“Birthing” versus “Being delivered”: Of Bodies, Ideologies, and Institutions

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Abstract

The paper at hand applies and extends Friedland and Alford’s model of institutional logics to the case of birth practices focusing on a number of interrelated topics, viz.: identity, trust, and ideology. It draws on Giddens’s theory of modernity in order to “bring society back in”, as Friedland and Alford have formulated one major point of critique against existing institutional approaches. In its theoretical discussion, the paper will focus on two issues: first, the treatment of conflict as a motor of institutional dynamics, and second, the relation between institutions and agency. The empirical data is based on participant observation, qualitative interviews with midwives and obstetricians, and a review of magazines and television material concerning birth and parenting.
Within the context of institutionalist theory, Friedland and Alford’s (1991) paper aims at (re-)introducing a meaningful perspective on society to a field that has traditionally focused on the relationship between organizations and institutions (Zucker, 1987). For this purpose, they propose two conceptual moves: first, to regard conflict (between various institutional logics) as the primary motor of institutional dynamics, and second, to develop the relationship between individual agency and institutions. The conflict perspective challenges the assumption of the (perfect) normative integration of an institutional field – and thus an “oversocialized” view of agency. Establishing a link between agency and institutions, on the other hand, counters an “overindividualized” view of agency by showing how individual interests are institutionally shaped.

Both issues – conflict and agency – have been the prime focus of critique levelled against institutionalist theory, especially in its classic expressions by Meyer and Rowan (1977/1992), DiMaggio and Powell (1983/1991), and Scott and Meyer (1991). The idea of change through isomorphism and related assumptions concerning the ideational homogeneity of a field has been criticized, among others, by DiMaggio and Powell (1991), Walgenbach (2002), and Munir (2005). On a more general plan, Barley and Tolbert (1997) as well as Hoffman (1999) have noted the lack of the political dimension characteristic of classic institutionalist theory (Selznick, 1996), which temporarily seemed to have been lost in the wake of discussions on efficiency and means-end rationality. The relation between institutions and agency has only recently received the attention some critics have felt was lacking for so long (e.g. Meyer and Jepperson, 2000, Scott, 2008). Before, institutionalist theory was perceived to occupy the “structuralist” pole and was criticized for neglecting individual or collective agency in its explanations altogether (Beckert, 1999, Colomy, 1998) or for portraying social actors as “dopes” (Fligstein, 2001; Jepperson, 1991; Jepperson and Meyer, 1991; DiMaggio, 1997;
Hensmans, 2003). And even if agency has been taken seriously, it was defined quite narrowly as providing the impulse for the emergence of new practises (Zilber, 2002).

This paper follows Friedland and Alford’s lead by using Giddens’s theory of modernity (1992) in order to develop a deeper understanding of the processes shaping individual agency in a dynamic institutional context. In particular, it will explore the connections between individual identity construction, trust, and control.

In suggesting a close degree of proximity between structuration and institutionalist theory, I follow several other authors (Barley and Tolbert, 1997; Fligstein, 2001; Lawrence and Phillips, 2004; Walgenbach, 2002). My focus, however, will be less on structuration theory and more on Giddens’s analysis of the relationship between individuals and institutions in high modernity (Giddens, 1992). His reflections fit the institutionalist approach exceptionally well as his fundamental credo is that “modernity must be understood on an institutional level” (Giddens, 1992: 1). In a movement which he calls “dialectics of modernity”, modern institutions interconnect global and personal aspects and choices. The importance of institutions to modern individuals and societies is, according to him, due to a changing concept of self-identity. In contrast to its pre-modern predecessors, self-identity has become increasingly reflexive, a matter of choice between various lifestyles that are offered by society. This choice, at the same time, calls for a more reflexive stance, i.e., the willingness to question and evaluate certain lifestyles. Reflexivity, however, is not limited to these personal choices but rather permeates modern societies on all levels. One consequence is that many beliefs that were once taken for granted are now called into question, which increases personal insecurity. At the same time, societal and global interdependencies grow and thereby create events and processes that are too complex to understand. Both developments – increasing complexity and increasing insecurity – lead to the necessity to rely on expert systems in order to assess or cope with the risks presented. This reliance is based on
institutional, not personal, trust and often results in the (further) de-skilling of the individual
users. The knowledge incorporated in expert systems is traditionally control knowledge –
again a major characteristic of high modernity. Control or mastery of potentially dangerous
situations is almost a modern obsession and has resulted in a number of general changes in the
modern worldview. One of them is the replacement of the notions of destiny and fate with the
concept of risk. Risk is based on rationality and calculation and implies the possibility of
control, whereas destiny and fate display an aspect of superhuman influence or inevitability.
In a similar vein, situations incurring existential anxieties or dangers are excluded from
modern daily life, as their “raw” qualities often resist human mastery. Instead, these
experiences become mediated – and thus controlled – through fictionalization.
In his discussion of expert systems, however, I believe that Giddens misses one rather
important point, which is their use of (existing or new) ideologies to promote their own
position. As my case study will show, ideology is necessary to understand how institutional
logics are “transmitted” to individual actors and how they influence them. The concept of
ideology, however, not only refers to a contested subject but also constitutes a contested
subject itself. Authors who use the concept agree that participation in social life creates and
presupposes an understanding of the social world, and that this understanding is
communicated by verbal and non-verbal means. From here, definitions branch out – not only
regarding different interpretations of the concept forwarded by different authors or schools
but also regarding the distinction between ideology and discourse – to the point where certain
definitions of discourse and ideology converge or even merge (for an in-depth discussion see
Purvis and Hunt, 1993, Chiapello, 2003). For the present purpose, I shall use “ideology” with
the following connotations:

- Ideology is not linked to distortion or false consciousness, but to a certain set of social
  representations forwarded by a certain group of actors sharing the same interests. Due to
  these interests, ideology always has a political dimension.
Multiple ideologies exist within a society. Ideology is not restricted to the ruling class or dominant group within a society.

Ideology does not presuppose a conscious subject in the classical tradition, but is a condition for individual identity construction as it provides a “set of ready-made and preconstituted ‘experiencings’ displayed and arranged through language” (Hall, quoted in Purvis and Hunt, 1993: 485).

Ideology has material as well as symbolic aspects; it is not “just talk”. It is rather based on a theory of action than on a theory of language.

Practises and institutions function through ideology, but are not reducible to it.

Set before this theoretical background, the case study finally aims to provide a more in-depth account of how

- technology and organizational demands create, sustain, and enforce different institutional logics,
- dangerous situations are instrumentalized to create trust,
- institutional logics and individual choice are linked through ideology,
- dominant institutional logics use communication to maintain their power position.

BIRTH PRACTISES IN GERMANY: THE INSTITUTIONAL BACKGROUND

At first glance, the institutional context regarding birth practises is similar in all industrial countries: The two professional groups involved in the field are midwives and obstetricians. Expecting mothers1 have a choice between giving birth at home, at a birth center, or at a clinic. Home births are attended by midwives, while birth centres are run either solely by self-

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1 I limit my argument to mothers even though I am aware that fathers, friends, and/or other family may have a great deal of influence on the decision. As these influences, however, differ from case to case, I shall keep to the mother as the only constant – because bodily-involved – decision maker.
employed midwives or, rarely, by a team of midwives and obstetricians. In clinics, obstetricians are hierarchically superior to the midwives employed there. In all countries except the Netherlands (see below), the home birth rate ranges between 1 and 2% of all births. Countries differ, however, with regard to the pace of the development towards this figure. At the end of the 19th century, all births in all countries took place at home. In the course of the 20th century, this situation was reversed so that now about 98% of births take place in a clinic. The speed of the reversion in each country depended on various factors, such as the speed of the modernization of hospitals, the financing of clinic births through insurance policies or government grants, government policy supporting clinic births, or the societal status and lobbying power of midwives and obstetricians respectively. The U.S. saw the quickest development with the greatest change from 1935 (36.9% clinic births) to 1944 (75.6% clinic births), and had reached 97% clinic births by 1960 (Declercq et al., 2001). In contrast, Britain still saw 30% of births taking place at home in 1966. This figure was then rapidly reduced to the current 1% by 1979 (Declercq et al., 2001). In West Germany, the major change came in 1968 when national health insurance policies began covering clinic births even for unproblematic pregnancies (Gubalke, 1985).

The Netherlands form a remarkable exception to this general development. Here, 30% of all births still take place at home. Declercq et al. (2001: 16) see this as “a product of the organization of health care, Dutch politics, and Dutch cultural ideas about home, women, family, medicine, and science.” With regard to health care, the Dutch system has always strengthened the position of the midwives, with national laws on certification and legitimation dating from as early as 1818. Even today, only 75 of 1000 applicants are accepted to start midwifery training (Damer et al., 1999). This strengthening was accompanied by a clear distinction between normal and high-risk pregnancies, which is quite important as it demarcates the competence of the midwife from that of the obstetrician. Although this distinction is used in most other countries as well, it is often vague and left to the discretion of
the caregiver. The Netherlands, however, have defined the difference very clearly through a
state regulation called the Kloosterman List. Since the 1970s, legislation has also stipulated
that it is the midwife, not the obstetrician, who is responsible for prenatal care, and who
decides if a pregnancy shows pathological signs and an obstetrician should be consulted.
Moreover, health insurers will not pay for an obstetrician-attended clinic birth if the
pregnancy has been without complications and an unproblematic birth is expected. Although
the system is harshly criticized by Dutch gynecologists, the midwives’ political standing is
strong enough to block these interventions. In cultural terms, there is an unbroken tradition of
home birthing with intact social mechanisms, such as birth parties in the home, or neighbors
and professional carers (Kraamverzorgende) supporting the new mother full-time in the
household. The underlying perception seems to be that midwives function as socio-
psychological counselors for the mothers during pregnancy and birth, and that they protect
them from unnecessary medical interventions (Damer et al., 1999; RWTH Aachen, 2006).
However, there seems to be an, albeit slow, convergence to the overall European trend in that
mothers increasingly choose midwife-attended clinic or birth center births, which has led to a
decrease of home births from 69% in 1965 to 31% in 1991 (Wiegers et al., 1996).
The present institutional context in Germany is characterized by a predominance of clinic
births (98%) and a powerful lobbying position of obstetricians. The midwives’ group is
divided into clinic midwives, who are employed by a clinic, and self-employed midwives,
who assist at home births, work in birth centers, or accompany women to the clinic on the
basis of “renting” the delivery room from the clinic. Birth centers were only introduced in the
1980s, and the 40 that currently exist are normally found in larger cities. In principle, mothers
may freely choose between home births, birth centres, and birth clinics. Health insurance

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2 Doctors have two major associations, the Bundesärztekammer and the Kassenärztliche Bundesvereinigung
representing 400,000 and 147,000 members, respectively. In contrast, the Bund deutscher Hebammen represents
15,000 midwives.
3 Not all self-employed midwives assist at births; some only offer pre- and postnatal care and advice. However,
as the present study focuses on birth practices, this latter group has been disregarded.
covers the costs in all cases, either by paying the bills directly or by refunding the mother’s expenses. In the last two decades, the non-clinic birth and “natural” birth (i.e., without technology intervention) factions have slowly gained some influence (Schücking, 2003). This has resulted in a growing pressure on birth clinics to introduce home-like settings (e.g., rooming-in) or “soft” practices (e.g., water births, homeopathy). There is also an increase in short-stay clinic births (i.e., 2-24 hours after birth as opposed to the 3-5 days considered “normal” for a clinic birth).

These institutional arrangements are embedded in a sociopolitical context that has seen a constant decline in the absolute number of births since 1970, and one of the lowest net reproduction rates in Europe at less than 0.4 per woman (Braun, 2006). German women have their first child very late at the age of 28.5 on average (Braun, 2006). About 40% of all female academics remain childless (Statistisches Bundesamt, 2005). These figures have sparked major debates in the public discourse, and recent administrations have felt pressure to offer substantial incentives for couples to have children.

METHOD

In order to inquire into institutional logics, identity, and power relations, I have adopted a life-world perspective and in consequence a constructivist, phenomenological approach in the tradition of Schütz and his followers. Although Friedland and Alford do not explicitly refer to Schütz, I believe his ideas on life worlds and multiple realities (Schütz, 1962/1973) fit quite well into this line of thought. As far as methods in the present study and paper are concerned, three basic concepts derived from this philosophy are important: Verstehen, ideal types, and narrative. Verstehen as a sociological method involves empathy and a certain familiarity with the life world in question in order to gain the “context knowledge”, as Strauss (2004) would...
call it, necessary to understand the actors’ sensemaking and purposes (Patton, 2005). I have
gained this context knowledge from my experience in giving birth to three children – once in
the clinic, once in a rented delivery room, and once at home –, which brought me into close
contact with the respective caregivers over a comparatively long time and which, naturally,
gave me an insight into the maternal perspective, bolstered by many informal talks with other
mothers and mothers-to-be. I believe this insight was important because the topics discussed
are of an implicit nature and cannot be fully captured by direct questions and conversations,
but instead presuppose observation and understanding of the practises involved. As always in
this type of (very modest) ethnography, the participant observer faces the task of switching
between the insider and outsider perspective becoming a “marginal man” or “professional
schizophrenic” (Honer, 2005).

In a second step, this participant observation was complemented by 15 qualitative, semi-
structured interviews with self-employed midwives, clinic midwives, and obstetricians. The
organizations involved (three midwife practises, one birth centre, one perinatal centre\textsuperscript{4}, one
regular hospital) were all located in Chemnitz, a German city of 260,000 inhabitants. Each
interview lasted between 30 and 60 minutes. These interviews were mainly intended to
describe the relationship between and identity of each professional group, but they also served
in a minor way as expert interviews on mothers’ preferences and decisions. Finally, The
aspect of ideology was researched by reviewing media reports (TV, women’s magazines,
books) on births and birth practises.\textsuperscript{5}

Concerning the presentation of the material, I have chosen a narrative approach. “Narrative is
retrospective meaning making”, as Chase (2005) puts it, and I thus consider an appropriate
device to present a constructivist study (for the use of narrative accounts in organization

\textsuperscript{4} Perinatal centers additionally care for high-risk pregnancies and babies born from the 25\textsuperscript{th} week of pregnancy with a weight of 500g upwards. There are about 70 perinatal centres in Germany.

\textsuperscript{5} This material only plays a secondary role in this paper. The review covered the years 2004 through 2006 of the following magazines: Eltern, Baby&Co., Brigitte, Frau im Trend, Familie&Co., as well as the very popular TV docusoap “Schnulleralarm” and the book by the model Verona Feldbusch on the birth of her baby.
studies, see also Boyce, 1995; Czarniawska-Joerges, 1995; Langley, 1999; Tsoukas and Hatch, 2001). Within this narrative approach, I tried to portray the two institutional logics as ideal types (see below), which, again, is something Weber and Schütz have proposed as adequate method for scientifically describing life world phenomena (Gerhardt, 2001).

PUTTING THE THEORY IN CONTEXT: BIRTH PRACTISES AND PERINATAL INSTITUTIONS

*Institutional Logics*

The field of perinatal care is split rather dichotomously between two logics, which I shall refer to as “clinic view” and “home birth view”. I shall portray them in this paper in what my observations suggested to be the “mainstream version”. This version is, of course, incomplete as there are always more “conservative” or “progressive” proponents in the empirical manifold, as Weber would call it. Moreover, by contrasting the one to the other logic in a rather condensed fashion, both logics are fitted with sharper contours than they may have in the minds of many adherents. I am, nevertheless, confident that their opposition as two categorically different logics is correct. To cite Weber again, they could be viewed as based on different value rationalities, which basically precludes a rational hybridization, as the competing ultimate values cannot be placed in a transitive order. Individuals may switch from one logic to the other by adopting first the one, then the other ultimate value, but they cannot rationally construe a hybrid logic including both. This underlying value tension to a great extent drives the institutional dynamics as both parties continuously strive for acceptance and promotion of their positions without ever reaching a satisfactory compromise. The two logics also divide the professions rather clearly. Almost all obstetricians subscribe to the clinic view (with differences in how much freedom the clinic midwives should be given); those few who
are critical of it are often not accepted and isolated in their professional community. They do not work in a birth clinic but have their own practises or birth centres. With regard to midwives, the logics basically distinguish self-employed from (clinic) employed midwives. There are, however, a number of employed midwives who would like to work autonomously (and favour the home birth logic) but have chosen to work in the clinic for financial reasons or to ensure regularity of their work hours. Self-employed midwives, on the other hand, all adopt the home birth logic, but may differ in the degree to which they accept or refuse the clinic view. This is most obvious in the distinction between self-employed midwives who only assist home births and those who also rent delivery rooms in a clinic.\(^6\)

The logic of the home birth faction can be rendered as follows: Birthing is a perfectly natural, basic process that a female body is fit to deal with. Nature has had thousands of years to equip women not only with an appropriate anatomy but also with the necessary instincts, endurance, hormones, etc. to cope with the exigencies of giving birth to a baby. Unless pathological developments are observed, every intervention on the part of the caregivers must be considered unnecessary and in most cases either impeditive or even damaging. This is due not only to the initial perfection of the natural process but also, firstly, to the limited knowledge of medicine concerning physical and psychological consequences of the birth for mother and baby. But even this concern, the home birth faction argues secondly, has hardly been paid attention for many years while the dominant themes were organizational and/or efficiency considerations. Until a decade ago, for example, giving birth to a baby while lying on one’s back was the only accepted practise in clinics. In many clinics, it still is, at least for the final phases. This is in spite of the – by now well-known – fact that this position, as one caregiver once remarked, is “the stupidest position to deliver a child right after standing on your head” (for a detailed account of the physiological disadvantages, see Schmidt, 2000). Still, the

\(^6\) The individual constructions of those persons switching between the logics would surely deserve to be analyzed in more detail, but this was not part of the study at hand.
position was very convenient for obstetricians and midwives, who otherwise would have had to kneel in front of the mother; consider the symbolic as well as the physical discomfort. Although the worst of these organizational sins may be a thing of the past, clinics’ willingness to put these concerns before a natural or mother-determined mode of delivery, critics say, still prevails. As a consequence, the birth is made more difficult, with ensuing health risks for mother and baby. On the other hand, highly sensitive technical instruments sometimes misread (in birth terms) “normal” phases of physiological over-activity or non-activity as pathologies. For example, the CTG (cardiotocography, a device that measures the fetal heartbeat and the contractions during birth) has been shown to sound false alarm in 80% of all cases in which it is used (Lutz and Kolip, 2006). The error is, statistically speaking, always a type II error: While it almost never fails to detect a pathological development, it indicates that problems exist in many non-pathological cases. The alarm, again, causes stress for the mother worrying about her baby, but also may lead to further interventions. This especially occurs when, as is often the case, the clinic midwife must look after several mothers in several delivery rooms and thus relies almost solely on the CTG for monitoring. This even results in a certain deskillling of the clinic midwives.

In contrast to this, home births involve no technology and no organizational demands and routines. The midwife has only one woman to attend to. She is thus continuously present and follows all developments during the birth process. She also knows the history of the pregnancy, the family situation, etc., and is thus better able to classify symptoms as harmless, momentarily problematic but to be overcome, or pathological. She is not tempted to intervene because, first, she believes it to be detrimental, and, second, she lacks the equipment. The mother is in a familiar environment. Moreover, women opting for a home birth seem to be in a different frame of mind concerning their responsibilities. They (and the midwives) are very clear about the fact that it is the mother and the baby who do the work.
“That, to me, is the essence of this sentence [uttered by doctors]: ‘I carry the responsibility.’ That’s not true. I don’t carry the responsibility either. I carry the responsibility for the examinations I make and for those I don’t. But the responsibility for the child and the life lies with the mother, and I can’t take that away from her.” (Self-employed midwife)

“That’s what I tell the women who go to the clinic with me [renting the delivery room]: ‘I am a guest at your birth. You have invited me to attend and to see if everything is okay in medical terms.’” (Self-employed midwife)

Mothers giving birth at home do not expect and often do not want help from technology or obstetricians. They expect and want to set the pace and mode of the birth, and to be in control of the birth environment. This active stance is captured in the will to “birth” the child instead of “being delivered of” it.

In contrast, the clinic logic is based on the all-pervading view of obstetricians and clinic midwives captured by the following quote:

“And it’s a simple fact, and that’s the principle I work by: The longer I am in this profession, the more I know what can happen.” (Obstetrician of 23 years)

Even seemingly normal births can develop pathologies, and in those cases every minute counts. If we knew for sure that no pathologies would develop, home births would be a viable alternative, but since we never know for sure, giving birth at home means taking an unnecessary risk. Furthermore, birth clinics have changed for the better in the way they approach births: delivery rooms have been redecorated to look like a living room, technology has become small and portable so as not to impede the mother, midwives are trained in
alternative birth practises and sometimes in alternative medicine, and the mother and baby can leave the clinic two hours after the birth if they wish. Hence, there is no difference in comfort between clinic and home births, but clinics offer a quantum leap in safety, as every desirable technology waits literally “behind the next wall”. Still, interventions are kept at a necessary minimum. The minimum is defined by 1) arresting pathological developments, 2) relieving mother and baby of the duress of the birth when it becomes obvious that they can no longer cope, 3) the explicit wish of the mother. The latter is especially important with regard to the application of PDA (peridural or epidural anesthesia, an anesthesia administered to the spine that numbs and paralyzes the body below the rib cage), a practise that is carried out in 80% of the births in some clinics. The mothers deciding on a clinic birth mostly want and expect technology to be ready, especially if it is their first birth. Moreover, they are prepared to surrender control and autonomy over the birth to the obstetricians.

“I just went with it because they knew better than I did. They are more experienced in childbirth, so I just let them…” (Mother, quoted in Kornelsen, 2005: 1500)

The quotation shows two characteristic features of clinic birth mothers. First, a birth, although it takes place within the woman’s body, is so complicated that it is not she, but an expert who possesses key knowledge about it. The quotation is made even more poignant by the fact that more often than not, women with this attitude are referring to a male doctor, i.e., someone who will never give birth himself. We shall return to this point in the section on trust. Second, the woman is referring to the obstetrician, not to the clinic midwife, although it is the midwife that is present during the birth, while the obstetrician only attends at the end (unless pathologies arise). Clinic midwives tend to be neglected both in the planning of the birth and in subsequent stories about it. (“Doctor X delivered my baby”). This leads directly to the view
of the clinic midwives themselves, who, in contrast to their self-employed counterparts, subscribe to the institutional logic of the clinic birth.

“I have been a midwife for 33 years now, and I always say: For a long time, nothing happens at all. But if something serious happens – and that has dominated my actions – then five minutes are too long.” (Clinic midwife)

While German law states that a midwife is solely responsible for a normal birth, and that she must surrender responsibility to the obstetrician if and only if the birth becomes pathological, the division of labor in reality is much more subtle. The continuum extends from clinics where the obstetrician is more or less continuously present and the midwife is merely his or her assistant to clinics where midwives work alone and doctors only attend at the end, if at all. Between these extremes is a large grey zone of individual negotiation, which more often than not depends on the individual characters and professional experience of the midwives and obstetricians involved. Still, in comparison with their self-employed colleagues, clinic midwives are more prepared to surrender responsibility to the obstetrician. My assumption is that this is due to the dominance of a pathological view expressed in the statement “I know what can happen”. The persisting prevalence of this pathological view, at least in a large clinic, is confirmed by one obstetrician:

“You always smell the danger. That’s very problematic if you have, for example, four delivery rooms, and in three of them you’ve got pathologies, multiples, early births, bleedings, then it is difficult to switch in the fourth room, where you’ve got a normal woman at due date, and not look at her through the lens ‘What’s is the problem here?’ There is none. But it is difficult to go back to the normal level. […] You’re a bit warped mentally. […] That’s surely a problem in all big clinics.” (Obstetrician at a perinatal center)
Working in a birth clinic, however, does not only involve hierarchy as an organizational fact. In all my interviews with clinic employees, financial and particularly the legal aspects of perinatal care were mentioned as factors structuring the task at hand. Almost all interviewees were aware of the legal dangers of their work, although none had ever been sued. They all, however, agreed that they would do things differently if they were not afraid of being sued. As a rule, “differently” meant the use of less (control) technology and fewer interventions.

And indeed, other studies show that this fear of legal prosecution is one major cause for the rise of caesarean sections in Germany. The caesarean section rate in Germany has risen from 15.2% in 1991 to 25.5% in 2003 (Lutz and Kolip, 2006). About 90% of these are performed without an absolute medical indication, i.e., a state that puts the baby’s or mother’s life at risk (Lutz and Kolip, 2006). When asked about this development, obstetricians replied:

““That’s just the fear you have. Just the fear that if something happens you can’t justify to not have performed a caesarean section.” (Assistant obstetrician)

“And in Germany – that’s unfortunately true – some things are done just so you can’t get sued. And that’s one of our problems. [...] I think that is one reason why so many caesareans are performed, just because they say, ‘We don’t want to have a problem: she’s getting a caesarean, then the baby is out and it’s over’. For in Germany, nobody has ever been sued for performing a caesarean.” (Obstetrician)

Other organizational considerations also contribute to the rise in caesarean sections. For example, a disproportionate number of the smaller clinics with fewer than 500 births p.a. have a section rate of over 50% (Lutz and Kolip, 2006). The reason is quite simple: While a vaginal
birth can take 24 hours or even longer, a caesarean section is performed in 30 minutes – and is even better paid for by health insurers. Especially small clinics that do not have a complete surgery team on duty around the clock tend to prefer the quick solution over the long one. To date, this development has in some respects come full circle, such as with regard to babies in breech position⁸. As a consequence of their lack of practise, young obstetricians become de-skilled to the extent that they must opt for a caesarean section because they cannot assist vaginal births with such complications. In comparison, this strong presence of organizational demands has no counterpart in the statements of the self-employed midwives, although the same legal and market rules apply to them. As for their salaries, although they may not be entirely happy with their pay, they have accepted that midwifery is not the path to wealth or prosperity. Some even adhere to the tradition⁹ that you need a husband with an income in order to survive as a midwife. Legal aspects, too, were only mentioned if I inquired about them, and then rather shrugged off. Compare the following quotations:

“If a child today at the age of six does not speak four languages, they will go and look if something went wrong at birth. And hence, naturally, you protect yourself, no question.”

(Obstetrician)

“... you sometimes walk on thin ice.” (Self-employed midwife)

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⁷ Perinatal care is high-risk medicine with the highest insurance premiums and amount of damages (Lutz and Kolip, 2006).
⁸ Breech position means that the baby is born with its feet coming first. Today, 90% of these babies in Germany are delivered by caesarean section, for first-time mothers the figure is almost 100% (Lutz and Kolip, 2006).
⁹ Especially in the decades after World War II, self-employed midwives could not earn a living on their own (Bierig et al., 1999).
Organizational demands can thus be seen as perpetuating and strengthening the logic of the clinic from which they originated\textsuperscript{10}, even to the extent of becoming dysfunctional. Above, I discussed the example of de-skilling with regard to handling vaginal births. I also suspect (but have no supporting data) that the rise in the number of lawsuits, which has such negative effects on the daily work of all clinic employees in the delivery room, is a consequence of the implicit or explicit promise of absolute control and safety promoted by clinics. Parents may feel betrayed if they opt for a clinic birth and the baby still dies. Therefore, one obstetrician asked to speculate on the reasons for the rise in lawsuits replied:

“\textit{Everything has to be perfect. It has to go according to plan. The child must be perfect, the woman must not be harmed. Fate is completely ignored. There is no fate. Today you can plan everything, organise everything to the point of perfection. Where is there room for fate in this? Nowhere.}”

This leads us directly to the issue of trust in the respective birthing institutions.

\textit{Trust}

With its strong secular tradition, western culture has apparently foregone metaphysical concerns and now focuses on the physical-medical aspects of the well-being of mother and baby. When asked, mothers-to-be, obstetricians, and midwives unanimously reply that this is their prime concern. Upon closer investigation, however, this clearly defined concern dissolves into several aspects, most of which carry some existential anxiety. In his study on risk perception, Langford (2002) classifies four fundamental arenas of existential anxieties, viz. death, isolation, meaninglessness, and the burden of freedom/responsibility. All of them

\textsuperscript{10} Compare Giddens’s “expert systems”.

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concern the individual as well as the social level. And all are present in the birth situation, as
the child or the mother may die (death), the woman is set apart from many of her previous
living circumstances by her special physical and emotional condition as well as the need to
care intensively for the newborn (isolation), and the need to reconsider and rearrange life
plans (the meaning of life). In the modern context with its lack of rigid social control, this
places a rather heavy burden of choice and responsibility on the prospective mother.
Thus, birth constitutes one example of what Giddens calls “fateful moments”. According to
him (1991: 109ff.), high modernity has – mostly successfully – sought to ban existential
concerns from daily life. In the case of birth, society has relegated it to secluded institutions –
clinics –, where only the mother-to-be, the midwife, an obstetrician and perhaps one other
person close to the mother are present. This together with the fact that the number of births in
Germany has been in constant decline since 1965, means that a considerable percentage of the
population has never attended a live birth. The gap is filled by the media in a roughly inverse
relation: the fewer people who see a live birth, the more films and reports are produced on the
subject. Giddens calls this “fictionalization”, a process intended to fill the void created by the
loss of an existential experience. This exclusion on the one hand creates a certain demand for
this experience (which is, after all, fundamental to the existence of human beings), but on the
other hand calls for a mediated form of the experience that can be controlled and mastered.
The existential angle is important for the discussion of trust in the context of birthing. Many
authors, among them Giddens (1991) and Zucker (1986), distinguish between (at least) two
forms of trust, one personal and one abstract-institutional. As Giddens maintains, both forms
are interrelated, or as Knights et al. (2001: 314f.) put it: “No institution can remain trusted
without the continual reproduction of trust through interpersonal relations. However, the latter
is facilitated by a reputation of trust at the institutional level.” Still, practises and institutions
may differ with regard to the extent to which they rely on either form.
Congruent to their institutional logic, personal trust is the basis of home births. The mother-to-be contacts the midwife several weeks before the birth with the aim of both of them getting to know each other. If the “chemistry” between the two does not fit, they normally decide to part ways before the birth. Clinics, on the other hand, build up institutional trust by way of professionalization, standards, certificates, technology, and other means. Even if a mother-to-be visits one of the prenatal courses offered by the clinic or has her examinations there, she can never be sure if the same midwife and the obstetrician she has met in person will be on duty the day she goes into labor.

Trust, however, is not just an internal state of the mother. Perinatal institutions also play an active role in producing the form of trust that works in their favour. Zucker (1986) gives three reasons for the emergence of institutional trust: social distance, geographic distance, and an increase in the interdependency of transactions. Of those three, only the latter plays a significant role in the production of “clinic trust”. In this case, birth is portrayed as a complex medical-physiological process that can only be handled and controlled by medical experts, i.e., doctors. A number of smaller factors contribute to this picture:

- The birth must take place in a special location (i.e., the clinic) with special technology.
- If a familiar person accompanies the mother, he or she is made unfamiliar by having to wear an sterile clothing.
- The mother herself is transformed into a de-sexualised person/object, for example by shaving her pubic hair.

As a cluster, these practises destroy the possibility of developing personal trust between mothers and clinic staff because they eliminate the required degree of familiarity and confidence.

Among the most influential factors, however, are the series of medical examinations a pregnant woman undergoes from the beginning of her pregnancy. In Germany, almost 90% of...
pregnant women see a gynaecologist by the end of the 12th week of pregnancy, and about 75% of them will continue to do so roughly every three weeks until birth (Schücking, 2003).

These examinations produce several effects:

- The woman is de-skilled with regard to reading the signs of her body and trusting her instincts. Instead, it is the doctor and his or her technology that tells her whether she and baby are in good condition.
- Particularly with the rise of prenatal diagnosis techniques, the continuous and sophisticated monitoring suggest that it is possible to master the birthing process and that with the help of medical expertise, it can be made perfectly safe.
- The mother-to-be becomes used to talking to a doctor instead of to a midwife about her pregnancy. Hence, she is more inclined to expect a doctor to be present at birth.
- A physiological bias: The progress of pregnancy is measured in quantitative-scientific terms alone. Results from blood tests, CTG, and ultrasound examinations are valued much higher in their validity than psycho-social factors or the mother’s feeling for herself and the baby (Schücking, 2003).
- A pathological bias: Doctors tend to look actively for pathologies, while midwives tend to wait until clear pathological signs show. As a consequence, two thirds of pregnant German women are considered to have “risk pregnancies” – a global pole position (Rüb, 2004).
- In some cases, the woman is actively discouraged by the gynecologist from contacting a self-employed midwife:

“…there are gynaecologists in Chemnitz who tell the women – I quote: ‘If you go to a midwife, they’ll send me to prison.’ […] Not: ‘If something happens…’ but ‘If you go to a midwife, they’ll send me to prison, because I carry the responsibility.’ (Self-employed midwife)

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In sum, these practices bolster the institutional logic of the clinic birth while devaluing the assumptions of the home birth logic. They create, or at least enforce, the feeling of being in danger, of not being able to cope on one’s own, and needing help from a professional doctor. Apart from these effects that are produced in more or less direct contact with the caregivers, there are a number of supporting issues, of which I shall discuss two, namely technology and the preference for mastery or morality. Technology is strongly linked to giving birth in a clinic; hence, the woman’s attitude toward technology plays an important role. In his study on the decision between home and clinic births, Kornelsen (2005) was able to show that women choosing to give birth in a clinic had a much more positive attitude towards technology than their home-birthing counterparts, some of whom expressed an outright aversion to technological interference. The reverse was true when asked what they considered embarrassing or uncomfortable: a higher proportion of the clinic-birthing mothers cited being touched or examined by a person.

In terms of trust, the de-skilling of the “users” creates a demand for expert systems as described by Giddens, that can only be satisfied by an institution. Second, other related institutions, viz. antenatal care and perinatal technology, “socialize” the mothers-to-be into taking the clinic and its assumptions and procedures for granted with regard to giving birth. Last but not least, fictionalization works in favor of institutional trust, because in most birthing stories the clinic birth is either taken for granted or portrayed as the rescuing institution in a horrible situation the mother is unable to cope with on her own.

Finally, Giddens’s concepts of mastery and morality come into play if we look at the degree of the mothers’ self-reliance and acceptance of “fate” if something unexpectedly goes wrong. Mothers who give birth at home seem more prepared to accept an adverse outcome as something that can happen even under the best circumstances or as God’s will.
[In response to the question of what distinguishes home birth from clinic birth mothers]: “... often, perhaps, people who believe in God, who in a way trust in God, [believe] that [birth] is something natural, and who can accept whatever comes. Those who do not say: ‘If something goes wrong, I’ll blame myself for the rest of my life.’” (Self-employed midwife)

“If you want to cut the baby out, fine, you’ve got control. But that’s not birthing a baby.”
(Mother, quoted in Kornelsen, 2005: 1499)

The latter attitude supports the idea of birth as a fateful moment, one that cannot be completely controlled. Hence, women entertaining this attitude are more inclined to follow the institutional logic of home birth and invest personal rather than institutional trust in those assisting them.

In fact, the desire for mastery is one of the major impulses for the creation of modern institutions in the sense of expert systems. In terms of trust, people driven by this desire value institutional trust (i.e., trust in expert systems) over personal trust as institutional trust suggests a higher degree of control (provided by examinations, professional standards, etc.) over its members and procedures. Personal trust, on the other hand, becomes important in fateful moments. In fateful moments, existential dangers and anxieties arise, and our familiar modern world including its institutions becomes, in Heidegger’s words, unfamiliar or unhomely (un-heimlich). It is then that individuals turn to older and simpler forms of interaction and communication, in our case to personal trust. Moreover, the strong emotional nature of these moments may prompt some to forsake reflexivity and “trust their gut”, which again works in favor of personal trust.

Ideology and Identity
Ideology and identity are related phenomena (Patriotta and Lanzara, 2006; O'Doherty and Willmott, 2000/2001; Foucault, 1976/1978). Identity, especially social identity, is built on narrative, or in Giddens’s words, is “the capacity to keep a particular narrative going” (Giddens 1991: 54). On the other hand, texts are reproduced and thus become ideologies if and only if they discuss topics that are somehow central to people’s concerns (Phillips et al., 2004), and one major concern is identity construction (Foucault, 1976/1978). Competing institutional logics provide individual actors with a choice between several ideologies with which to view the same topic. Giddens (1991) refers to this phenomenon, which he considers characteristic for high modernity, as “choice of lifestyle”. This paves the way for institutionalist approaches that argue for a “toolkit” perspective (DiMaggio, 1997) in which people incorporate into their identity various elements their culture offers them more or less at will. At the same time, the influence of socialization or other collective formation processes is relegated to the background. From an empirical angle, Meyer and Hammerschmid, for example, have also argued for the existence of “hybrid selves” who incorporate different, at times even conflicting notions concerning the same issue. To them, social identity is a feature “of a social situation, not a person” (2006: 1005). In consequence, identity should be viewed not as a collection of stable properties the individual “carries” but rather as an enactment of selective responses to a certain situation the individual considers appropriate. In this perspective, identity is an active process with many elements of choice, although, of course, certain restrictions or structural determinants to influence this choice are still in place.

Discussing the relationship between identity and birth practices, two types of ideology seem important. The first is the safety ideology. It goes hand in hand with the institutional logics as portrayed above, for which safety is the central concern. In answer to my question why mothers would choose the clinic, all interviewees indicated “safety” as the prime and often sole reason. This finding is confirmed by other studies (Fisher et al., 2006; Kornelsen, 2005; Longworth et al., 2001) as well as my own informal experience with other mothers-to-be.
However, as we have seen above, the notion of safety, as the complementary notion of “risk”, is subject to very different interpretations resulting in very different logics. Basically, and in accordance with the competing institutional logics, safety is on the one hand defined as “letting nature do what she is equipped for best” with risks lying in human or technological intervention. On the other hand, it is defined as “being in control to the best of scientific-medical knowledge” with risks lying in underestimating the potential dangers of childbirth.

In conclusion, the competition and dynamics of institutional logics is partly based on the indexicality of language; i.e., the fact that words may take on different meanings in different contexts. This feature allows individuals to entertain various interpretations for various situations (and thus create hybrid selves, for example), and collectives to integrate actors with different interpretations in one group (and thus create, for example, overarching logics). In the long run, this indexicality can also provide room for the establishment of new institutional logics based on yet another interpretation.

The link between institutional logics and mothers’ identities has been discussed above as well:

In the first case, mothers tend to see themselves as (sometimes solely) responsible for the birth (“giving birth to a baby”). Part of that responsibility is the strength to forsake the apparent (but false) safety of a clinic and the superficial (but ultimately damaging) comfort medical technology can offer. In this instance, being a woman implies being equipped with a number of unique (in comparison with men) physical and emotional qualities that make it possible to give birth.

In the second case, mothers tend to see the birth expertise as resting with the professional caregivers, and here mostly with the obstetricians. They are prepared to sacrifice their personal wishes and expectations, at least to a certain degree, for medical prescriptions and routines. The availability of medical technology is comforting for them, either as a worst-case option, or quite actively as something included in the birth plan from the start (e.g., planned PDA or elective caesarean sections). In terms of identity, the “worst case” patients accept that
they must go through the birth experience, but hope that if it exceeds their strength, someone will be there to rescue them from their plight. The “birth plan” mothers, on the other hand, take a more active stance in stating and asserting their wishes vis-à-vis the obstetricians. They are essentially motivated by a purely negative image of the birth process connoted with unnecessary and avoidable pain.

It seems that these fears are spread and worsened by the fictionalization of birth discussed above (Fisher et al., 2006; Lutz and Kolip, 2006). In the absence of personal experiences to correct them, the ubiquitous “horror stories” about birth can thrive to a much greater extent than they did decades ago.

INSERT TABLE 1 ABOUT HERE

Ideology and identity, however, possess not only cognitive and emotional features, but also a material side that is often overlooked and undertheorized\(^\text{11}\) – this is, among others, Friedland and Alford’s objection. In consequence, to my knowledge, no empirical studies\(^\text{12}\) exist that describe different “body styles” as part of the identity construction, at least not as far as mothers and their decisions are concerned. Thus, the following argument is new and mainly speculative, although I believe the styles to be well documented in magazines, TV, and other forms of public discourse. This second kind of ideology important to the identity construction and subsequently the choice of a birth practise is the way mothers-to-be view their body and its relation to the “I” or self. Public ideologies offer a number of different “styles” that construct this relation a bit differently each time. Table 1 does not claim to give a comprehensive list as styles change or merge, but should give an idea of some basic claims.

\(^\text{11}\) This is despite exciting developments in the sociology of the body (Schatzki and Natter, 1996; Shilling, 1993/1997).

\(^\text{12}\) The main empirically well-researched connections between body and identity concern sex/gender and weight problems.
and differences in an ideal-typical fashion. Taken together with the safety ideology, an explanation for the choice of a certain birth practise based on identity and ideology emerges. The first three types portray a view of the body as something material and separated from the spiritual soul or self (note the proximity to the Cartesian dichotomy of body and soul, which has provided the basis for modern science). The body hence can be designed or optimized like an object to suit individual aesthetics or other needs. Technical or medical intervention is viewed here as something comparatively unproblematic. On the other hand, these types, in their efforts to model or optimize it, value the body quite highly, which provides the motivation to escape pain or potential bodily damage induced by birth. Hence, identities based on these types will tend to opt for a clinic birth as they, on the one hand, do not fear interventions, and, on the other, see a chance to minimize pain and physical risk of the mother through anesthesia and surgery.

The following three types see the body as part of something larger, and thus may be less inclined to tamper with it as the results of an intervention for the (individual or supra-individual) whole cannot be determined or are at least not unproblematic. They are likely to favour giving birth at home, as they have a very positive image of nature and/or other forces guiding the birth and trust their own body (as part of these forces) to accomplish the task. They may also be better prepared to accept an adverse outcome as part of “nature’s plan” or “God’s will”.

The seventh type refuses intervention for different reasons. Its emphasis is on the control perspective and the opposition against dominant (male) societal mechanisms. Women of this type may refuse a clinic birth because they do not want to be treated by a male obstetrician and/or prefer the rather egalitarian atmosphere of the midwife-mother relation (see above: the midwife as guest) over the more directive doctor-patient relationship.

Finally, the eighth type is basically not interested in the choice between giving birth at a clinic or at home nor in the ideologies involved, but simply goes along with the mainstream for
reasons of convenience. This is the classic type for institutional reproduction, as it accepts the
dominant logic without any reflection or desire to modify the status quo.

While this section has focused on the role of ideology for the individual mother’s identity and
choice, the subsequent section will deal with the question of how these ideologies are
sustained and manipulated by the respective institutions.

*Ideology and Control*

Ideologies are not only key for individual identity construction, but perhaps even more so for
collective identities from group level up to the institutional logics of an institutional field. All
collective identity construction is, by necessity, based on communication. As identity
construction is closely linked to legitimation and symbolic resources, this communication, in
turn, is a mirror of the power relations structuring the collectivity or field. It is thus never
neutral or “just language”, but creative (or destructive) in the Foucaultian sense of ideology
(Foucault and Gordon, 1980/1992). Incumbent groups will use certain forms of ideology to
retain power, while opposition groups will use different forms to challenge or acquire power.
Vice versa, power and even more so legitimacy will determine which ideologies become
“listened to” and reproduced.\(^{13}\) Hensmans (2003) distinguishes between systemic power and
performatif power. The former belongs to the already powerful group seeking to maintain
the status quo, the latter to the challengers seeking change.

Thus, in the case of perinatal institutions, the powerful clinic faction can use the well-
established high regard for the competence of the natural sciences and medicine to present
themselves as the “obvious choice”. Three hundred years of Western medicine have already
institutionalized the doctor as the superior expert and the patient as a passive, subordinate object, the exclusion of existential concerns, a materialist view of the body, and other notions, so that very few additional arguments are required to make mothers-to-be comply with these rules. Critical studies on the dangers of medical intervention or clinic hygiene are suppressed rather easily because, first, competence is seen as residing with the doctors rejecting the studies, and second, it is the obstetricians, not the academics producing those studies that come into contact with the mothers. A closer look at historical studies of birth and mortality rates even shows that history has been rewritten to suit the clinic ideology of safety. There is, of course, no doubt that maternal and infant mortality are currently at an all-time low. In Germany, 8 out of 100,000 mothers die in the course of pregnancy and birth (Lutz and Kolip, 2006), and roughly 5,000 out of 750,000 babies are stillborn or die in the first seven days of their lives (WHO, 2006). Obstetricians argue that this decrease is due to the high percentage of clinic births, and take it as proof that home births are dangerous. This view is supported by the popular belief that in pre-modern times, women bore many children, most of whom died early on (Laslett, 1991). However, the apparent danger of births in former, i.e., non-clinic, times is grossly exaggerated. Based on studies of church registries in the 18th century, Labouvie (1998: 160) estimates an average mortality in the first four weeks after birth of 5-7% (albeit with considerable regional differences). What is comparatively high – and always has been until the 19th century – is the level of infant mortality; i.e., the mortality of children up to one year of age. In some places at certain times (e.g., the German Danube valley in the 19th century), this mortality reached sad peaks of up to 50% (Kölbl, 2004). Infant mortality, however, must not be confused with perinatal mortality, i.e. the death of the baby during birth or in the first seven days. It is perinatal mortality that may be affected by the decision for a clinic birth, while the decrease of infant mortality in Western countries has many reasons. And although there is no doubt that perinatal mortality rates have fallen in the course of the

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13 Bourdieu (1992) has provided a brilliant analysis of language, legitimacy, and symbolic power, which
20th century,\textsuperscript{14} the fall has never been as dramatic as common belief, based on infant mortality, suggests. Moreover, the causes for the decline are not as clear as clinics might like them to be. The WHO explains:

“Neonatal deaths and stillbirths stem from poor maternal health, inadequate care during pregnancy, inappropriate management of complications during pregnancy and delivery, poor hygiene during delivery and the first critical hours after birth, and lack of newborn care. Several factors such as women’s status in society, their nutritional status at the time of conception, early childbearing, too many closely spaced pregnancies and harmful practices, such as inadequate cord care, letting the baby stay wet and cold, discarding colostrum and feeding other food, are deeply rooted in the cultural fabric of societies and interact in ways that are not always clearly understood” (WHO, 2006: 2).

This implies that the decrease is not a result of selecting the clinic over the home, but a consequence of the high overall living standard in industrialized countries. Indeed, a look at the Netherlands shows that their perinatal mortality rate in 2000 is at 0.8% only insignificantly higher than Germany’s rate of 0.6% (WHO, 2006) despite the high percentage of home births.

The apparent neutrality of the systemic ideology is not only suggested by the clinic, but also by a number of other interest groups, most prominently politicians and health insurance companies. Both suggest that the choice for either clinic or home birth is an entirely free choice made by the mother between two equal institutions, and that any political or financial action on their part would result in “unfairness” or “infringement of the right of free choice”.

\textsuperscript{14} In Germany, for example, it decreased from 5% in the 1950s to 0.2% in the 1990s (Braun, 2006).
Thus, the German government replied to a formal query of the Left Party regarding political measures against the “discrimination of births outside the clinic” as follows:

“The government does not influence the decision on where an expecting mother gives birth. This is an autonomous decision of any pregnant woman which is taken in agreement with the respective obstetrician or midwife if necessary” (Deutscher Bundestag, 2006).

The fact that almost 98% of all pregnant women opt for a clinic birth therefore seems to be based on rational, neutral facts alone. This view, however, makes it difficult to explain why, in the ELTERN survey (Pohl, 2006), 76% of the respondents did not even consider a home birth, or why most mothers-to-be still believe that it is the obstetrician who is responsible for a birth. Moreover, it glosses over the fact that the medical lobby is very strong in Germany, as opposed to the – almost non-existent – lobbyism of the midwives’ association.

In addition, although home birth is now at least mentioned as a possibility in most parenting magazines, the emphasis is still on clinic births. They are often mentioned in articles with detailed instructions on “how to pack your suitcase for the clinic”, for example, while no such lists are given for home birth preparations.

Against these odds, the opposition ideology is mainly based on forming coalitions with other groups and ideologies promoting alternative lifestyles. Thus, the programs of a midwife practise and a birth center in Chemnitz offer the following courses on a regular basis:

- Bioenergetics,
- Yoga,
- System Constellations,
- Bhajan singing,
- Homeopathy for children.
One example concerning coalitions is that Hess, a major German producer and distributor of clothing made from natural textiles, promotes birth centers in its catalog. Another sponsor is Dydimos, the company that introduced baby slings to the German market as alternative forms of transporting one’s child.

In sum, distinctive “genres” or forms of communicating the respective ideology can be discerned. Powerful groups tend to use, first, their own power (for example, their recognized expertise and legitimacy); second, the power of other already established groups (e.g., the government); and third, the historical process of institutionalization that has worked in their favor. With the help of these factors, they can exert rather unobtrusive power and portray their stance as the “natural” or “reasonable” one (see, in a similar vein, Bourdieu, 1992). With regard to their competitors, they tend to take a coopting stance portraying them as differing only slightly from their own position:

“I would wish for all of us meeting somewhere in the middle, all midwives; I would be happy if our [local] birth center, that sends the women to me when things go bad, if they said in advance... It is the woman who should take priority. And as we open ourselves and let midwives act more and more on their own, then they should take the step as well. They can have their women give birth here.” (Obstetrician)

Opposition groups, on the other hand, tend to ally themselves with other marginalized groups. In order to challenge the status quo, they are forced to argue and act more openly political. A common generic theme of their argument is a certain form of liberalism or pluralism according to which “Everyone should be allowed to decide for themselves (having been given full information)”. The latter part of the sentence is important as it appeals, again, to the “facts” which, if unsuppressed, are seen as arguing in favor of one’s own position.
In terms of my theoretical model, it is important to see that both appeal to the knowledge or reason of the individual decision-makers, although with very different arguments, and that these arguments are generic in the sense that they are not tied to the case of perinatal institutions, but rather can be found whenever competing logics are analyzed.

CONCLUSION

Returning to Friedland and Alford’s two conceptual concerns – conflicting institutional logics and the relationship between agency and institutions –, we can now describe certain institutional processes in greater depth. I shall begin with four more detailed observations before discussing two results on a more general plane.

First, institutional logics are shaped by, and in turn shape, technology and organizational (financial, legal) requirements. This, at first glance, seems like a simple application of Giddens’s duality of structure. However, the case is not as straightforward as Giddens has portrayed it since there are two (or more) conflicting logics involved. Those logics deal with (in material terms) the same technology or requirement, but construe it quite differently. Thus, for example, a permanent CTG can be regarded as either a means of ensuring the baby’s well-being or as a rather unnecessary, disturbing, and potentially malfunctioning device. Thus, Giddens’s simple reproduction circle “technology ⇔ logics” must be extended to include a second circle “logics A ⇔ technology ⇔ logics B”. Both logics affect the technology to a different extent at different times, and are vice versa affected by it. Moreover, logic A may sometimes take logic B into account when changing the technology, for example when pro-technology clinics seek to attract anti-technology mothers. Hence, this double cycle can reframe the duality model to incorporate the notion of change (rather than reproduction).

Second, the establishment of institutional trust results in the de-skilling of individual actors. Again, Giddens has observed a similar phenomenon in his discussion on trust and expert
systems. He, however, was concerned with the layperson; i.e., the individual actor that seeks advice from or trusts the expert system. My case shows, moreover, that sometimes the experts themselves can become de-skilled, such as young obstetricians no longer capable of performing a vaginal breech birth, for example. This is due to the fact that practises that are considered too risky will be replaced by other practises in order to avoid legal, financial, or reputational repercussions. The establishment and maintenance of institutional trust here results in an extremely risk-averse culture, where professionals would rather not act at all than act in a way that involves personal or institutional liability. Further comparative research could help determine whether this is a feature of all expert systems, or limited to institutions with an explicit “safety logic”, as is the case with birth clinics.

Third, the case shows how a special class of occasions, viz existential ones, is reinterpreted in order to establish institutional trust. Zucker (1986) has listed two forms of distancing (social and geographical) as major reasons for the emergence of institutional trust. In the case of “fateful moments”, we find a third form of distancing, which reflects the modern trend of denial or exclusion of sexuality, madness, and death. The fictionalization of birth causes affectual distancing, which paves the way for institutional trust in the same manner as social and geographical distancing do.

Fourth, actors’ choices and institutional logics are connected by ideology. On the one hand, institutions try to control ideologies to promote their goals and values. They may do so by investing certain speakers with legitimacy, by rewriting history, or, in the case of dominant logics, by appealing to an apparent neutrality of the status quo which is already set in their favor. Actors, on the other hand, draw on certain – sometimes various – ideologies in order to enact their self-identity or construe their body style.

On a more general plane, two further results seem to be relevant with regard to Friedland and Alford’s initial concerns.
With regard to the dynamics of competing institutional logics, it should be noted that their interaction pattern is far more complex than mere competition would suggest. First, as they define themselves in difference to one another, they are much more dependent on each other because changes in the one will force the other to shift in response. Second, they are, to a certain extent, manipulated by skilled actors with a strategic interest. Hence they will, for example, react to fashions by including the fashionable elements in order to become more attractive to potential “users”. Third, they are, as we have seen, bound to different forms of argument (systemic vs performative). Thus, they will reinterpret external stimuli in accordance with these different forms. These forms of argument, moreover, depend on the relative power position (challenger vs incumbent) and thus can change with a change in that power position.

As for the relationship between institutions and agency, I believe it makes sense to take the semantic distinction between agent and agency seriously. As I have tried to show in the previous sections, institutions produce agency by providing the resources necessary to act, such as legitimacy. This conviction forms a central part of many “structuralist” social theories and institutionalist approaches. However, what is often overlooked is that institutions create agency, but not agents. Agents, i.e., human individuals or collectivities, are not just products, but to a certain extent free and skilled beings, as “voluntaristic” social theories assume. Agents desire agency, for example to construe their self-identity. In order to acquire this agency, they must choose, trust in, or use institutions that provide it. This rather simple sketch combines a conflict with a reproduction perspective as institutions compete for resources in order to become attractive to agents, and on the other hand, are reproduced by the choice of agents and by the characteristic acts born of the agency they provide. Thus, conflict and reproduction as well as institutions and agents become integral to the theory.
References


