised as "vitalism", a belief in the wholeness and unity of the human person (Doyal and Pennell 1979, p.33). The era of home-based medicine and holism came to an end through two key and interconnected changes, the scientification of medicine and the establishment of the hospital, which I discuss in turn. Before doing this, I clarify my perspective on techno-medicine.

Crucially, in this thesis I assert that techno-medicine is hegemonically connected with industrialisation (Doyal and Pennell 1979, Illich 1995), the super-valuation of technology (Doyal and Pennell 1979, Davis-Floyd 1992, 1994) and capitalism (Doyal and Pennell 1979, Davis-

Floyd 1992, 1994). I agree with Doyal and Pennell (1979) who describe the Western health system as functioning as a powerful agency of "socialisation and social control" (p.42). By claiming a scientific basis for its practice, techno-medicine is part of the machinery by which capitalism is legitimated in that capitalism is also aligned ideologically to scientific and technologic progress. Like mature capitalism, the health system involves relationships that are "bureaucratic, hierarchical and authoritarian" (Doyal and Pennell 1979, p.43). In acknowledgement of these connections, I hereafter refer to what is interchangeably described as the medical, biomedical (Engel 1977) or technocratic model (Davis-Floyd 1992, 1994) as the techno-medical model, a term used by Oakley (1986). This emphasises ideological alliance between medicine, technology and capitalism with medical technological 'progress' being continually fuelled by the enormous vested interests of the multinational corporations, for example the pharmaceutical, medical equipment and infant formula companies.

Scientification of medicine

The scientific assumptions of the Enlightenment came to powerfully influence the practice of medicine. Two major influences upon medicine were reductionism and dualism[8]. The combination of reductionism and dualism when applied to medicine enabled the patient to be conceptually separated into mind, body and soul, with the body seen, like a machine, as something which could be taken apart, examined and repaired (Davis-Floyd 1994, Aitken and Jellicoe 1996). Illich (1995) observes that Descarte's:

> Description effectively turned the human body into clock works and placed a new distance, not only between soul and body, but also between the patient's complaint and the physician's eye. Within this mechanised framework, pain turned into a red light and sickness into mechanical trouble (p.160).

Within this reductionist and separatist model, the medical practitioner came to be seen as a grand mechanic or engineer, the caretaker of the body and its component parts (Schwartz 1990, Davis-Floyd and St. John 1998). As Doyal and Pennell (1979) state, the separatist ideology extended to the practitioner and patient requiring the doctor, as if a natural scientist, to separate himself from the subject as the scientist does from the natural world. In this way, scientific medicine became "curative, individualistic and interventionist, objectifying patients and denying their status as social beings" (Doyal and Pennell 1979, p.30).

The effects of reductionism and dualism on the recipients of medicine are also referred to by Doyal and Pennell (1979):

> The belief that one's mind and body can be separated and treated according to the laws of science, both serve to emphasise the loss of individual autonomy and the feelings of powerlessness so common in other areas of social and economic life (p.43).

Stacey (1997) describes this sense of ontological separation in her reflexive account of a personal experience of developing cancer. She describes the ways in which she became little more that the owner of a growth with medical emphasis focusing upon concreteness, visibility, physicality and progress and presenting her disease as statistical, quantifiable and observable.

What is particularly alarming is the way in which medicine, despite it growing alignment with natural science, traditionally by-passed science that challenged its assumptions. As Engel (1977) argues, this made it little more than a dogma:

> The biomedical model has become a cultural imperative, its limitations easily overlooked [....] it has acquired the status of 'dogma'. In science, a model is revised or abandoned when it fails to account adequately for all the data. A dogma, on the other hand, requires that discrepant data be forced to fit the model or be excluded (p.40).

Establishment of the hospital

Doyal and Pennell (1979) refer to the mass movement of people during the industrial revolution into rapidly expanding cities. The working classes and their families were exposed to damp, unsanitary housing, with overcrowding, infections, inadequate nutrition and lack of sunlight,

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[8] I defined dualism and reductionism earlier in chapter 2.

leading to a multiple range of diseases and bone deformities. The profoundly unhealthy nature of cities during the late 18th and early 19th centuries paved the way for the establishment of large hospitals for the sick. The hospital thus represented the place and space in which the principles underpinning techno-medicine flourished with the scene set for a growing power base for medical doctors.

The discovery of disease as an identifiable entity through germ theory during the late 19th century and the development of microscopy and related diagnostic techniques, reinforced the authority of medicine and the power of the doctor (Apple 1987, Lupton 1994). In the hospital doctors were able to increasingly utilise the tools of their trade to diagnose, classify and treat disease. As Apple (1987) notes:

> New diagnostic tools unveiled to the physician but not the patient, the hidden mysteries of the human body. In providing the physicians with information not directly available to the patient, these instruments accentuated the esoteric nature of medical-scientific knowledge, thereby altering the doctor-patient relationship and strengthening the authority of the physician (p.17).

Ill health within cities was seen as justification for the needs of the growth of institutional medicine. The poor inevitably welcomed the provision of free medical care through the hospital forum (Doyal and Pennell 1979, Apple 1987, Lewis 1980, 1990) and like doctors, increasingly viewed science as progress and a symbol of medical authority (Apple 1987, Lupton 1994).[9] By the 20th century medical knowledge had gained supreme authoritative status through its inextricable links with prediction and control and prevention of the eruption of disease, uncertainty and chaos (Engel 1977, Doyal and Pennell 1979, Amey 1982, Apple 1987, Lupton 1994). The powerful socialising effects of hospital medicine, as Illich (1995) argues, constructed a population of consumers of this commodity, for "when cities are built around vehicles, they devalue human feet" (p.42).

The perspective of Foucault (1977) is of considerable relevance to this thesis in that he focuses upon the development of the hospital and the associated institution of medicine as an "examining apparatus" (p.185). He asserts that the model of the Panopticon was employed to enable the development of specific hierarchies, spatial arrangements and surveillance systems centred around the requirement to make visible and supervise activities (Foucault 1977, 1980). Hospitals became places where patients could be observed, separated and supervised to prevent the spread of disease. The Nightingale wards with their two rows of patients separated by a central walk-way facilitated this separation and scrutiny (Street 1992).

Foucault (1980) describes the hospital as a "fragment of space closed in upon itself, a place of internment", a place characterised by scrupulously imposed spatial order, while concomitantly conveying the "incessant disorder of comings and goings", "inefficient medical surveillance" and inadequate achievement of its objective to improve health (p.177-178):

> The space of the hospital must be organised according to a certain therapeutic strategy, through the uninterrupted presence and hierarchical prerogatives of doctors, through systems of observation, notation and record-taking which make it possible to fix the knowledge of different cases, to follow their particular evolution (p.180).

Foucault (1977, 1976, 1981) refers to normalizing judgement within hospitals, that is rituals and techniques which established a power of normalisation over individuals. For Foucault (1977) the normal was established in standardised trainings, for example the national medical profession and hospital systems capable of operating general norms of health and a level of standardisation seen in industrial processes and products. Normalisation is seen in "the case" and the way in which it is "described, judged, measured, compared with others" (p.191). Foucault (1981) emphasises the power of medicine through its techniques of questioning, monitoring, watching, spying, searching out, palpating and bringing into the light to label what is normal and what is deviant. Thus medicine socially constructs reality through its power to define what constitutes normality and therefore abnormality (deviance). Surveillance also extended to the body through the medical 'gaze' during the clinical encounter. This form of

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[9] Public health legislation and subsequent initiatives such as improvements to the quality of water and sewage disposal occurred concurrently but independently to techno-medicine (Doyal and Pennell 1979, Tew 1994). These had a major impact upon health from the late 19th century onwards but it was, and still is, commonly medicine that took the credit. This set the scene for the ongoing further proliferation of techno-medicine.

surveillance inscribes the body to such an extent that the individual starts to police or self-monitor her/his own body (Foucault 1976, 1980, Lupton 1994, Ribbens 1998), an issue that I elaborate upon further as the thesis progresses.[10]

A most striking example of the impact of the scientification of medicine and the establishment of the hospital may be seen in relation to women's (re)productive health. As breastfeeding is intricately connected with (re)production and especially birthing, an overview of the rise of techno-medical (re)production is warranted and it is to this that I now turn.

Techno-medical (re)production

Technologising birth

As the medicalisation of life and the conceptualisation of the body as a machine were largely male-led, the idealised machine was seen as that of the man. Deviations from this prototype were represented in the female body that came to be seen as dysfunctional (Ehrenreich and English 1979, Martin 1987, Davis-Floyd 1992, 1994). This view contributed in part to changing the face of the birth experience for women.

From the 17th century onwards an inexorable rise of the male obstetrician was accompanied by a diminishing definition of normality and an erosion of the midwife's domain (Ehrenreich and English 1979, Arney 1982, Kirkham 1983, Oakley 1986, Goer 1995, Tew 1995). Pregnancy and birth were gradually reconstituted and redefined from a social aspect of women's lives to a biomedical event prone to failure, danger and unpredictability and therefore requiring medical supervision and management (Oakley 1986, Schwarz 1990, Kohler Reissman 1992, Davis-Floyd 1992, 1994, Duden 1993). Franklin (1991) notes, in relation to the displacement of the social model with the biological one:

> The awesome measure of the power of medico-scientific discourse that it can accomplish this simultaneous erasure and replacement of something so basic to human social life as reproduction, through the power of its exclusive claim to represent the truth of 'natural facts' (p.200).

During the course of a single (20th) century hospital replaced the home as the place and space in which women gave birth and recovered postnatally. Hospital birth rates rose to over 60% by the 1950s and by the 1990s, 98% of women were birthing in NHS hospitals (Tew 1995). As Foley (1998) asserts, hospitalisation through a "simple but devastating manoeuvre" undermined women's knowledge about childbearing by "isolating it from the community" (p.37). In this way, women's knowledge generated from their embodied experiences came to be "superseded", "delegitimised", cognitively suppressed" and "behaviourally managed" (Jordan 1997, p.64).

The success of the techno-medical model of reproduction is complex and relates to several key issues. There was growing government concern and accompanying recommendations regarding infant mortality and morbidity (Doyal and Pennell 1979). The material conditions of women's lives and the powerfully persuasive lure of the hospital as the safe space and place in which to birth contributed to women making demands for hospital births (Doyal and Pennell 1979, Lewis 1990). As Lewis (1990) notes during the early 20th century women's groups such as the Women's Co-operative Guild, the Women's Labour League and the Fabian Women's Group campaigned actively for the pain relief and 'safety' offered by hospital births. Working class women saw hospital birth and postnatal recovery as a welcome respite from damp, overcrowded, unsanitary living conditions and the profound exhaustion from repeated pregnancies, caring for a large family and exploitative paid working conditions (Llewellyn Davies 1978, Doyal and Pennell 1979, Lewis 1980, 1990). Lewis (1990) states:

> What is clear is that women of all social classes in the early 20th century expressed fear of childbirth in terms of both the pain and the considerable chance of subsequent health problems. Their fears were real and arose directly from the conditions of maternity they experienced. When these are understood, their demand for hospital births becomes readily comprehensible (p.20).

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[10] The concept of the medical gaze has extended to a general increase in surveillance of the population by the state in the form of public health, for example child health clinics and medicine (Foucault 1976, Doyal and Pennell 1979, Lawler 1991, Lupton 1994,1995). Illich (1995) extends this notion in referring to society as having become a clinic overseeing and regulating people's health to ensure that they remain within normal limits.

Nevertheless, as Lewis (1990) asserts, women bought into a system in which medical domination and its accompanying "technological sophistication" came to wield an authority through the hospitals and a momentum that became very difficult to challenge or reverse (p.26). As Davis-Floyd and Dumit (1998) highlight, the crucial question is not whether technology is good or bad but rather who owns and controls the technology.

Martin (1987) highlights the hegemonic connections between the ensuing hospitalisation of women when in labour and birth and industrialisation. Based on interviews with women about their experiences of labour and birth she presents an extended and more sophisticated metaphor of woman's body from the machine with medics as mechanics. She argues that with the development of hospitalised, complex management of birth, woman came to be seen as part of an industrial factory. In this portrayal labour is a production process, the woman is the labourer, her uterus is the machine, her baby is product and the doctor is the factory supervisor or even owner. Although the midwife does not feature in Martin's text, she fits in well in this scenario as the "shop floor worker" following the supervisor's instructions, as described by Kirkham (1989, p.132).

As Davis-Floyd (1992) argues, this supports the assumptions that technocratic society, with the doctor as its representative, is the producer of the product, the baby, and through a series of symbolic rituals this becomes imposed upon the minds of women. Martin (1987) draws similar conclusions but frames her analysis within Marxist notions of man's alienation and separation from the product of his labour. She argues that, in accordance with this model, the labouring woman is likewise disconnected from her birth, seeing it as something that is managed and controlled by the system. Women thus represented themselves as "fragmented - lacking a sense of autonomy in the world and feeling carried along by forces beyond their control" (Martin, 1987, p.194). Thus, she asserts, women come to see their bodies as defined by the implicit scientific metaphors that assume that:

> Women's bodies are engaged in "production" with the separation this entails (given our conception of production) between labourer and labourer, labourer and product, labourer and labour, and manager and labourer (p.194).

Almost a decade later Davis-Floyd (1992) interviewed one hundred American, middle class women about their perceptions of birth. She found that almost half of the women saw themselves not as being controlled by technocracy, but as controlling and indeed manipulating the resources available to achieve their own requirements in birth. These women placed an enormous emphasis upon personal control and viewed their bodies as separate and indeed as serving them. Thus they had adopted the Cartesian, split mind-body view. The women saw modern birth facilities as empowering them to control an otherwise unpredictable biological experience. These women demonstrated "conceptual fusion" with "cognitive ease", with the techno-medical model and had come to see separateness and technology as normal and beneficial (p.239). This highlights the strong socialising power of the hegemonic techno-medical model.

Amey (1982) highlights the increasing dependency upon "monitoring, surveillance and normalisation" as the 20th century progressed (p.8). The fetus became the second patient whose safety was placed in the hands of obstetricians, further legitimating a range of interventions. Thus he asserts "the health of the baby, loaded with positive meanings for both mother and physician, justified continued active intervention in childbirth" (p.137). While the fetus grew in importance both literally and metaphorically, a concurrent compromise of feminine ontology occurred. As Blum (1999) states, in regard to erasure of the maternal body, "for the disembodied mother, her body is not her own-but more than that, she is treated, and pressed to treat herself, as if body-less" (p.60).

The experience for women of surveillance and an intrusive dependency on visualisation is highlighted by Duden (1993) as one far removed from nurturing her unborn baby as a "mystery" and "hope" into one of being a vehicle for an endangered, increasingly visible fetus growing within the maternal "ecosystem". She highlights the metaphorical "skinning" and "disembodiment" of woman, so that she serves a "nine month clientage" in which her "scientifically" defined needs for help and counsel are addressed by professionals (p4). This, she argues, necessitates dependency upon visual data that demystifies pregnancy and overrides sensations experienced by the woman. The mechanistic interpretations of such

material place doctors in control of the information and establish abstract information as the defining element of pregnancy.

Surveillance extended beyond the mother and her baby to those providing the service, as discussed above with reference to Foucault's (1977, 1980) discussion of Panopticism. As Amey (1982) states, "Monitoring is the new order of obstetrical control to which not only women and their pregnancies are subject but to which obstetrical personnel themselves are subject" (p102). Thus a system was generated which insidiously encouraged conformity to the techno-medical norms through a complex combination of socialisation and surveillance. While resistances to the technologising of birth are widely reported throughout the 20th century by women's groups, non-governmental organisations and indeed midwives (Lewis 1980, 1990, Oakley 1986, Foley 1998, Edwards 2000, 2001), I argue that the general trend continues towards maintenance and continuation of the techno-medical model of (re)production.[11]

Timing (re)production

The mechanical clock played an increasingly profound role in women's (re)productive experiences. As Forman and Sowton (1989) state, "the insatiable urge of scientists and their technologies to quantify and impose linearity on the life cycle is nowhere more vividly seen than in male-dominated obstetrics" (p. xiii). Over the course of the 20th century, in parallel with increasing hospitalisation, every aspect of women's (re)productive experience became increasingly viewed through the tyrannical lens of linear time (Fox 1989, Kahn 1989, Pizzini 1992, Thomas 1992, Davis-Floyd 1992, 1994, Edwards 2001, Simonds 2002). Thus, as Fox (1989) argues, by substituting a male model of productivity for the archetype of the creative and transformative mother, obstetrics turned birth into a mechanical act and a time bounded process. The pervasive effects of time on women's labouring bodies are emphasised by Thomas (1992):

> Time provides not only a way of describing the distribution of events but also a basis for interpretations and explanations. In reproduction it provides a way of distinguishing between normal and the abnormal, between the abnormal and the pathological. More generally this can be seen as a differentiation of the ordered from the disordered, the orderly from the disorderly (p.65).

While linear time now permeates many aspects of women's (re)productive experiences we see an exponential increase in its oppressive potential as labour progresses and reaches its climax, the birth. A recent discourse analysis of selected obstetric and midwifery texts conducted by Simonds (2002) illustrates the tyranny of obstetric timings well. She states that "obstetrics works on women's bodies to make them stay on time and on course" with the discourse of obstetrics managing pregnancy and birth by "institutionalising rigid time standards, carving procreative time up into increasingly fragmented units, which are imbued with the potential for danger" (p.559, 560). Simonds (2002) further asserts that in obstetric management:

> Interventions have become more common, the notion that obstetrics can - and should-work against the bodily clock that stops too soon or continues too long has gained credence...In obstetrics, time signifies the danger unmanaged women's bodies represent. Now women are bound by the clock rather than leather straps (p563, 568).

Simonds (2002) contrasts this notion of time seen in a classic obstetric text, *Williams Obstetrics* (from 1971-1997) (Cunningham et al 1993), with that seen in Ina May Gaskin's (1990) well known Midwifery text, *Spiritual Midwifery*. Recognising these as ideological poles she asserts that Spiritual Midwifery exemplifies an "essentialist orthodoxy wholly antithetical to medicalized environments and, thus, to prevalent cultural ideology about procreative events" (p.569). The obstetric text centres on women labouring against time while Gaskin's text focuses upon women being active in time, with indeed the focus moving clearly away from any notion of time constraint. Simonds (1992) states in relation to Gaskin's text:

> Time is not something to be rationed; not a scarce commodity that procreating women waste; not a route toward measuring pathology nor, in itself, an indication of pathology; not a series of obstacles against which women's performance must be measured; and

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[11] The rising caesarean section rates provide a crucial indicator that societal fusion with this model persists and indeed grows.

not a means of industrialising the labour process. Time just *is*. Birthing women can take their time, rather than have it taken from them (p.569).

As women's experiences of (re)production were reconstituted and reconfigured by 'Enlightenment' thought, so were their experiences of child-rearing which also became part of women's productive projects, to which I now turn.

Production of people to function in society

Preoccupation with industrial production for profit, eugenicist government concerns to produce sufficient quantities of future citizens to 'man' the army and industry and the super-valuation of rationalistic science pervasively and powerfully influenced child 'care' practices from the 'Enlightenment' period. Although production in the industrial and economic sense was ascribed largely as a matter for men, women in the designated (re)productive role were inextricably linked with production of the next generation. As Lupton (1996) states, "mothers domesticate children, propelling them from the creature of pure instinct and uncontrolled wildness of infancy into the civility and self-regulation of adulthood" (p.39).

This role of the 'good' mother in taming babies and preparing them for the requirements of and scrutiny by society is discussed in depth by Beekman (1977). In his historical analysis of child-rearing practices over the centuries, he highlights the parental project of creating and adapting children to society's demands whilst simultaneously protecting them from society's ills. Consequently child 'care' advice has "reflected the nature of society and morality in a given historical period" (p.xiii). Likewise, science and medicine not only infiltrated women's experiences of pregnancy and birth, but also became central in defining motherhood. As Miller (1998) states:

> Transition to motherhood is surrounded by pervasive ideologies-both biologically determined and socially constructed which can be clearly discerned before and long after a child is born (p.58).

It is crucial at this point to make it clear that we cannot simply see parenting advice and practices as being imposed upon women without regard to the complex socio-economic and cultural influences at play. Women were themselves socialised through society and exposed to the values and imperatives of the times. They participated in dissemination of the current contemporary thoughts on child-care through women's groups and related publications (Lewis 1980, 1990, Apple 1987, Carter 1995, Blum 1999). The material conditions of women's lives likewise influenced child care, for example a working class family would necessarily become engaged in 'producing' children capable of early independence and paid employment as a means of survival for the family. Nevertheless, the pervasive influence of dominant ideologies should not be underestimated.

In reading the works of Foucault (1977, 1981) and Beekman (1977) a central imperative emerges from the Enlightenment period onwards reaching a peak during the Victorian era (1800's), the requirement to mould individuals for the rigours of the factory. This combined with Puritan theology and the Protestant vision led to a growing obsession with authority, discipline, obedience and the desire to rid a child of bad habits such as manifestations of an emerging sexuality, self-love and self-indulgence (Beekman 1977, Foucault 1981). The Victorian obsession with the clock, routines, and schedules again related to the requirements of efficient factory production, meant that the baby could be disciplined by the clock. The progressive urbanisation of society with the accompanying social isolation and rootlessness meant that women increasingly sought and engaged with sources of 'expert advice' in place of intergenerational and embodied knowledges[12].

Beekman (1977) argues that by the 1900s there was a "conscious, systematic effort to actually turn the child into a biological machine" (p110):

> Little was known about children in a scientific sense but a good deal was known about production. Production demanded regularity, repetition and scheduling. All that seemed to be required of the family was that the parents submit to the kind of

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[12] Embodied knowledge may be defined as a subjective knowledge acquired through a person's experiences and perceptions of her/his body (Belenky et al 1986, Hastrup 1995).

systematization and discipline in the handling of their children as was routinely required of factory workers on a production line (p.113).

Although very little was known about children, this era marked the proliferation of scientific/medical dogma and advice related to children (Beekman 1977). From the late 19th and early 20th centuries, as Apple (1987) argues, scientific motherhood was culturally constructed and emerged as a "coherent ideology" (p.97). While women were defined as essentially maternal they were increasingly exhorted to pay regard to scientific and medical expertise. This related in part to government's concerns that the high levels of infant mortality were detrimental in terms of production of men for the army and industries (Doyal and Pennell 1979). This opened the door to a wide range of state interference ranging from education of mothers to comprehensive surveillance through, for example welfare clinics and health visiting (Doyal and Pennell 1979, Oakley 1986, Apple 1987, Lupton 1994, Carter 1995). These were carried out with "little regard for their material circumstances generated by the inequalities within the capitalist economy" (Doyal and Pennell 1979, p.164). An entire industry developed around mothering and baby care. As Apple (1987) describes, baby books and magazines started to flourish from the early 20th century, covering matters such as infant feeding, hygiene and toileting. Advertising in these magazines emphasised the importance of taking professional advice in choosing products, each advocating their own scientific and medically endorsed background.

The obsession with controlling the baby's behaviour combined with the supervaluation of objective rationalistic science reached its zenith when behavioural psychology came into vogue in the 1920s. As Beekman (1977) and Shaffer (1993) illustrate, it was during this period that institutional attitudes *most* powerfully infiltrated the home. The baby was considered to be a blank slate (tabula rasa) and mother and child were expected to be 'separate' both physically and emotionally, with love seen as corrupting. The child was to be taught self-control, routine and discipline with mothers avoiding playing, rocking, cuddling and any form of sensuous activity. Activities of the child were observed, measured, recorded, analysed and all compared to standards being set with increasing authority. This was also the age of sexual restriction, early demanding toilet training, disapproval of nudity, sex play or masturbation (Beekman 1977, Foucault 1981, Shaffer 1993). Blum (1995) asserts that the behaviourists reshaped the norms of embodied attachment as they warned mothers against being over solicitous or rewarding bad behaviour, for example crying, by rocking or cuddling the baby. This, she states was the era of rational discipline, habit training and measured love, *all* under medical supervision!

From the 1930s, as Beekman (1977) notes, society was in a state of flux and the economy in a state of collapse. Scientific ideas related to parenting and children likewise began to be challenged and changed. This led to a gradual emergence in some circles of an emphasis upon emotional interaction between mother and baby and a recognition that the mother should make allowance for the child as guide-in-part to her/his needs. The concept of demand feeding emerging in the 1940s, to which I return, constitutes an example of changing attitudes. Beekman (1977) associates the softening of attitudes with changing views regarding the individual being the mainstay of democracy and changes in societal views evolving during the two world wars. Nazi authoritarianism, for example, caused a major questioning about the desire for parents to exert absolute authority over their children.

It is important to recognise that although trends in child-care changed, there was not a mighty sweep across society. Throughout the remainder of the 20th and into the 21st century ideologies around 'natural' and baby/child-led approaches have been juxtaposed with counter-arguments.[13] Whichever philosophy of parenting women adopt in contemporary western society, they are still expected to civilise their baby with food and eating being key routes to achieving this (Lupton 1996, Schmied 1998). This brief overview of the ways in which the values of society influence parenting therefore sets the scene for my ensuing focus upon infant feeding practices.

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[13] A classical example may be seen in the current upsurge of 'authoritative' texts arguing for a return to the disciplined approaches of the early 20th century. The recent book by Ford (1999), *The Contented Baby Book*, speaks volumes about these contradictory trends. Ford advocates a return to management of the baby using hour-by hour, day-by-day routines, representing a rather chilling re-emphasis upon timings, precision, control and separation.

Formulating infant feeding

The influences of 'Enlightenment' thought

Changes in infant feeding practices from the 'Enlightenment' to the 21st century represent a powerful illustration of the highly complex interaction between dominant ideologies, commerce and women's lives. 'Enlightenment' principles had a profound impact upon subsequent infant feeding practices that I will elaborate upon. However, I avoid presenting breastfeeding, historically, as a 'simple' activity that was conducted exclusively by all until utterly disrupted by science and medicine. While techno-medicine and commercialisation have indeed contributed to a striking disruption of breastfeeding and a dramatic loss of intergenerational, community-based knowledge, this needs to be viewed in connection with the socio-cultural context of women's lives, an issue I discuss under a designated heading. While I acknowledge that there has been considerable hegemonic enculturation of women in this area, as Apple (1987) argues, women actively engaged with and participated in infant feeding practice changes during the past century, with the feminist movement playing a substantial role.

The historical (Fildes 1986) and anthropological literature (Maher 1992a, Dettwyler 1995, Wiessinger 1995, Vincent 1999) make it clear that the global history of infant feeding is very complex with women supplementing breast milk with a range of alternative, symbolic foods often from a very early age, throughout recorded history. Practices were highly varied as influenced by prevailing socio-economic systems, cultural beliefs about the role of women as mothers and the material conditions of women's lives. As Carter (1995) states:

> Many of the building blocks of current discourses have been moulded over centuries. The changing 'fashions' of infant feeding are frequently expressions of the way in which nature, culture and science are conceptualised within any particular period (p35).

It is beyond the scope of this thesis to provide a highly detailed historical account of infant feeding practices over the past three centuries. However, it is useful to illustrate the ways in which Enlightenment thought influenced attitudes to infant feeding in the UK and to link this with the way in which women negotiated this aspect of the mothering role.

Towards the end of the 19th century and into the 20th century there was growing scientific, medical and governmental interest and involvement in infant feeding practices. Prior to this era infant feeding was largely the domain of women. Both public policy and medical recommendations were related to concerns regarding high rates of infant mortality and the quality of the population (Doyal and Pennell 1979, Lewis 1980, Carter 1995). As Doyal and Pennell (1979) note, this agenda was driven by the need for the nation to provide plentiful 'fit' individuals to engage in the various forms of production. The behaviour of the mother was consequently scrutinised and called into question at all stages of the ongoing policy decision-making (Fildes 1989, Carter 1995).

One of the first major areas of debate and subsequent influence appears to be upon the practice of wet nursing, a key way in which women engaged either significant others or paid employees to nurture their babies when they were unavailable or indisposed (Fildes 1989). The medical profession increasingly discredited this practice during the 19th century. They expressed concerns about its biological, social and moral shortcomings, so that by the 20th century wet nursing was virtually non-existent in western culture (Apple 1987, Fildes 1989, Ebrahim 1991, Palmer 1993). Apple (1987) notes that during the same period the quality of the mother's milk or feeding practices came to be scientifically questioned. Although breast milk was considered to be natural and ideal it was proclaimed that not all women could produce enough or adequate milk with a growing list of medical reasons being put forward (Apple 1987, Wolf 2000). As Wolf (2000) states, "the notion that human lactation is an unreliable body function became a cultural truth that has persisted unabated to the present day" (p.93).

The scientific discourses around infant feeding at the turn of the 20th century (Rotch 1890, Budin 1907, Vincent 1910, King 1913) reflected the mechanistic, dualistic and reductionist assumptions of the Enlightenment. They also reflected the growing medical imperative to supervise and regulate women's bodies and minimise the threat of chaos (Palmer 1993, Carter 1995, Blum 1999, Smale 2000). Metaphors used presented breast milk as a disembodied product, produced in a mechanical way as in a classical factory of the times. The woman was

rendered invisible, unless there were problems that she was then blamed for. I have selected a paper to illustrate the discursive incorporation of the key tenets of the techno-medical model.[14]

The context for the paper by Rotch (1890) is clearly that of the industrial production process, with the dominant metaphor being the factory in this case a mill, as highlighted in the statement:

> The breasts of all mammals that suckle their young, are elaborators, producers; they are not storehouses for preserving sustenance for the infant until it is needed; they are beautifully-constructed mills, turning out when demand is made for it, a product which has been directly moulded within their walls, from the material which has been brought to it and through its portals from various parts of the economy (p89).

The baby is clearly the consumer of the product:

> This delicate mechanism adapts itself as to the bulk of its product, elaborating a smaller or greater supply according to the age and again the size of the consumer (p89).

The breasts in several places are referred to as "machinery":

> This machinery is regulated as to the time which it is required at different ages of the consumer to produce the average qualitative food (p.90).

The breasts appear to be viewed by Rotch (1890) as potentially defective in that the constituents and/or volume are easily disturbed and rendered incorrect:

> The epithelial cells are so finely organised, so sensitive with minute nerve connections, that changes of atmosphere, changes in food, the emotions, fatigue, sickness, the catamenia, pregnancy, and many influences, in fact, throw their mechanism out of gear most readily, and change essentially the proportions of their finished product (p.89)

Here the female body is once again represented as a machine that is unpredictable and prone to inefficiency and malfunction.

The mother is largely invisible from the twelve page paper by Rotch (1890), being mentioned only eight times in comparison to numerous references to "the breasts" and "the baby". The language clearly reproduces the Cartesian dualism that compartmentalises the parts of the body and separates them from the person. The text contains repeated reference to the breasts without reference to the mother. In one place, when she is referred to in association with her breasts she is simply referred to as an organism:

> The mechanism of the mammary gland, therefore, is in its most perfect condition after the colostrum period has ceased, and when the general organism, both physical and mental is in a state of rest (p91).

This rendering of the mother as invisible is raised in a number of other critical studies related to pregnancy and childbirth (Oakley 1986, Martin 1987, Duden 1993), but is little discussed in relation to her breastfeeding.

There is frequent reference by Rotch (1890) to the quantities of particular substances and minute breakdown of breast milk substances. The specific quantities of named nutrients, for example albuminoids, are attributed to the woman's diet, temperament and lifestyle and are seen as correctable:

> A sedentary life, with abundance of rich food (provided the woman has a strong healthy digestion) appears to increase the total solids and decrease the water (p.94).

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[14] The paper that I obtained from the Royal Society of Medicine, London was authored by Thomas Rotch (1890) and is entitled, *The management of human breast-milk in cases of difficult infantile digestion.* Rotch was Professor of the diseases of children, Harvard University; Physician to the Infant's Hospital, Boston and Consulting Physician to the Infant's Hospital, London, UK. His work was highly regarded on both sides of the Atlantic and indeed Ralph Vincent, senior physician to the Infant's hospital, Westminster dedicated his text book (1910) *The Nutrition of the Infant* to Rotch "in acknowledgement of his scientific achievements" (vi).

Several tables show the constituents of milk and refer to "normal milk", "poor milk", "over rich milk" and "bad milk" (p.95).

On the occasions in which Rotch (1890) refers to the mother it is in the context of her diet, temperament and behaviour and its influence upon the milk's constituents. Advice is then given as to how to increase specific constituents in the milk, e.g. "a meat or rather nitrogenous diet in the woman increases the fat in her milk" (p.94). Temperament/mental state is blamed for "throwing their (breasts cells) mechanism out of gear most readily and changing essentially the proportions of their finished product" (p.89). Behaviour is scrutinised, for example the mother is also blamed for neglecting to correctly time feed intervals... "a neglect, on the part of the mother, to adhere to the proper intervals for using the machinery results in decided qualitative changes" (p.90). The woman's behaviour is clearly seen to need to be regulated to ensure that the milk is of the right quality and quantity, for example:

> It is physical exercise which we must insist on, preferably walking in the open air, and within the limits of fatigue. An average of from one to two miles twice daily I have found to be about what the average healthy woman needs to reduce her albuminoid percentage (p.95).

The breasts appear to be seen by Rotch (1890) as in need of "management" seemingly independently of their owners! For example "I have a large number of breasts, in private practice especially, but also in the hospitals, pumped for analysis" (p.96). Breast milk itself is seen as in need of management, for example table VI "shows a bad milk, and one which was impossible to manage on account of the continual recurrence of the same cause, uncontrolled emotions" (p.96). Here we see the linking of the above themes of constituents, mother's temperament and how this may or may not be managed. Another illustration is seen in relation to table X headed, "Shows the value of retaining the breast-milk by managing even an unpromising case" (p.98). It is stated, "the above represents a bad milk from the failure of the healthy mother to conform to the rules of lactation" (p.98). This is followed by a meticulously precise description of the incremental improvements in the milk achieved by prescriptive management of the mother in terms of her mental state, pumping of her breast, one mile of exercise and eating more meat.

In summary, the paper by Rotch (1890) exemplifies the techno-medical approach, being worded in authoritative manner, rendering the woman's breasts and breast milk as disembodied from her person and managed as a production process along the highly regimented lines of the factories in existence at the turn of the century. The tone is highly paternalistic, with the mother only being referred to in terms of her correct or incorrect behaviour as dictated by male experts.

In reading some of the early texts about infant feeding (Rotch 1890, Budin 1907, Vincent 1910, King 1913) this fear of chaos and desire to control is highly consistent. An example is provided in the text by Vincent (1910), in this case in relation to overfeeding:

> In all cases the success or failure of maternal nursing must largely depend upon the way in which the practical details are carried out. Where the methods are haphazard, and the mother feeds her infant at all sorts of times, sometimes over feeding and at other times underfeeding it, the results are always unsatisfactory, and the infant is constantly suffering from digestive disturbance in some form; while in other cases the effects are much more serious. Twelve hours after the birth the infant should be put to the breast and allowed to suck for two or three minutes. From this time to the time that the breasts are freely supplying milk, the infant should be given the breast every four hours....It is a serious mistake to allow the infant to take freely of the colostrum when this is plentiful. In anything but a small amount, colostrum seriously disturbs the infant-a fact that is not at all surprising when its chemical constitution is considered (p.40).

The mother is again rendered almost invisible in this scenario, as her breasts are discussed as if independent of the owner, except to comment on failure to follow practical details. The reader is then referred to a table of feed frequencies commencing with the first day and continuing for 4-6 months, with one feed a night permitted until the infant is 12 weeks old when it should be discontinued. Medical anxiety is expressed regarding the initial weight loss with test-weighing becoming a part of the ritual, i.e. weighing before and after a feed in order to calculate the amount of milk taken and routine weighing also being developed as a means of ensuring that the correct amounts were taken. Later regimes also dictated that feeds should be meticulously

and rigidly controlled in terms of time spent at each breast measured to the nearest minute, for example 2 minutes per breast per feed on the first day, 5 minutes on the second day, 7 minutes on the third, 10 minutes on the fourth, and from then on 20 minutes maximum on each breast (Fisher 1985). This led to the baby being deprived of mother's fat rich hind milk creating a hungry dissatisfied baby, the potential to lead to a secondary milk insufficiency and a generally negative experience for the mother (Fisher 1985, Woolridge 1995). In this way, milk insufficiency becomes an embodied reality.

The hospital as centre stage for 'scientific' feeding

The 20th century brought with it the dramatic increase in hospitalisation of women during childbirth and postnatal recovery, as stated. This provided a system in which implementation of practices in line with Enlightenment thought could flourish (Carter 1995). The hospital was the place in which the principles of linear time, production, control and surveillance predominated. Scheduling and placing of rigid time controls upon every aspect of the breastfeeding relationship became central as the 20th century progressed. This scheduling of breastfeeding provides a classic example of the imposition of time constraints upon an inherently cyclical, rhythmical and relational process. As Simonds (2002) states, the "idiosyncratic rhythms of breastfeeding (determined by mothers and newborns) were obfuscated and mechanically regulated by an obsessively precise schedule" (p.566). Millard (1990) provides an excellent illustration of the ways in which the clock became central to medical ideology around infant feeding.[15] She states:

> The clock has provided the main frame of reference, creating regimentation reminiscent of factory work, segmenting breastfeeding into a series of steps, and emphasising efficiency in time and motion (p211)....it has an unparalleled position as a symbol of science, discipline, and the co-ordination of human effort. Its very use in formulating advice thus confers legitimacy on pediatric breastfeeding recommendations in the eyes of both lay women and physicians themselves. The cultural themes implicit in pediatric advice also connect to the clock-the factory model for physiological processes and social co-ordination, the ideal of flexible advice coupled with firm structuring, the ascendancy of professional advice in family matters, the necessity of regularity in maternal-infant interactions (p217).

Balsamo et al's (1992) research highlights the impact of this clock-controlled regimentation upon women. She interviewed forty women in their own homes regarding their experiences of breastfeeding following birthing in hospitals or clinics in Turin in the 1970s and 1980s. Women reported feeling alienated from their bodies and breastfeeding as they conformed to a factory like scheduling of their early mothering and breastfeeding experiences. Balsamo et al (1992) refer to the ways in which paediatric scheduling of breastfeeding brought the mother into a type of time which related to efficiency and productivity derived from industrial/patriarchal society. The imposition of industrial time upon the experience of breastfeeding caused conflict for the women.

With growing hospitalisation came a strong emphasis upon hygiene and the combat of infection. Doctors, midwives and nurses wholeheartedly enforced anti-infection control. As Palmer (1993) describes, the ideas around hygiene also contributed to the development of nurseries and separation of babies from mothers, for the duration of the hospital stay. The babies were attended to by masked nurses in the nurseries and brought to mothers for feeds only. Mothers were required to wear masks and cleansing of their nipples and breasts became routine. As Blum (1999) states, "as hospitals sanitized and covered the mother's body and breasts and scrubbed her nipples, they conveyed that she and her baby were not to be trusted" (p.30). The postnatal ward geography facilitated surveillance and separation of mothers 'safe' distances apart to avoid spread of infection.

The combination of practices described above was highly detrimental to the establishment of breastfeeding, leaving mothers with a profound loss of confidence in their ability to breastfeed (Fisher 1985, Palmer 1993). The loss of confidence was potentiated by the commercialisation of infant feeding, to which I now turn.

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[15] Millard (1990) conducted a literary analysis of 20th century paediatric texts as manifestations of the formal system of biomedical knowledge, in the USA.

The infant formula industry

The growth of the infant formula industry during the late 19th and early 20th century occurred concurrently and symbiotically with the scientific and medical interest in breastfeeding. Palmer (1993) summarises the impetus for this growth during the late 19th century commencing with a scientific interest in the analysis of milk, human and animal, and its conversion into formula for administration via a feeding bottle. The dairy industry was at the same time becoming more efficient and low cost cow's milk increased in availability. The availability of large quantities of surplus milk and the development of milk separation and drying processes encouraged the establishment of milk laboratories during the early 20th century for production of dried formula milk. Developing techniques such as pasteurisation of milk led to what has been described as the "clean milk movement" (Baumslag and Dia 1995, p.120), providing further justification for the "safe" humanisation of milk. The growth of the cheese industry created excess whey products that became increasingly expensive to transport or dispose of, so their use for infant formulae provided the ideal economic solution! (Ebrahim 1991, Palmer 1993).

As the 20th century progressed, the expanding multinational corporations increasingly used placards, posters and the growing media channels such as radio and television to market their products (Sokol 1997). Key advertising messages portrayed breastfeeding as prone to failure, unsophisticated, outmoded and primitive, with bottle feeding being associated with western affluence, consumerism and the liberated woman (Jelliffe and Jelliffe 1978, Palmer 1993). In line with the capitalist and consumerist society, the bottle was incorporated with the advertising of high status commodities such as fast cars and household luxuries (Baer 1982). These images were then juxtaposed by formula companies with images of black women with shrivelled breasts in situations where famine prevailed (Palmer 1993). The promotion of infant formula clearly located infant feeding within the discourses of production and consumerism, concepts central to the market economy.

The proliferation of health care facilities, such as maternity hospitals and child welfare clinics and the increasing hospitalisation of women giving birth during the 20th century provided an ideal focus for the promotion of infant formula. As Palmer (1993) describes, a model of co-operation developed as formula companies and doctors became aware of their interdependence. The formula companies rapidly realised that marketing through health care facilities caused the public to perceive direct endorsement of the products by the health workers and use of such channels enabled massive expansion of their sales. Consequently, they heavily courted medical staff, providing gifts and financial incentives to doctors and hospitals and directing their target consumer groups through doctors in order to obtain formula. As Apple (1987) remarks, the relationships that developed were mutually beneficial in that formula companies increasingly emphasised the importance of medical supervision in making up feeds and the feeding process in general. Doctors in turn endorsed the products that emphasised the importance of medical supervision as scientific and desirable. These two powerful groups, doctors and infant formula manufacturers, in turn influenced government policies.

Oakley (1986) connects the scientific interest in adapting animal milks with the growing infant welfare movement and as part of that development of milk dispensaries:[16]

> The main principle of the milk depot was municipal control over the quality of milk from before it left the cow until the mother opened the municipally-supplied bottle to feed it to her infant. The milk depots thus aimed to cure one cause of maternal fecklessness, namely contaminated milk (p.39).

Oakley (1986) describes this "safe milk movement" as the start of a "systematic investment in the monitoring of maternal behaviour" which was extended to "every crevice of the whole realm of housewifery and motherhood" (p.42). The development of the health visitor accompanied the milk depot movement. Carter (1995) refers to the payoff for the poor, in that if they attended for cheap milk they opened themselves and their lives up for public scrutiny. It was assumed that

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[16] These dispensaries originated in France in the 1890's and the idea took off in Britain and USA during the same decade. There were 15 such depots in Britain by 1907, administered by public health authorities. The purpose was to provide reduced cost, "safe", "humanised" milk and hygienic teats for mothers with the poor being specifically targeted (Oakley 1986, p.39).

women should breastfeed, but if they had a good excuse not to they would be availed of suitable alternatives along with supervision. In the UK, these milk depots became infant welfare centres in 1915 (Carter 1995). The growing state and medical involvement in formula milks served to create the increasing sense that they were medicinal and desirable (Lewis 1980). This notion increased during the two world wars as the government invested in low cost baby milks for mothers in an attempt to improve infant welfare (Carter 1995).

The formula companies influence expanded as the 20th century progressed. They even became involved in the design of hospitals, which no doubt was intended to appear philanthropic. However, as Baer (1982) points out, the design is founded on the principle of maximum separation between mother and baby, with nurseries situated long distances from the mothers' beds. One of the most powerful marketing strategies involved the issue of free milk samples to health centres and hospitals. Company representatives dressed as milk nurses gave free samples directly to mothers when they visited and prior to discharge from hospital. This practice contributed towards the normalisation of infant formula and undermining of breastfeeding (Bergevin et al 1983, Frank et al 1987, Adair et al 1993). Health care information on issues such as growth, with company and brand names, was displayed accompanied by potent messages suggesting that when breast milk was insufficient infant formula was there to ensure optimum growth and health (Sokol 1997).

Infant feeding trends and women's lives

From the end of the 19th century infant feeding 'prescriptions' and practices fluctuated enormously. As the 20th century progressed, the option of providing infant formula to a baby became real and although the general medical message centred upon breastfeeding as being the 'natural' and 'motherly' way to feed there was a concomitant medical acknowledgement that not all mothers could 'manage' this and that there was a safe alternative available (Apple 1987, Carter 1995).

Carter's (1995) in-depth study of women who had babies between 1920 and 1980 in a city in the North East of England highlights the influences upon women's infant feeding decisions. She firstly makes the important point that many women breast and bottle feed and each woman has her own complex, personal, socio-economic and intergenerational context. She conceptualises the situations in which infant feeding is practised as 'working conditions' to avoid seeing breastfeeding as simply a biological activity. This, she argues, provides a "disruptive reading of the dominant narrative of femininity" (p.79). She does, however, urge caution in this conceptualisation, in that it undervalues the relational aspect of infant feeding.

Carter's (1995) interviews revealed that for working class women there were clear conditions that precluded against prolonged and exclusive breastfeeding. These included unhealthy working conditions that were hazardous, time consuming and exhausting. Housing was often cramped with more than one generation co-existing. Breastfeeding became a symbol of poverty, associated with tough living conditions, large families, exhaustion, poverty, discomfort, embarrassment and restriction. Given the relentless demands upon women, Carter argues that bottle feeding provided women with some sense of control over their lives. It also enabled them to resist the exhortations to self-monitor their bodies and control aspects of their lives that were considered to affect their milk, for example their diet, emotions and exercise taken, a point also made by Apple (1987). The growing antipathy towards breastfeeding was compounded by reports of authoritarianism and lack of support in hospital combined with inadequate family support at home (Carter 1995).

Throughout the same period, middle class women and women's groups were engaged in a socio-political movement to demand improved rights and conditions for women (Lewis 1980, 1990). As Blum (1999) notes, while they were more likely to subscribe to medical recommendations middle class women also saw breastfeeding as biologically tying. With the option of wet nursing removed, the bottle and infant formula came to be seen as a symbol of modernity, progress and means to autonomy for affluent women. The clock and linear time were becoming rooted in the lives of women, as described above, and the precision, control and ability to measure infant formula was probably appealing. In contrast to women's socialisation into productive time, breastfeeding, as Carter (1995) notes, came to be seen as an activity conducted in women's own/private time.

Unique to the 20th century was the sexual portrayal of women's breasts through the growing media to sell commodities ranging from peanuts to fast cars and cigarettes (Palmer 1993). Breastfeeding, as stated, also came to be seen as associated with bodily fluids and therefore potentially 'dirty', contaminating and representative of the body being out of control (Bramwell 2001, Bartlett 2002). Consequently, while breastfeeding was commonly referred to as natural, it was becoming far from natural as a public activity creating dissonance, embarrassment and anxiety to women from all social groupings (Dyball 1992, McConville 1994, Van Esterik 1994a, Rodriguez and Frazier 1995, Blum 1999).

The combination of the public-private divide that developed with growing industrialisation and the sexualisation of women's breasts led to breastfeeding becoming increasingly seen as a private activity to be conducted away from the public gaze (Maher 1992b, Carter 1995,). However, as Carter (1995) notes, even in the so-called privacy of the woman's own home breastfeeding is not a neutral activity. Women wherever they were still had to negotiate "what to do, where to do it, in whose presence, and with whose approval it can be done" (p.107). She states, "what remained consistent was women's responsibility for being modest and discreet and checking out the implications of breastfeeding in each particular setting" (p.114).

Another constant throughout this period was the connection made by women's groups and medical establishment that breastfeeding was the natural ideal with a discursive connection being made between mothering, breastfeeding and naturalness (Apple 1987, Leff et al 1994, Carter 1995). This however created many difficulties for women. Firstly, notions of natural as a cultural construction were and are ever changing, as Franklin (1997) states:

> Not only are constructions of the natural culturally and historically specific; they are also shifting and contradictory. As is the case in the analysis of science, a cultural domain to which ideas of the natural are central, it is important not to overstate the discursive or cultural determinism operative in the 'naturalising' process (p.97).

As discussed earlier, the 'natural ideal' was seen as prone to weakness and therefore needing of medical management. It was called into question by the general acknowledgement of the place for infant formula in a variety of circumstances. Equally, breastfeeding was becoming less visible as the sexual breast was growing in visibility. Given the living conditions for many women referred to above, as Carter (1995) reports, the notion of natural mothering and its associations became increasingly unappealing. In advocating breastfeeding as a natural ideal within a culture where this was increasingly no longer the norm, women's confidence was further eroded as noted by Dyball (1992):

> The natural ideal...viewed as yet another cultural construction of our age...can be viewed as having ideological power and therefore as part of the problem for women since it sets the standard which women are unable to achieve because of cultural obstructions (p93).

So, as the 20[th]century progressed women who carried out the deeply embodied experience of breastfeeding were required to increasingly engage in the negotiation of space in which they breast fed, the time in which it was conducted and the relationships with those around them. The combination of barriers and constraints to this negotiation process within the fabric of their daily lives combined with increasing medicalisation of infant feeding and marketing of infant formula, not surprisingly, led to the situation by the 1970s whereby within three to four generations women had turned from predominantly breastfeeding to largely formula feeding.

Efforts to turn the 'clock' back

I now focus upon some of the relevant national and international initiatives that endeavoured to restore, protect, promote and support breastfeeding as a practice.

UK government initiatives

By 1975, recordable breastfeeding rates had reached an all time low in the UK (see table 2.1). Ironically, this was the time when there was also a growing body of scientific research highlighting the nutritional and immunological benefits of breastfeeding for babies. In response to this paradox the UK government conducted and published a series of quinquennial infant feeding surveys that have continued into the 21st century (Martin 1978, Martin and Monk 1982,

Martin and White 1988, White et al 1992, Foster et al 1997, Hamlyn et al 2002). These reports documented breastfeeding initiation and continuation rates as shown in table 2.1[17].

Table 2.1
Percentage of women breastfeeding at birth, 6 weeks and 4 months following the birth.

	1975 Eng & Wales	1980 GB	1985 GB	1990 UK	1995 UK	2000 UK
Birth	51	65	64	62	66	69
6 weeks	24	41	38	39	42	42
4 months	13	26	26	25	27	28

(Martin 1978, Martin and Monk 1982, Martin & White 1988, White et al 1992, Foster et al 1997, Hamlyn et al 2002).[18]

These survey reports were used by the government to inform a series of policy documents[19] (DHSS 1974, DHSS 1978, DHSS 1980, DHSS 1988a, DOH 1994). In the first report it was acknowledged that the UK was largely an "artificially fed nation" (DHSS 1974 p.4), and later after a lengthy discussion about the problems associated with bottle feeding in relation to its specific nutritional and anti-infective components compared to breast milk, it stated:

> We are convinced that satisfactory growth and development after birth is more certain when an infant is fed an adequate volume of breast milk, we recommend that all mothers be encouraged to breastfeed their babies for a minimum of two weeks and preferably for the first four to six months of life (p24).

Between 1975 and 1980s, the rates of women breastfeeding had increased quite markedly (see table 2.1). However, whilst those concerned with increasing rates may have seen the rise as reflective of their efforts, it seems more likely, as Woolridge (1994, 2000) suggests, that the change in women's practices reflected, particularly in the more highly educated sectors of the population, a return to whole foods and a healthier lifestyle. Indeed, figures presented for the sales of wholemeal bread over the last 20 years show a direct correlation with breastfeeding rates (Woolridge 2000). Blum (1999) refers to a similar trend in the USA as the "back to nature movement" (p.44). The breastfeeding rates thereafter have remained relatively static.[20]

In 1988, in response to concerns raised in the above reports and to the high discontinuation rates (DHSS 1988b), the Government set up the Joint Breastfeeding Initiative. This group represented voluntary breastfeeding support groups and health professionals. It was replaced by the National Breastfeeding working group in 1992. The latter was led by a central co-ordinator and a network of health professionals across the UK with a remit to act strategically to improve breastfeeding initiation and continuation rates. However, the paucity of government funding for these networks appears to have seriously limited any impact or effectiveness.

In 1999, the government specifically shifted its focus to one of targeting breastfeeding as a means to reducing inequalities in health (DH 1999), related to the striking demographic variations in breastfeeding rates (Hamlyn et al 2002). For example, 78% of mothers aged 30 or above commenced breastfeeding compared to 46% of mothers aged less than 20. The incidence of breastfeeding in London and South-East was 81% compared to 61% in the North of England. These variations correlated with socio-economic differences and although there were increases in the women in socially excluded areas commencing breastfeeding there were still striking differentials. In the UK, 85% of mothers classified to higher occupations breastfed initially compared with 73% of mothers in intermediate, 59% in lower occupations and 52% among those mothers who had never worked (Hamlyn et al 2002).[21]

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[17] The reports charted infant feeding trends in relation to demographic variables, in particular social class and its correlates such as levels of education beyond age 18, maternal age and place where living.

[18] The dates of publication reflect the 2-3 year period for analysis and compilation of the infant feeding data.

[19] The policy reports were compiled by a working party of the Department of Health and Social Security (DHSS) Committee on Medical Aspects of Food Policy, under the chairmanship of a London paediatrician, Professor Oppe. The underpinning agenda was explicitly the health of infants.

[20] Changes in sample characteristics from 1990 to 2000 render the small rises in rates between these years as even less significant than they appear to be.

[21] ONS National Statistics Socio-Economic Classification NS-SEC.

The government (DH 1999) therefore highlighted that infant feeding practices were an issue related to inequity. This public health issue was highlighted in the Government's NHS Plan in which a commitment to increase breastfeeding rates by 2004 formed part of the proposed strategy to improve diet and nutrition (DH 2000). The NHS Plan prioritised the reduction of health inequalities and highlighted that lower levels of breastfeeding contributed to increased morbidity in lower socio-economic groups with particular reference to cancers and coronary health. The Maternity Care Working Party (2001) document 'Modernising Maternity Care: A Commissioning Toolkit for Primary Care Trusts in England' in line with the government position advocated that service providers should demonstrate effective breastfeeding policies and practices that ensured ongoing support to breastfeeding mothers. Further commitment to increasing breastfeeding rates was reflected in Improvement, Expansion and Reform: The Next Three years Priority and Planning Framework 2003-2006 (DH 2002). This required all NHS Primary Care Trusts to facilitate an audited increase in their breastfeeding initiation rates by 2 percentage points per year with particular focus on women from disadvantaged groups.

While the focus upon socially excluded communities is laudable, government concern has continued with its preoccupation with rates rather than realities for women. However, one important shift may be seen in the government DH funding of seventy-nine breastfeeding practice projects from 1999-2002 (Dykes 2003)[22]. These outreach projects collectively illuminate the constraints and challenges for women and those supporting them in engaging in breastfeeding within communities in which there has been a deeply entrenched bottle feeding culture for several generations.

Breastfeeding support organisations

A concern for the loss of community-based, woman-centred, embodied and experiential knowledge related to breastfeeding led to the development of a range of breastfeeding support organisations, some international, others national. The La Leche League (LLL) was founded in 1956 in the USA in response to the breastfeeding rates having dropped to just over 20% (LLL 2003a). This organisation became established in the UK in the 1970s. The LLL ten point philosophy (LLL 2003b) and statement of purpose (LLL 2003c) is explicit in associating long term breastfeeding with good mothering and its organisational approach reflects this overtly essentialist position (Bobel 2001). The predominant support infrastructure of the LLL is through the development of peer support networks within local communities, specifically those in which women are least likely to breastfeed (LLL 2003d).[23] The peer supporters are mothers who have breastfed or are still breastfeeding. They are provided with a short programme of training that involves understanding their personal experiences and being able to provide mother-to-mother support.

The National Childbirth Trust was established in the UK in 1956 with a focus upon re-establishing birth and breastfeeding as natural and empowering experiences for women (Carter 1995). The Association for Breastfeeding Mothers was founded in 1980 (ABM 2003). The fourth voluntary organisation to become established in the UK was the Breastfeeding Network. This was founded in 1997 by a group of breastfeeding counsellors from the NCT, who objected to the organisation accepting sponsorship from Sainsbury's group of chain stores.[24] The BfN has a constitution that now ensures independence from commercial influence and it has a specific remit to provide 'outreach' breastfeeding support centres within socially deprived communities in an attempt to disrupt the potential development of a 'middle class' image (BfN 2003).

Despite philosophical differences between the four support groups, their fundamental approach is woman-centred and non-directive. The NCT, ABM and BfN provide support to breastfeeding mothers through support groups and one-to-one supporter-mother contact, by telephone or

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[22] I was commissioned by the DH to conduct this evaluation on their behalf.

[23] More recently peer support programmes have also been set up within the NHS, by health professionals (Dykes 2003). In some cases the LLL programme is utilised, in others a training programme is designed specifically. Hereafter, I utilise the term peer support to refer to mother-to-mother support within the same community as those supported and provided by women. The supporters have usually undergone a short training (e.g. 20 hours) in breastfeeding support. This contrasts with the qualified breastfeeding counsellors/supporters who receive a comprehensive 1-2 year programme of training accredited through one of the support organisations. Both peer supporters and breastfeeding counsellors work on a predominantly voluntary basis, but there are also some funded posts for both (Dykes 2003).

[24] Sainsbury's is also a manufacturer of its own brand infant formula and it was this that caused particular outrage by some of the members of the NCT. This sponsorship was subsequently abandoned.

home visit. The comprehensive programme of education has a strong reflexive component allowing the trainees to debrief on their own experiences. The trainees are supported in gaining person-centred counselling skills[25] to include empathic understanding, unconditional positive regard (non-judgemental acceptance) and genuineness. Central to this approach is active listening and validating women in making their own decisions. In this way, supporters combine a collective knowledge of the principles of effective breastfeeding with an individualised woman-to-woman approach that acknowledges women's experiential and embodied knowledge and her own unique circumstances[26]

International initiatives

Concerns within individual countries reflected a larger global effort to increase breastfeeding initiation and continuation rates by attempting initially to reverse the marketing of infant feeding and later the entrenched medical routines affecting infant feeding practices. This stemmed from growing international public concern during the 1970s in relation to the aggressive and unscrupulous marketing techniques used by multinational infant formula companies and their deleterious effects across the globe. The public outrage was initiated by the New Internationalist which prompted War on Want to publish *The Baby Killer* (Muller 1974), describing the advertising activities of the key milk manufacturers to include Nestle, the largest multinational baby food industry. Other publications followed such as *Commerciogenic Malnutrition*, by Jelliffe (1972). As a result of the controversy, the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) convened a meeting in 1979 on Infant and Young Child Feeding. This meeting resulted in a commitment to form an *International Code of Marketing of Breast Milk Substitutes* (WHO 1981)[27]. The WHO Code was established in 1981 in order to protect and encourage breastfeeding and to control inappropriate marketing practices used to sell products for artificial feeding (International Baby Food Action Network 1993). It has now been internationally endorsed but success in implementation is dependent on government commitment, public awareness, strength of powerful vested interests and the dominance of western techno-medicine. Governments that embrace capitalism as their mode of production are reluctant to alienate the multinational companies, as they possess considerable political and economic power. In such societies profit and capital accumulation come first, with inevitable conflict in relation to a national health agenda.

In 1989, following sporadic implementation of the WHO Code and continuing decline in breastfeeding in many countries, a renewed effort was made to reverse the global trend towards the use of infant formula and raise the momentum of political pressure on the infant formula companies. WHO and UNICEF published a joint statement *Protecting, Promoting and Supporting Breastfeeding* (WHO/UNICEF 1989). This statement included Ten Steps To Successful Breast Feeding, hereafter abbreviated to 'Ten Steps' (See Table 2.2)[28]. In 1990, WHO/UNICEF issued *The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding* (WHO/UNICEF 1990). This internationally endorsed declaration contained a comprehensive set of social policy targets to be reached by governments to assist a change of culture and facilitate increased breastfeeding initiation and duration rates. The declaration also contained a commitment to ensure that all maternity facilities meet the 'Ten Steps'. At the 1990 World Summit for Children the Convention on the Rights of the Child was ratified and governments represented reiterated their commitment to the 'Ten Steps' and to banning distribution of free and low cost breast milk substitutes to maternity facilities (Grant 1995).

[25] Person-centred counselling stems from the humanistic approach advocated by Carl Rogers (Rogers 1961).

[26] Having been a member of the NCT for several years until I joined the BfN at its outset in 1997, I have become aware of the differing nature of the voluntary supporter/counsellor approaches from that of midwives. I refer to the approaches of the support organisations here in that they provide an important contrast to the institutionalised forms of support for breastfeeding women that I witnessed during the ethnographic work and therefore they have relevance to my conclusions.

[27] Commonly referred to as the WHO Code.

[28] The 'Ten Steps' were constructed by the WHO/UNICEF to reflect what WHO/UNICEF felt were the crucial principles emerging from relevant research. This research underpinning the 'Ten Steps' is summarised in a related document (WHO 1998). However, many health care facilities were already involved in implementing some or all of these practices within maternity services to varying degrees.

Table 2.2
Ten Steps to Successful Breastfeeding

Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infant should:

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.

2. Train all healthcare staff in skills necessary to implement the breastfeeding policy.

3. Inform all pregnant women about the benefits and management of breastfeeding.

4. Help mothers initiate breastfeeding within half an hour of birth.

5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants.

6. Give newborn infants no food or drink other than breast milk, unless medically indicated.

7. Practice rooming-in, allowing mothers and infants to remain together 24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

(WHO/UNICEF 1989)

In 1991 WHO/UNICEF launched its global 'Baby Friendly Hospital Initiative' (BFHI). The purpose of this initiative was to support the development of an infrastructure by maternity care facilities which enabled them to implement the 'Ten Steps' (WHO/UNICEF 1989). WHO and UNICEF were then involved in setting up national teams in participating countries, with the remit of co-ordinating and monitoring implementation in hospitals. A Baby Friendly Award is issued to those deemed to have reached a minimum externally auditable standard in relation to the 'Ten Steps'[29]. The Baby Friendly Hospital Initiative was adopted in the UK in 1994 and was renamed the Baby Friendly Initiative (BFI)[30] to emphasise that it was not simply related to hospitals.[31]

Baby Friendly Hospital Initiative (BFHI)

It is not my purpose in this thesis to focus specifically upon the BFHI and the 'Ten Steps' and their impact upon practice and women's experiences in hospital. However, they play a considerable role in the nature of breastfeeding support offered to women in UK maternity units and therefore I present and discuss its key tenets. Maternity units in the UK are at various stages in engaging with the BFHI.[32] Some units are implementing aspects of the research underpinning the 'Ten Steps' without any specific reference to them or to the BFHI[33]. This may or may not involve use of some of the BFHI leaflets and posters. Some units have a certificate of commitment indicating that they are intending to apply to be assessed for the 'Baby Friendly Award' in the future. Other units have received the 'Baby Friendly Award' and are engaged in

[29] While the 'Ten Steps' relate to several WHO Initiatives, they tend to be associated by most with the BFHI.
[30] To distinguish between the global initiative and the UK branch of the initiative I utilise the abbreviation BFHI for the former and BFI for the latter.
[31] In recognition of the need to include community facilities, such as health centres, UNICEF UK also produced an adapted version of the 'Ten Steps' referred to as the 'Seven Point Community Plan' (UNICEF UK BFI 2001a).
[32] At the time of writing, there were 47 maternity units or community services with the 'Baby Friendly Award' and 75 facilities with a certificate of commitment (UNICEF UK BFI 2003).
[33] As in site 2 in this study.

maintaining the standards required pending reassessment. Some units have lost the 'Baby Friendly Award' due to a failed reassessment but are working towards reapplication. Other units have lost the award and have decided to no longer continue to engage with the initiative, although they may still retain a substantial engagement with the principles underpinning the 'Ten Steps'.[34] This leads to a complex and partial picture as to the impact of the initiative upon the experiences of breastfeeding women.[35]

The BFHI lies at the heart of a number of paradoxes and dilemmas that continue to challenge me. The paradoxes stem partly from the attempt to make uniform changes across the globe in enormously diverse cultural settings. At first glance the comprehensive initiative seems to provide 'the answer' to the *world's* breastfeeding problems. It's philosophy is one of 'simple' reversal, i.e. remove constraints such as routines, advertising of alternatives to breastfeeding, bottles, teats, hospital nurseries, uneducated health staff....*uneducated mothers* and all may journey 'back in time' to a place in which breastfeeding is restored as the norm, firstly in hospitals and then in communities. All stand to benefit, mothers, babies, health care systems and societies. The only losers are the infant formula companies and 'fat cats' associated with them. This simple, global, solution becomes particularly appealing when one takes into account the devastation that the introduction of western medical dogma and commercial activity has had upon non-western communities and women's birthing and breastfeeding experiences. The knowledge of women labouring and birthing on uncovered metal trolleys, in lithotomy position, with their babies being forcibly extracted, removed and separated to a stark nursery and fed breast milk substitutes are alarming and real[36]. The first hand accounts of Palmer (1993) related to the effects of poverty and lack of access to clean water upon the lives of babies and families when women utilise breast milk substitutes for their babies are equally devastating.

However, while the need for reversal of such inhumane practices is urgent and pressing, the mechanism by which change is managed and sustained needs to be further scrutinised. Ironically, the BFHI, an initiative which attempts to reverse medically instigated mother-baby separations and infant feeding routines, is being implemented in the same medical settings, i.e. hospitals, by utilising strict rules, policies, protocols and monitoring to manage the hospital culture. In this way it constitutes a 'natural medical model' with all its inherent paradoxes. The mode of implementation of the BFHI has involved what Wright (1998) describes, in relation to the general politicisation of culture, as a deliberate unsettling and replacing of a dominant ideology. This requires not just political activity but the making of interventions in "culture", involving manipulation of words, renaming and redefining key concepts. I therefore argue that the aim is to create a new ideology which, as Wright describes, "becomes so naturalised, taken for granted and 'true' that alternatives are beyond the limits of the thinkable" (p.5). In this way the new ideology appears to offer a medically mediated return to elements of a 'natural ideal'. It thus maintains hegemonic and authoritative power to permit 'experts' to define what is 'normal' or 'correct' while inadequately accounting for the political and socio-cultural complexities underpinning women's ongoing decisions regarding infant feeding. To illuminate some of the dilemmas and paradoxes further I now discuss each of the 'Ten Steps' in turn.

Step 1:
Have a written breastfeeding policy that is routinely communicated to all healthcare staff.

Step 1 requires a participating hospital to develop a breastfeeding policy which incorporates the 'Ten Steps' along with an institutional ban on advertising of infant formula (WHO/UNICEF 1992). The basis for this 'step' centres around the need to encourage provision of consistent evidence-based practice, based on the 'Ten Steps'. Taking a positive view, given the high levels of conflicting information offered to breastfeeding women (Garforth and Garcia 1989, Rajan 1993, Garcia et al 1998, Tarkka et al 1998, Dykes and Williams 1999, Hoddinott and Pill 2000, Lavender et al 2000, Simmons 2002a,b), this would seem to be highly justified. However, the counterbalancing issue to a reduction in conflicting information stems from the potential for such a policy to carry with it a rigidity that takes little account of the experiential knowledge of midwives and mothers. Secondly, it does not acknowledge the constraints upon midwives in relation to other priorities upon their time (West and Topping 2000, Stein et al 2000). The way

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[34] As in site 1 in this study.

[35] Research to date has largely focused upon the significant impact of implementation of the BFHI upon breastfeeding initiation and duration rates but has little to say regarding women's experiences within the specific cultural settings (Kramer et al 2001, Phillip et al 2001).

[36] Recent exposure to pictures taken with permission from mothers, in a non-western hospital, by a friend who works as a consultant for WHO have left me with a renewed, profound sense of horror.

in which these strengths and weaknesses manifest and interact is likely to relate to the nature of the institution within which the 'Ten Steps' are implemented and the mechanisms employed for operationalisation and audit.

Step 2:
Train all healthcare staff in skills necessary to implement the breastfeeding policy.

Step 2 advocates the provision of a programme of education for staff that makes them fully aware of the 'Ten Steps'. It is clearly acknowledged that this education needs to affect attitudes, knowledge and skills for it to make an impact upon practice. Again, the outcome of the education will depend very much upon the way in which this education is facilitated. Evaluations of a range of BFHI courses have demonstrated changes in attitudes, knowledge and skills (Bradley and Meme 1992, Valdes et al 1995, Westpall et al 1995, Dinwoodie et al 2000, Hall et al 2000, Wissett et al 2000). However, there is only one study that has involved assessment of effectiveness of these skills in the clinical setting (Rea et al 1999). This study showed an improvement in assessed knowledge, clinical and counselling skills. None of the studies qualitatively assessed the outcome of training from the breastfeeding women's perspective.

Step 3:
Inform all pregnant women about the benefits and management of breastfeeding.

Step 3 centres upon women being offered information about the health benefits of breastfeeding for mother and baby and secondly, information related to effective breastfeeding practices. However, a didactic transfer of information on potential health gains, in line with other parent-craft approaches in the UK, assumes that women make decisions in a rationale goal-orientated way, which is often not the case (Hoddinott and Pill 1999a,b). A didactic approach has been shown to have little impact upon the number of women who decide to initiate or continue to breastfeed (WHO 1998, Fairbank et al 2000). It may be contributing to women commencing breastfeeding without addressing the long term, socio-cultural and motivational issues facing women. This approach has the potential to create feelings of failure in women who experience difficulties with breastfeeding and discontinue (Schmied 1998, Moxingo 2000, Schmied et al 2001). The form of antenatal education that does appear to be valued by women is that based on an informal, interactive and skills-based approach (Duffy et al 1997, Britton 1998, 2000, Cox and Turnbull 1998, Sheehan 1999, Dykes 2003).

Step 4:
Help mothers initiate breastfeeding within half an hour of birth.[37]

Step 4 advocates the close and prolonged skin-to-skin contact between mother and baby following the birth. This recommendation is based on the video recorded observations by Widstrom et al (1987) and Righard and Alade (1990). These video recordings dramatically illustrate the innate ability of an unsedated baby to crawl up his/her mother's abdomen, reach for her breast and suckle. The experience for some women is powerfully transformative (Odent 1992, Price 2003) and reduces crying and distress in the baby (Christensson et al 1995). It is also argued that this practice is in line with 'bonding' theory (Klaus et al 1970, 1972) and is therefore likely to benefit the mother-baby relationship (Klaus et al 1970, 1972, Ball 1994, Sheridan 1999). Research tends to focus mainly upon demonstrating that early skin-to-skin contact and suckling increase the duration for which women breastfeed (de Chateau and Wiberg 1977, Sosa et al 1978, Ali and Lowry 1981), although this assertion has recently been challenged (Carfoot et al 2003). In order to operationalise this recommendation WHO state "an arbitrary but practical minimum recommendation is for skin-to-skin contact to start *within at most* half-an-hour of birth *and to continue for at least* 30 minutes" (WHO 1998 p.35). WHO (1998) and UNICEF UK BFI (2001a) strongly emphasise that this recommendation constitutes a minimum. However, when these linear-time orientated guidelines are implemented within a medicalised setting they have the potential to create prescriptive practices far removed from those that would occur following a birth without interference. Again the cultural context within which this practice is encouraged is likely to be crucial to woman's experiences.

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[37] In the UK this step has been reworded to "Help mothers initiate breastfeeding soon after birth" (UNICEF UK BFI 2001a, p.13).

Step 5
Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants.

Step 5 places emphasis upon women being offered early assistance with and information about breastfeeding within six hours of their birth, in addition to support offered during skin-to-skin contact. It also requires that mothers are shown how to hand express while in hospital and are assisted in expressing and giving milk to the baby if separated (WHO 1992). There is considerable emphasis placed on the importance of effective attachment of the baby to her/his mother's breast in reducing nipple pain and prolonging breastfeeding, based on the work of Woolridge (1986a, b) and Righard and Alade (1992). However, of concern is the growing emphasis upon technique to the detriment of other ways of supporting women, leading to a technically prescriptive approach to care, dramatically illustrated by Colson's critique (1998a,b).[38] It seems then that while rituals centring on rigid timing of feeds are fading, new rituals based on technique may be appearing. As Smale (1996) highlights, "where practice is changed without social agreement to a change in principles, it is possible that new forms of ritual and conditionalities will appear" (p.309). While there are clearly useful principles that women may apply to support them with effective attachment of their baby to their breast and which support ongoing breastfeeding, simply teaching specific techniques and issuing pre-defined packages of information is unlikely to meet individual needs, an issue I return to later.

Step 6
Give newborn infants no food or drink other than breast milk, unless medically indicated.

Step 6 attempts to reverse the medical practice of issuing supplements of formula to breastfed babies. This is based upon growing understandings of the health gains for the baby related to the recommended practice of exclusive breastfeeding for 6 months (WHO 2001a, WHO 2002, Kramer and Kakuma 2003). Research in this area is substantial and growing in methodological sophistication, for example Wilson et al (1998), Anderson et al (1999), Oddy et al (1999). In developing countries giving bottles of formula may be devastating due to difficulties with sterilisation and the cost of purchasing formula (Victora et al 1987). Giving formula by bottle to breastfed babies is also linked to early cessation of breastfeeding (Nylander et al 1991, Perez-Escamilla et al 1994). Few breastfeeding advocates would dispute the benefits of the exclusive approach to breastfeeding. However, its practice is highly sporadic globally (Maher 1992a, Vincent 1999) and research attention focused upon women's experiences related to achievement of this ideal has been neglected. As Dyball (1992) states:

> The more influential the natural ideal becomes, the more having to resort to bottle-feeding, whether for nutritional or social reasons, is likely to represent to mothers a compromise, a failure to achieve the ideal: either their bodies have failed to supply the nourishment needed, or they were not sufficiently self-sacrificing or well organised to cope with breastfeeding and the other demands of their every day lives (p.348).

Research conducted in Australia (Schmeid and Barclay 1999, Schmeid et al 2001) and USA (Mozingo et al 2000), based on in-depth interviews with women, is beginning to highlight the emotional difficulties for breastfeeding mothers in connecting advocated gold standards with their perceptions of themselves as mothers (Schmeid and Barclay 1999, Schmeid et al 2001). I return to this issue and address it in some depth in chapter 6, based on the data in this thesis.

Step 7
Practice rooming-in, allowing mothers and infants to remain together 24 hours a day.

Step 7 emphasises mothers and babies remaining together, day and night while in hospital thereby crucially reversing the enforced separation characteristic in earlier decades. Rooming-in was being advocated in some hospitals as early as 1948 (Apple 1987). It is also advocated in line with 'bonding theory' (Klaus et al 1970, 1972). The usual model involves the baby being placed in a cot beside the mother's bed. In some maternity units bedding-in, that is the baby being with her/his mother in bed is also encouraged (UNICEF 2001a,b). This constitutes a remarkable reversal of the earlier 'separation' philosophy. Research on rooming-in indicates

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[38] The growing emphasis upon prescriptive and intricate focus upon minutiae of technique is evident in a current DH funded 'Best Start' project (Carson 2001). This randomised controlled trial, to be published in 2004, utilised a highly detailed additional information giving session lasting 20-30 minutes to the experimental group of women.

that it increases the duration for which women breastfeed (Elander and Lindberg 1984, 1986, Strachan-Lindenberg et al 1990, Fairbank 2000). This is likely to relate to its association with ease of demand feeding (WHO 1998). It also ironically lowers the risk of infection to the new-born, which contradicts one of the key rationales for separation in the first place (WHO 1998). To ensure compliance by hospital staff many UK maternity units have simply dispensed with their nurseries. However, the stipulation that separation of mother and baby should *only* occur for up to one hour, for hospital procedures (WHO/UNICEF 1992) has been criticised by some as being inflexible, culturally insensitive and not conducive to rest (Cuttini et al 1995, Rice 1999, 2000). The work of Keefe (1988) is commonly quoted to counter objections, based on women's need for sleep. Keefe (1988) reported that there were no significant differences between hours and quality of sleep between a rooming-in group of women and those with their babies placed in a nursery at night. The difficulty seems to lie again in the pendulum having swung from one extreme to the other with insufficient emphasis upon the impact of this upon individual women's situations and experiences of breastfeeding. This is a cause for concern, with regard to women's emotional well-being, when rooming-in is accompanied by inadequate health professional support, as reported by Ball (1994).

Step 8
Encourage breastfeeding on demand.

Step 8 advocates that mothers avoid any restrictions upon breastfeeds in terms of frequency or duration, allowing the baby to feed whenever s/he is hungry. This is another clear reversal of the restricted practices advocated earlier in the century. Demand feeding appeared in the western literature in the 1950s (Illingworth and Stone 1952) but did not become a firmly established concept until the 1980s, with a particularly strong emphasis developing over the last ten years as a key recommendation of the BFHI. The concept came about with the recognition that if babies are given unlimited and un-timed access to their mother's breast then they would be able to regulate their own calorific and nutritional requirements. This body of knowledge has grown over the last 30 years and is summarised by Woolridge (1995). Demand feeding is associated with increased duration for which women breastfeed (Illingworth and Stone 1952, Slaven and Harvey 1981, Martines et al 1989). Again, while the physiological basis for demand feeding is strong, as Smale (1996) asserts, there has been little reference to women's abilities and experiences of responding to their baby's needs in this way. She highlights that:

> The vocabulary of the two main styles of breastfeeding "demand" and "schedule" feeding, carry considerable emotive weight; demand might be thought of as a strange word to use of any other member of a family requesting food when hungry (p.238).

To complicate matters further, the pendulum is still in motion regarding these two approaches with a resurgence of "schedule" advocates, for example Ford (1999), who contest the notion of the baby being placed in control. The emphasis instead is placed on timing and discipline in discourses barely distinguishable from those written a century ago.

Step 9
Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

Step 9 is underpinned by the belief that suckling on a teat alters the oral dynamics of breastfeeding and undermines a woman's milk-making potential related to under-stimulation of her breasts (WHO 1998). The research quoted in this context centres upon an association between pacifier use and early cessation of breastfeeding (Newman 1990, Victora et al 1997, Righard 1998, Aarts et al 1999, Howard et al 1999). However, a direct relationship cannot be inferred due to the issue of reverse causality, that is a mother having breastfeeding problems is more likely to use a pacifier to placate her baby (Victora et al 1997). The removal of dummies and teats in hospital does not in itself reverse the deeply entrenched culture of dummy usage within many communities across the globe.

Step 10
Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

This step recognises the importance of continuing support once a mother goes home from hospital. This may include continued support via the maternity service or by qualified breastfeeding counsellors/supporters and/or peer supporters. Midwives are expected to make

sure that women know about local groups and how to contact them, before they go home from hospital. This is indeed a crucial step but in some settings it may not extend past the simple issuing of contact numbers. While issuing telephone numbers may be of some help it does not necessarily ensure that women feel confident enough to access the community support infrastructure.

As may be seen there are many complex issues related to each of the 'Ten Steps' and their implementation. I return to these in chapters 6-10 in relation to the data generated in this thesis.

Continuing challenges

I now build a 'picture' of the current context within which women breastfeed in the UK, with particular reference to their early experiences of breastfeeding. In doing so, I set the scene for the research conducted as part of this thesis.

Contradictions for breastfeeding women

Despite the range of initiatives, breastfeeding rates have remained relatively static between 1980 and 2000, as illustrated in table 2.1. This stasis in rates superficially reflects the ongoing barriers and constraints for women during the latter part of the 20th and beginning of the 21st centuries. While the quinquennial review data is useful in providing an overview of population trends, as Smale (1996) states, it "excludes the personal voice" (p.4). In redressing the lack of personal voice there is a growing body of qualitative research that highlights the reasons why women do not breastfeed at all, prefer to partially breastfeed or discontinue breastfeeding early. This relates to a range of dilemmas and paradoxes surrounding breastfeeding.

Firstly, the general view that 'breast is best' has become ideologically pervasive and yet the multiple constraints are ever present. This 'double-think' is perhaps best summarised by Blum (1999). She refers to two contradictory trends in the USA, the dramatic increase in mother's wage earning activities and the revival of breastfeeding prescriptions:

> These two trends 'work' through (and on) maternal bodies - bodies which have to get out into the public sphere, to seek autonomy, but also to engage in a most interdependent, private and time consuming act (p.42).

The growing pressure upon women to be a part of the paid workforce is equalled only by the growing emphasis upon breastfeeding and increasingly exclusive breastfeeding for 6 months being 'best' (WHO 2002, Kramer and Kakuma 2003). Indeed, for the first time, in the 2000 quinquennial infant feeding survey 9% of women who breastfed stated that they felt pressured into breastfeeding, with the figure being 12% for first time mothers who breastfed. This pressure was mainly linked to midwives (76% of those reporting this feeling), a finding supported by Battersby (2000).

In addition to this double imperative to 'work' and breastfeed, many women in the UK still feel dissonant about breastfeeding in public. This relates to the inherent ambiguities between breastfeeding as a maternal activity and breasts being increasingly and ever more explicitly displayed throughout every media channel as sexual items (Hawkins and Heard 2001, Pain et al 2001, Mahon-Daly and Andrews 2002). Breastfeeding is still portrayed in the media and experienced by many women, particularly in socially deprived communities, as a marginal and liminal activity, rarely seen and barely spoken about (Hoddinott and Pill 1999a,b, Henderson et al 2000, Mahon-Daly & Andrews 2002). Women therefore continue to constantly negotiate the places and spaces in which they breastfeed (Pain et al 2001, Mahon-Daly and Andrews 2002).

Qualitative research also highlights that women continue to lack confidence in their ability to breastfeed (Hoddinott and Pill 1999a,b, Blyth et al 2002) and in particular their capacity to provide sufficient milk for their babies (Dykes and Williams 1999, Hawkins and Heard 2001, Dykes 2002). The latter is supported by the infant feeding surveys which show that one of the three key reasons given by women for discontinuing breastfeeding is still 'insufficient milk/baby hungry' (Foster et al 1997, Hamlyn et al 2002).

This emerging body of qualitative research points to the need for understanding women's decisions related to infant feeding through a socio-cultural conceptual lens. In addition to these

socio-cultural constraints women repeatedly report that the support from health professionals, particularly in hospital, is inadequate as I subsequently illustrate.

Women's early breastfeeding experiences

As stated, it is crucial to acknowledge the socio-cultural and emotional constraints upon women in relation to their infant feeding trajectories. The steepest decline in breastfeeding rates occurs during the first week with 16% of women who commenced breastfeeding having stopped altogether by one week in 2000 (Hamlyn et al 2002), the period during which women spend time in hospital. The three key reasons given by women for discontinuing breastfeeding in hospital were: the baby fussing and/or not latching onto his/her mother's breast; sore or cracked nipples; and the mother's perception that she has insufficient milk to satisfy her baby (Foster et al 1997, Hamlyn et al 2002).

Breastfeeding women are carrying out a partially learned activity which in the absence of exposure during the socialisation process combined with low levels of knowledge and support within a given community, requires support from health professionals (Renfrew et al 2000). This is particularly the case when a women enters a postnatal ward where she is separated from her family and friends for long periods throughout the day and night. However, the failure to meet women's needs on UK postnatal wards has been repeatedly highlighted (Filshie et al 1981, Maternity Services Advisory Committee 1985, House of Commons 1992, Ball 1994, Audit Commission 1997, Garcia et al 1998, Singh and Newburn 2000a, Briscoe et al 2002). Even within innovative schemes such as One-to-One Midwifery, that raised women's general satisfaction with maternity care, women still tended to feel less satisfied with hospital postnatal care (McCourt et al 1998). Low satisfaction with hospital postnatal care has also been reported in other countries, for example Australia (Stamp and Crowther 1994, Yelland et al 1998, Rice et al 1999) and Finland (Bondas-Salonen 1998).

The UK Audit Commission survey of women's views of maternity care (Garcia et al 1998) demonstrated that on postnatal wards, 24% of women reported receiving inconsistent advice (n=1,512), 16% insufficient practical help (n=1,499) and 18% insufficient active support and encouragement (n=1,510) (p.52). These findings were backed by the recent National Childbirth Trust report on women's experiences of postnatal care in a survey of 960 women who gave birth in 1999 or 2000. Only approximately 50% felt that their physical needs were being met and around 60% did not feel that their emotional needs were being met. First time mothers and those who had had a Caesarean Section were least satisfied with their care. In particular, women wanted more information and support commenting on shortages of staff. A quarter of respondents did not feel that staff were kind and understanding. One in five felt that staff could have been more respectful. The first few days after the birth were particularly criticised (Singh and Newburn 2000a,b). In the light of these reports and the continuing levels of conflicting advice the need for improved practical help, encouragement and support for women breastfeeding in hospital is acknowledged (Renfrew et al 2000).

A number of international studies have focused specifically on the influence of the timing of postnatal discharge upon women's breastfeeding patterns in the UK (Winterburn and Fraser 2000), Sweden (Waldenstrom et al 1987, Svedulf 1998) and North America (Margolis and Schwartz 2000, Sheehan et al 2001, McKeever et al 2002). However, the results are equivocal due to heterogeneity of the studies and methodological limitations. McKeever et al (2002) randomised women into two groups, a standard care and length of hospital stay versus earlier postnatal discharge with additional support from nurses who were also lactation consultants. The latter group were significantly more likely to sustain breastfeeding. However, as with other studies (Margolis and Schwartz 2000), this is more a comparison of types of support rather than 'place' in that in the early discharge group, women were receiving additional support from a health professional with a specific interest in breastfeeding. This support tends to increase breastfeeding duration (de Oliveira 2001, Sikorski and Renfrew 2003). Winterburn and Fraser (2000) randomised women into early (6-48 hours) or longer (3-7 days) postnatal discharges and reported no significant differences in breastfeeding rates. However, they acknowledge that a serious problem with the study stemmed from women's reluctance to remain in hospital, an important finding in itself! Indeed, Sheehan et al's (2001) survey leads to the conclusion that a postpartum stay of over 48 hours constitutes a "risk factor" for early discontinuation of breastfeeding (p.218). In summary, remaining in hospital versus early postnatal discharge does not appear to be of benefit to breastfeeding women and as Brown et al (2003) confirm has no significant impact upon breastfeeding rates.

A range of international studies have been conducted evaluating supportive interventions in hospital usually in the form of breastfeeding information packages issued to women by individuals with specialist skills (Grossman 1990, Redman 1995, Hoyer and Horvat 2000, Porteous et al 2000). However, the packages of information tend to be pre-defined by the researchers and as most interventions involve an element of community follow through, the isolated effect of the hospital support is difficult to evaluate. A systematic evaluation by Sikorski and Renfrew (2001) demonstrated that such interventions increase the numbers of women breastfeeding their babies until the age of 2 months. However, they exercise caution in interpreting the research as the supportive interventions during the postnatal period, levels of expertise of supporters and adherence to the support protocols were diverse and poorly defined. Sikorski and Renfrew (2001) recommend that there is a need for "fundamental qualitative research exploring different elements of breastfeeding support strategies" (p.8).

Research has also been conducted to evaluate very focused interventions to improve women's skills at attaching their baby to their breast. However, the results of such prescriptive studies to date are varied, for example Righard and Alade (1992) demonstrated a statistically significant increase in continuation rates in Scandinavia. Subsequent studies have not produced statistically significant improvements (Schy et al 1996, Henderson 2001, Woods et al 2002). However, Schy et al (1996) highlighted as a result of a factor analysis associated with their study that professional encouragement, satisfaction with the experience and familial relationships were important to women. This finding suggests that more research is needed related to women's experiences of breastfeeding in hospital to elicit factors which they perceive to be important in relation to early breastfeeding.

Only a few recent studies have adopted this woman-centred perspective specifically in relation to their breastfeeding experience in hospital. Vogel and Mitchell (1998) conducted focus groups with 45 mothers in New Zealand to elicit reasons for women discontinuing to breastfeed in hospital. Key factors highlighted were insufficient staff time, lack of continuity, staff who lacked the knowledge to teach the necessary skills and who "rammed the baby on", conflicting advice, noise, embarrassment and anxiety related to learning to feed in front of others and keeping others awake. Tarkka et al (1998) used questionnaires to collect data from 326 mothers in Finland regarding factors that contribute to breastfeeding success following childbirth on a maternity ward. Important factors that influenced women's ability to cope with breastfeeding in hospital were elicited using a logistic regression analysis. They included the effective harnessing of family support within hospital and ways in which the mother was assisted to feel rested, confident and less anxious.

Mozingo et al (2000) conducted a phenomenological study with 9 American women who discontinued breastfeeding in the first two weeks following the birth. The women described a clash between the reality of breastfeeding and their idealised notions contributed to by insensitive and intrusive approaches by nurses and inconsistent information. Mozingo et al (2000) recommend enormous sensitivity in approach by nurses, respect for maternal boundaries and the ability to offer consistent evidence-based advice to women. Bowes and Domokos (1998) conducted semi-structured interviews with 62 women of Pakistani heritage and 68 white women in a retrospective study related to women's experiences of the UK maternity system. From the data that related to women's experiences of breastfeeding in hospital, they theorised that breastfeeding was a negotiated process with success being related partly to women's existing knowledge, to access to staff with the skills to assist them at crucial moments and their personal ability to actively articulate their needs. The latter two factors became particularly relevant when the staff were busy, causing the women to have to compete for the limited resources. This favoured the more assertive and articulate women. However, even women who were knowledgeable about breastfeeding reported difficulties in challenging the 'expert' knowledge of hospital staff.

A synthesis of the literature that focuses specifically on the influence of professional encounters upon women's perception of their early breastfeeding experiences, which in most cases also encompasses aspects of their experiences of postnatal wards, illustrates the ways in which women need support with breastfeeding. The reverse of these categories make women feel unsupported, for example encouragement contrasts with discouragement.

Women repeatedly state that emotional support is crucial, to include a sense of being cared for and the staff showing concern and empathy (Tarkka and Paunenen 1996, Bondas-Salonen

1998, Bowes and Domokos 1998, Svedulf 1998, Tarkka et al 1998, Vogel and Mitchell 1998, Whelan and Lupton 1998, Hoddinott and Pill 2000, Hauck 2002). The forming of a relationship with the health carer(s) is valued although not necessarily expected (Vogel and Mitchell 1998, Whelan and Lupton 1998, Hoddinott and Pill 2000, Porteous et al 2000, Raisler 2000, Hauck 2002, McKeever et al 2002). Help with coping with emotions (Hoddinott and Pill 2000) general professional sensitivity (Mozingo et al 2000) and protection from embarrassment caused by learning to breastfeed in front of others or feeling that it is offensive to others (Vogel and Mitchell 1998, Hoddinott and Pill 2000, Hauck 2002) all relate to feeling cared for. Women welcome receiving adequate staff time and availability in contrast to feeling rushed (Tarkka and Paunenen 1996, Bondas-Salonen 1998, Bowes and Domokos 1998, Svedulf 1998, Tarkka et al 1998, Vogel and Mitchell 1998, Whelan and Lupton 1998, Hoddinott and Pill 2000, Hauck 2002, Hong et al 2003). They prefer a quiet hospital environment in which the mother is assisted in feeling rested, confident and less anxious (Ball 1994, Tarkka and Paunenen 1996, Bondas-Salonen 1998, Tarkka et al 1998, Vogel and Mitchell 1998).

Professional encouragement and confidence building are highly valued by women (Ball 1994, Schy et al 1996, Humenick et al 1998, Svedulf et al 1998, Hoddinott and Pill 2000, Gill 2001, McCreath et al 2001, Hauck et al 2002, Ingram et al 2002). This includes reassurance of the baby's well being (Hoddinott and Pill 2000) and that early difficulties may be overcome (Mozingo et al 2000, Hauck 2002).

In relation to the provision of information, women value respect for individuality versus standardised advice (Hauck et al 2002, Hoddinott and Pill 2000) and provision of information that is realistic, useful and accurate (Rajan 1993, Svedulf 1998, Whelan and Lupton 1998, Hoddinott and Pill 2000, Mozingo et al 2000, Gill 2001, Hauck 2002, McKeever et al 2002, McLeod 2002, Hong et al 2003). This information needs to be given by staff who are knowledgeable about breastfeeding and able to teach the necessary skills (Bowes and Domokos 1998, Vogel and Mitchell 1998, Raisler 2000, Ingram et al 2002, McKeever et al 2002). The information also needs to be consistent (Rajan 1993, Ball 1994, Tarkka and Paunenen 1996, Vogel and Mitchell 1998, Hoddinott and Pill 2000, Mozingo et al 2000, Simmons 2002a,b, Hauck 2002, Ingram et al 2002). In one study, women explicitly referred to the need to be respected for their own knowledge rather than feeling that expert knowledge was unchallengeable (Bowes and Domokos 1998). This relates to women's desire for facilitation of their own knowledge and problem solving abilities, rather than simply being advised as to what to do (Whelan and Lupton 1998, Hoddinott and Pill 2000, Gill 2001).

Women generally welcome practical assistance with breastfeeding when required (Rajan 1993, Hoddinott and Pill 2000, Mozingo et al 2000, Raisler 2000, Hong et al 2003). This however needs to be combined with sensitive respect for body boundaries (Vogel and Mitchell 1998, Whelan and Lupton 1998, Hoddinott and Pill 2000, Mozingo et al 2000, Ingram et al 2002). Finally, assistance with maintaining existing networks of significant others and the activation and establishment of supportive networks within the new situation are important to women (Bondas-Salonen1998, Tarkka et al 1998).

These studies highlight the importance of women's satisfaction with the hospital experience while embarking on their breastfeeding project. Emotional support from staff with knowledge, time and supportive skills such as encouragement and sensitivity, emerge as significant in relation to maternity service provision at this crucial time. However, this literature referred to has a number of key limitations. Firstly, it takes little account of the culture in which women are (or are not supported) and secondly, it relates to what women say, which is crucial, but it does not involve observational data to supplement stories heard and told. I go on to discuss these issues as they assisted me in making the case for the current study.

'Seeing' the cultural context

There is now a growing body of research that relates to the influence of the culture/environment upon health care worker's abilities to 'care', both in the UK (Street 1992, Kirkham 1999, Woodward 2000, Stevens and McCourt 2001a, Kirkham and Stapleton 2001b, Hughes et al 2002, Ball et al 2002, Hunter 2002, Deery 2003, Varcoe et al 2003) and internationally, for example Davis-Floyd (1992), Davis-Floyd and St. John (1998), Lugina et al (2001, 2002). The culture in which women learn to breastfeed and midwives provide (or don't provide) support is crucial to a critical study. It plays a key role in women's emotional wellbeing, in how they cope with their emotions, change of role and learning the new skills associated with motherhood. It is

also crucial in its influence upon midwives and how they cope with *their* emotions and role. As McCourt and Percival (2000) state, "the supportive or caring qualities of midwives cannot be readily separated from the organization of their work" (p.264). To assist me in developing a critical and culturally based perspective I draw upon the research of Street (1992), Davis-Floyd (1992), Davis-Floyd and St. John (1998), Kirkham (1999), Kirkham and Stapleton (2001b) and Ball et al (2002). These authors highlight the techno-medical, hierarchical, oppressive, gendered and separatist nature of the health care system in which health professionals are expected to work. I return to this body of work in more depth in chapter 9, but refer to some of it here very briefly to assist in setting the 'scene' for the study.

Kirkham focused upon the culture of NHS midwifery in the UK in two major studies (Kirkham 1999, Ball et al 2002). She refers to the hospital system with its hierarchical and gendered agenda as separating "birth from life" and "woman from their wider social environment" with skills of "support, caring and being with women" being difficult for midwives to achieve and becoming "invisible" within such institutions (Kirkham 1999, p.733). Indeed, she describes some of the characteristics of life in the NHS for midwives as akin to the conditions described by Freire (1972), in his *Pedagogy of the Oppressed* (Kirkham 1999). She also refers to the absence of a support infrastructure for the midwives who needed support in order to provide support for others (Kirkham 1999, Kirkham and Stapleton 2000, Ball et al 2002).

Davis-Floyd and St. John (1998) in the USA provide further insight into the dehumanising effects of the hospital culture upon health professionals themselves in a comprehensive qualitative study involving in-depth interviews with forty medical practitioners who had undergone a transformative journey to become healers. The practitioners described the "separatist world view" inherent in the conventional health care system. They referred to the ways in which they had turned their own bodies into tools and abused that tool "to make it continue to function in spite of overwork and high stress" (p.22). They had cut themselves off from their emotions leading to a sense of detachment and alienation. Davis-Floyd and St. John (1998) highlight some of the effects of the hierarchy to include privileging of specialists and specialist knowledge and the subordination of the individual to the institution.

It seems then that any account of women's experiences of breastfeeding within hospital should not and cannot 'skirt around' the context within which their supporters are working and yet this has not to my knowledge been directly addressed in any of the research I have referred to above. A crucial way to specifically focus upon the hospital experience prospectively and to 'see' as well as 'hear' what is happening is to conduct a study that includes observation. However, there is a striking absence of ethnographic work conducted on postnatal wards and considerably less that focuses upon aspects of breastfeeding within the postnatal ward setting.

Studies specifically involving postnatal ward observations but not specifically focusing on breastfeeding include the following. Lomax and colleagues (Lomax and Robinson 1996, Lomax and Casey 1998) conducted a postnatal ethnography in the UK around interactions between midwives and mothers, both in hospital and the community. They used videotaping to capture interactions and conversation analysis to analyse the data. They highlighted the asymmetrical organisation of interactions, with midwives taking control of the commencement and completion of interactions and topic selection. In contrast, clients rarely even attempted to control the agenda having little control over the timing and organisation of the encounters. They rarely spoke at any length and only did so at the specific request of a midwife. While clients were highly attentive to midwives talk, the reverse was not the case with midwives appearing to be preoccupied with other activities for example writing in the notes (Lomax and Robinson 1996, Lomax and Casey 1998).

Burden (1998) used an ethnographic approach involving participant observation and follow up discussions with women to observe the range of uses of curtains in a UK postnatal ward. The primary reason for curtain closing was a desire for privacy. She found that women used curtains to secure privacy and or to send signals to other room occupants, visitors and midwives. They completely closed the curtains for total withdrawal and this was associated with complications which made the woman feel anxious and unable to function effectively, for example feeling a sense of awkwardness and disapproval in relation to being the only bottle feeder in the bay. The complete closure was either short, i.e. less than 5 minutes while the person was changing for example, or prolonged for up to 5 hours. Women semi-closed their curtains as a signal that they wanted information or support and partly closed them across, i.e.

just pulled one curtain across, for periods of solitude or rest. In this way women created boundaries and barriers when they felt they needed them.

Kirkham and colleagues (Kirkham and Stapleton 2001a,b, Stapleton et al 2002) conducted ethnographic research in UK maternity units to include observation of consultations between midwives and service users on both antenatal and postnatal wards. This constituted part of a multi-method study to examine the use of evidence-based leaflets on informed choice in maternity services. They concluded that while health professionals were positive about the leaflets as a means to facilitate informed choices, competing demands within the clinical environment and cultural inertia hindered and undermined their effective use. Time pressures limited depth of discussions between midwives and women. Women's choices were limited by the normative clinical practices with the fear of litigation affecting the way health professionals 'steered' women towards making decisions that maintained the status quo. The authors concluded that the culture within which the leaflets were introduced contributed to women engaging in informed compliance rather than making informed choices.

Woodward (2000) conducted a comparative ethnographic study. She undertook non-participant observation and semi-structured interviews with staff in a palliative nursing setting with a maternity ward. She describes key differences between the two cultures. In the palliative care setting, practice was "other-centred, receptive, responsive and attentive to the patients' person and experience" (p.68). There was effective leadership that focused upon team cohesion with regular holding of debriefing meetings in which staff were encouraged to reflect upon care based on theoretical frameworks for caring. Staff felt motivated, energetic and part of a team. In contrast, on the maternity ward, practice tended to be task-orientated and unresponsive to women's needs. Midwives were constrained in developing relationships because of the rapid turnover of women, pressure of work and chronic staff shortages. Their care was often random, routinised and non-reflective, with no reference to a body of theory underpinning practice. Midwives lacked the effective leadership seen in the palliative care setting. This combination of factors left the midwives with low levels of motivation and energy. Woodward's (2000) description of institutionalised midwifery practice strongly resonates with Kirkham's (Kirkham 1999, Kirkham and Stapleton 2000, 2001b, Ball et al 2002).

Only four studies focused specifically upon breastfeeding women on postnatal wards. Renfrew (1989) reported on a small observational study in a maternity unit in the UK. This included interactions between midwives and breastfeeding women on the postnatal ward.[39] She highlighted that midwives seldom took time to observe the mother and baby together, feeding. They often used a controlling approach in directing a mother regarding feeding, with insufficient regard to her individuality. They did not recognise the two central factors involved in effective feeding, i.e. pain free for the mother and strong rhythmic suckling in the baby. They paid insufficient attention to the mother's position and that of their own and were often reluctant in persisting in helping the mother by trying alternative approaches to breastfeeding when the situation became challenging.

Marchand and Morrow (1994) in USA conducted a small study to explore the decision-making process around infant feeding in minority ethnic women in USA. They conducted a focus group interview, one-to-one in-depth interviews and participant observation of interactions between health care providers and the women both in hospital and community practice. The observational work revealed a varied knowledge of breastfeeding on the part of health care workers and inadequate discussion and information giving, particularly in relation to the women's perceived barriers to breastfeeding. Women tended to decide that the embarrassment, inconvenience and insecurity of breast-feeding outweighed any perceived health benefits.

Gill (2001) conducted a small ethnographic study on a postnatal ward in the USA to explore how maternal-child nurses care for and breastfeeding mothers and how the mothers perceive the support. She observed interactions between maternal-child nurses and breastfeeding mothers and interviewed both. Nurses placed their main emphasis upon information provision. While mothers also identified this need they emphasised the need for encouragement and interpersonal support to include the nurse staying with them during a feed.

Cloherty et al (2002) adopted an ethnographic approach to explore the beliefs, expectations and experiences of breastfeeding mothers and health professionals in relation to the supplementation of babies in hospital. The study involved participant observation and interviews with mothers and health professionals. They reported that supplementation was commonly not seen by health professionals as a significant 'intervention' with few staff being fully aware that supplements are associated with earlier discontinuation of breastfeeding. Supplementation was often seen as a short-term pragmatic solution to problems by both midwives and doctors. Some midwives saw protection from women from tiredness, distress and guilt as most important and therefore experienced conflict between their role in alleviating the immediate distress of the mother and that of promoting and facilitating effective breastfeeding. There was a lack of awareness of the long-term effects of supplementation. Other midwives went to considerable lengths in supporting women and effectively balanced the agendas of tiredness and distress and supporting women to breastfeed without resorting to supplements.

These observational studies focusing upon women and breastfeeding, although informative, are either dated (Renfrew 1989), relate to other countries (Marchand and Morrow 1994, Gill 2001) or explore a very specific aspect of breastfeeding (Cloherty et al 2002). As we move from the 20th to 21st century it is therefore timely to conduct an in-depth, critical ethnographic study exploring influences upon women's experiences of breastfeeding on UK postnatal wards.

Aim:

To explore the influences upon women's experiences of breastfeeding within the postnatal ward setting.

Objectives:

- To explore the ways in which women experience and negotiate breastfeeding within postnatal wards.
- To understand the cultural context within which breastfeeding women and midwives interact on postnatal wards.
- To observe the language, practices and approaches utilised by midwives when interacting with breastfeeding women on postnatal wards.
- To elicit breastfeeding mother's experiences of midwifery support in relation to their experience of breastfeeding while in hospital.
- To explore other influences upon women's experiences of breastfeeding while in hospital.

CHAPTER 3
KNOWING, BEING AND DISCOVERING

Introduction

In this chapter I discuss my epistemology, ontological position and theoretical perspectives underpinning the methodology I utilise. While my central epistemology stems from social constructionism and my theoretical perspective is most closely aligned with critical medical anthropology, I engage with and draw upon, often partially, other perspectives. This requires me to clarify my position with regard to issues such as relativism, power and knowledge by considering the convergences and divergences of the varying perspectives.

Paradigms

A useful starting place for a study whose central focus is upon culture and the ways in which human experiences and interactions are influenced, negotiated and understood is with the notion of the paradigm. Kuhn (1970) was the first to highlight that for a given community or discipline, there develops a specific range of beliefs, values and methods of solving a puzzle. He referred to this way of 'seeing' the world by a specific discipline as a paradigm. The definition of a paradigm has since been somewhat extended from focus upon specific disciplines to emphasis upon the basic human beliefs, world-view and constructions that guide action (Denzin and Lincoln 1994). A person's paradigmatic stance influences what s/he attends to and what is ignored or taken for granted. Davis-Floyd and St. John (1998) provide further insight:

> Paradigms provide clear conceptual models that facilitate one's movement in the world. In acting not only as models of-but also as templates for-reality, paradigms enable us to behave in organized ways, to take actions that make sense under a given set of principles. To "paradigm" if you will, is to create the world through the story we tell about it. We then can live as cultural beings in the organized and coherent paradigmatic world we have created. We cannot live without paradigms. But we can learn to be conscious and aware of how they influence our thoughts and shape our experience, to understand that they open some possibilities while closing others. That awareness can bring a rare kind of freedom to "think beyond" (p.3).

There are three elements encompassed by a paradigm; epistemology, ontology and methodology (Denzin and Lincoln 1994). Crotty (1998) provides definitions: epistemology is the "the theory of knowledge [....] a way of understanding and explaining how we know what we know" (p.3); ontology is the "the study of being [....] concerned with 'what is', with the nature of existence, with the structure of reality" (p.10); "methodology refers to the strategy, plan of action, process or design lying behind the choice and use of particular methods" (p.3). Put simply, epistemology is 'knowing', ontology is 'being' and methodology is 'discovering'.

Epistemology and ontology

I referred to objectivism, the epistemology of western science and techno-medicine in chapter 2. In contrast, I embrace a social constructionist epistemology as referred to by Berger and Luckmann (1966) in their classic text *The Social Construction of Reality*. They focused particularly on "reality" as it is perceived and experienced by "ordinary members of society" in their everyday lives (p.33). In this way, meaning is constructed by people as they engage with the world. Berger and Luckmann's (1966) perspective was, however, as Crotty (1998) argues embedded in the work of others, for example Marx, as related to economics, prior to these authors' writings. So social constructionism may be seen as originating, at least in part, from critical theory, to which I refer later. Crotty (1998) defines constructionism as the:

> View that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context [....]. Meaning is not discovered but constructed' (p42).

The term social constructionism is used widely with differing interpretations as to its meaning, causing considerable confusion (Murphy et al 1998). However, I take the position of Crotty

(1998) in making an important distinction between social constructionism and the rejection within other approaches, to include post-structuralism and postmodernism, of the "existentialist concept of humans as beings-in-the world" (p43). In this way, the social constructionist holds on to the notion that "experiences do not constitute a sphere of subjective reality separate from and in contrast to the objective realm of the external world" (p.45). This closeness to the immediate external world is emphasised by Berger and Luckmann (1966): "The reality of everyday life is organized around the 'here' of my body and the 'now' of my present. This 'here' and 'now' is the focus of my attention to the reality of everyday life" (p.36).

Social constructionism, as defined here, differs fundamentally from *constructivism*. Constructivism focuses upon the individual's mind and meaning-making related to phenomena, while the social constructionist perspective relates to the collective shared constructions of meaning and ways of knowing (Schwandt 1994, Crotty 1998, Murphy et al 1998). Social constructionism thus emphasises intersubjectivity and the shared experience of culture (Berger and Luckmann 1966, Schwandt 1994, Hammersley and Atkinson 1995, Crotty 1998).

To some extent the differences discussed above relate to the degree of relativity embraced. I therefore have had to carefully consider this issue in relation to my ontological position and epistemology. Again, I agree with Crotty (1998) in seeing the social constructionist position as firstly epistemologically relativistic:

> Social constructionism is relativist. What is said about 'the way things are' is really just 'the sense we make of them'. Once this standpoint is embraced, we will obviously hold our understandings much more lightly and tentatively and far less dogmatically, seeing them as historically and culturally effected interpretations [....]. This means that description and narration can no longer be seen as straightforwardly representational of reality. It is not a case of merely mirroring 'what is there'. When we describe something we are in the normal course of events, reporting how something is seen and reacted to, and thereby meaningfully constructed, within a given community or set of communities. When we narrate something [....] the voice of our own culture - its many voices in fact [....] are heard in what we say (p.64).

However, social constructionism is at the same time ontologically *realist*, in that it acknowledges that there is a world out there and the way in which we interpret and socially construct meaning provides us with an experience that is indeed a reality for us. Thus social constructionism rejects the epistemologically realist/objectivist notion that "meaning exists in objects independently of any consciousness" (Crotty 1998, p.10). It also rejects the ontologically relativist/idealist position of constructivism that reality is simply "mind created" (Murphy et al p.66).

This relationship between ontological realism and epistemological relativism provides a balance or middle position that prevents what is referred to as "naive realism" by Hammersley and Atkinson (1995, p.17) and Spradley (1980, p.4). This position asserts that there is a definitive knowledge simply 'there' and awaiting discovery independent of interpretation. On the other hand the 'middle position' treats with caution the extreme forms of relativism seen in constructivism which emphasise that human reality is simply created by the individual mind or the notions within post-structuralist theory whereby discourse constructs, inscribes and creates.

Culture and enculturation are important concepts in constructionism. These concepts are defined by Helman (1994) who states that:

> Culture is a set of guidelines (both explicit and implicit) which individuals inherit as particular members of a society, and which tells them how to *view* the world, how to experience it emotionally, and how to *behave* in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation - by the use of symbols, language, art and ritual. To some extent, culture can be seen as an inherited 'lens' through which the individual perceives and understands the world that he inhabits, and learns how to live within it. Growing up within any society is a form of *enculturation*, whereby the individual slowly aquires the cultural lens of that society. Without such a shared perception of the world, both the cohesion and continuity of any human group would be impossible (pp.2-3).

Spradley (1980) defines culture as "the aquired knowledge people use to interpret experience and generate behaviour" (p6). Crucially, however, I do not see culture as simply programming individuals and therefore agree with Spradley (1980) who challenges cultural determinism. He argues that culture should be viewed as a "cognitive map" acting as a reference and guide. It should not be seen as constraining the person to adopt only one course of action. Nevertheless he does acknowledge that culture does create in the person a taken for granted view of reality and in this sense individuals are *somewhat* "culture bound" (Spradley 1980, p14). In this way humans are able to exercise agency within their cultural parameters. This balance between enculturation and agency assists in understanding the differences between "tacit knowledge", a knowledge that remains largely outside our immediate awareness and "explicit knowledge", a form of knowledge that people may communicate about with a relative ease (Spradley 1980, p.7). I return to the notion of culture in subsequent sections, but firstly discuss my theoretical perspective.

Theoretical perspective

One's theoretical perspective may be described as "the philosophical stance" informing the methodology and thus providing a context for the research process (Crotty 1998, p.7). In this section, I discuss the theoretical perspectives that I engage with and, in doing so, I highlight some of the convergences and divergences between the perspectives.

Critical medical anthropology

I closely align myself with what is broadly termed as critical theory. Critical theory is generally associated with the Frankfurt school of Critical Inquiry and a range of political theorists to include Marx, Gramsci and Friere (Kincheloe and McClaren 1994). The definition proposed by Kincheloe and McClaren (1994) of a researcher or theorist embracing critical theory, is useful in illustrating the key tenets of this perspective:

> We are defining a criticalist as a researcher or theorist who attempts to use her or his work as a form of social or cultural criticism and who accepts certain basic assumptions: that all thought is fundamentally mediated by power relations that are social and historically constituted; that facts can never be isolated from the domain of values or removed from some form of ideological inscription; that the relationship between concept and object and between signifier and signified is never stable or fixed and is often mediated by the social relations of capitalist production and consumption; that language is central to the form of subjectivity (conscious and unconscious awareness); that certain groups in any society are privileged over others [....] that oppression has many faces (p.139-140).

However, Kincheloe and McClaren (1994) also include under their broad definition of critical theory, some post-structuralist theories such as those of Foucault. This inclusivity needs careful clarification when considering perspectives on, for example ideology and power, a discussion that I will return to. In general then, the critical perspective stands in contrast to interpretevist approaches such as symbolic interactionism, in that it seeks to move beyond understanding, to capturing issues related to ideology, power, conflict and oppression. In this way it seeks to be transformative.

More specifically, I align myself with the theoretical perspective embraced by critical medical anthropology with its focus upon blending the macro-perspective with the micro. Csordas (1988) emphasises the balance between macro and micro in summing up the essence of the critical medical anthropology perspective:

> It takes positions on the medicalisation of every day life in contemporary society, which it opposes; on biomedicine as a form of power, domination, and social control, which it also opposes; and on mind-body dualism, again in opposition. Its intellectual debts are to Marx, Gramsci, the Frankfurt school of critical theory, phenomenology and political economy. Its agenda includes critique of medicine as an institution, cultural criticism focused on the domain of health, analysis of capitalism in the macro-politics of health care systems and the micro-politics of bodies and persons, addition of historical depth to cultural analysis, and critique of allegedly non-critical medical anthropology (p.417).

Singer (1990) likewise summarises the balance between the macro and micro perspective in that it seeks:

> To add the traditional anthropological close-up view of local populations and their lifeways, systems of meaning, motivations for action, points of view, and daily experiences and emotions, to the encompassing holism of the political economy of health approach [....]. Macro is concerned with insights from political economy concerning 'what the system is' and micro with 'how the system works'- to include how players act and feel and know, where the contradictions and arenas of social conflict lie, and how power is distributed and exercised (p.297).

Lupton (1994), in her critique of illness, disease and the body in western societies, emphasises the importance of combining macro and micro perspectives. She refers to the macro perspective stemming from the political economy approach, emphasising structure over agency when focusing upon the influence of medicine in people's lives. The micro perspective, on the other hand, emphasises construction of meaning and enactment of individual agency within medical settings. This balance between structure and agency is crucial and I have constantly attended to it throughout the thesis.

Political economy of health

The political economy of health perspective underpinning critical medical anthropology requires further elaboration. Its focus is upon the relationships between capitalist modes of production, medical practice, health and illness. These are interpreted in various ways by leading authors in this field (Gough 1979, Frankenburg 1980, Doyal and Pennell 1981, Navarro 1992, Gray 1993b, Illich 1995), but the perspective of Doyal and Pennell (1981) has been particularly illuminating for me.

Doyal and Pennell (1981) illustrate the overwhelming contradictions between the goals of improving health and the imperatives of capital accumulation inherent within the capitalist mode of production. They also highlight the ways in which particular forms of medical practice have developed within societies that embrace the capitalist mode of production. They argue that medical techniques and technology are the "product of a particular conjunction of social, economic and political forces" (p.292). Therefore, the existence of any particular medical practice and its associated technology should be understood in relation to the activities of powerful groups within society whose interests are furthered by the development, maintenance and proliferation of such technologies. The medical equipment manufacturers and pharmaceutical companies are among the most powerful[40]. Frankenberg (1980) summarises these issues:

> The international political economy of medicine, dominated by great powers, themselves dominated by monopoly capitalist enterprise [have] an abiding interest in peddling pills and selling massive capital equipment, as well as changing the nutritional habits of the world's people's in order to sell their products (p.206).

Doyal and Pennell (1981) argue that many forms of medicine are indeed potentially or actually harmful, a point strongly reiterated by Illich (1995) in his examination of the iatrogenenic nature of western techno-medicine. Doyal and Pennell (1981) therefore challenge the continuing demands within society for *more* medicine as seriously misguided in that *more of the same* will not tackle the social, political and economic roots of ill health within society. They also challenge the direction being taken by the public health movement in that it now focuses upon the individual as responsible for her/his health maintenance and therefore places the person centre stage for blame should they become ill. This again shifts the focus away from the need for socio-economic reform. They further argue that despite rhetoric about equal access to health care through national services, the social organisation of medicine within nations employing the capitalist mode of production still reinforces socio-economic, sexual and race divisions.

Doyal and Pennell (1981) express particular anger in relation to the ways in which western capitalist modes of production have both contributed towards and failed to alleviate the "enormous burden of disease and premature death still borne by the mass of the population in

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[40] The techno-medical model of obstetrics presents us with a classic example of this interdependence.

underdeveloped parts of the world" (p.291), an issue also illuminated by others (Gray 1993b, George 1994). Doyal and Pennell (1981) heavily criticise the exponential growth in the practice of exporting western medicine to non-western communities in which this form of medicine is of limited value in alleviating sickness and disease in large sections of the population. In contrast, health promoting techniques and drugs that could potentially make a dramatic difference are either withheld because they are non-profit making or they are costed at prices that place them out of reach of large sections of the population[41].

Doyal and Pennell (1981) recognise that finding solutions to the problems they describe would be highly challenging and complex. They make it clear that a socialist government would not necessarily provide a better alternative, unless it addressed all of the following:

> A socialist health service would not only have to provide equal access to medical care but would also have to address itself seriously to such problems as how to demystify medical knowledge and how to break down barriers of authority and status among health workers themselves and also between workers and consumers. Indeed, the whole notion of 'treating patients' - of seeing them as passive recipients of medical expertise - would need to be rethought (p.194).

Although the analysis of Doyal and Pennell (1981) took place over two decades ago it seems to me to remain pertinent and highly relevant today, and it supports me considerably in making sense of the macro-political issues addressed within this thesis.

Feminism

As the central focus within this thesis is upon the undermining of women, I necessarily engage with aspects of feminism. In essence, the feminist theoretical perspective centres upon the challenge to dominant assumptions, inequities and social injustice that relate to women. It is critical in the sense that it seeks transformation and emancipation. However, feminism covers a diverse range of theoretical perspectives that reflect the many contentious phases in its development. Tong (1998) illustrates the diversities within feminism by typologising some of the perspectives to illustrate feminist's interconnections with other theoretical perspectives.[42] While many feminists avoid such demarcations, such labels do:

> Signal to the broader public that feminism is not a monolithic ideology, that all feminists do not think alike, and that, like all other time-honoured modes of thinking, feminist thought has a past as well as a present and future [....] They help mark the range of different approaches, perspectives and frameworks a variety of feminists have used to shape both their explanations for women's oppression and their proposed solutions for its elimination (Tong 1998, p.2).

I align myself broadly with feminists adopting a political economy of health perspective (Doyal and Pennel 1981, Martin 1987, Palmer 1993, Van Esterik 1994) in seeing oppression of women as being strongly related to political, social and economic structures with the capitalist mode of production being one such structure. Like these authors, I also recognise other forms of patriarchy, for example the growth of the traditionally male dominated medical system and male sexual appropriation of women's bodies. I see capitalism and patriarchy as inextricably linked and contributing to a series of dualistic separations: mind-body; public-private; nature-culture; production-(re)production; maternal-sexual, all limiting possibilities for women (Doyal and Pennel 1981, Martin 1987, Van Esterik 1989a,b,1994). I therefore see the need for transformative action to tackle financial inequities and the institutional and cultural practices that undermine women.

Breastfeeding is an embodied activity that women experience within a socio-cultural context. It has therefore posed enormous challenges for feminists, stemming from the well rehearsed but little resolved dualistic feminist debates related to sameness or difference. These debates focus upon women's dilemmas related to whether they would prefer to strive to be recognised and respected for their differences or sameness in relation to men (Humm 1992, Shildrick 1997). As Shildrick (1997) argues, on the one hand there is a celebration of femininity and

[41] The current controversy regarding price-fixing of drugs to combat AIDS provides a contemporary example.
[42] Tong (1998) devotes a chapter to each of the following: 'liberal feminism', 'radical feminism', 'Marxist and socialist feminism', 'psychoanalytical and gender feminism', 'existentialist feminism', 'postmodern feminism, 'multicultural and global feminism' and 'Ecofeminism'.

difference bringing with it the risks of essentialism and locating women within a maternal role. On the other hand, there is celebration of sameness and equality with men. Consequently, feminists appear to find it very difficult to know where to locate themselves along the essentialist - non-essentialist continuum. This has lead to a vacuum with regard to feminist critique related to breastfeeding that has only started to be addressed.

The feminist writings on breastfeeding appear to represent three key perspectives, historical (Apple 1987, Fildes 1989), a broadly political economy of health perspective (Van Esterik 1989a, 1994, Altergott 1991, Palmer 1993, Shelton 1994, Baumslag and Michels 1995, Galtry 2000) or a post-structuralist perspective (Dyball 1992, Maher 1992a, Carter 1995, Schmied 1998, Blum 1999, Schmied and Barclay 1999), although there are inevitably overlaps. I focus here upon the political-economic approaches and the post-structuralist perspective. The former presents breastfeeding as potentially transformative and empowering to women, but highlight the many constraints upon women related to macro-politics, economics and patriarchy. They highlight the interconnected impacts of medicalisation of breastfeeding, marketing of infant formula, and sexualisation of women's breasts upon women's choices, decisions and embodied experiences of breastfeeding (Van Esterik 1989a,b, Altergott 1991, 1994, Palmer 1993, Shelton 1994, Baumslag and Michels 1995). Galtry adopts a very specific focus upon the influence of labour relations and work place legislation upon women's experiences of breastfeeding in the USA (Galtry 1997a,b,c, 2000) and internationally (2003). The general emphasis for these authors is upon politically mediated reversal of constraints to enable and empower women across the globe to breastfeed. Van Esterik (1989b) summarises this position:

> Breastfeeding is a feminist issue because it encourages women's self-reliance, confirms a woman's power to control her own body, challenges models of women as consumers and sex objects, requires a new interpretation of women's work, and encourages solidarity among women (p.69).

The post-structuralist feminists argue that the position adopted by this politically motivated group of authors who they label as 'breastfeeding advocates' are still fundamentally essentialist (Dyball 1992, Maher 1992a, Carter 1995, Blum 1999). For example, Dyball (1992) asserts that these authors only differ from non-feminist breastfeeding advocates in that they acknowledge patriarchal structural obstacles to the fulfilment of the role of breastfeeding. She argues that they are aligned with non-feminist breastfeeding advocates in their connection of women with their reproductive functions. She criticises their call for a return to the pre-industrial 'golden age' asserting that their assumption that there is a 'natural ideal' sets unattainable standards for women, thus setting them up for feelings of guilt and failure. Indeed, she points to anti-feminist aspects of the 'natural ideal' approach, in that by 'bolting' the mother to her baby and making her subservient to his/her needs, it reinforces key reasons for maintaining male dominance in our society, i.e.

> The identification of women with motherhood, their subservience to the needs of others, and, with babies and especially breastfeeding segregated to the private sphere, their exclusion from the public sphere and positions of public influence (p.345).

Secondly, she argues that it assumes in a positivistic way that women ought to feel empowered by their reproductive role, given a lack of constraints upon them. She argues that this view lacks consideration of women's interpretations of their own experiences. These points are also made by Maher (1992a,b) from a global anthropological perspective, Carter (1995) following interviews with working class women who had their babies between 1920 and 1980 in the UK, Blum (1999) based on research with women in contemporary USA and Schmied following recent interviews with Australian women (Schmied 1998, Schmied and Barclay 1999). All critique what they see as a deterministic assumption that breastfeeding was, is or could be empowering for all women.

Engaging with the post-structuralist feminist literature has required me to consider carefully my own position. To support me in this, in addition to studying the post-structuralist writings of Foucault, to which I return shortly, I also engaged with the writings of feminists who chart their journey from a less relativistic, standpoint position into post-structuralism and then locate themselves somewhere 'in between', drawing from both (Haraway 1991, Burman 1992, Stanley and Wise 1993, Hastrup 1995, Standing 1998, Pujol 1999, Willig 1999a,b).

The critique of Burman (1992) was particularly useful in that she examines the need for a feminism that is neither positivistic, nor totally relativistic, highlighting four areas where feminism and post-structuralism converge: they both pay attention to difference, that is what dominant theories omit or repress; they make relative the practices of regulation, for example, medicine and deprive them of their claims to eternal and natural truth; they affirm reflexivity; and they highlight how practices of regulation do not exert their power without simultaneously producing resistance. In embracing aspects of post-structuralism, Burman (1992) warns that "celebrating plurality and indeterminacy" may lead to "total interpretative relativism" that disregards all models and theories (p.51). She thereby strongly argues for maintenance of the transformative and emancipatory potential of collective resistance embedded in the feminist project:

> Despite the focus on difference and dispersion, we need to retain the possibility of commitment to some unified theory to maintain the feminist project of social transformation, and equally to ward off linguistic relativism by ensuring that the politics of the theory is not only theoretical [....] we need to affirm for strategic purposes that there is some commonality in the positions and experiences of women by virtue of our subordination (p.48).

Standing (1998) likewise summarises for me some of the issues that I have grappled with. As a feminist materialist she felt that the post-structuralism was a:

> Vacuous theory, with no grounding in the material realities of everyday life. Power seemed to come from everywhere and nowhere. The emphasis on deconstruction seemed to me to alienate theory from practice, to individualize and leave me as a feminist, with nothing to organize around politically (p.196).

However, she reflects that she came to see that her earlier views on power were rather simplistic and she started to embrace some of the post-structuralist understandings regarding the diffuse nature of power and the modes of resistance. This reflects my position in relation to women and breastfeeding. My macro, political-economic perspective supports the position of Altergott (1991), Van Esterik (1989a,b, 1994), Palmer (1993) and Galtry (2000). However, my engagement with post-structuralist feminism, and in particular that applied to breastfeeding, in conjunction with deep reflection upon the data has enabled me to develop a micro-perspective. This reflects the complexity of women's experiences of breastfeeding and their active participation in negotiating this experience within a specific cultural milieu. In this way I endeavour to produce a synthesis that unites a macro-political perspective with a micro-perspective that stems from the meanings for women when engaging in a breastfeeding 'project' in a UK hospital setting.

Post-structuralism and power

As I have made evident in the thesis so far, I also engage with some of the post-structuralist thought of Foucault (1976, 1977, 1980, 1981), particularly in relation to surveillance[43]. As stated, in the broad sense Foucault's work is encompassed by the critical theory perspective (Kincheloe and McClaren 1994). However, while critical medical anthropology seeks to address the "micro/macro nexus as a means of constructing an integrated paradigm," post-structuralism is more concerned with discourse, that is the "social determinants of textual production" (Singer 1990 p.297). While the two are not fundamentally incompatible, the pluralistic, relativist and non-interventionist stance encompassed by post-structuralism may lead to a de-politicised approach lacking in transformative potential. With this in mind, I draw upon Foucault's theory with caution but welcome its challenge for me to (re)look through a less deterministic lens at the issues generated by the data. To clarify some of the convergences and divergences between these perspectives I discuss aspects of power here, in that it is central to both critical medical anthropology and post-structuralism and yet there are fundamental differences as to its conceptualisation.

(i) Power and ideology:

Central to the political economy of health perspective and critical medical anthopology are power structures, ideology, hegemony and oppression (Gramsci 1971, Freire 1972, Kapferer 1988, Bellamy 1995, Crotty 1998). The emphasis is placed upon:

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[43] I referred to surveillance in chapter 2, as it was necessary to set the scene for ongoing discussions.

Particular sets of meanings, because they have come into being in and out of the give-and-take of social existence [and] exist to serve hegemonic interests. Each set of meanings supports particular power structures, resists moves towards greater equity, and harbours oppression, manipulation and other modes of injustice and unfreedom (Crotty 1998, p.59-60).

Hegemony as a concept was a major political contribution developed by Gramsci (1971).[44] Gramsci emphasised "the ideological ascendancy of one or more groups or classes over others in civil society" (Bellamy 1995, p.33) and the transmission of economic power through ideology and culture. The Grampscian concept of hegemony presents culture as dynamic and central in the study of social processes, historical in nature and deeply embedded in human beings and existence (Kapferer 1988). Ideology refers to a shared set of fundamental beliefs about the world that justify "what is" (Thomas 1993, p.8) and these ideas serve as "weapons for social interests" (Berger and Luckmann 1966, p.18).

Foucault's (1977, 1980) view of power differs in his opposition to the concept of dominant ideologies exerting an oppressive power. He does acknowledge the "pyramidal organization" of power but he argues that this power is dispersed to the disciplinary apparatus (1977, p.176). As Fairclough (1992) argues, Foucault's resistance to the concept of ideology and to the idea of analysis as a form of ideological critique arises from his relativism. A major distinguishing feature of Foucault's concept of power stems from his argument that power is not vertically transmitted down through the political-economic systems, with powerful groups of society simply oppressing and dominating those in less powerful positions. He sees power as diffuse, diverse, ambiguous and located everywhere in day-to-day relationships and encounters, with everyone being caught up in the mechanisms of power:

> Power is exercised rather than possessed; it is not the 'privilege', acquired or preserved, of the dominant class, but the overall effect of its strategic positions - an effect that is manifested and sometimes extended by the position of those who are dominated. Furthermore, this power is not exercised simply as an obligation or a prohibition on those 'who do not have it'; it invests them, is transmitted by them and through them; it exerts pressure upon them, just as they themselves, in their struggle against it, resist the grip it has on them (Foucault 1977, p.26-27).

He is clear about what power is not:

> By power I do not mean 'Power' as a group of institutions and mechanisms that ensure the subservience of the citizens of a given state. By power I do not mean, either a mode of subjugation which in contrast to violence, has the form of the rule. Finally, I do not have in mind a general system of domination exerted by one group over another, a system whose effects, through successive derivations, pervade the entire social body (Foucault 1981, p.92).

Although Foucault (1977, 1980) makes reference to Panopticism as an architectural structure whereby power may be transmitted through the 'gaze', he emphasises the multidirectional nature of power in a hierarchized surveillance system arguing that power is everywhere, operating from top down, bottom up and laterally, with the supervisors being both objects and subjects of power:

> Power is everywhere; not because it embraces everything but because it comes from everywhere [....] Power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society [....]. Power is not something that is acquired, seized, or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the interplay of non egalitarian and mobile relations (Foucault 1981, p.93, 94).

Foucault (1980) refers to this dispersion of power as being ambiguous and passing through fine channels, in other words as a "capillary" form of power that "reaches into the very grain of

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[44] Gramsci was an Italian neo-Marxist. He wrote about hegemony in his prison diaries, whilst in a fascist prison, where he died. His diaries were later translated by Hoare and Nowell Smith in 1971.

individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives" (1980, p.39).

As stated, I do, unlike Foucault, see power as transmitted through ideology and as authoritarian and conspirational. However, embracing Foucault's notion of power as diffused through disciplinary surveillance (1977) also enables me to understand the complex ways in which power is embedded and intertwined within cultural systems.

(ii) Power and knowledge:

Foucault links power and knowledge as inseparable, mutually dependent and reinforcing:

> There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (Foucault 1977, p.27).

To assist understanding of the ways in which the "formation of knowledge and the increase of power regularly reinforce one another in a circular process" (Foucault 1977, p.224), Foucault takes us back to the 18th century, the era when the disciplines crossed the "technological threshold". Hospitals, for example, became:

> Apparatuses such that any mechanism of objectification could be used in them as an instrument of subjection, and any growth of power could give rise in them to possible branches of knowledge; it was this link which made possible within the disciplinary element the formation of clinical medicine, child psychiatry, child psychology, educational psychology, the rationalization of labour. It is a double process, then: an epistemological 'thaw' through a refinement of power relations; a multiplication of the effects of power through the formation and accumulation of new forms of knowledge (Foucault 1977, p.224).

In this way, Foucault points to the ability of the disciplines to "define a certain field of empirical truth" (Gordan 1980, p.237). However, he does not see knowledge as fundamentally oppressive, but as productive (Gordan 1980). Therefore, as Street (1992) argues, because Foucault views knowledge and power as inseparable, he must reject the notion of power as a medium through which emancipatory knowledge may be generated. This would imply a separation of power from knowledge with "knowledge being related to truth and power being equated with oppression and repression" (p.101). He therefore sees a separation of the concepts of power and knowledge as repressive in that it enables power to hide its own mechanisms.

While I agree that power and knowledge are inextricably interconnected, I see powerful groups as maintaining their version of truth to serve their ends and in turn to oppress less dominant groups and their knowledges.[45] In this way, I believe that challenging authoritative knowledge, their sources and modes of transmission has emancipatory potential (Freire 1972). However, engaging with Foucault's understanding of the mutual "enwrapping, interaction and interdependence of power and knowledge" (Gordan 1980, p.233) assists me in taking a 'middle' position that is neither wholly deterministic nor relativistic.

(iii) Power and the body:

One of the ways in which Foucault (1976, 1977, 1980, 1981) sees power as being transmitted is through the body and this constitutes a crucial focus within this thesis. It is only recently, that 'bodies' have 'come back' within sociology in recognition that "the corporeal grounds the existential" and "whatever is done to bodies is political" (Frank 1990, p.132). As Lupton (1994) highlights, the body used to be by-passed by the macro-sociological view that emphasised the political economic processes involved in social control and the micro-sociological perspective that focused upon social influences on behaviour but not embodied experience. Critical medical anthropology has, however, restored this balance with 'bodies' becoming a key focus (Frankenberg 1980, Csordas 1988, 1994a,b, Singer 1990, Lyon and Barbalet 1994).

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[45] This perspective is embedded within Jordan's (1997) notion of authoritative knowledge that I referred to in chapter 2.

The embodied experience is an area that cannot be ignored in a study about breastfeeding. As Merleau-Ponty (1962) states, "my body is the pivot of the world" and "I am conscious of my body via the world" (p.82). Kapferer (1988) likewise highlights that it is within the body that life is experienced and organised. He argues that in traditional medical anthropology there has been a development of abstract categories and their relationships without emphasis upon embodiment. The body was commonly regarded as an expressive vehicle of a world that surrounds the body, "the mind is separated from the body, the mental from the material, and the historical, social and political from their embodied realisation" (p.426).

Foucault (1976, 1977, 1981) conceptualises the body as a text inscribed upon and entirely constructed and constituted by discourse. The notion of Panopticism when transmitted to bodies leads to an intense form of self-discipline and body management.[46] However, while I agree with the potential for deep inscription of bodies by discourse, I disagree that the body may be viewed *merely* as a passive script to be inscribed by social structure. Like others, I argue that a person's body is also an agent in its own world construction (Fairclough 1992, Street 1992, Lyon and Barbalet 1994, Shildrik 1997). Again, in this way I return to my position of balance between structure and agency seeing women as active agents while acknowledging that there are many socio-cultural constraints upon them.

While Foucault focused upon the body, he had little to say about women's bodies apart from to comment on their sexuality (1981) and yet, as Shildrick (1997) argues, the concept of the 'gaze' and its self-regulating potential is *highly* relevant to the female body. "The imagery of nature unveiled before science, of the body stripped of its fleshy protection and penetrated by the empirical gaze is strongly gender-linked" (Shildrick 1997, p.31). Foucault also neglected any reference to male dominance and women's bodies, but he did see the body and sexuality as "central to the interplay of power and resistance", a crucial position within feminist perspectives (Shildrick 1997, p.22).

Again, considerable insight may be drawn from Foucault's notion of the inscribed body, but this must be balanced with a theory of embodiment. With regard to breastfeeding women this synthesis is provided by Schmied (1998), who argues that maternal subjectivity and breastfeeding must be viewed as *both* an embodied experience *and* a discursive construction. I agree with Schmied (1998) and further assert that a third dimension, stemming from political economy of health allows us to be ever aware of the profoundly political and medicalised nature of bodily experiences. Wherever there is discussion related to power and the body there must be reference to the various forms of resistance that I now refer to.

(iv) Power and resistance:

Foucault (1976, 1977, 1981) acknowledges resistance, but sees it as contained by power and posing no real threat, bodies being depicted as docile, disciplined, obedient and accommodating. As Fairclough (1992) comments: "The dominant impression is one of people being helplessly subjected to immovable systems of power" (p.57). Resistance is then "spontaneous, individual and elusive" (Burman 1992, p.50).

Whilst I agree that resistance may occur at an individual level, I believe that a balance is needed between the notions of structure and agency. I take a position along the continuum, seeing women not as docile scripts but as having some ability to actively negotiate their situations. However, I recognise that their projects in life such as mothering and feeding their babies are affected by multiple constraints that are discursive, cultural and political. Current arguments around passivity versus activity/agency appear to be somewhat polarised and tend to ignore the ways in which women may engage in both accommodation and resistance selectively as they negotiate various expectations and constraints upon them (Street 1992, Jolly 1998, Weitz 2001). However, for the purposes of description here, I refer to accommodation and resistance in turn.

Accommodation relates to the passivity and docility referred to by Foucault thus preventing disturbance of power/knowledge relationships (Street 1992). However, Foucault does not relate this docility to subordination to a dominant ideology in the way that others do, for example Kirkham (1999). Kirkham (1999) describes the sense of "helplessness", "low expectations",

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[46] I discuss self-discipline and body management further as the thesis progresses, in relation to the ways in which women conceptualise and 'manage' their breastfeeding bodies and midwives manage *their* working bodies.

"acceptance of the status quo" and "mutedness" (p.737) experienced by midwives in relation to the dominant UK NHS maternity service culture. I adopt Kirkham's (1999) position, in that I believe that dominant ideologies do indeed provide a base for subordination of individuals.

Resistance contrasts with accommodation and takes two forms. Firstly, passive resistance involves simply disregarding authoritative and public knowledges or ignoring or modifying guidelines, policies or instructions (Street 1992, Hutchinson 1990). Hutchinson (1990) refers to this in a nursing context as responsible subversion when carried out with the best interests of the patient in mind (p.3).[47]

Active resistance on the other hand, involves acting in a manner that is more liberating for either the individual or for others. This may involve challenging an ideology, public knowledge or authority who set the guidelines, policies or instructions (Street 1992, Weitz 2001). The most effective way in which to engage in active resistance is through collective action and challenge (Freire 1972, Burman 1992, Street 1992, Stanley and Wise 1993). This powerful form of resistance that in turn yields transformation and emancipatory change differs fundamentally from the Foucauldian concept of resistance located in the body, with the latter failing to deliver a political agenda (Freire 1972, Singer 1990, Burman 1992, Stanley and Wise 1993, Shildrik 1997, Standing 1998). As Burman (1992) states from a feminist perspective, "however much we deconstruct, comment on, take apart, we are still, *unlike* the deconstructionists, committed to putting something in its place" (p.50).[48]

Clearly, while Foucault's theory provides important insights regarding power and its various manifestations, it also has limitations with regard to its relativity and lack of transformatory potential. I return to the issues raised here in the following chapters in relation to the data, but firstly I focus upon my chosen methodology.

Methodology

I selected an ethnographic approach for the study to enable me to both see and hear what was happening, to provide a depth of understanding I did not feel I could achieve from simply conducting interviews with women. Ethnography originates from anthropology and is therefore informed and infused by the notion of culture. As Aamodt (1991) states:

> Ethnography is a way of collecting, describing and analysing the ways in which human beings categorise the meaning of their world [....]. It attempts to learn what knowledge people use to interpret experience and mould their behaviour within the context of their culturally constituted environment (p.41).

Spradley (1980) refers to two levels of cultural knowledge "explicit and "tacit"[49] (p.7). He argues that what we see represents "only the thin surface of a deep lake. Beneath the surface, hidden from view, lies a vast reservoir of *cultural knowledge*" (p.6). Ethnography aims to study both levels of knowledge. To study the latter the ethnographer must "make inferences about what people know by listening carefully to what they say, by observing their behaviour, and by studying artefacts and their use" (Spradley 1980, p.11). In this way. "the ethnographer observes behaviour but goes beyond it to inquire about the meaning of that behaviour" (p.7). To achieve this level of understanding of a given culture requires participating in people's lives over a considerable period of time, to include watching what happens, listening to what is said and asking questions (Hammersley and Atkinson 1995).

Hammersley and Atkinson (1995) chart ethnography's journey from a more descriptive and naturalistic discipline, to diversifying to embrace other theoretical perspectives ranging from interpretevist, critical inquiry, feminism and postmodernism. In its naturalistic form, ethnography rejected positivism which had previously dominated in the early 20th century by emphasising that human behaviour was "continually constructed and reconstructed" (p8). However, the naturalistic approach to ethnography itself came under criticism in that it attempted to understand social phenomena as objects existing independently of the researcher that could be

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[47] I discuss the concept of responsible subversion in more depth in chapter 6.
[48] I return to the concepts of resistance and accomodation in subsequent chapters as they arise from the data.
[49] To recap, "tacit knowledge" refers to a knowledge that remains largely outside our immediate awareness and "explicit knowledge" relates to a form of knowledge that people may communicate about with a relative ease (Spradley 1980, p.7).

described and even explained in some literal fashion. This, it was argued, was akin to positivism.

As a constructionist, I agree with this criticism in that, as Hammersley and Atkinson (1995) state, people construct their social world through their interpretations of it and their actions are then based on these interpretations. While these interpretations and actions reflect the underlying culture they are not simply dictated by it. The constructionist view also requires an acknowledgement that the ethnographer's interpretations are influenced by her/his own culture (Spradley 1980). As Boyle (2000) asserts, ethnography is contextual and reflexive emphasising the importance of context in understanding events and meanings and taking into account the effects of the researcher and the research strategy on findings. It therefore combines both the perspectives of the participant and the researcher.

It becomes clear then that, as Hammersley and Atkinson (1995) assert, once the ethnographer herself is seen to in any way be involved in constructing there is incompatibility with the assumptions that underpin naturalistic ethnography:

> Given the reflexivity of social inquiry, it is vital to recognise that ethnographers construct the accounts of the social world to be found in ethnographic texts, rather than those accounts simply mirroring reality (p.239).

Some ethnographers go further and embrace postmodernist or post-structuralist perspectives. Hastrup (1995) eloquently takes her readers on ethnography's journey through naturalism, interpretevism and finally postmodernism. She explodes the assumptions of early anthropologists by bringing the post-modern debate into the arena. She then arrives at a middle position in which she acknowledges that there is a place for ethnographic theories arguing for the balance between relativity and realism that I made a case for earlier. She presses for a firm move away from Cartesian epistemology with its emphasis upon "complete disengagement from the world" and its "instrumental stance towards it" (p.173). On the other hand, she acknowledges that any interpretation cannot be entirely subjective because meaning must in some way be shared for it to contain meaning at all thus reasserting that the explicit process of enculturation is still the cornerstone. This is my view and it links closely with the constructionist epistemology that I discussed earlier.

Clearly, the ethnographic approach may vary considerably according to the ethnographer's epistemology, that Boyle (2000) asserts exerts a strong influence throughout the research process.[50] Hammersley and Atkinson (1995) describe two key ways in which critical perspectives, to include feminism, have challenged traditional ethnography. Firstly, there is critique of the extent to which the political agenda influences the researcher and secondly the extent to which ethnography is utilised to influence political and emancipatory change. Bibeau (1988) for example, stresses the "powerful theoretical trend that stresses the importance of context, history and praxis in the interpretation of cultural codes". This "embraces the concepts of Foucault, Dumont, Gramsci, Bordieu and the neo-Marxists" (p.402). Thomas (1993) further elaborates, describing critical ethnography as a:

> Type of reflection that examines culture, knowledge and action. It expands our horizons for choice and widens our experiential capacity to see, hear and feel. It deepens and sharpens ethical commitments by forcing us to develop and act upon value commitments in the context of political agendas. Critical ethnographers describe, analyze, and open to scrutiny otherwise hidden agendas, power centres, and assumptions that inhibit, repress, and constrain (p.3).

Further Thomas (1993) argues that:

> The term critical describes both an activity and an ideology. As social activity, critical thinking implies a call to action that may range from modest rethinking of comfortable thoughts to more direct engagement that includes political activism. As ideology, critical thinking provides a shared body of principles about the relationship among knowledge its consequences, and scholars' obligations to society (p.17).

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[50] As stated, my epistemology stems from social constructionism and theoretical perspective from critical theory.

These definitions point to the centrality of ideology, power and control in the research process, analysis and theoretical conceptualisations. However, I agree with Hammersley and Atkinson (1995) in their emphasis upon the need for balance between the impactless ethnography which allows the "world to burn" and the ethnography which is underpinned by a clear political agenda (p.20). The latter may lead to a filtering out of information, thereby simply corroborating the political point making, with resulting compromise of the data. To maintain this balance, I subjected the data in this thesis to several readings, as I describe in chapter 4, endeavouring to represent the experiences and voices of the participants in combination with ideological critique.

Conclusion

In making connections between my epistemology, theoretical perspective and methodology I have highlighted my central theoretical perspective as aligned to critical medical anthropology with a political economy of health perspective underpinning it. I have also described the ways in which I have engaged, with caution, with some post-structuralist theory in particular that of Foucault and feminist post-structuralists. In drawing together various theoretical perspectives I have illuminated the ways in which they converge and diverge in relation to power, ideology, knowledge, the body and resistance, making explicit aspects that I embrace and those that I reject. With these perspectives in mind I have been able to justify my selection of a critical ethnographic approach to this research. Having justified my selection of methodology I now go on to describe the specific methods I employed.

CHAPTER 4
CONDUCTING THE ETHNOGRAPHIC STUDY

Introduction

In this chapter, I describe the method I adopted, to include gaining access to the two maternity units, selection and recruitment of participants and the conduct of observations and interviews. I move on to reflexively discuss ethical considerations, my presence in the field and the dilemmas that this created for me, with particular emphasis upon levels of participation. I describe the processes I utilised in the concurrent and iterative analysis of the data. These included a combination of categorical and non-categorical readings of the data and development of thematic networks. Finally, I discuss theoretical sensitivity and trustworthiness.

An ethnographic approach

I adopted an ethnographic approach, i.e. a topic-orientated ethnography that focuses upon a specific aspect of activity within a given community (Spradley 1980), in this case women's experiences of breastfeeding on postnatal wards. The ethnographic study involved long periods of observation of activities on the postnatal wards, with particular reference to interactions between midwives and breastfeeding women. The observations were supplemented by interviews with both midwives and mothers. As Hammersley and Atkinson (1995) state, the two methods are mutually enhancing in that what is seen informs what is asked about and what is heard at interview informs what is looked for. Observation also enabled me to become aware of culturally learnt behaviour that may not be articulated at interview because much of the participant's cultural knowledge is tacit (Spradley 1980). This emphasis on describing what people "do" as well as "believe" is fundamental to ethnography (Brink and Edgecombe 2003).

Ethnographic interviewing enables the eliciting of cultural meanings (Spradley 1980) and accessing participants' "feelings, intentions, purposes, motivations, emotions, perceptions and experiences" (Henry and Pashley 1990, p.5). It is a method closely aligned to my ontological position, that women's stories provide meaningful aspects of the social world that I am exploring (Mason 1997). This represents my epistemology, in that to generate data related to my ontological assumptions I need to interact with women, talk with them, listen and access their stories (Mason 1997).

Gaining access

I selected two maternity units, named hereafter as site 1 and 2, in the North of England, both within reasonable distance from my home. I decided not to conduct the research in the unit in which I had a liaison role as a midwifery lecturer as I was known too well. Therefore on the selected sites, although I was known to some of the midwives, I was not a particularly familiar 'face'. The sites were different, as I discuss under settings, but the research was not set up as a comparative ethnographic study. Rather the two sites were selected to give depth to the study.

On each of the sites I firstly visited the head of midwifery, the key 'gatekeeper', and discussed my proposed research with her having supplied her previously with a copy of my proposal and associated ethical considerations. Both agreed, provided that I was prepared to supply them with a summary report on completion. They provided a letter of approval for the relevant ethics committees. I then applied for and received ethical approval firstly through the University screening ethics committee and then through the two relevant NHS local research ethics committees. I was required to present my case in person at site 2.[51] Having gained ethical approval I then went back to see each head of midwifery to discuss start dates and specific details.

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[51] Both relevant NHS local research ethics committees approved the research but site 1 required me to make it explicit on the information sheets for mothers and staff that they had the right to listen to the tapes and request destruction or erasure of their material. This was amended and an approval letter followed.

Settings

Site 1 was a large consultant-led maternity unit in a city in the North of England. The annual birth rate was approximately four thousand. The Caesarean section rate was in the range of 20-25% and the midwife: births ratio approximately thirty. Thus, it was a unit that was highly medicalised with low staffing levels relative to other similar units. The BFI and its underpinning 'Ten Steps' formed the basis for policy and practice related to supporting breastfeeding women, although the hospital was no longer designated as 'Baby Friendly' following an unsuccessful reassessment. Audit data illustrated that approximately 66% of women initiated breastfeeding during the study year with 12% discontinuing while in hospital. These rates closely conformed to the national survey figures (Foster et al 1997, Hamlyn et al 2002). The breastfeeding rate at ten to fourteen days was approximately 40%, representing a fairly dramatic fall in rates during the first two weeks. The unit had two infant feeding specialists. Hospital stay was normally twenty-four hours for multiparous women, three days for primiparous women and five days for women who had had a Caesarean Section. The maternity unit was surrounded by a diverse range of areas in terms of the socio-economic status of the occupants. The unit served a predominantly white population but also served women from communities of South Asian origin, most being second and third generation.

The unit had two wards that had a mixture of ante and postnatal women. The two wards, named here as A and B, were of an almost identical design each consisting of two sides separated by a wall with each side having three, four bedded bays that opened into the central corridor. There was a central 'station' on each side that ran along the length of the middle bay providing visibility to the bays. This 'station' was rarely used by midwives as they tended to write their notes on women's bedside tables. One bay on each side was used for antenatal women, the others being used for postnatal women.[52] There were also four side wards, one at each end of the 'corridors'.

Site 2 was a consultant-led maternity unit in a small town, also in the North. The annual birth rate was approximately one thousand, the caesarean section rate in the range of 10-15% and the midwife-to-births ratio approximately twenty. It was therefore less medicalised and considerably better staffed than site 1. The breastfeeding initiation rate was only 50% with a high cessation rate in hospital of 17%. The breastfeeding rate at 10-14 days was only 31%. These rates were considerably lower than national averages (Foster et al 1997, Hamlyn et al 2002). The unit did not have an infant feeding specialist. Some of the BFI literature was used i.e. posters and leaflets, with complete absence of any formula company literature but there was not a co-ordinated statement of preferred practice and the unit was not actively engaging with the BFI. The staff had not received a planned programme of post-registration education on breastfeeding. Hospital stay was normally twenty-four hours for multiparous women, three days for primiparous women and five days for women who have had a Caesarean section. The unit supported the local town, several large villages, and a new town. The population of the new town had high levels of unemployment, socio-economic deprivation and teenage pregnancy. The town itself had considerably less socio-economic deprivation. The community served was predominantly white.

Site 2 had one ward for ante and postnatal women. This ward was divided into three four bedded bays, (rooms 1-3) one three bedded bay (room 4) and three side wards. Room 4 was largely used for antenatal women, 1, 2 and 3 usually for postnatal women and the side wards for women with problems, for example a woman who had birthed a stillborn baby. The ward was often less than half full. Each room was separated from a corridor by a door that was always closed.

Figure 3.1 (overleaf) illustrates the main differences in layout of the bays between the two sites. Only detail that is of immediate relevance to the conduct of the ethnography is included.

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[52] These details are relevant here as they influenced the way in which I actually conducted the research. Further details regarding my observations of the environment are referred to in the next chapter.

Figure 3.1.
Layout of the bays, beds and 'stations' on site1
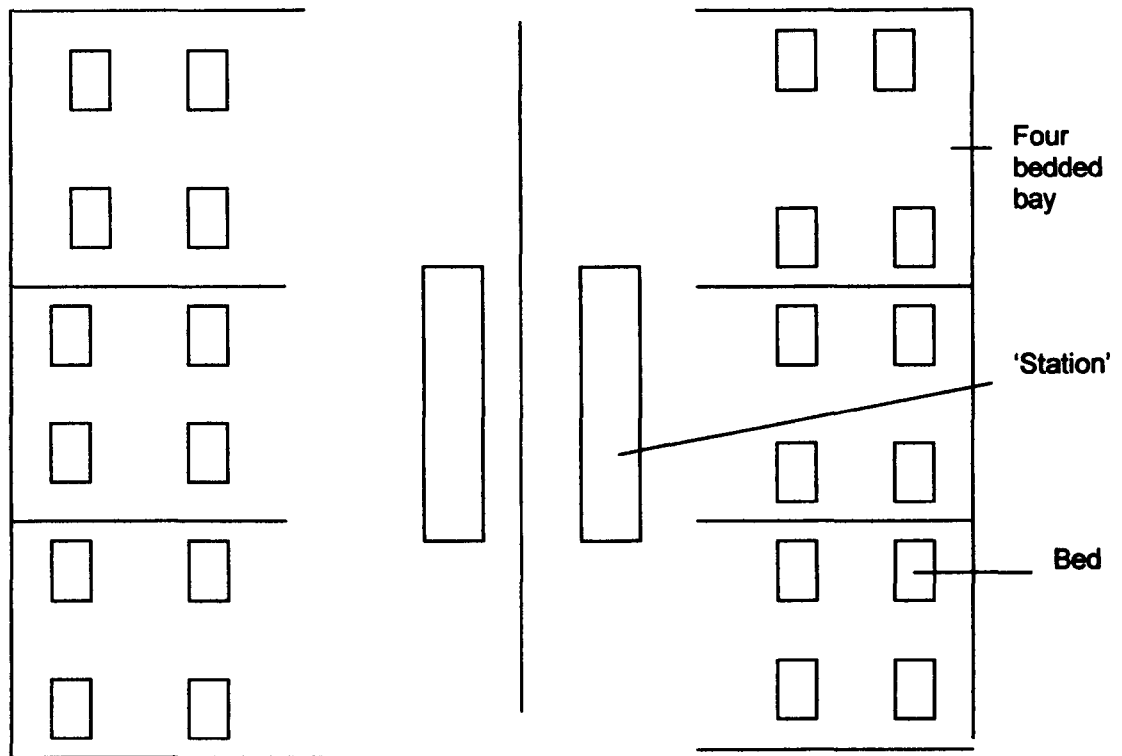
Figure 3.2.
Layout of the rooms and beds on site 2
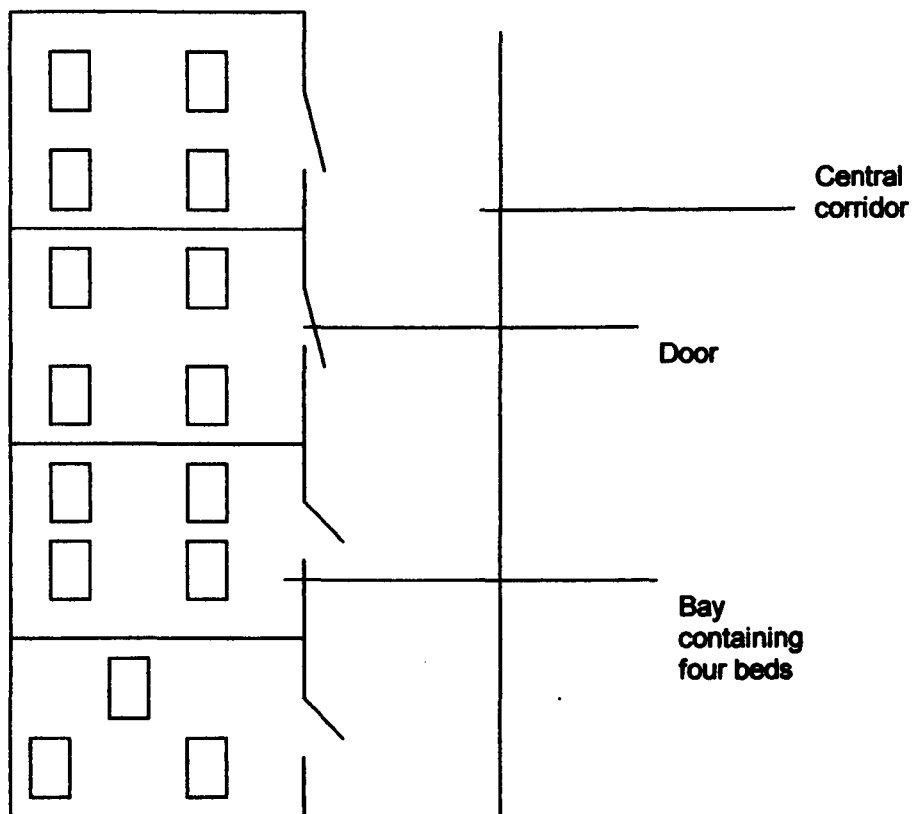
Participants

Sixty-one breastfeeding women participated in the study having provided written consent. This included forty women on site 1 and twenty-one on site 2. I included women who were admitted to the postnatal ward who had initiated breastfeeding and were able to communicate in written and verbal English. I excluded women whose babies were being cared for on the neonatal unit, women with serious obstetric, medical or emotional complications following childbirth and women who did not wish to participate.[53]

Table 3.1
Characteristics of the participants (postnatal women)

	Site 1	Site 2
Type of birth		
Women who had a 'normal' birth	22	15
Ventouse/forceps delivery	8	3
Caesarean Section	10	3
Parity		
Primiparous	25	15
Multiparous	15	6
Ethnic origin		
White	35	21
South Asian	5	0
Other	0	0
TOTAL no. of participants	40	21
Women who declined to participate	5	2

On site 1, I observed twenty-four midwives. The only exclusion criterion was refusal to participate. None of the midwives refused to be observed but they were often unavailable for any discussion following interactions. I conducted eighteen guided conversations[54] with thirteen of the midwives. On site two, I observed seven midwives in specific interactions related to breastfeeding. None of the midwives refused to be observed individually, but there was collective resistance when I phoned up and individual avoidance that I discuss later. I conducted nineteen guided conversations with ten of the midwives. Due to a number of unforeseen difficulties on site 2 with regard to conducting observations, the methods varied between sites. Therefore, I describe each site separately commencing with site 1. The specific numbers of participants, postnatal women and midwives that I observed and who participated in interviews are displayed in appendix 1.

Procedure - Site 1

Data collection commenced in April 2000. From July 2000, I had a period of four months leave in which I spent prolonged periods doing field-work. This was facilitated by sabbatical time combined with holidays. Data collection was completed by November 2000. I divided my time between wards A and B.

Observations

One of the decisions I had to make before entering the field was how to conduct the observations and to what extent I would be a participant or non-participant. Spradley (1980) describes all ethnographic observation as participant, in that the researcher is a part of the social situation. This may be contrasted with the form of non-participant observation conducted by, for example psychologists using a one way observational window in which there is no involvement with the participants at all. Hammersley and Atkinson (1995) likewise assert:

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[53] Further detail on the selection and recruitment of participants is presented under 'procedure'.
[54] I explain my use of the term 'guided conversation' later in the chapter.

There is a sense in which all social research takes the form of participant observation: it involves participating in the social world, in whatever role and reflecting on the products of that participation (p.17).

Spradley (1980) refers to four levels of participation ranging from "low" engagement to "high" (p.58). Firstly, "passive participation" involves the ethnographer being present at the scene but without interacting or participating with those s/he is observing, for example standing at a bus stop. "Moderate participation" involves maintaining a balance between participation and observation. This may involve fluctuating between simply observing and participating in some ways. The ethnographic work of Kirkham (1983, 1989) with women in labour rooms illustrates this fluctuation. At times she was able to sit and observe with minimal interaction, but at others she answered questions or held women's hands as appropriate. Hunt (1995) went a step further in her delivery suite ethnography by actively and deliberately taking on some basic tasks, for example answering the phone in order to make herself generally more acceptable to staff. The third level Spradley (1980) refers to is "active participation". This involves doing what the people in the study situation do to gain insight into the cultural codes and rules for behaviour. The final stage involves "complete participation". The researcher is this case tends to already be a member of the group/situation to be studied.

In addition to making a decision about the level of participation I intended to adopt I also needed to consider where to observe and when and who to talk to and what to ask and how to record information and data (Hammersley and Atkinson 1995). Ethical considerations clearly needed to be central in the decision making process[55]. After discussion with the head of midwifery it was agreed that on arrival to the ward at the start of a block of field-work, I would listen to the hand-over report to ascertain which women fulfilled the inclusion criteria. This also enabled me to introduce myself to the midwife-in-charge and other staff on the 'shift'. I then selected one side of the ward for observation. This decision was based on knowledge of which side had the most mothers who fulfilled the inclusion criteria and therefore the likelihood of recruiting mothers or the need to follow mothers up from the day before. I covered both sides of wards A and B in this way observing on ward A first and then B later. On arrival for a session of observation, following the 'report' I then approached all available women, on the selected side, that fulfilled the inclusion criteria, to request their participation.[56]

I based myself at the 'station' enabling me to view the three bays. I was then able to 'move in' to observe a particular mother and midwife more closely when appropriate. On other occasions I based myself in a four-bedded bay as there was a chair and table by the window in each case. I adopted this position when I wanted to focus upon one or two women in more depth or when a mother declined to be observed in another bay making sitting at the 'station' unethical. On a few occasions I shadowed a midwife for the shift or session but this was more difficult due to the fragmented nature of their work. My level of participation was therefore "moderate" (Spradley 1980, p.58), but fluctuated between levels of activity, being more intensive when sitting in a bay and even more so when sitting behind curtains with a mother and midwife.[57]

I sampled early (07.15 start), late (14.00 start) and night (20.30 start) periods of working, sometimes as single days and other times in blocks of two to five days. Periods of observation lasted approximately three to five hours during the day, eleven hours at night. My earlier observations were more general, with the 'station' being an ideal place to sit. Spradley (1980) recommends a broad approach to the initial stages of ethnographic observations. This involved conducting "descriptive observations". These were more general observations guided by a nine dimension framework for informing data collection (Spradley 1980, p.78):

1. Space: the physical place or places, i.e. ward layout, geography, nursery.
2. Actor: the people involved, i.e. the mothers and midwives.
3. Activity: a set of related acts people do, for example the postnatal examination or specific support with breastfeeding.
4. Object: the physical things that are present.
5. Act: single actions that people do.
6. Event: a set of related activities that people carry out.

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[55] I describe ethical considerations in more detail later in this chapter.
[56] I describe this process in more detail under ethical considerations.
[57] I discuss specific decisions around whether I became involved in certain situations under the section, 'my role in the field'.

7. Time: the sequencing that takes place over time.
8. Goal: the things people are trying to accomplish.
9. Feeling: the emotions felt and expressed.

As the ethnographic research got underway I spent more time making "focused observations" (Spradley 1980, p.128). These involved focusing down to elicit more specific aspects of cultural meaning, such as the nature of the support offered to women when they requested assistance with or information about breastfeeding. Finally, I engaged in "selective observations" involving a narrowing of the focus further to look for differences among specific cultural categories (Spradley 1980, p128). These required careful planning of very specific aspects to be observed. I conducted selective observations in response to the development of early theory and the need to test out my theorising and assumptions, for example I deliberately sought to observe the activities of a midwife whose approach was discrepant from that of previous midwives I had observed. This enabled me to build the emerging theme of 'taking time - touching base' more effectively (see chapter 9). This progressive focusing during data collection is also described by Hammersley and Atkinson (1995) as a gradual shift from describing social events and processes towards developing and testing theories. This included, as stated, searching for and focusing upon cases which would confirm or refute my early theorising.

In total, I observed and interviewed forty women on site 1 with nineteen being seen on one day only and twenty-one being followed through for two to five days. I observed and described in detail seventy-nine encounters between midwives and mothers. Sixteen of these were postnatal examinations that included a discussion about breastfeeding. All seventy-nine episodes specifically included a discussion about or assistance with breastfeeding. Each episode was concluded when the midwife left to attend to another matter.

I used a hand held tape recorder to record interactions and interviews where possible, unless either mother or midwife refused permission. However, the spontaneous nature of some of the interactions did not lend themselves to me asking for permission, requiring note taking instead. In all cases I took extensive notes as after the first few transcriptions I realised that some of the recordings were inaudible due to babies crying loudly, sudden lowering of voices or turning of heads away from the recorder. I noticed that when the midwife was actually assisting the mother to breastfeed, she would lean forwards and lower her voice to avoid disrupting the mother and baby's efforts. This meant that when I replayed the tape there would often be parts that were inaudible.

Interviews with postnatal women

I conducted sixty-six focused interviews with postnatal women. I interviewed one participant five times, two participants four times, four participants three times, twelve participants twice and seventeen once. Four women were observed with their consent, but then declined to be interviewed for various reasons, for example they said that they were too busy.

Where possible the interviews followed an interaction but this was necessarily very flexible related to women being involved in other activities, for example attending to their baby, wanting a rest, bath, a meal or expecting visitors. The interview length ranged from a few minutes up to twenty minutes. The interviews were flexibly guided by the specific context of each situation and the nature of preceding events and I therefore refer to them as 'focused'. They helped to clarify issues related to the interaction and included questions such as "How has this discussion/encounter with the midwife influenced you with regard to breastfeeding?" Although I had an agenda I took care to remain open and flexible to issues raised spontaneously by women.

My initial intention was to focus upon interactions when carrying out subsequent interviews. However, when I approached women a second time, I found that they were more interested in talking about their experience since I last saw them, which in some cases was the day before. I also found that I was not always seeing regular interactions around breastfeeding and therefore I decided to follow some women through, where possible, for two to three days of their stay, in one case five days. In these situations I commonly asked, "how do you feel about breastfeeding today?" and "tell me about your experiences of breastfeeding since I last saw you". In most interviews the following issues were covered at some point: reason(s) for deciding to breastfeed; what type of support she had had with breastfeeding so far; intentions regarding

breastfeeding after discharge from hospital; previous experience of breastfeeding (if multiparous). For the women who were interviewed on more than one day I was also able to 'check out' that my impressions of their experience to date seemed accurate to them, thus enhancing trustworthiness of the data.

Again, I progressively focused during data collection (Hammersley and Atkinson 1995), with individual women but also as the study progressed, in order to test out my early theorising. I avoided imposing *a priori* categories during the early periods of data collection but as categories emerged they were incorporated into later interviews, for example it became evident that plans for the future influenced ways of negotiating the hospital breastfeeding experience. I therefore carefully sought out further data on this relationship. At all times, I endeavoured to flexibly achieve a balance between eliciting individual stories while ensuring enough consistency to allow for comparison between participants (May 1991).

I asked women if they would like to talk to me in a private place with their baby with them, as there was usually an empty side room or day room. However, most preferred to talk by the bedside and due to the considerable volume of background noise these conversations were usually inaudible to others. In all cases I waited until the midwife had moved on to another bay if I was asking women about a specific interaction. The discussions tended to be quite intermittent due to the baby waking or a midwife approaching. I taped interviews when permission was given but also took notes due to background noise and possible loss of data.

Interviews with midwives

My original intention was to interview midwives in-depth about the specific interactions I had observed. However, their extreme busyness meant that they were often unavailable to be interviewed. Breaks were scarce and at the end of the 'shift' they wanted to get home, so opportunities were very limited. The most common ways in which midwives allowed me to elicit their views was by them initiating contact. This usually involved them coming up to me at the 'station' when I was the only person there[58] and talking to me, often rather vaguely, about an interaction but then moving swiftly on to provide me with contextual detail about the 'system'.[59] This provided me with broader contextual detail about the ways in which the culture within which they were working impinged upon them, influenced the women 'passing through' and impeded them in providing support for breastfeeding women. On these occasions I simply took notes as to suggest tape recording would, I felt, stifle the spontaneous nature of the discussions.

In one situation a midwife (Eunice MW19) approached me in the changing room at the end of a night shift with a series of issues concerning her. She agreed to come and sit in an empty side room and I was able to conduct a tape-recorded interview with her. I also conducted a prolonged taped interview with another midwife (Jenny MW14) whom I had shadowed over several days[60]. Other than this the interviews mainly took place at the 'station' which despite being an open, public space was quite private in that the volume of noise in the ward was generally so high that any conversation at the 'station' could not be heard. This lack of audibility was enhanced by the midwives aligning their bodies so that their backs faced the ward when talking to me. I conducted eighteen guided conversations with thirteen of the midwives. These involved discussions with one midwife on three occasions, three midwives on two occasions and nine midwives on one occasion. The discussions usually lasted about ten minutes but the two taped interviews lasted for thirty to forty minutes.

Although I had not anticipated the way in which midwives would direct the place, format and content of the conversations with me, the 'critical' nature of their comments assisted me in emphasising the influence of structure over agency in midwives and the political over the personal, an essential facet of a critical study. This participant-led agenda shift was also described by Menzies (1989)[61] in her classic organisational study of nursing. Despite her aim of developing new methods in nursing organisation, her focus was shifted by the nurses repeated reference to their "tension, distress and anxiety" (p.3).

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[58] As stated, the 'station' was rarely used by any of the staff in their normal ways of working as note making took place at the end of the beds. Therefore, I was usually the only person sitting there.
[59] Due to the participant initiated nature of the interviews, I refer to them as 'guided conversations'.
[60] I later refer to this midwife, Jenny (MW14), as a discrepant case, due to the differing nature of her interactions.
[61] I refer to the work of Menzies, in chapter 9, with regard to the ways in which midwives cope within a highly regulated institutional culture.

Procedure - Site 2

Data collection commenced in November 2000 and continued through the first half of 2001. This included two blocks of leave one being two months long and another one month long. These blocks enabled me to spend prolonged periods of time conducting field-work. Having had a fairly straightforward experience of observing on site 1, site 2 brought some unexpected and interesting methodological challenges. Each mother's curtains were drawn around her bed for most of the time, effectively closing off rooms, apart from a narrow gap down the middle of the bay. When all four sets of curtains were drawn there was a negligible space to walk through and nowhere to sit and observe activities within a room. I either had to sit with one woman behind the curtains, which I felt was too intrusive and intense for her, or sit by an empty bed, when the room wasn't full, waiting for a midwife to approach a woman. However, I tried the latter on two occasions but then abandoned further attempts, as I quickly realised that it constituted a covert way of observing, with women appearing to be uncomfortable with what I was doing despite having consented.

The midwives based themselves in the office, attending to women as they buzzed with postnatal checks of mother and baby usually being combined with a request from a mother for assistance. The only strategy I could use was to base myself in the office and then follow a midwife when she went to see a woman who had consented to participate. However, midwives tended to resist my attempts to observe them in this way by providing women with minimal attention, then saying that they would return in a few minutes or later, which they endeavoured to do without me in attendance. I also tried shadowing midwives but this was unpopular and again they would say, "there's no point you coming, this person is bottle feeding" or "she is an antenatal". They tended to structure their work to exclude me. When I started to shadow midwives I found that they would readily take up the opportunity to go to delivery suite, leaving me back at 'square one' again. On one occasion when I did successfully shadow a midwife, the next day when I phoned to say I would like to come she said that the staff would prefer not to be observed that day as they were too busy.

On other occasions when I phoned the midwives would say that there weren't any women for me to see, that they were all bottle feeding or that the 'breastfeeders' were going home first thing in the morning". I felt as though I was playing a game with them. I spent large amounts of time, sometimes several hours, sitting in the office and trying to follow a midwife to a breastfeeding mother's bed-side. I would sometimes arrive at the unit and after several hours go home having collected very little data. The night 'shift' was even more difficult, as again midwives avoided encounters when I was around and there was nowhere I could sit and be unobtrusive. I actually felt at times that I was compromising women's care because midwives were avoiding being involved in discussions about breastfeeding because I was there. The staff reluctance to be observed appeared to relate to their feeling that they lacked knowledge about breastfeeding and an accompanying lack of confidence. Secondly, there was resistance to feeling that they were under surveillance. This was striking in its contrast with site 1 where surveillance was so embedded in the culture that I was simply an additional minor irritation. I return in more depth to the issue of surveillance in chapter six.

As I had had permission from the ethics committee to follow women through and interview them about their experience of breastfeeding so far, in addition to observing them, I did this even in the absence of having seen interactions. This actually gave me rich data both related to women's experience of breastfeeding in hospital and to interactions I had seen or not seen and women's perceptions of these encounters. Thus the site 2 data helped me to further focus on women's personal meanings, experiences of breastfeeding and their bodies while in hospital. My observations, or lack of them, on site 2 brought the issues of surveillance and public-private activities of women to the forefront. The difficulties I experienced also reflected Hammersley and Atkinson's (1995) assertion that in spite of careful planning regarding what and who is observed, the nature of the setting shapes the development of the research.

As with site 1, on arrival to the ward at the start of a block of field-work, I listened to the hand-over report to ascertain which women fulfilled the inclusion criteria. I then approached all of the women fulfilling the inclusion criteria. There were often only one or two women, given the quietness of the ward, the low level of initiation of breastfeeding and high discontinuation rate in hospital. I sampled early, late and night periods of working sometimes as single days and other

times in blocks of two to three days.[62] I observed and/or interviewed twenty-one women, nine were seen on one day only and twelve were followed through for two to three days. Periods of time spent on the ward lasted approximately three to five hours. A tape recorder was used for interactions and interviews where possible, unless permission was refused requiring note taking instead.

Observations

Despite the difficulties I still managed to observe eighteen encounters between midwives and mothers, four of which were postnatal examinations. As in site 1, the eighteen episodes specifically included a discussion about or assistance with breastfeeding and the episode was concluded when the midwife left to attend to another matter.

Interviews with postnatal women

I conducted forty focused interviews with postnatal women. I interviewed one participant six times, one participant four times, two participants three times, seven participants twice and ten participants once. As stated, where possible the interviews followed an interaction but due to the low number of observed interactions the majority of interviews occurred without me having observed an interaction and centred around women's experiences of breastfeeding in hospital. This inevitably included their encounters with midwives and ways in which their needs regarding breastfeeding were met or not. The interview length ranged from a few minutes up to twenty-five minutes.

Interviews with midwives

I conducted nineteen short interviews with ten of the midwives, three midwives on three occasions, three midwives on two occasions and four midwives on one occasion. The discussions lasted from a few to ten minutes and took the form of conversations during which I simply made notes. They took place either in a bay or in the staff office depending on the context. The discussions related to interactions, associated issues or general ways of working and providing breastfeeding support. As in site 1, the midwives tended to volunteer contextual detail related to the general way of working, in preference to specific discussions related to interactions.

Field notes

Throughout the entire data collecting phase of the study I wrote up field notes. These are "relatively concrete descriptions of social processes and their context" (Hammersley and Atkinson 1995, p.175). These field notes included contextual details regarding place, who was present, times and circumstances. My descriptions were written in what Spradley (1980) describes as "concrete language", i.e. full descriptions minimising the amount of condensing, summarising, abbreviating and generalising (p.68). However, as Spradley (1980) points out, there were times when I only had time to jot down key words and phrases, which would trigger my memory later when a fuller description could be written down (p.69). In addition to recording contextual detail, observations and my reactions, I supplemented all interviews with field notes, carefully separating direct quotes from my own words and descriptions.

When I got home each day I rewrote my field notes while they were 'fresh' in my memory and added further comments and reflections. I carefully recorded the dates and the code numbers I allocated to each participant with the relevant field notes. I utilised these notes as an additional source of data for analysis and when re-reading them they provided me with a description of the postnatal wards and assisted me in contextualising the interactions. As Hammersley and Atkinson (1995) stated they had the "power to evoke the times and places of the 'field' and call to mind the sights, sounds and smells of 'elsewhere' when read and reread 'at home'" (p.176).

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[62] The start and finish times for the three 'shifts' were the same as for site 1.

Ethical considerations[63]

Participant autonomy/informed consent

Gaining access to a particular setting does not guarantee access to all the data available within it (Hammersley and Atkinson 1995). This becomes inevitable in the crucial protection and maintenance of each participant's autonomy. As Holloway and Wheeler (1995) state: "respect for autonomy means that the participants in the research must make a free, independent choice, without coercion" (p.224). This requires that informed consent is obtained, the principle of which "expresses the belief in the need for truthful and respectful exchanges between social researchers and the people whom they study" (ASA 1999, p.3).

Each time I commenced an episode of field-work I approached postnatal women fulfilling the inclusion criteria and asked if I might talk to them about the study. If they agreed to this conversation, I then sat and explained the study verbally and then provided written information and a consent form (see appendix 2). I invited women to take their time to read the information, after which I returned about thirty minutes to an hour later to answer further questions and obtain written consent from those who agreed to participate. A second copy of the information sheet was left with each consenting participant for her reference. Each potential participant had the option of discussing any issues with a midwife in the interim period or at any other time. I made the decision not to ask a midwife to introduce me to each participant as I felt that this could have a coercive element to it, in that women might endeavour to please the midwife providing support for them.

I made it clear to each potential participant that she had the right to opt out at any stage in the process and the right to refuse to answer any question. She could inform me at any time if she was no longer happy to be observed. Crucially, I made it clear that refusal to participate would not in any way affect women's care. It was particularly important to avoid intruding upon women's privacy and indeed space and therefore in any situation where a woman preferred not to be observed I specifically based myself in one or two of the other bays in site 1 rather than sitting at the 'station'. On both sites, if a woman in a bay/room did not want to participate, I only entered if observing a specific mother-midwife interaction or interviewing a woman. I also explained the nature of the study to mothers not included but in the same areas as mothers who I was observing.[64] I made it clear to non-participants that I would only be making notes related to those who had provided written consent. As stated earlier, in order to protect women from covert or intrusive observation, on site 2 due to curtaining of each bed, I adapted my methodology to maintain women's autonomy.

Consent in research is a process, not a one-off event, and may therefore require ongoing re-negotiation (ASA 1999). Bearing this in mind, each time I approached a postnatal woman to carry out a specific observation I asked for her verbal permission again. Secondly, when I followed a woman through for more than one day I approached her at the start of the next 'shift' and asked her again if she was accepting of my continuing observation and/or interview with her. In some cases the male partners were present during observations and/or interviews. When this occurred, I also gained their permission verbally to observe. Sometimes they spontaneously contributed to the interviews in which case I gained their consent to include their comments in the research.

Midwives were informed about the study verbally and in writing at 'report' time, see appendix 3. I asked them to inform me at the commencement of the 'shift' if they preferred not to be observed and/or approached regarding their encounters with postnatal women. I also stated that they had the right to refuse observation or discussion with me at any time. As with the postnatal women, each time I approached a midwife and mother prior to or during an interaction I again requested permission to join them. I made it clear that although I was taking notes during report time I was not using that information in the research. I also provided the same information to student midwives, nursery nurses and ancillary staff and, while they were not included in the study, they were asked to inform me if they had objections to me observing them if they were part of a mother-midwife interaction.[65] I did not receive any such objections.

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[63] I utilised the *Ethical Guidelines for Good Research Practice* produced by the Association of Social Anthropologists of the UK and the Commonwealth (ASA 1999) to guide me in making ethical decisions.

[64] None of these non-participating women objected to me being around but if they had have done I would have avoided that bay.

[65] For example, a student midwife might be accompanying a midwife during an encounter with a woman.

Spradley (1980) argues that the ethnographer should not simply aim to consider the interests of informants but to actually safeguard their rights, interests and sensitivities (p.21). At all times observations and interviews with staff and mothers were conducted with extreme sensitivity and flexibility, acknowledging their busyness and necessary preoccupation with other matters. Recognising that for postnatal women this was a vulnerable period, I endeavoured to be sensitive to body language. This included, as Mason (1997) suggests, noting expressions such as fatigue, embarrassment and anger and responding accordingly, in some cases by shifting my gaze elsewhere and in others by gently changing the subject or by carefully concluding an interview.

I took particular care with regard to consent in relation to using the tape recorder. As the ASA (1999) state with regard to technical data-gathering devices, "those studied should be made aware of the capacities of such devices and be free to reject their use" (p.3). The information sheet for both postnatal women and staff made it clear that they had the right to refuse to be taped and the right to listen to any tape recorded material pertaining to them and to request its destruction or removal.

Maintaining confidentiality and anonymity

Confidentiality and anonymity were assured and maintained at all stages of the process. All transcripts were anonymised with removal of any names. Names were replaced by sequential code numbers, for example P1 for a participant and MW1 for a midwife. Tape recordings were taped over once transcription had taken place. Signed consent forms were locked away and kept separate from the transcripts. All field and reflective notes were written utilising the allocated participant or midwife code numbers. It was made clear to all participants on the information sheets that the findings from the research would be utilised for my PhD and in published papers. The ASA (1999) state that: "If guarantees of privacy and confidentiality are made, they must be honoured unless they are clear and overriding ethical issues not to do so" (p.4). This would only be the case in the event of me observing or hearing about serious professional misconduct or if I was to observe child abuse. This was discussed with the heads of midwifery before hand, but there weren't any such incidents.

'Stepping into the ethnographer's role' - my presence in the field

There were many considerations I needed to make about how I entered the field and behaved once in the field. The decisions I made related to the nature of the setting and the need to gain access to a range of different types of data (Hammersley and Atkinson 1995).

Impression management

Hammersley and Atkinson (1995h) refer to the importance of "impression management", that is the impression given by appearance[66] (p.83). I needed to consider the impression I gave to mothers and secondly to staff. This not only related to how I wanted to be perceived but also to what extent I wanted to participate in the scene. The way in which I dressed was crucial in this context. I was aware of what Hammersley and Atkinson (1995) refer to as the "dual effect" of dress, in that it also has an effect on the researcher.

I felt I needed to look tidy and reasonably professional without appearing to be engaging in a clinical role, so I excluded wearing any form of uniform. I did not want to come across as an 'official person' by dressing in a suit, as I felt that this might coerce women into consenting and secondly it would make my interest in their stories rather official. I felt that neither a uniform nor a smart suit would be popular with the midwives as I was not 'one of them' and neither did I want to come across as being there in an official capacity. I therefore decided to dress in a fairly smart T-shirt with a collar, plain cotton trousers and flat, quiet shoes. I felt that quiet shoes were important as clicking heels give the impression of being official and indeed officious. I wore my University ID badge around my neck for security purposes and to reassure staff and mothers of my legitimacy on the ward. This way of dressing made me feel non-conspicuous, approachable, casual and yet acceptable to staff and mothers.

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[66] I also refer to impression management, in a broader sense with regard to midwives, in chapter 9.

Daily gatekeepers

Once in the clinical setting, I had to negotiate with a second level of gatekeeper[67], the midwives in charge of the wards. This re-negotiation had to be carried out on a daily basis and indeed if I crossed over a 'shift' I had to approach the 'incoming' gatekeeper. On site 1, there was a midwife 'in charge' of each side of the ward, so this involved negotiating with two 'gatekeepers' each time I entered the field. Attending for the report on both sites made this negotiation much simpler and enabled me to fully inform all members of staff about my activities. The report time enabled frank discussion about any issues, with staff knowing that I would not report on any discussions taking place during this 'hand-over' period.

Ethnographer or part of the surveillance apparatus?

Hammersley and Atkinson (1995) refer to two perceived identities of the researcher, the expert and the critic, which make the gatekeeper(s) uneasy, i.e. "The expectation of critical surveillance" (p.79). This was particularly challenging for me as although I selected sites in which I was least known, I was nevertheless known as a lecturer from the university with specialist knowledge of breastfeeding. The midwives were clearly aware of my presence in the field, particularly when I was 'sitting in' with the midwife and mother. However, through the information and consent forms and the verbal information giving, I made it clear that I was not there to provide any clinical care or to express any specific opinions. At first I felt that a few of the midwives were somewhat self-conscious and aimed to 'perform' well, making frequent eye contact with me to monitor my reaction. However, as time elapsed and it became clear to these midwives that I was not there to interact with them I found that they habituated to my presence and appeared not to be performing on my behalf.[68] This stemmed partly from their obvious preoccupation with more pressing and concerning issues than someone observing them. Kirkham (1983) and Hunt and Symmonds (1995) also describe this habituation and attention to greater pressures.

The 'Hawthorne effect' may have manifested. This relates to the effect of being studied upon those being studied with knowledge of the study possibly influencing behaviour. The participants may become more interested in the subject area or they may change their behaviour simply because someone (a researcher) is showing an interest in them (Bowling 1997). In this study I have to acknowledge that support for breastfeeding women may have improved because of my presence. This was also reported by Kirkham (1983) who noted that the participants she observed may have been on their "best behaviour" because she was observing them. However, as she further remarks, "this in itself highlights what behaviour is seen as 'best'", a matter of interest in itself (p.86). As the encounters and support (or lack of it) I observed still left considerable room for criticism I felt that any attempted improvements due to my presence did not fundamentally compromise the extent to which I was able to critique the situation. In line with a constructionist epistemology I also recognise my presence in the situation as an inevitable part of the construction of the social situation that should be exploited in a reflexive manner (Hammersley and Atkinson 1995).

On site 1 there were particular sensitivities regarding the UNICEF UK BFI.[69] I was asked on several occasions was I 'something to do with' the BFI. I made it clear that I was not and that I could see some of the positive aspects of it but also some of the negatives. This tended to put staff at ease in that they did not feel that I was monitoring compliance with their breastfeeding policy or adherence to the 'Ten Steps'. On site 2, I was relatively unknown to staff but as there was a fairly new head of midwifery who had a particular interest in breastfeeding promotion, they may have suspected that I might be auditing their activities in order to report back to her. I made it clear on both sites that a report would be submitted to the head of midwifery, but that I would not be including any specific interview material or individual observation reports and that it would simply be a summary of key practice issues.

As already discussed, on both sites staff endeavoured to illustrate to me contextual issues related to their support, or lack of it, for breastfeeding mothers. They did this through conversations with me and secondly through their actions. I describe this further in chapter 5.

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[67] The first level gatekeeper being the head of midwifery for each unit, as discussed earlier.
[68] This level of habituation did not develop on site 2 as my observations were limited by constraints in the field, as discussed.
[69] As stated, this unit no longer held 'Baby Friendly' accreditation.

Level of participation

I made it clear in the information form to all participants that I was a midwife researcher, there to observe and listen but not to provide health care or advice. However, as stated, I still needed to decide the level of participation that I was prepared to undertake. While I felt clear that I would be engaging in "moderate participation" (Spradley 1980, p.58), the degree to which I maintained a balance between participation and observation needed careful thought. When sitting at the 'station' I could simply observe from a distance. However, increasingly, as stated, midwives would come over to me and initiate a discussion that I responded to in every case. The station nevertheless provided me with a form of space that enabled me to think analytically and write up field notes. Hammersley and Atkinson (1995) refer to the importance of finding or creating such a space in the conduct of an ethnography.

When at the bedside I made myself as unobtrusive as possible by minimising eye-contact with either mother or midwife. Lomax and Casey (1998) refer to the difficulties with this stance, i.e. "being present but communicatively disengaged" (p.14). My way around this was to note-take, which I needed to do anyway. Note taking gave me a clear and seemingly legitimate role, thereby exempting me from engagement.[70] While remaining acceptably engaged in note taking I did respond to situations when not to have done so would have clearly shown a lack of empathy or respect. I did therefore look up when I felt invited to do so, for example, if mother and midwife were sharing something sad or funny. Likewise, if a mother asked me a direct question I either deferred it to the midwife if it related to clinical issues or answered it if it was more general. To not do this would have cast me into a 'cold' observer role that would be lacking in respect and would have made ongoing co-operation of mothers and midwives unlikely.

There were some situations in which I did get involved in order to ensure that women were not compromised by me being there. As Lipson (1991) states, one should "not forsake necessary intervention or an advocacy role for the sake of research purity" (p.19). One example of intervening occurred when a woman asked the midwife to show her how to hand express. The midwife, looking very hesitant, said that she would do that later. I sensed that my presence might have deterred her from wanting to provide the demonstration, so I suggested that the leaflet available on the ward might be useful. The midwife, who was apparently unaware of its existence, found the leaflet and returned with it. A little later, once the midwife had left the bedside of the participant I suggested to the midwife that the infant feeding specialist might be asked to demonstrate the hand expression and should I ask her when she came on to the ward? The midwife agreed and the infant feeding specialist invited the midwife along so that she learnt from the experience.

On another occasion, an adolescent mother who appeared to be keen to breastfeed after a poor experience of bottle feeding her first baby and who described it as a 'dead special experience' had not received any information about positioning, attachment and effective feeding. Thirty-six hours following the birth she was struggling with very sore nipples and had had very little support. She had not received any written information at all on the post-natal ward. I asked her if she would like to see the infant feeding specialist who was expected on the ward. Subsequently, the infant feeding specialist spent some considerable time with the young mother going through the principles of establishing effective pain free feeding. Clearly, this intervention will have influenced this mother's experience, but I felt that it would be unethical not to act in this situation and also it was the last time I was going to see her.

The informal referral arrangement on site 1 that enabled me to highlight specific needs to the infant feeding specialist provided an ethical way for me to cope with situations, as above. I did not discuss individual midwives or situations that would enable the infant feeding specialists to identify specific midwives, except in situations in which I first spoke to the midwife, as in the hand expression example above. I was also able to highlight general issues to the infant feeding specialists at the end of the field-work through providing them with a copy of the anonymised report given to the head of midwifery. In having access to the specialists in this way, I decided not to engage them personally in my observational and interview work as this could have compromised the relationship.

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[70] Note taking was also used by the midwives as a strategy at the close of an encounter, to indicate a period of disengagement (see chapter 9).

There were many occasions when there was what might be described as sub-optimal support in which I did not take any action. It would have been impossible to intervene in all of these cases and inappropriate to do so given the nature of my role. Johnson (1997) refers to taking this stance in his ethnographic nursing study, discerning what constitutes "conduct which is not bad but could possibly be better" and actions, or lack of action(s) with the potential to do harm (p.46). I felt that the best way to address the 'could be better' types of practice was through my reports to the two heads of midwifery. These reports summarised the range of practice issues but in a fully anonymised manner. This gave the heads the opportunity to focus upon necessary improvements through midwifery supervision, management and by providing opportunities for education. On site 1, the report I submitted was distributed by the head of midwifery through the cascade management system and was also discussed with the two infant feeding specialists.[71] On site 2, the report was discussed with the consultant midwife who was given the remit to ensure that ongoing education addressed the issues.

I found that during observations I was rarely asked questions by either mother or midwife, but the nature of the relationship changed during interviewing. This was perhaps inevitable as these were one-to-one encounters mediated by language between the participant and myself. Fontana and Frey (1994) make the point that to obtain rich and meaningful data the researcher must be prepared to give of herself, creating a two way dialogue. If a postnatal woman asked me a question I responded with sensitivity but avoided coming across as an 'expert'. I found that speaking as a mother was an effective way of avoiding this and yet responding flexibly to women's questions during interviews. Midwives' questions tended to centre upon knowing more about the research to which I responded unless they asked for my findings which I stated I could not disclose until the research was complete.

Observing or eating toast

One dilemma occurred over breaks. On site 1, staff took a morning coffee break during which most of the staff entered a specific room to eat toast and have a drink.[72] I decided at first to avoid entering this arena. However, after the first few days on ward A one of the midwives asked if I was observing toast-eating or participating in eating it and jokingly invited me to join the staff. Thereafter, I joined the staff when invited. I found that in this setting when my notebook was out of sight, staff asked me further questions about what I was doing and why. I answered their questions about the research aims and process but, as stated, made it clear that I could not talk about findings at this stage. I also made it clear that I was not there to give an opinion as this would change the nature of my role. As time elapsed staff tended to simply include me in general chatter that was unrelated to the ward, to include holidays, television programmes and shopping. I found myself living in two worlds, the informal world of the staff room, in which I was not actively 'doing ethnography', and the ward in which I was intensively observing and note taking. The breaks became as important to me as they were to the staff and my willingness to participate, I felt, made me more acceptable to the staff.

On site 2, coffee and toast were eaten in the ward office on a more ad hoc basis which I joined in if I happened to be in the office, engaging in casual conversations when appropriate. This was a more difficult situation, as it was also the base of activity and earlier in the field-work as I was constantly trying to 'catch' a midwife to follow to specific participants, my role in the office was blurred. Later, as I began to focus more upon the women and less on the midwives the tension reduced and midwives tended to ask me to come and join them for a drink and toast.

Stepping out of role

Although I had not worked in a hospital setting as a midwife for over ten years, I was very much aware that as a midwife I had been in the past encultured through the maternity ward sub-culture. Hunt and Symonds (1995) describe the challenge this creates in separating professional judgement from ethnographic analysis. They refer to the need to balance being a midwife with considerable expertise and inevitable preconceived ideas relating to what constitutes best practice with retaining the ability to treat the familiar as "anthropologically strange". They continue, "ethnographers are part of the social world they study" but must also "develop the ability to stand back and reflect upon themselves and the activities of the world" (p.40). Spradley (1980) also refers to the challenge of converting from a normal participant

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[71] However, to my knowledge it did not reach the 'grass roots' midwives in report form, only as a tool for discussion.
[72] On ward A this was the general-purpose kitchen and on ward B a designated staff room.

mode in which much information is ignored by a process of "selective inattention ('tuning out, not seeing and not hearing') to the observer who seeks to become explicitly aware of happenings" (p55). He describes the process of learning to see with a 'wide-angled' lens, i.e. taking in a much broader perspective of information. This, he argues, is crucial for the continuing eliciting of tacit cultural rules.

I had to carefully reflect on the influence of my own history both as a midwife and a mother in order to avoid ignoring aspects of the environment that I had become familiar with in the past. As Hammersley and Atkinson (1995) warn, it is crucial to avoid the "comfortable sense of being at home" with its associated risk of impeding ones' ability to see and hear critically (p.115). They refer to the rhetoric around research legitimacy with some arguing that the "insider" has exclusive rights and others that the "outsider" is better equipped. I felt that I was neither - somewhere in the middle. I was maintaining a "marginal position", i.e. a point between familiarity and strangeness (Hammersley and Atkinson 1995, p.109-110). One example of something that I became acutely aware of, which I had habituated to when working in a maternity unit, was the intensity of the background noises, an issue I return to in chapter 5. One of the profound ironies of being in the ethnographic role was that it enabled me to engage in a level of listening to women and understanding their situations that was impossible for the midwifery staff to achieve. Leap (2000) describes the importance of a midwife being able to watch, listen and know through the use of all of her senses. I return to this issue in chapter 10.

Reflexivity

Freire (1972) states that "reflection - true reflection - leads to action" (p.41). Reflexivity was crucial to this critical ethnographic study and involved a rejection of the bracketed ethnography and acknowledgement that I am inevitably influenced by my socio-cultural background and personal, political and intellectual values and beliefs (Stanley and Wise 1993, Hammersley and Atkinson 1995, Mauthner and Doucet 1998). As Mauthner and Doucet (1998) state, a "profound level of self-awareness" is needed to "capture the perspectives through which we view the world" and the "filters through which we experience the world" (p.122). They recognise that being reflexive about data analysis involves locating oneself socially in relation to the researched, paying attention to one's emotional responses to the participants and examining how one makes theoretical interpretations (Mauthner and Doucet 1998).

I utilised a specific section in my field note diary for reflections upon decisions I made throughout the study and justifications for them. This included an audit/decision-making trail for the research process, my feelings, experiences, general reminders, memos and early analytical thoughts (Guba and Lincoln 1989, Ely et al 1991, Koch 1994). This provided a connection between the data and the associated reflexivity. As Hammersley and Atkinson (1995) recommend, I was careful not to allow the field notes and transcripts to accumulate without regular reflection and analytical thought. I also recorded my own positive and negative feelings related to the experience. These feelings influence the way that I entered into relationships within the field (Hammersley and Atkinson 1995). Through increasing my introspection in the field I learnt to use myself as a flexible data-collecting instrument (Spradley 1980).

Crucial to the critical ethnographic study was a constant reflection on power issues related to the actual research. Alldred (1998) cautions that power may operate through the language we use with its inevitable hegemonic cultural basis, through our position as a researcher and our relationship with our participants. I needed to be constantly aware of the ways in which the researched might perceive me and how this would influence their responses to me. I have also reflected upon the power inherent in representing others, an issue I return to. Standing (1998) argues that in representing others' perspectives, the relationship is inevitably one of unequal power because the researcher decides which parts of the data, interviews and women's words to present and which to omit. The researcher then decides how to represent the findings and selects the language with which to do this (p189). This challenged me throughout the entire process of the research and continues to do so.

Keeping a reflective diary also provided me with an opportunity to work through my own feelings about the conduct of the research. The complex and unpredictable nature of conducting ethnographic field-work was quite unnerving at times and writing about my experiences supported me in coping.

Analysis

I now go on to describe the ways in which I analysed the data generated by the ethnographic field work. As Ely et al (1991) state, "to analyze is to find some way or ways to tease out what we consider to be essential meaning in the raw data [....] that speaks to the heart of what was learned" (p.140). My approach to the analysis could best be described as cyclical in that both questions and answers were discovered within the social situation being studied (Spradley 1980). This cycle involves discovering new questions during the field work which in turn guide the data collection through a process of iterative, concurrent data collection and analysis (Spradley 1980, Strauss and Corbin 1990, Hammersley and Atkinson 1995). Theory, data generation and data analysis developed simultaneously in a "dialectical process" (Mason 1996 p.141).

The initial stages of data collection were tentative and uncertain and therefore somewhat unnerving. Although I had had previous experience of supporting women in postnatal ward settings, I was now entering the field in a different role as an observer and listener. This gave me what Mauthner and Doucet (1998) refer to as a "sense of not knowing and of openness" (p.122). This openness assisted me in not making a priori assumptions about the data. The combination of intensive periods in the field followed by withdrawal and intermittent periods of observation, as recommended by Spradley (1980), enabled me to reflect upon the data and assisted the ongoing process of data analysis. I also carried out several stages of tentative writing of parts of the ethnography during the data collection phase and, as Spradley (1980) suggests, this assisted me in developing further questions and thereby guided subsequent data collection.

As I was confronted with ways in which to make meaning out of the data I faced several dilemmas. I wanted to represent the women's voices about their personal experiences and meanings as they breastfed within medical settings. I was also involved in interpreting not only postnatal women's meanings but to some extent those of midwives. I was also conscious that unlike interview data alone, my observations influenced what I heard and the interviews influenced what I looked for and saw. My interpretations were therefore based on what I saw as well as heard. While, as argued, this was central to my aims, it made for a more complex analysis. I agree with the view of Mauthner and Doucet (1998) that researchers cannot simply represent the voices of respondents as though they were speaking on their own. The interpretative process in this thesis therefore constituted a balancing act between representing the voices and stories of the postnatal women and midwives, my voice as the researcher, my interpretations of what I saw and the conceptual lenses through which I viewed the data.

I was conscious of the dilemmas in seeking to explore privately based knowledges and personal understandings and then reconstituting and presenting them in academic language in the public domain (Edwards and Ribbens 1998). In this way I felt that I was extending the dominance of publicly based knowledge and "colluding in its intrusion into every nook and cranny of social life" (Edwards and Ribbens 1998, p.13). However, without some form of collective representation these private knowledges would remain hidden and ways in which women may be struggling to carry out marginal, culturally ambiguous, embodied activities in a public domain would remain hidden and unspoken about. Standing (1998) sums up the dilemma in representing women:

> As feminist researchers one of our roles is to translate between the private world of women and the public world of academia, politics and policy. The dilemma remains of how we do this without reinforcing the stereotypes and cultural constructions we are challenging (p.193).

Another consideration in selecting methodology for analysis centred upon my endeavour to congruently connect my epistemology and theoretical perspective with the methodology. I therefore needed to adopt a critical perspective while avoiding an inflexible imposition of this perspective on the data in ways that might narrow my interpretation.

Given these considerations I decided that I needed to adopt more than one technique for reading and analysing the data. Mason (1996) refers to the option of conducting both categorical (cross-sectional) and non-categorical readings of data. The former, she argues, involves studying the transcripts carefully line-by-line and identification of preliminary and tentative categories emerging from each transcript. These categories are coded and then applied across all of the transcripts. This lengthy process is highly flexible initially with

renaming, collapsing and merging of categories. As the research develops, connections are identified between categories and in this way theory is gradually constructed.

I utilised a categorical technique, referred to as "thematic networks analysis" developed by Attride Stirling (2001, p.385).[73] Mason (1996) refers to the advantages of the categorical method as: providing a systematic and rigorous overview of the data; assisting the researcher in distancing herself from the initially striking or memorable events; allowing surprises to come from the data thereby moving the researcher beyond an impressionistic view. The criticism of this method lies in it being mechanistic and segmenting of the data (Van Manen 1990, Mason 1996) and for this reason, a decision to conduct only a categorical analysis needs clear justification.

The non-categorical technique referred to by Mason (1996) involves a more general reading of the data and rather than segmenting it, identifying the "particular rather than the common or consistent, and the holistic rather than the cross-sectional" (p.128). This, she argues, enables the researcher to become aware of the distinctiveness of parts of the data, to come to a deeper understanding of the highly complex social processes and practices and to recognise the idiosyncratic and non-cross sectional. I therefore applied this to the second reading of my data.

The final stage in the analytical process involved relating the key themes and patterns that resulted from the analysis to the original research aims and drawing conclusions through a synthesis of the network analyses (Attride-Stirling 2001).

Conducting the analysis

From the outset of the research, I transcribed verbatum any taped interviews and typed up all non-taped interviews, observational and related field notes. These were dated so that the notes matched the interviews. I then subjected all of this data to a thematic networks analysis. This method of data analysis was developed by Attride-Stirling (2001), although its origins are traced to some of the principles of argumentation theory developed by the English philosopher Toulmin (1958). Toulmin (1958) asserts that arguments take many different forms. These may include presenting cases in law courts, making meteorological statements or a historian defending the character of an historical figure. Toulmin (1958) recognises that the construction of trustworthy arguments is necessarily "field-dependent", but that there are also basic steps in the progression of an argument that cross interdisciplinary boundaries (p.240). Toulmin (1958) emphasises that in order to make a trustworthy argument, i.e. to draw some form of conclusion, one has to establish the merits of that "claim". This requires establishment of "warrants", i.e. principles and premises upon which the arguments in support of the claim are constructed. "Backing" is then required, i.e. supportive arguments for warrants. In this way the person constructing an argument progresses through three key stages, backing, warrants and a claim (Toulmin 1958, p.97, 98).

Attride-Stirling (2001) developed Toulmin's three stages in the construction of an argument into a specific methodology for analysing qualitative data. This involves developing a series of themes that are presented into a set of networks:

1.   Basic themes (Backing).
2.   Organising themes (Warrant).
3.   Global themes (Claim/Conclusion).

These are presented with the global theme placed centrally, the organising themes radiating from the global theme and the basic themes stemming out from the organising themes. Each network has one global theme at its centre so that the final presentation consists of several networks each with a different global theme at the centre. The connections between the themes in each network are clearly visible. In this way, as Attride Stirling (2001) asserts:

> The technique provides practical and effective procedures for conducting an analysis; it enables a methodological systematization of textual data, facilitates the disclosure of each step in the analytical process, aids the organization of an analysis and its presentation and allows a sensitive, insightful and rich exploration of a text's overt structures and underlying patterns (p.386).

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[73] I describe the stages of this method in further detail later in this chapter.

The step-by-step process of building theory, as Attride-Stirlling (2001) notes, has common links with other analytical techniques, for example 'Grounded Theory' with its concepts, categories and propositions (Corbin and Strauss 1990).

Steps in the analysis

The first stage in the analysis I conducted was the data reduction phase involving:

> The process of selecting, focusing, simplifying, abstracting, and transforming the data that appear in written-up field notes or transcriptions [....]. It sharpens, sorts, focuses, discards, and organises data in such a way that final conclusions can be drawn and verified (Miles and Huberman 1994, p.10).

The analysis that I conducted consisted of line-by-line reading of the text and coding of the basic themes in the margins of each transcript and then on to a large spreadsheet. In this way I constructed a coding framework that enabled the extraction of sections of text that related to each code. Over the duration of the field-work stage these codes were frequently readjusted, renamed, collapsed and merged in order to produce a manageable set of basic themes. As advocated by Attride-Stirling (2001), I carefully named each basic theme in order to summarise the text sections succinctly and in a way that differentiated it clearly from other basic themes.

The next stage in the analysis involved the construction of the thematic networks (Attride-Stirling 2001). I identified common groupings of basic themes and grouped them into organising themes. I allocated a title to each organising theme that reflected the nature of the cluster of basic themes. This naming process in itself made me reflect considerably upon the nature of the basic themes and how they underpinned the organising themes. I then grouped the organising themes into global themes. Each global theme thereby constituted the "core, principle metaphor that encapsulates the main point of the text" (Attride-Stirling 2001, p.393). I was then able to represent each global theme and its associated organising and basic themes as visual networks. I commenced this process of developing networks from an early stage in the data collection in a very tentative way and this process in itself assisted me in developing the field-work further. I constantly engaged in a process of refinement and verification of the networks throughout the research process until no further basic themes emerged, there was no further movement of the themes and the relationships between the themes were well established. This process is referred to by grounded theorists as "theoretical saturation" (Strauss and Corbin 1990, p.188).

Having considered the use of computer-assisted qualitative data analysis software CAQDAS (Webb 1999) I went on two courses, 'N.Vivo' and ATLAS/ti, to enable me to select and utilise computer software to conduct the network analysis. However, I found that the CAQDAS made me feel alienated from the data and I decided that my own paper alternative along with 'Windows' was very adequate for conducting the analysis. Utilising 'Windows' and paper gave me time and space to deeply reflect on the data rather than trying to become familiar with complex computer packages. The process of writing and rewriting assisted me in the verification and refinement process. A list of basic, organising and global themes is presented in appendix 4 and the final thematic networks are presented within chapters 6-9.

I analysed the 'guided conversations' with midwives separately, utilising thematic networks analysis. This involved setting up a separate coding scheme. However, as the analysis of the observational data and interviews with mothers progressed I started to see ways in which the midwife data fitted in with the developing coding scheme for mothers. Therefore I gradually incorporated the midwifery interview data with the main analysis and in this way I added depth and further context.

Throughout the analysis stages I placed particular attention upon language. As Hammersley and Atkinson (1995) state:

> The actual words people use can be of considerable analytic importance. The 'situated vocabularies' employed provide us with valuable information about the ways in which members of a particular culture organize their perceptions of the world, and so engage in the 'social construction of reality' (p.183).

As Attride-Stirling (2001) asserts, the thematic networks constitute a tool in the analysis, not the analysis itself. The networks enabled me to return to the transcripts and re-read them in relation to the networks in a cyclical way. I was then able to describe each network in turn and illustrate the description with sections of text. This supported me in theorising, in that I was actually exploring the networks and summarising the themes and the patterns characterising them. In order to make increasing sense of the data I utilised the developing networks along with ongoing reading of relevant literature to provide me with a deeper conceptual awareness that, in turn, supported me in a rich and in-depth analysis.

Non-categorical readings of the data enabled me to 'pull out' specific scenarios and longer sections of transcripts in order to "show" as well as "tell" (Spradley 1980, p.166). The non-categorical readings also enabled me to effectively link the micro issues identified in the categorical technique with a more macro and holistic perspective. This macro-micro connection is crucial to a critical anthropological analysis, as discussed in chapter 3. A macro perspective was further developed by another reading of the transcripts in which I specifically viewed the data through a critical lens in order to highlight the influences of dominant ideologies, as recommended by Thomas (1993). My field notes and reflective diary were utilised in contextualising the analysis within the socio-cultural and interactional contexts.

The non-categorical readings and analyses also assisted me in presenting discrepant cases. This was particularly the case for the encounters between midwives and mothers that I describe as 'taking time - touching base' (see chapter 9, section B). Because of the few instances of this type of encounter I could not subject the data to a formal networks analysis. However, I felt that the data warranted presenting in a specific section rather than simply juxtaposing it with the larger volume of more negative data. The non-categorical reading therefore enabled me to analyse each situation in turn and draw conclusions. Chapter 9(B) is therefore presented in a different way to the others.

The more holistic readings also enabled me to more effectively utilise the concepts that were increasingly informing my interpretations, as lenses. Thus, for example as I became increasingly aware of the impact of a linear interpretation of time in contemporary western society, I reread the transcripts and reviewed the networks with this very much 'in mind'. Likewise, the concepts of 'production' and 'surveillance' were utilised as conceptual lenses. This conceptual focus enhanced my depth of theorising considerably.

Throughout chapters 6-9 I illustrate the themes with sections of interviews and observations. While I do not specify which site the participants were from, unless particularly relevant, the numbering system enables this identification.[74]

Theoretical sensitivity

Whilst I did not specifically utilise grounded theory, I did embrace the notion of theoretical sensitivity advocated by Strauss and Corbin (1990). This relates to the ability of the researcher to become aware of the subtle meaning of the data and involves:

> Having insight, the ability to give meaning to the data, the capacity to understand, and capability to separate the pertinent from that which isn't [....]. It is theoretical sensitivity that allows one to develop a theory that is grounded, conceptually dense, and well integrated (p.42).

Sources of theoretical sensitivity included my knowledge of relevant literature, previous experiences in the field of postnatal care and personal experiences of having breastfed three children on postnatal wards. Further sources of theoretical sensitivity stemmed from frequent interaction with the data to develop insight and understanding, asking myself questions about the data, making comparisons, making hypotheses[75] and developing tentative theoretical frameworks (Strauss and Corbin 1990). Throughout the process, I maintained an "attitude of scepticism" toward the development of the themes and their interconnections, validating them repeatedly with the data (Strauss and Corbin 1990, p.45).

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[74] P1-40 represent the postnatal women on site 1 and P41-61 the postnatal women on site 2. Midwives (MW) 1-24 worked on site 1 and midwives (MW) 25-39 worked on site 2. See also appendix 1.

[75] Defined loosely here and not in the way used in research underpinned by positivistic assumptions.

Establishing trustworthiness

A key consideration in the conduct and reporting of this research was the need to maximise the trustworthiness of the research by appropriately representing the area I was studying. A term such as "trustworthiness" is commonly employed in research underpinned by a constructionist epistemology and the range of theoretical perspectives stemming from it (Lincoln and Guba 1985, p.289). Use of terms such as trustworthiness within qualitative research indicates recognition that criteria for deciding what constitutes rigour cannot be transferred between epistemologies underpinned by fundamentally different assumptions (Toulmin 1958, Lincoln and Guba 1985, Guba and Lincoln 1994, Ray 1994, Daly and McDonald 1992, Mason 1996). Lincoln and Guba (1985) state:

> The basic issue in relation to trustworthiness is simple: How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, that would be persuasive on this issue? (p.290).

My actions and interpretations throughout the research process were guided by the need to maximise the trustworthiness of the research. Firstly, I paid close attention at all stages of the research process to ensuring that there was coherence between my epistemology and ontological position, my theoretical perspective, methodology and methods (Guba and Lincoln 1994, Mason 1996, Crotty 1998). This included making explicit my critical standpoint or analytical lens and the ways in which they fed into my interpretation of the findings. My central ontological position was that the research participants' "knowledge, views, understandings, interpretations, experiences and interactions were meaningful properties of the social reality" that I sought to explore (Mason 1996, p.39). As Martin (1987) states:

> We must not make the mistake of hearing the particularistic, concrete stories of these and other women and assume that they are less likely than more universalistic, abstract discourse to contain an analysis of society. It is up to anyone who listens to a woman's tale to hear the implicit message, interpret the powerful rage, and watch for ways in which the narrative form gives "a weighted quality to incident" extending the meaning of an incident beyond itself (p.201).

The varied techniques I utilised for reading and analysing the data assisted me in being systematic and meticulous in 'teasing out' the range of issues generated rather than simply 'picking out' those that corroborated my standpoint. To assist with the categorical reading of the transcripts I maintained a balance between ensuring enough flexibility and rapport to elicit individuals' stories and yet maintaining enough consistency in type and depth of questioning to allow for comparison between the participants (May 1991). The non-categorical re-readings then assisted me in linking back to the macro-political perspective essential to a critical ethnography. This supported me in 'keeping hold' of the ethical orientation for critical research to maintain an emancipatory potential.

The cyclical and iterative process of concurrent data collection and analysis with progressive focusing and seeking out discrepant cases assisted with maximising the depth of the theoretical process, as discussed earlier (Spradley 1980, Hammersley and Atkinson 1995). Periods away from the field were valuable in enabling me to 'step back' and reflect upon the developing analytical themes. This formed part of the endeavour to reach theoretical saturation which, as discussed earlier, is an important aspect in achieving trustworthiness.

I was also able to obtain respondent validation (Morse 1994, Appleton 1995) in those women who I interviewed on more than one occasion. I was able to present them verbally with key issues that they had highlighted the day before during the interview and to ask them whether or not they felt that these were for *them* the key issues. While I was not able to do this for the participants who I did not follow up, I viewed the respondent validations that I was able to conduct as a form of moderation, in that, those women I approached in this way were in agreement with my interpretations. Given the size and complexity of the analysis, the critical nature of the research and the range of 'voices' represented, I made the decision not to re-present the analysis back to the participants after completion of the research for further respondent validation. I felt that to present back to women sensitive issues at a vulnerable time in their lives when they were moving on and through different stages of new motherhood could have the potential to do harm (Sandelowski 1993). The midwives were informed that a

summary report was to be sent to each head of midwifery, which they might like to request to access. On both sites the reports were discussed at a management level and may have assisted in planning for further practice and educational needs for the midwives, although this was beyond my control.

Throughout the research process my decision/audit trail (Lincoln and Guba 1985, Ely et al 1991, Koch 1994) was made transparent through the peer review and support process provided during supervision of the thesis development. The developing thematic analysis was discussed in detail with my degree supervisor and this assisted in enhancing the trustworthiness of the networks and conclusions. The reflexivity and openness encouraged through the supervision process also assisted in ensuring that my interpretation of the data was credible (Edwards and Ribbens 1998, Koch and Harrington 1998, Chesney 2001). I had the opportunity to present several papers on various aspects of my findings during the final year of my doctoral studies. Following these papers I received considerable feedback from members of the audiences related to strong resonance with their own experiences of supporting women with breastfeeding in hospitals and/or experiences as mothers in this context. This resonance adds to the trustworthiness of the research (Van Manen 1990). As Martin (1987) states:

> When the streams of talk we collected are gathered together, many hard truths are also revealed. But in addition, putting together many individual voices has produced a resounding chorus. The exhilaration and the wisdom in this chorus tell us of many visions of life, different for different women and powerfully different from the reality that now holds sway (p.203).

Conclusion

In describing the methods I utilised to gather, collate and analyse the data I have illuminated some of the controversies and challenges inherent in conducting ethnographic research. I have reflexively accounted for the ways in which I negotiated unpredictable situations and dilemmas that the research process generated. In the next chapter I describe, in more detail, my impressions of the postnatal ward cultures. I thereby set the scene for the ongoing 'findings' chapters.

Introduction

In this chapter I set the scene for chapters 6-9 in which I discuss the data by describing in more detail the settings in which I conducted the ethnographic study. This includes a description of relevant aspects of both sites to include the ways in which the medical sub-culture influenced midwives' practices and the experiences of women. The issues raised in this chapter are substantially expanded upon in the subsequent chapters. Site 1 and 2 are described separately in this descriptive chapter, but for further analyses in the subsequent chapters they are discussed together under the relevant basic, organising and global themes.

First impressions - Site1

The layout[76]

As stated, site 1 had two wards that had a mixture of ante and postnatal mothers. On entering each ward there was a staff office, a kitchen and on ward A, a nursery. The nursery on ward B had been converted into a staff sitting room. There was a 'patient's' sitting room at the opposite end of each ward. The patient's sitting rooms were rather bleak and uninviting. They contained several chairs, a hair dryer fixed to the wall, a call phone on a trolley and a television. In ward B sitting room there were rows of unused cots lined up by the window. I only occasionally saw women using the sitting rooms to use the hairdryer, phone or to watch television.

Signs

Before I even entered the wards the signs on the doors gave me a feel for what was to come. Firstly, they heralded medical territory by stating, "mobile phones must be turned off as they interfere with *vital* medical equipment" (my italics). Secondly, they highlighted that this was hospital territory with accompanying rules. Visiting times were boldly displayed, with a clear "two to a bed only" and "children must be supervised at all times" beneath the times.

Busyness and noise

As I sat at the 'station' I was immediately struck by the overwhelming and almost constant feeling of busyness and noise as summarised in my field notes:

> I'm feeling utterly bombarded by the busyness and noise. I'm acutely aware of the constant intrusions and interruptions which women face. The ward clerk calls to midwives to receive phone calls, or to inform them that a doctor has arrived to see a particular 'patient'. She conveys phone messages to mothers and asks for a response to relate back to the caller. The midwives are rushing up and down looking focused on the task, careful not to make eye contact with anyone in case they should divert them. The paediatrician arrives and zooms in on new mothers to do their 'baby check'[77]. Then the obstetric consultant arrives with one or two followers and makes a 'beeline' to designated post Caesarean section women. The physio trots around with her note-book, followed by the infant feeding specialist searching for specific mothers. The 'blood lady'[78] arrives next with her list and trolley followed closely by the 'photo lady' touting for business with her clicking high heeled shoes and noisy trolley. The 'Bounty lady'[79] arrives with her clip-board in search of new mothers. The care assistant comes round next looking for 'ladies' to take for a bath or shower. Each person is completely focused on her/his own task. There is no rhythm, no period of quiet [....]. To end the morning the meal trolley arrives and meals are briskly issued on trays to women. The noise is incredible, in addition to the often loud voices of the personnel coming and going and background conversations between women and midwives, I can hear the office telephone ringing, the blood pressure monitor on wheels, clattering across the

[76] Highly detailed descriptions of layout are avoided for ethical reasons.
[77] Newborn babies are medically checked by paediatricians (or midwives in some units) within twenty-four hours of birth.
[78] The phlebotomist takes a sample of women's blood to check their third day haemoglobin level.
[79] 'Bounty' bags are issued to new mothers. The 'Bounty' company provides a range of samples and related advertisements from various companies. Baby milk samples are not now provided in the hospital packs.

floor. There are fetal heart sounds blasting out noisily from at least one fetal heart monitor. Sometimes I can hear the heart rate accelerating, decelerating then the sound is lost and noisily resumed. The weighing scales are wheeled in making a clattering noise. A woman who has recently had a Caesarean section has 'Patient Controlled Analgesia' (PCA) in situ and this bleeps off intermittently, clearly worrying the mother who then buzzes-another intermittent noise (field notes).

There were commonly other serendipitous intrusions, for example on one morning I wrote:

To add to the extremely noisy and busy ward there is an environmental audit team led by a man in a grey suit and two attentive females in high heels following in his wake. All have clip boards, approaching women and asking them about the meals, the comfort of their beds and then 'nosing round' at bathrooms to survey levels of hygiene (field notes).

My perceptions were reinforced by one of midwives:

I mean, when women come here, they can't relax. They are constantly interrupted by doctors, you know, the paediatrician, then the surgeon if they've had a section, then the anaesthetist, then the physio turns up, then the blood lady arrives, then the midwife to check the mother and maybe later the baby, then its visiting.....It's just constant.... The ward rubs off on the women, it's bound to (Virginia, MW20).

After a medicalised birth

I developed an overwhelming sense that I was at the end of a medical production line. The maternity hospital has been described as a "conveyor belt" by Kirkham (1993, p.6), but the sense of being at the final stage of that system was powerful as I situated myself within the postnatal ward culture. I wrote:

My sense is one of being at the end of a fast medical conveyor belt. The women are often exhausted, stressed, and sedated. They are plunged into an unfamiliar setting, bombarded by a series of interactions with strangers and their spatial boundaries are constantly being invaded. A quarter of the women here have had Caesareans. It feels just like a post-op surgical ward. Women who have had a Caesarean Section, even if under spinal anaesthetic but especially if under general anaesthetic, spend the first day unable to do much for themselves. They are immobilised and dependent on the midwives for 12-24 hours. There is an actual and symbolic relinquishing of autonomy for the final stop in the hospital (field notes).

Women commonly referred back to their birth experience when interviewed. This enhanced the sense for me that they were living the experience of being at the end of the medical production line. One extreme example was highlighted by Sue:

I was going along fine, I felt really in control, just using the gas and air. It was fine but I wasn't making progress, so um, ...she (the midwife) broke my waters...then, um.... I knew as soon as she did it, I knew.....It was mad! She called an emergency and I was surrounded by ooh about eight or ten people. They were preparing me before they put me to sleep. The midwife was on the bed with her hand up me, keeping the head off the cord. She was fantastic though I had every faith in her (Sue, P29).

Sue subsequently had a postpartum haemorrhage and a haemoglobin level of 8.3, which left her feeling totally exhausted.

Vicky described her medicalised birth in some detail. Her description of her immobility and dependence afterwards vividly illustrates the hours following an emergency caesarean section:

Vicky (P30): When I was in the recovery room, I had no sensation, so I couldn't actually pick her up. So one of the midwives asked me how I was going to feed, did I want to breast or bottle feed. I said yes, I wanted to breast feed if there was anything there, so one of the midwives put her on to me because literally I couldn't move and she fed straight away?
F: How did that feel?

Vicky: It was nice but I was feeling a bit shell-shocked after being in labour for like.... 24 hours, I was really tired and I was all shaky from the anaesthetic.... my teeth were chattering and all my body was shaking so the midwife was just holding her on and....um....they wheeled me down here and they put me down and my husband put her next to me and she fed quite happily. We changed a couple of nappies and er.....The first night was actually OK but I was just so exhausted...um...You see they put me on the morphine and that made me really sick, so I was sort of laid there and every time she woke up one of the midwives put her onto me to feed her cos...um...I was still a bit..um couldn't manoeuvre myself properly and I was still being a bit sick as well with the morphine so it was a funny kind of a night.

Medical presence

There was an almost constant medical presence on the wards during week days. The unit employed seven consultants in obstetrics and gynaecology with four having their 'patients' warded onto ward A and three on to ward B. The consultants visited the wards mainly to see the post caesarean section women and complicated 'cases'. However there was a constant stream of doctors arriving to include junior paediatricians, junior and senior obstetricians and anaesthetists. I wrote in my field notes:

> There is a distinct medical presence about the ward, already, this morning (10.30) I have seen one of the male consultants in a slick suit followed by a registrar and midwife. The midwife swiftly pulls the curtains around the bed. The consultant briefly informs the woman about the reason for her Caesarean section and answers her questions. The anaesthetist, wanders around looking for his yesterday's Caesarean section mothers, and then approaches, gives the woman a brief resume and goes. The paediatrician with obligatory stethoscope around her shoulders briskly approaches mothers and examines their babies then rushes to the next person (field notes).

Constraints upon midwives - linear time, unpredictability and restricted spaces

The unit was clearly under-resourced, understaffed and almost always very busy, now recognised as a frequent situation in the maternity services (Kirkham 1999, Kirkham and Stapleton 2001b). There appeared to be two major constraints upon midwives, firstly the powerful effects of linear time, as they were tied into a system in which their daily work centred upon urgency, meeting deadlines and literally racing against time. Midwives frequently commented upon the extreme busyness of the wards, for example, *"Trouble is we are often so busy, we can't give them much help, we're just rushing about* (Kim, MW15).

> *There isn't the time needed to help women, let alone give them appropriate breastfeeding support......you can't do that when you're busy. You might have several antenatals, an early labourer, post sections and we're even the over spill for gynae.......You just can't do it* (Virginia, MW20).

Midwives' activities appeared to centre around saving time and using time efficiently, as also observed in related ethnographies (Street 1992, Kirkham and Stapleton 2001a and Stapleton et al 2002b, Varcoe et al 2003). However, their way of working was indeed far from efficient, based on the second major constraint, unpredictability.

Unpredictability was created by the work patterns of midwives, in addition to the general uncertainty as to who would arrive on the ward or go into labour etc. The seven consultants each had their 'own' team of hospital midwives based on wards A or B, to be dispatched off to antenatal clinic on 'their' consultant's clinic session.[60] The midwives on these wards could be called to delivery suite or theatre when needed, at a moment's notice. A midwife could come on duty on to the ward and then go to clinic an hour and a half later for the reminder of the morning. The remaining staff would continue the ward work, knowing that they could be called to 'scrub-up' in theatre or to help out when delivery suite needed them. This created anxiety and insecurity and led to a philosophy of needing to get the work done on the ward in case the staff were suddenly depleted, in some cases leaving only two midwives and a care assistant

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[60] The community midwifery service ran separately from that in the hospital, with midwives being allocated to one or other area, i.e. a non-integrated midwifery service.

with the entire ward.[81] The midwives referred to the lack of control over working conditions, inability to get to know women, inflexibility and insecurity created by the 'rotating' team structure. The following quotes speak volumes on this issue:

The main problem is never knowing when you might be moved...can you really get to know anyone when you may be shifted off at a moments notice. I mean some staff can be working on the ward, clinic, delivery and theatre all in one day. On top of that there aren't enough staff and therefore we can only try to give breastfeeding advice but often that's not enough (June, MW5).

The staff are draining away. It's the team system we have here. It's disruptive. There's no flexibility. We are losing experienced staff. There's low morale....nobody knows what is going on. They're here there and everywhere (Jade, MW12).

There's currently a mass exodus of staff here. They just can't stand the teams, the way they work here...Someone can come on in the morning and move to clinic or delivery, often with a minute's notice. It's making them very insecure and there's no ownership whatsoever. I mean they don't feel a part of this ward at all.... you are moving round so fast you can't think (Jenny, MW14).

My problem today is that I've come on at 8-15. I have to cover clinic later, so if I came on at 7-15 and then covered clinic to 5 it would be too long a day. So... I come on at 8-15. I don't get a report, I know nothing about the women and I'm not even here to hand over to the next shift. What sort of continuity is that? The system needs to be changed (Virginia, MW20).

Not only were midwives under immense temporal pressures but they were also restricted in many ways spatially. They were unable to leave the ward due to lack of staff and the need to be around for emergencies. On ward A, the only place to have a break was the kitchen in which other activities took place. On ward B there was a staff room that enabled midwives to relax. Nevertheless, on both sites midwives were confined to the ward space for most of the day. This restriction is a clear additional source of stress (Street 1992, Halford and Leonard 2003). Midwives powerfully illustrated their dissatisfaction with the 'system' by their actions and body language as they passed me at the 'station'. They often let out a loud 'sigh' and made comments indicating their relief at completing aspects of their work, surviving the shift and going off duty soon.

There appeared to be varying degrees of accommodation or resistance to this way of working. Some midwives felt that they simply had to put up with the 'system':

We've got three midwives on for the whole ward. It's very poor, very poor. You don't even get a break. You just put up with it because you have to but...um...it's not very good at all (Francis, MW24).

This position of accommodation, helplessness and acceptance with the status quo is well documented in nursing and midwifery practice (Street 1992, Kirkham 1999, Ball et al 2002, Varcoe et al 2003). Other midwives expressed a desire to return to the certainty of the past, for example, *"this way of working doesn't suit a busy postnatal ward....task orientated work does in my opinion"* (Shannon, MW6).

There were several ways in which the system was passively resisted. Some midwives attempted to avoid being moved by providing reasons why they needed to stay, for example because they were allocated to a woman or baby with particular problems, requiring continuity of carer. Another strategy involved blocking beds by encouraging women to stay in for another day to avoid another admission. Other midwives simply described their plans to leave but this was discussed with me as an 'off the record' issue. I return to the issue of resistance in chapter 6.

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[81] I return to the issues of lack of time and unpredictability in more depth in chapter 9, with reference to relevant theory, as they are of particular relevance and importance within this study.

Posters

The posters on display on site 1 portrayed issues that resonated strongly with the themes I developed in this thesis. There was an array of posters (1, 2 and 3 below) in the hospital corridors before even reaching the wards, giving me a clear sense that promotion of breastfeeding was a strong agenda item in this unit. I was immediately struck by their alignment with both the techno-medical and 'breast is best' ideologies that pervaded the maternity hospital culture. Overwhelmingly, they represented the concepts of production, separation and maternal duty. They illustrated what Fairclough (1992) describes as proliferation of the commodity model outside the conventional sectors of the economy, related to the enterprise culture with the accompanying pressure to "package" activities as "commodities" and "sell" them to "consumers" (p.116). The separatist ideology so very central to the techno-medical model (Martin 1987, Davis-Floyd 1992) was clearly evident, with the central picture on posters 1 and 2 depicting a baby at 'a breast' but an absence of the mother's face. This illustrated her role as producer and deliverer of a disembodied product, breast milk, to her baby, or consumer. Each poster had the central statement, *"you've got what it takes to make a healthy baby - And it doesn't cost a thing"* and ended with the source - *"infant maternal nutrition education, Toronto".* This illustrates the woman's role as producer and deliverer of breast milk to the consumer, her baby. Furthermore, the notion that it is "cost free" ignores the work involved on the woman's part. I now make brief further comments on each poster.

Poster 1

This Union offers security, no dues and great benefits.

Picture of a baby at the breast

You've got what it takes to make a healthy baby. And it doesn't cost a thing.

Infant maternal nutrition education, Toronto.
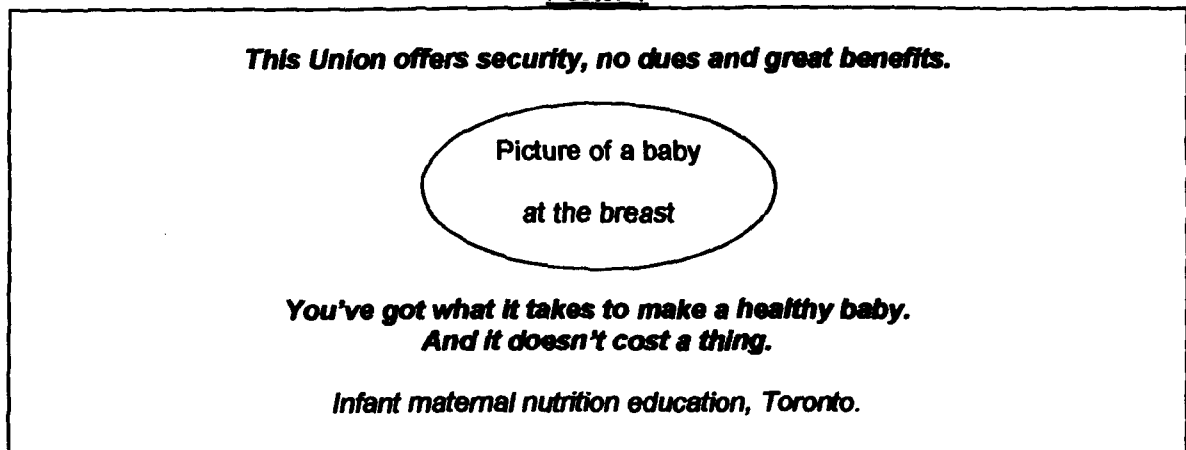
The entire emphasis of poster 1 is an economic one. The word union, relates to the mother and baby, but could also be interpreted as a Trade Union. The suggestion that there are "no dues, great benefits and that it doesn't cost a thing" combined with the statement "you've got what it takes to make a healthy baby", suggests that the mother is equipped to do this, that it is her obligation and further more that because it is 'free' economically then it is 'cost' free.

Poster 2

Sometimes its OK to suck up to the boss.

Picture of a baby at the breast

You've got what it takes to make a healthy baby. And it doesn't cost a thing.

Infant maternal nutrition education, Toronto.
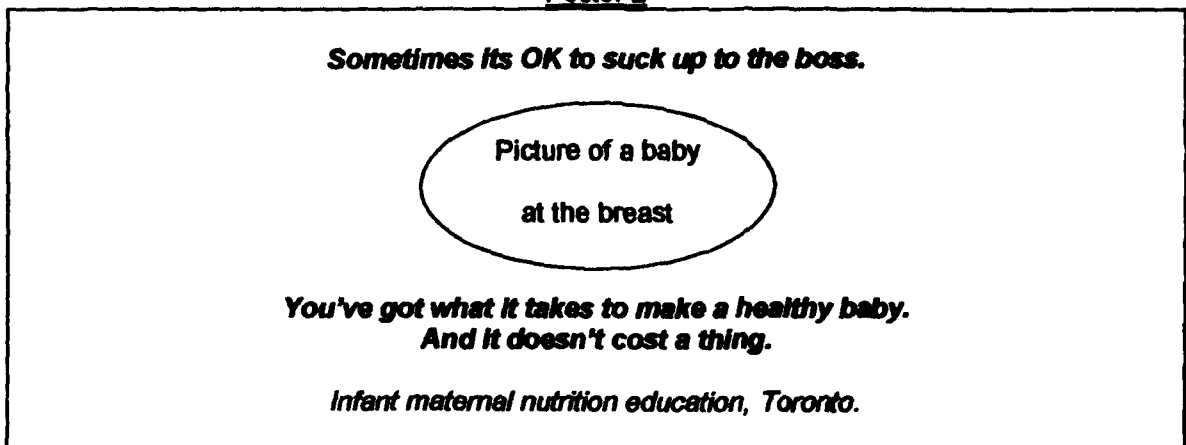
Poster 2 also employed a work place metaphor, *"sometimes its OK to suck up to the boss"* which is implicitly patriarchal in nature and again places breastfeeding in the market place context.

Poster 3

<div style="border:1px solid black">

A breastfed baby leaves fewer leftovers.

Picture of empty tins, bottles

and teats in a clear plastic bag

You've got what it takes to make a healthy baby.
And it doesn't cost a thing.

Infant maternal nutrition education, Toronto.

</div>
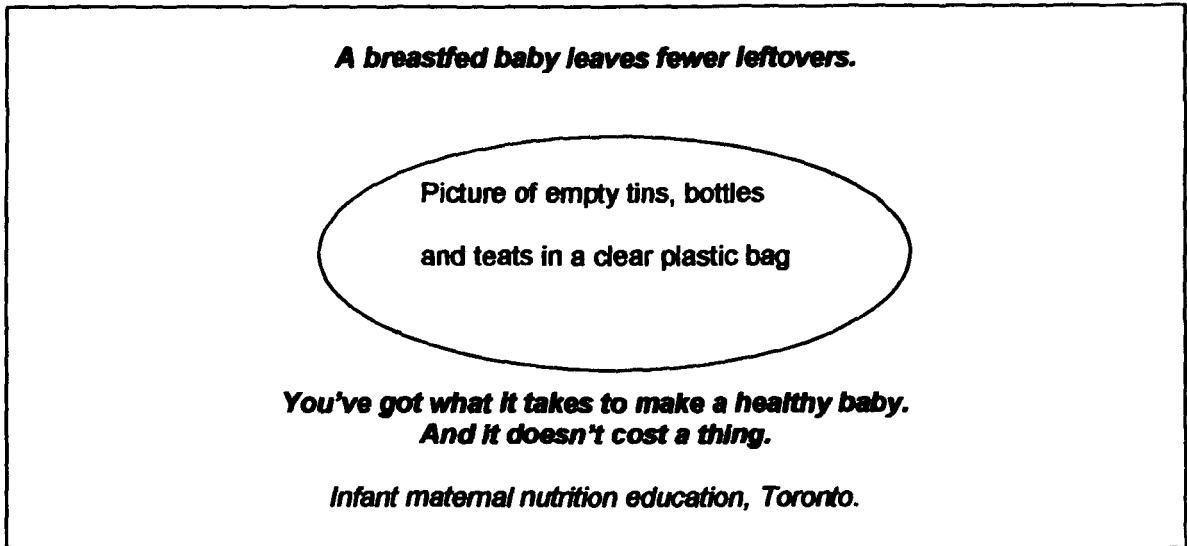
Poster 3 also has industrial connotations in that it refers to the lesser waste involved in the production process when breast milk is the product.

The second type of poster on display on the wards and corridors were those which listed the health benefits of breastfeeding, again emphasising that 'breast milk is best':

Poster 4

<div style="border:1px solid black">

You can't get fitter than a breastfed nipper

Picture of a baby

surrounded by health

benefits

Benefits to mum too e.g. ....

Breastfed is bestfed

</div>
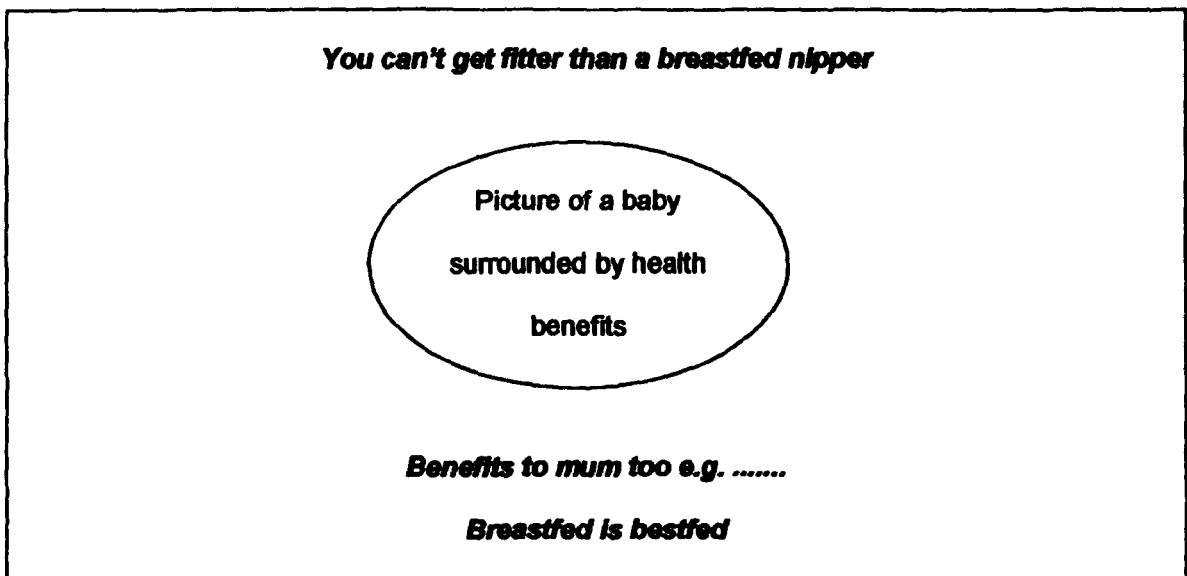
Poster 4 was produced by The Scottish National Breastfeeding Working group.

<u>Poster 5</u>

Breastfeeding's world of benefits

Picture of a baby surrounded by

health benefits
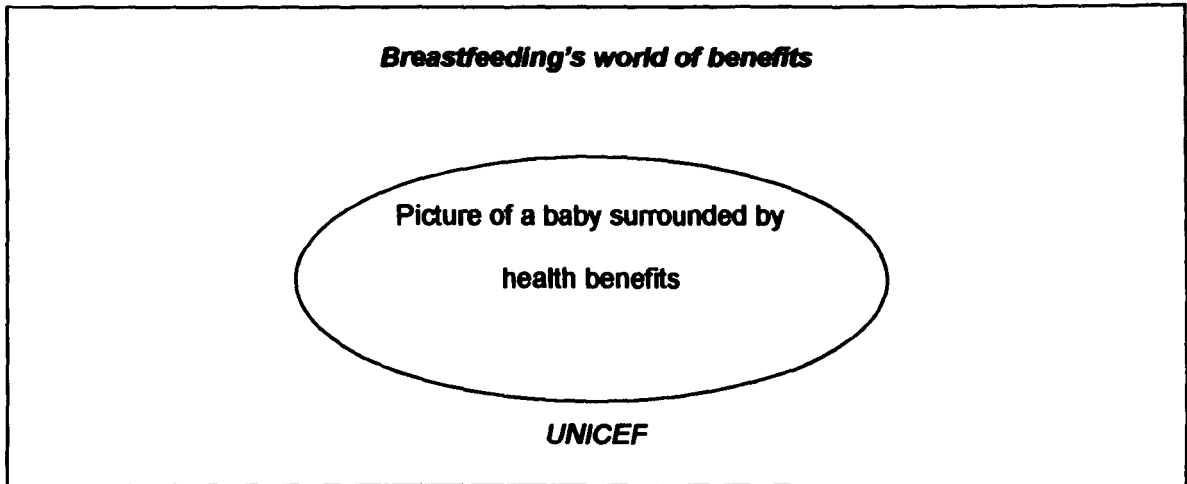
UNICEF

Poster 5 was produced by UNICEF UK BFI.

Finally, there were posters produced by the government DH.[82] The 1999 posters featured a range of products, in this case, designer jeans, sporting the label on the back stating *"Breast Milk"*. The accompanying logo stated, *"Free Fast Food for Babies"*. Here the word breastfeeding is omitted altogether and replaced by breast milk. The emphasis is again on supplying a product, *"fast"* and indeed *"free"* to the consumer. Again, it is considered free of economic cost and therefore does not imply any cost to the mother. The 2000 DH posters in line with the endeavour to encourage socially excluded groups to breastfeed, contained a range of multicultural and multi-class images. Each poster showed a man or woman holding a baby with a range of logos underneath, for example a West Indian man with the logo stating, *"My baby gets the best - she's breastfed"*. The images were cleverly produced and served to reduce stereotypes around breastfeeding, but they could be advertising any "product" and they avoided showing any breastfeeding taking place.

First impressions – Site 2

The layout

Site 2 was a smaller maternity unit. On entry to the ward there was a staff office with the ward clerk's desk just outside. The day room and side rooms were off to one side and rooms 1-4 off to the other. The sitting room was pleasantly decorated and contained comfortable chairs and a dining table and chairs. Women could go and help themselves to meals and drinks. They could then eat them in there or take them to their bed. However, after a few periods of noticing that it was usually used merely for collecting meals and drinks I asked some of the women and midwives why it wasn't used. I was told that women could not take their babies in there because, on passing the entrance door to get to the sitting room, they would set the alarm off. The women did not want to leave their babies unattended so only went to collect a meal or drink.

Next to the wards there was a room which used to be the nursery but was now called the treatment room to emphasise that babies would remain with their mothers. Baby's were taken there if they needed a heel prick and the mother preferred that the baby be taken else where. The room contained a resuscitaire and shelves with dressing packs, the drugs trolley and the drugs fridge. It was the only room with a very clinical 'feel'. Otherwise the entire ward was carpeted and had a less overtly clinical atmosphere than that of site 1. Each of the rooms was fairly quiet as midwifery business, and indeed busyness, occurred in the office and corridors.

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[82] The DH Infant Feeding Initiative produces posters with a different theme each year as part of the annual UK National Breastfeeding Awareness Week.

Medical presence

Three white male obstetricians covered the maternity unit supported by largely south Asian women doctors and one South Asian male, a senior registrar. Given the 'lower-tech', less medical feel of the place, I was surprised that every morning at 9am a consultant round took place during which all antenatal women and post-Caesarean section women were visited by the consultant or senior registrar 'covering for that day'. The staff office acted as a central place in which the midwives, care assistants, medical staff, the ward clerk, physiotherapists and other staff 'came and went' combining business with casual chatter. Anyone arriving at coffee time would be offered a drink and toast. At such times the small office would be crammed with people, some sitting and some standing.

Visiting

There was open visiting for partners, with two fixed periods in the afternoon and evening for other visitors. Many of the women I saw had their partners with them for most of the day as they were either off work or unemployed. The curtains were normally closed around each bed, so the new family unit of mother, father and baby was left alone. This created the sense of the women and their partners being in their own 'private space' within a public domain. I return to this issue in the next chapter.

Structure of working for midwives

The pattern of working for midwives on site 2 was similar to that on site 1. There was a core staff on the ante/postnatal ward and delivery suite. The hospital antenatal clinic had its own permanent staff. The remaining midwives were designated to practice in both community and on the postnatal ward, going to delivery suite when required. They worked in four teams based around GP practices. In practice, the midwives had negotiated between themselves so that some covered community and others hospital, with a degree of flexibility. Betty explained:

> F: *How does the team structure work on here?*
> Betty (MW26): *Well, we have four teams which are based around GP practices.*
> F: *Are they geographically based?*
> Betty: *No, the practices aren't necessarily clustered together.*
> F: *So, do the midwives come in to see the women they have been supporting?*
> Betty: *No, in theory we all do community and hospital, but in practice some members of the team stay in hospital, others go out and mostly work in the community.*
> F: *So what about delivery suite?*
> Betty: *Well, we'll be called from the ward if we're needed on there. It's quiet on there today, so we're all here.*
> F: *So when you're on delivery suite do you look after women from your team?*
> Betty: *Well, if that works out, but not necessarily. It depends on who is in and who is on.*
> F: *What about on here?*
> Betty: *No we all muck in here. It's easier.*
> F: *Do you tend to look after the same women each day?*
> Betty: *Sometimes, but quite often we'll be on here one day, delivery the next, so not really.*

Clearly continuity of care in hospital was compromised by these patterns of working although women in the community received continuity of carer from those who designated themselves as predominantly community-based. Like site 1, the midwives could be called to delivery suite at short notice and the decision was taken depending on who was doing what on the ward.

Midwives were sometimes very busy and at other times they were much less pressured for time. However, like the midwives on site 1, they faced constant unpredictability in that at any moment either they or a colleague could be called to cover delivery suite or theatre. This would require rapid reorientation of the 'sent' individual and reorganisation by remaining staff who would suddenly be left one or two members of staff short. The smallness of the unit meant that the wards could lurch from being well staffed to very understaffed within a few minutes, in a more acute way that site 1. Emergencies could arise at any time particularly with the antenatal women, creating more unpredictability. This unpredictability meant that whether busy or not there was pressure to get through the work in case circumstances dramatically changed. It

contributed to a rushed, chaotic and fragmented approach to care as described by others (Ball 1994, Kirkham 1999, Kirkham and Stapleton 2000, Ball et al 2002). Linda referred to the unpredictability of the working situation that again reflected the super-valuation of the delivery suite:

> *The difficulty with this ward is that you can start off with only one bay and an hour later you could have the whole ward. So you can't just take your time because you don't know when someone will be moved to delivery* (MW32).

On one of the busier days on which I attended the unit, Felix clearly felt that the concept of 'team' was not being actualised when she was the only midwife left after the others had been relocated:

> Felix (MW29): *It's ridiculous. They've* (the other midwives) *all been sent to delivery, they've got a few problems on there.*
> F: *Who's left*
> Felix: *Well, no one. Just me and the auxiliary.....and the clinical manager is helping out with the antenatals. It's a joke isn't it? Team... well, they call it team....(laughs)......It's not working.... it's not team.*

The midwives and student midwives could choose whether to wear their own clothes or a uniform dress. On most spans of duty I saw a range. The midwives who selected to wear uniform tended to be older and more traditional. This variety of dress codes gave the feel of a unit in transition. Midwives tended to have breaks 'on the job' in the small office, the place in which staff converged to discuss client issues, to write up notes, to meet with other health staff and answer phone calls.

Posters

The only posters I saw on site 2 were situated on the notice boards in each of the main three to four bedded rooms. This discrete presence of posters reflected the lower profile of breastfeeding evident on site 2. The first poster stated:

The Hospital's Rooming-in Policy.

We have a rooming-in policy:
- As mother we encourage you to assume primary responsibility for the care of your baby.
- Separation of mother and baby while in hospital will normally occur only where the health of either of you prevents care from being given by you.
- We do not have a designated nursery.
- Mothers and babies are together during the day and night whether the baby is being breast or bottle fed.

The second poster was entitled the 'Benefits of skin-to-skin contact after the birth' and simply listed the benefits underneath a title:

Benefits of skin-to-skin contact after the birth:

- Best for bonding
- Calms baby
- Keeps baby warm
- Regulates baby's heart beat and breathing
- Gets breastfeeding off to a good start

The UNICEF UK benefits of breastfeeding poster, also displayed on site 1 (poster 5), was on display as was a DH "Eating out Together" poster, showing a picture of women breastfeeding their babies in a restaurant. Finally, the numbers of voluntary breastfeeding supporters were listed on a small poster.

Conclusion

Audit and research conducted at the turn of this century largely reflects a gloomy picture, showing growing medicalisation, for example Caesarean rates commonly above 20%, births attended primarily by midwives falling and most maternity services reporting staff shortages (English National Board 1999, Anderson 2000a). This 'picture' was also reflected in this ethnographic study. Whilst I have highlighted some differences between sites 1 and 2 there were more similarities. Both represented the bureaucratic hospital culture with its production line ethos, hierarchical structure and unpredictable time constrained working conditions for midwives and related staff. The experience for women was largely of a medical nature and encounters reflected the sub-culture from which they emanated. Both units were medicalised and becoming increasingly so with Caesarean section rates rising year by year.

While site 2 had a less medicalised atmosphere and a higher ratio of midwives to women, both sites presented midwives with a daily experience of unpredictability in terms of workload, movement to other wards and the inevitable uncertainty of new admissions. The insecurity and uncertainty created by the possibility of being sent to delivery suite at a moment's notice reflects the cultural supremacy of the place where women labour, that is, the place where medical technology and expertise are most prominent. Postnatal care as a result of it's low position in the techno-medical hierarchy is often described as the 'Cinderella' of the maternity service reflecting its impoverished status in terms of resources and staffing (Ball 1994, Garcia et al 1998, Anderson and Podkolinski 2000, McCourt and Percival 2000, Royal College of Midwives 2000a,b, Singh and Newburn 2000a,b). As Edwards (2000) states:

> The medical model, as a dominant ideology, has imposed its own structures and policies to manage birth and govern the distribution of resources in maternity services in ways that profoundly affect relationships between women and midwives (p.61).

The system precluded any sense of relationship developing between midwives and women. Neither midwives nor mothers had any real influence regarding who they encountered in hospital. The ways in which midwives 'cope with caring' within this environment and the ways in which it impacts upon postnatal women are returned to in depth in chapter 9. I have focused more upon midwives than mothers in this chapter in order to set the scene for the following chapters. This setting of the midwifery context I felt was important as encounters with midwives inevitably reflect the culture within which these are constructed. In the next chapter I switch from unpredictability and time pressure...for a time....and focus upon the ways in which breastfeeding women and indeed midwives experience the pressure of 'doing the correct thing...the right way'.

CHAPTER 6
DOING THE CORRECT THING...THE RIGHT WAY

Introduction

In this chapter I discuss the development of the global theme, 'Doing the correct thing....the right way' and its underpinning organising themes of 'feeling the pressure' and 'resisting the gaze' (see figure 6.1). As I highlighted in chapter 2, during the latter part of the twentieth century and into this century the notion that 'breast is best' has become increasingly ideologically pervasive with an exponential growth in scientific evidence to support this. In addition there is a proliferation in recommended practices and techniques related to 'how best to breastfeed.' These authoritative knowledges appear to have constantly shifted and changed since the 'Enlightenment'.

A classic example of a constructed version of breastfeeding is seen in the 'techno-medical model' of infant feeding, discussed in depth in chapter 2. Along with the development of infant formula as a medically endorsed alternative to breast milk came the increasingly prescriptive regimentation of feeding practices whether breast or bottle and the limiting of contact between mother and baby. Breastfeeding was discursively disconnected and separated from women's bodies, seen as a mechanical process with strict timing of feed frequency and duration. Linear time management, separation and control were super-valued. Milk, whether formula or breast came to be seen in terms of its constituents with emphasis placed upon production and transmission of milk to the baby. The mother became invisible except to be held accountable for deficiencies in her milk or the feeding of her baby. Van Esterik (1989a) refers to this western biomedical version of infant feeding as the "product" model in contrast to the "process" model that centres upon a more holistic representation of breastfeeding as a nurturing relationship. She states:

> Process models emphasise the continuity between pregnancy, birth, and the process of lactation rather than the product, breast milk. The adoption of the biomedical model with its accumulated scientific evidence about the nutrient composition of breast milk and breast milk substitutes is a product-orientated model (p.5).

Gradually over the second half of the 20th century, notions of naturalness were reintroduced through emerging mother-infant theories. Examples of authoritative discourses that urged a return to 'natural' practices are seen in the recommendation that demand feeding was more physiological (Illingworth 1952) and Klaus et al's (1970,1972) theory of bonding. This medically endorsed return to natural as normal is exemplified in the BFI, as discussed in chapter 2. I described it as the 'natural medical model', because, in spite of its emphasis upon removing time constraints and avoiding separation of mother and baby, breastfeeding is still seen as very much in need of institutional regulation, management and monitoring. The primary emphasis remains clearly upon the benefits of breast milk as a product for the baby. Thus it fails to move significantly away from a product model.

A non-medically mediated representation of a 'natural' model, as an alternative to the 'natural medical model', is exemplified in the philosophy of La Leche League (2003b). LLL places emphasis upon closeness, nurture and longevity related to breastfeeding and indeed the mothering relationship. Mothers and babies remain closely together, with mothers being totally devoted and focused on the baby's needs over a long period of time. The baby is offered unlimited access to mother's breasts throughout the day and night. There is a strong emphasis upon connectedness, relationality and embodiedness (Blum 1999, Bobel 2001). Clearly, the key tenets of this model align it to Van Esterik's (1989a,b) process model. This 'natural model', however, may be seen as fundamentally essentialist in that it arguably imposes an often unattainable standard upon women within cultures where the support for and protection of breastfeeding women is seriously lacking. It thus fails to address some of the complex and dualistic representations of women and women's bodies.

Over the last 30 years in the UK, breastfeeding has become inextricably woven with notions of 'good' motherhood, an issue that has been subjected to substantial critique (Maclean 1989, Dyball 1992, Blum 1993, 1999, Carter 1995, Schmied 1998, Murphy 1999, Schmied and Barclay 1999, Stearns 1999, Bartlett 2000, Britton 2000, Pain et al 2001, Wall 2001, Meyer and de Oliveira 2003, Shaw 2003). The idealised notions of motherhood and breastfeeding are heavily constructed, located and defined within a historical and cultural context. As Standing

Figure 6.1
Thematic Network:
Doing the correct thing....the right way
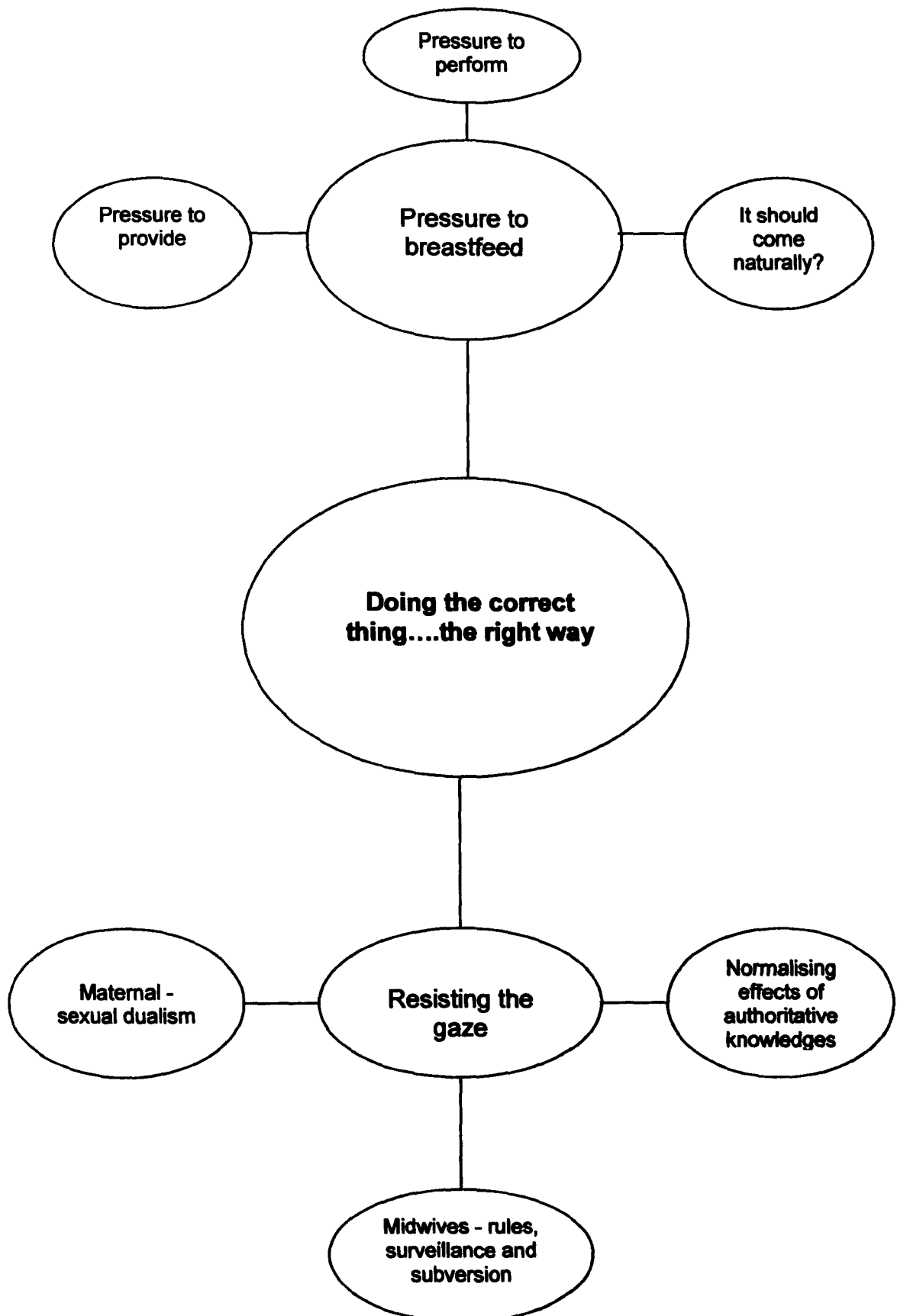
(1998) argues, the social construction of 'correct' and 'good' motherhood has developed through the dominant discourses around normative mothering resulting in women being defined in relationship to motherhood. She states that this construction of all women as potential mothers, be they 'good' or 'bad', inevitably impacts on women's lives.

However 'good' motherhood is constructed, women still come into the lime light for blame as eloquently illustrated by Jolly (1998) through her exploration of colonial and postcolonial endeavours to transform indigenous patterns of motherhood in Asian and Pacific countries in the "name of civilisation, modernity and scientific medicine" (p.1). She refers to the way in which the "embodied maternal subject is pervaded by a profound tension [....] even a split [...] as the mother is sundered in contests between 'tradition' and 'modernity'"(p.2). This 'tension' was evident in the data for this thesis in relation to women's interpretations of acceptable breastfeeding and indeed mothering. The contradictory versions of 'doing the correct thing....the right way' in relation to infant feeding and the accompanying surveillance created feelings of pressure, confusion and dissonance for women. In addition, women experienced further dissonance around breastfeeding at a vulnerable stage of learning in a public domain, the hospital, when within the UK culture breastfeeding has become a predominantly private activity.

Pressure to breastfeed

The organising theme of 'pressure to breastfeed' emerged from the basic themes, 'pressure to provide' and 'pressure to perform' (Figure 6.1).

Pressure to provide

Just as the language around labour is medical in the sense that it emphasises measurable progress and fails to "conceptualize the experience of those involved" (Kirkham 1989, p.134), so the language around breastfeeding currently centres on its health benefits and its success in terms of delivery to the baby, duration and exclusivity. When I asked mothers about their reasons for deciding to breastfeed few referred to breastfeeding as something to be experienced for mother and baby. There was a sense in which they might see a personal experience perspective as appearing to be self-indulgent, departing from the required selflessness of the ideal mother. The reasons women gave were closely aligned with the strong biomedical and institutionally pervasive emphasis on the health benefits of breast milk stemming from governmental recommendations and non-governmental programmes such as the BFI. The women's reference to the health benefits was often made in a very automatic way, as if giving me the required answer. Women appeared to see breastfeeding as the 'correct' behaviour, standardised ideal and as a one-way non-reciprocal transmission of health to their baby via the medium of breast milk. As Shaw (2003) states:

> As an expression of corporeal generosity between mother and child, the transferring of nourishment from mother to infant is conventionally identified as a natural, non-contractual, bio-physiological act (p.68).

What alarmed me was the dispassionate manner in which the decision to breastfeed was expressed. Women appeared to have internalised the public and disconnected discourse that 'breast is best', to such an extent that they were no longer expressing their "feeling voices" (Ribbens 1998, p.35). Ribbens (1998) refers to the replacement of "feeling voices" by "moral voices", be they "pragmatic", "puritanical", "idealistic" or "watch for the future" (p.35). Sophie illustrated this in her impersonal use of institutional language:

> Um...just because of everything you read is breast is best....you know...helps you .. helps your baby .. it does help you lose your weight but its best for babies...more settled babies... and obviously everything's in breast milk but er.....its good for them ....so breast is best (P61).

Selina appeared to be 'doing it' because she had been taught and told to!

> Well I was always taught to at school, and my husband's a biology teacher, so he said you've got to. I mean it's there so, it must be there for a reason, it must be better (P48).

By far the main reason given for breastfeeding by women, as reported by others (Schmied 1998, Murphy 1999, 2000, Britton 2000, Schmied et al 2001), was that breast milk conferred health benefits on the baby due to its superior nature deriving from its immunological and nutritional factors, for example, *"it's better for the baby, more nutrients and it's balanced and there's everything there that they need"*(Jackie, P33), *"for her sake really as much as anything, for giving antibodies and things, especially in the first few weeks"*(Anthea, P54). The breast milk is natural discourse was very strong, for example:

> *I mean I think its obviously natural with immunity things and everything else, and err, I just think if it wasn't produced (laughs), there's a reason for everything isn't there, so err, that's the way nature intended, so stick with it* (Barbara, P37).

A few women referred to bonding, usually in a rather matter of fact way, with little reference to intimacy *"bonding, I'm doing it for bonding"* (Bev, P2)

It is beyond the scope of this research to draw conclusions related to differences between Asian and White women, particularly as the Asian women may have lived in the UK for most or all of their lives. However, it was striking that only one woman, from Gujarat, referred to intimacy, closeness and nurture, seeing breastfeeding as much more than providing breast milk to the baby, *"it's best for the kid and its intimate to you. Intimacy really is the main reason. I'm from India, from Gujarat...People there breastfeed for about 2 years"* (Usha, P36). This contrast reflects the western biomedical conceptualisation of breast milk as product important for its nutritional components in contrast to breastfeeding seen as an holistic and integrated process by some of the more traditional communities (Van Esterik 1988). It strongly resonates with Spiro's (1994) research with Gujarati women living in the UK that I discuss further in chapter 7.

Mothers who gave reasons other than for the baby tended to label themselves as lazy, *"well it's free, it's convenient and best for them. I'm lazy (laughs). I couldn't be doing with all them bottles. I've had the experience of doing it before"* (Lucy, P15), or selfish, *"well, one for the benefit of the baby and two selfishly because hopefully you lose weight quickly and go back to normal size* (Debbie, P13).

The reasons given above for deciding to breastfeed might suggest that women had made rational goal-orientated decisions, based on health outcomes, as emphasised within western, individualistic culture. In spite of women giving me the official discourse, as I probed I became increasingly aware of ambivalence in many of the women, for example:

> Megan (P53): *I decided earlier on in the pregnancy that I was gonna breastfeed, but coming up to it I was doubtful*
> F: *Coming up to the end of your pregnancy?*
> Megan: *Yeah,*
> F: *What gave you the doubts?*
> Megan: *Um, I suppose like its been nine months no drinking and now its 3 months on top (laughs). But..er..I'll see if I can manage it......... I mean until I start getting too sore or until she stops taking to it....*

Sandy, one of the midwives referred to this ambivalence:

> *Some of these mothers are not really committed to breastfeeding, so they give up at the first hurdle. I think they are just doing it for us really. To persist at breastfeeding you've got to really want to do it. Until people are convinced that human milk is for human babies then there won't be that commitment* (MW30).

She appeared to see the 'breast is best' ideology as the way in which women could be convinced. However, sociologically orientated qualitative research is revealing that women's decision making around breastfeeding relates most strongly to the embodiment of local cultural norms, experiences of family and friends, reactions to visual experiences of breastfeeding and ideologies around parenting (Maclean 1989, Hoddinott and Pill 1999a, Hawkins and Heard 2001, Pain 2001). The perceived pressure to provide, i.e. to breastfeed, was closely related to women's cognitive linkage between breastfeeding and ideal motherhood, as I now move on to.

Pressure to perform

Women tended to see breastfeeding as being a part of the performance or project of good motherhood (Maclean 1989, Bottorff 1990, Dyball 1992, Blum 1993, 1999, Carter 1995, Schmied 1998, Murphy 1999, Schmied and Barclay 1999, Stearns 1999, Bartlett 2000, Britton 2000, Pain et al 2001, Wall 2001, Meyer and de Oliveira 2003, Shaw 2003). They expressed the power and pressure of the 'breast is best' ideology upon their experience of new motherhood. Anthea talked about her previous experience as being one of pressure, guilt and failure to achieve her idealised notions of motherhood:

F: *Have you got any other children?*
Anthea (P54): *Yes, I've got a little boy, he's three and a half.*
F: *How did you feed him?*
Anthea: *I breast fed, but not for very long... I had very sore nipples and then I got mastitis, so I expressed for a while instead and then I finished breastfeeding when he was six or seven weeks.*
F: *Oh, so how does that make you feel about feeding this time?*
Anthea: *Em, coming into it I was thinking if it didn't work it didn't matter. Whereas when I had Tom I was so guilt ridden that I couldn't do it. It had been my fault and all that sort of business, so I've come into it a lot more relaxed this time.*
F: *When you say you were guilt ridden the first time why do you think that was?*
Anthea: *I think it's because there's a lot of pressure, there's a lot of expectations that you will breastfeed without problems, so when I had problems, I felt guilty as if it was my fault, that there shouldn't be problems.*
F: *Did anyone help you to work through that?*
Anthea: *The midwife was very supportive. It was at (name of the town), but it was so much inside me that it was difficult.*
F: *Did it affect the way you felt as a mother?*
Anthea: *Em, I think so... in a way, I think..... once I made a decision to bottle feed I felt so much better, because I didn't have this sort of pulling, this sort of guilt feeling.*
F: *So what do you think has given you a different attitude this time?*
Anthea: *Well, realising that bottle feeding wasn't a problem, he's been fine on it. You come into it thinking well if it doesn't work, it doesn't matter she'll be fine, so I think that relaxes you and it's made it so much easier, a day and half, already................With last time, if he didn't latch on immediately I was immediately tense. Now if it takes five, six, seven times, it doesn't matter.......If it works it works and if it doesn't it doesn't.*

Anthea's partner referred to the pressure of reaching perfection:

I definitely added to the pressure the first time. I mean I wanted everything to be perfect. I wanted the feeding to be perfect and I was on edge all the time. I mean we were bombarded at the other hospital by the 'Breast is Best' thing, you know..... So you have this vision of perfection and the pressure builds up to do everything how it should be done....

He later commented:

They sell breastfeeding like they market a car. It's just the same it's like a sales thing. So when you see a red Farari and you're not driving around in it you feel like you haven't achieved. It's the same with breastfeeding, if you don't manage it you feel like a failure. Marketing is pressure - that's it. I mean breastfeeding is pushed now to the extent where it doesn't seem like a life choice any more and I wonder if it turns some people the other way, like cold calling where they push something and it really gets your back up and you do the opposite...

Later again he further expanded on the concept of pressure:

There's a sort of snobbery about breastfeeding, so that you feel guilty if you don't do it. I mean perhaps it would be better to discuss the options more openly, like a pros and cons approach.............They could take the pressure off by taking the emphasis off one or the other, breast or bottle. Maybe if people thought they could combine the two they wouldn't feel the pressure just building up.........I mean we went to NCT classes and they were good.... they didn't really push breastfeeding but they didn't prepare you for

realism. Then all of a sudden you're on your own and when things don't work you don't know what to do.

Pressure to perform was also transmitted through some of the women's social networks:

I just thought I'd try it once to get everybody off my back, cos there was a lot of people, you know, my partner was going on and grandparents and his parents, so I thought I'll try it and then I can say I've tried it, but I've carried on (Carole, P31).

Some women expressed their dislike for what they saw as 'pushing breastfeeding' and zealous extremes, the 'all or nothing' stance displayed by some midwives. Barbara used an illustration of someone she felt had gone from one extreme to the other:

Um, I have heard a lot about....um.... breast is best and all the rest of it, but...I've made my mind up myself. One of my friends was a midwife and she constantly went on about it and she's now selling SMA products. But I'm like well I'm sorry, I've never had that stance in the first place so, but each to his own sort of thing. She obviously encouraged it to everyone, and is now doing the opposite (laughs), *which I couldn't do. I mean I just think it's down to the individualist and er...... I don't know......* (P37).

Women were generally very keen to keep an open mind as to how long they would breastfeed for and this commonly centred upon the fear of having problems and feeling negative about themselves, for example:

Um, I do think it's the best thing to do, but I didn't want to say I'd definitely do it in case I had problems and I couldn't do it, so... I just said I'd play it by ear and see what happens, but up to now, it seems to be working (laughs) (Barbara, P37).

For Stella this feeling related to her problems with breastfeeding the first time:

I mean I'm not gonna get het up about it and if I feel I can't continue after I get home. I'm not going to and I'm not going to let it get me down this time, cos it really was a big downer for me last time (P46).

Some women clearly decided to protect themselves from criticism, self or otherwise, for example:

I wanted to (breastfeed) *but I just kept an open mind about it really. I'll give it a go, but if I can't persevere, then she'll have to have a bottle. I've got all the bottle equipment at home. I'll give it a go. I'm not going to beat myself up about it* (Sam, P19).

In spite of women's intentions to breastfeed once they commenced breastfeeding there were clear mismatches between expectations of a natural ideal and the lived reality of the experience as I now discuss.

It should come naturally?

Despite women's reiteration of the notion that breastfeeding was the 'natural ideal', women who were breastfeeding for the first time and some for a subsequent time tended to describe their early experiences as far from 'natural' or 'ideal'. There was a strong sense of dissonance[83] between expectation and reality and, as Baron and Byrne (1991) argue, there is an immense human drive to resolve these feelings in order to restore a sense of balance and self-esteem. Various manifestations of reality-expectation dissonance are referred to in the literature related to new motherhood (Humenick and Bugen 1987, Barclay et al 1997, Miller 1998) and to breastfeeding (Houston et al 1983, Hewat and Ellis 1984, Britton 1997, 1998, 2000, Bowes and Domokos 1998, Schmeid 1998, Dykes and Williams 1999, Hoddinott and Pill 2000, Mozingo 2000, Pain et al 2001, Hauck and Irurita 2003). The dissonance in this study between the expectation of a 'natural experience' and the reality left women with a sense of detachment from

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[83] Dissonance is defined in the Oxford Dictionary as "not in harmony; incongruous" (Sykes 1982, p.276). It has subsequently been adopted within social psychology and relates to a discordant feeling that arises when there are inconsistencies between our attitudes or attitude and behaviours (Baron and Byrne 1991).

breastfeeding that they had difficulty expressing verbally. As Miller (1998) asserts in relation to mothering:

> It is not easy to give an account of experiencing something which does not resonate with the public story of becoming a mother, especially when the public assumption exists that all women naturally know how to mother (p.61).

Shaw (2003) challenges the tendency to naturalise and sentimentalise what may be perceived as "bodily exchanges" between social subjects who are engaged in a gift relationship a notion which for some women brings with it a complex cultural politics of risk and uncertainty (p.61). The discursive connection between 'good' mothering and naturalness is particularly strong, with breastfeeding being portrayed as a significant activity within the natural realm of women (Apple 1987, Schmied 1998, Leff et al 1994, Carter 1995, Britton 2000, Shaw 2003). It is then assumed that if breastfeeding is natural, it should be straightforward and simple. However, as Shaw (2003) again argues:

> The relation between maternal desires, one's identification as a 'good mother' and actual experiences of breastfeeding are not so straightforward. Bad experiences of breastfeeding - for whatever reason - may in fact induce or motivate women to distance themselves from disciplinary technologies and social norms and expectations they regard at odds with their own sensory understandings and dispositions (p.64).

The embedding of breastfeeding into notions of what women are and should be caused particular dissonance for women if breastfeeding became difficult. Kate expressed surprise at the challenge breastfeeding created, "it looked quite um...simple (laughs) um....until you come to do it. Like I'm impatient, I thought she'd just take to it, cos um......it's natural and that" (P39). Chloe exemplified the feelings of dissonance between her notion of breastfeeding as natural and therefore simple and the reality of her actual experience during an interview 3 days following her baby's birth. Her baby was 37 weeks gestation when born and was given a cup feed of formula on the first night and a bottle on the second by the midwife because both the mother and staff had been having difficulty in encouraging the baby to attach to her breast. The mother and her partner had become quite anxious about the baby's unsettledness. She referred to the midwife who gave a bottle on the second night and spent time talking with her as helping her to be less idealistic and more realistic:

> The talk I had with the midwife last night, made me see that there's no such thing as getting it absolutely right from the first moment, because I think you have fairly high expectations of yourself, and she made me see things from a bit more of a realistic perspective (laughs).... You know, it's a new process and you can't expect it to be wonderful straight away and you know, not every baby's the same.... You know, things that I hadn't really thought of before.....it all happened more quickly that I expected, I was at sea with everything. I mean the midwives here have been fantastic, they've been really good, I can't praise them enough. (P50).

The giving of a bottle and the discussion Chloe had with the midwife seemed to release her from the pressure of "getting it absolutely right". This really challenged me as my initial tendency would be to argue that midwife and mother would have been better to persevere with exclusive breastfeeding with hand expression and giving the milk by cup being the first way of overcoming difficulty with attachment. On the other hand, giving a bottle released Chloe from negative feelings related to the pressure of high personal expectations. This is an example of a situation in which the communication skills of the midwife may have been much more important than her following the rules of the 'medical natural ideal' in a rigid way. Chloe went on to explain the issues and difficulties for her in attaining a natural ideal by drawing clear parallels between her labour and breastfeeding:

> I think there's an expectation that you'll be able to do it and there's been a lot of medical attention, media attention and so on about breastfeeding being the best thing for your baby, and particularly here, you've got lots of sort of media posters downstairs on breastfeeding and that's the whole image that's conveyed, that this is something that you should be doing.....And I think if you had difficulty doing it then you'd probably feel as I felt yesterday- I'm not really adequate, you know....... I'm not doing this properly, I've failed somehow. I felt that about my labour as well, because I knew I wasn't pushing the way they wanted me to push, I didn't understand how to do it differently......

And it's that, I think, because there's such sort of emphasis on it, as being a process that is natural and instinctive, you think, yes it must be because people have been giving birth behind bushes for centuries and all sorts of things - it must be a natural thing to do. But if it doesn't come naturally to you then you feel like you've failed. I think it's that..... I mean I've never really entertained the possibility of it just not happening (laughs).

F: *So you seem to see parallels with breastfeeding and the birth process?*

Chloe (P50): *Yes, I think it's um, just you know....obviously you have time to reflect on things when you're in hospital, you just think your life is sophisticated and so much influenced by technology, and then you're in a situation where you're expected to do something which as I say is sort of instinctive and back to your roots again, and you haven't been there for so long. You haven't done anything instinctive because you know you're part of this digital world and everything. It's really quite strange......Have you seen the Nigella Lawson book, 'How to be a Domestic Goddess'?*

F: *No I don't think I have.*

Chloe: *It's a cookery book, but it's really..... I've only used one or two recipes out of it, but at the beginning of it she's sort of self-parodying really in terms of why she's chosen that title, you know sort of cooking a nice cake or something that's home made doesn't make you into a domestic goddess, but it makes you feel as though you're somebody whose actually providing in a different way than if you go out and do your pot noodle or whatever, and that's the sort of essence of it and er, that was what I was doing on Monday* (laughs) *when my waters broke......But yes, I got some cakes at the end of it, but it's just a sort of bizarre feeling, that somebody's saying, you know have the freedom to do this rather than all nouvelle cuisine sort of thing......*

Chloe's reflections illustrate some of the confusing dilemmas for women between notions of naturalness and life in the 'digital age'. She felt strangely disconnected from her busy technologically dependent life as a teacher:

I mean our LEA's (Local Education Authority) being inspected in February so the last few weeks have been about action planning and statistics and that sort of thing and you know I haven't got a clue now and to be honest I couldn't care less (Laughs)*......Oh well if we've not got that many 4's at key stage two, who cares. It's strange..... your whole mentality just switches over, so it's quite nice to have left all that lap top business behind and just think, oh I can actually have a bit of time where I'm in touch with what, you know, life was like in a different age. I feel like going out and reading lots of Thomas Hardy novels* (laughs). *It's that feeling that perhaps none of all that really matters, you know, this is a new life and in the end she's going to hopefully survive all those government agendas and things and its what goes on between you and the baby that's important.*

Here Chloe illustrated the way in which her temporality altered from a pressured linear perspective to a more cyclical experience (Kahn 1989). I discuss this notion of changing experiences of temporality in chapter 7. Chloe reflected on the change in the role of women:

I don't know if Nigella Lawson realises how clever the book is really. It's just about the whole bit about the image of what you are as a women, cos I can remember my Mum having some good cook books, and one was sort of talking about 'when your husband comes home, you'll have had time to have made his tea, put some makeup on and a clean pinafore or something ..... it was really funny the way it was written and I was just thinking that was in the day, the early 50s, when she got married. I think she got it as a wedding present. I was just thinking, you know half a century on, that those sort of values in terms of making your family feel good, but recognising that you're not going to spend all your days with your hands in a bowl of flour all day, it's just (laughs)*...well, it's really interesting how the role of women has changed.*

Chloe's narrative powerfully illustrates the transformative experiences of pregnancy, birth, motherhood and breastfeeding and the potential for these processes to be disrupted by unrealistic expectations about what women 'should naturally achieve.' Women didn't seem to be prepared for the uncertainty of early breastfeeding and indeed new motherhood, a theme discussed in chapter 7. In some cases women commented that breastfeeding was a more positive experience than expected, an issue I return to in chapter 8. The pressure and

dissonance which I have highlighted in relation to the organising theme 'feeling the pressure' were potentiated further through the experience of breastfeeding *in hospital*, as I now discuss.

Resisting the gaze

The second organising theme, 'resisting the gaze', was underpinned by the basic themes of 'maternal-sexual dualism', 'normalising effects of authoritative knowledges' and 'midwives - rules, surveillance and subversion'. In chapters 2 and 3, I referred to Foucault's concept of surveillance that operates at various levels. Firstly, he refers to "hierarchical surveillance", i.e. by the disciplinary institution with the building being designed to accommodate a high level of scrutiny. Secondly, he refers to the "normalising gaze" upon the body by medical personnel (1977, p.170). He links the disciplinary regimes with the body and emphasises the power of medicine through its techniques of questioning, monitoring, watching, spying, searching out, palpating and bringing into the light to label what is normal and what is deviant (Foucault 1981). As Spiro (1994) states, medicine may then define "what is said, who looks, who prescribes, who defines practice" (p.18). Rituals and techniques then establish a power of normalisation over individuals (Foucault 1976, 1977, 1980, 1981). For Foucault (1977) normalisation is seen in "the case" and the way in which it is "described, judged, measured, compared with others" (p.191). In this way the medical gaze during the clinical encounter inscribes the body until eventually the individual will start to police, self-monitor and discipline her/his own body.

When examining my observational and interview data I became aware of the multiple levels at which women were being surveyed within hospital and the range of resistances to this. This was powerfully illustrated to me when I reflected upon striking contrasts between site 1 and 2 related to the visibility and invisibility of women. On site 1, as discussed, the design of the postnatal wards constituted an attenuated version of the Nightingale ward which itself resembled the 'Panopticon' in that it enables separation of patients and maximum surveillance. Like factory workers the mothers could be observed from a central station and their performance monitored. Women in this context used their curtains to convey messages to the staff and others. This related to their varying needs for support counterbalanced by their desire to resist surveillance. This use of curtains on site 1 was very similar to that described by Burden (1998).[84] On site 2 women were hidden from the public gaze by a fairly consistent practice of curtaining every bed off from view. This pattern of curtaining was in part influenced by the unpredictable presence of other women's male visitors as permitted by the 'open visiting for partners' policy. I will return to these differences in more detail.

The forms of surveillance I observed provided a striking representation and indeed magnification of the ambiguous positions women are faced with when breastfeeding in Western communities. Foucault's (1977) reference to the "productive" yet "subjected" body seems to be very appropriate to breastfeeding mothers who are expected to be productive - producing breast milk, but their bodies are also subjected to surveillance of their performance and to dominant and authoritative forms of knowledge (p.26). Indeed Foucault (1981) refers to breastfeeding as a "dangerous period"...."saturated with prescriptions" (p.37). The concept of the gaze upon individual bodies and its self-regulating potential is highly relevant to the female body. As Shildrick (1997) argues:

> The gaze now cast over the subject body is that of the subject herself. What is demanded of her is that she should police her own body, and report in intricate detail its failure to meet standards of normalcy; that she should render herself, in effect transparent. At the same time the capillary processes of power reach even deeper into the body, multiplying here not desire but the norms of function/dysfunction. As with confession, everything must be told, not by coercive extraction, but 'freely' offered up to scrutiny' (p.49).

This is particularly relevant for women as they embark on breastfeeding. Breastfeeding on a postnatal ward presented and indeed magnified dilemmas for women at the very heart of dualistic discourses around culture and nature, public and private, maternal and sexual. The notion of "natural", as Blum (1999) asserts, usually signals what is "good, authentic, and untainted by social or human manipulation, and thus 'natural' motherhood seems to belong outside the public realm" (p.13). However, as Martin (1987) states, "women's bodily processes go with them everywhere, forcing them to juxtapose biology and culture" (p.200).

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[84] I outlined Burden's findings in chapter 2 under 'seeing the cultural context'.

Maternal-sexual dualism

The "mother as nurturing" versus "woman as sexual" dualism was magnified for women in hospital. As stated, breastfeeding currently symbolises good mothering and, as Stearns (1999) argues, "it is a visual performance of mothering with the maternal body at centre stage" (p.308). She refers to breastfeeding in public as "transgressing the boundaries of both the good maternal body and women as - (hetero)sexual object" with the sexual breast and maternal breast being required to be independent of each other as the "meaning and place of women's breasts is contested" in Western culture (p.310). The dissonance created for women by the blurring of boundaries between breastfeeding as a maternal activity and display of sexual breasts is highlighted in the literature (Van Esterik 1994, Carter 1995, Rodriguez and Frazier 1995, Blum 1999, Stearns 1999, Hawkins and Heard 2001, Mahon-Daly 2002). This dissonance may be increased by the embodied experience of breastfeeding as intimate, sensuous and erotic (Odent 1992, Rodriguez and Frazier 1995, Shaw 2003). The leakiness of the body may potentiate dissonance as women contend with the additional dualism between breast milk as pure and life-giving and their secretions as a subversive corporeal manifestation of unboundedness (Spiro 1994, Britton 1997, Shildrick 1997, 2000, Bramwell 2001, Bartlett 2002).

Site 2 provided an excellent 'public' example of the dilemmas faced by women with regard to societal ambiguities around the nature and function of women's breasts. The women on site 2 with its open visiting for partners were constantly aware of the potential 'gaze' of the male visitor and therefore preferred to feed in private. The closed curtains symbolically represented the dilemmas of the nurturing/sexual breast and public/private places for women. In addition, the curtains with the nuclear family behind them represented for me that not only are women metaphorically disconnected from their bodies and breasts by dualistic representations but also the nuclear family is set apart from society with women being separated from other women. Women tended to monitor and resist the male gaze, "I like the privacy, while I'm feeding,....you don't want an audience do you (laughs) and there's husbands and that" (laughs) (Corrine, P41). Corinne was also concerned about how the visitors would feel, "I mean I don't want to feed in front of visitors, like I'm not bothered, but er, it puts them in an awkward position, like". Stella referred to a similar concern about others viewing her body:

> Well, I just leave them (curtains) round cos I'm feeding all day. Like if any of my own relatives come and that like..... that doesn't bother me but em....and like trying to get out of bed it's not very lady like really (Stella, P46).

This concern of women about others' reactions to them and their bodies is referred to by Stearns (1999). When the women I interviewed spoke about privacy issues they often related breastfeeding in a hospital to dilemmas regarding breastfeeding in external public places: This is illustrated by Selina. Selina was surrounded by three bottle feeding mothers and on this unusual occasion the three bottle feeders had their curtains open. This left her as the only mother with curtains closed, making her feel awkward. After a postnatal examination she declined having her curtains open:

> Felix (MW29): Do you want the curtains left round?
> Selina (P48): No, I'd rather have them left closed cos the visitors will be here soon.
> Felix: You don't want everyone watching you?
> Selina: I don't (laughs)

Selina expressed antipathy towards breastfeeding in public places. This related in part to her feelings of inexperience and lack of confidence but her feelings were also influenced by attitudes to breastfeeding in the public domain:

> Selina (P48): I'd prefer to have them (curtains) around, cos I'm recovering from the birth and also when I'm breastfeeding, until I get used to it I'd feel better having them around.....Yeah, I think it'll be a while before I'm confident to do it in front of people. I mean when you go out you can express and give it in a bottle, can't you?
> F: Yes.... Would it bother you to breastfeed in public?
> Selina: It's the attitudes of people that would bother me really. I mean they may think ooh, she shouldn't do that here.....And I don't think shops and places of leisure have anywhere near what they should have, and the shop changing rooms, I've seen them,

they're not very nice really. So, I'd have to express and put it in a bottle, but you don't really want them to use a teat too early do you?

Clearly, Selina was 'weighing up' the ways in which she would negotiate breastfeeding in public, by giving expressed milk by bottle, with the problems that that might create in hospital in terms of introducing a teat too early. The feeling that to breastfeed in public was problematic was reiterated by Jasmin who had breast fed previously:

> *I do think there's a certain attitude to breastfeeding, particularly when you're round and about, there's an awful lot of negativity around and that's a pressure for people who want to breastfeed. I mean I wanted to do it and I'm too lazy to bottle feed, but, I'm sure it could put people off. It certainly colours things for me, you know I have to stick my head down and get on with it (P51).*

Some mothers still felt under surveillance even behind the curtains. Chloe had asked to be moved to a side ward. She spoke retrospectively:

> Chloe (P50): *The thing about hospitals is that you feel as though...um, you're a bit on display and even with the curtain round you, there isn't a lot of sanctuary, and um I found that quite hard, because you couldn't just shut yourself off from people, or sort of go and be a part of it if you wanted to.... I find it quite difficult not being able to just close the doors and say that's it now.*
> F: *So, did you feel your conversations could be heard even behind the curtains?*
> Chloe: *Oh, yes, I think people generally do, I think you feel.... you know...when you sort of come into hospital that your body's not your own, then when you go home again, you're sort of back in your own safe place sort of.*

Chloe's reference to home as 'your own safe place' provides a reminder that the hospital does not feel like a safe place to some women. This resonates with the powerful phenomenological research conducted by Lock and Gibb (2003) in which they examine the power of place by contrasting hospital with home for postnatal women asserting that the hospital is *not* an emotionally safe place for women.

When I spoke to the midwives about the curtains they seemed to see it as something the women had agency over.

> Tonia (MW 39): *The women seem to keep drawing the curtains around. I think it was the midwives who started it, leaving them round and now, it's the women who do it. I mean there could be 4 women in a bay and they don't speak at all.*
> F: *Is it because they are breastfeeding and don't like doing it in front of people?*
> Tonia: *Well, for some that's the reason, but it's the bottle feeders as well. It never used to be like that.*

My perception was that the curtains were around as the norm within this cultural milieu although women did say that they felt that they could open them if they wanted to:

> Tracy(P44): *The curtains...... they've always been drawn from when I came in. But I'd rather they be open of a day, but yesterday I was glad of the privacy when I was in a lot of pain and I was terrified of disturbing anyone.....but today I'd like them open really.*
> F: *Do you feel you could just get up and open them?*
> Tracy: *Yes, we've been told we can do if we want to, so yes, I could.*

On site 1, women were highly visible. They could be openly observed as they breast fed, both from a distance as midwives walked past and in close proximity as midwives would approach women while feeding and make a comment. However, visiting was limited to one hour in the afternoon and two hours in the evening. Women tended to partially close their curtains, i.e. pull one curtain across during these periods. They commonly avoided breastfeeding during visiting times. When a baby became unsettled attempts would be made to settle him/her in any way possible other than by breastfeeding, for example the mother or visitor would rock the baby in the cot or in their arms. I only found one discrepant 'case', Denise (P4), a multiparous woman who appeared to reject and personally resist all social imperatives for being 'discrete'. She sat with both breasts fully exposed while vigorously hand expressing into a cup in front of a male visitor sitting with the woman opposite. The care assistant came along and looking rather

embarrassed, asked her if she would like the curtains closed. She said *no - I'm past bothering now* and laughed. The male visitor carefully avoided looking at her!

The careful negotiation of space and place in relation to breastfeeding that I observed has become a feature of women's breastfeeding experiences (Britton 2000, Pain et al 2001, Mahon-Daly 2002). As Stearns states, "women accomplish the breastfeeding of their children with constant vigilance to location, situation, and observer" (p.322). This negotiation does not simply occur in public places such as shopping areas, but may occur at home when visitors arrive. Thus, as Britton (2000) argues, "the traditional way of looking at the public/private paradigm does not represent a static truth or capture the interactive nature of everyday life" (p.125). High levels of visibility, particularly on site 1, created problems for women when they were experiencing difficulties with breastfeeding, as I now go on to discuss.

Normalising effect of authoritative knowledges

As stated, authoritative health knowledges, although unstable and shifting, exert a coercive power over women in that they bring with them an apparatus of institutional regulation and surveillance. The ways in which women accommodate, resist or disregard these knowledges and the related surveillance varies depending upon the context. In this section I illustrate one example of an authoritative knowledge, 'exclusive breastfeeding is best' to illustrate the connections between knowledge, power and surveillance and their influence upon women's experiences.

In chapter 2, I discussed the rationale for exclusive breastfeeding and the way in which it has become a fundamental element of the BFI based on the 'Ten Steps'. While few would argue with the value of exclusive breastfeeding for infant health on physiological and immunological grounds (WHO 2001a, WHO 2002, Kramer and Kakuma 2003), the socio-cultural context is more complex. Indeed, anthropological and historical literature illustrate the numerous ways in which women have combined breastfeeding with other forms of food and drink throughout recorded history and across the globe (Fildes 1989, Maher 1992a). In the UK, the percentage of breastfeeding mothers using formula milk for their four to ten week old babies was 41% in 2000. Only 25% of mothers were exclusively breastfeeding at this stage in the survey (Hamlyn et al 2002, p.48). Despite this knowledge that many mothers breast and formula feed simultaneously, as Blum (1999) asserts (with regard to the USA), there is now a public health discourse in the UK that presents the bottle versus breast decision as either-or absolutes. However, in many communities in the UK the breast *or* bottle option stands in contradiction to a cultural norm and I would argue has taken on the status of a new doctrine of dualisms.

I find the issue of exclusive breastfeeding very challenging personally. I am well aware that the BFI agenda seeks to reverse the earlier practice of giving almost all babies supplements with or without parental consent, recognising that giving formula milk to breastfed babies is closely connected with early cessation of breastfeeding. I am also fully aware of the exploitative role formula companies have played in demoting the practice of exclusive breastfeeding. However, the data provides a striking illustration of the dilemmas created for women by an unsympathetic adherence to the 'exclusive breastfeeding is best' authoritative knowledge within a culture where this practice is far from the current norm.

On site 1, the BFI agenda had a significant influence upon both postnatal mothers and midwives to the extent that giving a bottle to a breastfed baby was considered to create almost irreversible problems for breastfeeding. This concern led to increased surveillance of both mothers and midwives. If breastfeeding became problematic women became invested with feelings of judgement, guilt and even deviance. Emotive language used by some midwives in relation to bottle feeding reinforced these feelings, for example Holly (MW7) said to Bryony (P7) whose baby had been supplemented due to difficulties attaching, "well, sometimes formula is a necessary evil". Mauthner and Doucet (1998) refer to these "moral voices", such as "good", "bad" and "should" as reflecting the "dominant and normative conceptions of motherhood" (p.133). As Renfrew et al (2000) state, words such as:

> 'Bad', 'incorrect', or 'inadequate' are prejudicial and when used to describe a woman's feeding technique, as they often are, their effect on her can be dispiriting and disempowering, reducing both her confidence in her ability to feed and her self-esteem (p.31).

A series of encounters and interviews with Anna (P1) illustrate her feelings of deviance, the ways in which she felt under surveillance and how she endeavoured to resist the 'gaze' when faced with breastfeeding difficulties and her desire to mix breast and bottle. I met Anna on the third day following birth by forceps. Her baby was 36-37 weeks gestation and therefore was receiving three hourly blood sugar measurements as per hospital policy. She was breastfeeding by waking the baby three hourly as recommended by the paediatrician. On the second night the baby's blood sugar was low and the midwife tried to assist Anna to hand express which she found to be distressing particularly as there was 'no milk' produced by the procedure. The midwife suggested that Anna should go for a bath to try and relax while she gave Anna's baby a bottle.

When I interviewed Anna she had been encouraged to return to exclusive breastfeeding as to combine breastfeeding with bottle feeding was problematic. This was ironical given that it had been a midwife who gave the bottle during the night and, had the midwife been more skilled at teaching hand expression, this necessity for formula (if indeed it was necessary?) may have been alleviated. Anna referred to her reality-expectation dissonance:

> *It's drummed in at parent-craft, there are posters everywhere, books, breastfeeding is all rosy......I mean you get pregnant and read all the magazines and books, like Mother and Baby and Miriam Stoppard. Its all a happy picture of breastfeeding, but when it comes down to it you've had pethidine, you're drowsy, the baby's blood sugar is low and you end up giving a bottle. Then I felt a failure (P1).*

Anna was highly ambivalent about returning to exclusive breastfeeding and wanted to have the flexibility of doing 'both'. However, she felt that from the midwives' points of view this was not an option.

> *I feel a failure...um...The advice you get is like all or nothing....There's nothing about bottle feeding, except... 'how bad'. I wanted the best but bottle feeding can't be all that bad....I tried expressing, the midwives tried....they mauled at them...but nothing came out......It becomes a really big thing like you've got to breastfeed. It's taken over and I am really anxious and upset...um......I'm feeling like a bad mum, full of anxiety.......I mean.... she wouldn't feed last night. Then in the morning I tried again (breastfeeding) and she just did it. I've got my options open, but there's too much pressure. When I was shaking a bottle up this morning and then when the midwife went past I tried to hide it, cos I felt naughty (laughing).*

The staff appeared to give little explanation as to *why* exclusive breastfeeding was the optimum way of feeding, tending to simply restate that it was better for the baby. Any form of discussion about ways in which Anna might combine breastfeeding with bottle feeding, even in the short-term, was also strikingly absent even though this was clearly Anna's preference given the difficulties she had experienced. This led Anna to increasingly feel that that her best option would be to exclusively bottle feed with infant formula. The absence of dialogue and Anna's movement to the position of wanting to switch altogether to bottle feeding is illustrated in this encounter:

> Anna (P1): *I'd be better bottle feeding......What's the problem with not breastfeeding?*
> Holly (MW7): *It's better for the baby*
> Anna: *Yes, but I'm going home today, so what am I going to do, I might as well give the bottle. ......She's premature........ What's the point of staying here and not sleeping. I'm going home. I've had midwives squeezing my nips and nothing coming out.*
> Holly: *Its good to give her some breast milk.*
> Anna: *I don't want to give breast milk.*
> Holly: *It is better.*

A lack of rapport and effective communication was clearly an issue in this scenario and I suggest it stemmed in part from the dilemmas for midwives in balancing the strong emphasis upon exclusive breastfeeding and the realities of women's experiences. Anna commented:

> *There must be something wrong if I feel this way. Maybe they are getting pressure from higher up. I don't see why it has to be that bad. I mean they wouldn't sell it if it was that bad. They don't want you to go home until you do what they say. There's this sense of someone telling them that they've got to stay in hospital till they've tried breastfeeding.*

A little later I saw Anna sitting on the side of her bed, in a hunched up position with her curtains closed for privacy, facing away from the place where curtains would be opened, crying. Shortly after this she called for a midwife and told her that she was going home which she did in a confused, upset and angry state.

Anna exercised personal resistance to the 'gaze' stemming from the authoritative knowledge 'exclusive breastfeeding is best' by use of her curtains and then by going home. Further resistance could then be achieved once home by exclusively bottle feeding. In this way, she exercised some agency to reduce surveillance. Observing this mother left me with enormous anxiety related to her sense of self as a mother. As Mozingo et al (2000) and Schmied et al (2001) emphasise, breastfeeding can symbolise the embodiment of maternal role attainment. They warn that midwives should avoid linking successful breastfeeding with being a good mother leaving those who discontinue with feelings of guilt, shame and anger which may be difficult to resolve. Likewise Blum (1999) states:

> To nurse our babies at the breast may offer a way to re-value our bodies and force a public re-evaluation of care giving - or - at the same time, it may represent acquiescence to dominant regimes of self-sacrifice, overwork and surveillance. It can blur into a disembodied regime and threaten an overriding sense of failure (p.198-199).

As stated, Anna resisted surveillance in ways open to her. This illustrates, as Ribbens (1998) comments that women do exercise agency in their lives and do not simply accept some ideology per se. Nevertheless, little is known about the extent to which the idealised way of breastfeeding and the surveillance in place to monitor it may be internalised negatively by women who feel they fall short of the standard.

Despite the strong emphasis upon exclusive breastfeeding on site 1 some women intermittently accommodated and resisted this authoritative knowledge and related surveillance. Bev (P2), for example enjoyed breastfeeding while in hospital but planned to bottle feed as well. She commented during the first interview with me during the morning:

> Oh it's a lovely experience, the skin-to-skin contact. I like having her next to my chest. I like having her in bed with me. She was very sleepy at first and they had to undress her, but she's feeding well now. I'm planning to bottle feed as well, I'll probably give her some tomorrow on the ward, to get the experience of both while I'm here (P2).

However, when she suggested giving a bottle during the late evening she felt that the midwife neither entered a dialogue with her about her plans nor explained why giving a bottle might create challenges for breastfeeding. I interviewed her the next day:

> Bev (P2): She was unsettled last night and I considered giving her a bottle, but the midwife said you were being stupid when breastfeeding is going so well.
> F: Did she explain why she felt it was better not to give bottles?
> Bev: No, she just said it was stupid.
> F: So what are you going to do?
> Bev: Well I'm going home today. I'll probably buy a tin of formula milk on the way home so that I can do both.

Bev complied/accommodated in order to avoid conflict and keep the health professionals happy, a strategy also reported by Smale (1996). As a result, Bev went home to commence formula having had no dialogue or information on this method of feeding at all.

On site 2 there was a much more flexible attitude to combining breast and bottle feeding, however this moved towards a situation in which 'top ups' of formula were often seen as necessary and normal. This relates to a different set of issues and the global theme of 'gaining control-maintaining boundaries' which I refer to in chapter 7. However, it was perhaps significant that on site 2 women tended to see me as a member of the breastfeeding surveillance system. This was illustrated by Annette (P58) who changed to bottle feeding on day two and thereafter did not want to be interviewed and appeared to be angry and annoyed when I entered her bay (which I subsequently stopped doing). This sense of the disapproval of others when bottle feeding is highlighted by others (Burden 1998, Murphy 1999, 2000).

The closed curtains contributed to women on site 2 not feeling watched, judged or pressured by the midwives, as articulated by Millie a teenage mother:

> Millie (P43): *The midwives have been great. They've tried to help me out and then they've left me alone.... you know..... and said if I need them, instead of them watching me all the time. I wouldn't like it if they were sat there watching me the whole time cos it would put me off. You know especially if she weren't taking to it, I'd panic a bit more, if people were watching and judging, but.... er.... they just seem.....if you need them they're there, if you don't then great.*
> F: *Do you feel that people do judge you?*
> Millie: *No up till now I don't think that they do, but....er.... like if I was getting watched I'd feel like they were then.*
> F: *So they help you then leave you to it?*
> Millie: *Yeah, like last night as well when I was upstairs she said em... but if the baby won't take to it, just keep her held close to you and then if she goes to sleep put her back to bed. She said you don't have to rush it, if she's not taking to it, so she weren't even rushing me and like pushing me or anything.*

Other examples that relate to breastfeeding 'the correct way' include the way in which positioning and attachment of the baby to the breast has become a technically precise skill. I return to this issue in chapter 9 in relation to the nature of encounters between mothers and midwives.

Midwives - rules, surveillance and subversion

Monitoring and surveillance of midwives was also evident. This was observed by Anna (above) in her comment *'maybe they are getting pressure from higher up'.* I commented in my site 1 field notes:

> Sitting here at the station, where I can view the three bays and the women in them, I am aware that not only am I another part of the surveillance, but also that no individual is left unobserved and unscrutinised (field notes).

This surveillance of the surveyors relates to Foucault's (1977) reference to the Panopticon which provides an apparatus for supervising its own activities. The director may observe all of the employees, judge them continuously, influence their behaviour and impose upon them ways of behaving. It is also made possible to observe the director through the arrival of an inspector to judge how the entire institution is functioning. Arney (1982) translates this to the hospital birth setting, "monitoring is the Janus-faced structure with one face watching over women and their births, the other watching over physicians" (p.123).

The midwives, like the women, were placed centre stage under a constant 'gaze' from others (Foucault 1980). Their performance could be monitored by others at any moment in time. On site 1, breastfeeding was institutionally regulated through the operationalisation of a breastfeeding policy centred on the BFI 'Ten Steps'. Breach of this policy could lead to the invoking of disciplinary action. For illustrative purposes, in the following discussion, I remain with the example of exclusive breastfeeding with 'Step Six' stating, "Give newborn infants no food or drink other than breast milk, unless medically indicated" (WHO/UNICEF 1989). The infant feeding specialists (directors in Foucault's scenario) were charged with monitoring the implementation of the policy through, for example, regular audit and staff surveys. Staff were required to 'police' themselves in the completion of details related to, for example giving formula milk to a breastfed baby. The infant feeding advisers could monitor the staff by paying unexpected visits, rounds and audit. Prior to the units disengagement with the BFI accreditation scheme, they were monitored by the UNICEF team (inspectors) via audit documentation and periodic assessment visits. Within this context as Arney (1982) states:

> Changes in practice are simply a demonstration that the new structure of control-monitoring-is working. Controversy, and the refinement of concepts, practices, and the organization that it may affect, merely strengthens monitoring and magnifies its influence (p.153).

Kirkham (1999) refers to midwives policing other midwives and labelling as deviant those who do not conform. This increases midwives' powerlessness to challenge or circumvent policies

and procedures, as observed by Levy (1999a), in her study of antenatal information giving. This 'policing' culture was described in detail by Eunice (MW19), a member of the permanent night staff. As I arrived one morning for a 07.15 hand-over report she approached me in the changing room and talked about a letter she had just received from the infant feeding specialist querying her decision-making with regard to giving a baby a bottle feed. She explained that there were now audit forms to be filled in every time formula was given to a breast fed baby, day or night. The infant feeding specialist would then review the form and see the individual if it looked like an unsatisfactory decision had been made. The previous night she had given a bottle to a baby and had not completed an audit form, but the infant feeding specialist had 'found out' and written her a letter. She was in a highly agitated state, near to tears. I asked her could I conduct a tape-recorded interview in one of the free side rooms, which she agreed to do. I illustrate the issues with extracts from the interview:

> F: *Can you tell me why you feel so upset ?*
> Eunice (MW19): *Well I feel sometimes that when we are on nights we are left messages about breastfeeding, and it's difficult when you can't reply straight away. To write back would involve an awful lot of writing and still the point might not get across. Interaction between two people is much easier. I sometimes wish that even they'd ring us up at night, to ask us about it rather than a letter.*
> F: *What were the difficult issues that night?*
> Eunice: *Well, women at night are often at a low ebb, and we've just got to get them through that night in the best possible way. Often people who have not worked nights for a long time are often not too happy with the decisions that have been made. They forget that we have been here for eleven hours on a shift observing and helping a lady. It's a long time and you don't make decisions lightly and its hurtful when you're criticised and no right to reply.*
> F: *How do you feel that communication could be improved?*
> Eunice: *We should be allowed as midwives to use our own judgement. I feel that there's not a lot of room for manoeuvre, and perhaps we need to see the breastfeeding sisters more at night. I think it would be good if they came and did some work at night, especially if we had a particular patient who has given problems.....When we were working towards 'Baby Friendly' it got a lot worse. It has lightened up a little bit now. It doesn't seem to be quite so severe. I don't think that patients feel under as much pressure as they were doing before. But I don't know if that was intended or unintentional.*
> F: *When you say severe, what do you mean?*
> Eunice: *We were left instructions on how to behave and there was no room for manoeuvre. You were seen and spoken to if you breached the policy. But it does seem to have eased off a bit. I think when you try to stamp a midwife's individuality out you're at risk of damaging her practice in some way.*

Eunice emphasised the inflexibility that had pervaded practices around breastfeeding and the need to get women over hurdles, referring to the mother she had supported:

> *This mother was struggling. The night staff had worked very hard and kept her mind open, but she really wanted to give a bottle feed. I mean there's an 'all or nothing' attitude now to breastfeeding which is putting women off altogether because it's too inflexible. Women comment that they feel that there isn't any flexibility anymore.......The pendulum has swung too far –yes we need to move away from the free and easy issuing of complementary feeds, but not to the point of total avoidance of bottle feeding under any circumstances for breast feeders. I mean it seems that mother's choice is not enough any more, but not everyone is comfortable with exclusive breastfeeding, let's face it......I was a breast feeder and I think its lovely when its going well, and sometimes its not and its just a little blip, if you can get the mum over the blip in whatever way you can, even if it means a complimentary feed, or even using a bottle teat, but if that mother continues to breastfeed then you've been successful, but we are constantly told that we mustn't use these things, that we mustn't do it.......I think that leads to a lot of mums giving up.... altogether. If you can just sometimes get past that and with persuasion and help and restoring her confidence...I remember a Mum who was adamant that she wanted to bottle feed, after finding breastfeeding too demanding in the first few days when she was recovering from the birth and everything. Anyway, I encouraged her to keep an open mind and said that perhaps we could compromise a little. She was OK with this and in the end she had given the occasional bottle in the*

early days..... about 4 bottles she gave and then she returned to exclusive breastfeeding. Now she would almost certainly have given up if occasional bottles weren't an option.

This dialogue illustrates the power of authoritative knowledges and related surveillance upon mothers *and* midwives. Although I did not interview the infant feeding specialists, I suspect that they too felt 'duty-bound' to conduct the audits and monitoring exercises in line with the policy and their job description. The interview with Eunice also highlighted that midwives may want to be flexible regarding feeding but that the powerful institutional monitoring mechanisms prevented them from meeting individual women's agendas. I return to this issue in chapter 9.

Despite the strong imperative to 'tow the line' a number of staff did indeed disregard authoritative knowledges in order to support women in the way that they felt was best. This was more noticeable on 'nights', probably because the surveillance mechanisms were less evident at night and easier to circumvent. The night staff tended to be more open in stating that they saw the 'exclusive breastfeeding is best' agenda as rigid and that it could be disregarded if it saw a mother 'through a night'. I return to this issue in chapter 8 under the organising theme 'getting through the night'.

Again, utilising the example of one of a number of authoritative knowledges I have illustrated the powerful effects of the accompanying surveillance mechanisms. While the cases described above are complex it seems that midwives in these situations did make carefully considered judgements based on women's positions and the need for flexibility. Eunice disregarded the policy and avoided policing (although unsuccessfully) by personally resisting a requirement to complete an audit form. This relates to the concept generated by Hutchinson (1990) as 'responsible subversion'. This involves nurses bending the rules for the sake of the client/patient with the notion of 'beneficence', i.e. the good of the patient, playing a central role. By conducting an ethnographic study in the USA in a range of clinical settings to include maternity services, Hutchinson (1990) identified the ways in which nurses subvert implicit and explicit rules within bureaucratic institutions within the "context of ambiguity, conflict and frustration" (p.15):

> Many times the web of institutional and medical rules conflict with the nurse's own internal "rules" or beliefs about patient care. Responsible subversion occurs only in response to a conflict between systems and/or people. A conflict exists when the accepted rules in a given situation prohibit nurses from doing what they believe is in the patient's best interest (p.7).

As Hutchinson (1990) notes, responsible subversion is a complex process requiring considerable energy and effort while following the rules is inevitably simpler and easier. To responsibly subvert, nurses require knowledge and experience of the 'system' and a personal ideology that enables them to rationalise the process. There are four stages involved in the act of responsible subversion: evaluating; predicting; rule-bending; covering (p.3). Evaluating involves analysis of the 'patient' and context, the rule itself and one's own motives. Predicting involves anticipating the consequences of a particular behaviour for the 'patient', self and rule-maker. Rule-bending involves the act of engaging in a behaviour that 'bends' the rule based on a belief that the 'bending' constitutes good nursing judgement. This rule bending may be conducted overtly or covertly depending on the context. Finally, the practitioner engages in covering. This involves self-protection by developing a rationale for the action, selecting a covering strategy and redefining the behaviour involved.

Eunice, referred to above, clearly engaged in 'responsible subversion' by evaluating the context, rule and personal motives, predicting the consequences, bending the rule believing it to be a good midwifery judgement and finally covering by avoiding the self-policing procedure. I saw similar examples of 'responsible subversion' on site 1, for example, in relation to the rooming-in policy (see chapter 8). Eunice also questioned the drive towards the 'natural ideal' in breastfeeding:

> *We all say breastfeeding is natural, but what's natural any more. We don't get our food from the garden, we buy frozen peas (laughs). We come home and bung a ready meal in the microwave. What is natural?....The BFI stimulated a lot of conversation and argument. I think we all had to examine how we felt about breastfeeding one way or the other and yes, I think a lot of good came out of it. It stopped the people just giving*

feeds willy nilly and it stopped babies being taken off mums who really didn't want them taken away. Yeah, I think there was a lot of positive things about it. I think we certainly bath more babies now at night....I think the BFI is good, but I don't like to see it enforced, it is too inflexible (MW19).

Eunice referred to the 'un-breastfeeding friendly' attitude to staff:

We are also not very friendly to our staff who are breastfeeding, speaking from personal experience. Um..we don't have a pump for staff....we don't have a room where they can go and express their milk. How can a unit wanting the Baby Friendly award not look after its own staff? How could we do that? There have been many staff who have struggled to feed. They've had to bring their own pumps in, but then we're not very good at giving them time to express milk. We don't support them. I was never given time to go and express milk when I was breastfeeding. Yet we wanted a Baby Friendly award, well.. (laughs) (MW19).

This highlights the difficulty of attempting to impose an ideology that is openly contradicted in the cultural norms.

The 'Ten steps' clearly created dilemmas for midwives and these were eloquently summarised by Jenny (MW14), who described herself as very pro-breastfeeding:

The trouble with the BFI is you start with a lovely philosophy, which I share totally, but the approach seems to be to make people do it, so you end up with a set of rules to make the reluctant ones practice in the way that is expected......I mean it's an insoluble one, because you have staff who just don't believe in it so if you don't make them do it, they wouldn't do it. I mean change like that will probably take decades to come about. Take skin-to-skin, er.. or should I say 'thou shalt have skin to skin contact'. It's got to be documented and ticked off. It was a great problem in hospital that people didn't have their babies to hold after the delivery. That was one of the good reasons for having the baby at home, but here it's.... compulsory. It's gone from being almost impossible to compulsory.
F: *For the midwives?*
MW14: *And the mothers almost.....We get into trouble if we've not documented skin to skin- yes, x minutes. The only get out is if has not taken place you document 'not wanted by the mother'.*
F: *Do you see it as choice for the mother?*
MW14: *There's definitely pressure, because there's pressure on the midwives to do it, you know, as part of the policy and it results in situations which must be the total opposite of skin-to-skin advocates. You see these lovely videos with babies crawling up the mother's tummies and finding the breast and things. Its all very quiet, very peaceful and the baby's given all the space it needs and the mother's got space to observe the baby and do all those, you know instinctive things that mother's and babies do if they've got time. Here you'll see a baby rammed down a mother's nighty, looking very uncomfy for both the mother and the baby, you know and it's allegedly, in inverted commas, getting skin-to-skin and it's a travesty. It's not skin-to-skin at all in the true sense, but you know, you're meant to try and do it, unless the mother says she specifically doesn't want it.*

Jenny clearly recognised the tensions between attempts to reverse medically imposed rituals and routines through a new set of rules and regulations. She saw the attempts to reconstruct the natural in hospitals by implementing the BFI as constructing a superficial veneer of naturalness that was nothing like her notion of 'natural'. Jenny's reference to the *'travesty'* of current ways of implementing mother-baby contact are aligned with Martin's (1987). She refers to the sundering of the woman's birth and removal of any sense of her involvement, by the application of the production metaphor:

Surely restoring contact between mothers and babies immediately after birth could not restore automatically a sense of engrossment with the baby when the process of birth has been so deeply interrupted (p.86).

On site 2, breastfeeding did not appear to be institutionally regulated and therefore there was little associated surveillance. There were implicit rules that became more explicit through the

posters discussed in chapter 5, for example regarding 'skin-to-skin contact' and 'rooming-in'. However, there was a general disregard for these guidelines with midwives, again doing what they judged to be the most appropriate actions for the women. As stated, however, this often constituted a laissez-faire attitude with little regard to the long-term consequences for mothers. Taking the exclusive breastfeeding example again, as I discuss further in chapter 7, midwives appeared to expect most women to 'top up' with formula and frequently encouraged them to do so. This equally problematic scenario was reported by Cloherty et al (2002) (see chapter 2).

The contrast between site 1 and 2 with regard to one aspect of breast feeding practice illustrates the way in which neither a highly institutionally regulated system nor a totally unregulated system appear to be meeting the needs of women. This reflects the absence in either unit of an appropriate mechanism for staff to reflect upon their practice and its short and long term implications for women and their babies with whom they engage. The absence of a mechanism for midwives to reflect upon practice, as Street (1992) argues, highlights at least in part, the hegemony of the hospital system. I return to this issue in more detail in chapters 9 and 10.

Summary

The notion that 'breast is best' has become ideologically pervasive as have the 'right ways of doing it'. This reflects the ways in which authoritative knowledges regarding breastfeeding have been constructed and advocated at given times in history and within specific cultural settings. Although these knowledges shift and change they bring with them a power to "invest" women and "exert pressure" upon them (Foucault 1977, p. 26-27) as the body becomes the "the ultimate site of political and ideological control, surveillance and regulation" Lupton (1994, p23).

Women identified breastfeeding as the 'correct behaviour' and the 'natural ideal' seeing it as being a part of the project of good motherhood. They expressed the power and pressure of the 'breast is best' ideology upon their experience of new motherhood. Despite women's reiteration of the notion that breastfeeding was the 'natural ideal', most reported their early experiences as neither natural nor ideal. There was a strong sense of dissonance between expectation and reality.

Breastfeeding has become increasingly institutionally regulated and breastfeeding mothers while being expected to be productive - producing breast milk, felt subjected to surveillance of their bodies and performances related to dominant and authoritative forms of knowledge. Women experienced dissonance in carrying out an activity that in the UK society is portrayed as private and home based, in a public place the hospital. This related to the maternal-sexual dualism and the dissonance it creates. Thus, like hospital birth, breastfeeding on postnatal wards has become separated from women's private lives and placed on view in the public domain. Like the mothers, the midwives are also subject to monitoring and surveillance, particularly in cultural milieu in which breastfeeding is highly institutionally regulated. The ways in which women, both mothers and midwives, accommodate, resist or disregard authoritative knowledges and the related surveillance illustrate the complexities created by 'doing the correct thing...in the right way'.

In the next chapter I explore further ways in which women experience the pressures and uncertainties during their early days of breastfeeding by examining the notions of 'supplying', 'demanding' and 'controlling' in relation to breastfeeding.

CHAPTER 7
SUPPLYING, DEMANDING AND CONTROLLING

Introduction

In this chapter the interconnecting and interdependent concepts of linear time, production, separation and control that run through the thesis continue and strengthen. As I highlighted in chapter 2, these concepts are a growing feature of technocratic societies as they seek to control expanding populations and produce bodies to engage in efficient, technologically mediated production (Foucault 1977, 1981). In this way, people are constituted for capitalism.

While rigid practices of separating mothers from babies have been largely reversed, separation was ever present in this study in the way many of the women understood and experienced breastfeeding. Women commonly conceptually separated the act of nutrition from the notions of nurture and relationality. They saw their breasts as functioning to make milk that they were required to deliver/transfer to the baby. However, they were deeply mistrusting of their body's ability to produce the correct amount and the right quality of the product, breast milk, and they doubted their ability to transfer this to the baby. The baby was expected to quickly display orderly behaviour at the breast and any suckling for comfort or nurture was often felt to be unnecessary and indeed undesirable.

Women commonly expressed discord centring on the breaching of boundaries between themselves and their babies created by the disorderliness inherent in the notion of demand/baby-led feeding. Women's fears related to the inherent uncertainty embedded in the notion of demand feeding led them to feel the need to place control upon the situation. The strikingly consistent personal lack of confidence in women's beliefs about their ability to 'produce' appropriate breast milk and exclusively feed their own baby also contributed to the desire for control.

Women's plans to return to paid employment influenced their feelings about breastfeeding, and this was a striking, yet unexpected finding in a study conducted at such an early stage post birthing. Women were not only coping with recovery from birthing and with the pressing matters of new motherhood and breastfeeding, but they were coping with their plans for the future with concepts of linear time being central. At this early stage in new motherhood there was already a linear sense of time running on and out.

The combination of concerns regarding 'supplying', 'demanding' and planning to return to work contributed to women endeavouring to impose order upon chaos by adopting practices which were designed to supplement or attenuate breastfeeding in a range of ways.

In part acknowledgement of the separations I have described, I have separated sections of the data to illustrate firstly women's experiences of 'supplying', secondly their experiences of babies 'demanding' and thirdly the ways in which women engaged in 'gaining control and maintaining boundaries'. These headings constitute three global themes with their underpinning networks (see figures 7.1, 7.2, 7.3). However, the three themes were closely interconnected for women as they were all occurring simultaneously.

SECTION 7A
SUPPLYING: PRODUCTION AND DELIVERY

Introduction

By far the most striking and consistent theme to emerge from the data from both sites was women's lack of confidence and trust in their ability to produce enough milk or milk of the right quality. This lack of confidence was clearly voiced by the women themselves, but was also implicitly evident in the language and actions of some of the midwives. I became aware of women's lack of confidence, indeed mistrust at an epistemological level - knowing and an ontological level - being. Secondly, women lacked confidence in the act of delivery or transfer of milk to the baby. [85] This centred again upon knowing (or not knowing) what was happening and upon doing/performing, for example latching the baby on effectively.

There has been considerable reference in the literature related to perceived "insufficient milk"(Hill and Humenick 1989, Hill and Aldag 1991, Hillervik-Lindquist 1991,1992, Segura-Millan et al 1994, Dykes and Williams 1999,[86] Blyth et al 2002, Dykes 2002, Hamlyn et al 2002, Cooke et al 2003). It remains the most common reason why women in the UK discontinue breastfeeding, a consistent feature of six quinquennial infant feeding reports (Martin 1978, Martin and Monk 1982, Martin and White 1988, White et al 1992, Foster et al 1997, Hamlyn 2002). Cross-cultural anthropological studies illustrate that "insufficient milk syndrome" is a phenomenon which predominates in cultures infiltrated by the western biomedical view that breast milk is primarily a product (Van Esterik 1988).

For women to express mistrust in their capabilities at such an early stage suggests that they have come to the experience of breastfeeding with many doubts. This relates to the discussion in chapter 2 centring on the development of dualistic and mechanistic representations of the body (Beekman 1977, Illich 1995, Hastrup 1995, Davis-Floyd & Dumit 1998) and in particular the defining discourses of femininity over the last two centuries in the West, which have assisted in constructing the female body as weak, defective, and deeply untrustworthy (Oakley 1986, Martin 1987, Schwarz 1990, Kohler Reissman 1992, Davis-Floyd 1992, 1994, Duden 1993, Carter 1995, Shildrick 1997, Blum 1999). Superimposed upon this mistrust is the reinforcement of the tenets of the techno-medical paradigm during pregnancy, labour and birth. As Millard (1990) states in relation to women's births:

> Women thus are made to conform to schedules, and the signals they receive from their own bodies are interpreted as irrelevant or misleading in contrast to measurements taken by machines and nurses. Women come to breastfeeding with a recent intense experience in ignoring their own bodily signals, which have been redefined as problems instead of guides to action (p.212).

As discussed in chapter 2, the current 'seeing is believing' culture in the UK is exemplified during pregnancy, labour and birth during which women become increasingly exposed to the notion of dependency upon visual verification and validation of embodied experiences (Duden 1993). Ironically, as the quest for visualisation has increased exponentially, the mother appears to have become increasingly invisible (Oakley 1986, Martin 1987, Duden 1993).

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[85] I use the words 'produce', 'deliver' and 'transfer', being fully aware of their metaphorical alignment with industry and the production line. As I discussed in chapter 2, this language was, and indeed still is, highly evident in biomedical texts on breastfeeding. It also reflects the ways in which women appeared to understand and experience breastfeeding whilst still in hospital.

[86] My earlier hermeneutic phenomenological research conducted in 1996-1998 focused very specifically upon women's concerns related to the adequacy of their breast milk (Dykes 1998, Dykes and Williams 1999, Dykes 2002), as discussed in the background. However, the focus of my research and of others has been upon these perceptions and anxieties as the breastfeeding relationship unfolds over weeks and months. I did not commence interviews with women until their babies were six weeks old. I had not expected these concerns to manifest themselves in the first days of breastfeeding in hospital and had therefore not expected to be addressing this issue in any depth in this thesis. However, the context in this thesis is quite different and therefore raises new issues and from a different perspective. The focus is upon the hospital culture, although inevitably there were many other 'outside' issues impinging upon women while in this setting. An ethnographic approach is utilised rather than a phenomenological one and the study incorporates not only interview material but also findings from direct observations of mothers and babies and their encounters with midwives.

In relation to breastfeeding, in the West, the focus is very much upon breastfeeding as a physical activity whose function is to provide nutrition for the baby. In essence, it is about breast milk feeding the physical body (Vincent 1999). Growth can be seen and measured as verification of the effectiveness of this process with the mother being placed centre stage for any blame related to her baby failing to grow at the prescribed rate. Therefore, women are faced with a combination of feeling accountable for producing breast milk and performing appropriately to ensure effective delivery to the baby. At the same time their bodies are the subject of mistrust and seen as in need of surveillance and management. Oakley (1986) refers to this "uneasy balance between a dependence on medical authority and the need to trust one's own knowledge of one's body" (p.238). The preoccupation with measurement of breast milk that developed with the general medicalisation of infant feeding at the turn of the last century is still highly evident in today's biomedical literature.[87]

As I discussed in chapter 2, the aggressive global marketing of infant formula by powerful multinational corporations and display of breast milk substitute slogans in health care clinics is also argued to have played a major role in the lack of cultural belief in the efficacy of breastfeeding (Greiner et al 1981, Palmer 1993, Sokol 1997). This was greatly assisted by the super-valuation of science and its associated developments to assist with modern ways of living. The bottle therefore represented liberation and formula milk represented the superiority of science (Apple 1987, Palmer 1993, Quandt 1995).

Breastfeeding in the UK is now seen very much as a learned skill. This relates to women in the UK entering their transition to motherhood, from an essentially bottle feeding culture, often having had little or no previous personal experience of breastfeeding and having little opportunity for vicarious experience - watching others (Hoddinott 1998, Hoddinott and Pill 1999a,b). The lack of culturally acquired knowledge creates an opening for authoritative biomedical knowledge related to breastfeeding to predominate and a lack of confidence in breastfeeding. Women then become dependent upon health workers, for example midwives, to provide them with support in the form of practical assistance, information and encouragement.

To assist my understanding related to the effects of this lack of cultural knowledge and confidence, I have engaged with Bandura's theory of self-efficacy. Self-efficacy theory was first defined by the social learning theorist Bandura (1977), and continues to be developed (Bandura 1982, 1986, 1995). My use of Bandura's theory for understanding, in part, the data in this thesis was prompted by the recent work of Dennis (1999), Dennis and Faux (1999) and Blyth et al (2002). The collective findings illustrate that women's confidence or self-efficacy with regard to breastfeeding influences the duration for which they breastfeed. In this thesis, I largely focus upon the data by integrating theory generated within the fields of social science with midwifery research. I therefore initially viewed the psychologically based theory of self-efficacy with extreme caution. However, to exclude theory that is generated by another discipline such as psychology would deny the bio-psychosocial nature of the breastfeeding experience and the related practice implications. Indeed, in his more recent work Bandura (1995) appears to freely cross disciplinary boundaries. He highlights the strong cultural component to self-efficacy emphasising the social construction of self-efficacy through transactional experiences with one's surroundings. He also appears to align himself with a macro, critical theoretical perspective in referring to the concept of collective efficacy in arguing that increasing technology, bureaucracy and fragmentation of society tend to create collective powerlessness rather than efficacy.

Self-efficacy theory has tended to be applied in a positivistic way within health care (Drummond and Rickwood 1997, McClennan Reece and Harkless 1998, Dennis and Faux 1999, Sinclair and O'Boyle 1999). This constitutes an epistemological challenge in that it is underpinned by objectivist assumptions. Dennis and Faux (1999), for example, developed, validated and tested a self-efficacy in breastfeeding tool. This approach with its causal assumptions is incongruent with constructionist epistemology. It tends to focus upon describing behaviours that may be explained and subsequently modified. This is definitely not my purpose and I therefore refer to the theory only in assisting me to make sense of specific sections of the data which have ironically arisen through the stated and created dependence upon authoritative breastfeeding knowledge.

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[87] While the methods have become more sophisticated, the principles are the same. An example of the perpetuation of these principles may be seen in a description of the 'pros' and 'cons' of measurements to include, test weighing, isotope measurement, breast expression and the recent technique of computerized breast measurement (Cregan and Hartmann 1999). Here they discuss the measurement of rate of milk synthesis, breast storage capacity, degree of breast fullness and volume of milk removed.

Self-efficacy relates to the personal conviction that one can successfully carry out a particular activity to reach a personal goal:

> Expectations of personal efficacy determine whether coping behaviour will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and aversive experiences (Bandura 1977, p.191).

Bandura (1977) carefully distinguishes between "outcome expectancy" and "efficacy expectation":

> An outcome expectancy is defined as a person's estimate that a given behaviour will lend to certain outcomes. An efficacy expectation is the conviction that one can successfully execute the behaviour required producing the outcomes. Outcome and efficacy expectations are differentiated, because individuals can believe that a particular course of action will produce certain outcomes, but if they entertain serious doubts about whether they can perform the necessary activities such information does not influence their behaviour (p.193).

There are four influences upon self-efficacy for a given skill, listed from the most to least influential in terms of effect: performance accomplishments which relate to direct previous experiences of success and failure; vicarious experience (role modelling) which stems from appraisals following observing others in this situation; verbal persuasion which relates to encouragement or discouragement from others and emotional arousal which relates to a person's judgement of their physiological state and emotional feelings (Bandura 1977,1982, 1986, 1995).

My data illustrates that previous experience and whether it was positive or negative was indeed an important influence upon women's confidence in breastfeeding. As women have generally had limited vicarious experience related to enculturation through a predominantly bottle feeding culture they were therefore very susceptible to positive or negative forms of encounter with midwives[88] and were vulnerable to the undermining effects of uncertainty, pain and fatigue.[89]

The global theme of 'supplying' was underpinned by two organising themes, 'production' and 'delivery', which I now go on to discuss (see figure 7.1). In relation to the notion of supplying, I also discuss the influence of previous experience and I illustrate some of the mechanistic dialogues that relate to these themes. Past experience and mechanistic dialogues do not constitute part of the thematic network but discussing them in this context supports the network analysis.

Production

Malfunctioning breasts

Women appeared to conceptualise their breasts as 'machine-like', as seen when Annette who had recently given birth during the night referred to her breast as "not working":

> She hasn't had much, she has a few sucks, but she's not that interested.....The midwives said to 'just keep trying'..... but, its not working (laughs). I'm not very confident because it's not working (Annette, P58).

The language Annette and other women used in relation to their concerns tended to objectify their breasts, illustrated by a striking lack of use of personal pronouns. Mahon-Daly and Andrews (2002) also reported this distancing from one's body and conceptual disconnection from one's breasts, particularly when the body does not appear to be functioning. Balsamo et al (1992) likewise refer to the alienation of the self, the body and its products, which are experienced as outside the self when breastfeeding is problematic.

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[88] Discussed in depth in chapter 9.
[89] Discussed in depth in chapter 8.

Figure 7.1
Thematic Network:
Supplying
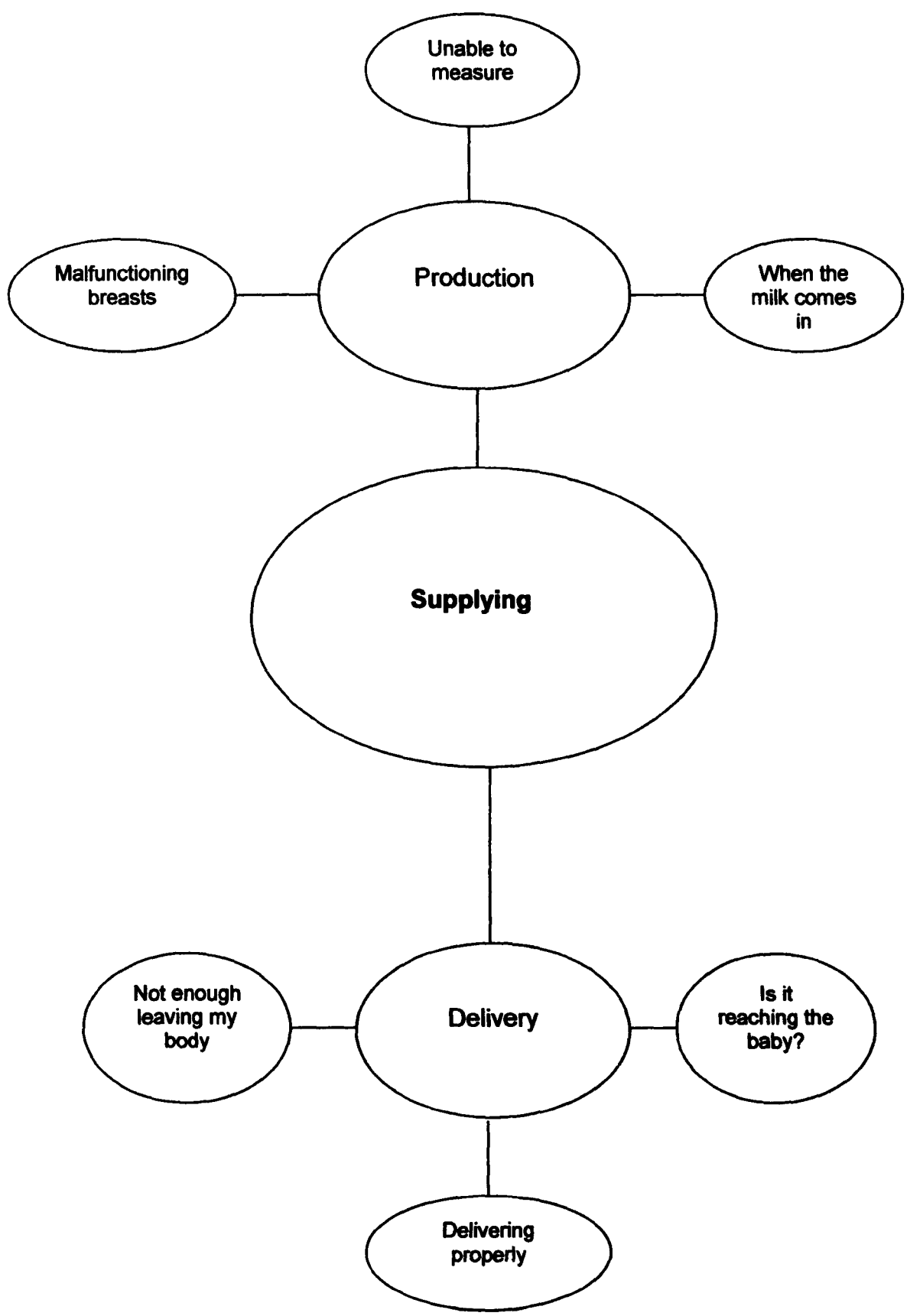
One of the midwives, Virginia, illustrated women's lack of body confidence making clear connections between birth and breastfeeding:

The trouble is that women don't believe in themselves, in relation to their birth or breastfeeding. They don't think they can do it. Look at the section rates. They're nearly 25% and they're increasing all the time. In my opinion there are too many inductions, then you get failure to progress, and then a section. Then if you've had a previous emergency section, you end up choosing an elective section next time so its bound to go up and up. Women don't believe they can manage in labour and they don't believe they can breastfeed. Some of them-they just sit there (Gestures arms out, chest out), they don't have a clue, and yet others, like funnily enough, the teenagers, they seem to just do it. It's the middle class mothers, they're all tense, they've read all the books and they make it so complicated. It's like the dreaded Baby Friendly assessments - they ask you how you do it, but it's hard to articulate, it's like driving a car (Virginia, MW20).

Unable to measure

Women tended to discuss breastfeeding in relation to the contrasting certainty inherent in bottle feeding and being able to measure how much the baby was getting. Nadine felt that she could not measure because she was unable to visualise the quantity of breast milk being provided:

It still worries me that I don't know how much she's taking...(laughs)....but they've told me not to worry about that so....but I think it's purely because if you're giving a bottle you know...you can actually physically see how much she's taken, whereas I know like it's demand feeding and they're only taking what they want and what they need...apparently...but it's still...you can't physically see it....you can't see it and that's the worry...(Nadine, P60).

Some women endeavoured to monitor their milk through visualisation by, for example squeezing milk out:

I did get a bit worried though and I asked the Midwife to come because when I squeezed to get a bit of milk before I fed her there was nothing there, and then she sucked for half an hour and when she came off she was crying (Sally, P40).

Jo saw linear time as a crude way of assessing the volume of breast milk taken by her baby. This was seen as inferior to the accuracy possible when measuring formula milk:

I'm worried if she's getting enough. You know with formula you can measure. With breast milk it's difficult to get an accurate amount, you can only go on time, but... I suppose though, if she wanted more she would keep going? (Jo, P45).

The above quotes from women reflect a clear desire to measure breast milk in order to provide reassurance and validation that they had enough. Leff et al (1994) and Kavanagh et al (1995) also reported this anxiety related to inability to visualise the volume of breast milk. This relates to desire for predictability through quantification and the general feeling that to see is to know (Duden 1993). While in the field I inevitably heard midwives talking to women who were bottle feeding with infant formula. I am unable to report on this as data as neither the mothers nor midwives had consented to me using these encounters as data. However, as a general statement I was particularly struck by the emphasis upon accurate measurement at every stage of the process with too much or too little powder being portrayed as problematic and even dangerous, which indeed it can be when formula feeding. This stark contrast between the way in which women are expected to trust the process of breastfeeding for meeting their baby's entire nutritional needs and the scientific precision related to formula feeding clarified for me one of the sources of dissonance for women. Demand feeding, with all its inherent irregularity and unpredictability, increased women's anxieties related to the adequacy of their milk, as illustrated in section 7B.

When the milk comes in

The colostrum phase appeared to be experienced as particularly uncertain for most women who felt anxious that colostrum was insufficient for their baby, for example:

He's not getting much milk-only colostrum....I mean... you know.... he's feeding but you don't know how much they're getting cos you can't see it coming, you know, cos it's still only the colostrum (Corinne, P41).

Women anxiously awaited the arrival of the 'proper milk', as illustrated by Sandra (P34) who had breast fed for a few weeks with her first baby. She thought that feeling heavy breasts would reassure her that she had milk, in contrast to the lack of any tangible sign in relation to colostrum:

When he's not fed really like you just think, if you see other babies feeding you just worry that they're not getting enough food really, um...but then everyone says he's all right and I mean he's not screaming or anything....You can't see how much they are getting its very strange because I know there's like colostrum, I know that's in there but, you can't see it and sometimes you think, is there anything actually coming out (laughs). It's illogical really isn't it (laughs)...... it's that you can't see it. I mean I know once your milk comes in its different again, cos you can feel your breast becoming heavy and solid and you can see it coming out, but right at the very very beginning.......I mean its tangible then isn't it, whereas with colostrum you can only squeeze a tiny bit out (Sandra, P34).

Sandra's reference to food, again, illustrates the way in which women conceptualised breastfeeding primarily as a source of nutrition with little apparent emphasis upon relationship. Her sense of waiting for the next stage - for the milk to come in, reflects the general desire to advance to the next stage - for progress to take place. Simonds (2002) refers to this conceptualising of reproductive experiences into reified time slices whose progression to the next stage is a mark of progress. This fracturing of procreative events, she argues, reflects the masculinist ideologies which permeate obstetric care.

A sense of embodied progress was experienced when the milk came in:

During the course of the night my milk was coming and the baby fed straight away this morning, so I feel a lot happier about things this morning.........She seemed to sense that there was something different this morning when she came back, she was pleased to see me and took to it straight away, so......... I feel a lot better this morning, thinking that I can now feel that something more tangible is happening (laughs) (Chloe, P50).

They're (breasts) a lot harder now and there's definitely more come through because I can tell by the way he's sort of gulping more rather than just, it's the noise he makes I can tell he's taking more (Corinne, P41).

In spite of the waiting for the milk to come in some women still tended to feel anxious thereafter:

His feeding has changed since my milk's come in - before he was feeding quite frequently, but now it's less often and not for so long... I haven't got much confidence because I don't know whether he's getting enough or I don't like the fact that he's not feeding so regularly now. I think it's about your expectations isn't it, because when they're on the bottle you can see exactly how much they're getting...:I didn't really know what to expect (Harriet P52).

Delivery

Women were not only concerned about production but also delivery of the produced milk to the baby.

Not enough leaving my body

Women sometimes expressed concerns related to the actual flow of breast milk from their bodies:

I didn't feel.... you know..... that there was enough leaving my body, it's a weird sort of feeling, you want to give the baby the best start in life, but you're not sure (Chloe, P50).

This relates to the western expectation that milk will flow according to linear time constraints as illustrated by Spiro's (1994) research with women who had moved to the UK from rural Gujarat who had not encountered this anxiety about milk flow in India. She argues that it relates to a loss of closeness to body rhythms in western societies and a loss of closeness between two bodies that of the mother and that of the baby.

Is it reaching the baby?

Women tended to be concerned that her milk might not be actually reaching their baby:

It's just knowing what's happening. You know she just gorges herself and then its like coming out of her nose and everywhere, so you don't know if they're getting enough, like if it's coming out of there how do you know she's getting enough.... and the other thing like yesterday she fed at half past 7 in the morning, but she'd been on that incubator so she was tired and cosy, and I had to wake her at ten to two and I was quite worried cos I thought well.... she was feeding for up to an hour before that so there was like this big change in time and I just thought well..... is she not well?... cos obviously I had to wake her in the first place and secondly is that 10 minutes enough for her when its so rich? (Jane, P12).

Jane appears to have conceptualised the changes in 'time' between feeds as indicative that all might not be well in terms of delivery to the baby.

Delivering properly

Women saw gaining confidence in the skill of breastfeeding as a primary goal in ensuring effective delivery to the baby, *"I mean mainly at the moment, I want to be confident that I can do it"* (Selina, P48). This links back to the notion of 'doing it the right way' discussed in chapter 6. Women tended to state that they knew that breast milk was best but then felt that they needed to know what to do:

I'm confident knowing that it's the best for her, that's why I decided when I was pregnant to breastfeed her, but I want to feel confident with what I'm doing ..... you know, with what to do (Kate, P39).

In Bandura's (1977) terms this relates to a stronger sense of outcome expectancy than efficacy expectation. Women tended to become anxious when the baby became discontented and unhappy, and this made them doubt their abilities to deliver the 'product' effectively:

I was a bit stressed in the night-cos he was crying-you don't know what's wrong with them - you don't know if it's something that you've done, like you've not fed em enough or you're not doing it properly...(Glynnis, P59).

Sam (P19) said, *"I'm not convinced I'm doing it right meself. The milk hasn't come through yet. It's still colostrum......she just doesn't seem happy."* Her baby did not appear to be very effectively attached to her breast and she had very sore nipples, which probably contributed to the baby being unsettled. The associations between what women see as unsettled behaviours and their perceptions of insufficient milk are well established (Hill and Aldag 1991, Perez-Escamilla et al 1994, Segura-Millan et al 1994, Foster et al 1997, Hamlyn et al 2002) and, when related to ineffective patterns of breastfeeding, are likely to have a physiological basis (Woolridge 1995).

In contrast, women felt confident when their baby was settling between feeds. This enhanced their feeling that they were producing and delivering enough milk:

Up till now, I feel confident, just because she seems content on it and like as soon as she's had enough she just goes straight to sleep, em....I mean it's early days so I don't know if it's gonna stay like this or whether she's just behaving herself for now. But it

gives me confidence to know that she's feeding and then she seems quite content after it (Millie P43).

Women endeavoured to assess their milk transfer to the baby through various means, for example watching what comes out:

My only worry at the moment is that he passed a stool yesterday, he did his meconium and then he passed a normal stool but he hasn't since, so my worry is that I mean I hope he is getting what he needs because he seems to be sleeping afterwards, and he's content, but because nothing is coming out my fear is that he is just kind of suckling rather than well, you know, he's doing it for comfort rather than... But I think he'd probably be crying and upset if he wasn't getting enough....um... I just assumed that with them having such little stomachs that it would just come straight through them (Alison, P38).

Women focused on using the correct technique to deliver the milk and this led to preoccupation with for example which breast to offer next:

It's just getting her used to it and once my milk kicks in a bit more as well (laughs)......an' another thing that worries me (laughs) is which breast I've I fed her on, like remembering to swap over each time, so she gets a proper feed like.
Partner: *You could put a mark on them (laughs).*
Millie: *Yeah, I've been writing them down on a piece of paper ticking them off like (laughs), but like last night she'd only feed for like a couple of minutes on one and then she was on for like nearly an hour on the other, so... like... I was trying to, you know, balance it out like* (Millie, P43).

The notion of 'correct positioning and attachment' also relates to the sense of 'correctly' delivering milk to the baby, but I discuss this in chapter 9 as it forms a crucial component of breastfeeding management.

Previous experience

As stated, previous experience constituted an important influence upon confidence in breastfeeding both in terms of 'producing and delivering', with positive experiences increasing confidence and negative experiences having the potential to lower confidence depending upon how they were overcome (Bandura 1995). Louise (P14) related to her previous experience and feeling of lack of control:

I get very hung up about things, like last time he didn't gain weight...in the end the Doctor said we'd better put him on the bottle. I was very stressed and I could have fed him all day and it wouldn't have filled him up. Once I had stopped the Doctor said maybe I could give him a morning, midday and evening feed, but once I gave up, within a day and a half my milk had disappeared completely. I don't think he was getting anything and I think it was a combination of things, including a lack of control. This time I'm hoping that things will be different (Louise, P14).

Women were aware that lack of previous experience contributed to them feeling less confident:

I'm not very confident yet (laughs), cos I've read the books, I think I've read too many books, but I think you need practical experience which I haven't had, but I feel more confident than I did yesterday (laughs), but it's things like holding her which make me feel less confident. Like we haven't got any babies in the family, so it's quite hard..... But, I'll just keep trying. She is latching on but she doesn't seem to be getting very much. It's hard work, because she's not used to it and you're not used to it, you know it's a skill (Selina, P48).

Women who had breastfed before tended to feel more relaxed and confident:

With it being me second...I'm more relaxed this time (laughs)..... The problem I had with my other little girl was that one of me nipples was inverted and I used to find it was difficult to latch her on to it, because she actually had to suck at it to draw the nipple out, so that was a bit frustrating. But I'm aware of that-it seems easier with Louise, probably

again, because of my confidence, she seems to be able to suck on it and get the nipple extended....It's certainly easier the second time (Shirley P57).

Mechanistic dialogues

It is argued that women need to be prepared for the insecurity and uncertainty of breastfeeding with regards to quantification (Marchand and Morrow 1994, Mozingo 2000). This preparation was not evident in the interactions I observed between midwives and mothers. Indeed midwives tended to employ a range of mechanistic assumptions related to breastfeeding, suggesting that they *also* saw breastfeeding primarily as a source of nutrition for feeding the baby's physical body with breast milk needing to be transferred effectively.

Counting calories

Chloe (P50), whose baby had been born at 37 weeks gestation, was undermined by the paediatrician's comments regarding her baby getting enough calories:

> *She doesn't seem to suck for very long then she gazes round the place, so I'm a bit uncertain as to whether she's actually getting enough milk, what's it called, colostrum. I got really concerned about it, so she had a cup feed yesterday. She took that down really quickly. That was at 4 o'clock yesterday afternoon, so I thought then, well I'm not giving her enough. I mean she hadn't really fed for about 12 hours. It was the paediatrician - she came round yesterday and it was shortly after that that she had a cup feed, cos she said you need to make sure she's getting the calories from the milk and I thought, oh, I've got no way of knowing, you know* (Chloe, P50).

Emphasising the baby's size

In a number of interactions midwives emphasised that the baby was big in a way that appeared to link size with potential insufficiency of milk, for example:

> Virginia (MW20) physically attached the baby on to Sue's breast.
> Virginia: *Have you leaked any colostrum while you were pregnant?*
> Sue (P29): *Yeah*
> Virginia: *You have. He's a big bold baby.*

Emphasising the baby's hunger

Reference to the baby's hunger were sometimes made, for example Hannah (P49) was holding her baby who had hiccups. Isabel (MW34) went past and said, *"Oooh..... what's the matter with you, are you hungry?"*

Supply and demand

References to the way in which the more a baby suckles the more s/he stimulates the mother's milk formation tended to be rather brief and mechanistic:

> Sandy (MW30): *How's it going?*
> Selina (P48): *Do you think she's getting enough?*
> Sandy: *Of course she is, that's what your breasts are made for, course she is. When she's suckling, that sends signals to your brain, to make more milk.*

Looking for signs of colostrum

Midwives tended to indicate ways in which women could see or know that they had breast milk, for example Felix (MW29) suggested that Selina (P48) look for signs of colostrum through expressing, but did not show the mother how to do this effectively:

> Felix (MW29) was assisting Selina (P48) to attach her baby:
> Felix: *Try turning her towards you.*
> Selina attempts to latch her on to her right breast. The baby fidgets at the breast. She is rather scrunched up, with head twisted and body curled. She can't really access the breast adequately.

Felix: *Do you want to try expressing a little bit of milk onto your nipple?*
She doesn't give any guidance. Mother squeezes right up by the nipple -unlikely to express colostrum in this position.
Selina (P48), on seeing that no milk is evident, says: *This is what I'm worried about, there's nothing there.*
Felix: *Not everyone can express colostrums....so don't worry.*

Having suggested that the mother expressed colostrum Felix then indicated that not everyone could express colostrum, clearly giving Selina mixed messages.

Breast size as a mark of progress

As part of the same dialogue just described, Felix emphasised progression to the next stage:

Felix (MW29): *Are your breasts starting to feel any fuller?*
Selina (P48): *They're a bit tender, but that's all*
Felix: *You should start to feel a bit fuller by about tonight.*
Selina: *Tonight, oh.*

Selina was very anxious about what the baby was getting. She was still not attaching her baby to the breast effectively. By the 3rd day her breasts were still soft and the baby had received a cup feed as he appeared to be dehydrated.

Other interactions emphasised looking for evidence of colostrum and breast fullness, for example Virginia (MW20) passed Vicky (P30) who was lying on her side trying to place her crying baby on to her breast:

Virginia (MW20): *How do you find feeding on your side?*
Vicky (P30): *All right. I fell asleep with her during the night, so she just fed when she wanted to.*
Virginia: *Good, that's great. Do your breasts feel any fuller?*
Vicky: *Um, yes, just starting to feel a bit fuller.*
Virginia: *Have you felt any colostrum coming out?*
Vicky: *Yes, there's colostrum there.*

When your milk comes in

Women were repeatedly 'reassured' that things would be all right when their milk came through. Damaris (MW18) came to see how Grace's (P15) baby was feeding (she was first day post Caesarean section):

Damaris (MW18): *Oh he's doing fine.*
Grace (P28): *There doesn't seem to be much there, he keeps coming off.*
Damaris: *You'll have colostrum which will usually see him through, then your milk will come in about the third day.* The baby came off her breast, so the midwife helped him back on, saying, *Remember to point your nipple to his nose.*

Here Damaris referred to colostrum as *"usually"* seeing a baby through which implicitly suggests that it may not. Secondly, she reiterates the linear fracturing of procreative events and progression to the next stage referred to by Simonds (2000) and discussed above.

What goes in comes out

Midwives often "reassured" mothers by emphasising that what goes in necessarily comes out, a mechanistic expression typical of the western conceptualisation of the body as machine (Helman 1994). However, as seen above with Alison (P38), this led to insecurity if the expected output did not occur on a particular day. The following interaction illustrates this issue:

Chloe (P50): *I'm not sure she's feeding enough?*
Isabel (MW34): *Is she weeing and pooing?*
Chloe: *Yes.*
Isabel: *Well, if there isn't anything else going in there wouldn't be anything coming out.*
Chloe: *Oh.*

Isabel: *And she was suckling and gulping before so that shows you she's getting something.*
Chloe: *Oh.*
Isabel: *We'll leave it until she's a bit more alert and then we'll see how she's feeding.*
Chloe: *All right.*

Afterwards Isabel said to me: *You can't force feed them*

Lucy (P15) voiced similar concerns to the midwife, Kerry (MW11) following a postnatal examination:

Kerry (MW11): *Anything you want to ask me?*
Lucy: *Well I'm not sure there's anything there?*
Kerry : *Do you want me to show you?* (Presumably offering to express some milk for her)
Lucy: *No, I can see the milk coming out*
Kerry *Has she been wet and dirty?*
Lucy: *Yes*
Kerry : *Well that shows she's getting milk*
Lucy: *Oh*

Weighing

Finally, the ritual of weighing the baby while in hospital was testimony to the continued use of mechanistic ways of assessing output. The practice of weighing in hospital has been discontinued in many maternity units for healthy term babies, related to its inaccuracy and undermining effects. However, on site 1 this practice was still very much in evidence. The babies were weighed at birth on delivery suite and thereafter every other day, i.e. third, fifth etc. Weighing was referred to as something that happens and was not discussed as a choice:

Kim (MW 15): *You know we'll be weighing tomorrow. We weigh on the third day.*
Barbara (P37): *Oh I was hoping to go home today or...*
Kim : *We like you to stay a bit longer with it being your first baby, until tomorrow anyway. Give you a chance to get your breastfeeding established.*
Barbara : *Oh.*
Kim: *So we'll weigh him tomorrow, but you know he'll lose 10% of his birth weight, breastfed babies do. Bottle fed babies don't because they're getting the full amount straight away.*
Barbara: *Oh, I didn't know that.*
Kim: *Once you're milk comes in he'll be more settled.*

Here Kim's language implied that breastfeeding would not provide the *"full amount"* in the early days, linking it to a weight loss. The weighing ritual was generally conducted with little background discussion or explanation:

Holly (MW7): *You know they lose up to 10% of their weight ?* (as she lifted her on to the scales).
Vicky (P30) : *Do they? Oh.*
Holly (MW7): *6-8.*
Vicky: *Is that all right?*
Alice: *I need to convert it over.* Focused on the chart: *Yeah, you're fine there. You can dress her now.*

However, the procedure didn't seem to have concerned Vicky, particularly:

F: *So how did you feel about her being weighed earlier?*
Vicky (P30): *Fine, I didn't feel worried because she's been eating more than enough over the last 3 days, so the only thing that worried me was that they said she looked a bit yellow, but she looks better today. I suppose I've just been fortunate, she's just been an easy baby really.*

However, weighing appeared to increase some women's anxieties about their breast milk. Even though they were informed that up to 10% weight loss was normal, for example:

Carol (P31): *She's lost 10 ounces, but....er it's only 10% of her original weight, so, she's allowed to lose that.... Um, I didn't like the fact that she lost weight..... Even though they said it was normal. It made me think, why's she lost weight, has she not been fed properly?*

Some midwives used routine weighing for reassuring mothers, for example Jenny (MW14) to Jocelyn (P18):

Right, let's see what you weigh....1900grams, He's only lost, let me see, 80 grams. That's nowhere near the amount she's allowed to lose. Excellent well done!

However, when I interviewed Jenny following another interaction with Lois (P20) during which she weighed the baby, she expressed her dislike of the procedure using aviation metaphors:

F: *What is your view of weighing on alternate days like this?*
Jenny: *Very negative. I mean the scales we use.....you need the reflexes of a fighter pilot to get an accurate reading. Then, OK, if the reading is positive it reassures women, in fact they seem to ask for it, even if it is not offered. It's a number to go on. They've been conditioned to expect it. But what happens when the weight is down, mothers do a nose dive. Babies can be assessed without numbers. I think all midwives should have a month here without access to scales or weighing. It would make them use other means to assess a baby. They would have to watch the baby...... The trouble is weight is an endless source of tension between the paeds and midwives* (MW14).

Weighing may be seen as the ultimate way of monitoring and surveillance of an otherwise unpredictable process, breastfeeding. This has certainly been the case in the past when medicalisation of infant feeding reached its zenith (Balsamo et al 1992, Vincent 1999). In this way weighing of the baby represents the continuing influence of authoritative medical knowledge and surveillance upon women's experiences of breastfeeding. My earlier research illustrated the ways in which this ritual which was repeated regularly over several months following the birth contributed towards an undermining of women's confidence in the adequacy of their breast milk (Dykes and Williams 1999, Dykes 2002).[90]

Breastfeeding as labour

As illustrated, women expressed deep doubts about their ability to 'produce' and 'deliver' their breast milk to their baby. In relation to women's ways of experiencing breastfeeding in hospital, I contend that my data represents an extension of Martin's (1987) industrial model applied to labouring women. Martin frames her analysis within Marxist notions of the people's alienation and separation from the product of their labour. In accordance with this model, she argues that the labouring woman is disconnected from her birth seeing it as something that is managed and controlled by the system. To recap, Martin portrays labour as a production process; the woman as the labourer, her uterus as the machine, her baby as the product and the doctor is the factory supervisor or owner.[91] Thus, she asserts, women come to see their bodies as defined by the implicit scientific metaphors that assume that:

Women's bodies are engaged in "production" with the separation this entails (given our conception of production) between labourer and labourer, labourer and product, labourer and labour, and manager and labourer (p.194).

The later empirical work of Davis-Floyd (1992, 1994) in the USA yielded similar conclusions to Martin, as a large number of women saw their bodies as vessels through which specific functions could be performed. They expressed open acceptance of the techno-medical aid on offer to supplement their body's activities. Davis-Floyd (1992) refers to these women as being conceptually fused with the technocratic model of birth.

In extending this model to breastfeeding women on postnatal wards, breastfeeding becomes the production process, the woman is still the labourer and her breasts now replace the uterus

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[90] The long term effects of this ritual upon breastfeeding mothers are currently being researched in-depth (Sachs et al 2002).
[91] As stated in chapter 2, although the midwife does not feature in Martin's text, she fits in well in this scenario as the "shop floor worker", a metaphor utilised by Kirkham (1989) in her labour ward study (p.132).

as the key functional machines. Now breast milk becomes the product, with her baby assuming the role of consumer. If the breasts (machines) are in 'good working order' then they will 'produce' the right amount and quality of the 'product', breast milk. If they are used effectively, by the labourer, then they will transfer the 'product efficiently and effectively and in the correct amount to the 'consumer', the baby. However, given that the above processes are seen as prone to unreliability and failure, supervision is required. In the UK this role is largely designated to the midwife, who assumes the role of middle-management as the shop floor supervisor.

Not only does this series of mechanistic metaphors fit well with the images used to promote or market breastfeeding, but it also aids understanding regarding women's lack of confidence in their role as accountable producer. As Lupton (1996) states, the "infant's body becomes a symbol of a mother's ability to feed and care for it well" (p.42). This well-being or otherwise is visible and open to surveillance and the mother subsequently exposes herself to blame.

This biomedical and mechanistic view of breastfeeding stands in stark contrast to the holistic conceptualisations in some non-westernised communities, for example parts of rural India. Here breastfeeding is seen more as a total mind-body experience enhancing a knowing and love between mother and baby with breastfeeding transmitting emotions, cultural knowledge and moral character to the baby. If the mother has good thoughts during breastfeeding then her baby will grow up to be a good listener and a well balanced person (Spiro 1994, Vincent 1999). It is interesting however to note that whatever the cultural beliefs about breastfeeding, the potential for blaming the mother is ever present (Spiro 1994, Jolly 1998, Vincent 1999).

Summary

Breastfeeding in not only discursively reduced to a substance, breast-milk - valued for its components (Van Esterik 1988, Blum 1993, Dettwyler 1995, Nadesan and Sotirin 1998), but experienced as such by women in this study. Women conceptualised their bodies as vessels that were apart from them. There was a sense of alienation and separation from the product, breast milk. These dualistic understandings of bodies were reinforced within the hospital setting through the mechanistic monologues of midwives. Women reflected their deep mistrust in the efficacy of their bodies and a profound lack of personal confidence, unless they had breastfed with some degree of felt success previously. When conceptualising their bodies in this way, as machines, the task was inevitably seen as demanding, as I now go on to discuss by making a connection between women's embodiment of the requirement to produce and deliver breast milk and their anxieties related to the experience of feeding their babies 'on demand'.

SECTION 7B
DEMANDING: BREACHING TEMPORAL AND BODILY BOUNDARIES

Introduction

I discussed the origins, definitions and rationale for the introduction of the concept of demand/baby-led feeding in chapter 2. The notion of demand feeding represents a dramatic reversal of the authoritative knowledges presented in the earlier decades of last century in which scheduling of feeding was reified. In essence, it represents removal of time restrictions from breastfeeding so that the baby may feed whenever and for as long as s/he wants to. Demand feeding is interchangeably referred to as baby-led feeding (Woolridge 1995, UNICEF 2001a) although the principles underpinning the relationship are unchanged. The term 'demand' constitutes an industrial metaphor that links with the notion of the production line.

The concept of the baby demanding a feed and indeed her/his demands being willingly met day and night is, however, antithetical to many of the beliefs around child care which have developed since the "Enlightenment". Dyball (1992) argues that it represents a transfer of control from the medical model to the natural ideal. The former model maintains the feeding process, mother and baby under medical supervision, through carefully defined rules and measurements. This contrasts with the natural ideal in which the baby is in control with the mother responding to her/his demands. In this chapter I highlight the ways in which demand feeding was experienced by women as breaching temporal and spatial boundaries, as constructed within UK culture.

To assist in conceptualising the ways in which 'demand feeding' is perceived in a western culture, I return to the notion of linear and cyclical time. Spiro's (1994) research with Gujarati women was particularly illuminating in relation to cultural interpretations of time. She utilised an ethnographic approach to study the meaning of breastfeeding for Gujarati women living in Harrow, UK. The study involved participant observation and discussions with Gujarati women at a mother and toddler group and in-depth interviews with women. She also conducted a focus group with Gujarati women from an older women's group (ages 60-85) and held discussions with women at an Asian women's network meeting. Her findings illustrate that the women who had recently lived in rural communities in Gujarat had an agricultural, cyclical concept of time, related to the sun and the seasons rather than the clock. However, those who spent longer in a western culture developed a more linear concept of time, the extent of which related to the length of time in the latter community. Spiro (1994), therefore, illustrates that cyclical and linear time may be seen as poles with women being positioned along a continuum between them.

Agricultural time, Spiro (1994) notes, relates not only to life styles but also religion in that central to the Hindu belief is the 'Karma', the spirit of the individual tied to the cycle of birth, death and rebirth. All bodily practices including birth and breastfeeding form part of a person's Karma. For rural Gujarat women, time is rhythmical and seasonal with breastfeeding being part of the cycle of life. Childbirth and breastfeeding are seen as 'time out', a time of rest, with the mother's relationship with the baby being seen as a time of intimacy, mutuality, harmony and flexibility.[92] This 'time out', which is common in many cultures around the world (Baumslag and Michels 1995, Vincent 1999), stands in total contrast to the experiences of some women in the UK.

Kahn (1989) refers to a form of time that relates to cyclical time which she names "Maialogical time" (p. 27). Using this neologism, she refers to the period during a woman's life when she bears children and lactates. She develops the word from the Greek word "Maia" which means to mother or nurse. This word maia originated from the Indo-European root "ma" which derives from the notion of the child's cry for the breast. She chooses this word stem because it is free from male construction and secondly because it gives voice to the baby:

> From a maialogical perspective childbirth becomes the founding moment of the relation of self to other, grounded in the body, since both the one being born and the one giving birth are taken into account (Kahn 1989, p.27).

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[92] The Hindu beliefs underpin this in that for 40 days following the birth the mother is seen to be in a state of ritual pollution and vulnerable to evil spirits. She is attended to by women-folk while she rests and takes care of the baby. The women cook for her and bring her special symbolic foods (Vincent 1999).

Kahn (1989) contrasts the concept of maialogical time with linear time. The former embraces mutuality, inter-relatedness, interaction and reciprocity. It relates to the relational self, that is a "self essentially related to others in mind and body" (p.28). Linear time, she states, is:

> Inhabited by individuated western man who follows the linear trajectory of history, a trajectory considered to be healthy [....] it's sociability is based upon the collective activity of "autonomous" individuals frequently in competition with one another, or working for the benefit of someone else at the expense of the self (p. 28).

Forman (1989) refers to Kahn's development of the notion of maiological time and argues that this concept of time would allow women as a collective to not only "live *in* time" but to "*give* time" (p.7). This notion of being able, or indeed unable to 'give time' arises throughout this thesis.

It could be argued that many women in western industrialised cultures have become so programmed by linear/clock time that they may be unable to enter or experience cyclical time (Kahn 1989, Adam 1992). However, it is important to avoid dualistic representations of living in and with time, suggesting that we can only engage with one form of time or another. Kahn (1989) indeed illustrates this with her own experiences of motherhood and feeding which she argues allowed her to experience cyclical time in spite of living in linear time. In particular she refers to her own experience of returning to work, where linear time predominated and contrasts it with her experience of cyclical time when breastfeeding her baby in the evening:

> One of my favourite times of day was when I came home from work at one o'clock. I would lie down to nurse him off for a nap. After being at work, with deadlines, schedules and meetings, everything marked off by the clock, I would float with him into a different kind of time. It was more cyclical, like the seasons, the tides, like the milk which kept its own appointment with him without my planning it out. I lived during those years in two types of time - agricultural and industrial. I loved the two of them side by side (p. 21).

Kahn (1989) thus argues that women, through the experiences of pregnancy, birth and lactation can potentially recover something of maiological time (p.29). However, she acknowledges that living in a culture where linear time dominates militates against this. Balsamo (1992) likewise argues that breastfeeding is an experience that takes a person outside the industrial conception of time. However, as she argues, trying to negotiate the two types of time creates feelings of conflict for women. The data I present here from women a decade later when scheduling of feeds is no longer formally imposed, reflects similar tensions. I now discuss, in turn, the two organising themes underpinning the global theme of 'demanding', that is 'breaching temporal boundaries' and 'merging and breaching bodily boundaries' (see figure 7.2).

Breaching temporal boundaries

There is considerable ambiguity in relation to the notion of demand feeding, for example breastfeeding texts tend to refer to the need to allow a baby to feed without restriction but then go on to define the "normal" range of frequency and duration of feeds at particular stages following birth. A classic example of this emphasis may be seen in the third edition of the well known and widely read midwifery text "Successful Breastfeeding" in which chapter 3 is entitled "Duration and Frequency of feeds" following which the authors describe the normal variations in feed frequency (RCM 2002).

A glance at the language used by the WHO in relation to demand feeding illustrates the persistence of biomedical language, which remains distinctly time, transfer and measurement related, as illustrated in the following passage, in which I have underlined the words related to time:

> It is advisable for numerous reasons to feed young infants whenever they indicate a desire to feed. When left to their own devices, infants feed for greatly <u>varying durations</u>, with <u>length</u> probably determined by the <u>rate and effectiveness</u> of milk transfer. Infants who are permitted to <u>regulate the frequency and duration</u> of their feeds <u>suckle more, gain weight more rapidly</u>, and <u>breastfeed for longer periods</u> than infants who are <u>restricted</u> in their <u>feeding patterns</u> (Saadeh and Akre 1996, p.156).

Figure 7.2
Thematic Network:
Demanding
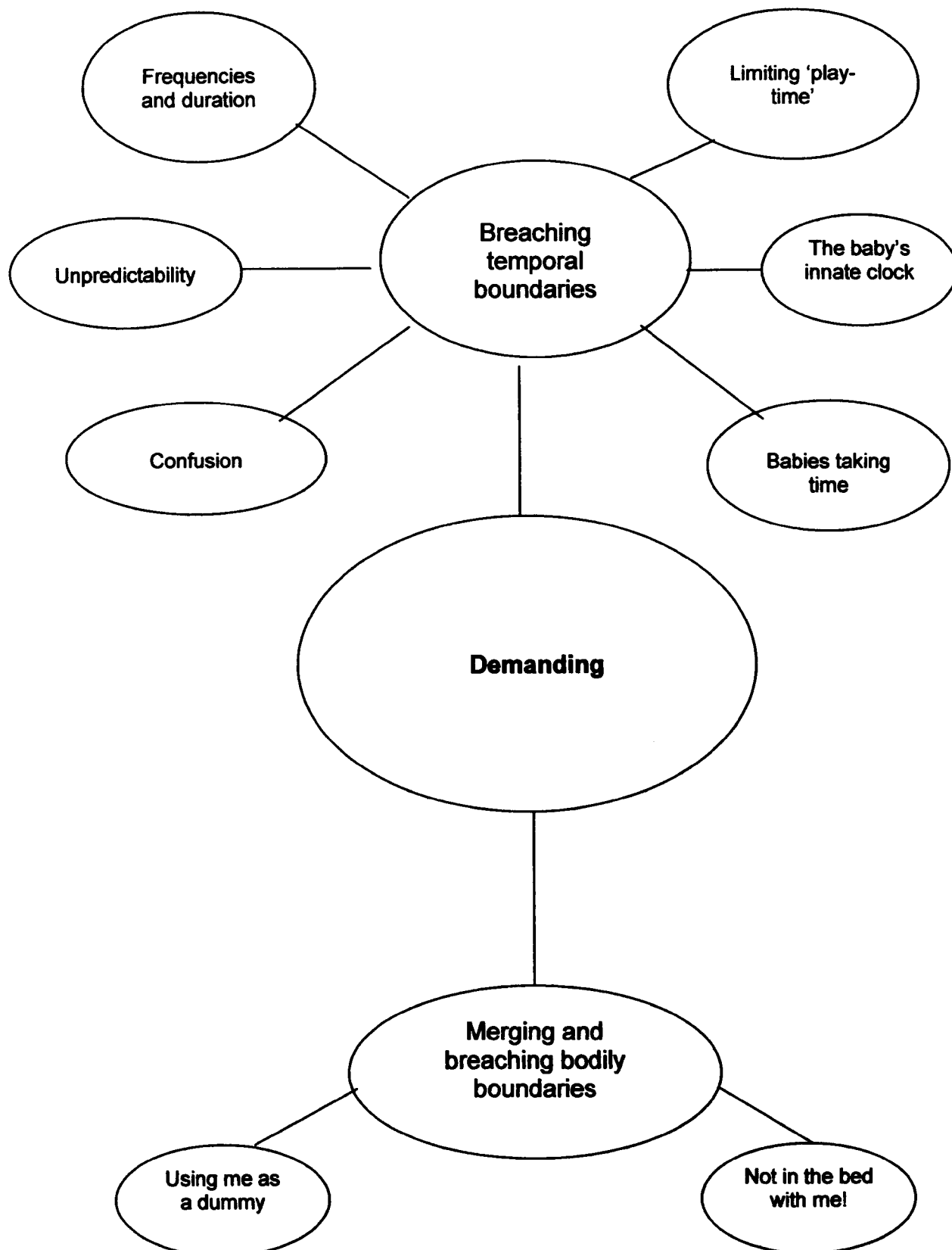
Like the biomedical literature I referred to in chapter 2, the mother is invisible here and any suggestion of mutuality and relationship is absent. The emphasis remains on efficient production and transfer of milk from mother to baby. These time-orientated constructions of demand feeding (Saadeh and Akre 1996, RCM 2002) stand in stark contrast to the ways of feeding seen in cultures in which babies are carried on their mother's abdomens with constant access to the breast. As Palmer (1993) notes, to ask a mother in some cultures about the frequency of breastfeeds would be like asking her how often she scratches when she has an itch.

Confusion

The ambiguities in the ways in which demand feeding may be described have the potential to create temporal confusion for women. Once again, what constitutes 'doing the correct thing...the right way' is far from obvious. Women are still likely to have relatives and members of their communities who schedule fed their babies so the intergenerational conflict of ideas plays a role in increasing confusion. To complicate matters further, the authoritative knowledge pendulum is still in motion regarding these two approaches with a resurgence of "schedule" advocates, for example Ford (1999) who contests the notion of the baby being placed in control with emphasis instead being placed on timing and discipline imposed by the parents.

The data from this study illustrates that women were indeed confused about demand feeding. They knew it involved a flexible approach, i.e. feeding the baby when s/he was hungry, but still often felt unsure about what this involved:

> *I don't know whether I'm feeding him enough. How long should you feed when they are demanding?* (Helen, P35).

> *I think in the night, it was more what I expected it to be, just sort of every 4 hours, but since 11 (Now 5pm) it's just been constant...I didn't expect that. It's all so contradictory, so many pros and cons....You never truly know* (Barbara, P37).

Unpredictability

As I discussed in chapter 2, what appears to be largely missing in the literature is reference to the ways in which women in a western culture interpret, experience and negotiate demand feeding their babies and yet in this study demand feeding was clearly crucial and central to women's experiences. The removal of culturally ingrained linear temporal markers from a lived and embodied experience created considerable discord. The inherent irregularity, uncertainty and symbiotic assumptions underpinning demand feeding led to confusion and uncertainty. Women seemed to feel dislocated in time. Balsamo et al (1992) refers to this "social conditioning to order" in western communities with unscheduled breastfeeding representing "disorderliness" and being perceived as "never-ending and exhausting" (p.74).

The discord women experienced in relation to the variable and unpredictable nature of demand feeding is illustrated by Lesley:

> *Basically he wasn't taking a lot and he was just taking little bits and I was winding him and seeing if he was interested, so I put him down and as soon as I put him down he was starting off again, but as soon as I put him back to me breast he was drinking again, so I was like..what's going on, but when I spoke to the midwife she said it was just down to me milk coming in, so......I don't really know what I was expecting to be honest.........It's been a bit irregular and yesterday I don't know whether it was cos there was a lot of visitors around but he wasn't taking a lot. It was just little bits here and there and then I was winding him and putting him down and he wasn't settling and he was... like... he wanted more, so I was up till about 2 o'clock .....(Lesley, P55).*

This entire narrative is punctuated by time. Lesley's reference to her baby taking *"little bits"* reflects what Helman (1992) refers to as the Western linear assumption that "every event or phenomenon will have both a beginning and an end" (p.37). In contrast women felt confident if a baby stayed latched on to the breast for a period of time which they felt was acceptable, for example:

I felt more confident once she'd actually latched on, and once she's there she tends to stay there. I think if she'd been mooching about and coming on and off all the time I think that would have made me really nervous (Tracy, P44).

Women became anxious when there were changes in the "pattern" of demand feeding, *"OK, she's been feeding every few hours, but, she's not woke up since 5 so I'm feeling a bit like well, not so confident"* (Megan, P53). Midwives used the language of demand feeding, but often appeared to have similar anxieties related to the uncertainty of breastfeeding, for example Sharlene saw demand feeding as an additional source of chaos:

The wards are chaos. Medics and everyone else come and go all day. The midwives come and go and the babies feed whenever they want to....When I fed mine we had a routine and it fitted in with my life - I could go to the supermarket and do some shopping. I was talking to someone the other day and she demand fed for a year and the baby just took over her life. Babies snacking all the time don't fit in with our culture and I think that's why women are giving up. It's difficult to sustain with current lifestyles (Sharlene, MW6).

One of the midwives highlighted some of the tensions for midwives and other women related to their personal attitudes on demand feeding:

I think midwives tend to be guided by what worked for them, no matter how many courses you go on, you tend to do what works for you. I think demand feeding is one of the slowest items of all. Mothers come in with this idea of 4 hourly feeds, they have that expectation and they're concerned if the baby goes longer and they're concerned if they go more frequently. I think that's part of the tension around breastfeeding, they have this expectation of 3 or 4 hourly, time tabled feeding and when a baby is feeding virtually continuously or on and off for long long periods, they think there's something wrong, that they've not got enough milk or the baby is excessively hungry (Jenny, MW14).

Frequencies and duration

Most of the women including the midwives spoke in ways that indicated a strong orientation towards the clock and a preoccupation with schedules, times and routines. As stated, the deep embeddedness of linear time in western bodies is in total contradiction to the concept of demand feeding. In spite of women referring to themselves as carrying out demand feeding they were intensely preoccupied with frequencies and durations of feeds, referring to these with meticulous reference to the clock:

Sometimes she'll go 5 hours....em.....4 or 5 hours.....but that tends to be in the day...and then she'll have a good sleep, but the last couple of nights...em...like last night she fed about quarter past 8 and then she fed again about 12 and then she slept through till 3....... so it was only 3 hours but then she was awake again at 4...just after 4 and then she slept though ..... so (laughs)...its...so I have been doing demand feeding but she seems to want more or up till last night she's wanted more in the night... (Nadine, P60).

Well, she had a proper feed just before visiting hours, like.... and then another feed just after visiting hours, like for about 45 minutes and she was sucking really hard and that was on each breast and then about 12 o'clock from then on till half five she was like feeding and then sleeping and waking up and having more and that. Then they took her out then she had about a 30 minute one at quarter to 7 and after that she went to sleep until about 10 o'clock (Millie, P43).

The reference to a *"proper feed"* by Millie appears to relate to women's seeing breastfeeding as primarily a source of nutrition and therefore their expectations that babies would take a "proper meal" of breast milk. As stated above, it is again reflective of the western linear assumption related to beginning and ends (Helman 1992).

Women tended to refer to bottle feeding as the preferable norm in terms of predictability of frequency and duration of feeding, for example:

I mean like the bottle feeders, I hear them say, oh, she's had this much and they don't feed again for this many hours, but you can't really judge with breastfeeding and that bothers me while she's so demanding (Millie, P43).

Midwives paid lip service to the notion of demand feeding but in their language tended to give mixed messages by requesting fairly detailed information about the baby's frequency and duration of suckling, for example:

Veronica (P27): *He's feeding all the time*
Damaris (MW18): *He seems content at the moment. What time did he last feed?*
Veronica: *An hour ago*
Damaris: *And what about previous to that?*
Veronica: *A couple of hours before that*
Damaris: *How long did he feed for?*
Veronica: *Oh about half an hour or so*

Damaris's preoccupation with frequency and duration of feeds reflects the common assumption that these measures can be equated with quantity of milk taken. While this assumption is fraught with problems in terms of physiological understandings (Woolridge 1995), it is understandable in relation to western associations between time and quantity. As Adam (1992) states:

Clock time, the organizational frame and structure of industrial production is governed by the non-temporal principle of invariant repetition. Objectified and reified it is related to as a quantity (p.160).

The adherence to the philosophy of measurement of feed frequencies and durations was unsurprisingly at its most striking in paediatric advice issued in case notes, as described by Jenny (MW14). She referred to the philosophy of demand feeding as being totally antithetical to paediatricians ways of knowing and working, representing them as being at the extreme end of a range of views related to flexibility versus routines for breastfeeding:

Demand feeding.... it's an endless source of tension with paediatricians. For a normal baby, the paediatricians have this idea of regular feeds and they frequently write it on the charts when the paediatrician has been called to delivery for something like meconium liquor, low Apgar. Even when resuscitation hasn't been needed or has been successful, they'll put 'plan', to ward with mother, monitor temperature, 4 hourly temps, 3 hourly feeds, early feeding. It's like a mantra really, and you've got a strong, healthy normal baby who doesn't need any particular regime at all. You know the paediatric chart with the tick list, when the paediatrician has been at delivery, you'll see that on almost every one. It's the beginning of pathologising (Jenny, MW14).

This illustrates the point made by Thomas (1992) that "time provides not only ways of describing the distribution of events but also a basis for interpretations and explanations" (p.65).

Limiting 'play time'

During the analysis I became increasingly aware of the mother's expectations of a 'good baby', i.e. one that limits his/her demands. This was part of women's project to produce the perfect adult for their own society. This project commenced before or during pregnancy, to include decisions around feeding method, as discussed in chapter 6, but it continued following the birth. The requirement upon mother's to tame their baby and prepare her/him for the requirements of and scrutiny by the society of that time were discussed in chapter 2, with particular reference to the historical analysis of child-rearing practices by Beekman (1977). Whichever philosophy of parenting and infant feeding that women adopt in a given western society, they were and are still expected to civilise their baby (Lupton 1996, Schmied 1998, Meyer and de Oliveira 2003). As Lupton (1996) states, "mothers domesticate children, propelling them from the creature of pure instinct and uncontrolled wildness of infancy into the civility and self-regulation of adulthood" (p.39). Food and eating have constituted a key route to achieving this civility throughout recorded history (Fildes 1989, Maher 1992a,b, Vincent 1999).

The project of producing a future citizen for our society is an extremely complex and culturally mediated endeavour. In the data that I have presented so far and the data I move on to include,

I illustrate that mothers and midwives are still preoccupied to varying degrees with the baby being able to develop routines, be 'good', passive and docile. This involved the baby not being too demanding, sleeping for acceptable periods and not playing at the breast. This expectation appeared to run alongside the desire that the baby would be capable of early independence and even separation, i.e. willing to take a dummy, sleep in the cot and able to engage in self amusement. The following interview with Millie highlights some of these issues:

> She was just crying for nothing really....She just wanted to be cuddled, but she'd been cuddled all night......and I was asking this morning, like, do you think I should just leave her in the cot and let her just cry and try to rock her to sleep or take her out and feed her and she (the midwife) said I don't think she needs a feed now, she's just doing it to get into bed with you..... just feed her and then put her down an' I did but she wouldn't settle properly, so I had to get her up. I think I should be able to cope when she gets into a routine and especially once I get home. I'll be able to sleep better in me own bed... you know. What's worrying me is the fact that she is up in the night and it is demand feeding. If she wants to feed she will cry until she gets fed, you know, whether I'm ready to feed her or not.....and you can't tell, you know, as much... whether she's had enough or is she awake cos she's awake or does she want feeding or...cos she will latch on and sometimes she just falls asleep and starts playing and I think that's when she just wants to play. She doesn't want feeding. And I mean that worries me a little bit, cos obviously it's keeping me awake all night..... (Millie P43).

The midwife clearly reinforced the sense that the baby was simply 'playing up' in her suggestion that the baby was trying to get into her mother's bed and Millie was concerned that this night time behaviour would be a major inconvenience by keeping her awake. Women also referred to having or desiring a 'good baby':

> I've kept an open mind if it didn't work...like I know people who have breast fed...em....you know for ages...you know....with both their children....and I know another couple of people who just couldn't...you know.....get the hang of it and just turned to bottles straight away.....and their babies have been absolutely fine....there's nothing....you know....they slept and you know they were good babies...so I've kept an open mind so that I wouldn't be disappointed...if he needs the bottle....(Sophie, P61).

Tracy saw good behaviour as not messing around:

> Yesterday, I felt a bit (negative gesture)... cos she wasn't feeding, but then as soon as she started feeding in the night, I felt OK. She either feeds or she doesn't, she's quite good she won't just sort of mess with it all the time (Tracy, P44).

It seems that women expected their babies to fit certain activities into specific, bounded sections of time, as Helman (1992) states, "the clock - as a crucial organising principle in industrial society - symbolizes control, conformity and co-operation in social and economic life" (p.43). As stated, women appeared to expect passivity and docility in their baby, yet desired steady and visible progress towards independence. The data illustrates women's dissonance related to competing agendas of flexible, child-centred responsive parent and training the baby to conform to societal norms. This discord strongly resonates with the findings of Schmied (1998).

It could be argued that passive dependence on consumables, yet independence from the mother, is best achieved through bottle feeding a baby with infant formula. Van Esterik (1995) highlights the fundamental difference between breast and bottle feeding, in that with the former, the baby, if permitted to engage in demand feeding, can actively control the way in which s/he drinks milk. The bottle fed infant, she argues, is passive, controlled by others, and becomes a dependent consumer from birth (p.161).

The baby's innate clock

Vincent (1999) refers to the emphasis in the earlier decades of last century upon infants needing to be disciplined through an "external schedule to accustom their nervous systems to certain types of food, rest and play" (p.53). This was seen to prepare the infant for a scheduled life and the constraints of the clock that would be a major feature of their life as adults. However, she argues that by the 1960s the timetable was not simply seen as an external

means of imposing discipline. Rather it came to be seen as an innate characteristic of the child. She states:

> The clock has moved from the realm of culture as perceived in science, training and discipline to that of nature and organic processes. It has moved from outside to inside the human body.....The clock having been internalised is now thought to be inherent in human behaviour. Schedules are considered necessary for many activities such as work, sports, leisure, family life and have become a standard for judging competence, adequacy and normality. Thus the expectation that babies will conform to a feeding timetable, even though it may derive from their internal needs, is a reflection of a general cultural expectation that all behaviour is governed by schedules. The clock is at the core of many cultural themes and it is not surprising that it is still considered to be a fundamental element of infant feeding, even though the way it is described has changed (p.54).

As discussed earlier, the clock has indeed become innate through its effects upon physiological processes (Helman 1992). However, this social conditioning to clock time could hardly be expected to be present in a baby only one or two days old. Women in this study did, however, appear to have the expectation that even if demand feeding was practised that the baby should and would after a short time display her/his innate programming to get into a routine. Sophie anxiously awaited the development of a routine giving the impression that if this did not happen soon that she would reconsider her feeding options:

> He's slept and settled...so....but it's me first day and sometimes they don't feed as much on the first day...do they so...I'll see how I go on through tonight and tomorrow and er... see if he gets in a routine....I think if he was in a routine...I could feed him for 20 minutes/half and hour and then three hours later...four hours later he'd take it again (Sophie, P61).

Kate clearly saw her baby as having moved positively in the direction of establishing a routine:

> She seems to be getting into a bit more of a routine and the last feed she didn't have as long on. She's had a bath this morning too at 08.15. Then she fed at 9 and she's just fed now, for about 20 or 30 minutes (Kate, P39).

Smale (1996) highlighted a similar expectation in some of her clients, "that a period of total unpredictability would resolve into a set regime" (p.236). Thus demand feeding tends to be seen as a transient phase that in time will resolve to a conformity to external and indeed internal clock time.

Babies taking time

The emphasis (above) upon babies behaving and *conforming* to clock time is in stark contrast to research around babies *taking time*. The notion of babies taking time is referred to in neonatal developmental studies, for example Meyer Palmer (1993) who outlines the stages in development of competent co-ordination of suckling and swallowing. It also features in the feminist literature, for example Kahn (1989) highlights that babies live in maialogical time illustrating our fundamental sociability from birth. She refers to babies' innate abilities and tendencies which are particularly evident following an unimpeded birth. For example the baby actively, indeed interactively, displays sociable gestures and makes her way to the mother's breast and suckles.[93] This in turn brings about placental separation. The baby, therefore, initiates her realignment to her mother. Kahn (1989) argues that maialogical time is slow, enabling babies to display sociability and illustrate their "integration into the organic cycle of life" (p.29). She refers to the "baby's embeddedness in organic or cyclical time, which knows nothing of the clock" (p.22).

Hannah who had several children illustrated the notion of babies being given time...to take their time:

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[93] This forms the basis for the BFI, Step 4, i.e. the recommendation that mothers and babies are enabled to have time together in skin-to-skin contact.

I'd say for everybody to just bear with it, cos a lot of people want to breastfeed, but because the baby won't take off them they tend to get upset as well.....Me friend was like that, but em, if she'd 'ave just stuck with it, the baby would eventually...She got very depressed with it cos she'd really been looking forward to breastfeeding but her baby was constantly crying and was just taking a few sucks at the breast, but er if she'd stuck with it it would have been all right.... she ended up bottle feeding cos she was thinking why doesn't the baby want to know. I think that that should be put on leaflets and stuff, because its very frustrating if you want to do something, but your baby won't do it. They need to point out that it's not just your baby that's like that, and that if your baby doesn't take to it straight away it's not that its discontented with you but it's just taking time...... just put the baby in the nighty and lie with them of a night or when they're cuddling them and they will eventually mooch (Hannah, P49).

However, Hannah's emphasis upon babies 'taking their time' in contrast to babies 'taking up time', was rarely referred to by mothers or midwives. It seems that an explanation around this principle might well alleviate considerable anxiety in women. If women understood the concept of maialogical time they might feel less pressured about their babies need for time with them. However, the drive to establish routines in child care and to return to a 'normal' life as quickly as possible are in tension with this notion of maialogical time. There was a sense in the data which resonates with that of others (Schmied 1998, Mahon-Daly and Andrews 2002) that women felt their lives were "on hold" (Schmied 1998, p.292). While this is the predominant feeling, breastfeeding will continue to be seen as short term, marginal and disruptive. I now turn to another way in which women felt that breastfeeding encroached on their boundaries, though space rather than time.

Merging and breaching bodily boundaries:

The second organising theme underpinning 'demanding' was 'merging and breaching bodily boundaries'. As I have discussed, women in this study tended to view breastfeeding as a means of transferring food to the baby. The notion of breastfeeding as a nurturing relationship involving long periods of mother-baby contact was only referred to by one mother.[94] Women expressed discord related to the temporal unpredictability of breastfeeding, as discussed, but also in relation to the erratic disruption to spatial bodily boundaries. Breastfeeding as a lived embodied experience constituted an intermittent disrupting of their bodily boundaries with previously invisible spatial norms being violated. Women's concerns appeared to be closely linked to a partial fear of intensive mothering and an accompanying desire to place control and distance within the feeding and mothering encounter. These concerns were also reported by Schmied (1998) in her Australian study, although she focused upon the ongoing experience of breastfeeding for women, not on the hospital period. She reported that for some women, some of the time, breastfeeding with its commitment to intensive mothering was experienced as a draining, disconnected and disruptive experience (Schmied 1998, Schmied and Barclay 1999).

The sense of disruption to spatial boundaries that women expressed while in hospital, took me by surprise, but it perhaps should not have done given that the breastfeeding experience contrasts with the predominant ontological position of western culture which centres around the "separate, self-sufficient, independent, rational "self" or "individual" (Mauthner and Doucet 1998, p125). Shildrick (1997) refers to the leakiness of woman's bodies breaching socially prescribed boundaries, "those differences - mind/body, self/other, inner/outer - which should remain clear and distinct are threatened by loss of definition, or by dissolution" (p.17). In relation to inner and outer - women's bodies are contrasted with the "self-contained and self-containing men", being seen as leaky and uncontained (Shildrick, p.34). In relation to self and other - Shildrick (1997) states:

> The indeterminacy of body boundaries challenges that most fundamental dichotomy between self and other, unsettling ontological certainty and threatening to undermine the basis on which the knowing self establishes control [....]. The capacity to be simultaneously both self and other in pregnancy, which is the potential of every woman, is the paradigm case of breached boundaries (p35).

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[94] That is not to say that this relationship will not have developed, but at this early stage it was not something that women appeared to conceptualise.

When women have a new baby and begin to breastfeed, the breaching of boundaries is enormously potentiated as they undertake a profoundly new bodily experience. Their body's boundaries are now accessed with increasing unpredictability by another, further blurring the distinctions between self and other. Their breast milk comes from within and is manifest without through a part of their body that is constructed as both maternal and sexual in nature. Not only does the woman now need to come to terms with her unboundedness in relation to the baby, but she also has a re-negotiation of private and public space. She now shares her private space with her baby and in hospital she and her baby are also together in a very public place. This adds further blurring to the woman's sense of self in relation to others. Lupton (1996) refers to the ways in which breastfeeding breaches the boundaries between other and self:

> Just as the fetus/mother is a highly ambiguous category of subjectivity, there is a liminal stage between the mother's body and the infant's body, in which the milk acts as the connection; the milk is generated by the mother, taken in by the infant held close to the breast and becomes part of the infant's body. This liminality arouses anxieties around the defining of boundaries between self/other and nature/culture (p.45).

Van Esterik (1994) likewise refers to experience of "other as self" - that makes breastfeeding both a powerful transforming experience for some and a terrifying loss of personal autonomy for others (or both at the same time)" (p.S47). Schmied (1998) also refers to breastfeeding as challenging dualistic boundaries between mind-body, nature-culture, inside-outside and motherhood-sexuality. Indeed it could be argued that it is the ultimate form of breaching boundaries, hence its dangerous possibilities (Foucault 1981).

Using me as a dummy

The most common way in which women expressed discord around breaching of spatial boundaries centred around use of their breasts as 'dummies':

> I'm worried about using the nipple as a comforter, and I know you've got to demand feed, but, I don't want her to be permanently on (laughs)... That's why I want to wean her off it before I go back to work, cos obviously I'm going back, not quite full time, but 30 hours a week, so it'll be more difficult to sort of demand feed and what have you through the night (Nadine, P60).

Nadine's reference to the nipple, and weaning her off it, further illustrates women's objectification and conceptual detachment from their breasts, that I referred to in section 7A. Women tended to describe sucking for comfort or using them as a dummy as unacceptable, "He wants to have something in his mouth all the time" (Julie, P9); "I think he was using it as a dummy last night, he seemed to be feeding for ages, like just wanting it next to his mouth" (Sarah, P10).

Barbara reiterated these concerns and emphasised that it should not become a "habit" preferring that he learn to "relax in the cot."

> I mean feeding is a last resort, but I don't want it to become like a dummy, just a comfort thing. Er...I don't mind, but I'm a bit concerned because once he's on he just falls asleep. He doesn't actually take anything, as I was saying it's just a comfort thing.....Er, I don't want him just on me for no reason (laughs)..... I'm a bit don't know what to do really....... I am just concerned that its going to be a habit, that I don't want to...I really don't want it to be a habit where he's needed this much. I mean comfort wise I want him to relax in the cot rather than this (Barbara, P37).

Some women felt that by wanting to remain at the breast, the baby was engaging in unnecessary dependency upon them, "I'm not always sure when she's had enough. She's quite content to hold my nipple, so it's knowing when to put her down.... like she's depending on me" (Jane, P12); "She's needing it all the time, you know, I can't get away from the bed" (Stella, P46).

Hannah, an experienced mother, commented that there were several types of sucking, but she saw sucking for comfort as a replacement for a dummy:

Hannah (P49): *I can see she actually enjoys sucking, you know the different types of sucking that they do, like sucking for a drink, for a feed, or for comfort....like a quick suck for a drink, then like a long suck when they're actually feeding, then like a quivering suck like, for comfort and like a dummy.*

F: *Do you use dummies at all?*

Hannah: *I do, yeah, she hasn't had one yet, but because you're feeding on demand she'd be there all the time, when it is just a dummy that she wants.*

Midwives tended to reinforce the view that babies were using their mother's breast as a dummy, *"don't let him use you as a dummy* "(Francesca, MW28); *"Is he using you for comfort?"* (Kim, MW15). One of the midwives emphasised that babies suck for nurture as well as nutrition, although it was worded rather as an either/or scenario, *"they suck for nutrition, but sometimes they suck for comfort as well"* (Sandy, MW30).

The interesting reversal from 'dummies replacing breasts' to 'breasts replacing dummies' highlights the strength of the pacifier as a cultural norm along with bottles and related paraphernalia in the West. This cultural reversal is characteristic of the bottle feeding culture (Auerbach 1995, Wiessinger 1995, 1996). Indeed, as Weissinger (1996) argues, the cultural reversal has entered the language used both in professional and lay literature and spoken language so that bottle feeding and associated activities such as dummy usage are represented as the norm. Breastfeeding then becomes the activity to which we attribute difference.[95]

Not in bed with me!

One of the other areas in which mothers appeared to express discord related to their boundaries was that of bedding-in.[96] This is an attempt at complete reversal of the institutionally entrenched notion of physical separation of mother and baby. However, simply changing a recommendation related to care of the baby does not undo the embeddedness of a particular concept such as separation in specific cultural contexts. Like linear time, the notion of separation of mother and baby, both physically and philosophically, has developed in relation to parenting over more than a century. A series of risk discourses centring upon, for example infection and more recently sudden infant death syndrome, have served to perpetuate and strengthen the imperative to be separate rather than close. This creates a situation in which bedding-in is seen as a subversive activity by many women and midwives.

The notion of bedding-in is one that endorses maximum blurring of maternal and infant bodies and therefore creates dissonance for women in negotiating their boundaries. Women were generally very cautious about the idea of having the baby in their bed, even when suggested by a midwife:

I was struggling. I was so tired me head was spinning and um...I couldn't settle him. They said I could take him in the bed with me, um...but I'm not comfortable with that.....I mean I never did that with me other two, so...and I'd be frightened of squashing him (Sue, P29).

Women generally saw having the baby in the bed as a short term activity not to be encouraged once home and therefore they felt cautious about the baby becoming used to being in the bed, for example Millie (P43) felt that she would not want her baby to get used to bedding-in.

F: *Do you have her in bed with you?*

Millie (P43): *Um, up to now she has been when I was feeding, cos I couldn't move. I was too tired and that. But I mean I've got a chair in the room for when I go home and that.....I'll just have to see what happens and that.......I don't want her getting used to being in the bed with me though.*

F: *You wouldn't fancy that?*

Millie: *No, (laughs), not all the time, no. It's nice and.... easier.... but I don't want her getting used to it* (laughs).

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[95] The way in which the health benefits of breastfeeding are referred to provides another example, suggesting that to breastfeed offers something additional to the 'normal' method formula feeding.

[96] Bedding-in refers to the mother and baby occupying the same bed. I discussed this issue in chapter 2 in the context of the BFI now encouraging bedding-in.

Millie intended to breastfeed in a chair at night to keep her domain, the bed, separate from that of the baby. Midwives generally encouraged bedding-in on site 1, in line with the BFI. However, they were very tentative about suggesting bedding in on site 2:

> F: *I just wondered if you would suggest to a mother that she has the baby in bed with her to settle a baby? I've seen that elsewhere, but not here?*
> Francesca (MW28): *No we wouldn't encourage it* (Frowns), *but we wouldn't stop someone from doing it.*

Corinne (P41) highlighted that when bedding-in was encouraged she was placed under close observation by the midwives. This gave the message that it was an activity requiring surveillance and by implication unsafe at home:

> Corinne (P41): *She* (The night midwife) *you know..... she put him in bed with me and said try and get some sleep and she laid him next to me which he seemed to like. He just wanted to be close really, rather than in the cot. I was a bit worried about rolling on him and that but she said she'd keep looking in on him, so she did that and I had him in bed with me for about an hour or so.....so....*
> F: *How did you feel about having him in with you like that?*
> Corinne: *Yeah, it was nice but I wouldn't do it at home, no, I wouldn't do it.*
> F: *What would put you off?*
> Corinne: *I just wouldn't feel safe, no, I'd be frightened I'd roll on him* (laughs). *Cos she* (the midwife) *said she was coming in all the time and having a look.*

In the data there were two other important contributing factors to women's feelings of breached boundaries and demanding nature of breastfeeding. These were nipple pain and fatigue with the latter affecting every mother to some extent. However, the strength of these two aspects of women's experiences warrants them being addressed separately, in chapter 8 in which I focus upon some very specific positive and negative embodied experiences referred to by women. I also discuss further the issue of bedding-in, rooming in and taking the baby to a nursery in relation to midwives being expected to endorse a policy, rooming - in, but finding ways of subverting this "rule" in order to facilitate women in getting some sleep.

Summary

I have highlighted the ways in which demand feeding breaches temporal and spatial boundaries as constructed in a western culture. This removal of temporal and spatial markers through a lived, bodily experience created confusion and uncertainty for women while they were on the postnatal wards. It was very striking that the notion of breastfeeding being demanding in various ways was reported by almost all of the participants I interviewed, although this is not to say that this was always construed negatively. There were several women who described breastfeeding as a positive embodied experience, even at this early stage and this overrode some of the challenges. I discuss this further in the chapter 9.

During this hospital period, women were also coping with the recovery from pregnancy, labour and birth in an unfamiliar setting, surrounded by strangers who also encroached upon their temporal and spatial boundaries (see chapter 9). It seems highly likely that early negative experiences may have shifted to later more positive ones as women returned home and adapted to the temporal and spatial unpredictability. This research focuses only on women's very early breastfeeding experiences and therefore I am not able to report on the ways in which this experience changes over time. In section 7C, I now focus upon ways in which women negotiate the temporal and spatial uncertainty inherent in breastfeeding, their felt imperative to return to paid employment and their lack of trust in their ability to breastfeed.

SECTION 7C
GAINING CONTORL - MAINTAINING BOUNDARIES

Introduction

In section 7A, 'supplying', I focused on anxieties experienced by women in relation to their production and delivery of their breast milk to the baby. In 7B, 'demanding', I discussed the ways in which women experienced dissonance related to the inherent uncertainty of demand feeding and the blurring of boundaries between themselves and their babies. In 7C, I now focus upon the ways in which women coped and planned to cope with the inherent tensions related to the embodied disorderliness of breastfeeding and concerns about how they would return to and manage their busy 'normal' lives once home and their return to 'productive' employment.

In a society in which productivity, in the industrial sense, is super-valued and with lives structured around daily routines, breastfeeding women are faced with multiple contradictions. Their bodily rhythms and flows and the maialogical time of their babies contrast with the socially dominant form of time, linear time. Kahn (1989) summarises this dilemma as she refers to western industrial societies where women are subjected to an institution of motherhood in which they are expected to mother within a social system dominated by linear time. This expectation upon women centres upon a form of time which is "extremely inhospitable to the slower tempo of children" in a culture in which there is little support for women who are still asked to put in most of the "time" in the care of the young (p.28).

Women are now increasingly engaged in two forms of production, reproductive and industrial, and this creates specific pressures upon them (Galtry 1997a,b,c, 2000). One of these pressures centres upon conflicting notions of temporality. Balsamo (1992) eloquently summarises the tensions between the "natural" time of women's bodily inherent rhythms, flows and fluctuations and "production or social" time:

> Milk comes as the contractions of labour come and then the child and before them all menstruation, breaking into patterns of social time. They have rhythms of their own, linked to the relationship of the women to her physical and social background. They constitute a disturbance to the organisation of labour and thus 'natural individual time' come into conflict through the body of the woman. This conflict is even more dramatic today because production times have been accelerated with respect to 'natural time', but also because women are becoming more and more integrated into the world of production and its forms of knowledge and are ever more dominated by it (p.85).

The notion of the production line with its inherent super-valuation of speed, efficiency and productivity was central to women's concerns in my study. If time is seen as linear and related to efficiency and productivity, in the industrial sense, then women will see breastfeeding as time consuming and potentially time wasting. This links with what Adam (1992) refers to as a notion of time as a quantifiable and finite resource with "time running on and out" (p.162). She asserts that this conceptualisation is exclusive to a clock-time understanding of the world in total contrast to the notion of "becoming" (p.163).

The fear of using up too much time was reflected in women's concerns related to the time between feeds and the time their babies slept for. Women's anxieties about the disordered and wasted time inherent in breastfeeding and the pressure upon them to get their bodies out into society and to engage with production as paid employees were evident within the first one to three days of their new mothering experiences. I was not expecting this finding in a hospital-based study when women had only just birthed. As a consequence of women's concerns they endeavoured to place controls upon the timing and time taken in the act of breastfeeding. This conflict between women taking time out with their babies and resuming a 'normal' life to include getting back to work was ever present. There is now an entire service industry that separates out the supply function of the mother from the demands of the baby. Mothers can now express breast milk or give formula milk that may be issued to the baby by someone else, somewhere else. The baby's needs for nurture may be satisfied with a dummy rather than the breast. Meanwhile, the woman can restore her figure, put on her suit or jeans and stride out into the workplace in order to resume efficient productivity.

A glance at the breast pump advertisements in, for example the *Journal of Human Lactation*, illustrates this philosophy perfectly as the well dressed, slim woman may be seen marching off into the distance with breast pump in a smart compact briefcase. No doubt the case could also contain breast pads to prevent any sign of uncontrolled bodily fluids becoming evident. The baby is strikingly absent. Blum (1999) refers to the breast milk feeding philosophy that has grown recently in the USA:

> The breastfeeding-wage-earning supermom, who is, paradoxically, free from any embodied constraints or wants. She is treated and treats herself as nearly body-less, and can be endlessly self-disciplining [....]. Today's supermom gets medical approval to carry her breast pump to work, and, through her milk, to maintain her claim to exclusive, class enhancing motherhood (p.183).

The marketing of the bottle, breast milk substitutes and breastfeeding aids, discussed in the background, is designed to target this 'modern' mother (Palmer 1993, Baumslag and Michels 1995, Sokol 1997) who is portrayed as confident in the work place, but paradoxically has little trust in her own body.

Paradoxes of control

In this study gaining and regaining control appeared to be very important to women. The concept of control relates not only to power and *being* controlled but also to individual's desires and needs to feel *in control* of their lives and circumstances in an endeavour to maintain predictability (Bandura 1995). The extent of the desire to be in control varies from culture to culture (Oettingen 1995). In western cultures, heavily influenced by Cartesian dualism, control involves disengaging from our material selves, controlling our bodily sources of error and making rational, instrumental decisions (Hastrup 1995).

A paradox of control in the context of breastfeeding is that, like labour and childbirth, the process is at its most effective as an embodied experience when it involves relaxation and going with the 'flow', rather than trying to control it in an instrumental, goal-centred way (Odent 1992, Britton 1997). As Anderson (2000b) states: "'letting go' occurs on a psychological level that allows the physical body to take control. Thus the woman still retains her sense of control"....because she "is the body that is in control" (p.96). The physiological connections are clear, in that in both labour and breastfeeding, release of the hormone oxytocin is hampered by stress hormones, adrenaline and noradrenaline (Odent 1992, Ueda 1994, Nissen et al 1998).

In spite of the physiological basis this concept of 'letting go' directly contradicts the valued western concept of individuals exerting rational and instrumental control over their lives and bodies (Britton 1997). It also contravenes the philosophy of western medicine with its profound fear of chaos and uncertainty in relation to the body and bodily processes and its consequent focus on controlling the body (Davis-Floyd 1994, Lupton 1994). This is particularly relevant in relation to breastfeeding as a bodily secretion which brings with it all the fears of disorderly losses from the body as they leak, seep, gush, flow and surge (Foucault 1981, Martin 1987, Lupton 1994, Shildrick 1997, Bramwell 2001).

Women in this study were endeavouring to cope with and control three dimensions of temporality, the past, the present and the future. They were recovering and re-orientating from their labour and birthing experience, they were coping with the moment to moment challenges and unpredictability of new mothering and breastfeeding in a strange place, and they were planning ways of coping in the future when they returned firstly home and secondly to a 'normal', usually economically productive life. I now elaborate upon the three organising themes underpinning the global theme of 'gaining control – maintaining boundaries': 'regaining control around birth'; 'controlling breastfeeding' and 'supplementing breastfeeding' (see figure 7.3).

Figure 7.3
Thematic Network:
Gaining control – Maintaining boundaries
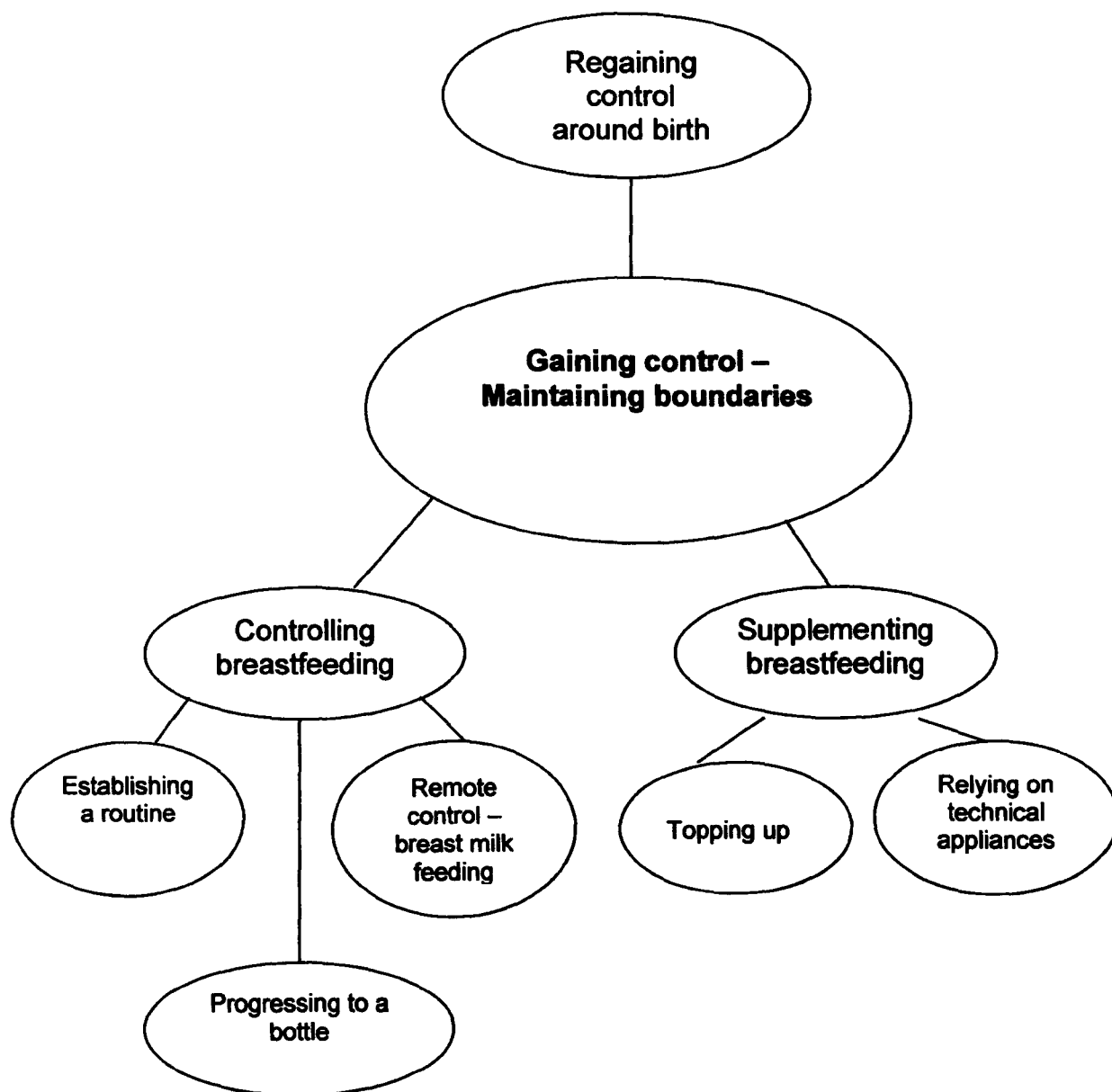
Regaining control around birth

The connection between birth and breastfeeding was illustrated in the data when women linked the two in relation to feelings of lack of control and the need to regain it. Several women related their need to regain control over their external and internal circumstances having undergone a medicalised pregnancy and birthing and then been relocated to yet another environment. They felt they had little control over the surrounding milieu or their own bodies. Illich (1995) refers to this double loss of control as an aspect of social iatrogenesis, defined as removal of "those conditions that endow individuals, families, and neighbours with control over their own internal states and over their milieu" (p.127).

Lupton (1994) comments in relation to the hospitalisation of birth that:

> Women, at an extremely vulnerable time in their lives, are put into a system which has little to do with them as individuals, but is concerned only to process the greatest number of women through birth without incident...the emphasis is usually on the needs of the baby rather than the mother. The situation encourages the pregnant woman to be distant from the process, to hand over control of her body to others and to take advice, which may make it difficult to take back control after the birth, when she may have no real knowledge of her own feelings or her baby (p.148, 149).

The need to gain rational and instrumental control of the situation was illustrated by Louise who contrasted her previous labour and birth experience with this one, emphasising being in control:

> I had a Caesarean for my first baby, but it wasn't like this. It was an emergency and they put me to sleep. I was in labour for 26 hours and only got to 4 cm dilated and he was distressed. This time I didn't want a repeat of last time....So we agreed on an elective Caesarean and I wanted to be awake. It was very nice and completely different......um, I didn't have any control last time. I mean I felt so much more relaxed this time knowing when I was coming in and everything, and I feel more relaxed about breastfeeding because of that...I mean first time round I found it was really traumatic - I found it difficult to cope... I'm that kind of person...I need to know what's happening, why it's happening, I'm a control freak! (Louise, P14).

This time, Louise extended this desire to impose some control to her breastfeeding experience:

> I've decided to write down his feeds today, because I can't remember when I fed him, which side I fed him on, how long the feeds were. Then people come and ask me and I say I can't remember. For those first few days before the milk comes in I think it's important (Louise, P14).

Clearly, Louise felt the need to carefully record the details of feeds in order to feel in control, but also to be able to respond to requests for information from midwives.

Controlling breastfeeding

Much of the data that follows emphasises the ways in which women controlled, supplemented or attenuated breastfeeding, utilising a range of breastfeeding aids, appliances and supplements.

Establishing a routine

In section 7B, 'demanding', I discussed the ways in which women commonly aspired towards a routine developing with breastfeeding, sometimes appearing to see this as innate behaviour in the baby. In this section I transfer the focus to constraints that women spoke about in relation to their ability to demand feed, exclusively breastfeed or feed for more than a few weeks or months, and the ways they planned to negotiate these. Woman tended to look ahead and worry about how demand feeding would 'fit in' with their lifestyle. Consequently, they desired to control breastfeeding through placing time constraints upon it and developing a routine, for example Gemma commented that she was somewhat ambivalent about breastfeeding while she was pregnant, "what put me off was the demand feeding. I've got horses and I like to be out with them. The idea of sitting and feeding all day wasn't me (P5).

Most women tended to see demand feeding as a short term endeavour, again emphasising their goal of developing a routine:

> I mean this demand feeding, it's OK to begin with but then I want to get her into some sort of a pattern by 1 or 2 months you know, like 6 to 8 weeks or something. Once she's settled into a routine I'll put her cot in the nursery we've got ready (Kate, P39).

As may be seen in this quote a primary goal in relation to mothering the baby centred on progressing the baby towards independence. Development of a routine was a key element of this goal. Another example of a mother who emphasised her desire to impose an early routine may be seen in the following 'staccato' conversation with Pauline. She was a health professional who had given birth to her third child. She appeared to see breastfeeding as purely functional for transfer of milk and not as sensuous, relational or nurturing in any way. She saw expressing and giving formula and getting the baby used to bottles as early as possible as the ideal. She rejected the notion of intensive mothering. For her, breastfeeding appeared to be a largely pleasureless, mechanical act centring on the transmission of milk to the baby. Establishment of a routine was a priority:

> F: Why did you choose breastfeeding?
>
> Pauline (P56): Em, better for the baby, it's cheaper, it's convenient (said very abruptly).
>
> F: How did you find the experience of breastfeeding?
>
> Pauline: It's all right. It's not something I really enjoy. It's not something I dislike...it's fine, except that I had mastitis both times.
>
> F: When did you have that?
>
> Pauline: About 2 or 3 weeks old. I had it twice with both of them.
>
> F: Do you know what caused that?
>
> Pauline: You get a blocked duct and an abscess
>
> F: How long did you breastfeed your other two children for?
>
> Pauline: Around about 12 weeks
>
> F: What was your reason for discontinuing?
>
> Pauline: Back at work
>
> F: What are your plans this time?
>
> Pauline: Probably about the same. I switch to SMA formula. I give it to them from quite early on, just to get used to it
>
> F: From how early would you say?
>
> Pauline: After a few weeks, but I express and get them used to a bottle straight away, because I want them to get used to a bottle and I never had any problem with that.........I like to be quite routined. I do it on demand but try and get them into a routine, so looking at four hourly really in an ideal world. I think they do suck for comfort and I don't want him sucking for comfort just on me. I'd rather he had a dummy. I've given him a dummy. If he isn't settling I just give him a dummy and see if he just wants comfort or not......I mean literally he's had two sucks at it and he's asleep, just to settle him last night....

Pauline saw the need to express milk and give it by bottle and use of formula milk as a part of the routinisation of feeding. Further examples of these strategies are presented in the next section.

Remote control - breast milk feeding

As stated, women commonly conceptualised breastfeeding as transferring or delivering breast milk to the baby. This enabled/facilitated an easy step to the provision of breast milk without the baby being at the breast, i.e. breast milk feeding. Expressing breast milk enabled this shift. As Van Esterik (1996) states: "Breast pumps contribute to the medicalization of breastfeeding and emphasise breast milk as a product rather than breastfeeding as a process" (p.273). Blum (1999) refers to expressing milk to give to the baby as a disembodied approach with breastfeeding as a relationship vanishing and mother love being replaced by the pump and breast milk. Jane (P12) illustrated this form of control over breastfeeding as enabling a return to a "normal life":

> Because breast milk is what's advised for the baby's health, I said I'd give it a go. I'll be going back to work full time, so I'd like to be able to express, so if that's all right, but I don't know how easy that's going to be. I'm just concentrating on getting over the first

stages first. I'd like to be able....if I can express I'd like to think I can carry on doing it, depending on how I can work it round. Being able to express obviously makes it more convenient socially and you know having more of a normal life (Jane, P12).

This emphasis upon returning to 'normal' by expressing, resonates with the findings of Morse and Bottorf (1988) in which they refer to women's knowledge that their infant was receiving breast milk even in their absence as the "door to freedom" (p.165). The desire to return to 'normal' in relation to one's body and life, as Schmied (1998) argues, parallels dominant discourses around "control, management and efficiency" (p.277).

Expressing also related to the desire to reduce the intensity of the one-to-one mother-to-baby relationship, as illustrated by Liz who saw the reduction of intensive mothering as part of a shared parenting endeavour, a reason increasingly identified by women for not exclusively breastfeeding or for bottle feeding (Schmied 1998, Earle 2000, Dykes et al 2003).

Well I'd like to use a breast pump so my husband can take his turn as well. I think that's important. Otherwise you become very isolated together, it's a mother-child thing - breastfeeding (Liz, P11).

Shirley referred to "somebody else" being able to give a feed, based on her previous experience:

Shirley (P57): *I used to express for Heather and freeze it into ice cubes just for if you were going out or, sometimes if I was tired somebody else could give her a feed.*
F: *Did you give that by bottle?*
Shirley : *Yeah*
F: *Would you do that again this time?*
Shirley: *Yeah, oh yeah*
F: *Who first talked with you about expressing?*
Shirley: *The midwife. I think its good to get them used to a bottle, cos once Heather decided she didn't want me anymore it was easier to put her onto bottles because she had had bottles, you know, whereas if they get established for too long on the breast it can be difficult to put them on a bottle if you do want to go back to work or there's another reason for stopping breastfeeding, then you can have a problem.*

Both Liz and Shirley, above, appeared to endeavour to shift accountability away from exclusive breast feeding to shared breast milk feeding.

Progressing to a bottle

The reference by Shirley, above, to getting the baby used to the bottle relates to the strong sense that transferring the baby to bottles symbolised progress. Indeed, the baby bottle has become such a strong symbol of babyhood in our culture (Henderson et al 2000), that it is seen as an almost inevitable step in the creation of an independent individual. Some of the women in this study appeared to be uncomfortable with the idea of expressing milk to give by bottle preferring to give a bottle of formula. This probably reflects the socio-economic classification of many of the participants as expressing milk is more prevalent in "higher occupations" while giving formula milk becomes increasingly prevalent in "lower occupations" (Hamlyn et al 2002, p.18).[97] This was particularly the case on site two where there was little reference to expressing by either mother or midwife, reflecting the cultural prevalence of formula milk feeding.

Almost without exception women saw breastfeeding as a relatively short term project, with three to six months being the longest stated duration. Returning to work was usually given as the reason for discontinuing:

Carol (P31): *I'm going back to work in 3 months time, so I'll probably start bottle feeding then, it'll be easier cos I won't be with her all the time.*
F: *Have you thought about expressing milk?*
Carol: *I 'ave, but I don't fancy that.*

The nature of the work was often seen as incompatible with breastfeeding:

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[97] ONS National Statistics Socio-Economic Classification NS-SEC.

F: *How long do you plan to breast feed for?*
Harriet (P52): *Um, well I've got to go back to work in 18 weeks, so probably until then.*
F: *Have you thought about expressing your milk?*
Harriet: *No, I work for an airline, so that's not practical. If they gave us longer maternity I would* (laughs).

Glynnis, having tried her baby on a bottle expressed anxiety that he wouldn't take it and that this could cause difficulties for the future:

> Glynnis (P59): *I am a bit concerned, you know, when I go back to work I'll need to give him bottles during the day and breastfeeds during the night, cos he just will not take a bottle. I work full time you see, I'm a chef, so, me mums going to have him.*

Mandy planned to combine breastfeeding and giving formula milk and then at three months to probably 'progress' to predominantly or all bottle feeding:

> *I aim to give him 3 months start. I've read in the evening you can give a bottle to help them sleep. It's thicker. I've spoken to others with practical experience - they have combined both. Then it may be a bit more difficult after 3 months, there'll be a few more restrictions, 'cos I'm going back to work* (Mandy, P25).

As stated, planning to breastfeed beyond three to six months appeared to be the exception and beyond six months was rarely anticipated,[98] with the notion of breastfeeding a toddler as undesirable, for example:

> F: *How long would you like to breastfeed for?*
> Sophie (P61): *Probably till I go back to work in September...*
> F: *Yes, then what would you plan?*
> Sophie: *Um....depending on....I'd probably be going back almost full time...so I don't fancy having to express all that milk....em...so I'd probably change then...at least I'd have done a good six months ...more or less...I suppose it depends on how it went....like I don't like the idea of breastfeeding when the teeth are there..but I don't know really.... to be honest...I've not thought about it that much....see how it goes....*

Some multiparous women spoke about other reasons why they intended to introduce bottles, for example:

> *After about three months they tend to get a harder suck and a longer suck. It gets very irritating so I've gorra stop. So I tend to wait for that feeling and then stop, well gradually like, say I'll give a bottle of a day....and of a night I'll breastfeed, so it's not sore (Hannah, P49).*

Midwives expedited the progression to bottle feeding in several ways. Firstly, on site 2 by a readiness to recommend formula top ups, as discussed later. Secondly, the 'all or nothing' philosophy displayed on site 1 led to women who started giving bottles completely switching from one to the other, as illustrated in the discussion between Joy and Veronica. Veronica decided to bottle feed during the second night but told me that she would like to try breastfeeding again, once her milk came in. However, she had little opportunity for further dialogue as there appeared to be a finality in the midwife's mind as she bustled in and stood in the middle of the bay:

> Joy (MW4): *Have you decided you're going to bottle feed full stop now?*
> Veronica (P27): *Yes* (Looked taken aback, and smiled uncertainly).

Ironically then, on site 1 the zealous desire to promote exclusive breastfeeding contributed to the 'progression' to bottle feeding in women expressing varying degrees of uncertainty and ambivalence. On site 2, the laissez faire attitude to giving formula milk also expedited the progression to bottle feeding as I now discuss.

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[98] Again, this probably also relates to socio-economic classification with 41% of women in "higher occupations" still giving some breast milk at 6 months compared to only 27% in "lower occupations" (Hamlyn et al 2002, p.35).

Supplementing breastfeeding

Topping up

Women commonly felt that they needed back ups to breastfeeding, reflecting their uncertainty and lack of confidence in the notion of exclusive breastfeeding and their desire to shift some of the accountability. The most commonly used backup was a formula supplement:

> *I've got some formula at home in case we need it....., but I think both my husband and myself, we feel that if we've actually got something in the house, if we're actually at the stage where the baby's not feeding then we've actually got something to rely on* (Chloe, P50).

Some of the midwives encouraged women to have formula available as a backup, *"I'm hoping to go home today, and one of the midwives suggested that I buy some formula just in case"* (Jasmin, P51). Some women saw bottle feeding as a possible answer to unsettled behaviour or wind, *"I just wondered if she would have less wind with a bottle"* (Jocelyn, P18).

The dependency upon top ups was particularly striking in site 2 where 6 out of the 21 women, i.e. about a third of the participants, had given either a bottle or cup of formula prior to discharge. Midwives tended to suggest that women give formula at the first sign of difficulty, often by cup.[99]

Corinne's baby had been taken out and given a top up of formula by cup with apparently very little dialogue:

> Corinne (P41): *I'm just waiting for my milk to come through properly, he's been sort of feeding non-stop. He was at it for three hours in the night, so the midwife came and took him and gave him a top up and then he slept all night until 8o'clock.* (laughs)......*So that was nice, but not nice cos it wasn't me* (laughs).
> F: *When you say a top up, how did they give it?*
> Corinne: *They said they'd give a cup, just a little bit, not a bottle....it's just a bit disheartening when it's not you that's sort of filled him up and sent him to sleep, you know* (laughs)......*it's just that I'm not filling him up. He's just so big, he's 8-13.*
> F: *Did the midwife discuss the issue of giving him top ups?*
> Corinne: *No, no.....she just immediately said we'll give him.....I'll take him off you and give him a top up, a cup they called it and then I just went to sleep which was nice.......They were very helpful.*

Corinne expressed a sense of regret at not having *"filled him up herself"*, but on the other hand saw the midwife as having been very helpful. The next day I watched a midwife who the mother had not met before:

> Corinne (P41): *He's feeding all the time*
> Francesca (MW 28): *Frequent feeding is normal in the early days.* Looks over at the baby feeding: *He's on properly.*
> Corinne: *Should I just let him carry on?*
> Francesca: *Well, don't let him use you as a dummy. If he's finished feeding, break the seal by putting your little finger in...let me know if you get desperate and we can give another top up.*
> Corinne: *It was just the night that was difficult*
> Francesca: *Well, it's better if you can persevere, because to give a top up once or twice is OK, but you need to give your own milk really.*

The midwife, Francesca, gave mixed messages. She commented that frequent feeding was normal, but advised her not to let him use her as a *"dummy"*. She also stated that it was better not to give top ups but all right if *"desperate"*. Finally, she emphasised that it was better to persevere with giving breast milk. She gave the woman only a cursory glance before saying

[99] The cup had obviously been introduced, but was being used for formula. It was intended to be used with hand expressed breast milk, more specifically with pre-term babies, although useful for term babies who were for some reason unable to access breast milk effectively (Lang et al 1994). However, it was being used in order to justify giving formula but was considered acceptable because it would not cause nipple-teat confusion, a much contested issue in itself.

"he's on properly". The baby did not appear to me to be attached or suckling very effectively, an observation further evidenced by the mother's increasing nipple soreness. The mother, however, saw the positive side of the encounter, particularly the emphasis upon perseverance:

F: *How do you feel after that discussion?*
Corinne P41: *Well, better knowing that he's on properly and it's normal for him to want to feed frequently....and she said try and persevere which I wanted to do, like she said that one or two cups is all right but after that try and persevere...so....I'll just carry on, see how it goes.*

I asked Francesca, the midwife, later, under which circumstances would she give top ups. She said:

If the mother was really struggling, but we would emphasise it's a one off rather than a regular thing. He's a big baby, so he's quite hungry (Francesca, MW28).

On the third day when I saw the mother she was referring to topping the baby up herself!

Corinne (P41): *We didn't do any more top ups yesterday and he was great, he slept no problem in the afternoon and I was just topping him up and no problems?*
F: *Do you mean topping him up with your milk?*
Corinne: *Yeah, yes,*

I followed another mother, Selina, through for 3 days. On the third day her baby was jaundiced and had been given a top up of formula. This related to the baby not being effectively attached to her mother's breast and becoming dehydrated.

F: *So, when I saw you yesterday, you said you had a very busy night, but she had been feeding better?*
Selina (P48): *Well, she's was quite sleepy for the rest of the day and then in the night she fed at 1, 2, and then at 6 o'clock. One of the midwives came and she said her mouth was very dry, so they gave her a cup feed of formula and then she fell asleep so she hasn't woken up since then.*
F: *Oh, so has she had any other cup feeds?*
Selina: *No, but she said she was having to pull quite hard and her lips were quite dry. She said it's hard work at first when they're trying to breastfeed, so she's topped her up with 20 mls of SMA, she's been fine since then, she's slept.*
F: *OK, so how did you feel about her having a cup feed?*
Selina: *Em, I suppose I didn't want her not to have something to drink, but I'm doing my best but in the end you've got to do what's best for her really. I'll have a chat with the midwife today. I'll keep trying anyway.*

Both Corinne and Selina referred to above may not have given "top ups" if their babies had been more effectively attached to their breasts.

Jasmin (P51) related that the midwife actually reassured her that a cup would not interfere with feeding. She appeared to have been persuaded to use formula.

Jasmin (P51): *Well, he's content now, but during the first night he was quite unsettled, it was a manic night, so the midwife suggested he could have a cup feed, so he's had one or two cup feeds at night, the last couple of nights.*
F: *Did you cup feed your last baby?*
Jasmin (P51): *Um, no, I was quite determined last time not to. I didn't think he should have anything else. I wanted to persevere, but this time the midwife reassured me that cup feeds wouldn't interfere with breastfeeding, so I thought well, it will give him a chance to settle, and so I could get some sleep, while they kept an eye on him.*
F: *So, did the midwives suggest the cup feed?*
Jasmin (P51): *Yes, they did, because of what I was saying about this manic night. He was just feeding and turning his head and feeding, so...but I'm hoping to go home today......*

When women had previously changed to bottle feeding, they tended to be less confident and more likely to do the same the next time, a finding supported by Hamlyn et al (2002). Veronica

(P27) had stopped breastfeeding last time much earlier than she would have liked to. I interviewed her on her first day following the birth:

> F: *How did you feed your last baby?*
>
> Veronica (P27): *Well I was quite ill last time after the birth and the milk didn't seem to come in. I think ..I was quite anxious... but I don't think I gave it quite long enough.. So I'll have a try with this one* (laughs).
>
> F: *How long did you breastfeed your first baby*
>
> Veronica: *About 3 weeks, but I just felt he wasn't getting anything and I got quite anxious about it.*
>
> F: *Mmm, so what made you feel that he wasn't getting anything?*
>
> Veronica: *Cos he was crying all the time and he was constantly on the breast, sucking, but he didn't seem to be getting anywhere.*
>
> F: *So is there anything you'd do differently this time?*
>
> Veronica: *Well, I had a better birth this time, so hopefully I won't be ill this time. I was feeling quite down about it... and I was really down about breastfeeding. I felt I couldn't do it...and the easiest thing to do was to stop and go on to a bottle....Says to the baby, we're going to really try hard this time aren't we.*

Veronica came to the current breastfeeding experience with low levels of confidence and this combined with little praise or reinforcement and negative judgements about her ability to nourish a big baby led to her giving a bottle on night two and exclusively bottle feeding by her third postnatal day.

It seems then that both mothers and the midwives tend to readily resort to 'top-up' of formula milk. The exception to this was seen in the site 1 midwives and, as discussed, this related to the 'rules' and surveillance in place. With regard to site 2 midwives, the scenario resonates with the recent ethnographic work of Cloherty et al (2002). They reported that supplementation was often seen as a short term pragmatic solution to problems by midwives with little regard to the long term feeding outcomes. This related in part to a desire on the part of midwives to protect women from fatigue and distress. This issue is returned to in chapter 8.

Relying on technical appliances

Another way in which women displayed a heavy reliance on backups to breastfeeding was through the use of technical appliances, for example niplettes[100] and nipple shields[101] while in hospital. This was again more prevalent on site 2, as on site 1 such aids were discouraged under the Baby Friendly Agenda. Selina (P48) had bought a niplette. In the following discussion it becomes clear that she was reassured by having a technical addition to relying on her own body-seeing her body/breasts as fundamentally flawed and prone to failure:

> Selina (P48): *It's a nice feeling of closeness, like bonding together, it's a good way to have contact with her, cos I was worried I wouldn't be able to, but see how it goes, I said I wanted to breastfeed, so.....but I'm having to use these niplettes* (showed me the box), *because my nipples won't come out very well, especially this one* (points to her right nipple), *so I was a bit nervous at first, but the midwife - she was very helpful and I've managed to breastfeed four times.....I've just changed position, like lying down, because when I was holding her, she was finding that me boob was a bit hard, so she showed me a different position and it worked really well. Because I did intend to breastfeed, I was just worried that I wouldn't be able to.*
>
> F: *Can you tell me a little bit about the niplette?*
>
> Selina: *Um, well you use it just before you breastfeed and it just draws it out a bit....it's only really for one breast that I need it for.....but, when I've put the right part in her mouth, I don't think she's really needed it anyway.....you've got to put it all in, and the mouth's got to be wide, whereas when you just put the end in she finds it very hard to latch on, but em, the midwife, especially last night when I was on my own, she was very helpful.*
>
> F: *Mmm, so who suggested the niplette?*

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[100] Niplettes were developed as a cosmetic device for altering the shape of women's nipples. They have since been utilised by some mothers and indeed advocated by some midwives for assisting in 'pulling out' inverted nipples. They are now sold in large chain store pharmaceutical departments along with all the other breastfeeding equipment.

[101] Plastic covers for the woman's nipple, to prevent soreness or assist the baby to latch on in mothers with inverted nipples. They are strongly discouraged on a range of physiological bases and in particular by the BFI.

Selina: *I went to a chemist, but I've fed her without it, but it's always there to rely on when I get home, but the midwife said to try without it.*
F: *Did you use it in pregnancy?*
Selina: *No, it says, on the box you shouldn't use it later in pregnancy, and I was 5 months when I bought it, so it was too late. So I just bought it for afterwards, but I'm not going to use it today, it's more for when I get home, as a sort of safety measure for when I'm on my own, but I think when I'm in hospital and the midwives are here, then, like last night she showed me different positions last night, so that worked really well.*

She later said to me:

My concern is that she's not getting enough to eat, but if that's... I'll have to change, I'll have to put her on the bottle, cos the first bit isn't proper milk anyway, it's that sucking she has to do to try and draw it out (Selina, P48).

Here she demonstrated that she would use bottles if her baby appeared to not be getting enough to eat.

Sandy, the midwife, in some ways reinforced the view that women were inadequate for the task. She was with Selina while she was breastfeeding. The baby came off the breast and cried and Selina started to put him back on again:

Sandy (MW30): *Are you all right getting her back on? God had to be a man or he'd have given women a third arm...wouldn't he.*
Selina continued to try to put the baby on.
Sandy: *I'm not sure she's all that interested now, she's sucked well hasn't she.* Baby cries.
Sandy: *Lets see,* She attaches the baby to the mother's breast manually *that's it, that's right, bring that little hand out of the way a bit, that's it. Right* (baby suckles again), *try and get a drink.*

Here Sandy alluded to God as being in favour of the male prototype. She manually assisted the mother in attaching the baby, thereby doing little to enable her to develop the skill needed. Finally, she used the words *"try and get a drink"* suggesting some inherent difficulties. I asked the midwife about the niplette:

F: *What do you think about the niplettes?*
Sandy (MW 30): *Well, I suppose if they give her confidence, knowing that they're there then that's all right, but she doesn't need them. I was amazed at the price of them.*

Nipple shields, although not advocated by the midwives, were seen by some mothers as a way of reducing nipple soreness:

Megan (P53) *I know you can get like these covers with holes in.*
F: *Did you talk with the midwife about that?*
Megan: *No, but I've heard other people talking about it.*

The need to understand women's desire to use technical aids was emphasised by Virginia (MW20, site 1):

I mean we should be suggesting that women try breastfeeding, at least try but with the clear understanding that it's up to them to decide when they want to finish. That way women would not feel that they are committing themselves to something which they haven't experienced. Our job then is to support and encourage them, to build their confidence, not to bully. That may mean using an occasional nipple shield or giving the odd cup feed, if that helps to build her confidence. I mean the most important thing is to make sure the woman can fix her baby well, early. I ask them to press the buzzer when they come to feed so that I can come and watch then attach the baby. That's essential for her confidence, but it doesn't just stop there. For example, one woman last week was very sore and her husband brought her some nipple shields. She was prepared to continue with those or give up. Now I know they have limitations, but in some circumstances they can save the day, you know and if they build the woman's confidence and see her through then that's surely better than her giving up......(MW20).

Clearly the issues surrounding the use of technical aids are complex and challenging and need to be seen in the context of women's lives and cultural norms. They represent women's lack of confidence and appear to support women in relation to their uncertainty.

Summary

Women were heavily influenced by their need to be in control, with linear time placing powerful limits upon their experiences and expectations with regard to breastfeeding. While in hospital they were coping with the past, the birth, the present with all its challenges and transitions and the future. The future was marked by the temporal notion of time moving on towards the re-establishment of 'normality' with a major part of that being related to returning to paid 'production'. Women's ways of negotiating breastfeeding in hospital therefore related to varying degrees of desire to be in control of their life both in their immediate situations and in the projected longer term.

The preoccupation with return to 'normal activity', control and predictability combined with women's lack of confidence contributed to a desire to shift accountability so that women were not solely responsible for nourishing their baby. This desire to avoid being totally accountable for the baby's well being through breastfeeding, by utilising partial or total bottle feeding is referred to in other anthropological studies (Maher 1992b, Zeitlyn and Rowsham 1997[102]).

It would be tempting to relate the degree of control women wished to place on to breastfeeding with their like or dislike of it. However, women sometimes reported a positive experience of breastfeeding, but fully intended to introduce bottles. A range of other socio-cultural constraints and influences were inevitably involved. The various forms of supplementing or attenuating breastfeeding enabled women to cope with the present and plan for the future. The bottle, and in particular the bottle of formula milk was a symbolic marker in that return. The tendency to attenuate and supplement breastfeeding was potentiated for some women on the postnatal wards by fatigue and nipple pain an issue to which I now turn in chapter 8.

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[102] In Bangladesh this related very much to avoiding accountability for illness, such as gastroenteritis in the baby, which would invariably be blamed upon the mother. Ironically, giving formula milk in many countries is the most likely way to cause gastro-enteritis (Howie et al 1990).

CHAPTER 8
'CARRYING ON':
PERSEVERING THROUGH TROUBLES AND TRIUMPHS

Introduction

In chapter 6 I discussed the pressures upon women to 'do the correct thing....in the right way' and in chapter 7 I discussed the demanding nature of breastfeeding, when viewed from a 'productive' perspective. In this chapter I highlight the influences upon women's desire to 'carry on' and 'persevere' during the early days of breastfeeding. I discuss the concept of perseverance in its connections with confidence (self-efficacy), but also with regard to the ideologically pervasive notion that 'breast is best'. The challenges to women's sense of self and self-confidence were enormous and in some cases overwhelming, with the two most immediate and pressing concerns for breastfeeding women in hospital being nipple pain and fatigue. I highlight the ways in which women described and negotiated both the positive and negative experiences during their postnatal ward stay.

As women spoke about breastfeeding their use of the word 'persevere' was striking in its frequency. The concept of perseverance or persistence in the face of difficulties is referred to in other qualitative studies with breastfeeding women, although these reflect the ongoing project of breastfeeding rather than focusing upon the first few days (Bottorff 1990, Hauck and Reinhold 1996, Schmied 1998, Schmied et al 2001, Hauck et al 2002). As I studied the data I became aware that the concept of perseverance related to several aspects of women's postnatal breastfeeding experience. It was associated with 'doing the correct thing' because breastfeeding was 'best' for the baby. Perseverance was discussed in relation to gaining confidence with breastfeeding. It was also referred to in relation to 'putting up' with nipple pain and 'getting through' postnatal fatigue, particularly during the night. Finally, women spoke of special moments and experiences that made it worth while to carry on or persevere. I discuss each of these issues as organising themes (see also figure 8.1), but for women they were highly interconnected, with the motivation for persevering being counter-balanced by the daily challenges of breastfeeding on a postnatal ward.

Self-efficacy theory provides a useful framework for considering the concept of perseverance.[103] As stated, self-efficacy (personal confidence) in relation to a particular activity relates to the extent to which a person feels that s/he can achieve the required activities in order to meet a personal goal. Expectations of ability to achieve the goals will determine the extent to which coping behaviour is initiated, maintained and sustained in the face of challenges (Bandura 1977).

The women I observed and spoke to were clearly engaged in this negotiation process. On the one hand they spoke repeatedly about breastfeeding being best for the baby, but on the other hand they experienced a range of challenges to their felt ability to actually carry out breastfeeding. As stated, the four key influences upon self-efficacy for a specific activity are previous personal experience (which I discussed in chapter 7A), observation of others, encouragement or discouragement from others (which I turn to in chapter 9) and emotional arousal related to a person's judgement of their own physiological state (Bandura 1977,1982, 1986, 1995). When the person feels anxious and/or experiences pain and fatigue they become more vulnerable to 'failure' in the activity (Bandura 1977,1982, 1986, 1995). This fourth component of self-efficacy was particularly relevant to the data in this chapter.

Dyball (1992) refers to the stay in hospital as a "physical endurance test" (p.190), which seems to be an apt description. Women came onto a postnatal ward following the experience of a medicalised pregnancy, labour and birth. They were undergoing profound and often painful bodily changes and a dramatic social transition to becoming a mother of a new baby. This took place within an unfamiliar setting surrounded by strangers. In the midst of this transitional experience they were often learning a completely new skill, that of breastfeeding. Bandura (1995) highlights the potentially negative effects of fatigue, anxiety, stress and pain upon confidence/self-efficacy. As he states, "it is difficult to achieve much while fighting self-doubt" (p.6) and "when faced with obstacles and failures, people who distrust their capabilities slacken

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[103] I introduced self-efficacy theory in chapter 7A in relation to women's lack of confidence in their ability to 'produce' and 'deliver' enough milk to their baby.

Figure 8.1
Thematic Network:
'Carrying on':
Persevering through troubles and triumphs
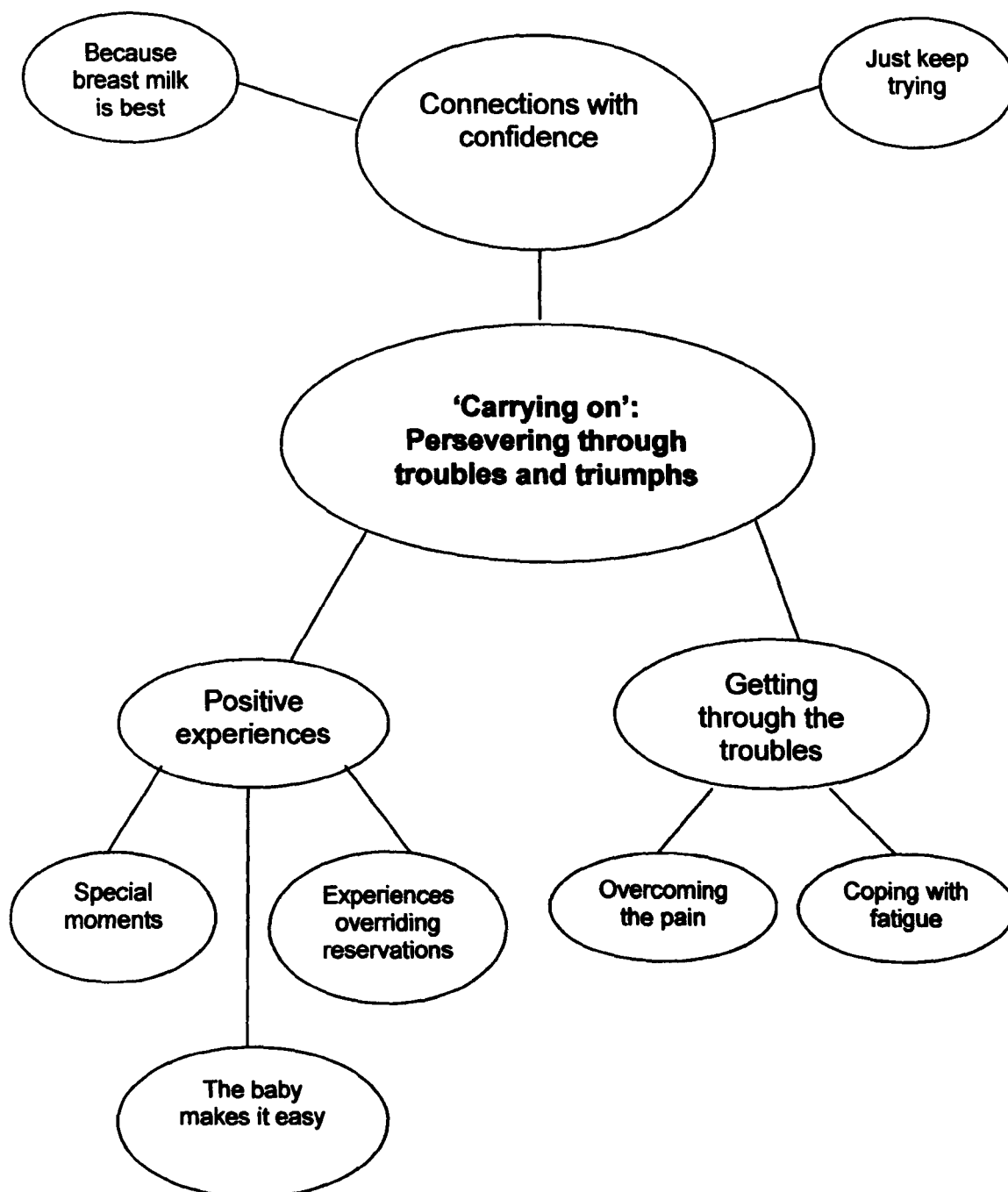
their efforts or give up quickly" (p.8). When these obstacles are superimposed with high levels of doubt, which is particularly the case for first time mothers, they can debilitate the development of a new skill, such as breastfeeding. The situational circumstances and the amount of practical support and reinforcement also exert an influence (Jerusalem and Mittag 1995).

Connections with confidence

Women talked about two types of confidence. They expressed their confidence in breast milk as best for the baby and linked this with the need to persevere. Secondly, they spoke about persevering in order to gain confidence.

Because breast milk is best

It was clear that women felt that they should persevere with breastfeeding because it was healthier for the baby. This formed a goal to which they aspired and subsequently led them to want to persevere through the challenges. This was illustrated by Sandra who clearly linked her 'confidence' in the benefits of breastfeeding with her desire to persevere:

> *I wouldn't say I have much confidence but I want to keep going...It is better isn't it really. It is better for the baby really......It's that thought really that makes you persevere, its perseverance...... I don't think I've got confidence, it's perseverance.....Yes, perseverance* (laughs). *It's confidence in the benefits, and then perseverance to try and keep going* (Sandra, P34).

Selina appeared to link her partner's occupation as a biology teacher with her imperative to 'keep trying' in spite of difficulties:

> *I knew it was going to be difficult and I thought, well I'm going to persevere for a bit longer. My neighbour started and it wasn't for her, so she gave up, but I said I was going to do it. You get a bit disheartened when you can't do something, but you can't just give up, you've got to keep trying* (laughs). *Some people probably find it easier and some harder. I'm probably finding it harder.....I've discussed it with my husband who is a biology teacher, so I'll persevere* (P48).

This strong emphasis upon persevering due to the health benefits of breastfeeding relates to what Miller (1998) refers to as an "epistemological struggle" between knowledges, i.e. voicing the official, acceptable privileged version but having a personal narrative which conflicted (p.69). This can be seen in the way Sandra, above, like other women when talking with me seemed to be having a dialogue with herself. This dialogue reflected the dissonance experienced between the public discourse that 'breast is best' and the concomitant personal struggle with doubts based on a lack of confidence in one's body and the process and activity of breastfeeding.

While a motivating factor is crucial to continuing with any activity there is also cause for concern regarding the extent to which this perseverance with breastfeeding is linked with the role identity of 'good' motherhood. This point is made by Schmeid (1998), who challenges an uncritical stance to the concept of perseverance and questions the "appropriateness of linking breastfeeding to maternal subjectivity" (p.248). The women in her longitudinal study frequently spoke of persevering, which Schmied (1998) argues represented the "extraordinary physical and emotional work that women undertake to achieve an identity as a breastfeeding mother" (p.254). Shaw (2003) sums up such concerns, stating:

> The power of the body politic to define and impose unattainable norms that are authorized by dominant institutions and articulated in dominant discourses (such as 'Breast is best') often force women to persevere with practices that could have long since been relinquished. In this respect, the everyday tasks of breastfeeding are moral in the conventional sense of the term, insofar as women's bodies are conceived as surfaces upon which rules, customs and laws are inscribed (p.64).

The concern of Schmied and others relates to the distress experienced by women when their efforts to persevere 'fail' and the connection they have made between good motherhood and breastfeeding is broken (Schmied 1998, Mozingo et al 2000, Schmied et al 2001). While the

imperative to breastfeed is particularly strong in Australia, where Schmied conducted her research, the resonances with this study are evident.

Just keep trying

I discussed women's lack of confidence in 'supplying' and 'delivering' in chapter 7. The issue of confidence also arose in connection with perseverance. As stated, self-efficacy and perseverance are interconnected and interdependent (Bandura 1977, 1982). Women tended to see the need to persevere in order to gain confidence:

> *I've only been doing it for a day really, so I'm still finding my feet. Um, he latches on, he just comes off quite a few times, but its just perseverance really....I've never done it before so it's a case of not being sure about what I'm doing yet and it'll take a while to get established and to get used to each other and get used to doing it* (Jackie, P33).

Selina also felt that her lack of experience and confidence would require her to keep trying to gain the necessary confidence:

> *Well, I'm not very confident yet* (laughs), *cos I've read the books, I think I've read too many books, but I think you need practical experience which I haven't had, but I feel more confident than I did yesterday* (laughs), *but it's things like holding her which make me feel less confident. Like we haven't got any babies in the family, so it's quite hard....... we'll just have to keep doing it.....just keep trying. It's hard work, because she's not used to it and you're not used to it, you know it's a skill........ I mean mainly at the moment, I want to be confident that I can do it.....*(P48).

Experiences that supported growing confidence in women, equally encouraged them to continue breastfeeding. The trigger to growing confidence often came from the baby's behaviour, for example, *"I mean watching him when he feeds, builds my confidence"* (Alison, P38).

> *I felt more confident once she'd actually latched on, and once she's there she tends to stay there. I think if she'd been mooching about and coming on and off all the time I think that would have made me really nervous* (Tracy, P44).

The sense of validation through the baby's contentedness is referred to by others (Leff et al 1994, Vandiver 1997, Hamlyn et al 2002, DH 2003).

Getting through the troubles

Two aspects of the postnatal ward experience challenged women enormously in their efforts to persevere with breastfeeding, these being nipple pain and fatigue. When experienced in combination they were particularly difficult to overcome. *"I don't mind some sleeplessness, but pain and sleeplessness would make me think, is it worth it"* (Debbie, P13).

Overcoming the pain

The experience of nipple pain when breastfeeding is widely reported (Foster et al 1997, Bowes and Domokos 1998, Schmied 1998, Schmied and Barclay 1999, Mozingo 2000, Hamlyn et al 2002, Woods et al 2002). It is usually associated with ineffective attachment of the baby to the mother's breast (Woolridge 1986b) and may contribute to a disrupted, disconnected and distorted experience of breastfeeding for women (Schmied 1998, Schmied and Barclay 1999). It also contributes to dissonance with regard to expectation and reality (Bowes and Domokos 1998). It is the main reason for women (28%) discontinuing breastfeeding during the first week following their baby's birth in the UK (Hamlyn et al 2002).

Of the sixty-one women I observed and spoke with, just over a third referred to their painful nipples indicating that they were experiencing difficulties with effective attachment. Nipple pain was more frequently referred to by women on site 2. Some women talked about the combination of pain from the birth and nipple pain. *"The Caesarean pain is quite bad.....It's restricting me and I can't move around, and me nipples are a bit sore"* (Annie, P42). Nipple pain in itself caused women to wonder whether they could continue. *"My nipple.....the pain is like...... its debatable whether to carry on or not....: They're starting to get really sore"* (Megan P53).

The combination of demand feeding and nipple pain led to feelings of conflict and a desire to protect one's body and turn to bottle feeding:

> *Well, I've been feeding most of the night and my nipples are very sore, but I'm trying my best to persevere, but I don't know if I'm going to be able to do it ....if my nipples crack, I think they might crack, I think I'll go on to bottle – I'll have to wait and see. I just didn't realise it would be this painful* (Sam, P19).

Sam saw herself as needing to persevere through the pain but was considering bottle feeding as way of preserving her bodily integrity and reducing the pain. Veronica, who expressed similar concerns, switched totally to bottle feeding on her second night on the postnatal ward:

> *It made me very, very sore. It just got progressively worse and worse, um last night, he was just constantly on the breast, sucking all the time. So I decided I'd had enough. It was a bit emotional. Um, so we've gone on to the bottle although it might not be for good. We'll have to see how it goes, after a few days, maybe.....* (Veronica, P27).

Sadly, this scenario could have been avoided, in that sore nipples, such as experienced by Veronica, strongly suggest ineffective attachment. The latter is commonly associated with an unsatisfied baby who may therefore want to breastfeed more frequently than s/he might otherwise, if s/he were able to feed effectively (Woolridge 1995).[104]

The support midwives provided for women with regard to nipple soreness was largely inadequate. This related to the many other calls upon their 'time'. Commonly, when women commented on soreness, midwives would indicate that the attachment/latch needed checking. However, they usually said they would come back and check it, but invariably did not. When they did 'check' the latch this often involved a transient glance and then they rushed off again. Often it was clear to me that the attachment and feeding dynamic was far from effective. There were only a few occasions when midwives sat and observed a feed.

Midwives did not appear to facilitate women in understanding how and why effective attachment would support effective breastfeeding. Carol was regularly *'checked'* to see if she was doing it *"right"*, but she appeared to be none the wiser about what constituted effective attachment. By the time she saw the infant feeding specialist, she was needing assistance with a fissured nipple.

> Carol (P31): *Well, it's been really, really sore. I've been really sore and she was just wanting it more and more often. She was like feeding for an hour and she wanted it every half hour.....I've seen the breastfeeding adviser this morning and she's given me some Lansinoh cream* (shows me).
> F: *So how do your nipples feel now?*
> Carol: *Well, the cream has soothed them a bit, but they are cracked.*
> F: *So has anybody shown you how to attach the baby?*
> Carol: *Yeah, they've all checked and they said I have been doing it right.... if it doesn't get better in the next day, I don't think I'll be able to carry on, because I'm like that all the time* (grimaces) *when I'm feeding her and its starting to make me feel.... put off feeding when its like that..... it's just the pain. I do wanna carry on, its just overcoming the pain* (laughs).

Glynnis, likewise appeared to have little understanding:

> Glynnis (P59): *I've got sore nipples and that makes it worse, cos you can't feed on one side then..*
> F: *So what are you doing with the sore side?*
> Glynnis: *Well, I left it last night and tried to give a bottle and then I asked the midwife and she said try to make him go on the top and it wouldn't be so sore then.*
> F: *What do you mean by the top?*
> Glynnis: *Cos it's cracked underneath you see.*
> F: *Oh, I see, so where would you point your nipple in relation to your baby's mouth?*

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[104] This was the basis upon which women used to be advised to restrict the duration and frequency of feeds when understanding regarding effective attachment of a baby to the mother's breast was minimal (Fisher 1985).

Glynnis: *Towards his mouth. I usually start you know just push me nipple together and get some milk out and then he just goes on.*

Chris was developing sore nipples three days following a caesarean section. Shannon gave her some prescriptive advice about how to sit, but did not assist her with attaching her baby.

Shannon (MW6): *How's the feeding going ?*
Chris (P32): *All right, but my nipples are a bit sore.*
Shannon: *Can I have a look?* Chris lifts her bra up.
Shannon: *You need to be sat on your chair love when you're feeding. Feeding in bed is very hard. We'll position her later cos this nipple looks very sore. Have you been feeding with her across your tummy?*
Chris: *Yes*
Shannon: *Well, we'll try an underarm position, because changing positions can help if you've got sore nipples....All right, I'll pop back later* (Which she didn't manage to do).

I saw Chris again on the next day:

F: *What sort of a night did you have?*
Chris (P32): *It were quite bad actually... she was slipping on and off the breast all night and she's made me really sore. It's quite painful now. She were just feeding on and off all night.....didn't really get much sleep, em she settled about 4 o'clock this morning and she's had 2 really good feeds this morning...so*
F: *How did you feel during the night?*
Chris: *Um, I was tired......I don't know really.....I was tired and me boobs are really hurting me. I 'ave to keep squeezing me breast milk on 'em to try and dry them out......nobody's really sat with me. They've come over...I've 'ad to buzz 'em if I can't get 'er on and they'll come over, but nobody has really sat down with me and they sort of like put her on me...they've just put her on me..... if they sat with you and showed you how to put her on proper...cos sometimes when I've been putting her on, I've been putting her on wrong and that's how me nipples have got really sore, because she's been sucking on them wrong and she's made me nipples really sore....So if they could of showed me 'ow to put her on proper I might not be sore now.*

Chris appeared to be keen to breastfeed this time after a poor experience of bottle feeding her last baby, describing breastfeeding as a *"dead special experience"*. However, she was not receiving information about effective positioning and attaching. Consequently, she was struggling with very sore nipples and had had very little support. She hadn't received any written information at all on the postnatal ward. Feeling that it was unethical to watch as she struggled in this way, I asked her if she would like to see the infant feeding specialist, which she said she would. I spoke to the infant feeding specialist and she spent some considerable time with her going through the principles of establishing effective pain-free feeding.

Midwives commonly suggested that milk was expressed onto the woman's nipples and that she expose her breast to the air:

My nipples are a little bit tender, I must admit at the moment. The midwives said keep them in the air as much as you can and put a little bit of....er.... milk on them, just extract a bit of milk and rub it on (Lesley, P55).

Demand feeding and, by implication, using the mother as a 'dummy' was connected with nipple soreness by some midwives. Kim approached Barbara and took a quick glance at her breastfeeding, whilst stating:

Kim (MW15): *Feeding again?*
Barbara (P37): *I don't know if he's feeding really?*
Kim: *Is he stopping and starting?*
Barbara: *Yes*
Kim: *I'll come back in about half an hour and see how he's getting on. You're going to get sore otherwise aren't you?*
Barbara: *Yes*
Midwife rushed off.

Again, this connection between length of feeding and nipple soreness may well have related to ineffective attachment as from my own observation the baby did not appear to be attaching effectively to the mother's breast.

Midwives commonly exhorted women to persevere through the pain:

> My nipples are very sore..... I just keep going , it makes your toes curl (laughs). One's better than the other you see which is quite common apparently.....The midwife just said to keep persevering, um...they will get better.....As my milk comes through, he'll probably not... you know guzzle, chomp quite as much you know......Suck quite as hard sort of thing (Corinne P41).

Encouragement to persevere through the pain also stemmed from the experiences of significant others, for example:

> My Mum's friend, whose been breastfeeding, said that after a couple of days it went really sore......She said...... but she persevered with it and it was... um... she found it absolutely brilliant afterwards. She told me if I get any soreness to persevere and then if I can't do it don't worry (P43).

While other researchers who apply a sociological perspective to breastfeeding identify the disruptive nature of sore nipples (Bowes and Domokos 1998, Schmied 1998, Schmied and Barclay 1999, Mozingo 2000), they do not elaborate on the potential for changing the nature of the relationship and women's feelings about breastfeeding through providing support with effective attachment. Such a focus moves research onto the edges of the 'breastfeeding management' domain which is carefully avoided as it stands in contradiction to the epistemological assumptions underpinning sociological research. However, given the current understandings of the relationships between ineffective attachment and sore nipples (Woolridge 1986b), this is an area which requires highlighting as effective support from midwives has the potential to enhance women's experiences.

Coping with fatigue

Almost without exception, on both sites, women referred to their feelings of exhaustion and fatigue. Fatigue is recognised as a part of the postnatal experience of women, particularly manifesting in the first few days following the birth (Ball 1994, Cuttini et al 1995, Rice et al 1999, Rice 2000, McQueen and Mander 2003). It is a feature and challenge of early motherhood (Flagler 1990, Ball 1994, Barclay et at 1997, Rogan et al 1997, Larkin and Butler 2000) and tends to be connected by women with breastfeeding (Vogel and Mitchell 1998, Mozingo et al 2000, Hauck et al 2002).

The women in this study commonly referred to the cumulative effect of their labour and birth and the associated pain and distress compounded by sleeplessness on the postnatal ward. Sam referred to the pain of labour contributing to her tiredness:

> Feeling very tired - the labour was very very painful. I knew it would be painful, but I just didn't have a clue how painful it would be. I wanted an epidural, but by the time I got here it was too late, so I had gas and air. Then I had to have an episiotomy and tore as well, so had to have stitches. Not a very pleasurable experience (Sam, P19).

The combination of a baby feeding 'all the time' and the mother feeling that she didn't have enough time to sleep increased the feelings of demandingness of breastfeeding. The fatigue tended to be connected by women to what they felt was prolonged or frequent feeding:

> Well, she had two very long goes at feeding overnight, like for an hour or so each and then she needs winding for about forty minutes, so I didn't get much sleep really (Megan, P53).

Women connected having a "bad night" with a lowering of their confidence:

> At night.....he's been all night on and off really.. So, em... it was just my time to feed, sort of feed for half an hour, put him down for 10, 15 minutes then he'd wake up. The nurse was lovely. She came and em, she tried to...she took him off me em and then

tried to settle him herself.... not with top ups. Then she put him back in the cot and that didn't work and he kept waking up (laughs). Um.... but.... er.... he was just sort of every half an hour......Having a bad night makes me feel less confident.....but he's worth it so .....(laughs) (Corinne, P41).

Corrine indicated her desire to persevere, because *"he's worth it"*. Women also tended to feel more anxious at night. *"I get anxious at night, like when he wakes up"* (Annie, P42). Women worried about their baby disturbing other mothers:

Once I'm at home I won't be getting anxious about waking other mothers..... I felt anxious because I was keeping people awake. I knew he was going to go on and on (Jasmin, P51).

Women's anxiety also related to the noise of other babies:

I feel anxious in the night....yeah.....you know people being disturbed and the babies start crying and... I presume it's going to be the same, everyday, yeah, so......you know, at least you've only got one to contend with when you're at home (laughs) Barbara (P37).

This anxiety and inability to obtain the rest that women needed has been reported by women in other studies (Vogel and Mitchell 1998, Lock 1999).

On site 1, the midwives drew the curtains around the mothers at night to give them some privacy. This was appreciated by women: *"I suppose its good in that you're not watching them constantly go up and down. It's your own little world really"* (Sue, P29). However, while privacy did protect women from seeing the midwives going up and down, it didn't really stop them from experiencing the busyness and noise on the ward because there were noises in the corridor, as women were admitted, or other women went into labour and were then moved to delivery suite. Eunice (MW19) commented on the factors that hindered women from relaxing at night:

Its very noisy at night, cos babies are now on the ward, so if you've just helped a lady to breastfeed and then put her baby has just settled, then the baby in the next bed wakes and is fractious, then it can disturb her baby and then the other mothers may object to the light being on while you help someone. We often bring a mum into the nursery and sit with her and help her to feed, so she's not as conscious of the other patients.....I don't object to babies being out on the ward, but there should be somewhere where women can go and feed their babies in privacy. Cos, I think if you've got a mum at the end of her tether and a difficult baby to feed, and the mum is very tired I don't think they often want to discuss everything in front of the other patients and at night, I think perhaps the conversations are heard more than during the day (Eunice, MW19).

The second night seemed to be particularly harrowing for mothers. They had often been awake through the first night in a state of excitement and then by night two the fatigue was becoming intense. This existing tiredness was compounded by frequent feeding and sleeplessness on the postnatal ward: *"I can't keep this up for long, cos he was born in the night so I didn't get any sleep that night. I need some sleep"* (Barbara, P37-third morning).

Sue spoke to me on her second postnatal day:

I mean the way I feel at the moment I'm SO tired. I'm anaemic, but they were debating giving me a transfusion, cos its 8.3. She said if was below 8 so I'd have to have a transfusion, um, but because it was above 8 they said I could have iron tablets, but the doctor's been to me this morning and she's still not very sure. She wanted to see em, the registrar about it, so.. maybe they are wanting to transfuse me. The way I feel at the moment, I'm just SO tired......I feel very thirsty, I just don't feel particularly well. I don't know if I've been trying to do too much (Sue, P29).

During the night the midwives took the baby to the nursery, as described by Sue, on her third morning:

Sue: The midwives took him out for me during the night. I was struggling. I was so tired.....and me head was spinning and um...I couldn't settle him. They said I could take

> *him in the bed with me, um...but I'm not comfortable with that.....I mean I never did that with me other two, so...and I'd be frightened of squashing him. No, I don't think I could have managed last night without help - I mean I'd have struggled on, but...*
> F: *When did he go out?*
> Sue: *Well, bed time, they put him in his crib and took him out. They brought him to me at 3 for a feed, then brought him again at 6. I feel better now.....*

From Sue's perspective taking the baby to the nursery on night two supported her to continue. I observed some of the feeds and the baby appeared to be well attached and suckling competently. I observed her through the fourth night from the 'station' during which she breastfed totally but pushed her baby out into the nursery between feeds so that she could sleep. This is an example of a complex breastfeeding situation in which the mother gaining sleep seemed to be a priority for her, leaving her with the resources to cope.

There were other examples in which a baby was taken out at night to assist a woman in continuing to breastfeed, but this may not have been necessary. I interviewed Barbara in the morning following her second night. Her baby had been crying all day and part of the night. She was asking if she should give him a bottle, but the night staff offered to take him out at 4 am for a couple of hours so she got some sleep. This seemed to ease the situation from Barbara's perspective:

> Barbara (P37): *It's been awful really...Em, he was starting to get moody yesterday afternoon, you know he was just wanting to be on all night and not necessarily feeding. It's just for......He's not slept in the cot at all, he's just....The nurses have had him in their arms trying to get him to sleep...They checked he was latched on properly and that he wasn't genuinely hungry and not getting anything. They told me that he was feeding fine. They told me the alternatives, like they said about putting this up (touches cot side) and um, seeing if he'd just settle next to me. But even though he'd sleep here as soon as you go to put him in there (points to the cot), he's off again. So, about 4, I actually said, "shall I put him on the bottle and see if he is just really hungry and needs something I'm not giving him or whatever". But they didn't encourage that they were quite good about that. So they said we'll just have him for a couple of hours and let you have a rest, so... They just kept hold of him so I could have a bit of a rest (laughs)*
> F: *Do you know where they took him?*
> Barbara: *No, I think they just walked round with him, but she said he never settled. She said he just didn't sleep at all, but he was quiet when she brought him back. But he's not slept from 8 o'clock at night. It's quite a stint of wanting the attention isn't it.*

There are several issues highlighted here. It would certainly have been helpful if the midwife had taken time to sit with the mother through a feed. This may have highlighted ways in which it could have been suggested to the mother that she could increase the effectiveness of the feeding. Although Barbara stated that the midwives had checked the latching on, when I saw her she wasn't attaching her baby in a way which would optimise effective feeding. This may have contributed to the baby being unsettled and nipple soreness for the mother. This mother continued to struggle through the next day, until Kim (MW15) actually assisted her to latch her baby on more effectively and sat with her for part of the feed.

The midwife, like others on site1, had suggested bedding-in to Barbara, clearly seeing it as an effective way of settling a baby.[106] However, the mother was keen to avoid having the baby in bed with her, seeing it as a 'comfort thing' that should be avoided, as discussed in-depth in chapter 7(B). The midwives had also suggested that Barbara should try putting her nighty into the cot, an example of an attempt to provide an aspect of the 'natural ideal', whilst maintaining separation preferred by the mother.

Although on both sites there was a policy of rooming-in, this was disregarded by midwives at night when they felt that it was inappropriate. My presence at night didn't seem to make any difference to the midwives practices, a source of affirmation that my being there was largely inconsequential to their activities. On both sites they made it clear to me that they would take a baby out if they felt that it was necessary:

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[106] This was an example of positive cultural change in hospitals encouraged by the implementation of the 'Ten Steps' and something which was almost unheard of in UK hospitals until the later 1990s.

What's wrong with saying to a mother we'll look after your baby tonight, for a while. You get some sleep. I mean they're only in for a day or two, so surely we can help them, as long as they know we'll bring the baby to them for feeds, if they're breastfeeding (Sandy, MW30).

Jenny, discussed the inflexibility of the rooming-in *"rule"* and the lack of account of the influence of extreme fatigue upon mothers:

I agree with rooming-in but lots of midwives mention the days when you could bung them all in the nursery, quite nostalgically. Again, it's the problem with the rule, because lots of staff would probably use the leeway to take babies out and give them bottles at night or something, so you end up with a rule. If you could be flexible about it, which in practice we are..... Even very pro breastfeeding midwives will take a baby out at night and do their best to nurse it for an hour or two, in the hope that the mother can have an hour or two's sleep. I perceive one major breastfeeding problem which isn't addressed as mother's fatigue. We go on and on about latching and lactation, positioning, nutrition and so on, but in the thick of it with somebody on the verge of giving up breastfeeding, often if you could write a prescription as it were to ensure the mother got 3 hours sleep..... I've managed to do that a few times, I've managed to bend the rules, take a baby away, by hook or by crook and give the mother some sleep and it suddenly makes things go much better. Again, if you gave that leeway to people who weren't really positive about breastfeeding, you'd probably have droves of babies in the nursery, you know, maybe crying. If you knew everybody was 100% pro breastfeeding you could leave the rules and know that people would be flexible and juggle things around the overwhelming need to maintain breastfeeding – treating that as absolutely primary (MW14).

Jenny highlighted the difficulty with the rule in that it prevented some midwives from freely administering formula in nurseries, the reason for the 'rule' in the first place. However, she pointed to its rigidity in supporting women who were exhausted, an issue also raised by others (Ball 1994, Cuttini et al 1995, Rice et al 1999, Rice 2000). Staff appeared to use their professional judgement in relation to rooming in and took babies out either at the request of the mother or in discussion with the mother if she was having difficulties in the night. This constituted a form of responsible subversion, as described by Hutchinson (1990) and discussed in more detail in chapter 6.

Clearly, postnatal fatigue is a real and pressing issue for women. It constitutes another aspect of the demanding nature of new motherhood within the postnatal ward. For the breastfeeding mother it places yet another demand on the maternal body. Focus upon fatigue on the postnatal ward highlights a range of complex issues for both mothers and midwives. Women need appropriate support from midwives to 'get through' but the nature of the support requires an individualised approach not a simple following of a rule. Despite the many challenges described above women spoke of special moments that increased their desire to persevere, to which I now turn.

Positive experiences

Special moments

Women sometimes reflected back to their experience of skin-to-skin contact with their baby after the birth: *"I held her close, next to my skin and I cried my eyes out. I couldn't believe that she came from my own body, I was awake all night. So excited you know"* (Usha, P36).

It's a very surreal moment ...... I thought actually before oh, I'd like him cleaned up and you know wrapped up, and (laughs).....No it was straight on and it was just wonderful...then afterwards we were left with him and he was on my breast straight away then..it was just the three of us.......I'd thoroughly recommend it, you know, from being somebody who thought it would be nicer if we were all cleaned up. You don't, you don't care, and it's er.... You know he was obviously all covered in blood and quite blue and not looking very babyish at that point, but it doesn't matter somehow...it's just a wonderful thing (Alison, P38).

Alison described how this positive experience overrode her sense of 'orderliness' and 'cleanliness'. The study of the 'skin-to skin' experience, following birth was not focused on in this study, but these comments from women resonate with those of others (Sheridan 1999, Price 2002).

Some women referred to their first experience of breastfeeding as special: *"Um, dead special, really good....., I feel like more closer to her"* (Chris, P32); *"It was making me cry* (laughs), *not painful.... just 'cos I was happy....yeah"* (Millie, P43).

Women also talked about special moments with their baby during their ongoing breastfeeding experience: *"I think it's such a nice moment to have with your baby"* (Alison, P38); *"Well its relaxing and you feel like you're bonding...like you can cuddle and stare at the baby you know"* (Sarah, P10); *"It's been lovely, he's really taken to it so far. I like the fact that I'm giving the feed not just sticking a bottle in 'is mouth. Its lovely"* (Julie, P9).

Experiences overriding reservations

Some women who had experienced ambivalence felt very differently as a result of breastfeeding and closeness with their baby. This gave them the desire to carry on: *"Now she's with me and breastfeeding I can feel the bonding and I have become convinced that I want to breastfeed"* (Gemma, P5); *It feels really natural. It wasn't what I expected, it's the strong bond .....It's nice actually, it just feels so right, so natural. I didn't think it would feel like this"* (Jo, P45).

Denise emphasised a harmony between herself and her baby that made her desire to breastfeed entirely: *"I like the feeling that you are together - the feeling that he's accepted you really... I would like to try and breastfeed entirely now"* (Denise, P4). This harmony, synchrony and mutuality was rarely mentioned at this early stage of breastfeeding, but is reported in relation to the ongoing relationship of breastfeeding for some women (Hewat and Ellis 1984, Bottorff 1990, Wrigley 1990, Leff et al 1994, Schmeid and Barclay 1999).

Jane commented that the embodied experience overrode her potential feelings of embarrassment:

> *Um it's hard to know what to expect, like pushing you don't know what its like and breastfeeding's the same really cos I thought I'd be kind of shy, but you know, it doesn't bother me at all.... I mean I've never been topless really but I don't seem to mind showing me boobs off here really, it doesn't bother me. It's cos you're so taken up with her* (Jane, P12).

This overcoming embarrassment did, however, constitute a discrepant case as it was not the experience of most women.

The baby makes it easy

Positive feelings were sometimes linked to feelings that the baby *"could do it"*: *"It feels brilliant...it feels nice that she can do it* (Millie, P43). They also related to positive interpretations of the baby's temperament, known to contribute to a longer duration of breastfeeding (Leff et al 1994, Vandiver 1997):[106]

> *She took to it so quickly, really in the first few days....I know she had a paddy last night, but she made it easy for me to feed, cos she was very easy, she was there, yes, she was easy...... I think if I'd have had a more difficult baby, but she just latched on dead quickly, in some ways its like I've been shown what to do, but she showed me, she's just been waiting to get on me and she's done the rest really. So she's made it easier for me.....*(Vicky, P30).

The reference to 'special moments' by women illustrates that even at this early stage a few women had positive embodied experiences that had the potential to change the nature and course of their breastfeeding experience. However, sadly, some developed sore nipples and

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[106] Part of this interpretation of temperament may relate to whether the mother is attaching and feeding her baby effectively which will influence the baby's behaviour and responses to her.

other difficulties, for example Chris (P32) referred to above. This changed the nature of the experience to a disrupted and disconnected one during the first few days of breastfeeding. This potential for fluctuation between positive and negative interpretations of the breastfeeding experience is described by Schmied and Barclay (1999).

Summary

In this chapter I have highlighted some of the influences upon women's desire to 'carry on' and 'persevere' during the early days of breastfeeding. As stated, the challenges to women's sense of self and indeed self-confidence were enormous and in some cases overwhelming. Like others, I argue that the connections women make between breastfeeding and being or becoming good mothers are potentially problematic to women's ongoing emotional wellbeing (Schmied 1998, Mozingo et al 2000, Schmied et al 2001). These connections relate to the ideological pervasiveness of the 'breast is best' ideology.

The connections between women's confidence and desire to persevere are clear in the data and in this way I extend self-efficacy theory to the qualitative experiences of breastfeeding women on UK postnatal wards (Bandura 1977,1982, 1986, 1995). This chapter has mainly focused upon the corporeality of breastfeeding and this early embodied experience was more often negative than positive. Women shared with me their internal dialogue in which they constantly weighed up the 'pros and cons' of breastfeeding at any given moment. For some the pain and fatigue overwhelmed them and they decided to protect themselves by changing to formula milk feeding. Some of the negative situations could have been averted by midwifery staff providing more appropriate practical, informational and emotional support and confidence building. However, the constraints upon midwives in providing a high level of support within an institutionalised setting should not be underestimated. In chapter 10, I focus very specifically upon the nature of encounters between mothers and midwives within the medicalised culture of the postnatal ward.

CHAPTER 9
TAKING TIME - TOUCHING BASE

Introduction

In this chapter I focus specifically upon the nature of encounters between mothers and midwives, the influences upon the interactions, and their impact upon women's breastfeeding experiences. There are four main ways in which people experience situations, through: temporality; spaciality; corporeality; and relationality (Merleau-Ponty 1962). While the main focus in this section is upon relational aspects of women's experiences, time, space and the body were intricately interwoven for both mothers and midwives. Taking this into account, I contextualise the work by describing the cultural settings in which midwives are coping (or not) with 'caring'. To support this contextualisation I draw upon midwifery and nursing theory with regard to caring/uncaring encounters but also upon research that highlights the constraints upon midwives and nurses within the UK NHS. I extend this theory by producing a synthesis that reflects not only the style of encounters I witnessed and their impact upon women but also highlights some of the reasons why encounters take the form that they do within hospital settings.

I divide the chapter into two sections: 9A 'Failing to take time-touch base' and 9B 'Taking time-touching base'. I define 'touching base', a metaphor used by one of the participants, as 'touching the personal experience of another'. The notion of time is integral to both sections. In section 9A I describe ways in which time was 'taken' away from midwives and mothers. In section 9B I refer to encounters in which midwives 'took time', in the sense that they made ways of 'finding time', to facilitate positive relationships with and between women.

The nature of encounters

Interpreting the data with regard to the relational aspects of women's experiences has been the most difficult. There is a vast literature from which to draw which relates to positive and negative encounters within health care settings. The literature in relation to health and maternity care refers to a range of interchangeable and overlapping terms, for example. supportive/unsupportive (Gill 2001, Lugina et al 2001), caring/uncaring (Halldorsdottir 1996, Woodward 2000), empowering/disempowering (Halldorsdottir and Karlsdottir 1996a), helpful/unhelpful (Chen 2001), sensitive/insensitive (Mozingo et al 2000), facilitative/inhibitive (Fenwick et al 2000, 2001). Some authors utilise one term, for example support, to encompass caring along with other desirable aspects within encounters and relationships. For example, Sarafino (1994) highlights five types of essential "social support": "emotional support" (caring and empathy); "esteem support" (positive regard by others, agreement and encouragement); "instrumental support" (practical assistance); "informational support" (provision of information); and "network support" (company and membership of a group with common interests) (p.103).

There is also a vast literature on communications in health care settings, some of which overlaps considerably with the above (for example Kirkham 1983, 1989, 1993, 1997a). Effective communication may be seen simply as a means of conveying information but is more recently being described in its fundamental links with relationships in health care settings (Morse et al 1997, Kirkham 2000a,b, Edwards 2001). However, an encounter may arguably still be considered caring even if a relationship has not been established. Finally, there is a growing literature on the influence of the culture/environment upon health care worker's abilities to support clients (Kirkham 1999, Woodward 2000, Kirkham and Stapleton 2001b, Ball et al 2002, Hughes et al 2002, Hunter 2002, Deery 2003). This array of perspectives and definitions creates an extremely complex 'picture' which makes utilising specific conceptual frameworks for understanding data quite challenging.

As I have reflected on this literature in relation to the data, I have come to realise the possible contradictions inherent in some of these classifications when applied to women starting out as new mothers and embarking upon the experience of breastfeeding. The methodology I used enabled me to elicit from mothers and to a lesser extent from midwives how they felt about the nature of their encounters with each other. However, I was also able to observe the encounters resulting in a synthesis of perspectives, the mother's, the midwives and my own. I move beyond describing what is *said* to include what is *done*. As an observer, I watched encounters in which the information given regarding breastfeeding was misleading and counterproductive to

the effective establishment and maintenance of breastfeeding. However, these encounters, if conducted in a pleasant and encouraging way, might be perceived as supportive by women. In contrast, midwives might provide information that was useful for the establishment of breastfeeding, but because it was delivered in a disconnected, routine and unfriendly manner was discouraging for women. Thus encounters could be encouraging but not enabling to effective breastfeeding or potentially helpful in relation to breastfeeding but generally discouraging.

The 'bridge' and the 'wall'

Acknowledging the vastness of the literature in this area I now highlight research which has particularly assisted me in understanding the data discussed in this chapter. The theory on caring developed by Halldorsdottir through her phenomenological research on the nature of encounters within two health care contexts, oncology nursing and care in labour/birth in maternity care settings has informed my data analysis (Halldorsdottir 1991, Halldorsdottir and Karlsdottir 1996a, b, Halldorsdottir 1996). Central to this theory on caring are the metaphors, "the bridge" and "the wall", which describe the health professional at two ends of a caring continuum, with the former leading to "empowerment" and the latter to "discouragement" (Halldorsdottir 1996, pp. 5,30). She refers to empowerment as an "increased sense of wellbeing and health. A subjective sense of being strengthened, for example by gaining or regaining a sense of control" (p.32).

The "bridge" symbolises a trusting, connected, caring relationship based on respect and open forms of communication and seeing the person being cared for in her/his own inner and outer contexts, resulting in the client feeling empowered. Halldorsdottir (1996) refers to three key specific aspects of this positive encounter: "competence"; "caring"; and "connection" (p.30). She refers to competence in empowering patients, in building relationships, in educating patients in a facilitative way, in making clinical judgements and in undertaking tasks and taking action on behalf of people when necessary. The expressed desire of clients to be attended by competent health professionals in combination with feeling that they care was strongly reiterated by Green et al (1998).

Halldorsdottir (1996) describes caring as "being open to and perceptive to others; being genuinely concerned for and interested" in the person, "being morally responsible; being truly present" and "dedicated" (p.30). The notion of 'presence' is crucial here and features within other accounts of 'being with' women (Berg et al 1996, Fleming 1998b, Lock 1999, Varcoe et al 2003). Being "truly present" is defined by Halldorsdottir (1996) as "attentiveness to the present moment-present in dialogue, in listening and responding - present in a situation, physically and emotionally" (p.34).

Connection involves "reaching out and responding" by the nurse or midwife and client and "mutual acknowledgement of personhood" through "reciprocal self disclosure" that may be limited, but is "sufficient to remove the masks of anonymity" (Halldorsdottir 1996, p.34). It involves having a sensitive balance between intimacy and a comfortable distance that maintains respect for the person being cared for. Care is negotiated taking full account of the woman's perspective. Thus the health carer works "with" the woman as "an equal toward a common goal" (p.34). This notion of partnership or professional friendship is described in the midwifery context by Pairman (2000). The health carer is also seen as having competence combined with genuine concern (Halldorsdottir 1996). Once the bridge is established the person feels free to ask for help when needed.

In contrast, the "wall" represents poor communication, incompetence, "detachment" and "lack of a caring connection (Halldorsdottir 1996, p.5). More specifically the nurse or midwife appears to be "disinterested", "insensitive", "cold/business-like" and at its most extreme shows "inhumanity" (p.36). A sense of mutual avoidance develops with the "nurse being perceived as unwilling or unable to connect with the patient" (p. 32). This form of encounter creates a lack of trust and the client experiences discouragement, a sense of aloneness, insecurity and anxiety, lowering of confidence, decreased sense of being in control and sometimes a sense of failure.

'Facilitative' and 'inhibitive' nursing action

A limitation of Halldorsdottir's theory, as Paley (2001) argues in relation to generation of knowledge on 'caring', is that it is based on what is *said* but not on what is *seen* by the

researchers. Fenwick et al's (1999, 2000, 2001) research in an Australian neonatal unit setting moves closer to addressing the latter in that they tape recorded interactions between nurses and parents in addition to conducting interviews with both groups. They found that the verbal exchanges between nurse and mother influenced a woman's confidence, sense of control and her feelings of connection with her infant. They identified two types of nursing behaviour with the first described as "facilitative nursing action" which women felt helped them to feel connected with their babies (Fenwick et al 2000, p.197). This involved the use of positive language which expressed care, support and interest in parents with "chatting" and using personal experience in a sensitive way being used as a strategy through which positive interactions were initiated, maintained and enhanced (Fenwick et al 2001, p.253). Mothers, when interviewed, were more interested in how things were said than what was being said (Fenwick et al 2001, p. 588). The other two key facilitative nursing actions involved nurses "walking beside the mother", that is working with the mother, encouraging her and sharing information with her and "respecting the woman's status as a mother", that is listening, negotiating, sharing decisions and giving the mother space (Fenwick et al 2000, p.199).

The second type of behaviour described as "inhibitive nursing action" reflected a more authoritarian style of approach (Fenwick et al 2000, p.197). It included nurses maintaining their position as expert, maintaining control, directing care, supervising and directing the mother, dismissing women's skills, showing preoccupation with protecting the infant and guarding safety. The approach was autocratic, didactic, clinical, robotic, cold and unfriendly and the language was medical and technical (Fenwick et al 2000). Meticulous rituals were performed and there was a felt power differential with women feeling chastised, naughty and child-like. Women described how this nursing behaviour made them feel defensive and helpless, heightened their sense of isolation and separation from their infant and constrained them in their mothering role and relationship with the baby (Fenwick et al 2000, 2001).

The grounded theory on facilitative and inhibitive nursing care developed by Fenwick et al (2000) is highly resonant with the phenomenologically generated theory of Halldorsdottir (1996).[107] Both of these contributions to caring theory recognise that the development of a trusting relationship is highly desirable but also illustrate that a single encounter in itself can be positive or highly negative to the way a woman feels. This provides an important perspective because in reality in many clinical situations encounters are short-lived and not based on an intimate, therapeutic or intense relationship that has developed over a considerable period time.

'Good enough' care

The fertility clinic ethnography described by Allan (2001) further illuminates issues in relation to the short term clinical encounter. She argues that caring in this context is not based on an intense relationship but on practical, skilled support accompanied by "emotional awareness" (p.51). The women wanted nurses to know what they were going through and to be there when they were needed. In contrast, women described "emotional distance" as the nurse acting practically for the patients but not responding at times when they expressed emotional distress. These nurses were seen to be "caring for the clinic" rather than the patients (p.54). Allan (2001) argues that good enough nursing allows nurses enough distance to be able to cope with the emotional difficulties inherent in their work and that, provided that they are able to respond to emotional needs when expressed, that patients accept this care as "good enough" (p.57). This perspective has enabled me to avoid placing my own ideals upon the data in terms of relational aspects of encounters and rather to accept that by the time women have come through the fragmented care systems of the current NHS maternity services that they are unlikely to voice any sense of loss at not having a deep relationship with midwives. They may be satisfied with 'good enough' care during this final phase in their journey through the maternity service. This does not justify the way things are but it assists me in reviewing data based on the brief encounters I saw. Nevertheless, many of the experiences of the women in my study illustrated that the care they received was not 'good enough' for them and it is upon this that I firstly focus.

Allan's (2001) research moves some way to supporting understanding of the nature of institutional 'caring', but like Halldorsdottir (1996) and Fenwick et al (2000, 2001) she adopts a fairly apolitical stance having little to say about the context of care and its impact upon midwives ways of working. However, the culture through which women learn to breastfeed and midwives

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[107] Fenwick was unaware of Halldorsdottir's research (personal communication with Jennnnifer Fenwick-2000). There was no cross referencing by either to the other.

work is considered to be crucial in this thesis. It plays a key role in how women cope with their emotions, change of role and learning to breastfeed and how midwives cope with *their* emotions and role. The importance of a political and cultural awareness of the context within which midwives work is highlighted by Davis-Floyd (1992), Davis-Floyd and St. John (1998) in the USA and Kirkham (1999), Kirkham and Stapleton (2001b) and Ball et al (2002) in the UK. As stated in chapter 2, these authors powerfully illustrate aspects of the maternity hospital setting with its techno-medical culture and hierarchical, separatist, gendered and indeed oppressive systems.

Coping with caring in an institution

There is also a growing literature on nurses and midwives coping behaviours within institutions and their negative effects on service users and indeed themselves. The study by Menzies (1960, 1970) appears to be the first to relate to the ways in which nursing organisation and practice influences the development of behaviours. Her study within the UK hospital nursing system reflects the anxieties and tensions inherent in hospital based work. Drawing on psychoanalytical theory, she refers to the development of nursing "social defence" techniques (p.11). These include task-orientation thus limiting relationship building with 'patients' and indeed colleagues, depersonalisation of the individual patient, detachment and denial of the nurse's feelings and avoidance of change. She argues that these defences limit the capacity to engage in creative, symbolic and abstract thought and conceptualisation and sense of one's own potential. Thus the institution of the hospital and its activities creates a way of being and working for health staff that exacerbates the negative effects upon them and in turn the service-users.

The widely quoted work of Hochschild (1979) on emotional labour and emotion management extends that of Menzies in that she refers to the ways in which social ordering and expectations actually affect what people allow themselves to feel, "feeling rules" (p551), and how social factors affect what people actually think and do about what they feel. The latter results in "emotion management" (p.551). While she refers to this management of feelings in relation to air hostesses, they are highly applicable to midwives. This connection with midwives is made by Hunter (2001, 2002) who extensively explored how midwives experience and manage emotion in their work.[108] Hunter (2002) was able to study midwives' "emotion work"[109] in the hospital setting and compare this with those emotions generated and managed within the community setting. The opportunity to achieve this was presented through a recent integration of the maternity service, with midwives now entering both settings but remembering their original place of work. A similar opportunity to compare both settings was described by Lock (1999) in her phenomenological study with Australian women taking early postnatal discharge. While her focus was primarily upon the experience of women, she too was able to fortuitously focus upon the difference between midwifery practice at home and in hospital by the same midwives. While neither author refers to each other, some of their conclusions are striking in their similarity, as I will go on to highlight.

Hunter (2002) argues that there are several contributory factors to the emotion work of hospital midwives. The most profound source stems from a lack of congruence between beliefs and ideals and the reality of practice within a discipline that has many contradictory values. This was particularly the case for students and recently qualified midwives. This creates cognitive dissonance.[110] Hunter (2002) argues that an increase in dissonance relates in part to the widely acclaimed 'new midwifery' philosophy (Page 2000) with its 'ideal' low-tech women-centred, one-to-one focus. This contrasts with the 'reality' of a highly medicalised, fragmented and frequently interrupted form of institutional midwifery still evident in many UK maternity units. The hospital midwife is also bound by the implicit and explicit rules of the organisation and her occupational autonomy is thereby seriously limited. This results in the midwife being clearly "with institution" rather than "with woman" (Hunter 2002, p.357), as also noted by others (Lock 1999, Allan 2001,

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[108] Hunter (2002) does not refer to Foucault, but she perhaps could have done in that the self disciplining and regulation of bodies seems to link closely with the concept of emotion work, as referred to by Frank (1990), "panopticism takes on a new intensity in emotional labour" (p.159).

[109] 'Emotion work', is a term Hunter (2002) uses to extend Hochschild's specific focus upon interactions between workers and clients in acknowledgement that there are other aspects of work that contribute to emotion work. Hunter (2002) defines "emotion work" as "the work involved in managing feelings in both self and others" (p.62). It is beyond the scope of this thesis to delve in-depth into emotion work, however the insights brought through Hunter's study, which became available during writing-up, support understanding the data.

[110] A concept I discussed in chapter 6 in relation to women's expectations and realities related to breastfeeding.

Kirkham and Stapleton 2001b, Shallow 2001a,b,c,d, Ball et al 2002, Deery 2003, Lock and Gibb 2003)

Hunter (2002) highlights the ways in which hospital midwives engage in emotion work. One of the strategies involves task orientation and routinisation in an attempt to impose control and keep workloads manageable. The midwife becomes emotionally gratified by getting through the work, completing tasks and handing over to the next shift, thus providing her with a sense that the story has ended. In contrast, community work is more emotionally gratifying through relationships and the story continues rather than ending. To cope with the emotion work, midwives engage in "impression management", involving controlling and hiding of emotions (p.323). They develop "self-protective barriers" and boundaries in which they are able to enter a disengaged state of withdrawal and distancing when overwhelmed emotionally. This contributes to midwives becoming "affectively neutral" rather than "affectively aware" (p.319), with the former leading to negative forms of caring referred to by, for example, Halldorsdottir (1996). Hospital midwives seek 'time out' to engage in transient relationship building with colleagues. This involves chatter and humour in an attempt to conserve energy for potentially unpredictable situations. However, these relationships often increase rather than decrease emotion work due to horizontal violence, as also described by Kirkham (1999) and Ball et al (2002). Hunter (2002) takes care to point out that not all midwives are able to manage their emotions in order to achieve some form of balance. These more vulnerable midwives, likely to be those with high ideals, may lack the emotional "armour" to cope and and are likely to engage in destructive forms of self-criticism (p.349).

While Hunter (2002) is careful to avoid blurring emotion work with caring, the effects of emotion work upon encounters between midwives and mothers become apparent. Both Lock (1999) and Hunter (2002) highlight fundamental differences between the hospital and home encounter. In the home there was an opportunity for relationality and the midwife had more occupational autonomy (Lock 1999, Hunter 2002). Talk at home was more likely to be woman initiated, as this was *her* territory, not the midwife's (Lock 1999). The encounters at home took on a more informal, social and reciprocal nature with more chatter and use of self by midwives (Lock 1999, Hunter 2002). Lock (1999) stated that there was little presencing by midwives in hospital in contrast to the home, where this was evident. Hunter (2002) notes that community midwives often commented on what they "got back" from this relationship, so that while the work was still emotionally demanding it was also fulfilling (p.193). In contrast, hospital talk was midwife initiated, directed and constituted a more formal one way type of encounter (Lock 1999, Hunter 2002). Hunter (2002) notes that the midwife becomes more focused upon surveillance than support, although this is not expanded upon or discussed theoretically. Lock and Gibb (2003) importantly refer to the midwife having temporal autonomy in the home, with the mothers being highly aware that they had the midwife one-to-one for a period of uninterrupted time. Thus time at home was prescribed by the needs of the woman, not the institution. It becomes clear then, that while institutions and their rules do encroach upon community midwifery, particularly in integrated services (Edwards 2001, Hunter 2002), the "power of place" (Lock and Gibb 2003) upon midwives' emotion work and resulting approach to women is tangible and significant (p.132).

In making sense of her data, Hunter (2002) draws heavily upon Lipsky's (1980) work[111]. Lipsky (1980) explored the work practices of public service workers within "street level bureaucracies", i.e. schools, police, welfare departments and other agencies that provide a dispensatory service to the public (p.xi). The staff within these organisations are placed in a situation whereby the requirements of their jobs make it impossible for them to achieve their ideal conceptions of the job. Due to the volume of work, restricted resources and unpredictability, they develop "modes of mass production" that enable them to process clients through the system most effectively (xii). This inevitably involves the development of strategies to ration and routinise work, alter their expectations of the job and in some cases stereotype and/or select some clients for which they provide the ideal service, thus providing themselves with a limited form of job satisfaction. Kaplan et al (1996) illustrated the effects upon encounters with clients, in health care situations where health professionals are coping with high volumes of work. They established a clear link between volume of work, levels of occupational autonomy and in turn participatory styles in medical doctors. They concluded:

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[111] My own reading of Lipsky's (1980) account of life for public service workers towards completion of this thesis, illuminated issues raised in the data in a powerful way for me and served as a source of validation for what I had observed.

If a sense of personal autonomy is related to a more participatory style, then those physicians who view themselves as more able to control their practice environment may show a more flexible style with their patients (p.503).

Low levels of occupational autonomy are strongly related to occupational stress with inevitable consequences for service users. Indeed occupational stress is maximised in situations where high pressure is *combined with* low levels of control/autonomy over working conditions (Brunner 1996, Syme 1996 Tarlov 1996). The relationship between low occupational autonomy and high levels of stress and burnout has been identified in midwifery contexts (Sandall 1997, Mackin and Sinclair 1999, Shallow 2001c, Ball et al 2002), as has the relationship between inability to experience relationality with women and stress and burnout (Sandall 1997, Shallow 2001b, Ball et al 2002). In contrast, high levels of occupational autonomy and opportunity for relationality with women increase satisfaction and morale in midwifery work (Sandall 1997, Hunter 1999, 2002, Stevens and McCourt 2002b).

Tyranny of time

The complex and detrimental combination of low occupational autonomy, ideological dissonance and absence of relationality in midwifery work cannot be separated from the power of linear time upon midwives, as I illustrate with the data I present. The critical ethnography of nursing by Street (1992) is particularly useful in relation to my growing awareness of the tyranny of linear time upon midwives. She refers to the work of Foucault (1977) in stating that "timetables, whether rigidly imposed or tacitly agreed upon, penetrate the rhythms of the body, disciplining and controlling them" (p.109). She refers to the ways in which times, rhythms and manoeuvres turn hospital nurses' bodies into efficient machines. She describes the discipline and subjugation of nurses' bodies through a multiplicity of processes within hospitals. These range from unsociable shifts, rigid timetables, requirement to eat and drink at specific times in specific places and wearing of restrictive uniforms. She describes the regulated and disciplined way in which they are trained to conduct tasks such as making beds with required efficiency, economy and synchronisation of movement. Under these circumstances activities centre around saving time and using time efficiently. In addition Street (1992) refers to the stress placed on nurses when trying to make clinical judgements under the pressure of constantly changing and unpredictable scenarios.

The collective nursing ethnographies of Varcoe et al (2003) also illustrate the continuing nature of the culture of "efficient processing" (p.962) with nurses maintaining a culture in which colleagues are valued for their emotional strength and efficiency. Nurses passively accept and embrace an "ideology of scarcity" (p.964) related to inadequacies of time, money and staffing. The notion of efficient use of time is also highlighted in midwifery contexts (Kirkham and Stapleton 2001a, Ball et al 2002, Stapleton et al 2002b).

By critically observing the nature of midwife-mother encounters on postnatal wards, I am able to further elaborate upon the above theoretical understandings with particular reference to midwife-mother encounters and women's experience of breastfeeding on postnatal wards. I firstly discuss aspects of encounters that represented a lack of 'taking time-touching base' with women.

SECTION 9A
FAILING TO TAKE TIME - TOUCH BASE

Introduction

In this section, I describe negative aspects of the midwife-mother interactions. Women commonly started their short postnatal journey following a medicalised birth. They were then subjected to a range of rituals and procedures, mechanistic language and a reductionist approach to breastfeeding support. Reference to breastfeeding was often disconnected from the woman's birth experience, previous experience, life in general, her agenda and metaphorically from her body. Women tended to describe their encounters with midwives as representing a "failure to touch base". This was compounded by lack of information, misinformation, conflicting advice and unhelpful use of personal experience. The encounters generally failed to meet women's needs for confidence building, encouragement, emotional, practical and informational support.

In chapter 5, I described the settings in which midwives were working and mothers breastfeeding. On both sites the ways of working resembled production line conditions and like factory staff their work was spatially restricted, segmented, repetitive and constrained by clock time (Menzies 1960, Forman 1989, Street 1992). On site 1, there were particularly powerful constraints of linear time upon midwives' bodies as they were tied into a system in which their daily work centred upon urgency and meeting unrealistic deadlines. Almost every midwife I spoke to on this site referred to the constant pressure of racing against time.

On site 2, the midwives were sometimes very busy and at other times they were much less pressured for time. However, on both sites midwives faced constant unpredictability in that at any moment either they or a colleague could be called to cover delivery suite. This would require rapid reorientation of the 'sent' individual and reorganisation by remaining staff who would suddenly be left one or two members of staff short. Emergencies could arise at any time particularly with the antenatal women, creating more unpredictability. This unpredictability meant that whether busy or not there was pressure to get through the work in case circumstances changed. This contributed to a rushed and fragmented approach to care as referred to by others (Ball 1994, Kirkham 1999, Kirkham and Stapleton 2000, Ball et al 2002).

As stated, on site 1, midwives came under surveillance related to 'doing the correct thing... the right way'. This surveillance related in particular to the breastfeeding policy based on the 'Ten Steps'. Midwives appeared to be fairly knowledgeable about breastfeeding. This probably related to the large emphasis upon post-registration education in infant feeding. There appeared to be more staff confidence in relation to women's ability to breastfeed their babies than on site 2, but also more of an authoritative and managerial approach. On site 2, as stated, I was unable to directly observe many interactions between mothers and midwives. However, from the interviews with women and the observations I undertook I was able to build a picture of aspects of care for women related to breastfeeding. There was less surveillance than on site 1 but greater mistrust of women's ability to breastfeed. I suggest that the greater mistrust stemmed in part from the midwives' lack of knowledge, but secondly from the predominance of the bottle feeding culture in this particular geographical area. Midwives tended to give information based on their own experiences that were often negative and, as Battersby (1999, 2002) asserts, midwives' personal, experiential and embodied knowledge constitutes an important influence upon their interactions with mothers. In this case the combination of a predominantly bottle feeding culture and midwives lack of knowledge and confidence in supporting women with breastfeeding, led to them readily offering bottles of formula in problematic situations.

The mode of communication I most commonly observed with regard to breastfeeding particularly was one of issuing advice in a monologic manner according to a pre-set agenda. There appeared to be little attempt to listen to the mother, to come to know her expectations, to ascertain what she already knew or to learn about how breastfeeding fitted in with her life and recent birthing. This conforms with other critiques of postnatal care (Ball 1994, Lomax and Robinson 1996, Audit commission 1997, Bondas-Salonen 1998, Garcia et al 1998, Lavender et al 2000, Singh and Newburn 2000a,b). Midwives commonly approached women with an authoritative air and a knowledge that seemed to be owned by them. They thus displayed the characteristic mode of communication within the techno-medical model which the professional is assumed to have the expert and authoritative knowledge and the mother to be a passive

recipient or receptacle of the wisdom instilled (Jordan 1997, Edwards 2000). This relates to Freire's (1972) notion of depositing knowledge while the recipient is simply a depository. This way of communicating left women in a state of tension between dependence on health professionals for information and advice and their need to be in touch with signals both from their bodies and babies. This inevitably undermined their confidence. The inequality in power created by the midwives approaches rendered effective dialogue, a two-way process between equals, almost impossible to fulfil, as also reported by Kirkham (1993) and Stapleton et al (2002b).

As I have studied the data on encounters between mothers and midwives I have become increasingly aware of the parallels. In chapter 7, I highlighted ways in which women experienced a lack of confidence and control with regard to breastfeeding that related in part to current and projected concerns about their productivity and the unpredictability and time consuming nature of breastfeeding. They sought to regain control over the erosion of their temporal and spatial boundaries in a range of ways. Like the women, midwives work centred upon productivity and output. They utilised physical and emotional strategies to get through the work in ways which enabled them to partially control for the general unpredictability and temporal pressures. To illustrate the nature of encounters within this setting, I discuss the organising themes of 'communicating pressure', 'rituals, routines and procedures', 'disconnected encounters', 'managing breastfeeding...women' and 'rationing information' (see figure 9.1).

Communicating pressure

Midwives ways of working and communicating reflected the ongoing pressures created by linear time constraints and unpredictability. I discussed this from the perspective of midwives in chapter 5. However, women powerfully illustrated the same points as highlighted in the two basic themes, 'communicating temporal pressure' and 'reflecting unpredictability'.

Communicating temporal pressure

Midwives communicated a powerful sense of urgency that led to rushed and disconnected communications. The theme of temporal pressure came through most strongly when I interviewed women on site 1: "*They seem to be pressured, panicking and anxious*" (Bryony, P7); "*The midwives seem to be, you know..um..spread very thinly and they don't have much time*" (Alison, P38). Women disliked receiving inadequate staff time and availability and feeling rushed, as referred to in related studies (Tarkka and Paunenen 1996, Bondas-Salonen 1998, Bowes and Domokos 1998, Svedulf 1998, Tarkka et al 1998, Vogel and Mitchell 1998, Whelan and Lupton 1998, Lock 1999, Hoddinott and Pill 2000, Hauck 2002, Hong et al 2003). Women felt that their needs were only petty and insignificant in the grand scheme of things and that to call a busy midwife for breastfeeding was to "*drag her away*" from an important or urgent task:

> *I mean, you don't like bothering people* (Grimaces). *Cos I know that they are SO SO busy. You know, they keep saying buzz us to lift him out of the crib for you, because he's so heavy as well. But I mean... you know....um....its dragging them away from somebody who has just given birth, or...whatever. I just won't...I mean something like lifting him out of the crib seems so...petty really, to be asking them that...*(Sue, P29 - first day post Caesarean Section).

Women recognised that there was understaffing:

> *They do seem to be so busy and understaffed. You have to catch people when you can, but its not always the right timing, but when they have come they've been very helpful. I'd like to have someone checking to see that I'm doing all right.....The staff are rushing around. They are really helpful, but it can take a long time to get a little job done.....There's emergencies going on, and you don't feel that your request is important enough to bother them with* (Helen, P35 - on a very busy night).

As a result of this awareness of the midwives' pressure and busyness, women tended to struggle on quietly recognising that asking for support or information was to request midwifery time. Under these busy conditions, mothers were reluctant to ask for help, findings that

Figure 9.1
Thematic Network:
Failing to 'Take time' – 'Touch base'
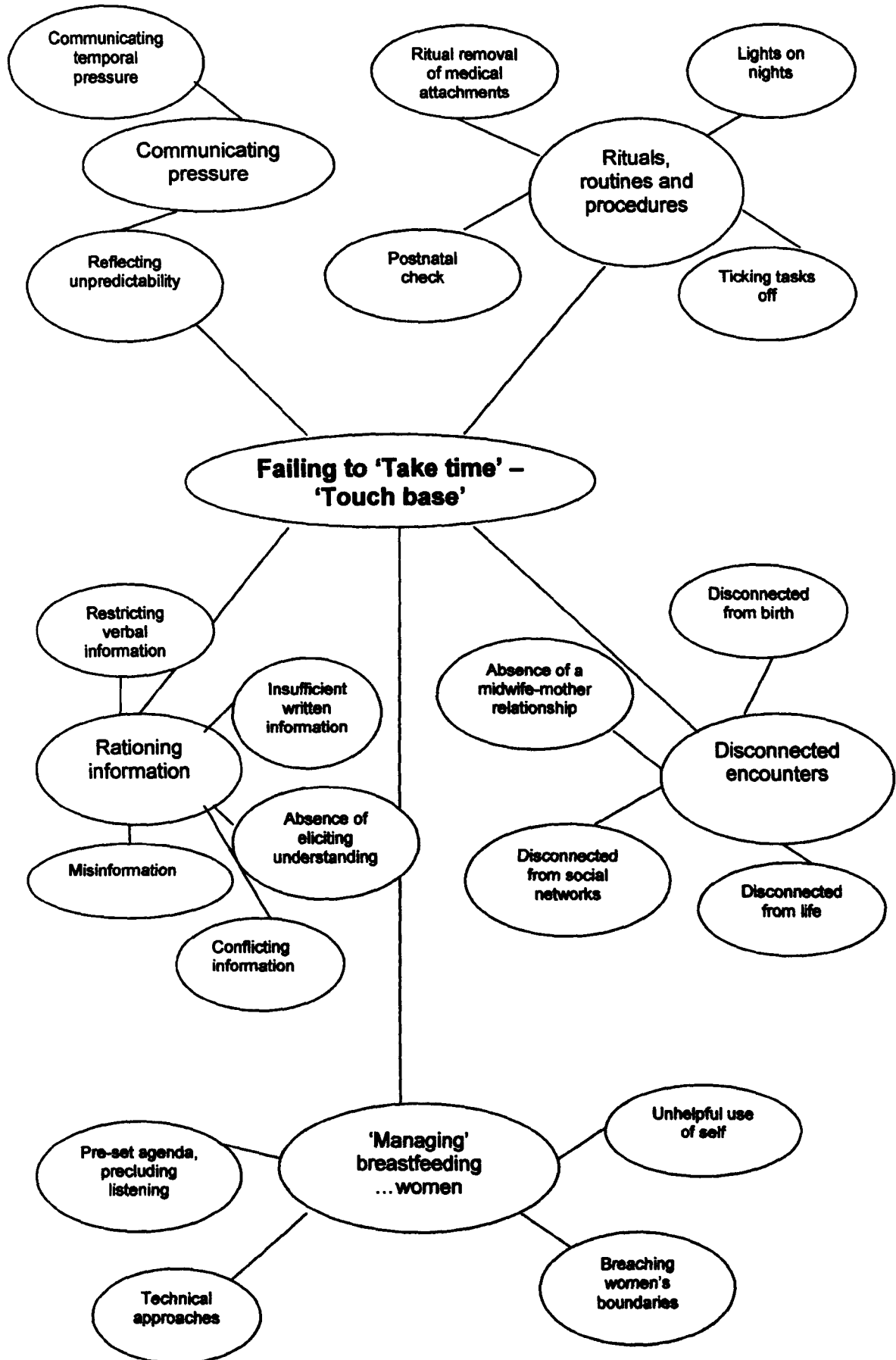
resonate with those of Kirkham and Stapleton (2001b), and Bowes and Domokos (1998). Only some women were able to secure midwives time leaving women who were less confident and assertive particularly silent. The more silent women tended to be those from lower income groups and therefore I saw the inverse care law (Lipsky 1980, Townsend and Davidson 1992) in operation. This has also been highlighted within maternity care settings by Kirkham et al (2002b).

On both sites midwives commonly told women that they would come back later but I rarely saw this happen:

> Francesca (MW28): *How's the breastfeeding going?*
> Annie (P42): *Me nipples are sore.*
> Francesca: *Can I have a look?* Annie showed her nipples. *Right, well you may feel some tenderness, but we don't want them to get cracked and bleeding. When you next feed can you give us a shout and I'll check the position for you.*
> Annie: *Yeah, OK.*

Women made excuses for the midwives and generally recognised the constraints upon them, as illustrated by Louise (P14). Although Louise was highly dissatisfied with the nature of her encounters with midwives, she did not blame them as individuals, rather she highlighted problems with the system and it's effect upon midwives making them busy, pressured and stressed:

> *I mean it's not their fault, the midwives, they want to give but they just can't. It's not their fault-it's the pressure here-with the best will in the world they can't do it* (Louise, P14).

This sympathy expressed by several of the women towards midwives was also reported by Halldorsdottir (1996) and Kirkham and Stapleton (2001b). Indeed Kirkham and Stapleton (2001b) state: "A number of service users recognised midwives as an oppressed group" (p.147).

In order to test to see whether midwives approaches changed when the wards were quiet I followed the same midwives through during busy and quiet periods. I became aware that while a few midwives adjusted their pace depending on the busyness, most adopted the busy mode whatever the ward state. This maintenance of 'busy mode' in hospital regardless of number of women to care for resonates with the findings of Lock and Gibb (2003). The lack of slowing of pace in quieter periods probably relates in part to the sense that at any moment a member of staff could be moved, immediately changing the distribution of work load. Secondly, once midwives have developed a particular way of engaging with women, it becomes a patterned form of behaviour that is difficult to change. Jenny corroborated this view:

> *I notice some midwives get very frustrated when it's quiet, bored as they call it. Maybe they are happier in a busy mode, running around telling people what to do and advising people much more* (Jenny MW14).

Reflecting unpredictability

I referred to the unpredictable working conditions for the midwives from their perspective in chapter 5, but this was also reported by the women:

> *They're all so busy. There don't seem to be a lot of staff, they're rushed off their feet, they really are. There was one day this week when it wasn't so busy...um...a few had been discharged and they had more time to spend with you, but like the other night, there were that many people coming in and out, people delivering, they don't have time to do anything. It seems like a few staff are trying to see to a lot of people. I suppose they never know how busy they're going to be. I mean, on a ward where they have booked operations it's different, but here you don't know whose going to have a baby* (Vicky, P30).

Here Vicky alluded to the notion of mass processing of women described by Lipsky (1980) in relation to public sector workers. The erratic and serendipitous nature of care on both sites led to some women being completely overlooked, for example Annette (P58) was being looked

after by one midwife who was later sent elsewhere so no one saw her for most of the first day. She appeared to have a low sense of confidence in breastfeeding. By day 2 she had decided to bottle feed and refused to be interviewed. I discussed this with Anthea (MW25):

> F: *Do you know why Annette stopped breastfeeding?*
> Anthea (MW25): *No, we just came on in the morning and she'd changed to bottle feeding. She got a bit missed yesterday, because Sandy (MW30) had to go to theatre and no one really got to see the ladies in her bay until after handover, so her baby hadn't really fed properly since 10pm the night before. Anyway, we took her temperature and she was a bit cold and we did a BM which was 2.5, which wasn't bad, so we warmed her up and then she fed better, when she was warmer. But in the night she gave up breastfeeding.*

Clearly, the combination of temporal pressure and unpredictability set the scene for a series of encounters with women that were largely inadequate in meeting their needs. The most striking manifestation of emotion management occurred through the use of rituals, routines and procedures.

Rituals, Routines and Procedures

A substantial part of activity conducted on the postnatal ward centred around ritualistic performance of procedures. There is lack of consensus as to what a ritual actually involves (Philpin 2002), but for the purposes of this thesis I adopt an anthropological definition. Anthropologist Davis-Floyd (1992) defines a ritual as a "patterned, repetitive, and symbolic enactment of a cultural belief or value" (p.8):

> In all cultures, people use repetitive rituals to provide themselves with a sense of order, stability, and control. In professions like medicine, where chaos and uncertainty pervade daily practice, cleaving to ritualistic routines in which they can demonstrate clear competence can hold fear at bay and give practitioners a much-valued sense of confidence and control over what are often very uncertain outcomes (Davis-Floyd and St. John 1998, p.32).

Menzies (1960) refers to ritual task-performance as a mechanism for reducing the anxiety created by the emotive and unpredictable nature of hospital nursing, although she notes that these defence mechanisms often increase rather than reduce anxiety in the long term. Health worker's adherence to ritual activity was illustrated by Davies and Atkinson (1991) in an ethnographic study of a cohort of nurses during early clinical placements on their midwifery course. The authors described "doing the obs" as a coping strategy for dealing with feelings of strangeness, inadequacy and low self-esteem. This ritual, they argue, has become the exclusive responsibility of the nurse. Both Menzies (1960) and Davies and Atkinson (1991) note that this routinised behaviour forms a very early part of the socialisation of student nurses within the hospital environment.

Fox (1989) likewise refers to the turning of obstetrics into a mechanical act and a time bound process that assists the "caregiver" to cope with her/his inner turmoil with time being reduced from a "subjective experience to a rational, intelligible, measurable means of orientation" (p.126). She argues that obstetric "caregivers" protect themselves by introducing an orderliness to the process invoking feelings of being in control over the painful issues of life and death and their own helplessness:

> This painful state is literally covered over by the ceaseless demands and absorbing routines of medical practice. There is not time to linger over what's past: onward to new problems, new patients, new treatments. The present is thus materialized, fuelled with concrete evidence of one's productivity (p.126).

This emphasis upon the place of routinised and ritual behaviour in coping with anxiety and giving people a feeling of being in control, especially in the face of ambiguity, unpredictability and aversive situations, is being increasingly recognised in public service (Lipsky 1980) and health settings (Kirkham 1989, Davies and Atkinson 1991, Ball 1994, Hunt and Symonds 1995, Begley 2001, Hunter 2002, Philpin 2002, Waterworth 2003). In terms of the effects on recipients of care, as Hunt and Symonds (1995) state, "women's wants, needs and even rights are swallowed up in procedures and routines" (p.129). The passivity created by the system is

highlighted by Kirkham (1989) who describes the "medicalized nature of the setting" in which "patients" are "processed", with rules and routines emphasising their role as "passive work objects" (p.131).

The women I interviewed and observed had had many aspects of their pregnant and labouring bodies subjected to measurement such as weighing the mother, ultrasound measurement of the fetus, counting fetal movements. This measurement then reached a climax in the labouring mother, when every aspect of her progress was charted meticulously on a partogram and judged against linear time, for example the dilatation of her cervix in centimetres, the frequency and length of her contractions. Finally women arrived on to the postnatal ward, only to be introduced to a new set of routines, with the potential to perpetuate their perception of themselves as passive recipients of 'care' and prone to deficiencies, as expressed in their beliefs about their milk. To illustrate the organising theme of rituals, routines and procedures I refer to four underpinning basic themes: the 'postnatal check'; 'ritual removal of medical attachments', 'lights on nights'; 'ticking tasks off'.

The postnatal check

The postnatal examination or check constituted the dominant procedure on the wards. It is not the purpose of this thesis to suggest the appropriateness or otherwise of this procedure or to analyse in-depth the content of the postnatal examinations. However, as the 'check' often set the 'scene' for subsequent communications it requires a mention. The postnatal check was usually conducted in an asymmetrical manner, also referred to by Lomax and Robinson (1996), with the midwife very much controlling the agenda. In most cases there was a brief discussion commenced by an open question, such as *"what kind of night did you have?"* Conversation which preceded the postnatal check was closed down with an indication that the 'business' was about to commence, with comments such as *"right I'll just check you over now"*, or *"I'll just wash my hands then I'll sort you out"*, a finding also reported by Lomax and Robinson (1996). In some cases, when the ward was busy, the midwife launched straight into the check:

> Tina (MW1): *I'll just check your temperature and pulse* (proceeded to do so). *Breasts nice and soft?*
> Bev (P2): *Yes fine*
> Tina: *Not sore anywhere?*
> Bev: *No*
> Tina: *Getting him on properly?*
> Bev: *Yes*
> Tina: *Legs all right ?*
> Bev: *Fine*
> Tina: *Can I just feel your tummy*
> Mother wriggled down the bed and lifted her nighty up
> Tina: *OK, that's nice and firm. How's your loss?*
> Bev: *It's like a period..um...sort of red.*
> Tina: *Have you passed any clots?*
> Bev: *No*
> Tina: *Appetite OK?*
> Bev: *Yes*
> Tina: *Bowels and waterworks?*
> Bev: *All right*
> Tina: *Sleeping OK?*
> Bev: *Yes, I slept well last night*
> Tina: *Anything you want to ask?*
> Bev: *When will I be able to go home?*
> Tina: *Probably tomorrow if all's well*

This encounter was conducted in a highly directive, monologic, midwife-led way, full of closed and leading questions with little scope for discussion. This type of communication which clearly centred upon a predetermined agenda resonates with the findings of others (Bondas-Salonen 1998, Kirkham and Stapleton 2001a,d, Stapleton 2002d). The postnatal checks were often concluded by the midwife taking up a standing position behind the mother's table and carefully concentrating on the records. This giving of a clear message, "I'm concentrating, do not disturb", was referred to in Kirkham's (1993) labour ward study (p.1) and subsequent research (Kirkham and Stapleton 2001a, Stapleton et al 2002b).

The predominance of the postnatal check on both sites emphasised what appeared to be the central role of the midwife in monitoring and checking the woman and baby for problems which should then be corrected, as highlighted in related studies (Ball 1994, Edwards 2000, Kirkham and Stapleton 2001a). Indeed, Stapleton et al (2002d), refer to the midwife as seeing the woman as a "body to be thoroughly and appropriately checked" (p.395). Most women appeared to be resigned to the checking role of the midwife and therefore I saw little questioning or resistance. This emphasis upon checking has come to be seen as a central role of midwives by women in their care as highlighted by others (Fleming 1998a, Leach et al 1998).

Ritual removal of medical attachments

At a time when women were undergoing a major life transition to that of mother of a first or new baby, women who had had a Caesarean Section were subjected to a ritual removal of the various tubes inserted during the Caesarean section:

> There is almost a ceremonial removal of catheters, drains, IVs, analgesia. It is like a rite of passage. This is followed by low levels of support due to the urgency created by the next "case". The removal of the tubes which symbolically connect the women to the medical system appear to give the midwives a sense of achievement and progress, a sense of a job well done. The women on the other hand appear to be confused in the face of such a dramatic transition from dependency to relative independence (Field notes).

Interactions around breastfeeding were often interspersed with post-operative routines:

> Di (MW18): arrived and looked at the baby in the cot: *Has he gone back to sleep?*
> Veronica (P27): *Yes*
> Di: *Right my love, we'll give you a suppository, for the pain, then we'll get you in the bath, then we'll put him on the breast - how does that sound?*
> Veronica: *Um...fine, thanks*
> Di: *Right my love. How are you feeling?*
> Veronica: *Um, my nipples are sore*
> Di: *Oh, we'll need to check he's on properly when he goes on, OK?*
> Veronica: *Yes, thanks*
> Di: *Right, can you just turn onto your left side and I'll give you this suppository.*
> Mother turned onto her side.
> Di: *That's it, all right you'll just feel me inserting it now.* Proceeded to give her a suppository. *All right?*
> Veronica: *Yes*
> Di: Went to wash her hands and returned: *We'll take the drip down, take your catheter out, sit you up and you'll feel a new woman* (laughs).
> Veronica: Laughed. The baby cried.
> Di: *We're coming. Lets look at your nipples.* Mother opened her nighty. *Mmm, they don't look sore. OK, OK, come on* (to the baby). Lifted the baby to the mother who is on her side. Holding the baby and the mother's breast she "connected" the two saying, *right, so point the nipple to nose, then you'll see more of areola above than below, the top lip is curled back see and the bottom lip turned down. Look you can see his lips?*
> Veronica: *It doesn't feel sore now he's on, it's when he goes on.*
> Di: *OK, um, I'll pop back in a minute*

> A few minutes later:
> Midwife, Di, returned a few minutes later. "*How's he doing? I'll give you a pack of leaflets-we'll go through those when we discharge you*" Mother put the leaflets away and midwife went again. No further reference was made to the leaflets.

> A few minutes later:
> Di returned: *How does it feel now? Any soreness?* (Referring to the breastfeeding).
> Veronica: *Oh it's all right now. It's just when he goes on. He's just sucking and sucking.*
> Di: *See how he's slipped off a little - he's just sucking on the end of your nipple, that's when you'll get a bit sore.*
> Baby came off and cried

Veronica: *I'll just take a sample from the catheter and then take it out.* Proceeded to take her catheter out and went off with it.

A few minutes later:
Di, returned. *Right, I think we'll try the other side. You are a hungry boy - you are a hungry lad aren't you. Right, point your nipple upwards.* She helped the baby onto the other side and sat with the mother for a few minutes and then the baby came off.
Di: *Well, we can't say he hasn't had a good feed. Right, if you could just turn onto your back a bit, I'll take your drip down and your dressing off.*
Then with accompanying explanation, she removed the intravenous infusion and then the dressing, etc. and asked the care assistant to take her for a shower. *When you come back from the shower, we'll pop him next to you again.*

A few minutes later:
Care assistant (CA) came to take her for a shower. Mother was holding her baby.
CA: *Still feeding?*
Veronica: *Well, he's just lying next to me*
CA: *I'll take you for a shower now if you like? He'll be all right in the cot.*
Veronica: *Thanks. Could you put him in for me*
CA: *Certainly love. Come on young man.* Put him in the cot. Helped mother collect together her wash things and escorted her to the shower.

Again, once routine procedures had been completed the midwives would stand by the bed and complete their forms, tick boxes etc. This sense that completing records was more important than the care which they were writing about is referred to again later.

Lights on nights

I observed specific 'night time' routines that were almost uniformly practised by staff. These are referred to by Davis-Floyd and St. John (1998):

> The most basic kind of medical hierarchy is the subordination of the individual to the institution - many hospital routines, for example, operate in ways convenient for the medical staff but not for the patient. Middle-of-the-night ministrations - weighing patients, taking blood pressure, drawing blood - may be an efficient use of staff time when not much else is likely to be going on, but seem like harassment from the point of view of patients whose sleep cycles are constantly disrupted (p28).

One example of a routine which paid little regard to the needs of women was the turning on and off of lights at night, as described in extracts from my field notes:

> 00.05: There are 3 sets of lights, strip lights in the corridor running past the bays, three central lights in each bay and then women's own bedside lights. It's 00.05 and the midwife is "doing the drugs". She enters the "corridor" and turns all of the lights in the corridor and bay on. I feel really angry at her disregard for women's autonomy and need for sleep. (The lights had been turned off by one of the mothers half an hour earlier). The midwife chats to mothers as she goes round, as if it's the middle of the day. She asks each mother if they want anything for pain or to help them sleep! (Field notes).

> 07.30: The lights were turned on full at 6.30 on one "corridor" and at 07-15 the other side. One midwife goes round "doing the drugs" and another "doing the obs" on post-section women. From 7-15 to 7-45 nothing happens (the day staff are receiving the report). At 07-45 the drinks trolley comes round and the care assistant offers women drinks (Field notes).

Women objected to this disturbance of sleep, as Sue (P29) during an interview at 10.30 pm, commented:

> Sue (P29): *At this time I'd like the lights to be off really.....It can be midnight, really. Last night, it was brilliant, cos these lights went off (points to circular lights in the bay) and the majority of the corridor lights went off but the staff often don't put them off until they've done drugs, and that can be near midnight.*

F: *Oh, so what time do they put them on in the morning?*
Sue: *Um...That's varies as well. They can go on at half past 6..um... like the morning they gave the bottle it was about half past 6 and we just got him settled and I was about to go back to sleep and then they promptly switched all the lights on* (laughs).

Midwives appeared to be encultured into the linear/productive time that as Kahn (1989) states erases the differences between day and night. Val who was doing a night as a "one off" stated:

I don't usually do nights, here, I'm just helping a friend out and I'm glad I don't. It's ridiculous, especially on a night like this. There's a lot I don't agree with, like doing a medicine round at nearly midnight, with the lights still on. That's just not on. Then it's the same in the morning (Val, MW22).

A permanent member of the night staff, Eunice, stated:

I would like to see continental breakfasts on the ward. I think it's terrible that we wake a woman up whose been up most of the night feeding her baby and then we wake her at quarter to 7 to give her a jug and then we disturb her again to give her her breakfast and all the lights go on. We should have buffet style meals (Eunice, MW19).

Despite their comments, both Val and Eunice carried out the practices rather than resisting or changing them. This reflects the strength of implicit institutional rules and their power to create conformity in workers (Lipsky 1980, Lock 1999, Hunter 2002).

Ticking tasks off

Midwives throughout their work illustrated their central and instrumental preoccupation with getting tasks completed and ticking boxes. This related to the pressures upon their time and to the unpredictability. It was also a powerful manifestation of task related behaviour. This was also referred to by women, as was vividly illustrated in my interview with Louise:

They were very busy yesterday. I'd sort of approached her (the midwife) with a sample and then all of a sudden ooh I'll do all your notes while you're here sort of thing (laughs). She was taking her opportunity. I mean nobody spoke to me then all afternoon, which was fine I didn't need anything and I would have called if I had needed anything. I think it was the pressure that had contributed, that she thought I'll get all this done, you know I don't know if there was a box that she had to tick, to say that she had covered everything. To me she seemed to be only interested in checking my pulse, filling all her forms out and ticking the boxes. I mean I think that whoever is looking after you should come at least twice a day and say 'how are you doing' and 'how are you getting on', you know just check that everything is going all right. I got the impression that it was more 'oh I'll get this done'. I mean they should at least touch base with you once or twice a day. The night staff didn't speak to me, they were so busy and now 2 days have gone by (Louise, P14).

Louise clearly emphasised the importance of midwives "touching base" with women. While I was interviewing her a midwife, Shannon, arrived and with complete disregard for us stated:

I'm going to take this down for you (Patient controlled analgesia-PCA) and I'm going to give you a suppository if you don't mind - that's good pain relief for you, all right? Shannon (MW6).

During the two days I observed Louise she highlighted the issues for me in a profound way, not simply with language but with eye contact and body language. She was showing me as well as telling me. I wrote in my field notes:

I feel a strange sense of connection with Louise. She's watching me as I watch her. We're both aware of the same things. We're watching together as people come and go, rarely touching base, rarely listening, working their way through the tasks and ticking things off. We make frequent eye contact as each person approaches her one-by-one with clip board, notebook or case notes in hand - dedicated to task. There's a sense that we understand each other's situation. She's silently highlighting the issues for me as they occur and then as we meet and talk she's summarising for me, constructing the

story for me. I feel that closeness to her that I know the midwives here can't have. I want to reach out to her and meet her needs, but I know she'll be all right. I know she has an inner knowing and strength through deep reflection on her first birth, mothering and feeding experience. I know she empathises with me too. I know she wants me to see what it is like for women here and to lay bare the deficiencies in the system. That is our partnership. I know she trusts me to do that - we've both somehow shared something intimate (Field notes).

I was acutely aware that I had more opportunity for having a connected encounter with Louise than the midwives did whilst being a so called non-participant in her care. This was a profound period for me in which I realised in a deep sense, that as Leap (2000) states: "The less we do, the more we give" (p.1). It also resonated with the phenomenological work of Bondas-Salonen (1998) who referred to women wanting midwives to be there and be mindful of the mother and the sense of isolation that an absence of this created.

As Louise (above) illustrated not only were women subjected to routines and procedures but also an associated and profound sense of disconnection from midwives. In the rituals I observed and have described women were constrained by time: lack of time; fixing of time both day and night; timing of bodily ministrations; and overriding of personal and bodily times with a rigid form of public time. In this way women's bodies were disciplined as are those of prisoners or factory workers (Foucault 1977). As Frankenburg (1992) states: "The rigid time structures of the hospital emphasise the anti-temporality of the experience in relation to 'normal' worldly time" (p.23). This anti-temporality was reinforced by a series of disconnected encounters that I now go on to discuss.

Disconnected encounters

As already illustrated, communications on both sites appeared to be largely confined to what needed to be done. They were strikingly fragmented and disconnected from the woman's context with little emphasis upon individual needs or concerns. This related in part to the impersonal nature of care with midwives and women usually being complete strangers. To illustrate the organising theme of 'disconnected encounters' I now describe four underpinning basic themes: 'absence of a midwife-mother relationship'; 'disconnected from birth'; 'disconnected from life'; 'disconnected from social relationships'.

Absence of a midwife-mother relationship

The fragmented ways of working on both sites, combined with a rapid turn over of women, created very little continuity of carer and the midwives frequently commenced a 'shift' being faced with having to relate to completely different women to those they related to on the previous shift. The same applied to the women the midwives were attending to. The notion of developing any form of relationship with women was eerily absent. Under these circumstances, midwives were constrained from developing what Varcoe et al (2003) refer to as an "authentic presence" (p.966) resulting in the making of rapid judgements about women that were not based on a trusting relationship. This inevitably led to labelling and stereotyping of women for the purposes of rapid action. This absence of relationality, lack of presencing and stereotyping which I observed was strikingly resonant with that described by Kirkham and her colleagues (Kirkham 1999, Kirkham and Stapleton 2001b, Ball et al 2002, Kirkham et al 2002c).

Annie appeared to have more of a relationship with the physiotherapist than the midwife:

> I went to relaxation classes with the physio (named her). She's been great, she's seen me on here every day an' ..er.. given me ways to relax, like when I'm in pain and that. (Annie, P42).

The absence of a relationship with the midwife affected all subsequent communications in that they reflected the lack of "caring connection" and consequential failure to engage with women's "inner context", referred to by Halldorsdottir (1996).

Disconnected from birth

A key way in which women's inner context was ignored centred upon the lack of reference to women's birth experiences. There was little attempt to contextualise feeding with the earlier

birth experience and in the time I was observing I only saw a few instances of midwives facilitating the mother in discussing her birth. Even when women appeared to be desperate for some discussion around the birth this need was not normally met. Their ability to express themselves appeared to be blocked, for example Grace (P28) had had a previous Caesarean section and had chosen to have an elective Caesarean under spinal anaesthetic this time. However, she had a failed spinal and a postpartum haemorrhage leaving her with a very low haemoglobin level and clearly disappointed. The only person to discuss it was the anaesthetist who came and explained that spinals are sometimes ineffective, but this was brief and a one way dialogue. The following series of interactions illustrates the lack of sensitivity or reaction to the mother's cues. Di (MW18) approached Grace and conducted a brief postnatal check and then assisted her with breastfeeding whilst on her side. She explained the principles of effective feeding quite clearly, but then Grace, who appeared to be completely detached from any feeding issue, began crying.

0835 (approx): Di (MW18): *Are you all right?*
Grace (P28): *Just upset by the birth*
Di: *I know, I know.* Put her arm on her shoulder. *It'll be all right. You'll feel better in a while.* Focuses on the baby - *just leave her there for a little while and I'll pop back.* The midwife left. The mother wanted to discuss the birth, but cue clearly missed/avoided.
09-20: Grace: Called the midwife as she went past. *Can you pull my curtains around please?*
Di: *Yes*-glanced at the baby and drew the curtains half way.
09-25: Di returned. *I'm just going to empty the catheter.* Looked at the baby - *still suckling.* Removed the catheter. *OK that's sorted.*
09-40: Care assistant came - *ready for a shower? oh I can see you're not.*
10.00: Di: *feeling a bit better now? yeah?*
Grace: *Yes.*
Di: *Got it out of your system?*
Grace: *Yeah, what do I need for the shower?* Discussion around shower etc.
Di: *Well, you're both doing fabulously with your feeding*
(Making eye-contact with two mothers, Veronica (P27) and Grace (P28).
10-25: Di: *All right? I'll get back to you soon.*
A few minutes later: A different midwife, Joy (MW4) bussled in. *Your iron levels are very low. You need blood.*
Grace: *What is the level?*
Joy: *You've got a haemoglobin of 6-9.*
Doctor arrived and explained the need for blood very briefly and then left hurriedly.
Grace became tearful.
Joy: *Oh, what's up* (put her arm around her briefly). *You don't have to have blood you know. It just brings the levels up much better.*
Grace stopped crying
Joy: *Oh you're all right now. I thought you were going to burst into floods of tears. Are you all right now?*
Grace: *Yes*
Joy: *All right* – Then she left. The mother started crying. She went and wheeled the phone over and spoke to her partner asking him not to bring the other child in. Her baby cried and she picked him up. When she had finished on the phone she turned to Veronica (P27) who was eating her lunch.
Grace: *Are you allowed to eat when you're having blood?*
Veronica (P27): *Yes, I think so. Yes, I could eat when I had blood with my last baby.*

She started eating her lunch, obviously still shaken.

As may be seen in a short space of time this mother was seen by the anaesthetist, just before the above encounter, two midwives, a junior doctor and a care assistant. None of these staff met the woman's needs by responding to her distress in a constructive, sensitive or helpful way. I was unable to get back to Grace that day due to her wanting time alone with her visitors following which I was engaged in another situation. However, I felt alarmed by this situation:

I have just witnessed a profound lack of sensitivity to the woman's sense of being, her anxieties and concerns, her needs and expectations. In a short space of time I have seen the downward spiral of discouragement (Field notes).

Disconnected from life

Breastfeeding was commonly not connected with women's birthing, as I have just illustrated, but neither was it connected with women's previous feeding experiences, with other aspects of parenting, with women's lives or with their existing and personal knowledge. This can only be illustrated by an absence, rather than presence, of quotes in which this connection took place. However, Barbara (P37) did go some way to highlight the disconnnectedness of encounters:

> I generally need more advice, but not necessarily breastfeeding, you know knowing whether you've covered all the reasons why they get wingey, that sort of thing (Barbara, P37).

Stapleton et al (2002c) also refer to the way in which midwives rarely explore women's existing personal knowledge and yet this is identified by women as important both in general (Halldorsdottir 1996) and in relation to breastfeeding (Bowes and Domokos 1998, Whelan and Lupton 1998, Hoddinott and Pill 2000, DH 2003).

Disconnected from social networks

Being connected to networks of significant others has been shown to be important to new mothers (Bondas-Salonen 1998, Tarkka et al 1998). However, the women I observed and interviewed not only experienced disconnected encounters with midwives but were commonly cut off from their social networks, particularly on site 1. Some participants clearly wanted to rely on their community networks rather than the medical system as their source of information. However, in site 1 this was quite difficult as visiting times were restricted and mothers had little autonomy over who visited them and when:

> Barbara (P37): Um, without sounding really horrible, I just didn't see the point in going to classes and mixing with those people. Obviously you've got a child in common, but...you know, I have a very strong circle of people. So I don't really feel the need to go elsewhere and mix with others and all of the rest of it...
> F: No, what about the sort of skills for parenting side of the classes?
> Barbara: Um, I know a lot of parents (laughs)
> F: Well, that's a good way to learn about it all.
> Barbara: Exactly, so err.. I'd never say that I know what I've got ahead of me at all...but I know I've got good...shall we say back up team...I've got good support.
> F: Relatives?
> Barbara: Yeah, they are people who have...there'll be someone with whatever experience I'll experience sort of thing.
> F: Mmm, so you'd rather draw from your community network?
> Barbara: Definitely, yes, definitely.

The need for women to draw upon others for information was rarely facilitated with placing in bays designated for postnatal women on both sites being largely serendipitous. When I asked midwives about this I got a common reply on both sites, for example:

> F: Do you have any particular way that you select where women will go in the bays?
> Anthea (MW25): Well, bay 1 is for antenatals, bay 2 we put any sections or high risk women in there and bay 3 and 4 other postnatals. Side rooms are for woman with problems, or if they need the quiet. If we have more antenatals then they just go in the bays with the postnatals, so sometimes there's a mixture.
> F: Does feeding method influence where they go?
> Anthea: No, but I suppose it should. I mean sometimes you get one breastfeeder in with all bottle feeders.
> (Site 2)

Barbara (P37), referred to above, was placed in a four bedded bay with an antenatal woman and a multiparous mother who had changed from breastfeeding to bottle feeding. The other bed was empty for most of her stay. I observed her asking the multiparous mother various questions, for example "He keeps putting his tongue up - I don't know what to do with you?" and when her baby was crying, "Am I better just ignoring him?" However, she got little in the way of an answer and as the other mother had stopped breastfeeding abruptly, her replies tended to be fairly negative. This absence of other mothers who were able to support a new

breastfeeding mother made it difficult for the women to network and develop any sense of relationship with those surrounding them. I did not see any attempts to place breastfeeding mothers near to each other for support.

This lack of emphasis upon creating a sense of community within the ward was highlighted by one of the midwives, Eunice:

> We don't do a baby bath demonstration any more, but when we did there was a lot of chit chat amongst the mothers and they used to ask a lot of questions. There isn't anywhere where we bring the mothers together now....The physio used to come and do exercises on the ward post-delivery and everyone used to do them together, but we don't bring anybody together at all now (Eunice MW19).

One might expect that the day rooms would be places where women talked and networked with each other. However, as stated, on site 1 the day rooms were very uninviting and on site 2 there were several obstacles placed in the women's way as highlighted by Jacinta (MW38).

> F: Do women use the day room at all?
> Jacinta (MW38): No, they don't. They go in to get their meals or sometimes they send their husbands in......They won't leave their babies.
> F: Can't they take their babies in with them?
> Jacinta: Well, they're discouraged from carrying their babies about and if they wheel the cot in there the security alarm goes off. Anyway there isn't room in there for cots.
> F: Oh, well it's no wonder they won't go in then?
> Jacinta: Yes, but their babies are safe. I don't know why they don't just leave them in the bays.
> F: Maybe they don't have confidence in the security system?
> Jacinta: Well, they should have because they hear the alarms if a baby goes near the door.

On site 2, network support was encouraged by an open visiting policy for partners. This appeared to be largely appreciated by women. Millie (P43) had her partner with her all of the time:

> Millie (P43): He's gonna stay here during the day, aren't you, while I try an 'ave a sleep and see if she settles and then he can just see to her until she needs another feed, until she won't settle anymore.
> F: What do you think of the open visiting hours for partners?
> Millie: I think it's definitely a good idea cos like, not so much today, but yesterday I was really tired after the night before an' he come at 9 in the morning and he just took her off me while I just got meself ready and 'ad half an hours sleep, you know when she didn't need feeding, when she was just awake......But..... em..... then when she was sleeping I got some sleep and then every time she made a noise I knew he was there to like see to her and check if she needed feeding, so I could concentrate on getting a little bit of sleep. So it's definitely a good idea, otherwise I'd be on me own all day (laughs).
> F: What time does he stay until?
> Millie: He stays until about half eight when the visitors go of an evening, then I settle her down for the night and give her a bath.

However, some partners were not necessarily particularly helpful in relation to women breastfeeding being more anxious than their partners, leading to lowering of confidence in women. In some situations the partner appeared to dominate the woman rather than support her:

> Francesca (MW28): How are your breasts?
> Partner: Big (laughs).
> Annie (P42): They're all right, like the milk's coming in now and they're very full.
> Francesca:Good. How's the feeding?
> Annie: OK, fine.
> Partner: He's sucking his fingers-come on feed him.
> Francesca: I just need to do a check first.

Following the postnatal check:

Francesca: *How are you feeling emotionally?*

Annie: *I had a bit of a cry last night.*

Francesca: *That's probably because you're between the 3rd and 4th day, with your milk coming in and your hormones adjusting and everything. I've got a discharge pack here, do you want to go through it now or a bit later?*

Partner: *Do it now?*

Annie: *I want to have me dinner first.*

Francesca: *Well, I'll bring you your meal and we can talk through this then while you're having it, so you can get home.*

Annie: *OK, Thanks.*

Here the midwife diplomatically reached a compromise by suggesting that Annie could have her meal at the same time as she went through the discharge details.

Women tended to value advice from their mothers:

F: *Has anyone talked with you about expression?*

Harriet (P52): *Not here, but my Mum went through quite a few things with me, so.*

F: *Oh, yes, you said she breastfed you.*

However, on site 1 women's mothers were often there amidst several other visitors due to the restricted visiting times. On site 2 the partners were often there making mother-to-daughter encounters difficult.

The organising theme of disconnected encounters resonates with Kirkham's (1989) reference to "linguistic non-touch technique", i.e. midwives not coming into "contact with the woman's worries or concerns"(p.125-126). More than a decade later, Kirkham and Stapleton (2001a) highlight numerous further examples of this approach. The data I have presented relates closely to that of Halldorsdottir (1996) who refers to care which lacks connection as a concept underpinning the 'wall'. It also resonates with Fenwick et al's (2000, 2001) inhibitive nursing actions. Disconnected encounters were further exemplified and potentiated through the managerial approaches I observed and now go on to describe.

'Managing' breastfeeding...women

In chapter 6, I referred to the ways in which women felt that they came under surveillance in relation to the 'correct' way to breastfeed, creating feelings of being productive yet subjected. In this section I focus further upon the way in which encounters between midwives and mothers and knowledges midwives draw upon, construct a situation in which women feel watched but strangely invisible, managed but not supported, told but not guided. The instrumental, managerial and authoritative approach adopted by midwives related to the requirements of the organisation, breastfeeding 'rules' and in some cases their lack of confidence in the bodily process of breastfeeding. As Shildrick (1997) states:

> The objectifying gaze of the human sciences which fragments and divides the body against itself has its counterpart in an insight which equally finds the body untrustworthy and in need of governance. Moreover, each form of surveillance incites the other (p.55).

The organising theme of 'managing breastfeeding' illustrates an approach that disregards the woman and her personal agenda. The ritualistic management of 'breasts' and breastfeeding that I observed appeared to result in disembodiment and fragmentation of women's bodies. Shildrick (1997) refers to this destruction of the wholeness of "one's being-in-the-world" as intrinsically compromising of "feminine ontology". The reproductive organs are referred to as discrete entities to be managed. "The woman as a person plays little or no part, but is obscured as an intentional agent by the clinical concentration on a set of functional norms." The woman's body is seen as a "container" or "bounded space" within which specific processes occur (p.25). The overriding of women's bodily boundaries that I repeatedly observed appeared to compound the sense for women that they were disconnected from their bodies and breasts. I now describe, in turn, key aspects relating to the basic themes underpinning the organising theme of 'managing breastfeeding': 'technical approaches'; pre-set agenda precluding listening; over-ridding the mother's agenda with unhelpful chatter'; 'breaching women's boundaries'.

Technical approaches

In chapter 7, I presented examples of mechanistic dialogues centring upon production and transfer of milk. In this section I refer to the way in which reductionist language was also used in presenting breastfeeding as one component in a series of technical activities. The instrumental and goal-orientated philosophy thus objectified the woman's breast and rendered her as almost invisible. Many of the encounters between mothers and midwives related to breastfeeding centred upon the best ways to ensure the effective transfer of milk from mother to baby. On site 1, particular emphasis was placed on 'latching on,' more recently referred to as 'positioning and attaching'. This was also a major preoccupation for women as they commenced breastfeeding.

The emphasis upon this aspect of breastfeeding 'management' has grown considerably related to research which links effective attachment to the mother's breast with improved breastfeeding outcomes, for example duration for which women breastfeed, reduction of sore nipples, and growth of the baby (Woolridge 1986a, b, Righard and Alade 1992, Woods 2000, Ingram et al 2002). While this knowledge has undoubtedly brought gains for women in establishing effective breastfeeding, it has the potential to disrupt women's experiences when used in a monologic, managerial way. The growing emphasis upon technique has become super-valued over other ways of supporting women, leading to a technically prescriptive approach to care (Colson 1998a,b). While rituals centring on rigid timing of feeds are fading new rituals based on technique and technical mastery and transfer of milk are appearing.

In my position as observer of practice during this study, I was very challenged by the emphasis upon technique. I am aware that there are indeed fundamental principles related to ensuring that breastfeeding is an effective process for the reasons stated above but I did not wish to place myself in a position in which I was making positivistic and deterministic assumptions about the correctness of 'technique'. However, being able to see what was actually happening has added a perspective to this research which as stated in chapter 8 is absent from much of the sociologically focused literature on breastfeeding (Bottorff 1990, Schmeid and Barclay 1999, Pain et al 2001).

In spite of the emphasis upon the 'correct' attachment of the baby to her/his mother's breast this 'technique' was not always facilitated effectively, particularly on site 2, as discussed in chapter 8. For example, a midwife would miss out key points, like making sure the baby's mouth was wide open and bringing the baby's chin into the mother's breast, while focusing on less important points. This meant that a technical approach to women was prevalent in relation to their breastfeeding and yet they were not always facilitated in achieving the 'technique'! Secondly, the teaching of specific techniques in reductionist ways and the issuing of pre-defined packages of information by-passed other needs which women had. The shortage of time potentiated this imbalance. This emphasis upon technical correctness may be seen in the following encounters:

> Shannon (MW6) returns 10 minutes following physically attaching the baby for Jackie (P33): *Has he come off?*
> Jackie: *I don't think he needs feeding at the moment.*
> Shannon: *When you're feeding you need to sit up straight, otherwise you'll get a backache. I like the underarm hold, its more comfortable for me and quite good for latching on. Anyway, I'll come back later and help you breastfeed.*

Shannon gave prescriptive advice, apparently according to her own preferences, without any accompanying support or guidance. In the next scenario, Di likewise issued prescriptive advice but also assisted with feeding. However, she selected a time to assist that did not fit with the baby's desire to feed. This was another aspect of managing feeding which was dictated the needs of the organisation rather than mother or baby's needs:

> Di (MW18) was passing. Mother was sitting in the chair after her shower and the baby had just started crying in the cot: *Shall we have a go at feeding him?*
> Veronica (P27): *Yes, all right*
> Di: *How do you want to feed him? Sat up?*
> Veronica: *Yes, I think so...*
> Di: *He's a big baby. Now then, when you're sitting you can try him across you lap or under your arm. Let's try this underarm position. OK, guide him with your hand. She*

guided the mother's hands. *Oh he's too angry to go on really. Let's try and wrap him up.* Wrapped him up and tried again in underarm hold saying: *Nipple upward towards the roof of his mouth.*

The baby latched on. The midwife sat with the mother. The baby had a few suckles and then came off.

Veronica: *He's not really bothered now is he?*

Di: *He's probably just wanting to be next to you. Shall we take him for his bath then?*

Veronica: *Yes, I'll come too*

Di: *You want to come do you?... OK.*

Midwife and mother went to give the baby a bath.

'Correct' or 'incorrect' technique was implied in one of the practices that I saw repeatedly. This involved the midwife approaching the woman, peering at the baby whilst feeding, making a cursory comment that the baby was on well and then leaving.

Corinne (P41): *He's feeding all the time*

Francesca (MW 28): *Frequent feeding is normal in the early days.* Looked over at the baby feeding: *He's on properly.*

The lack of clarification as to what 'being on properly' meant was highlighted by Barbara (P37): "*They've checked that he's on right, but I haven't really had a conversation about it*".

Midwives rarely sat with a woman while she fed to observe part or all of a breastfeed. Therefore, they would only get a snap shot and gained little sense of the dynamics of the feed and yet they made statements about the 'correctness' of the attachment with considerable authority. As I was in a position to observe breastfeeding for longer, I felt that the assessments of midwives were sometimes inadequate and women were not always feeding their babies in effective ways that would minimise nipple soreness. I discussed the link between attachment to the woman's breast and nipple soreness in more depth in chapter 8, as this constituted a significant and negative aspect of women's experience.

Pre-set agenda precluding listening

Midwives often appeared to control interactions in accordance with their own pre-set agenda, provided information and assistance that they considered to be important and appropriate for women to receive. They largely appeared to ignore the woman's expressions of need for information in other areas, findings resonant with Kirkham et al (2002a) and Stapleton et al (2002b,c,d). An example of an encounter in which the midwife clearly had a pre-set agenda that differed to that of the woman illustrates this:

Alex (MW9): *Would you like me to show you how to hand express?*

Louise (P14): *No thanks, I don't really want to.*

Alex: *Well it would reassure you that you have milk*

Louise: *Oh I can see that when she feeds.*

Alex: *It's a technique we like to teach ladies. I'll just show you.*

She demonstrated on herself while Louise graciously listened, in spite of saying she was not interested. Done and ticked off!

Louise discussed her feelings related to this afterwards:

I wasn't ready for her telling me how to express. I wasn't at the stage where I wanted to know about that. I felt that things were going well and she was latching on really well and I didn't see the need for expressing and I thought well she was determined to tell me. She was trying to be helpful, but I was saying no its all right I'm OK. I knew that everything was all right because milk came out when she came off....I just think she wasn't listening to what I had to say. I think she thought she was doing me a favour, but I didn't want to know. I thought, well, if I need to know I'll ask you then....I think they feel they have got to tell you certain things (Louise P14).

Other participants echoed the sense that the midwife wasn't listening to their concerns, for example:

It would be nice if somebody could just come and spend ten minutes with you to talk about breastfeeding. If they did that they could learn about your concerns and anything you feel you need help with? I mean I'm not very confident at all (laughs) (Helen P35).

In some cases midwives overrode women's concerns with unhelpful chatter:

Joy (MW4) passed the bed.
Grace (P28): *He seems to go blue when he feeds.*
Joy: *Put him over your shoulder then.* Took the baby from the mother and sat and winded him. *Breastfed babies don't get much wind. Look at your lovely flowers. Beautiful aren't they. Is your other child a boy or a girl?*
Grace: *A boy*
Joy: *Oh they're very different aren't they? No matter what people say, they are different. Men, I don't know why we bother with them* (laughs).

The midwife here completely led the agenda while the mother had no say in the course of the conversation. This is an example of the blocking of conversations described by Kirkham (1989) in which questions weren't answered properly and the conversation was diverted away from the subject about which women sought information. Fenwick et al (2001) refer to the controlling nature of this form of "dismissive chatter" which prevents or limits disclosure or depth of conversation (p.591).

The ways in which midwives conformed to an agenda that was not necessarily aligned to the women's resonates with the findings of others (Bondas-Salonen 1998, Levy 1999a,b,d, Lock 1999, Edwards 2000, Hoddinott and Pill 2000, Kirkham and Stapleton 2001a, Stapleton and Thomas 2001, Hunter 2002, Stapleton et al 2002b). The reluctance I observed in women to interrupt the flow of the midwife's conversation was also reported by Stapleton et al (2002c). The resulting conversational dominance and asymmetrical style of interactions, with midwives taking control of the start of, the course of and completion of interactions has also been highlighted (Lomax and Robinson 1996, Lomax and Casey 1998, Stapleton et al 2002b).

The absence of listening to women was particularly evident during my observations and this is a key feature of the asymmetrical form of communication I describe. Frank (2003) refers to this form of communication as monologic:

The monologic voice speaks truth <u>about</u> a world of which this voice claims privileged knowledge. Monologues tell others what the speaker already knows and the listener must listen. The speaker is at one end of the pipeline, the listener at the other, and information - knowledge and truth - flows one way (p.5)

Unhelpful use of self

Unhelpful reference to personal experiences formed another way in which women's agendas were over-ridden, for example in the following encounter Holly (MW7) approached Barbara (P37) who was struggling to settle her baby in the cot. She picked up the baby, without seeking permission and then stated:

When I had my first baby I was ready for giving up - I said "I'm tired and me boobs are hurting", but once I got home she was fine (MW7).

Stella had been exposed to a midwife's problems and this led to her using nipple shields.

Stella (P46): *I've got these nipple shields.*
F: *Did you bring them in with you?*
Stella: *No I didn't, me husband went and got them for me. When I was having Katie I was talking to one of the midwives and she'd had the same problem with her two children. She said with the last one even though they weren't miracle cures, they helped her carry on for a little bit longer, you know than she did with the first one. So* (husband's name) *went and got me some.*
F: *So when have you used the nipple shields?*
Stella: *I've used those this morning and yesterday. The lady came and showed me how to put them on........She suckles fine on them, but I just don't think she gets the same amount out as she would normally.*

There were only a few examples of use of self, as midwives tended to adopt a formal approach to women. However, when midwives did use personal, experiential and embodied knowledge, it tended to be inappropriate. Exceptions are referred to in section 9B. The inappropriate use of self is referred to by Battersby (2002), in a study centring upon midwives attitudes to breastfeeding. This she argues relates to the need for midwives to experience some form of debriefing of personal experience during their undergraduate training. The notion of debriefing is central within the voluntary breastfeeding organisations and this reduces emotional residues stemming from unresolved breastfeeding issues. This makes way for congruence and appropriate use of self when considered to be helpful to a particular woman's situation (Personal communication, Sachs 2003 [BfN] and Smale 2003 [NCT]).

<u>Breaching women's boundaries</u>

In chapter 7(B), I referred to the ways in which women's spatial boundaries were altered by their baby and in particular by breastfeeding. In this section I illustrate another way in which women's boundaries were eroded through being handled by midwives. In section 7A, I referred to the influence of dualistic and separatist ideologies upon representations of women's reproductive activities. I extended Martin's (1987) notion of the woman as separated and alienated from her birth, to woman as separated from breastfeeding. This was reinforced for me as I watched women's breastfeeding being managed and controlled with midwives handling women's breast in order to 'latch the baby on', often without seeking permission. This occurred on both sites. This was the case with Denise (P4) who had very large breasts and was struggling to attach her baby. Tamara (MW2) arrived and having suggested she try the other side, she grasped the woman's breast in one hand and the baby in the other and united the two in silence. I was stunned at the insensitivity of this encounter. This was an example of an approach that seemed to show a profound lack of respect for the person and her bodily boundaries. This management and objectification of women's bodies undermined women's sense of confidence (self-efficacy), in that they were unable to repeat the actions themselves requiring them to request help on several occasions during the course of a feed. This meant that their sense of dependency and inadequacy was reinforced and that they were susceptible to the combination of feelings of being almost separate from their bodies and breasts and yet enormously accountable for producing milk in appropriate amounts.

I was surprised that midwives appeared to be unaware that this 'hands on approach' might be unacceptable to women. There is a growing literature now, based on women's negative comments, about their breasts being handled, the baby being 'rammed' on to their breast and their desire to be taught breastfeeding skills verbally (Whelan and Lupton 1998, Vogel and Mitchell 1998, Mozingo et al 2000, Hoddinott and Pill 2000, Ingram et al 2002). However, to achieve this, midwives must be able to verbally articulate the skills required (Cox and Turnbull 1998, Vogel and Mitchell 1998, Whelan and Lupton 1998, Fletcher and Harris 2000, UNICEF 2001a, Ingram et al 2002). By sensitively articulating, rather than 'doing for' women, midwives may provide care which "counteracts" rather than "re-enacts" earlier violations of women's bodies (Kitzinger 1992, p.221).

Women who were post Caesarean were particularly vulnerable to handling, for example Virginia (MW20) with Sue (P29) following her Caesarean section:

Virginia (MW20): *Is your baby wanting a feed?*
Sue (P29): *Yes, but I can't feed like this, I think I need to sit up*
Virginia: *I'll just call another midwife.* The other midwife arrived and they sat her up in a semi-recumbent position which was not a helpful position for attaching the baby. *Now then* - The midwife, Virginia, took hold of the mother's breast and the baby and then whilst trying to 'connect' the two said, *do you mind if I help?*
Sue: *No* (drowsy and drifting in and out of sleep).
Virginia: *He gets on but then he keeps slipping off.* She turned to the student midwife: *He needs to be close to mum, facing her and at the right height - there he's sucking nicely. The bottom lip should be turned down and the brown areola goes in and out if he's suckling well. They don't breastfeed all the time, they stop and start - that's normal.*
She then turned to Sue and said: *All right I'll leave you for a little while.* Then to the student, *would you sit with her for a little while?*

Women seemed to see the handling of their breasts following a Caesarean section as inevitable during the early stages. However, they expected this to be short lived, for example:

> Sandra (P34): *Yesterday afternoon, the lady that was on, she did a lot of helping, trying to latch him on. They've all helped today. I wouldn't say advice, they've just helped trying to get him on, then they disappear off and he comes off again* (laughs). *It's a lot easier when you've got two hands, to put your nipple into his mouth, but when you've got one hand and you're trying to do it yourself* (laughs).
> F: *So how do you feel about that type of assistance?*
> Sandra: *All right, I like them to help me, I mean at first, then once he gets used to latching on it should gradually get easier for me.*

This seen need for midwives to "do for them" is referred to by Fleming (1998b) as "supplementing" (p.141). In some cases a midwife would attach a baby for a mother and this would be accompanied by the sort of banter reminiscent of exhortations to the woman to push during labour, for example:

> Virginia (MW20): *What have you got at home?*
> Sue (P29): *2 boys*
> Virginia (MW20): *Ooh 3 boys* (laughs). *Well, what do you think. We'd better put him back on the breast, what do you think? Hungry Horace. We're going to have to put him back on, let's try the other side.*
> Sue: *All right*
> Midwife assisted her by holding the baby and mother's breast: *Eh come on* - continued trying. *I'll just get you a pillow to bring him up a bit.*
> Sue: *I'd rather sit up a bit.*
> Virginia: *All right.* She helped her to sit up. She tried again...*shhh, Mum's not very mobile at the moment is she* (laughs). She continued trying. *You're not taking a big mouthful at the moment are you....oh come on.* She said to Sue: *There's plenty there, you've got plenty of colostrum.*
> Sue: *'e seems to give it a good suck and then pulls 'is head away.*
> Virginia: *We're trying to do it for you aren't we* (Apologetically). *Right go on, keep going.......Every which way but.....You're being silly, come on you're messing......come on you're being silly.......Oh he's grabbed it there* -the baby latched on.......*ooh you're nicer than David Beckham, nicer than David Beckham aren't you......come on* -the baby continues to suckle.......*Do you want me to leave the curtains around or not?*
> Sue: *No, I'm quite warm.*
> Virginia: *It is warm isn't it.* She turned to me: *We're back on the breast again, it's going to be full time I think.* She turned to the mother: *Still once things kick in and your lactation is going you'll be away won't you.* -She drew the curtain around.
> Sue said to me, after she'd left the mother: *I think this one's going to need a lot of feeding!*

Some women actually used words such as "being handled" and even "mauled at": "*They manually help you*" (Joy, P4); "*I tried expressing, the midwives tried, they mauled at them, but nothing came...I've had midwives squeezing me nips and nothing coming out*"(Tina, P1). Sophie's 'hands on' experience was accompanied by advice on being more forceful!

> Sophie (P61): *He wasn't latching on properly...so one of the midwives come and said....be a bit more forceful...just so they latch on a bit harder....she did it herself just to show me and then I did it after...so ...yeah.....but I don't know...to me he's not over keen on it....but I'll keep trying it and see how it goes....*
> F: *Mmm, so what have you learnt about latching on then?*
> Sophie: *Just be a bit more forceful than I was being.....I thought he was latched on when he wasn't.....you can tell....its a lot stronger...(laughs).......you can tell.*
> F: *I see...so what do you mean by being a bit more forceful?*
> Sophie: *Just when they open the... mouth...to push it in....just try it and push it in a little bit so that they do latch on* (mimes an open mouth moving forward)..*instead of just latching on to the end and I could tell the difference when she showed me...so he did better at half past six...so we'll see on the next one* (laughs).

Women's breasts were sometimes squeezed to 'reassure' women that they had enough milk:

I've just said to the midwife I don't think I've got any milk and she said that I had and squeezed my nipple – and said look there's milk there (Sam, P19).

Sam appeared to find the midwives interventions helpful although it didn't seem to be assist with confidence building:

The midwives are very helpful, doing it for me, cos I'm not convinced I'm doing it right meself, so that I know I'm doing it right, they'll check it for me (Sam, P19).

Some midwives assisted the women to hand express in order to give the milk by a cup to a baby having feeding problems. Again, the midwife sometimes carried this out with little in the way of explanation. Bryony (P7) was approached by the midwife who expressed her breast milk into a cup, without requesting permission, and without explanation. She commented, *"they tell you to express but they don't actually show you how to do it"* (Bryony, P7).

Jenny (MW14) was one of the few midwives who avoided a hands-on approach:

Some of the midwives will just go about showing the mothers how to hand express and you hear the mothers making wry jokes to one another about being manhandled and mucked about and things. I don't think we should touch women's breast. I mime it and tell them what to do and get the mother to express herself, and it may be a bit more cumbersome, she probably feels her way through to it and I feel that's a much more sensitive and kinder way of doing it. Lots of people think that because they are the same sex as the mothers, it's all right to peep, to intrude, to touch, wherever, you know, in intimate areas. I think that assumption is just taken for granted, and from what women say and I hear, you know when you hear these snippets of conversation between them, they describe it as intrusive and distressing, especially if its done rudely and uncaringly and insensitively (Jenny, MW14).

Smale (2000) highlights this need for awareness in health professionals that breasts are attached to real people recognising the tensions inherent in relation to their advice, cultural norms and women's body image. Otherwise, she asserts, they may come to be seen as the "nipple police" (p.2).

Midwives not only unnecessarily breached women's bodily boundaries but also invaded women's wider spatial boundaries:

Shannon (MW6): *Right are you ready for feeding love.* The baby was crying and mother was preparing to feed, sitting in the chair.
Jackie (P33): Yes
Shannon: *Right, I need you to get some of these teddies and things taken home cos we need some space, all right love* -Established territory.
Jackie: *Yes, all right, I'll tell my husband this afternoon*
Shannon: *Let's get baby feeding under your arm.* (This midwife's preference from other observations). She moved forward and grasped the woman's breast and baby and put them together. *All right, love we'll leave you to it.*
Baby came off in a couple of minutes. Mother looked tearful and carried on trying.

This midwife firstly asserted her power in terms of what was 'allowed' in the space and then invaded the mother's bodily boundaries in her handling of her breast, without permission or discussion. I saw other examples of invasion of boundaries when midwives simply picked up babies without permission or discussion, for example Joy with Grace's baby – discussed above. I now go on to discuss the ways in which midwives rationed information.

Rationing Information

Provision of information is of little use unless it is enabling or educationally useful. Nevertheless, when provided appropriately it may constitute an aspect of caring (Halldorsdottir 1996) and empowerment (Freire 1972). Women in this study generally felt that they needed information from midwives. However, this was often delivered rapidly and with little reference to prior knowledge and understanding. The amount of information was commonly insufficient, in some cases it conflicted with other sources and in other situations it constituted misinformation. In some situations, the information being given was potentially detrimental to the establishment of an effective breastfeeding experience although the women were often unaware of this. The

organising theme of 'rationing information' is underpinned by the basic themes of: 'restricting verbal information'; 'insufficient written information'; 'absence of eliciting understanding'; 'conflicting information'; 'misinformation'.

<u>Restricting verbal information</u>

The sense of temporal pressure upon midwives impacted on the ways in which they 'delivered' information, with speed being the essence as referred to by Jane (P12): "*The nurses are very good. They tell you everything very quickly, so sometimes it's like you've got to pick up everything very quickly, they're very quick....but thorough*". As in Kirkham's (1989) labour ward study, the pressure on midwives time led to "information being compressed into dense routine packages" (p.127). This meant that women often felt that they had insufficient information to enable them to breastfeed effectively and with confidence. Veronica (P27) had stopped breastfeeding very early last time due to a feeling that she had insufficient milk and "*couldn't do it*". She felt that she needed more help this time:

> Veronica (P27): *I'm not too confident at the minute. I need more help with what to do, what positions to have him in, comfortable positions.*
> F: *Have you read about some of that or had some information about it?*
> Veronica: *I've read about it in a leaflet somewhere* -looks around at the locker, *but nobody actually went through it with me this time. I think they thought well, you've had a baby before, they assume you know, you've been through it before.*
> F: *Would you have liked somebody to have gone through it with you?*
> Veronica: *Yeah, or asked me how I wanted to feed the baby. They didn't this time.*

In some cases the lack of information related to midwives not knowing enough about the subject, for example Jane sought information on expressing following her postnatal check:

> Jane (P12): *If you express milk how long can you store it for?*
> June (MW5): *I'm not sure*-looks at me for some help.
> F: *I noticed it's in the leaflet on expression.*
> June: *Oh have you had your leaflets?*
> Jane: *No I don't think so...*
> June went and collected a leaflet on expression - looked through it very briefly with Jane. *Oh yes, here, in a fridge for 24 hours in a freezer for 48 hours. Needs to be in a sterile container.*
> Jane: *Is Milton all right?*
> June: *Fine*
> Jane: *Would you show me how to hand express my milk?*
> June: Looks very unsure...*Um yes, I'll show you later,* Finishes off observations and charts information. *Right I'll pop back later* (Which she didn't - until I intervened):

This was one of the few cases in which I did intervene. It appeared to me that the midwife was not confident to teach this skill. I asked the midwife, June, if it might be an idea for the infant feeding specialist to show the mother and that June could go along as a refresher. This occurred later, so that the mother was equipped with the information she had requested and the midwife was able to participate.

Women generally felt that they needed a more skills-based approach to teaching, for example:

> Helen (P35): *I'd like to be given help with the practical skills. You can read as much as you like but it needs to be more skill based......There seems to be a lack of information about breastfeeding.*

This desire for more information related to practical skills required resonates with other studies, for example Britton (1998, 2000) and Hoddinott and Pill (1999a,b).

On site 2, midwives appeared to give very little information to women about aspects of feeding, as illustrated in my interview with Tracy:

> Tracy (P44): *I fed her just before I came on here* (postnatal ward). *She was mooching round again* (turned her head to mimic rooting), *so I fed her, not very much cos we had*

to come back up. Then she fed again this morning. I did it meself, but the nurse just come in and I asked her to check.

F: *Did you buzz her?*

Tracy: *No she was around. She just popped her head in and said 'are you OK?', .and I just asked her to check and she just said she's your baby, feed her when you want to feed her and she said you ask us if you're not sure about anything, ask us, but if you want to feed her whenever you like that's fine, and if you want any help just ask us.......I mean I feel awkward about holding her, never mind breastfeeding her, but em....I suppose that will come with time.*

F: *Have you had any leaflets?*

Tracy: *No.... I haven't.*

From Tracy's account the encounters seem to have been dismissive and definitely did not meet her need for information. A further example of insufficient information provision is seen in the encounter between Sandy (MW30) and Selina (P48). Sandy spent time with Selina providing information. However, it was still insufficient. She used a "hands on" approach attaching the baby for Selina several times leaving her without the feeling that she could do it for herself. The key principles of effective positioning and attachment were not adequately addressed, for example the importance of the baby having her mouth open, so the baby repeatedly slid on with her mouth only half open. The cradle hold suggested was awkward for the mother and the baby was curled up making access to the breast difficult.

Sandy (MW30): *Lets get you comfy in the chair.*

Selina (P48): *I fed lying down before.*

Sandy: *Well, shall we try sitting up this time for a change?*

Selina: *OK*

Sandy passed her a semi-circular breastfeeding cushion

Selina: *I'll have to get one of these at home* (laughs)

Sandy kneels down in front of the mother, holding the baby.

Sandy: *Well, you don't really need one of these, an ordinary one will do. Now just let yourself relax, let your shoulders relax, that's it, now what I'll do is I'll hold him and you can support him behind, OK?*

Selina: *Yeah*

Sandy: *All right*

Selina: *Right,*

Sandy: *Again, like yesterday point your nipple up to the roof of her mouth. See she's quite close to you.* Sandy attached the baby for the mother-baby's head supported in one hand, mother's breast in the other. Mother supporting the baby using the cradle hold).

Selina: *Don't I wait for her mouth to open wide?*

Sandy: *That's all right, she'll open it you know* (the baby did not have a wide enough gape).

Selina: *Ooh, it's a bit tender.* (Grimaces).

Sandy: *It will be tender at first but it'll ease off in a minute. Ooh she's stopped for a breather, let's see if she carries on or comes off. Oh yes she's carrying on, she's learnt too, from yesterday.*

Selina: *Yeah* (laughs)

Sandy: *Now you're on tippy toes there* (probably due to the nipple pain). *You need to bring your feet up a bit, we'll raise them on this* (Pulled the bed table across, and Selina lifted her feet onto it). *When you're at home depending on the chair, you might need to lift your feet up on a few books or something. The other thing is, you know, when you're feeding your mouth may feel very dry, so have a drink handy, OK?*

The midwife actually sat with Selina for some time. However, in terms of assessing the feed, her lack of knowledge limited the benefits of being with her during a feed. She placed emphasis upon relatively trivial issues like raising her feet while ignoring the need for the baby to have a wide gape as she went onto her mother's breast. I got the impression that Selina was better informed about attaching the baby than the midwife. This was an example in which the midwife had time to give information but had insufficient knowledge herself for the encounter to be particularly useful.

As referred to above, the information women gained tended to relate to how articulate women were in expressing their needs in this area and to how assertive they were in gaining a

midwife's time. This inevitably disadvantaged less educated women from socially excluded groups as highlighted by others (Bowes and Domokos 1998, Kirkham et al 2000, Kirkham and Stapleton 2001b, Kirkham et al 2002b).

Insufficient written information

On site 1, the women were issued with a pack of approximately fifteen leaflets upon discharge, with those who were breastfeeding receiving some specific information on breastfeeding and those bottle feeding specific information on making up bottle feeds. These leaflets were supposed to be issued earlier as a part of the information giving while women were on the ward, but I only saw this happen on a few occasions. I only saw one example of leaflets being referred to during a discussion of breastfeeding or being used to reinforce information given. Thus women were telling me they wanted more information but were usually unaware that these leaflets were available to them.

On site 2, leaflets were rarely used effectively. There was a UNICEF leaflet in the Baby Welcome pack, but this was not pointed out and most midwives did not appear to even know of its existence.

> F: *Do they receive a breastfeeding leaflet?*
> Sandy (MW30): *Yes, they're in the packs at the end the bed, with the contact numbers and everything. Have you seen this?* (Shows me the pack at the end of the bed).
> F: *Oh, yes, I have. Do they get one in the Welcome pack?*
> Sandy: *Um, I'm not sure*

It was therefore unsurprising that mothers did not know about them either:

> F: *Have you actually had any leaflets on breastfeeding?*
> Chloe (P50): *Um, I'm not sure I don't think so.*
> F: *Have you got the Baby Welcome pack, there's one in there*
> Chloe: *Oh, Er..... I think it's in there* (points to the cot).

The same UNICEF leaflet was then issued at discharge as part of an information pack. This was often clipped to the end of the bed, but was rarely pointed out to women. Every mother on discharge was issued with a leaflet on how to make up bottles (not produced by a formula company) entitled "Preparing a bottle feed using baby milk powder". On the reverse was information entitled "Sterilising baby feeding equipment".

In some cases the leaflets were offered instead of giving information, for example:

> Selina (P48): *Do you think I need to draw this nipple out with a niplette?*
> Felix (MW29): *Um, have you got the breastfeeding leaflet ?*
> Selina: *Yes,*
> Felix: *Well, it tells you about hand expression on there. You could do that to draw your nipple out.*

The only time the midwives appeared to make reference to the leaflet was as part of a very standard and monologic discharge "patter", for example Anthea (MW25) discussed; the mother's haemoglobin level, her medication, 6 week postnatal check, registration of the baby's birth, the leaflet about reducing the risk of cot death, contraception/family planning clinics and the midwife's visit the next day. She then referred to the UNICEF breastfeeding leaflet:

> Anthea (MW25): *Here's your breastfeeding leaflet "Breastfeeding Your Baby".*
> Annie (P42): *Yeah, thanks.*
> Anthea: *It shows you all the different ways of holding your baby and putting the baby on. Then there's some tips for breastfeeding. You might notice at about 2-3 weeks a slight milk reduction. It usually happens when you start to do a bit more. I'm mentioning it so that you won't need to worry if it happens. It may last for about 24 hours. It also tells you about expressing your milk and how to encourage your milk flow by gently kneading your breast, to get your milk flowing. It also mentions breast pumps in here. Then there are these breastfeeding contact numbers here, so if you want any extra support you can ring one of these or you can ring your midwife and have a chat with her.*

Anthea: *Yeah, OK*
Annie *Goes through the postnatal discharge records. These are your exercises, and this is a leaflet about sterilisation and making up bottles which I'm sure you won't need to but just in case. There's a breastfeeding survey, so the Midwife will tick off how you are feeding at 10 days.*
Anthea: *OK*

The midwife then moved on to inform Annie about a blood test on the baby (PKU) on day 6, taking off of the baby's security tag before discharge and taking the mother down to the car. I heard this monologue several times and was amazed at its conformity within and across midwives. The telephone numbers of follow up breastfeeding supporters were supplied with the discharge pack but were rarely emphasised to women.

This data on leaflet use conforms to the findings of Kirkham and colleagues (Kirkham and Stapleton 2001a,b, Stapleton et al 2002) in the NHS commissioned multi-centre study. The multi-methods study incorporated an ethnographic component involving observation and interviews to examine the use of evidence-based leaflets on informed choice in maternity services. They concluded that while health professionals were positive about the leaflets as a means to facilitate informed choices, competing demands within the clinical environment to include time pressures hindered and undermined their effective use. Midwives rarely held open discussions on the content of the leaflets. The leaflets themselves were rendered largely invisible as they were commonly inserted with other leaflets, information or hand held notes.

Absence of eliciting understanding

The monologic nature of information giving and absence of listening to women meant that there was little attempt to elicit understanding, for example:

Kerry (MW11): *Now breastfeeding...... has he had a feed?*
Laura (P16): *Yes, he fed once*
Kerry : *Did he get on properly?*
Laura : *I think so*
Kerry : *Right.*

Women were commonly left in a rather confused state of mind regarding what constituted effective feeding. I asked some of the women who had been given some guidance about breastfeeding about the key principles associated with effective breastfeeding. Frequently, the answers suggested that they had little understanding related to effective breastfeeding or the principles underpinning it:

Mandy (P25): *The first night the midwives pointed out the principles.*
F: *Could you tell me what they are?*
Mandy: *Well, you guide the nipple around until he takes it, then you feel a harder sensation. They told me about the ear movements.*
F: *Did they say anything about where to point your nipple?*
Mandy: *Um, no not really*
F: *How have you positioned yourself and him?*
Mandy: *Oh its trial and error really, I've fed on my side mostly* (The baby was feeding on the side-not in a position which would facilitate effective suckling.).

Chris (P32): *She's on proper now, she's latched on proper, so hopefully, it should go right soon.*
F: *So what do you mean by latching on properly?*
Chris: *Um, trying to get all the nipple into her mouth so that she's like sucking most of it in her mouth, so she's not chewing on the end of the nipple...then she don't get fed properly.*

Conflicting information

Conflicting information and/or advice is repeatedly referred to in relation to hospital practices and, as Krogstad et al (2002) reflect, it often relates to a lack of a common approach, co-ordination and co-operation among health professionals. Conflicting information appears to be a continuing problem that undermines women's confidence in relation to breastfeeding, (Rajan

1993, Ball 1994, Garcia et al 1998, Tarkka et al 1998, Vogel and Mitchell 1998, Dykes and Williams 1999, Lavender et al 2000, Simmons 2002a,b). In this study, I saw a number of examples of conflicting information related to breastfeeding that stemmed in part from the attitude individual midwives adopted. The problem of conflicting information and advice was then compounded by the lack of continuity of carer: *"Like I've seen different people this morning and they've all had a different approach"* (Kate P39). Barbara (P37) expressed her distress:

> *All he wants to do is just be on the breast. It's a bit tiring to be honest. I don't want that, but I must admit, I've had one nurse who said its OK and one who said not to encourage it, so I am a bit.... do I or don't I.... sort of thing....Because I don't particularly want to get into it, but I've been told its OK, until your milk comes through...* (Barbara P37).

Bryony (P7) appeared to passively accept a range of confusing and conflicting advice. However, when I asked her how she felt about her support she expressed deep dissatisfaction:

> *I'm glad you are asking me about this because......um...I was going to write to someone about it. There are just so many people.. um.. there isn't a consistent game plan... I find it all so confusing. They tell you to, um..... express but they don't actually show you how to do it. The infant feeding advisor came yesterday, but she didn't have time to show me, she was in a rush. Anyway, you don't get the follow through. She's not here round the clock. They are all helping but in different ways. The team here are not supportive of the infant feeding specialist at all. They are not supportive of the expert approach* (Grimaces). *What should be happening is that the infant feeding specialist should meet with the team, there should be some sort of a meeting. The team should be following the experts advice and if that is not supported then something needs to be done about it. They should implement that plan. It leaves me feeling guilty at not following advice...um..a team front is needed. They should be presenting one approach. There should be a leaflet on the problems too...that would be useful* (Bryony P7).

She saw the conflict as a form of politics. *"There's a lot of politics here between staff and I'm caught up in it. I shouldn't have to be in the middle of this."* She eloquently highlighted two philosophies of care, the time-driven mechanistic approach and a more sensitive closeness approach:

> *There seem to be two schools of thought. The pumping and nipple shield and the hand expression and cup feed. The pumping ones seem to stress time shortage* (Bryony P7).

While observing this mother I became acutely aware of her desire to avoid tensions in the relationships upon which she was dependent and her uncertainty as to how to socially negotiate encounters with midwives. These findings are supported by Hunt and Symonds (1995), Smale (1996), Bowes and Domokos (1998), Edwards (2000) and Curtis et al (2001). The infant feeding adviser was seen by Bryony and other women as more expert than the midwives and this contributed to a lack of confidence in the midwives. This reflects the development of hierarchies of knowledges (Jordan 1997) and its potentially undermining consequences.

Misinformation

In some situations the advice given simply constituted misinformation, i.e. information which would be counterproductive to effective feeding, for example Carol (P31) was told that she had sore nipples because she was "freckly". Amina (P23) expressed concern about her milk, to which the midwife both blocked her concern and gave some misleading advice.

Amina (P23): *I don't know if there's any milk?*
Charis (MW16): *Just feed one side this time and one next time* (subject changed).

Some women had adopted practices based on what appeared to be information that was confusing and therefore constituted misinformation. Millie was feeding from one side only, so that she was not stimulating her other breast at all:

Millie (P43): *She said try her out on different breasts if she wouldn't you know take from one, so I've only fed with one, I've fed her a couple of times, last night and she seems content with one.*

F: *Did the midwives suggest you feed with one breast?*

Millie: *Well, they actually told me that if she seemed content with the one just stick with the one for now and em, but if she's not taking to it I can change her over and see if there's any more milk in the other one, but up to now I've had enough in...*

As discussed earlier, midwives on site 2 tended to readily advocate giving of formula. Another example of this was referred to by Millie (P43):

I'm enjoying it though. It's definitely hard work, but em definitely worth it......I think I should be able to manage it. I was speaking to the midwife and she was saying about like..... get some formula milk in just in case, should you ever run down and she's not feeding and you know your milk's not strong enough or whatever.......She said I'm not really supposed to say this but for your sake just get some in handy otherwise you're gonna be too tired, but she said just persevere for as long as you can but for your sake just have some in handy and you don't 'ave to use it if you don't want to.... (Millie, P43).

Summary

I have highlighted key elements of encounters that constituted a 'failure to touch base' with women as they sought to grow in confidence with breastfeeding during the first days following the birth. These findings resonate strongly with the encounters for which Halldorsdottir's (1996) uses the metaphor of the "wall". They also link with Fenwick's (2000, 2001) inhibitive nursing actions. The midwives like the women were 'productive' yet 'subjected'. They were heavily constrained by linear time, in that their work was unpredictable and rushed, coping with women who were usually complete or almost complete strangers. Their work was time pressured, routine, disconnected, fragmented and unsatisfying. In this context they saw themselves as 'supplying' a service under extremely 'demanding' conditions. By highlighting these constraints upon midwives within a medicalised, institutionalised culture, the postnatal ward, I add to the critical theory generated by Kirkham and colleagues (Kirkham 1999, Kirkham and Stapleton 2001b, Ball et al 2002).

To support understanding of the ways in which midwives cope with these demands I draw upon the concept of emotion work (Hunter 2002). Like the mothers, midwives' work was conducted out of relationship or relational context and this meant that their actions were seen as 'one-way' and therefore emotionally draining. Midwives engaged in ways of coping (emotionally managing) with the pressure and chaos. This included adopting rituals and routines and approaching women in disconnected, monologic, directive and managerial ways. The focus appeared to be upon the needs of the institution first, mothers and babies second, as described by others (Lock 1999, Hunter 2002, Deery 2003). Satisfaction was gained by completing tasks, ticking them off and writing up the paper work.

On site 1, midwives drew upon a mixture of authoritative knowledge, based upon the 'Ten Steps' embedded in their unit policy. On site 2, midwives utilised a combination of this 'new breastfeeding knowledge' as outlined in the 'Ten Steps' and a 'custom and practice' based knowledge that reflected the local cultural norms. The use of their own experience tended to reflect personal and negative experiences in ways that were unhelpful to women. On both sites there was a striking absence of reference to the womans' personal embodied knowledge and experiences. The encounters were largely characterised by monologue and consequently overrode women's agendas and silenced them.

The women were therefore subjected to an experience of breastfeeding a new baby in a public place, surrounded by strangers who adopted a largely instrumental and managerial approach. They had to constantly compete for a midwife's time and attention. This culture left women feeling physically 'managed' but emotionally vulnerable. It was counter-productive to the building of women's confidence and emotional recuperation. The atmosphere and encounters reinforced women's sense of alienation and separation from their body and appeared to inhibit development of relationality with their babies, as referred to by others (Halldorsdottir 1996, Lock 1999, Fenwick et al 2000, 2001). However, there were some exceptions to the above in which midwives created situations for women to feel emotionally safe and to grow in confidence. I now turn to these in section 9B.

<div align="center">
<u>SECTION 9B</u>
<u>TAKING TIME - TOUCHING BASE:</u>
<u>DISCREPANT SCENARIOS</u>
</div>

Introduction

In this section I focus upon encounters that assisted women in coping with uncertainty, sensitively encouraged them to persevere, built their confidence (self-efficacy), and supported them in developing the practical skills to carry out breastfeeding effectively. As stated, in a culture like the UK where the bottle of formula milk dominates, women have often had little in the way of previous positive personal experiences of successful breastfeeding and minimal exposure to positive role models who breastfeed, particularly in socially deprived communities. This means that verbal persuasion (encouragement) becomes particularly important (Bandura 1995), along with personal interpretations of bodily states which I discussed in chapter 8. Professional encouragement and confidence building appear repeatedly in the literature as important to breastfeeding women (Ball 1994, Schy et al 1996, Humenick et al 1998, Svedulf 1998, Hoddinott and Pill 2000, Gill 2001, McCreath et al 2001, Hauck et al 2002, Ingram et al 2002). Thus, encounters with what Bandura (1995) describes as self-efficacy (self-confidence) builders would seem to be crucial for women, especially during the first most vulnerable days.

Bandura (1995) highlights some of the characteristics of self-efficacy builders, for example "raising peoples beliefs in their capabilities", structuring situations for them "in ways that bring success and avoid placing people in situations prematurely where they are likely to fail often". "They encourage individuals to measure their success in terms of self-improvement rather than by triumph over others" (p.4). Thus they convey validation and positive appraisals, creating situations in which people can achieve success, "modelling for others how to manage difficult situations", "demonstrating the value of perseverance" and "providing positive incentives and resources for efficacious coping" (p.10). These characteristics of the efficacy-builder are aligned to the care described by Halldorsdottir (1996), as representing a "bridge" (p.530).

Davis-Floyd and St. John (1998) employ the metaphor of the "bridge" as a symbol representing physicians who had undergone a transformative journey from techno-medicine to holistic healing in their attempts to mediate between the paradigms (p.231). In a sense this was what I saw when I observed certain midwives attempting to provide a bridge between a clinical institution with its time driven production line ethos and the personal needs of individual women. In the case of the breastfeeding mother there was also a need to facilitate the women in feeling connected and in relationship with her baby, as emphasised by Fenwick et al (2000, 2001).

There is a dearth of literature relating to the efficacy building role of the midwife in relation to breastfeeding women in hospital. As stated, research on professional assistance for breastfeeding women normally relates to components and timing of a 'package' of information, for example Righard and Alade (1992) Schy et al (1996) Carson (2001), Woods et al (2002). It has placed less emphasis on the types of encounter with midwives that women find enhance or undermine their confidence and contribute to whether they feel enabled or not to persevere with breastfeeding whilst in hospital.

Given the clinical culture in which the midwives were working, I became intrigued as to why some individuals were different in their approach. It became evident to me that these midwives had a profound belief in the value of supporting breastfeeding women. This in some cases was combined with fewer external time/unpredictability constraints upon them and therefore a greater sense of temporal autonomy, even if transient. However, I am unable to record some the comments made about the personal cost to them of 'swimming against the tide' as they wished this to remain 'off the record'.

As stated in chapter 4, I utilised both categorical and non-categorical ways of analysing the data. The latter approach allowed a more holistic reading of the texts that contrasted with the more segmenting approach of the categorical technique. I found that for the data on 'taking time - touching base' encounters, the non-categorical approach yielded a more useful way of analysing the data for several reasons. The data was limited as I saw only few examples of this form of encounter and therefore the examples I saw and heard about constituted discrepant cases. Indeed, as stated, I had to actively search out midwives who worked differently. The data on site 2 to support this section was even more limited as I saw few interactions. I also

found that it was quite difficult to break down the data on supportive encounters in that by its very nature such an interaction was helpful through its multifaceted and synergistic nature. Therefore, I present this data by referring to specific midwives and the ways in which their encounters were supportive to breastfeeding women.

Tasmin: Connecting

Tasmin was a mature midwife with a degree in Midwifery. The day I saw her at her most enabling was when she had come to the ward from clinic because it wasn't busy. She was therefore just helping out with no sense of having to account for her 'output'. She appeared to listen and learn from the mother and respond to her cues, for example during a postnatal examination:

Tasmin (MW3): *How was your delivery?*
Mother talked for a few minutes about her birth. Tasmin actively listened to her story.
Tasmin: *So have you any stitches?*
Julie (P9): *No*
Tasmin: *That's good*
Julie: *But I've passed a clot*
Tasmin and Julie discussed the size of the clot and Tasmin suggested that Julie showed a midwife next time, if possible.
Temperature (under arm) and blood pressure taken. A discussion took place about the birth while waiting for the thermometer. The mother was reassured that the readings are fine.
Tasmin: *How did you sleep?* Short discussion took place about sleep, related to the birth again. The midwife asked her about her other children.
Tasmin: *I'll just feel your tummy-your uterus is lovely and firm-would you like to feel it yourself?*
Julie: *Oh yes-*The midwife guided her hand.
Tasmin: *How are your legs-*Short discussion followed re: cramp.
Tasmin: *Did you breastfeed your other children?*
Julie: *No, this is the first time.*
Tasmin: *How do your breasts feel?*
Julie: *My nipples are a bit sore. He wants to have something in his mouth all the time.*
Tasmin: *He needs to suckle as much as possible because that helps with your milk supply. At first it is colostrum which is very thick and very nutritious. Then your breasts will start to feel full in a day or two and the milk will change, then your breasts will become more comfy again. The milk at the start of the feed is called first milk and then it becomes richer so you need to leave him on for some time. I remember when I fed mine she seemed to like one side better than the other, but I thought it would have been the other side.*
Julie: *Yes, I like my left breast best, but he seems to like my right.* The mother became more animated by sharing of information. *What can I put on my nipples to stop them cracking and that?*
Tasmin: *Well, they may be uncomfortable the first couple of days, but if you get someone to check how he's on your breast then they should feel better. You can express a bit of milk and let air get to your breasts. Next time he wakes up we'll have a look.*
Julie: *Will he need water?*
Tasmin: *No, he doesn't need extra water. Remember as well that each baby is different and often they want to feed very frequently at first, but later they feed less frequently.*
Julie: *How long did you feed yours?*
Tasmin: *Oh until 9 months.*
Julie: *What about her teeth?*
Tasmin: *Well somehow they don't seem to bite you when they have got teeth.*
Julie: *Oh, because I was worried about that.*
Tasmin: *And its good to keep feeding, as it's so full of goodness and protein.*
Julie: *I've heard it reduces eczema?*
Tasmin: *Yes, that's right, it's a good idea. Well he looks great, when he wakes up either I or the other midwife will check him as well. I'll just go and get your postnatal exercise leaflets.*
She came back and discussed postnatal exercises.

This was an encounter in which the midwife and mother did not know each other and yet a rapport was built up quickly whereby the mother was able to explore a range of issues that were of concern to her. Tasmin contextualised breastfeeding with Julie's birth asking her about her birth experience to which she actively listened. She then contextualised it with Julie's life by enquiring about her other children. The encounter illustrates information giving in response to the mother's cues, i.e. *"He wants to have something in his mouth all the time"*. The information was then given in a way to enhance the mother's understanding of the principles underpinning baby-led feeding. Tasmin also sensitively shared personal experiences. I rarely saw this use of self, probably due to the culture within which midwives were working in making them unable or unwilling to draw on and use their own experiential learning as mothers (Kirkham 1989).

The personal revelation offered by Tasmin i.e. *"I remember when I fed mine she seemed to like one side better than the other, but I thought it would have been the other side"* assisted the mother in relating to her and created an opening for her to ask questions: *"Yes, I like my left breast best, but he seems to like my right. What can I put on my nipples to stop them cracking and that?"* A discussion followed about prevention of sore nipples. This use of personal experience in a sensitive way relates to that described by Fenwick et al (2000, 2001). Likewise, Halldorsdottir (1996) refers to this as an aspect of connection, i.e. "mutual acknowledgement of personhood" through "some reciprocal self disclosure, limited, but sufficient to remove the masks of anonymity" (p.34). Tasmin, also emphasised the individuality and uncertainty of feeding: *"Remember as well that each baby is different and often they want to feed very frequently at first, but later they feed less frequently."* I interviewed Julie (P9) following this encounter:

F: *Could I just ask you how you feel after the discussion you have just had with the Midwife?*
Julie: *Well it has stopped me panicking that he isn't getting enough cos he is really.*
F: *Yes, what has reassured you on that?*
Julie: *Cos the midwife breast fed herself, her own babies-she's not just saying it cos she's read it, she's saying it cos she knows.*
F: *How does that reassure you?*
Julie: *You know, she's not just got it out of a book and she's sayin' it. She obviously knows herself cos she's done it 3 times- yeah... Everybody has been so negative, but it's not the case all the time.*
F: *What else did you learn from the discussion?*
Julie: *Well I don't need to give extra drinks, he doesn't need extra and she said I didn't need a dummy, it's just the baby building the supply up. I thought he was just stuck on it cos he wanted a bit of comfort, see I didn't know that. I would have just stuck a dummy in his mouth. So now I'll persevere-I'll try not to give it. I know I'm not gonna be pain free, I'm not naive I know there'll be some discomfort. I don't feel disheartened now. I did, cos of the thought of feeding on my own every hour. I know now it's gonna get harder, but it will be better in the end.*

I had only a brief chance to ask Tasmin about the interaction because she had to "dash back" to clinic:

F: *I notice you share with women some of your own experiences as a mother?*
Tasmin: *Oh, well, I share my experiences in response to intuitive cues. I'm very careful about how I do it. I wouldn't always do it, but I do it with sensitivity when I need to.*
F: *How do you feel that helps?*
Tasmin: *I'm not sure really, it's just something I do fairly spontaneously when I think it's relevant.*

This was the only one of two references to midwives using intuitive cues made during the study which points to the general lack of acknowledgement of its relevance or even existence. Tasmin also demonstrated active listening, a key aspect of caring (Kirkham 1993, Halldorsdottir 1996, Bondas-Salonen 1998, Davis-Floyd and St. John 1998, Fenwick et al 1999, 2000, 2001, Pairman 2000). Davis-Floyd and St. John (1998) emphasise the importance of listening and sharing in recreating a place for the "human values of partnership, relationship, compassion, and caring" (p107). Kirkham (1993) states, "we need to let women speak in order to know their concerns and to improve our ability to listen to women's words and cues" (p.9).

I actively sought to observe Tasmin on a very busy day when she was rushing from one bed to another in order to see how this may have changed her approach. She was asked by Kate (P39) to come and check her breastfeeding. She said to me. *"If you're observing this interaction, it's going to be VERY quick. I've got an antenatal woman with problems over the other side, so I've only got 2 minutes".* The encounter was therefore quite directive but she did get across some key points within a very short space of time:

> Tasmin: *Now lets see what I can do? Are you comfy? Lets take away these extra blankets...that's better, now, aim to put her chest next to yours. Line her up nicely and point her nose to about level with your nipple. Then make sure her mouth is really wide open, yes........ tease her lips with your nipple, that's it, yes, good now bring her on quickly.* Mother does this as Tasmin watches for a minute, then she apologises and goes. The baby attaches well and suckles for a while.

I then asked Kate:

> F: *How do you feel after that time with the midwife?*
> Kate (P39): *Well that's the first time I've been shown what to do. Now I understand what to do. I wish they'd told me that, you know, earlier and I wouldn't have needed to keep buzzing them.*

This very brief encounter was "good enough" (Alan 2000) under the circumstances and the mother was pleased to have been shown, albeit rapidly, how to attach her baby effectively. The encounter illustrates the way in which this midwife changed her approach given the constraints, but did what she felt was most effective. I would have liked to have observed her assisting a woman with attachment when there was more time, but did not get the opportunity as Tasmin was rarely on this ward as she tended to be one of the midwives who was frequently asked to go to delivery suite, clinic or theatre!

Leanne: Touching base

The contextualisation with the woman's birth and life and response to women's concerns was also evident in a dialogue between Leanne (MW17) and Sue (P29). Leanne also supported the mother sensitively through the process of breastfeeding and made time to stay with her for a while.

> Leanne (MW17): Introduced herself. Baby crying. *How are you?*
> Sue (P29): *Oh, all right, but I can't move me-self much.*
> Leanne: *How was your birth?*
> Sue: *Well, I ended up with a caesarean cos the cord came down*
> Leanne: *Oh, did you have a general anaesthetic?*
> Sue: *Yeah, so I'm half asleep now and I can't move around much.*
> Leanne: *Mmm, you'll feel a lot better when you are more mobile. Let's see if we can help you?* She stood by and encouraged the mother to support him. *Can you support him yourself with your arm?*
> Sue: *Yeah*
> Leanne: *Good, now aim your breast up to the roof of his mouth - that's it, I'll just watch.* Baby attached and suckling. *Have you got other children?*
> Sue: *Yeah I've got 2 boys at home.*
> Leanne: *How did you feed them?*
> Sue: *I fed the first one for 2 weeks then I got mastitis and ended up giving up. Then the same thing happened again with my second one, but me community midwife was really helpful so I fed him for 6 months. That was 3 years ago.*
> Leanne: *That's good, you did well....silence* while she observed the feed. *They stop and start, so don't worry. Sometimes when you have a caesarean section it takes a little longer for them to get going. You may find feeding on your side helpful and sometimes skin contact can be useful just to calm him. How does that feel?*
> Sue: *OK, but the after pains are awful.*
> Leanne: *Yes, they'll be stronger when you feed him at your breast, because it's helping your uterus to contract down........ You can see he's starting to take lovely deep sucks. So have your other children been in to see him?*
> Sue: *No they'll be in today*
> Leanne: *Have you got a name for him?*

Sue: *Yes* (name)
Leanne: *Do you feel you have enough knowledge about mastitis?*
Sue: *Um, why do women get it?*
Leanne: *It can be for various reasons, it could be poor drainage if the baby isn't well attached or isn't finishing the breast feed, or a tight fitting bra. The thing to do is to wait until the baby comes off your breast, try not to take him off before he's ready. I've got a very good leaflet on mastitis, I'll bring you a copy when I come back a little later.* (She did this later and talked her through it)
Sue: *Thanks.*

Leanne 'touched base' with Sue by asking about her birth, her other children and her current concerns. This enabled her to then provided useful information that focused upon individual needs and concerns, for example with regards to mastitis. This contrasted with the standard patter seen in many encounters. Leanne also used positive language to emphasise progress, "*You can see he's starting to take lovely deep sucks.*"

Jenny: Taking time, establishing trust and building confidence

I shadowed Jenny over a period of 3 days as she supported Jocelyn (P18) through her 5 day postnatal stay. Jocelyn came from an area with high levels of social deprivation. She had two older children at home. Her current baby was born at 36+ weeks gestation and was also small for gestational age. Jenny was able to follow her through for the duration of her stay carrying out a range of confidence (self-efficacy) building practices.

Jocelyn (P18): *My placenta weren't feeding him proper. I hope he's all right?*
Jenny (MW14): *What do your instincts tell you?*
Jocelyn: *I think he's all right.*
Jenny: *Yes, he's doing very well.*
Jocelyn: *He looks a bit yellow.*
Jenny: *Just slightly, that's common, but the best thing for that is to keep feeding him. We'll put him by the sun after this and let the sun get on his face.*

A little later:
Jocelyn: *Is he feeding all right?*
Jenny: *Your body feelings are the best guide - what do you think?*
Jocelyn: *I can hear him sucking*
Jenny: *Yes and I can hear him swallowing. We can see milk and we know from his wet and dirty nappies. What colour is his pooh now?*
Jocelyn: *Oh it's changed now, It's not black any more.*
Jenny: *Good, that's another good sign. Oh look you can see milk dribbling out onto his chin, that's good.*

Here Jenny assisted Jocelyn in connecting with her body signals and confirmed these by way of reassuring her about the adequacy of her milk. This "process of inspiring confidence in women by our confidence in their abilities" is referred to by Leap (2000, p7). Cronk (2000) believes that this enhancing approach will have further wider ramifications. "Our input in terms of nurturing, enhancing and respecting the development of feelings of parental responsibility will, I believe, benefit society" (p23).

Later Jocelyn suggested giving a bottle rather than cup or syringe feeds to her baby:

Jocelyn: *I just wondered if she would have less wind with a bottle?*
Jenny: *No I don't think so and you would be risking the whole breastfeeding by bottle feeding. You're milk is so wonderful for him, there's just no comparison and especially for a smaller baby it's even more important to breastfeed.*

The value of breastfeeding was referred to in order to encourage Jocelyn to persevere. This was done in a positive way unlike some of the negative encounters in which the health benefits of breastfeeding were referred to in what seemed to be a coercive way, as discussed in chapter 6. Following the interactions Jocelyn commented to me:

I couldn't have done it without the staff here. I mean Jenny has been fantastic. She has been with me every day and has really helped me. They build your confidence by

praise and saying you're doing fine. They're there for ya whenever you need em (Jocelyn, P18).

Jenny came over at the end of an interview I was conducting:

Jocelyn (P18): *We was just praising ya* (laughs) *Is yer 'ead getting bigger* (laughs).
Jenny (MW14): *Well, remember you are the one who has stuck at it. It has been very hard and you've stuck at it, so it's you who you should be pleased with. Well done.*

Thus the midwife gave the praise back to the mother reinforcing her role and underplaying her own. Jenny particularly praised Jocelyn for persevering. Following comments from Jocelyn that Jenny had built up her confidence, I asked Jenny how she had attempted to build her confidence:

Well I kept hammering away that it would get better, it would get easier and that baby was doing very well with that weight and with those problems. I got the feeling that eventually that was filtering through to her, but initially it was just running off her, you know she was just unsettled, insecure, wasn't even certain that she wanted to go on feeding....And that was my conscious tactic anyway, you know, to keep bashing away and that it will be OK and that she was doing very well. It seemed to work. With all that's going on she's got a very poor attention span and there's a sort of low grade chaos surrounding the whole thing. She was often...She would start a conversation and then I noticed she veered off into the distance half way through. She seemed to find it quite taxing to get involved in a sort of planning discussion as to what to do with the next feed. Literally, I would see her just staring out of the window, just cutting off. Um, once I realised that, I tailored my approach towards her, to give less information and to keep the horizons down to the next hour or 2 rather than the long term (Jenny, MW14).

Here Jenny emphasises her growing understanding of Jocelyn's needs and her tailoring of information to meet her individual needs. She recognised that Jocelyn felt uncertain and unsure of herself and needed to be supported by discussion of short rather than long terms issues at this stage. This understanding and tailoring of support could only occur in a situation in which the midwife and mother had time together to get to know each other. The way in which Jenny helped Jocelyn to cope in this context is summed up well by Leap (2000). She uses the metaphor of the journey, in which the terrain is rocky, as she emphasises the value of the midwife and mother "embracing uncertainty together" (p.4):

The midwife provides a map for the woman if she needs one, warning her at the same time that the journey includes uncharted landscapes for which there can be no planning. She points out the sign posts for various alternative routes and warns of hazards to avoid or obstacles that can be circumvented or surmounted (p.15).

One of the key ways I saw Jenny building confidence in Jocelyn centred on emphasising a sense of progress and achievement as seen in the two following extracts.

Jocelyn's baby, who was small for gestational age had required formula by cup during the first 2 days following the birth due to unstable blood glucose levels.
Jenny (MW14) (Following a breastfeed): *I think we need to give a little Aptamil this time, but soon he won't need that.*
Jocelyn (P18): *Yeah, I don't like that stuff anyway.*
Jenny: *It's only very short term because he is preterm. He's needing less and less.*
Jenny turned to me: *It's an intuitive process juggling breast with EBM and Aptamil, but the main priority is keeping him down here and not having him go to NICU. That's been a major achievement.* Turned to mother: *I mean he's had no drips, no tubes, no antibiotics. We really are winning.*

A little later:

Jenny: *Oh that's great, he's really suckling keenly there. We're definitely winning. This is great; he's really progressing. I can see the daylight between the trees. He's coping beautifully. That's splendid, perfect. I think all being well he may be totally breastfeeding from you in the next day or two. Look he's rapidly becoming a normal baby now, he's maturing. He knows what to do.*

Like Tasmin, Jenny referred to midwives using intuitive knowledge. As stated, this was very unusual and as it occurred in two positive encounters suggests to me that the midwives engaging in supportive encounters valued different knowledges, for example intuitive knowledge.

Jocelyn appeared to see the midwife as the participants in Fleming's (1998b) study did as "being for" her or "attending" (p140):

> Oh all that time with Jenny, she were there regular like, you know same midwife doing the cup feeds an that. I mean when he kept having the injection like in his foot (heel prick) I were all for going over to that Aptamil cos it would stop him needing it like. But Jenny kept saying come on, keep going it's best for the baby and I'm glad she did like. She knew exactly what was going on (Jocelyn, P18).

One of the most striking observations I made when observing Jocelyn and Jenny was the way in which Jenny was there for Jocelyn forming a relationship with her. This relationship was assisted by there being continuity of carer, but it was more than that. It was a relationship of trust. As stated, this ability to form a trusting relationship is now emerging in the literature as enormously beneficial to women and the quality of their maternity care experience (Halldorsdottir and Karlsdottir 1996a,b, Halldorsdottir 1996, Edwards 2000, 2001, Fenwick et al 2000, 2001, Pairman 2000, Curtis et al 2001). Jocelyn's trust in Jenny appeared to be fundamental to the incremental confidence building that took place. As Edwards (2000) research showed: "Where trust was the foundation of the relationship between the woman and her midwife, the woman interpreted her experience in terms of growth and change" (p.77).

Jocelyn also emphasised that Jenny had time for her: "She seems to have more time than the others, they're all rushing around - you know they seem to be very busy but Jenny, she spends time with you". This resonates with the findings of Curtis et al (2001) who reported that maternity care clients described staff who "made time for them" as giving "good care" (p.128). Hoddinott and Pill (2000) likewise emphasised the way in which women valued midwives spending time with them. However, Jenny pointed out that the opportunity to follow a mother through and develop a relationship was quite unique:

> I've been involved with Jocelyn from transfer to this ward. It's one of those lovely situations where she's had the same person most of the time and the same advice. I mean so often you see someone one day, you set things in motion and the next day someone else has scuppered it and the person is bottle feeding. In this case the night staff have carried on as I have and so she's had no conflicting advice. The thing is this is the exception. We've been quiet over the weekend. I've spent hours with her. Normally though she just wouldn't have got anything like this attention and she would have ended up most probably with the baby in NICU. She's got a very poor ability to retain information and she just could not have coped with minimal attention. Then because of lack of staff she would have ended up separated from the baby, and all that extra time and expense would be involved with a baby on neonatal unit. That is what happens when there aren't the staff. It's just been lovely to be able to support someone through this process like this (Jenny MW14).

This relates to Fleming's (1998b) concept of the midwife identifying herself as "being with" the woman or "presencing" (p.140). However, Jenny did recognise that things could have been different:

> Things could have been very different, if the ward was very busy and I wasn't able to communicate the support she was needing to others. I mean what so often happens is that the midwife just pops her head round the curtain and says where have you got to, what is she doing or whatever - right I'll be back in quarter of an hour, half an hour. That might have done for some people, but I don't think it would have done for Jocelyn. She'd have said hold on, what do you mean, what did you say and wanting it repeated. I think it would have been really really difficult with her. Thank goodness it wasn't. I don't know but that would be my guess as to what would have happened (Jenny, MW14).

When I asked Jenny how her care might have changed in a busier situation she stated:

Well, I think there's more pressure when you're busy, not to discuss things and just to tell a mother what to do, and because most mothers, particularly in a stressed situation like that will just do what you tell them...and its very easy to fall into a situation where you almost exploit that. I mean given the current staffing situation you cannot give woman centred - care. I mean I would hope I still discuss things with women and try to discuss things with them. But it's incredibly difficult with someone who's a bit slow, who needs time, time to burst into tears and then settle down afterwards, without saying anything.

Jenny remarked regarding Jocelyn's perseverance and gave her the credit:

I just feel that that was a wonderful case. It just illustrated all the problems, with some of her problems as a mother thrown in regardless of the baby. She found it difficult to take in information.... I take my hat off to her for her perseverance, given how upset and tearful and wobbly she felt at the beginning, she stuck at it very well.

Jenny had worked hard to create the relationship she knew would support, encourage and build Jocelyn's confidence and help her cope with her emotions. However, it was clear to me that providing this type of care left Jenny marginalised and isolated among the majority of the staff. She was working against the prevailing culture on the postnatal wards to form meaningful relationships based on trust and to provide a high level of support. The challenges of achieving this within divisive and hierarchical settings in which this form of care is not the norm is dramatically highlighted by a series of works by Kirkham and colleagues (Kirkham 1999, 2000, Edwards 2000, Kirkham and Stapleton 2000, Kirkham and Stapleton 2001a, Ball et al 2002, Stapleton et al 2002, Stapleton et al 2002d,e). As Fleming (1998a) states in relation to midwives who take the lead from how the woman feels:

Midwives, in attempting to practice within a framework which is different from that of the dominant medical model of birth, and which is accepting of the women as a partner in her own experience, are.... basing their clinical judgement on knowledge which does not come from traditional Western epistemologies (p11).

In contrast, as Wilkins (2000) asserts, the western "professional outlook" of midwifery has made it "conceptually blind" to the processes that make a relationship "special for mothers" (p.29).

To summarise, Jenny touched base with Jocelyn in several ways. She followed her through her hospital stay until discharge and she made considerable time for her. She built up a relationship of trust with Jocelyn and used an approach that was based upon understanding her as an individual. She made clear plans of support that were carefully communicated to the staff who came on at the next "shift". She praised Jocelyn, she built her confidence and she encouraged her to persevere, by providing small short team goals. She helped her to cope with the uncertainty and emphasised progress being made. She encouraged Jocelyn to listen to intuitive cues thus helping her to feel competent at making judgements herself.

Kim: Building networks

Kim was pregnant and worked part-time. She was 'not allowed' to be called to delivery suite due to being pregnant, therefore when she came onto the ward she felt more secure. She appeared to connect with the women because she was pregnant. She shared of herself and women saw her pregnancy as an opening point for conversation. The encounters were non-directive and woman-centred. In the following extract from my field notes I illustrate how she created an atmosphere which assisted women in developing a network of support from other mothers:

I observed Kim (MW15) during a morning. She was based in one bay where she largely stayed, focusing particularly on a woman who had just returned from having a Caesarean Section under GA and who needed a lot of assistance with breastfeeding. The woman spoke little English, so I didn't approach her. Kim was sensitively assisting the mother with breastfeeding, quietly observing the feed and also making herself available to the other women. The other three women were also breastfeeding. The three other women asked her questions about her forthcoming baby and her existing family, which she answered as a mother to mother. They also asked her many questions of concern to them that she answered in a very non-directive and non-

authoritative way drawing on her combined experience of being a mother and a midwife. She had a very facilitative style, drawing the mothers into the conversation. The women started to chat among themselves with increasing freedom and confidence both when she was there and when she wasn't. I observed a huge amount of exchange of useful discussion and suggestions related to breastfeeding and parenting in general, which was clearly the women's main concern at this point (Field notes).

This facilitation of what Leap (2000) describes as the fourth "C" – "Community" (p.8), involving encouraging the development of supportive relationships and enabling women to learn from each other is commonly overlooked in hospital. The limited visiting hours often make it difficult for women to communicate effectively with their community network of social support. The system by which the woman could only phone out using a portable phone that was often much in demand or out of order creates a further barrier to communication with the outside world. The importance of psychosocial factors such as sensitive social support, particularly network support and social cohesion upon health and well being is being increasingly recognised (Sarafino 1994, Wilkinson 1996). Wilkinson (1996) referring to anthropological evidence argues that collectivism, sharing and reciprocity were cultural norms, globally, for most of human existence until the outset of capitalism and consumerism, bringing with them a philosophy of individualism.

The 'chatting' between Kim and the women in the bay was akin to that described by Fenwick et al (2001). They describe this sharing generated by "chatting"- i.e. relating, exchanging and sharing lifestyles. They refer to talking changing the atmosphere. Yet in their study only 12 % of communications at the bedside contained examples of chatting. The facilitative interaction was described as:

> No one person appeared to be guiding the turn taking or setting the agenda. Women were 'noted' to be engaged in the conversation, asking questions of the nurse and leading the discussion. The nurse appeared comfortable in the exchange. Both participants shared equally and the interactions were characterised by a sense of equality (p.588).

They noted that self-disclosure by the nurses, through informal chatter encouraged similar disclosure by the woman, enabling nurses to access the woman's world. They were sharing rather than telling. They noted that elements found in "chat" to include, "asserting similarity", "displaying empathy", "calming reciprocity" and using "conversation politeness gestures", all enhanced the other's sense of self (p590).

Turning to site 2, as stated, there was less opportunity to observe interactions. There were some differences between site 1 and 2. Firstly, because women were behind curtains on site 2, they tended to call the midwife when they wanted her. The midwife would answer the buzzer and attend to the woman's concern. This meant that the ensuing agenda was less midwife dominated than on site 1 with the postnatal check often being conducted at the same time as a call. The midwives appeared to be socially and culturally more similar to the women than on site 1 which may have contributed to there being slightly less of a professional barrier between the midwives and the mothers than was evident on site 1. The time spent with women varied, depending on midwives anticipation of staff being needed elsewhere at short notice.

The approach whereby midwives provided information when a mother buzzed was perceived as acceptable to women, as illustrated by Millie:

> Millie (P43): Like they have been helpful, like whatever I've asked really...... but they don't interfere too much either cos.....I was saying they just leave you alone, but I've realised what they're actually doing is coming when you need them, when you ask for them and they tell you then what you need to know...... They're not giving it you all at once, saying you should do this and you should do that, you know, trying to tell you cos I'd just forget it all anyway (laughs).......Yeah, cos the first night I didn't have a clue like, luckily she just latched on and she took to it so, I s'pose if I'd been having more difficulties they might have been there more but...
> Partner: They don't come with a big list like and say this is what you've gotta do.
> Millie: I know that's what I'm saying, like I'd forget, I'd be panicking, thinking they told me to do this and they told me to do that....

I followed this teenage mother, Millie, through for three days during which her partner was with her most of the time and there was very little input at all from the midwives related to breastfeeding. However, the mother appeared to be feeding her baby very effectively, so it was felt that she didn't need any additional information. While this lack of "interference" was clearly appreciated by Millie, others developed sore nipples and one stopped breastfeeding probably due to insufficient attention as discussed in earlier sections. Again an individualised approach is the only way that support needs of a given person can be provided effectively but without continuity of carer this is difficult. There were situations on site 2 in which the midwife already knew a mother from delivery suite. This appeared to make a difference to communications, as may be seen in the following interaction.

Sandy: Building a relationship

Sandy was the midwife who supported Selina during her labour and birth, so the dialogue showed a clear link up with earlier discussions. It was contextualised with the birth. The midwife had also got to know the partner. She remembered aspects of the mother's physical as well as emotional well being.

> Sandy (MW30): *How are things?*
> Selina (P48): *Oh, well, I was up all night feeling very excited.*
> Sandy: *Yes, it's all so different isn't it. Has your husband been in?*
> Selina: *He's coming in later, with his parents from London*
> Sandy: *Will you have some time on your own with him?*
> Selina: *Yes, after they've gone.*
> Sandy: *That's good, cos like we were saying yesterday, you're a threesome now and your relationship changes, but you need to have some time together.*
> Selina: *Yeah, he had some time on here last night, but he was tired too.*
> Sandy: *Oh, he looked tired. OK, I'll go through your check, check your tummy and everything, check your stitches and then we'll look at her and bath her and get her feeding, all right?*
> Selina: *Yeah*
> Sandy: *How are you feeling ?*
> Selina: *Just exhausted, totally exhausted.*
> Sandy: *You need to catch up on your sleep. When she's sleeping, you sleep and at home the same. Forget all the bits of jobs you can see around you, they can wait, but when you can catch up on your sleep. Jean (the physio) will be popping in to see you later. She'll help you through the exercise programme.*
> Selina: *That's good*
> Sandy: *Do you feel as though you are hungry today?*
> Selina: *Yes*
> Sandy: *Oh good. You don't feel as though you've got a temperature?*
> Selina: *No*
> Sandy Took her pulse. *How's the feeding been? Did you use the niplette?*
> Selina: *Well, I didn't need to because ....in the labour ward they showed me how to feed on my side, which worked really well.*
> Sandy: *She did really well on the labour ward as well, didn't she, she really got on your poorer side if anything, she did really well!*
> Selina: *It's just.... you know..... comforting to know when I go home if I need it just in case.*
> Sandy: *Well, if you feel the need, it's there isn't it, but you know, stay in until you're ready to go home. Don't feel you've got to rush out tomorrow or anything.....Now your breasts are going to be soft, for about three days, then you'll feel them start to get fuller. You might get some pain when you feed as it helps your uterus to go down.*
> Baby starts crying, mother turns to her.
> Sandy: *You'll find you have one ear open all the time for the baby.*

Sandy completed the postnatal check and then demonstrated a baby bath. The encounter was two-way, with the mother asking questions intermittently, for example:

> *"Can you use baby wipes on the face?"*
> *"How do you know what temperature to have the water?"*
> *"Is that a good baby bath solution to use?"*
> *"When should I bath her?"*

"Should I put scratch mittens on her?"

It was clear that because Selina had already got to know the midwife that she felt quite comfortable asking questions. This was one of the very few examples that illustrated a change in the nature of the encounter related to the midwife and mother not being strangers.

Summary

In this section I have highlighted some of the ways in which midwives 'took time' and 'touched base', that is touched the personal experience of women and supported them in relation to breast feeding their babies. The strategies utilised included contextualising breastfeeding with the woman's birth and personal experiences in general. There were examples of active listening, sensitive use of self and an individualised approach to care. Ways of building self-efficacy included assisting women to connect with their own bodies and baby's signals, validating the mothers experiences, encouraging and praising her and emphasising progress and achievement. Women were supported with understanding the principles of effective feeding as appropriate to their situation. Midwives found ways of making enough time to meet the needs of the women. Opportunities to create networks with other women were created. Sadly, these examples were very few as relationships between mothers and midwives were almost impossible to establish and few of the midwives appeared to truly seek ways of working in connection with women or indeed even appeared to have the desire or ability to do this.

The question that arises from the data in chapter 9, is how can we reconstruct a culture in which the concepts of embodiment, relational skill and caring/nurturance are celebrated and made possible in postnatal midwifery practice? How may the midwife-mother relationship be one which values connected encounters in which midwives touch base with women meeting their individual needs in the context of their lives? How may we ensure a dramatic move away from an instrumental, technical and authoritative approach to breastfeeding women which causes them to feel that they are reduced to being productive yet subjected? To what extent can real change be achieved within an NHS maternity unit given the origins, nature and culture of hospital institutions? I now address these issues in chapter 10.

CHAPTER 10
'PRODUCTIVE YET SUBJECTED':
DISCUSSION AND CONCLUSIONS

People want everything in black and white.....but being a new mother and breastfeeding are not like that at all. Breastfeeding is like midwifery, you have to wait and see what happens, you don't know what is going to happen next. You have to go with the flow.......There's no answer to breastfeeding - it's complicated, people have different lives, different circumstances, different pressures from outside. I know that from my own experience of breastfeeding. Then midwives bring their own attitudes, you know. It's very complicated (Virginia, MW20).

Introduction

In this critical ethnographic study I have explored the postnatal ward experiences of sixty-one women who commenced breastfeeding. Through observations and related interviews with mothers and midwives, the postnatal ward cultural milieu within which women breastfeed their babies and midwives work is highlighted. In this chapter I discuss some boundaries/limitations of the study and the ways in which I have extended knowledge. I draw together the thematic networks to synthesise parts into a whole and make recommendations for transformative change and further research.

New territory

This study extends existing knowledge in a number of ways. It is the first critical ethnographic study that focuses specifically and exclusively on the range of influences upon women's experiences of breastfeeding in UK postnatal wards. Women's experiences are inevitably impacted upon by a combination of wider socio-cultural influences in addition to the specific events taking place within the postnatal ward. I illuminate this blend of influences through analysis and presentation of the data. In this way I unite a macro-political economy of health perspective with a micro focus upon the postnatal ward culture and the personal experiences of women as they engage in the embodied experience of breastfeeding in a specific cultural setting. This blend of micro and macro is crucial to a critical medical anthropological perspective (Frankenberg 1980, Csordas 1988, 1994a,b, Singer 1990, Lyon and Barbalet 1994). In this way, I provide a new area of exploration to critical medical anthropology and add to midwifery knowledge. I utilise a range of concepts: 'production'; 'linear time'; 'separation/space'; 'authoritative knowledge'; 'surveillance' and 'control' to illuminate the issues raised within the data.

One of my key foci is upon the interactions between midwives and postnatal women, as this constitutes a major part of women's experiences while in hospital. While focusing upon the nature of health professional-client encounters to inform my analysis, I also critically examine the nature of the culture within which these interactions take place and the ways in which this cultural milieu influences midwives in their approaches. Therefore, I emphasise the interaction between structural constraints and agency on the part of both mothers and midwives. In this way, as led by the data, I draw parallels between midwives and mothers within the postnatal ward culture in illustrating that they are both 'productive' yet 'subjected' (Foucault 1977, p.26).

In theorising about this data and considering the implications, like others, I have to accept that development of any form of breastfeeding meta-narrative as empowering for women is inappropriate (Carter 1995, Schmied 1998, Blum 1999). However, I believe that transformative action is possible through awareness raising of the social, political and economic 'limit situations' and a consequent confrontation with 'limit acts' (Peters and Lankshear 1994). In this way, the macro-micro connections, so fundamental to critical medical anthropology are maintained. To confront limit acts requires collective action and this in turn requires collective conscientization (Freire 1972). In order to theorise about these limit situations or constraints upon women and their breastfeeding projects, whilst connecting theory with praxis, I turn to five key areas that emerge for transformative action. I argue for: a reconsideration of the way in which women's bodies are portrayed; a re-conceptualisation of women's time; reconfiguration of knowledge about breastfeeding; re-visioning of the mother-baby and midwife-mother relationships; and relocation of the place and space in which mothers commence breastfeeding. I explore the implications of my findings for women *and* also for professional practice within these five areas and I subsequently make recommendations for further research.

Boundaries/Limitations

This study involved two maternity services and a total of three postnatal wards. It therefore cannot be said to represent the postnatal ward experiences of women across the UK. As is acknowledged within anthropology, cultures may vary considerably from place to place. Nevertheless, the findings I report regarding the constraints upon midwives and the experiences of women have many resonances with other ethnographic accounts within UK maternity services (Kirkham 1999, Woodward 2000, Kirkham and Stapleton 2001b). The study was not set up as a comparative ethnography of two units, rather I selected a second site to add depth. There were nevertheless some differences between units that I have highlighted in support of my analysis, although there were substantially more similarities.

I had intended to collect data in the same way on both sites, however, as discussed in chapter 4, it was difficult to observe interactions on site 2. Nevertheless, I was able to conduct in-depth interviews with women and their accounts provided considerable insight into the interactions that had taken place. The contrast between the sites in terms of the (in)visibility of women was indeed useful in understanding the nature of the private-public overlaps and the ways in which surveillance was operationalised and resisted. I was not able to conduct as many interviews with midwives as I would have liked as they were too busy on site 1 and largely inaccessible on site 2. As stated, when I did speak with midwives, they pointedly steered the agenda away from interactions with women and towards the ways in which the hospital culture constrained them. I had not expected this barrage of negativity, but looking back I should have done! This fortuitously strengthened my analysis rather than weakening it.

This was not a study of the Baby Friendly Initiative (BFI) *per se*. Neither unit could be described as a 'Baby Friendly Hospital' and therefore I cannot make statements about the nature of a fully accredited unit. However, the BFI and 'Ten Steps', featured in several ways in issues raised through the data. I therefore examine these issues in relation to the unit's partial engagement with aspects of the 'Ten Steps' and the BFI.[112]

The study findings may have been different for an integrated midwifery service.[113] This was not the case in either maternity unit, with site 1 having a separate community and hospital midwifery service. On site 2, the midwives self-selected to work predominantly within the hospital *or* community. I had not anticipated this manipulation of the 'system' on site 2 and had therefore believed initially that I would be observing within an integrated system. Nevertheless, other research in areas where midwives do cross the community-hospital interface illustrates some striking differences in the ways of working of the *same* midwives when in hospital versus the community (Lock 1999, Hunter 2002, Lock and Gibb 2003). In this way, the "power of place" (Lock and Gibb 2003, p.132) is highlighted, with midwives being more institutionally-orientated while in hospital and more woman-centred while in the community (Lock 1999, Hunter 2002, Lock and Gibb 2003). This institutional orientation was very striking in my data.

Connecting the networks

The experience for the women in this study may best be illustrated by the metaphor of the production line and its accompanying notions of efficient production and supply, against linear time, with all of the associated demands upon those engaged in the production process. The postnatal ward was the final hospital stop of a medicalised journey in which women's bodies were subjected to multiple measures and timings of the quality and pace of their productivity. On the postnatal ward they entered a place in which they were engaged in a new form of productivity involving the making and delivering of their breast milk to their young baby. This was a part of the project of motherhood to produce a new citizen who could meet the needs of society.

Women conceptualised their bodies as vessels that were apart from them and functioning (or not) despite them. There was a sense of alienation and separation from the product, breast milk. These dualistic understandings of their bodies were reinforced within the hospital setting through the mechanistic monologues of midwives. Women's productive projects were largely

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[112] It would have been interesting to conduct this study in a fully accredited 'Baby Friendly' hospital but this was not possible as discussed in chapter 4.
[113] An integrated midwifery service involves the midwives regularly crossing the community-hospital interface.

viewed by the women themselves as transient and temporary as they planned, even at this early stage, for their return to their 'normal' productive lives with return to paid employment being a central consideration.

There were three dimensions to women's productive projects; supplying, demanding and controlling. They saw themselves as producing and supplying milk. However, almost without exception, women expressed doubts about their 'bodies' ability to do this. The exceptions were among those who had previously breastfed and for whom the experience had been a positive one. Women reflected their deep mistrust in the efficacy of their bodies and a profound lack of personal confidence in breastfeeding. When conceptualising their bodies in this way, as machines, the task was inevitably seen as demanding. The demanding nature of breastfeeding also related to the unpredictable way in which women's babies 'demanded' breast milk and thereby breached their once ordered temporal boundaries. In addition, the baby made indentations into their spatial and bodily boundaries. Women often felt wary of their baby 'depending' upon them in this way.

It was particularly striking that women spoke repeatedly about breastfeeding as if it were simply breast milk feeding. There was rarely a notion of relationality with the baby. It seems then unsurprising that the task was seen as demanding as the act of breastfeeding was understood as a one-way transfer of nutrition. Without the two-way reciprocity of a relationship, the act of providing for another is experienced as depleting. While the hospital culture in itself could not account for women's perceptions of their bodies and bodily functions, it played a reinforcing role. The combination of lack of confidence, fear of chaos, unpredictability and sense of planning for the future, led to women trying to maintain their boundaries and control breastfeeding through making plans to incorporate 'bottles'. This was commonly seen as a necessary and desirable progression towards independence for mother and child and return to normality. Technical aids were seen by some women as assisting them to cope.

Women were not only 'productive' but they were also 'subjected' (Foucault 1977, p.26) to ideologically pervasive and authoritative notions that 'breast is best' and 'correct ways to breastfeed', both of which created pressures upon them. Women's felt pressures to perform and provide were compounded by feelings of discord related to a 'natural' process often being experienced as complicated and challenging. Nipple soreness and fatigue constituted two particularly strong challenges for women. In combination, these led to women seriously reconsidering their desire to persevere with breastfeeding. While these pressures are not unique to the hospital experience they were strongly reinforced by the atmosphere of surveillance.

Surveillance was experienced in relation to authoritative versions of 'correct breastfeeding', with exclusive breastfeeding being the most predominant. On site 1, the structure of the wards resembled the 'Panopticon' (Foucault 1977), an architecture that allows midwives to see all. The midwives were themselves under surveillance as they too were required to 'do the correct thing...in the right way' in line with a policy that enshrined the 'Ten Steps'. The Foucauldian (1977) reference to the 'subjected' body is not utilised here as referring to complete inscription and subjection. Both midwives and mothers exercised a degree of agency, with a range of accommodations and resistances being manifested.

Surveillance did not simply stem from institutional regulation of breastfeeding and the power of authoritative knowledge. Women were also ever conscious that they were carrying out an intensely personal and culturally private activity in a highly public place, in which they were surrounded by strangers. The hospital setting therefore magnified one of the major dilemmas for mothers in breastfeeding, the breaching of public - private boundaries. Women were very aware of their breastfeeding act as transgressing cultural norms that breasts were primarily sexual items. Consequently, women adopted a range of techniques for creating a private place in a public domain. The use of curtains on site 2 was a particularly powerful illustration of women's ways of negotiating the sexual versus maternal body contradictions.

In the hospital setting, women were largely separated from family, friends and community networks at a time during which they were recovering from pregnancy and birth and coping with the newness of mothering a baby. They had to rapidly adapt to another place, the postnatal ward. Given this set of challenges they sought emotional support, encouragement and confidence building. The encounters with midwives, in most cases, did very little to meet these needs and indeed were often counterproductive.

The midwives themselves were 'productive' yet 'subjected'. They were heavily constrained by linear time, in that their work was unpredictable and rushed, coping with women who were usually complete or almost complete strangers. Their work was like that of production line workers; time pressured, routine, disconnected, fragmented and unsatisfying. In this context they saw themselves as 'supplying' a service under extremely 'demanding' conditions. They were required to do the correct thing as required by the institution, under surveillance. Despite the pressures, pain and fatigue they persevered, day after day.... Like the mothers their work was conducted 'out of relationship' or relational context and this meant that their actions were seen as 'one-way' and therefore draining. Midwives engaged in ways of coping with the pressure and chaos. This included adopting rituals and routines and approaching women in disconnected, monologic, directive and managerial ways. The focus appeared to be upon the needs of the institution first, mothers and babies second.

The parallels between mothers 'supplying' breast milk and midwives 'supplying' a service are immediately both striking and alarming. The inevitable consequences for the postnatal women were that their needs for support were largely unmet and the encounters they experienced increased their emotional vulnerability and their alienation from their bodies and babies. Equally, midwives' needs were neither met through the organisations nor through their relationships (or lack of them). They too were emotionally vulnerable and alienated.

Rethinking breastfeeding bodies

Breastfeeding is undoubtedly an embodied experience and in discussing women's bodies I am ever mindful of the well rehearsed but little resolved dualistic feminist debates related to sameness or difference. These debates focus upon women's dilemmas as to whether they would prefer to strive to be recognised and respected for their differences or sameness in relation to men (Humm 1992, Van Esterik 1994, Shildrick 1997). As Shildrick (1997) argues, whichever of the positions are held, women will be blamed for their inadequacies as individuals and seen as inferior to men and the "male prototype" (p.31):

> Whatever forms the dominant representation has taken, the bodies of women, whether all too present or disconcertingly absent, have served to ground the devaluation of women by men (p.14).

Shildrick (1997) proposes that it is the "body itself in whatever physical form it is experienced, which positions women as both morally deficient and existentially disabled" (p.14).

As I discussed in chapter 3, breastfeeding creates particular dilemmas for feminists with regards to the sameness or difference debate (Van Esterik 1994, Carter 1995, Galtry 1997a,b,c, 2000). Breastfeeding is a culturally mediated bio-psychosocial activity and, as such, there is an interaction between the physical body and social world. The data generated through this thesis highlights ways in which women's bodily experiences appear to be heavily influenced by the concept of public place production, both conceptually and in the sense that the imperative to 'work' at least partially influenced their plans during the first days of breast feeding. Women often saw their bodies as being a means of production and yet they seemed to be strangely alienated from the product, describing to me a striking lack of trust or confidence in their body's ability to 'produce' milk. The demandingness of breastfeeding and the imperative to plan for the future contributed to this distancing.

I therefore contend, in this thesis that my data represents an extension of Martin's (1987) industrial model applied to labouring women. Like the labouring woman, the breastfeeding mothers expressed alienation and separation from the production process, breastfeeding, and from the product of their labour, breast milk. While the breasts replace the uterus as the operational machines, women profoundly doubted their ability to produce and deliver the product effectively, efficiently, on time and in the right measures. Given the limitations of women's 'machinery', management and control was required and this was conducted by the hospital midwives, referred to by Kirkham (1989) in her labour ward study as "shop floor workers" (p.132). The baby, conceptualised as the consumer, was also seen as separate and indeed independent. The alienation and separation from both women's bodies and babies was reinforced by being in a highly public, unfamiliar place, surrounded by unknown people in a setting in which breastfeeding was institutionally regulated and managed. The alienation was compounded by profound experiences of fatigue and for some of the women, nipple pain.

Women are clearly engaged in a 'productive' project and I suggest that part of this involves creating a dependent consumer paradoxically capable of early independence from her/his mother. Bottle feeding with formula milk marks progress in this direction. In this way women engage in the construction of citizens that will be relatively comfortable with the corporate control over food production, supply, purchasing and consumption, in line with capitalist ideology.

Having extended Martin's (1987) model from a labour to breastfeeding situation, I further elaborate upon the model in several ways. While Martin (1987) referred to women's bodies being monitored by machinery, she did not extend this through to a Foucauldian perspective of surveillance.[114] I have therefore added complexity to the notion of productive bodies by introducing the concomitant concept of the 'subjected' body (Foucault 1997). Secondly, I focus in parallel on the productive experiences of the 'shop-floor workers' and highlight the ways in which the culture within which midwives work contributes to both their own and the women's disconnected and alienating experiences. Thirdly, I highlight some of the further paradoxes related to women and 'their' (re)productive machinery, as I now discuss.

The embodied experience of 'exclusive' breastfeeding may be used to illustrate some of the paradoxes, contradictions and dilemmas created through the data with regard to women's experiences of their bodies. Given the hegemonic influences of a patriarchal and technocratic society's values upon women's attitudes and beliefs about themselves and their bodies is it appropriate to argue that most women could reach a position of total trust in exclusive breastfeeding? Even if they did totally trust their bodies they might well *not* want to engage in this form of feeding. With this dilemma in mind and the strength of women's reliance on supplements to breastfeeding I partially embrace Haraway's (1991) post-modern conceptualisation related to women and machines. Through reading Haraway (1991) I became strangely aware of what she describes as the growing 'leaky distinction' between people and machines (p.152). She argues that we are all to some extent leading cyborgified lives, describing a cyborg as a "theorized and fabricated hybrid of machine and organism" (p. 151). Being a cyborg then, she states, is about:

> Transgressed boundaries, potent fusions, and dangerous possibilities which progressive people might explore as one part of much needed political work [....]. A cyborg world might be about lived social and bodily realities in which people are not afraid of permanently partial identities and contradictory standpoints (p. 154).

Haraway (1991) suggests taking "pleasure" in the "confusion of boundaries" (p.150). She sums up this position:

> Cyborg imagery can suggest a way out of the maze of dualisms in which we have explained our bodies and our tools to ourselves [....] it means both building and destroying machines, identities, categories, relationships, space stories (p.181).

However, I remain unconvinced of Haraway's "pleasure" when she makes statements such as "machines are disturbingly lively and we ourselves frighteningly inert" (p.152). Nevertheless, Haraway (1991) does provide a "unitary paradigm" (Pujol 1999, p.106) that avoids clearly dichotomising the 'natural' from the 'technological'.

The key issue for me when considering the place of technology in women's embodied breastfeeding experiences still relates to the crucial questions posed by Jordan in conversation with Davis-Floyd (1998) that it is not whether technology is "good or bad" but "who controls the technology, who owns it, who can speak authoritatively about it, and for whose benefit is it used?" (p.273). From a feminist, political economy of health perspective, I see the combination of doubt and mistrust in women's bodies and the concomitant use of those same bodies, in the public domain - fuelling the capitalist economy, often under exploitative conditions as intricately connected with patriarchal dominance. I am passionate about seeing an increase in trust in women's bodies by women themselves and others in relation to breastfeeding. This could empower *some* women to see the need for technical aids and supplements as unnecessary and

even undesirable. I also see dualistic and mechanistic notions of the body and breastfeeding as limiting possibilities for women.

However, I no longer hold the rather dualistic notion that any form of supplementing or attenuation of breastfeeding simply represents a negative pole in opposition to the 'natural ideal'. This position would support the judgmental notion that breastfeeding in certain ways fall short of 'doing the correct thing...in the right way'. This position simply perpetuates the 'breast or bottle' dualism with all its dangerous and binding possibilities and advocates what Van Esterik (1994) describes as "politically correct breastfeeding - the idea that there is only one way to breastfeed" (p.73).

My position then requires me to acknowledge the range of detrimental influences upon women's experiences of breastfeeding. I would extend Dumit and Davis-Floyd's (1998) point that 'our culture has naturalised technobirth' to our culture has naturalised techno-breastfeeding. This means that, for some women, a supplemented or attenuated form of breastfeeding may meet their perceived needs for a time...at this time, in this culture. I therefore wish to argue for a reversal of dualisms such as exclusive breastfeeding or bottle feeding as this can be highly problematic for women given the current cultural constraints.

However, acknowledging difference and diversity in the way women breastfeed need not necessitate disembodiment. I believe that women could come to recognise and celebrate the concepts of embodiment, relationality and caring/nurturance, whilst avoiding a return to essentialism. Secondly, I believe that as part of a collective project we need to re-establish trust in ourselves as women, our bodies and the art of breastfeeding but without returning to a form of essentialism that simply binds women to reproduction. This requires a collective effort by women to erode the dominant, male-orientated base metaphors applied to our bodies away from those centring on efficient production aided by machines and devices. This requires theorising new forms of female embodiment, as suggested by Shildrick (1997):

> What a feminist project might aim to do is to uncover the mechanisms of construction, flaunt the contradictions and transgressions which destabilise the binaries, and insist on a diversity of provisional bodily identifications. The move towards embodied selves need not entail a new form of essentialism nor a covert recuperation of biological determinism. Rather it celebrates embodiment as process, and speaks both to the refusal to split body and mind, and to the refusal to allow ourselves to be either normalised or pathologised. At the same time to stress both particularity and substantiality for the female body challenges the universalised male standard and opens up for us new possibilities of (well) being-in-the-world (p.61).

If women's bodies are inscribed, at least in part by powerful notions of efficient production and linear time, as the data in this thesis supports, then a crucial aspect of rethinking 'breastfeeding bodies' stems from a re-conceptualisation of time, to which I now turn.

Re-conceptualising time

The data illustrated that women's experiences of breastfeeding were heavily influenced by linear time and the associated pressures. Women were coping at the same time with the past, present and future. They were coping with the past events of pregnancy, and previous experiences of mothering in some cases, and their more immediate experience of labour and birth. They were living in the present with all of the pressing matters of new motherhood and breastfeeding. Most striking and unexpected was the way in which they expressed the linear sense of time running on and out. Breastfeeding was then experienced as time consuming, impeding, or potentially impeding more pressing calls upon women's time. The sense of urgency in relation to time was powerfully reinforced by the ways in which midwives communicated their own time pressures to women. This required women to compete for time in order to protect themselves from time 'going' elsewhere.

The conceptual lens through which I viewed this data stemmed from the contrasting notions of cyclical and linear time (Cipolla 1967, Kahn 1989, Adam 1992, Bellaby 1992, Helman 1992, Starkey 1992). As Kahn (1989) asserts, linear time is so deeply embedded within western culture that any other notion of time is rarely considered. It is a time that is pitched relentlessly towards the future and is centred upon the notion of efficient production. Cyclical time, Kahn (1989) argues, is a bodily, rhythmic time that is a part of ones' ontology and not separate and

'outside' like a linear time. Whist I agree with Kahn's differentiation between linear and cyclical time, my data suggested that linear time had indeed become a powerful part of women's being or ontology. This requires me to shift in the direction of Foucault's (1977) theorising on time, in that he states "time penetrates the body and with it all the meticulous controls of power" (p.152).

However, unlike Foucault, I argue that we *can* reconceptualise time and in turn change our ontology. After all if some of the limits or constraints upon women's time were lifted.... for a time..... then their perceptions of their breastfeeding bodies would, I believe also change. Breastfeeding would not be seen as simply using time up and taking time from other activities. Kahn's (1989) notion of maialogical time, I believe, has enormous possibilities for changing our notions of time and restoring time for women to engage in breastfeeding their baby in a more fulfilling way. However, as she again asserts, maialogical time may be seen as part of "birth time" for women but it may not be helpful for them to feel that it must continue throughout motherhood. This could recreate the tensions around essentialist notions of mothers being confined to the childcare role, the so called "full time earth mother" (p.31). She argues that:

> Uncorseting our maternal bodies does not have to be incompatible with living in linear time, providing that this time moves forward more slowly and with more digressions. Thus there would be time out for children [....]. Perhaps the time will come when both productive and reproductive labour will be honoured equally. Not the tokenism of Mother's Day, but an appreciation expressed through the reorganisation of work structures to accommodate the uncorseted maternal body (p.31).

Forman (1989) likewise argues that feminisation of women's time should "resist the definition of woman as nature". It should not mean a return to a form of "lunar consciousness nor a celebration of women's natural cycle" (p7,8). Simonds (2002) also argues for changing conceptualisations of time as she warns us against the strictures imposed by the medical model's clock. She states:

> Time is not only money, as the well-known aphorism claims. It is also power. If we take the time to reconsider these models, perhaps with time, demystification may lead us toward the reconceptualisation of procreative time and the enhancement of procreative experiences (p.569).

Political activity is needed to restore the possibilities for women to take 'time-out' for mothering and breastfeeding, should they wish to do this. Seventy percent of women with babies currently return to work within nine months of birthing. Therefore, combining paid employment, usually away from the home, with child care is now a key issue for the majority of women (Maternity Alliance 2003). It is also clear that returning to work constitutes a key reason for women reducing or stopping breastfeeding (Bick et al 1998, Hamlyn et al 2002). The recent extensions to UK maternity pay and leave in line with EC guidelines is a positive move that reduces penalties upon vulnerable low paid part-time workers, whose rights were often very limited.[115] Prior to these changes a third of women returned to work before their 18 weeks of Statutory Maternity leave end because they couldn't afford to stay off work (Maternity Alliance 2003). Improving maternity rights, pay and work place flexibility through statutory processes has had a marked impact upon the duration for which women breastfeed within Scandinavian countries (Austveg and Sundby 1995, Gerrard 2001, Galtry 2003).[116] Clearly such statutory recognition sends powerful messages related to valuing parenting.

However, providing women with 'more time' will not necessarily lead to an automatic reconceptualisation of time. This would require, as Adam (1992) states, recognition of the:

> Difference and the continuity between the times of becoming and the time of created invariability, the times of life and the times of death. We need to lift time from the level of the taken-for-granted meaning to an understanding that knows the relation between

the finite resource, birth-death and being - becoming, between chronology, the seasons and growth. We need to de-alienate time: reconnect clock time to its sources and recognise its created machine character (p.163).

With this recognition, women, as Forman and Sowton (1989) argue, could be encouraged to seek to subvert the power of time over their bodies by creating rhythms of their own. Merleau-Ponty (1962) likewise argues that time needs to be understood as a dimension of our being and not as a transfer upon ourselves of a phenomenon that is external.

It would be tempting to suggest that midwives could assist women in reconceptualising time in this way, so that there is an opening up of possibilities for women as they embark on motherhood. However, midwives would need to reflect on the ways in which *they* were controlled by time and indeed controlled time to even begin to engage with women on this issue. Sadly, my data shows that, for midwives on a busy postnatal ward, there were powerful constraints of linear time upon their own bodies as they worked in settings that resembled early factories. Not only were they subjected to pressing linear time, but to an experience of unpredictability, so that they never knew at any time how much or little time they might have to complete their tasks. It needs to be remembered that as Lynch (2002) argues, "hospitals are organised as corporate work places overseen by managers whose job is to economise health care and in the case of privatised health care, make a profit" (p.180). Within this model, as demand outstrips supply, like other public services, hospitals are always likely to be under resourced and it is the personal aspect of the service that is usually sacrificed. As Lipsky (1980) states:

> There are several ways in which street level bureaucracies characteristically provide fewer resources than necessary for workers to do their jobs adequately. The two most important are the ratio of workers to clients or cases and time (p.29).

Unrelenting pressure upon midwives time is a key source of oppression. As Lynch (2002) argues, we have lost our understanding of the "rhythm of work and rest", of "being" as well as "doing", of recognising the need for "spaces of contemplation, meditation and mediation" (p.184). The political ramifications of the pressures upon midwives time are enormous and *pressing*. The growing literature that relates to the misery experienced by many midwives working within UK NHS hospitals illustrates this only too vividly (Kirkham 1999, Woodward 2000, Kirkham and Stapleton 2001b, Ball et al 2002, Hughes et al 2002, Deery 2003). Midwives are currently the main group of health workers and supporters of women during the postnatal period. Therefore, urgent political action is required to radically restructure the current maternity 'system' in the UK to address the now clear understanding that midwives as an oppressed and disempowered group are in turn disempowering women.

A reconceptualisation of women's time, both midwives and mothers, would be an essential part of any transformative action. There would need to be recognition that women need time in order to give time to others. This in turn requires recognition that caring time is cyclical and rhythmical allowing for relationality, sociability, mutuality and reciprocity. A crucial aspect of reorganising the maternity system would necessarily require a re-visioning of midwife-mother relationships and I believe that in turn this would support a re-visioning of early mother-baby relationships, issues I now turn to.

Re-visioning relationships

Human experience in any situation is hugely impacted upon by relationships (Merleau-Ponty 1962), and these appear to be particularly influential during periods of emotional vulnerability, with new motherhood being a striking example (Ball 1994, Halldorsdottir and Karlsdottir 1996b, Barclay et al 1997, Fenwick et al 2000, 2001). Through observing and listening to women and midwives in an institutionalised maternity setting, the postnatal ward, I have been able to build upon existing theory centring upon the nature of encounters between midwives and mothers (Kirkham 1993, 1989, 1993, 1997, Halldorsdottir and Karlsdottir 1996b, Halldorsdottir 1996, Fenwick et al 1999, 2000, 2001, Lock 1999, Lock and Gibb 2003). The majority of encounters I observed resonated strongly with those for which the metaphor of the "wall" referred to by Halldorsdottir (1996) applied. They also commonly conformed to the notion of "inhibitive nursing action" referred to by Fenwick et al (2000, 2003) in a neonatal unit.

I further extend the 'caring/uncaring' encounter literature by critically highlighting the nature of the culture within which midwives were working, thus connecting with and extending the focus of other critical accounts within midwifery (Kirkham 1999, Woodward 2000, Kirkham and Stapleton 2001b, Ball et al 2002, Hughes et al 2002). In extending this synthesis further, I turned to literature that supported understanding of the development of the types of encounter I most commonly saw. Hunter's (2002) theory centring upon emotion work within midwives in the UK came to my attention while writing up the thesis and provided an additional depth of insight into my data. The ritualistic, routinised, disconnected and managerial approaches of most midwives reflected, at least in part, their inability to gain any satisfaction through relationships with women. The tyranny of being under constant pressure of linear time combined with intense unpredictability were additional but central components to midwives' emotion work. Midwives developed satisfaction through completing tasks, getting through the work and indeed getting off duty. Taking this analysis further I focus upon the striking parallels between mothers and midwives, with regard to the constraints upon them, in experiencing relationality within the postnatal ward context.

The women were subjected to superficial, formal, intermittent and time-pressured encounters at a time when they were very emotionally vulnerable and lacking in confidence with breastfeeding. To consider the issue of confidence and ways in which it could be built or undermined, I turned to self efficacy theory (Bandura 1982, 1986, 1995). While this has been examined in positivistic ways with regard to breastfeeding women (Dennis 1999, Dennis and Faux 1999 and Blyth 2002), it has not been applied specifically to theoretically support qualitative research in this area. Through understanding the crucial aspects of confidence-building encounters, those that create situations in which women feel emotionally supported, encouraged and validated, I have been able to identify some of the encounters that supported women in meeting the challenges they face when breastfeeding during the early days. However, as I have highlighted, the individuals who engaged in this confidence-building form of encounter struggled to create a relational context within which to achieve this. This was highly challenging within a cultural milieu in which midwives were primarily attending to the requirements of the institution rather than those of the women (Lock 1999, Kirkham and Stapleton 2001b, Shallow 2001a,b,c,d, Ball et al 2002, Hunter 2002, Deery 2003, Lock and Gibb 2003).

The breastfeeding woman enters another new form of relationality, with her baby, that of intimately sharing her body with another (Hewat and Ellis 1984, Bottorff 1990, Wrigley 1990, Driscoll 1992, Leff et al 1994, Dignam 1995, Lock 1999, Schmeid and Barclay 1999, Shaw 2003). This relationship may be experienced by women as a harmony, synchrony and mutuality (Hewat and Ellis 1984, Bottorff 1990, Wrigley 1990, Leff et al 1994, Schmeid and Barclay 1999). However, from my observations and through listening to women I became aware that women's relationships with their babies were commonly placed 'on hold' while on the postnatal wards. There was a striking absence of a sense of breastfeeding as a relationship between mother and baby. Relationship was rarely spoken about between mother or midwife or to me during conversations and interviews. This silence on relationships related in part to the way in which women conceptualised their bodies and breastfeeding, as discussed.

Breastfeeding a baby in a public place, surrounded by strangers and having to constantly compete for a midwife's time and attention created counterproductive conditions to the building of women's confidence and to their sense of emotional well-being, both important to the development of a relationship with one's baby. The absence of reinforcing and validating midwife-mother relationships while in hospital appeared to contribute to a delay in early mother-child interaction, as referred to by others (Halldorsdottir 1996, Lock 1999, Fenwick et al 2000, 2001). As I have stated, if midwives are unable to relate to women in a relational context they are unlikely to inculcate a positive relational feeling in women.

The parallels and connections between midwives and mothers are immediately striking and as I studied the data I became aware that any sense of 'giving' by both mothers (to their babies) and midwives (to women) in the postnatal ward setting was experienced as largely one-way and therefore draining. This was actually and symbolically characterised by what Frank (2003) refers to as monologue. In contrast, Frank (2003) argues that being with another is exemplified in meaningful dialogue: "Dialogue is wanting to touch (not necessarily literally) each other in ways that expand us both, leaving us both more than who we were before" (p.9). In this way, Frank (2003) argues, we may engage in a generosity that does not constitute a one-way giving,

rather "generous care - care that proceeds through dialogical relations and shifts the burden from any individual into a space between" (p.11).

So how may we move closer to a dialogic situation? If midwives were able to experience relationality with women they would not only 'give' but also receive emotionally (Hunter 2002). Likewise, if women could go beyond the one-way notion of 'giving out' to their baby and conceptualise breastfeeding in a more symmetrical relational context, then giving to a baby would be seen as part of a reciprocal relationship in which the mother also receives. This would both require and support a move away from women simply seeing themselves as labourers whose machines (breasts) may be emptied and refilled in order to supply the consumer. However, I do not wish to create an essentialist meta-narrative that implies that all women *should* experience breastfeeding in positive relational terms during the early days of breastfeeding. However, I believe that within a supportive culture to include caring relationships, women would be more likely to experience relationality with their babies. I argue that for this to be actualised while in hospital, then a meaningful relationship between mother and midwife must be made possible.

Given the time constraints upon midwives within the postnatal ward settings, it may be appropriate to mobilise alternative forms of support for women while in hospital, as an interim solution. Two such schemes have recently been explored as part of a portfolio of seventy-nine DH funded infant feeding projects (Dykes 2003). Clarke et al (2002a) engaged La Leche League trained peer counsellors to hold breastfeeding support sessions on postnatal wards for women. Midwives were encouraged to attend as a means to integrate the services and enhance the peer-professional interface, although they were often unable to do this due to pressure on their time! This programme of additional support was positively evaluated by the women using the service, by the peer supporters and the midwives. Other peer support projects involve the peer supporters visiting postnatal wards as a part of their networking with new mothers (Dykes 2003). Peer supporter involvement on postnatal wards holds promise in that it restores a sense of community network support to an institutionalised setting, as also described by Merewood and Philipp (2003) in the USA. This additional form of peer support that crosses the community-hospital interface appears to be likely to develop further in the UK under comprehensive Sure Start programmes.[117]

Sookhoo and King (2002) employed six health care assistants, two within each of three maternity units as supporters for postnatal breastfeeding mothers. The assistants were provided with a specifically designed training programme by the local university. Again, the scheme was positively evaluated by midwives, supporters and mothers. This model differs from the peer support programmes in that it utilises existing hospital employees to provide the support and it remains to be seen to what extent, over time, they too become constrained in the ways midwives do, by growing demands on their services, time restrictions and the needs of the institution. This model of additional support therefore requires further longitudinal exploration and evaluation. It also has to be stated that this model constitutes a way of keeping the cost of support down and, given the low value placed on interpersonally satisfying relationships within the NHS, this move should be viewed through a lens of political scepticism.

Moving to a more radical position, from my analysis and that of others in related contexts (Lipsky 1980, Hunter 2002), it seems unlikely that 'tinkering' with the current system of institutionalised postnatal care will achieve much in changing the situation for women. As mothers and midwives, we need to be empowered to incorporate relationality into our epistemology and ontology, but we must ensure that we enable this to be actualised not simply theorised. The postnatal ward culture, as described in this study, is prohibitive to the shift to a relational conceptualisation. The data therefore supports a radical reappraisal of midwifery practice to enable the forming of meaningful relationships between mothers and midwives at this emotionally vulnerable time for women.

It seems that midwives exert peer pressure upon each other in an attempt to maintain institutional status quo (Kirkham 1999, Ball et al 2002, Hunter 2002, Deery 2003). Therefore, to change a culture it seems unlikely that encouraging individuals to change their practice will be successful. We need collective resistance and transformational change to introduce models of

[117] Sure Start is a UK government initiative to provide community health care and education, with a particular focus upon socially excluded communities, as part of the government's commitment to halve child poverty by 2010 (Department for Education and Skills 2003).

postnatal care that enable midwives to engage with women meaningfully, in relationship *and* with sufficient time to do so. This can only be achieved via strong and collective actions through midwifery networks and organisations. Clinical supervision[118] would appear to be a clear way forward, as advocated by others (Deery 1999, 2003, Woodward 2000, Clarke et al 2002b, Hunter 2002). However, I argue that the changes required are unlikely to be achieved while women are receiving postnatal care in a medicalised, hospital-based setting, a point I return to later. I now go on to argue that the ways in which breastfeeding knowledge is generated and 'delivered' require reconfiguration.

Reconfiguration of knowledge about breastfeeding

I have focused within this thesis on the impact of 'Enlightenment' thought with its rationalistic and dualistic underpinnings upon the development of knowledge regarding the body and women's (re)productive and infant feeding practices. I have argued that the techno-medical model reached an authoritative status that has systematically and progressively subordinated other knowledges, in particular those held through the traditional, collective and embodied experiences of women within specific cultures and communities. The powerful 'authenticicty' of the scientifically-based knowledge supported the construction of a professional expertise and prowess that became increasingly difficult to challenge. As Jordan (1997) states, "the power of authoritative knowledge is not that it is correct but that it counts" (p.58). However, as I have illustrated, over the last century there have been major fluctuations in what is considered to be 'authoritative' knowledge regarding infant feeding.[119]

The most striking oscillation in authoritative knowledges may be seen in the attempts this decade to reverse the medically advocated regimentation of breastfeeding based on new understandings of the physiology of breastfeeding (Woolridge 1986a, 1986b, 1995). The global BFHI constitutes one of the key mechanisms through which change is being managed in hospitals. However, as I have argued, this initiative raises many dilemmas that illuminate the complexities inherent with regard to translating knowledge(s) into practice. The difficulty in critiquing these issues has created a tendency for avoidance. The political-economic breastfeeding 'advocates', for example Palmer (1993), tend to support the BFHI wholeheartedly in its attempt to 'tackle' aggressive marketing of infant formula and the regimentation of infant feeding. The post-structuralists prefer to distance themselves, in that they label all professionally generated knowledge and related discourses as authoritative and therefore highly questionable (Carter 1995, Blum 1999). These authors tend to carefully avoid reference to the physiology of breastfeeding as this would represent a cross into biomedical territory. A more discursive approach is provided by those who cross the 'health professional-sociological' boundary such as Schmied (1998) and Schmied et al (2001) who have a background in midwifery and/or nursing but clearly engage, with confidence, with sociological and in particular post-structuralist theory.

There *is* a huge and growing body of research that highlights that breastfeeding appears to confer physiological benefits upon the mother and child (Wilson et al 1998, Anderson et al 1999, Oddy et al 1999). There is also a growing understanding of the ways in which breastfeeding women may be supported in effectively attaching their baby to their breast in a way that enhances the physiological process of lactation, satiates the baby and minimises nipple trauma (Woolridge 1986a, 1986b, 1995, Righard and Alade 1992, Renfrew et al 2000). This issue, as stated, is rarely discussed within sociological critiques and yet it is embraced by the voluntary breastfeeding organisations, in that they pay considerable attention to supporting women with attachment and effective feeding practices. Indeed, it seems that women are highly appreciative of skilled support with breastfeeding from breastfeeding counsellors and/or peer supporters (Dykes 2003).[120] However, a fundamental difference lies in the approaches adopted by voluntary supporters. As stated in chapter 2, they adopt a person-centred, dialogic and individualised approach that acknowledges the importance of women's experiential and embodied knowledge. This means that they engage with women's agendas and tailor the principles of effective breastfeeding to women's individual needs.

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[118] Clinical supervision refers to a mechanism within practice settings whereby teams of midwives or nurses are facilitated in discussing models of care, reflections upon practice and issues of concern. The term 'clinical supervision' is however, rather unfortunate given its Foucauldian connotations.

[119] This is exemplified in the current juxtaposition of baby-led/demand feeding advocates with those who continue to recommend the imposition of control and routines for babies.

[120] Qualitative data generated from service users of both peer support and breastfeeding counsellor programmes indicates the strength of women's appreciation of skilled woman-to-woman support (Dykes 2003).

By contrast, as the data in this thesis illustrates, when breastfeeding information and support is provided in hospital, by midwives, it is commonly issued in a routinised, prescriptive, authoritative manner that disregards the personal agenda of the woman. The encounters, as stated, are time pressured and monologic. This approach conforms to the techno-medical ideology which, as Doyal and Pennell (1981) state, emphasises "the physical and the quantifiable at the expense of the psychological and phenomenological" (p226). The resulting inequality in power renders two-way dialogue between equals almost impossible to fulfil (Kirkham 1993, Stapleton et al 2002b). The professional is assumed to have the expert and authoritative knowledge and the mother to be a passive recipient of the wisdom imparted (Jordan 1997, Edwards 2000). This authoritative approach within a setting in which women have to compete for midwives' limited time contributes to their emotional vulnerability. The didactic approach of the midwives also contributes towards an undermining of women's confidence in their bodies and their ability to breastfeed. Of even more concern is the situation that Cronk (2000) describes whereby the "power over women" which accompanies this transmission of authoritative knowledge at the beginning of their experience of parenting may contribute to an ongoing process of female disempowerment (p.23).

There is now a major emphasis in the UK upon the promotion of breastfeeding as a public health issue (DH 1995, 1999, 2000, 2002). The provision of information on the health benefits of breastfeeding also forms a key aspect of step 3 of the BFI 'Ten Steps'. While there is indeed a substantial basis for the provision of this information to women the ways in which it is being conveyed, within some organisations, creates pressure for women, as I illustrated in chapter 6. This promotion of breastfeeding is often not counterbalanced by effective support for women. Therefore, women appear to be commencing breastfeeding in hospital, influenced by the strong promotional messages, but are then conducting breastfeeding within an environment that resembles a factory production line with little in the way of a supportive infrastructure. This imbalance between *promotion* and *effective support* appears from the data to be highly problematic for women's emotional well-being and sense of personal confidence with breastfeeding.

The 'Ten Steps' encompassed by the BFI constitute a medically mediated institutional norm and indeed ideology that, when operationalised within hierarchical and medicalised institutions, create a series of challenges for midwives and mothers.[121] The policies and rules, when applied within specific institutions, are being implemented in a manner that has the potential to override women's agendas in ways that resemble some of the regimented practices of the early twentieth century. Midwives experience subjugation of traditional and experiential midwifery knowledge and in turn they subjugate women's experiential knowledge (Kirkham 2000b). However, as Wright (1998) argues:

> No ideology, however hegemonic and entrenched in institutions and in everyday life, is beyond contest; 'culture' is a dynamic concept, always negotiable and in process of endorsement, contestation and transformation (p.5).

Wright's (1998) assertion was evident in this study, in the ways in which midwives on both sites engaged in subverting aspects of the 'Ten Steps' that they considered to be inappropriate. Nevertheless, the power of an enforceable policy centring upon the 'Ten Steps', operationalised with rigidity, upon women's ways of negotiating breastfeeding was evident, particularly in relation to the 'exclusive' breastfeeding on site 1. This led to feelings of pressure, subjection and surveillance (Foucault 1976, 1977, 1980), making breastfeeding in hospital emotionally 'unsafe' for women. It seems that a breastfeeding reality is being constructed that is often impossible to achieve and hence increasing women's sense of dissonance.

Site 2 only partially engaged with the 'Ten Steps'. However, the situation here was equally problematic for women. There was an absence of effective support, based on principles of effective breastfeeding. Midwives tended to draw on their own experience in largely unhelpful ways and there was a readiness on the part of midwives to utilise formula at the first sign of difficulty with breastfeeding, as reported by Cloherty et al (2003). This contrast between site 1 and 2 illuminates the dilemmas. On the one hand a breastfeeding policy, that seeks to avoid the situation described on site 2 may improve the standard of information provision and support

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[121] As stated earlier, even units not directly engaging with the BFI are usually employing the 'Ten Steps' to some extent.

but, on the other hand, may potentiate an already rigid, institutionally orientated approach that is equally detrimental for women.

There are inherent challenges in making recommendations based on the arguments above. If I am to question the nature of authoritative knowledge, how then do I promote another standpoint? As Willig (1999b) argues, to engage in a post-structuralist never ending cycle of reflexive deconstruction would tend to dissolve a person's standpoint before s/he had taken it up. However, in asserting my 'middle position', I argue that we *can* learn from *other* ways of knowing and make recommendations for transformative changes. I therefore argue that knowledge about breastfeeding generated through scientific methods cannot be disregarded outright simply because it stems from techno-medical disciplines. However, such knowledge should not be considered as more legitimate than women's embodied knowledge simply because it constitutes 'evidence-based' enquiry. Insights from this field have a place, *but* their position must be alongside, and not above, the knowledges generated through the experiences and accounts of women. The meanings of breastfeeding for women may be presented as they stand without theorising (Brown and McPherson 1998) or within theoretical frameworks. These knowledges need to take account of the embodied, emotional and social nature of breastfeeding, the ways in which women negotiate breastfeeding in a range of cultural contexts *and* the macro-political influences upon women in relation to their infant feeding patterns. It is this synthesis of perspectives that I seek to provide within this thesis.

As midwives involved with supporting breastfeeding women, I argue that we need to learn from women's experiential and embodied knowledges and from the voluntary organisations and peer support programmes. This requires that midwives are facilitated in exploring their own personal and vicarious experiences of breastfeeding, as argued by Battersby (1999, 2002), so that they may use 'self' when appropriate and in ways that support, not undermine. Midwives would then be more likely to respect knowledge generated from women's personal and embodied experiences. Midwives would require a working knowledge of person-centred counselling to include learning to *listen to women* and a concomitant knowledge of the principles underpinning effective breastfeeding. By combining person-centred counselling with supporting effective breastfeeding, women's individual needs may be met while at the same time information that is supportive to them is provided effectively and in dialogue. In this way the principles of effective breastfeeding constitute a guide *not* a prescription and support confidence building and encouragement. This approach would also enable midwives to support women if they decide to combine breastfeeding with formula feeding or indeed consider changing from one method of feeding to another.

Advocating this approach causes me to question the place of an institutional policy and associated monitoring and surveillance with regard to breastfeeding. I suggest that there needs to be an implementation of mechanisms to support midwives in reflexive practice that enables them to collectively consider the issues related to supporting breastfeeding women and the implications of their practice. This need to address the reflexive cycle of professional practice, as recommended by others, could take place via clinical supervision and within midwifery education (Deery 1999, 2003, Woodward 2000, Battersby 2002, Clarke et al 2002b, Hunter 2002). The approach to this should facilitate not simply personal reflection upon practice but critical engagement with broader socio-political issues (Hunter 2002), thus allowing for *collective* understandings of limit situations and limit acts (Peters and Lankshear 1994).

Having embraced a critical outlook and developed an understanding regarding ideological tensions and dilemmas, midwives could collectively engage in the development of flexible guidelines *in collaboration with* breastfeeding support groups and service-user representatives. Any guidelines should acknowledge the primacy of women's own knowledge and the local cultural context. The 'Ten Steps' could be utilised as a catalyst for these reflective and inclusive discussions and may indeed provide a framework for development of flexible guidelines. I am not therefore arguing for a dismantling of the global BFHI but rather a reconfiguration to enable it to support a flexible, discursive, culturally sensitive engagement with local needs in relation to women and breastfeeding.

However, having observed the settings within which midwives are charged with the role of supporting women, I argue that it is pointless to simply target midwives with these messages. While the educational programmes and clinical supervision networks should be utilised to facilitate midwives in developing the skills to support women in effective ways, this is still only a part of the picture. To educate midwives in this way and then release them into current clinical

environments, like the ones described in this thesis may simply raise their levels of dissonance and dissatisfaction. I therefore argue for a more radical agenda that offers real alternatives to midwives and women through the provision of non-institutionalised postnatal settings. I expand upon this point in the next section.

Relocation of the place and space in which women commence breastfeeding.

The emphasis upon spatiality as part of human experience (Merleau-Ponty 1962, Berger and Luckmann 1966) has gained growing attention as medical geographers (Pain et al 2001, Cartier 2002, Mahon-Daly and Andrews 2002), sociologists (Casey 2003, Halford and Leonard 2003) and midwives (Lock and Gibb 2003) focus attention upon place and space in the health service.

In this study, women's spatial boundaries were dramatically redefined as they shared their external body and internal fluids with their baby through breastfeeding. This contributed to women's felt demandingness of the baby, given their conceptualisation of breastfeeding as transfer of nutrients. Additional time at the breast was seen as the baby using women as a 'dummy'. Further complex boundary issues arose through the issue of bedding-in. Women endeavoured to retain some personal identity and space, within a public place, with the curtains utilised as a barrier. However, in reality, they had little claim to any space and were subjected to strangers entering their personal space in unpredictable ways to include moving into their bodily space through handling of their breasts and related activities associated with postnatal care. In addition, women were obliged to breastfeed in a public place, contributing to feelings of dissonance and requiring considerable personal negotiation of their situation. Both mothers and midwives come under a powerful gaze in this public setting (Foucault 1980).

The hospital is not the mother's territory and therefore can never become like home, despite attention to architecture and furnishings. It is a place where women are removed from their community, where medical management is super-valued and rituals and routines thrive. The institutional orientation created by hospital settings inevitably reduces relationality and woman centredness, as asserted by others (Lock 1999, Allan 2001, Kirkham and Stapleton 2001b, Shallow 2001a,b,c,d, Ball et al 2002, Hunter 2002, Deery 2003, Lock and Gibb 2003). Lock and Gibb (2003) highlight the enormous power of the hospital place over both midwives and women. As they assert, it a place of physical, emotional and spiritual alienation and is therefore counterproductive to independence, confidence and emotional recuperation for women. While hospital may be seen as a place of safety, should something 'go wrong', as Lock (1999) argues, it is *not* emotionally safe. While it is not my purpose to evaluate postnatal care *per se*, I agree with those who challenge the largely unproven need for routine and often time-consuming examinations and observations on postnatal wards (Marchant 1995, Fraser and Cullen 2003).

In focusing upon women's embodied experiences, the power of linear time, authoritative knowledges and relationships, I challenge the suitabilty of the hospital as the place in which women begin to establish breastfeeding.[122] I believe that it is now time to radically change the place in which postnatal support for women is provided. While a hospital setting will always be required for some women and desired by others, if an appealing alternative was offered then women might well opt for it. I argue that women could be offered postnatal care in their own home, but with increased support. The savings in resources by de-medicalising postnatal care would enable a relocation of resources to community care.

As stated in chapter 2, studies have failed to show any advantage with regard to breastfeeding duration when comparing standard hospital postnatal care to early discharge and care in the community (Waldenstrom et al 1987, Svedulf 1998, Margolis and Schwartz 2000, Winterburn and Fraser 2000, Sheehan et al 2001, McKeever et al 2002). However, it was clear within these studies that women appreciated the one-to-one support with breastfeeding, provided in their own home in addition to the comfort, privacy and rejoining their family.

While the above studies all employed a nurse or midwife to provide the additional community support this is not the only model available. Recent studies have assessed the efficacy of providing additional community support for breastfeeding women in the form of health care

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[122] I also challenge the suitability of hospital as a place for birthing for the majority of women and if this issue were to be addressed, women would receive their entire postnatal care in the home following birthing either in their own home or a birth centre. I also advocate independent midwifery as an alternative to the current system, in that even when in community practice midwives are still somewhat accountable to their nearby institution, as cogently illustrated by Edwards (2000, 2001). However, the discussion here relates to women who continue to birth in hospital within the NHS.

assistants who were provided with a training package on supporting breastfeeding women (Beake and McCourt 2002, Foyle and Wilson 2002). These schemes were extensively evaluated and appeared to be highly supportive to breastfeeding women. Other recently implemented alternatives that hold promise for community postnatal breastfeeding support include paid peer supporter schemes (Battersby 2001a,b) and/or paid breastfeeding counsellor/supporter schemes (Ginty and Umusu 2002, Spiby et al 2002). While these models require further evaluation in a range of settings they offer hope for real change. I now proceed on to discuss areas for research development stemming from this study.

Future Research

There are several areas highlighted within this thesis that warrant further exploration. It would be particularly useful to conduct a comparative ethnographic study focusing on breastfeeding women's contrasting experiences at home following home birth or early postnatal discharge from hospital and birth centres.[123] This may support my suggestion for a radical review and relocation of place in which women commence their breastfeeding journey. I also suggest that a range of studies is needed to research the comparative differences between voluntary breastfeeding supporters and midwives in supporting breastfeeding women[124]. This should involve ethnographic work involving observation of interactions. Further research that explores alternative ways of supporting women on postnatal wards with breastfeeding needs to be conducted to include peer support schemes and schemes engaging designated employees.[125] Finally, research needs to continue into the influence of the BFHI upon organisational culture and midwives and women's experiences and interactions within a range of global settings. This could take the form of longitudinal research with units from initial engagement with the BFHI to accreditation and beyond. Participatory action research might well be appropriate for this form of exploration.

Conclusion

Breastfeeding is a complex relationship between mother and baby, the wider family and community. It is a fluid, literally and metaphorically, ever changing process influenced by the counterbalancing effects of past events, the daily lived experience and future plans. Women's experiences are influenced by their corporeality, temporality, breastfeeding knowledge(s), relationships and place. The postnatal ward experience is temporary and transient in a series of medicalised steps from pregnancy through to the ongoing project of motherhood. Inevitably, the influences upon women while on a postnatal ward reflect the interaction between the immediate issues generated within the specific cultural milieu and wider socio-cultural considerations. The hospital culture both reflects and reinforces many of the constraints upon women when breastfeeding and upon midwives in providing support and it acts as a powerful marker along the journey towards motherhood. Within this setting both mothers and midwives are engaged in 'productive' activities under considerable emotional pressure in a highly public place, open to many observers.

The ideological pervasiveness of breastfeeding as 'doing the correct thing....in the right way', is at its most powerful in the hospital setting. This is particularly evident when breastfeeding practice is heavily institutionally regulated. Women experience pressure and dissonance as reality and expectation clash and they accommodate and/or resist authoritative knowledges, cultural ambiguities and associated surveillance of their bodies, within public places. The hospital constitutes a place in which linear time is always in 'short supply', yet reified and randomised, creating major challenges for mothers and midwives in coping with their daily activities. 'Supplying' for another's needs within a cultural milieu, and indeed macro-culture, in which linear temporal pressures are magnified and possibilities for relationality minimised leads

[123] An NHS Research and Development funded study being conducted at Leeds University by Marshall J, exploring the ways in which evidence on infant feeding is translated into practice by health visitors and midwives in community settings, may yield some useful comparative data (Mother and Infant Research Unit, Leeds 2003).

[124] I was recently a member of a team involved in conducting a study that started to explore this area. The DH funded project involved developing four vignettes from focus group data generated with adolescent mothers. A group of midwives and BfN supporters were then asked to provide a written response regarding the ways that they would support a young woman in this situation. In-depth analysis of this data is currently being conducted by Shuck C at the University of Central Lancashire. The study also involved assessment of breastfeeding knowledge and skills of both groups utilising a pre-validated breastfeeding skills tool (Hall Moran et al 1999, 2000). The scores for the BfN group were significantly higher than for the midwives (Hall Moran et al in press).

[125] As stated earlier, such schemes have recently been implemented and evaluated (Clarke et al 2002b, Sookhoo et al 2002, Dykes 2003) but further research would be valuable.

to both mothers and midwives experiencing their work as 'demanding'. While demandingness remains the predominant feeling, breastfeeding will continue to be seen as short term, marginal and disruptive, as will 'caring' by midwives. Both then have to construct ways of coping with and controlling their situation.

Despite the challenges, most mothers and midwives persevere through the troubles and triumphs, the pain, fatigue and special moments. The nature of the encounters between mothers and midwives within hospital reflect the time driven, rule bound, institutional orientation of midwives and the ways in which both groups feel the pressure and cope with chaos. Both breastfeeding mothers and midwives are indeed 'productive' yet 'subjected' in this setting.

Through this study, I seek to represent the experiences of breastfeeding women as an integrated paradigm in several ways. Firstly, the hospital-based study reflects the complexity of women's experiences of breastfeeding and their active participation in negotiating this experience within a specific cultural milieu. This micro-perspective that stems from the meanings for women when engaging in a breastfeeding 'project' in UK hospital settings is then contextualised within a macro-political economic perspective. The latter highlights the constraints upon breastfeeding women in relation to continued medical centralisation and management of (re)productive activities, the power of commercial influences, the reification of linear time and the devaluing of women's embodied experiences and relationality within a western patriarchal society. By combining the micro perspective with the macro, the balance between recognition of individual agency and structural impositions is achieved.

Secondly, I argue against purely essentialist notions that all women may be empowered to breastfeed, simply through socio-political and health practice reform. While I argue that social policy should indeed recognise the competing demands upon women and their need for flexible options with regard to their various forms of work, I also assert that full consideration needs to be made for the contemporary cultural context within which women breastfeed. This requires recognition of the embodied, emotional and social nature of breastfeeding and the ways in which women negotiate the experience. Thus social policy should enable but not coerce women to breastfeed and the ways in which breastfeeding is promoted should strongly move away from maternal duty and essentialist notions of mothering.

I argue for a balanced approach to Protecting, Promoting, and Supporting Breastfeeding (WHO 1990) to allow for a considerable increase in the protection and support and a reduction in promotion. This requires a clear redefining of breastfeeding as both a relational and socially valued activity while moving away from a model in which the body becomes little more that a potentially dysfunctional machine producing, supplying and transferring nutrients to a consumer. This re-balancing would make way for flexibility within individual women's circumstances at a given time within a specific cultural context. I therefore argue for a balance between the political economic and post-structuralist feminist perspectives, thus focusing upon constraints for breastfeeding women while valuing and recognising difference.

In combining theory with praxis, several issues need to be addressed - from social policy level through to breastfeeding supporter practices. Maternity legislation needs to enable women to have the time and space to engage in breastfeeding as an embodied activity, while still maintaining a career. Women would not then have to make a choice between abandoning their career but neither would they be obliged to become a disembodied career woman whose expressed milk provides their only connection with their baby. If women anticipated this 'time out' without financial loss then their postnatal period might be considerably less pressured. If women understood the concept of maialogical time and were able to incorporate it, at least partially, into their lives, they might feel less pressured about their babies need to take their time. However, women may still decide that they prefer to bottle feed, or prefer to express, or return to work early and these positions too should be accommodated. Perhaps it is time to rethink what constitutes liberation for women and having time to work flexibly and experience relationality would be fundamental in any such review.

The ways in which breastfeeding knowledge is generated and circulated needs radical reappraisal. While there are evidence-based knowledges, these must be juxtaposed with community based collective, embodied knowledges generated by women. A proliferation of community projects such as peer support schemes appears to offer a strong way forward in this community capacity building endeavour (Fairbank et al 2000, Dennis 2002, Dykes 2003). Such schemes could constitute part of a relocation of women's postnatal care into the community.

It is inappropriate to simply make recommendations for midwives to implement given that their practices are heavily constrained by social structures that impinge upon their corporeality, temporality, knowledge(s), relationships and physical spaces. Rather, organisations need to be accessed and mobilised to lobby, lead and act as catalysts in changing the ways and places in which midwives are enabled to support women. Organisations such as the International Confederation of Midwives, the Royal College of Midwives, the Association for Improvement in Maternity Services, the Association of Radical Midwives and the voluntary breastfeeding support organisations can all play their part in collectively lobbying the UK government on behalf of service users and midwives. While this action will take time, I argue that now *is* the time for this agenda to proceed.

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	SITE 1	SITE 2
Number of postnatal women participating	40 (P 1-40)	21 (P 41-61)
Number of midwives participating	24 (MW 1-24)	15 (MW 25-39)
Midwife – postnatal woman encounters observed	79	18
Interviews with postnatal women	17 women interviewed once 12 women interviewed twice 4 women interviewed x 3 2 women interviewed x 4 1 woman interviewed x 5 Total interviews: 66	10 women interviewed once 7 women interviewed twice 2 women interviewed x 3 1 woman interviewed x 4 1 woman interviewed x 6 Total interviews: 40
Guided conversations with midwives	9 midwives - 1 conversation 3 midwives – 2 conversations 1 midwife – 3 conversations Total guided conversations: 18	4 midwives – 1 conversation 3 midwives – 2 conversations 3 midwives – 3 conversations Total guided conversations: 19

Note: Four postnatal women, on site 1, were observed but subsequently declined to be interviewed. Therefore, thirty-six postnatal women were interviewed on site 1.

Appendix 2
Information and consent form - Postnatal women

University address

My name is Fiona Dykes. I am a midwife researcher and plan to carry out a study which involves watching midwives talking to and assisting women with breastfeeding their babies. I aim to find out about influences upon women's confidence in breastfeeding their babies.

This will involve observing you and the midwife at times when breastfeeding is likely to be discussed, e.g. during a postnatal examination or at times when you request information and help.

I may then ask you for further information related to the time you spent with the midwife about what you found to be most helpful or if anything less helpful in terms of you feeling confident about breastfeeding.

If I do approach you I may ask if you are happy for me to use a tape recorder during your interaction with the midwife and/or short interview afterwards. This makes it easier for me to record information. If you would prefer me not to tape either your interaction with the midwife or the short interview with me afterwards (or both) please say so and I will just take notes instead. If you consent to me using a tape recorder, you are welcome to hear it played back so that you may request removal of any of your comments or destruction of the tape if you change your mind about them. Of course you may request that I turn the tape recorder off at any time during an interview.

You may refuse to take part in the study from the outset. If you are happy to get involved then you can refuse to further participate at any stage. You may refuse to answer any question at any time. Refusal to participate will in no way at all affect the care you receive.

I will not reveal your name or personal details to anyone. All information and interview reports will be filed under a number and not your name. I will erase the tapes as soon as I have typed up the information on them. No one else other than myself and possibly my research supervisor will be permitted to listen to them. Small parts of interviews may be included in my final write up and in any articles I write, but of course no names will be included.

The research to be carried out has been approved by the Hospital NHS Trust Ethics Committee. The Director of Midwifery Services [name] has also approved this research.

I am a qualified Midwife, currently working as a Lecturer in the Department of Midwifery Studies at the University of Central Lancashire, Preston. However, as a researcher I will not be in a position to provide health care or advice to you. I am here as an observer and listener.

I am studying for a PhD under the supervision of Dr. Mavis Kirkham, Professor of Midwifery, at Sheffield University. My findings will be published in journals for health professionals.

My contact address and telephone number are listed above.

If you are still happy to take part, having read this information, could you sign and date this form to show that you understand the contents.

Signature   ....   Date   ....

Thank you for your participation,

Yours sincerely,

Fiona Dykes
(Senior Lecturer-Midwifery)

One copy of this form should be kept by the participant and the other copy should be signed by the participant and kept by the interviewer.

Appendix 3
Information form for Midwives

My name is Fiona Dykes. I am a Midwife, currently working as a lecturer in the Department of Midwifery studies at the University of Central Lancashire, Preston.

I am studying for a PhD under the supervision of Dr. Mavis Kirkham, Professor of Midwifery at Sheffield University. I plan to carry out a study which involves watching midwives talking to and assisting women with breastfeeding their babies. I aim to find out about influences upon women's confidence in breastfeeding their babies.

This will involve observing you interacting with women at times when breastfeeding is likely to be discussed, e.g. during a postnatal examination or at times when there are requests for information and help.

I may then ask you for further information related to the time you spent with the woman, for clarification related to what I have observed.

If I do approach you, to interview you, I may ask if you are happy for me to use a tape recorder during interactions with mothers and/or interviews. This makes it easier for me to record information. If you would prefer me not to please say so and I will just take notes instead.

You may refuse to take part in the study from the outset. If you are happy to get involved then you can refuse to further participate at any stage. You may refuse to answer any question at any time.

I will not reveal your name or personal details to anyone whether you consent or refuse. All information and interview reports will be filed under a number and not your name. I will erase the tapes as soon as I have typed up the information on them. If you consent to me using a tape recorder, you are welcome to hear it played back so that you may request removal of any of your comments or destruction of the tape if you change your mind about them. No one else other than myself and possibly my research supervisor will be permitted to listen to them. Small parts of interviews may be included in my final write up and in any articles I write, but of course no names will be included.

The research to be carried out has been approved by the Hospital NHS Trust Ethics Committee. The Director of Midwifery [name] has also approved this research. I will be supplying both with reports of the research, but these will not include names.

As a researcher I will not be in a position to provide health care or advice. I am here as an observer and listener.

Thank you for your participation,
Yours sincerely,

Fiona Dykes (Senior Lecturer-Midwifery)

Appendix 4
Basic, organising and global themes

Basic Themes	Organising Themes	Global themes
• Pressure to provide • Pressure to perform • It should come naturally? • Maternal-sexual dualism • Normalising effects of authoritative knowledges • Midwives - rules, surveillance & subversion	Pressure to breastfeed Resisting the gaze	Doing the correct thing...the right way
• Malfunctioning breasts • Unable to measure • When the milk comes in • Not enough leaving my body • Is it reaching the baby? • Delivering properly	Production Delivery	Supplying
• Confusion • Unpredictability • Frequencies and duration • Limiting 'play time' • The baby's innate clock • Babies taking time • Using me as a dummy • Not in bed with me!	Breaching temporal boundaries Merging and breaching bodily boundaries	Demanding
   • Establishing a routine • Remote control - breast milk feeding • Progressing to a bottle • Topping up • Relying on technical appliances	Regaining control around birth Controlling breastfeeding Supplementing breastfeeding	Gaining control - maintaining boundaries.

Basic Themes	Organising Themes	Global themes
• Because breast milk is best • Just keep trying	Connections with confidence	'Carrying on': persevering through troubles and triumphs
• Overcoming the pain • Coping with fatigue	Getting through the troubles	
• Special moments • Experiences overriding reservations • The baby makes it easy	Positive experiences	
• Communicating temporal pressure • Reflecting unpredictability	Communicating pressure	Failing to take time - touch base
• Postnatal check • Ritual removal of medical attachments • Lights on nights • Ticking tasks off	Ritual, routines and procedures	
• Absence of a midwife-mother relationship • Disconnected from birth • Disconnected from life • Disconnected from social networks	Disconnected encounters	
• Technical approaches • Pre-set agenda precluding listening • Unhelpful use of self • Breaching women's boundaries.	Managing breastfeeding...women	
• Restricting verbal information • Insufficient written information • Absence of eliciting understanding • Conflicting information • Misinformation	Rationing information	