

Normal birth: a thing of the past or the new future for primary health care?

Tracy Reibel National Executive of the Maternity Coalition Australia, Fremantle, Western Australia

This paper will explore the similarities and contrasts between the United Kingdom, Netherlands and Australian systems of maternity service delivery, focusing on the status of midwives as primary care providers. Increasingly, women in western industrialized nations are subject to medical models of maternity care. These medical models stem from the field of obstetrics, which has an increasing influence in determining service provision in all three countries. The World Health Organization has stated that midwives are the most appropriate primary carers for women during pregnancy and childbirth. Yet the rise of obstetrics as a dominant model of care has displaced midwives as primary carers, giving greater privilege to an obstetric construction of pregnancy and childbirth. While midwives are educated to understand and support normal physiological birth and assess and respond to deviations (wellness model), by contrast, obstetricians are educated to assess risk and address concerns through active clinical management (illness model). It will be argued that the fundamental difference between midwifery and obstetric views of pregnancy and childbirth rest on the differing perceptions of wellness and illness; that the obstetric view has gained broad dominance as a result of unequal power relationships; and, that this in turn has altered service delivery to privilege medical models of care. While service delivery in the UK and Australia has tended to follow a similar pattern of dislodging midwives as primary carers, the Netherlands system of maternity care, while broadly resisting the displacement of midwives as primary carers, is nonetheless provided within a medicalized framework. By contrast, in the UK and Australia there is an increasing awareness of the need to reconfigure maternity services to give greater autonomy to midwifery practitioners, a situation that is not as relevant in the Netherlands. The conclusion highlights the need to develop core principles to strengthen maternity care systems in order to ensure that midwives are not further alienated from service provision, and that strong midwifery workforces can be sustained. The discussion is based on research undertaken during a study tour of the United Kingdom and Netherlands by the author.

Key words: childbirth; maternity services; midwifery-led care; place of birth; pregnancy

Overview

Across the globe, childbirth is increasingly dominated by obstetric specialists and medically oriented systems of care, with Caesarean surgery promoted as a safe alternative to normal vaginal

birth (Goer, 1995). The shift from normal life event to medical episode has had profound effects on the way in which maternity services are provided. Over time, but especially since the development of reproductive technologies, the female body has become a site of increasingly invasive procedures as obstetric practice has sought to perfect childbearing and its outcomes (O'Brien, 1981; Scutt, 1988; Wagner, 1994; Devries *et al.*, 2001). Midwifery practice, once the primary mode of birth care and support

Address for correspondence: 49 East Street, Fremantle, Western Australia, 6160, Australia. Email: tribal@dodo.com.au

in most cultures, has in many places been relegated to assistant care, a hand maiden to the specialization of obstetrics.

The dichotomy between midwifery and obstetric care is not just a matter of debate about clinical expertise. It incorporates issues of philosophy, legislative control, power relations, risk and cultural conditioning and has had far reaching consequences for women, as their input into the circumstances and modalities of childbearing has been undermined. Once the exclusive domain of women, childbirth practices are now dominated by a largely male obstetric workforce, displacing the traditionally female dominated practice of midwifery. As a result women have become progressively disenfranchised from their maternity experience.

The main areas of debate have centred on questions of safety and how to achieve the best possible outcomes for mothers and their babies. Medical discourse has dominated this debate, utilizing science and technology to validate its knowledge of childbirth. This has been further aided by assumptions regarding risk potential and requisite management strategies to influence how maternity care is provided (Bryar, 1995). The medicalization of maternity services has promoted safety as only being possible through intensive medical surveillance (Papps and Olssen, 1997). However, it has also been identified that the medicalization of childbirth has dehumanized its potential as a life event of deep significance for women (Wagner, 2001).

While it is true that medical achievements have contributed to the reduction of both maternal and neonatal mortality in many settings, it is equally true that socio-economic factors have also contributed to improved outcomes for women and babies during the reproductive years. These have been well documented and need not be summarized here. Instead, the question to be explored in this paper is, have we embraced a medical approach to childbearing to the detriment of normal birth? Further, is it time to reclaim normal birth as the right of women, free from unwanted and unnecessary interventions until clinical indications are apparent? In other words, has medical dominance gone too far in its control of birth practices, and, is it time to reassess contemporary approaches to maternity service provision?

The World Health Organization (WHO) has developed extensive guidelines and recommendations intended to direct governments on the most appropriate way to provide quality maternal and neonatal services. This includes an emphasis on the support of normal physiological birth as the best condition for mothers and babies, and the assertion that midwives are the most appropriate professionals to facilitate normal birth. The relevance of WHO recommendations will be considered in this paper within the context of midwifery led models of care in the United Kingdom, the Netherlands, and Australia and their impact on birth outcomes.

In all three countries, midwifery-led care has been a traditional aspect of maternity services. Currently, however, there is a significant disparity between the capacities of midwives to be the principal maternity provider. Largely dependent on the location they work in, and which body is ultimately responsible for determining services, midwives in many instances are answerable to medical practitioners rather than working in collaborative partnerships as professionals in their own right. Regulation of midwives in these three countries ranges from complete autonomy and independence of practice, for example in the Netherlands, to a near incapacity to provide primary care in Australia. The United Kingdom has this range within its borders, and midwifery practice varies widely within and between England, Wales, Scotland and Ireland (Reibel, 2003). It is against this background that women are challenged to assert their agency in childbirth and retain their birth rights.

Background

Midwifery practice has undergone significant changes throughout the twentieth century, particularly in the last few decades. Many of these have been a direct response to the diminution of midwifery as a primary care profession, particularly in western industrialized countries (van Teijlingen *et al.*, 1999). The similarities and contrasts between the systems of maternity service delivery in the United Kingdom, the Netherlands and Australia and to what extent each country meets WHO recommendations for maternal and neonatal care will be analysed within this context.

The focus will be on the role of midwives as relevant primary care providers and how they

continue to facilitate normal birth despite a medically dominated environment. This requires challenging embedded contemporary perceptions of childbearing as a medical and surgical event and instead embracing the capabilities of women as agents of their own birth experiences (Johanson *et al.*, 2002). It also requires understanding where services are located, and why, and to what extent midwifery practice is either ignored or validated dependent upon these factors.

It is evident that a medically oriented approach to maternity services has led to an increase in assisted births, with an alarming rise in instrumental deliveries and Caesarean surgery. For example, the World Health Organization has determined that a Caesarean surgery rate of 10%, with an upper limit of 15%, should be the goal for maternity services (WHO, 1999). Yet in Australia, currently one in four babies are born by Caesarean surgery and this rate is increasing annually, the overall rate in the United Kingdom is 22% but stable, while in the Netherlands it is now 14%, up from 8% a decade ago. These discrepancies exist despite all three countries having similar socioeconomic demographics and is largely due to contrasting approaches to maternity service provision based on key assumptions regarding the function of childbearing in the sociocultural milieu.

The purpose of this discussion, therefore, is primarily aimed at developing an understanding of midwifery-led care where it is established and how and why primary midwifery care contributes to improved maternal and neonatal outcomes, including a decreased need for surgical birth.

The medicolegal context of birth

Why has childbirth ceased to be a normal life event and instead been redefined as a medical episode, or even emergency, that should take place in hospital with the attendance of a number of specialists, including anaesthetists, obstetricians, and paediatricians? In the UK and Australia in particular, the shift to routine obstetric surveillance for low risk women was undertaken in combination with the closure of small community based services and an upgrading of large tertiary units, providing care for up to 5000 women per annum. Even in the Netherlands, where home birth accounted for over 70% of births in the

early 1960s, the figure had slumped to 32% by 1982 (Wiegers, 1997).

The trend from home to hospital birth started in the 1940s and reached its peak in the 1970s by which time hospital birth, under the control of the obstetric profession, was firmly established and supported as being the safest and most desirable alternative. Midwives as the traditional primary birth attendants were discredited, and women subjugated within the institutional machine of the hospital. Medicine and technology constructed hospital birth as safe, and home birth as dangerous. Locating services in institutional settings enabled a high degree of clinical supervision and the trials required to support the assumptions of obstetric practice. Hospital birth was also believed to promote efficiencies in clinical and administrative planning and functions. It also enabled intense scrutiny of midwives and women in an impersonal and regimented environment, downgraded the role of the midwife and removed the possibility for women to establish a beneficial relationship with a known caregiver. In the Netherlands, this scenario has been resisted.

In more recent times, risk management and litigation appear to have become crucial factors in determining maternity care. Former key determinants of providing safe care for mothers and babies have now been displaced by a focus on the presence of risk for practitioners when providing care (Skinner, 2003). The effect of litigation has been put forward as the reason that the specialization of obstetrics is being taken up by fewer medical practitioners. In Australia, data that demonstrate an ageing and declining obstetric workforce has been collated and similar findings have been made in the United Kingdom (AMWAC, 1998). In the final analysis, though, what is the cost to the health and well-being of women and their babies as medicolegal shifts influence maternity care?

The medical model of health is premised on the control of nature by human beings accompanied by an assumption that disease is somehow disembodied from an individual. Environment as a contributory factor to well-being is often disregarded within this model creating the dichotomy between social and medical models of health. Such a view is representative of maternity care in acute and tertiary settings, but has become a feature of maternity services in general.

The medical model of maternity care has contributed to some modes of midwifery practice in contemporary settings, as midwives have sought to maintain relevance in medically dominated environments.

The desire of some midwives to maintain a connection to both the art and science components of their practice causes consternation amid the midwifery profession today. While it is acknowledged by WHO that midwives are experts in assisting normal childbirth, the profession still battles for wider acceptance of its knowledge and guidance (the art) and expertise in clinical assessment and support (the science). The challenge for midwives in the twenty-first century is how to achieve the balance of providing individualized care for women while maintaining adherence to clinical requirements that have usually been determined within an obstetric context (Proctor and Renfrew, 2000). Managing risk has also become an important facet of midwifery care, and threatens to overtake midwives in their attempts to support women within a social model of health (Walsh, 2003).

It is becoming more evident that health systems are unable to sustain the economic or social cost of intensive medical care, where there are no apparent clinical benefits for their use. In maternity services, the capacity of large institutions to provide appropriate and effective care as subscribed to by WHO, is far less certain than previously presumed. Substantive evidence is beginning to accumulate that undermines assumptions of the usefulness of intensive medical surveillance as intervention rates soar, with no attendant improvement in maternal or neonatal outcomes evident (Wagner, 1994). The consequence of short and long-term health outcomes for women subjected to invasive medical technologies is now being more closely examined (Chalmers *et al.*, 1996). So while it could be argued that as the agents of technologized childbearing medical practitioners have successfully infiltrated community views by utilizing the validity of scientifically determined knowledge systems, it is also true that these knowledge systems are now being increasingly scrutinized.

While the importance of medical care to communities is reflected in the anxiety generated when medical services are cut back or discontinued, and this reaction does not appear to vary greatly from country to country, there is a concomitant change

in community attitudes to medical practice and its limitations. The need for new approaches to health care is shifting the focus from medical practitioners to other health care providers and how all groups can best be utilized to deliver good quality health care within communities. Primary and preventative health strategies are increasingly guiding health service provision, particularly as pressure on medical services increases. In maternity care, there is a subtle shift in the perception of women's knowledge as unreliable, anecdotal, and unscientific to a more holistic view that acknowledges that women understand their bodies and when provided with appropriate care, take control of, and responsibility for their births leading to improved outcomes for themselves and their babies (Wagner, 2001).

So while the demise of maternity services in rural locations, for example, in both the United Kingdom and Australia during the 1970s and 1980s, occurred in combination with centralization of services to large regional and urban locations, the trend in some parts of the UK now is towards re-establishing community-based services to meet community expectations. In Australia, however, women in rural and remote parts of the country are increasingly being denied access to community-based services, and more often than not have to travel lengthy distances to access obstetric services. Midwifery-led care in rural and remote Australia is a rarity (Kildea, 2003).

In the Netherlands, the domain of midwifery practice and home birth appears to have stabilized. As in both the UK and Australia, however, there is an additional concern regarding adequate numbers of midwives to provide maternity care. To what extent a resurgence of midwifery-led care will be accommodated remains to be fully assessed. Nonetheless, it is becoming increasingly evident that all current indicators of preventative and primary health care support the necessity to provide midwifery-led maternity services for as many women as possible in their own communities (WHO, 1999).

WHO and maternal care

In *Care in normal birth: a practical guide* (1999), WHO has defined the elements of supporting normal childbirth by considering how evidence-based medicine is applied, the value of common practice to women and/or their newborns, and the place of

such practices in normal birth care. As such, the WHO working group classified its recommendations on practices related to normal birth into four categories:

- 1) Practices which are demonstrably useful and should be encouraged;
- 2) Practices which are clearly harmful or ineffective and should be eliminated;
- 3) Practices for which insufficient evidence exists to support a clear recommendation and which should be used with caution while further research clarifies the issue;
- 4) Practices which are frequently used inappropriately.

The context of the WHO *Care in normal birth* guide is to achieve both the definition and appropriate arrangement of care to achieve normal birth based on the premise that the 'aim of the care is to achieve a healthy mother and child with the least possible level of intervention that is compatible with safety'.

It is often within the semantics of 'safety' that midwives and obstetricians hold widely disparate views. Both groups would assert that they provide the safest possible care within their scope of practice and with the intention of providing a positive outcome for mother and baby. It is precisely within the scope of practice that the debate becomes unbalanced. Based on the assessment by WHO that pregnancy and childbirth should be a normal event for the majority of women, then it follows that midwives should provide the majority of care. In the Netherlands this is the case, and the results are high levels of normal births, and excellent maternal and infant outcomes. In both the UK and Australia, however, medical practitioners continue to either provide or supervise the majority of care. In both locations, interventions are climbing, and the maternal and neonatal mortality and morbidity outcomes for these populations are not equal to the Netherlands.

Within the arena of health provision, it is reasonable to assume that each practitioner's early experiences of attending childbirth will have an enduring effect on their perspectives of what safe childbirth constitutes. This assumption is equally true for midwives and obstetricians.

On the one hand, where a practitioner has worked in acute service settings, observing and par-

ticipating in the routine use of interventions, their view of childbirth will be highly likely to lean towards this approach to care, including standardized care for all patients regardless of individual needs and circumstances. In these settings WHO notes, 'there is a temptation to treat all births routinely with the same high level of intervention required by those who experience complications'. That is, consider and manage for all possibilities, with greatest emphasis on the high-risk end of the scale. This approach ignores that childbirth will be a straightforward process for the majority of women, where the circumstances exist to appropriately support such outcomes.

On the other hand, where the practitioner's experience of childbirth has been in the domain of no intervention except where indicators exist for their use, there is a significant probability that the practitioner will enable each woman's birth to complete its course unaided by unnecessary interventions. This approach is more compatible with the achievement of WHO objectives for maternal care and should be the goal of maternity services. Accordingly, normal birth includes 'spontaneous onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition' (WHO, 1999).

In the UK, the sociopolitical will to achieve this has been boosted by the consistent reviews of maternity service provision undertaken over the past decade. Since the Winterton (1992) and Cumberledge (1993) inquiry reports created the circumstances for changing maternity care, the aim of assessing changes and identifying remaining challenges in service provision has been the focus of a recent review (UK House of Commons, 2003). The Select Committee on Health review found that there are still significant changes that needed to be made. Nonetheless, where change has been embraced by the newly created primary health care trusts, woman-focused, midwifery-led care services had been (re)established (Reibel, 2003).

By contrast, in Australia, despite numerous state and federal government reports into maternity services since 1985, intervention rates have continued to climb, with no demonstrable improvement in maternal and neonatal outcomes,

but with spiralling economic and social costs. Indeed the 1994–1997 triennium report of the Australian National Health and Medical Research Council into maternal and neonatal outcomes found that maternal mortality showed an upward trend (NHMRC, 2001). While it is yet to be determined whether this trend will continue, it is of deep concern, particularly as it is the result of highly medicalized maternity care that is promoted as reducing risk.

Compare this situation to the Netherlands, where the structure of health services gives complete autonomy to midwives, who are able to set up practice in any location. Further, midwives provide the majority of primary care, and only refer women to specialist care where indications are evident. Ironically for women in the Netherlands, there are doubts about the future of midwifery care as more midwives choose to work part-time. This may eventually contribute to a shortage of midwives to provide primary care, and women would then be more reliant on consultant-led care. Although this situation has been disputed (Oudshoorn, 2003).

The concept of low and high risk is increasingly problematic in the context of maternity services. While the WHO have determined that childbirth is a normal life event for the majority of women, most medicalized service provision is focused on the high-risk end of the maternity scale. Medical care supports a risk assessment model that channels women into clinical pathways that may not be the most beneficial for their individual requirements or indeed present the least risky circumstances for the practitioner to provide care. ‘The problem with many systems is that they have resulted in a disproportionately high number of women being categorised as “at risk”, with a concomitant risk of having a high level of intervention in the birth’ (WHO, 1999).

Risk assessment and active management, promoted as key themes in a discourse that carries great currency in the sociopolitical environment, appears to have overtaken concern for maternal and infant outcomes. Previously, the principle goal of medicalized childbirth was to achieve the lowest possible maternal and perinatal mortality and morbidity outcomes. While mortality and morbidity outcomes for women and their babies in western nations steadily declined medical care retained its status. Now there is an appearance

that the goal is to avoid legal action. Meanwhile, growing evidence supports an approach to child-bearing, such as that adopted by WHO, that exposes many of the myths created by obstetric practice.

While individual assessment is now acknowledged as a primary indicator of quality maternity care, large institutions are not configured to deal with individuals and instead became reliant on streaming women into clinical pathways through predictive values and indicators (Murphy-Lawless, 1998). Further, this approach overlooks women’s variety of experiences, and imposes unnatural and prescriptive categories of risk determination. The continued dominance of this system therefore raises questions regarding the vested interests of those involved in maintaining the status quo.

While service delivery in the UK and Australia has followed a similar pattern of succumbing to medicalized childbirth and dislodging midwives as primary carers, the Netherlands system of maternity care has broadly resisted the displacement of midwives as primary carers. Instead, Dutch people have maintained a strong cultural inclination to respecting childbirth as a normal and family-centred event. Ironically, midwifery care is provided within a medicalized framework, and midwives in the Netherlands are considered to be specialist medical practitioners within their area of expertise. However, midwives are not tertiary educated as they now are in the United Kingdom and Australia. By contrast to this situation, in the UK and Australia, awareness among women and midwives of the need to reconfigure maternity services to give greater autonomy to midwifery practitioners is increasingly evident. The UK has made more progress towards change particularly in England and Wales, with Australia still constrained by a lucrative obstetric industry reluctant to relinquish its role as the dominant service provider.

Different approaches to maternity service provision

Midwifery-led care has been shown to reduce all interventions rates for women including pain relief, inductions, augmentations, instrumental deliveries, episiotomies and Caesarean surgery (Flint and Poulengeris, 1989; Biro and Lumley, 1991; Hundley *et al.*, 1994; Rowley *et al.*, 1995; Waldenstrom and Turnbull, 1998; Homer *et al.*,

2001). It has also been shown to be associated with better outcomes for babies, with fewer babies requiring resuscitation or admission to special care nurseries (Chalmers *et al.*, 1996).

In the UK and in the Netherlands, the national health services cater to the majority of the population and cost effectiveness is a key determinant in the delivery of services. As such, women are generally able to access midwives for community-based ante- and postnatal care through the national health services. In the UK, women then often give birth in hospital, but have the right to request support for a home birth and have their expectations met. In the Netherlands, about one third of women give birth at home with a midwife who has also provided their antenatal care, or, in hospital with midwives (short stay), or with obstetricians where complex care is required. In Australia, at least 80% of women give birth in hospital labour wards, with midwives in attendance, but under the direction and supervision of obstetricians.

Access to primary midwifery care with a nominated practitioner for all of pregnancy, birth and the first few postnatal weeks is still fragmented in England, Scotland and Wales, and virtually non-existent in Ireland, but there are many examples of change being implemented to make midwifery-led care more widely accessible. The situation in the Netherlands is more consistent, with at least 65% of women receiving primary midwifery care, with the remaining 25% of women receiving a combination of midwife and consultant care.

In Australia, there are pockets of midwifery-led models of care, catering to less than 10% of the overall episodes of care per annum. Since the advent of the National Maternity Action Plan: For the Introduction of Community Midwifery Services in Urban and Regional Australia (NMAP), however, new models of midwifery-led care are currently being established in some locations, and the government of New South Wales (the most densely populated Australian state) have recently announced their intention to establish a state-wide home birth service. Currently, less than 1% of women in Australia have home births, and in the majority of these cases engage the services of a midwife in private practice, as home birth is not provided through the public health system. There are two very minor exceptions to this in two states, but the

programmes providing care for home births are limited by strict funding arrangements.

It is significant that in both the UK and Netherlands, midwifery is an autonomous profession protected by legislation, policy and regulation. Access to consultant or specialist obstetric care for abnormalities or deviations is often by referral from a midwife (in the UK) and usual in the Netherlands. General practitioners do not generally participate in maternity care in the Netherlands. In the UK and Australia large numbers of general practitioners have over time opted out of providing maternity care.

It is apparent that no one model of care can cater to the needs of all women and their families in all circumstances. In England and Wales maternity services are increasingly being structured to allow women access to care that suits their individual needs. Midwives as experts in normal pregnancy and childbirth are progressively providing more primary care, with childbearing complications referred for secondary specialist care. This has led to greater professional collaboration and the successful integration of services in some locations. The circumstances in Scotland and Ireland are less certain, with centralization of services still on the agenda.

There is more fragmentation in service delivery in England, than in Wales, where a strategic framework for midwifery is defining a consistent approach of maternity services across Wales. This is due to an integrated whole-of-government approach to realizing the potential of midwives, therefore, opportunities for midwifery-led services is being facilitated.

It is evident that midwifery managers in various health trusts in England approach the delivery of services in their catchment area according to their assessment of the region or areas needs and are prepared to adapt services as necessary to meet the diversity of requirements. In this way they remain committed to the principles of women-centred care by remaining responsive to community needs.

In Australia, there are clear indications that changes to service provision are finally being considered. The increasing dollar cost of providing public health services with disproportionate intervention rates is creating the momentum for women and midwives to demand that maternity

care includes access to midwifery-led care. Time will tell if this will occur.

Conclusion

Institutionalization of childbirth marked the end of women's autonomy in childbirth, displaced midwives as primary carers, and enabled the medical professional to dictate the terms and conditions of women's childbearing experiences. This has not necessarily been in the best interests of women, babies and families.

This highlights the need for governments to develop core principles and strategies based on WHO guidelines to strengthen maternity care systems for the benefit of women and their babies. This includes ensuring that midwives are not further alienated from service provision, that strong midwifery workforces can be sustained, and that midwives are restored as primary care providers wherever possible.

By adopting WHO directives for the provision of maternal and neonatal care, women are better served to achieve normal birth. The goal of all health systems should be to provide the most appropriate maternal care for individual circumstances, within the recommendations of WHO guidelines.

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