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THE DEATH OF BIRTH: A CRITICAL INTERPRETIVE ANALYSIS OF SECOND WAVE LIBERAL FEMINIST EFFORTS TO INFLUENCE WOMEN'S CHILDBIRTH EXPERIENCES IN THE UNITED STATES DURING THE LAST THIRD OF THE TWENTIETH CENTURY

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ABSTRACT

THE DEATH OF BIRTH: A CRITICAL INTERPRETIVE ANALYSIS OF SECOND WAVE LIBERAL FEMINIST EFFORTS TO INFLUENCE WOMEN'S CHILDBIRTH EXPERIENCES IN THE UNITED STATES DURING THE LAST THIRD OF THE TWENTIETH CENTURY

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Mid-twentieth century "second wave" liberal feminists responded to concerns over increasing medical appropriation of women's reproductive bodies with directed efforts focused on an agenda of increased lay health awareness through individual agency. This agenda assumed that increased lay medical knowledge would ultimately equalize the asymmetrical power relationship with health care providers, thus enabling women to make informed choices. It was further assumed that given a choice, most women would choose a demedicalized birth experience. A review the state of medicalized birth at the close of the twentieth century suggests that such efforts have largely been unsuccessful. Liberal feminist assumptions proved to be naive regarding individual choice and individual control. Individual health choices occur in a climate limited by institutional interests which serve to limit available choices to those in the institutions own best economic and political interests.

This thesis is dedicated to my parents and their partners, who have taught me by example that living means a lifetime of learning, and to my partner Bill who continues to both pursue and embrace a lifetime of learning with me and with our children, Will and Rachel.

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This thesis has benefited from the advice and assistance of several people. I appreciate the direction I received from committee members Dr. Howard Brody and Dr. Patricia Mullan, whose collective insights into the intricacies of the health care system served to improve my many thesis drafts. I wish to extend a special expression of my gratitude to co-chairs, Dr. Judith Andre and Dr. Maxine Baca Zinn. Their professional dedication to student achievement is selfless and noteworthy. I continued to realize how much I had learned from both of them through every step of the production of this work.

I will always be grateful to Dr. Peter Vinten-Johansen, founding father and former director of the Interdisciplinary Programs in Health and Humanities for his guidance, his support, and his daily modeling of the virtue of social responsibility. My thanks also goes to the current director, Dr. Tom Tomlinson for his continuation of this support.

The idea for this thesis grew out of the ongoing struggles experienced by a forthright and dedicated group of women who saw then and continue to see that the transformative experience of childbirth can be an empowering and self-affirming event in a woman's life. Without the many long, heartfelt and passionate discussions with Kip Kozlowski, Susan Ekstrom, Katchen Schibilsky, and Lynette Biery, this thesis would not have been realized. My thanks to my sisters.

Finally, my heartfelt gratitude goes out to my mentor and life partner, Bill, and to our children. Their continuous support and encouragement allowed me to pursue my goals.

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CHAPTER 1

INTRODUCTION

Second wave feminism, having its inception in the 1960's, had then and continues to have many faces (Grant 1993). In this thesis I first describe and then critique the efforts of what I term liberal feminists; those who sought modification of the social order through manipulation of the existing order. Liberal feminists,

> ...maintained that the women's problem was...ideological [and] it could be effectively countered by a program that combined persuasion, reeducation, the provision of "role models" and the development of pressure groups. Liberal feminists see the social subordination of women reflected in the sexual structure of the organization of medicine, i.e., in a field where women are the majority of health care workers, the upper reaches of the medical hierarchy constitutes a virtual male monopoly...another area of criticism concerns the nature of the doctor/patient interaction. [Male] physicians heal (or do not heal) from a position of power; they relate in either a paternalistic or an authoritarian manner to their patients...(Fee 1983: 19).

The liberal feminist critique thus approached problems of women's medical care at the point most visible and presumably accessible to middle- and upper-middle-class individual women -- as consumers. This view offered less to female staff persons whose work maintained the everyday functioning of the medical system, and less to underserved women from historically marginalized populations for whom medical care was often unavailable and, who commonly suffered from conditions of deprivation and abuse in everyday life.

In the reproductive arena of childbirth, such an approach focused on a concern over the increasing medicalization of birth. Second wave liberal

feminists questioned benefits realized over such excessive medicalization. They addressed such concerns by challenging the basic assumptions of the medical model of birth, which were based on a representation of the female body as both unpredictable and unreliable and in need of constant surveillance, maintenance, and repair. Second wave liberal feminists thus put forth an agenda that suggested the solution to the increasing medicalization of birth was to manipulate the following three variables, 1) gender - suggesting an increase the number of women physicians; 2) knowledge - suggesting an increase in lay women's birth knowledge; and 3) socially constructed expectations - attempting to influence the birthing woman's expectations of the birth experience to include a demedicalized event. Such an agenda was inattentive to conditions of everyday life for women from historically marginalized populations. Moreover, the agenda proved to be naive regarding the potential for individuals to either control or to influence their "choices" in health care delivery.

In this thesis, I assume a social science critical interpretive approach, which has a "commitment to understanding the distribution of power and wealth and its effects on health and healing" (Morgan 1990: 945). As explicated by anthropologist Merrill Singer:

> Critical medical anthropology maintains that discussion of specific health problems apart from macrolevel political and economic issues only serves to mystify social relationships that underlie environmental, occupational, nutritional, residential, and experimental conditions...Importantly, the ultimate origin of these problems is not environmental or biological but social, namely the existence of inherently oppressive social relationships of production and expropriation (Singer 1986: 129).

With this approach, I first critically review the history of medicalized childbirth in the United States. I then follow this historical review with an examination of how certain selected second wave feminist social scientists exposed the failings of medicalized birth in delivering optimal care to parturient women; all of the scholars utilized a comparative analysis of alternative models for childbirth management to reach their conclusions. I use their findings as a lens by which to further examine a range of second wave efforts in the area of childbirth,with a special focus on those efforts characterized as liberal feminist. I pay careful attention in this examination to those suggested correctives by the respective author's which manifest liberal feminist assumptions. In doing so, I set the stage for the next part of my work which is a critical interpretive analysis of the birth stories from two women who had attended my childbirth classes with a desire to minimize medicalization in their respective birth experiences. The resultant analysis of their failure to achieve such a desired demedicalized birth, reveals the hegemonic influence of the professional-medical-industrial complex in controlling the limiting factors which constrain women's birth experiences.

In my conclusions, I offer my assessment that liberal feminists stopped short of putting forth an agenda which could indeed truly demedicalize women's childbirth experiences, that of birthing outside of the institution of the hospital utilizing birth attendants other than physicians (midwives). This paper critically assesses the influence and coercion of power, economics, and politics in shaping the norms of social behavior and social policy in childbirth practice.

CHAPTER 2

THE UNDERLYING STRUCTURE OF MY INQUIRY

Background

What should a normal birth be like for healthy women in the United States? This question merits attention for many reasons, but certainly access, safety, cost, and quality of experience are variables to be considered. The dominant model of birth in the United States, the medical model, is based on an assumption that birth, regularly, is essentially a pathological event; sufficiently complicated and dangerous to warrant a hospital setting, a plethora of technology, and a physician in attendance. Equally, it is believed that medical intervention will optimize the health of the baby as it is travels through the dangerous and unpredictable journey of birth. Consequently the goal of the medical model of birth is to theoretically insure that all birthing women have access to a hospital and are attended by a physician who is in turn, supported by the latest available birth technology. Yet, beginning as early as the 1940's, research which questioned the efficacy of this model began to surface (Dick-Read 1944).

Childbearing women became concerned about the potentially harmful side-effects of particular technological and pharmacological "tools" regularly employed by physicians. Specifically, their concerns were focused on the risks to the baby from interpartum use of anesthesia for the mother, and the use of forceps, a mechanical spoon-shaped device used to assist in pulling the baby out of the birth canal. The use of forceps in delivery was frequentlymade necessary by administration of anesthesia to the birthing

woman, as the anesthesia diminished the woman's ability to actively participate in pushing the baby out of her body. It was this concern on the part of childbearing women over the potential technological and pharmacological risks to their babies which paved the way for the introduction of the consumer model of "prepared childbirth" (Lamaze 1956; Karmel 1959).

Prepared childbirth was a popular strategy implemented by middle- and upper-middle-class women to prepare women for the experience of childbirth and was intended to teach women breathing strategies to cope with the pain of labor and thereby minimize a reliance on anesthesia. It was also intended that this strategy, when combined with a rudimentary knowledge of the anatomy and physiology of birth, would provide a means whereby laboring women might more fully participate in both the control of labor pain and in decision making during the birth process.

Toward the end of the decade of the 1960's and into the early 1970's a convergence of three distinct but related "grass-roots" movements occurred: 1) second wave feminist efforts to regain control of women's bodies from medical appropriation through access to reproductive freedom and reproductive control, 2) "natural childbirth" efforts designed to encourage women to experience childbirth without pain-relieving drugs, and 3) the consumer movement which encouraged self-help efforts, second opinions and health care shopping (Matthews and Zadak 1991). While this convergence was neither easy nor uncontested,[1] among the many efforts it spawned was one intended to demedicalize the birth experience. As the focus on women's reproductive care broadened, concerns surfaced which questioned the dramatic escalation of technological and pharmacological intervention in

women's childbearing experiences. Feminist research proliferated which questioned the benefits of technocratic, that is to say institutionally controlled and technologically dependent hospital birth, over the risks to both the mother and the baby.[2] By constructing a social platform on this research, second wave liberal feminists used childbirth preparation classes as a tool to more fully educate women about not just the anatomy and physiology of labor and birth, but also to educate them about the range of alternative choices which were theoretically available to manage childbirth and its attendant pain. Certain of the available liberal feminist childbirth preparation classes retained controlled breathing strategies as the mainstay of labor control, others modified it, while still others rejected it entirely. The new enhanced agenda advocated by liberal feminists included strategies for conflict resolution, positional maneuvers for pain management, both positional maneuvers and strategies which attempted to enhance the progress of labor, techniques to avoid an episiotomy, and many other such manipulative techniques. It was felt that knowledge was power, and that the transfer of such knowledge regarding birth management to pregnant women would serve to equalize the asymmetrical and hierarchical power equation with health care providers.

Through such resistance to the dominant, technocratic model, a variety of alternative models surfaced. While some feminists rejected the institutionalized model entirely and opted for homebirth, others sought care in the few available out-of-hospital birthing clinics. However, by far the most common and socially acceptable model was to attempt to manipulate the existing institutional birth experience. Built on a modification of the medical model, this approach maintained that change was to be accomplished through

the manipulation of the gender of the health care provider, followed by increasing the birth knowledge of the pregnant woman and influencing her birth expectations. Using gender arguments, liberal feminists advocated that women as health care consumers seek care from woman physicians over male physicians. Using the model of an educated and aware consumer, they advocated educating pregnant women so that during labor and delivery, the laboring woman could choose to construct the birth experience in such a way as to meet her own individual preferences; and with altered expectations, liberal feminists sought to reframe childbirth from an experience that was fraught with potential pathology and danger to one that was a normal, healthy, and powerfully transformative part of a woman's life. Another goal of this multifaceted alternative model was to theoretically insure that women had access to either a female physician, or at a minimum, a male physician who embraced the liberal feminist childbirth agenda. Further, this model assumed that such a provider would thus be willing to honor the birth plans articulated by a pregnant woman who was both educated about available childbirth management choices, including alternatives to standard technological, pharmacological, and surgical management, and who was, moreover, willing to make these choices.

When this alternative model was introduced in the late 1960's it received a great deal of media coverage which heralded its benefits to both the mother and the baby. In reality, however, it enjoyed very limited success for a very select and privileged population of women.[3] The women who were able to fulfill the model's expectations were largely middle- and upper-middle-class women who had available to them, 1) the time to attend childbirth classes, 2) a husband or close friend who was willing to provide labor support to them, 3) a

hospital which would allow such a support person into the labor and delivery unit, 4) a supportive physician, 5) the self-determination necessary to avoid the potential risks of anesthesia through distraction breathing techniques, and finally, 6) a labor and delivery which met the care provider's expectations of normal (Nelson 1983). Certain aspects of the model, such as the breathing gymnastics and a patient-supplied labor support person, did indeed garner a great deal of credibility within the hospital setting and won enthusiastic support from hospital staff. Yet, ironically, these two strategies served hospital needs well by making women better patients; it made the laboring women quieter and also had them assume the responsibility of bringing their own labor support person (Shaw 1974). Notably, over this same period of time, the rate of technological and surgical intervention in birth increased dramatically (Arms 1975; Corea 1977; Marieskind 1979). Today, despite thirty years of liberal feminist effort to demedicalize childbirth in the United States, the dominant model of childbirth continues to be the technocratic medical model. This thesis will explore why liberal feminist efforts have failed to achieve their goals.

Justification for Research

If liberal feminist criticism of the medical model was justified, if routine technological and surgical intervention was unnecessary for normal healthy women, and if an alternative model existed, then the demedicalization of childbirth in and of itself continues to be a worthy goal; and likewise critical evaluation of past efforts to achieve this goal ought to prove valuable in influencing the direction of future efforts. Careful examination of the maxims girding past liberal feminist efforts, individual choice and individual control,

ought to be useful in revealing the inherent weaknesses in such an approach. Furthermore, the demedicalization of childbirth in the United States could potentially have significant and far-reaching beneficial consequences world-wide.

Modernization pressures for full assimilation and proliferation of the technocratic medical model of childbirth as the "ideal type" is currently viewed as desirable by a professional-medical-industrial complex which controls the birth experience, including the medical profession, the legal profession, and the insurance and health care industries (Starr 1982). The power inherent in this corporate endorsement influences the treatment of pregnant women not only at the local and national level, but also at the international level. Health care delivery in the United States is held up as an ideal model for health care implementation on an international scale (Kay 1982). Hence, the way that childbirth is managed in the United States has influenced and will continue to influence the way childbirth is managed for the rest of the world (Jordan 1993).

Technocratic birth is also very expensive. Obstetrics as currently practiced in the United States monopolizes an unwarranted and excessive portion of the limited health care dollar pie, without contributing in an equivalent manner to meet the health needs of women and children (Lazarus 1988). In 1987, the United States ranked 22nd in neonatal mortality statistics (Collaborative Position Paper from the Women's Institute for Childbearing Policy 1994). The unmet needs of the underserved substantially contribute to this unfortunate statistic.

Attention to ethical considerations is also an important consideration. The need for careful adherence to the medical maxim "First of all, do no harm"

continues to provide an important yardstick by which to evaluate the worth of medical effort. Efforts to objectify and scientifically measure normal life events such as childbirth have created cultural, social, and psychological barriers which ultimately serve to disrupt such life events (Davis-Floyd 1994: 1125). These barriers have served to constrain and negatively influence the most often, non-pathological course of normal labor and birth. It is thus that the underlying assumptions of Western birth had created a self-serving ideology.

Childbirth as it is occurs in the United States is controlled by and is responsive to the needs of major power groups, which control the environment defining women's health needs. Elaborating on Irving Zola's classic essay which revealed how medicine had became a twentieth century tool of social control, sociologist Diane Scully noted how physician's social status as experts led to "almost unprecedented power over people's lives" (Scully 1980: 20). Rather than offering women the opportunity for greater autonomy, more advanced technological tools in childbirth provide the dominant culture of childbirth, the medical model, with greater access to control (Jagger 1983).

The current medical model of birth as practiced in the United States, with its accompanying average cesarean rate of 25%, deserves critical examination. "Rates well below 10% have been maintained in some other developed nations (and as low as 1.3% in certain practice settings) without any demonstrated compromise in maternal and fetal outcomes" (Berwick 1994). The burden of proof for its standard of excessive surgical intervention lies with the medical model. It is clearly time to ask why this model has perpetrated a climate of social acceptance for aggressive and unnecessary

intervention. As Brody and Thompson noted in a 1981 article in the Journal of Family Practice "although the use of sophisticated technology may be appropriate for some high-risk birth, few interventions have been proven effective in routine use." Monies spent on sophisticated, unnecessary and potentially dangerous invasive procedures would be much better spent on truly high risk pregnancies where it is warranted (Rapp and Ginsberg 1991), or conversely on public health measures to improve the general health and living conditions of underserved mothers and babies in the United States (Collaborative Position Paper from the Women's Institute for Childbearing Policy 1994).

Assumptions

This analysis is based on a number of basic operating assumptions. The first is that major institutions are ultimately (but not exclusively) motivated by economic forces; that is to say institutions have in their own best interest, control of both the production of and access to limited or scarce resources. Second, as a society based on a value of equal opportunity for all we, in the United States, are uncomfortable in both the recognition and open discussion of how this maxim applies to the institution of health care delivery (Arney and Bergen 1984). Third, that technocratic, institutionally controlled, medicalized birth is a manifestation of the social control of women (Conrad and Schneider 1992).[4] Fourth, that the benefits realized by the use of technological, pharmacological, and surgical intervention in birth for healthy women do not justify the risks involved, or the harm done, by their routine use (Stoller Shaw 1974; Ruzek 1978; Scully 1980). Finally, that while a morally just burden to those occupying a privileged social role is the social responsibility to be

attentive to the needs of those less-privileged who stand to either benefit of to be disadvantaged by one's efforts, self-interest in gaining access to limited or control of scarce resources frequently creates barriers to assumption of this responsibility.

Methodology

Employing triangulation, whereby a combination of methodological strategies are used to enrich one's analysis, I rely on two combined research methods to guide my interpretation of the forces negatively influencing women's control over their childbirth experiences. My first method is interrogatory. Through a series of three focused questions I examine four scholarly texts spanning the last third of the twentieth century in the United States each of which analyzes the medicalization of childbirth. In these texts: Forced Labor: Maternity Care in the United States (Stoller Shaw 1974); Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists (Scully 1980); Giving Birth: Alternatives in Childbirth (Katz Rothman 1984);[5] and Birth as an American Rite of Passage (Davis-Floyd 1992) the authors deconstruct the medical model of birth from the vantage points offered by the two disciplines in my areas of concentration: anthropology and sociology.

Using the authors' respective analyses, the following questions inform my own analysis.

1. What is the disjuncture between the authors' insights on the social construction of the American birth experience and the continuing and rapidly accelerating rate of intervention in childbirth experienced over the past thirty years, i.e., what really influences and controls the experience?

2. Why have the insights offered in the respective analyses failed to reverse the trend towards the ever-increasing medicalization of childbirth. Indeed, over the past thirty years, the kinds of technological intervention have become more subtle and more profound.

3. Why do certain of the authors' suggested correctives either fail to respond to or respond in a conflicting and at times paradoxical manner to the intersecting limitations of race, class, gender and social location on women's birth experiences. This question is intriguing since, as social scientists, all four authors recognize these limitations within their respective analyses.

These four books were chosen because they not only approach the subject from a feminist social science perspective but, moreover, because each of the texts moves from a description of the problem: the increasing medicalization of women's birth experiences, arising (as the authors explicate) in part from individual women's gender-influenced lack of power and knowledge in an institutional setting, to suggestions for strategies to implement subsequent changes. That is to say, these four books each bridge theory and application.

In the second methodological strategy, I shift focus to my own personal application of liberal feminism in childbirth preparation. Examining my efforts as a prepared childbirth educator, I undertake an ethnographic analysis using observations I made as a participant-observer in the birthing process. These observations are illustrated through a retrospective analysis of two birth stories which have been reviewed by the subjects for historical accuracy. I do not maintain that the selection of birth stories is fully representational of either the range of experiences of the women who took my classes, or of the average experience. I choose them instead, to illustrate my

interpretation of certain selected contextual dynamics involving women who participated in childbirth preparation classes with the intention of achieving a non-technocratic childbirth experience. The dynamics involved in these two narratives are representational of those dynamics related by women in my childbirth classes. I critically interpret the medical model management of the two selected birth narratives by considering other management options for each of the labors. I include in these alternative considerations midwifery strategies for normal birth. Through this comparative analysis I reveal the limitations of the liberal feminist approach in addressing the medicalization of birth. With these same two birth analyses, I address the way in which the information and strategies which I offered in my childbirth classes proved to be ineffectual to the women in their attempts to demedicalize their respective birth experiences.

Background On My Childbirth Classes

From 1979 to 1990 I taught childbirth preparation classes in a mid-size, midwestern urban area. This study focuses on the last eight years of this period when I was self-employed as an independent childbirth educator. The women who chose to attend my classes were a multiracial, multiethnic, and multicultural group. In fact, other than that the women who attended my classes had voluntarily chosen to do so, and were pregnant, healthy, and anticipating a normal birth experience (I will discuss this aspect in greater detail later), my classes attracted a surprisingly representative sampling of the diverse population of women in the United States. This included: the unemployed, blue collar, pink collar and white collar workers; married and unmarried teens, and married and unmarried adults; lesbian women who had

conceived through artificial insemination and married women who had used a range of artificial reproductive technologies to conceive; rural and urban, full or part-time homemakers; students and professionals. Approximately half of my clients had learned of my classes through referral from their physician or midwife, while the others had learned of them through word of mouth from friends; often previous clients of my classes. Commonalities which lent cohesion to this variable group were that (as reported by the pregnant women), they were healthy, they desired to have some combination of their partner, friends, or family members present at the birth in order to provide labor support, they believed that the classes provided relevant birth information and that this information would give them and their support persons the skills necessary to guide the birth experiences in the ways they desired, they were concerned about losing control, and they were seeking to have a *normal birth experience.*

The term "normal birth" is subject to various interpretations. However, a summary definition of the philosophical translation of the term as used by these women is that they believed that childbirth was a normal physiological event in a woman's life that does not usually require medical attention.[6] With the exception of rare, unforeseen, and extreme circumstances, they felt that normal birth required a supportive, safe environment, and the ministrations of a competent birth attendant. For some women, this personal philosophy translated into plans for giving birth in a hospital with a specialist (obstetrician-gynecologist) in attendance. The women who made such a choice saw this arrangement as one which allowed for a medical-specialist's response to the possibility of unforeseen emergency. For others, this philosophy meant giving birth at home with a midwife in attendance. For the majority of my

clients, however, it meant birthing in a hospital with a primary care provider; usually a family practitioner. For all the women, it meant that they were highly motivated to give birth with a minimum of technological and preferably no surgical intervention. The women believed that by actively participating in my childbirth preparation classes, they would ultimately be able to control certain aspects of the birth experience.

It was also the particular personal expectation of a normal birth experience that brought them to my classes. The information I offered, my teaching style, the message and content of literature I chose to distribute, and the slides I showed reflected this same liberal feminist philosophy. I believed that for healthy women childbirth was indeed a normal, non-pathological, physiological event. While the event undeniably included an element of risk for both the woman and the baby, in normal, healthy women, I believed the element of risk to be minimal. Hence, I rejected the tendency to rank pregnant women within a "risk" category and then to manage them accordingly.[7] I believed that for healthy women, physiologically sound and morally responsible normal birth rarely required anything more than careful and caring attendance by trained professionals.

As such, I saw my role as that of a consumer and health educator, and in this capacity I felt my primary responsibility was to encourage the women in healthy life habits, to educate them about the expected normal physiological events of birth, and to inform them as to the range of choices available in their preferred mode of birth such that they could participate in decision-making throughout pregnancy, labor, and birth, with their health caregivers, in order to actualize their model of normal birth.

Influenced by the second wave feminist focus on consumerism and health as manifested in such popular texts as: Our Bodies, Ourselves: A Book By and for Women (Boston's Women's Health Collective 1973), and Immaculate Deception: A New Look at Women and Childbirth (Arms 1975), I believed that decision-making was a matter of knowing one's options, and then making one's choices, that is to say, informed choice.

It was as a consequence of my teaching experiences that the problem I chose to address in my thesis emerged; I came to realize that my teaching strategies were ineffectual in achieving my pedagogical goals. In the eight years of teaching as an independent educator, a pattern of change emerged from my client's birth reports. The pattern was that of a significant increase in the incidence of technological and surgical intervention in the women's birth experiences. Specifically, an increase occurred in the use of aggressive labor management (artificial rupture of membranes, pitocin augmentation), analgesia and anesthesia (especially the use of epidurals), the electronic monitoring of labor, and the incidence of episiotomy and cesarean deliveries.

As the women told their birth stories at the final postpartum class session, they continued to espouse the model of normal birth which originally drew them to my classes, explaining their personal failure to adhere to the model as an unfortunate yet unavoidable consequence of some combination of their own or their baby's anomalous physiology or circumstances. They expressed their beliefs that "in their case" the intervention(s) were unquestionably necessary as ascertained and advised by the certain, unquestionable judgement of their chosen provider. Provider judgements were reportedly reached after assessing the abnormal deviation of a particular labor or delivery from the sequence or timing of events expected in normal

birth. The determination of the need to intervene, either technologically, pharmacologically, or surgically, was usually reached after assessment of a particular labor's deviation from the expected normal sequence or timing of events, which, in turn, served to influence the choice to avoid pain, uncertainty, or danger. As such, the determined deviation in turn served to influence subsequent choices to avoid further pain (opting for analgesia and anesthesia), uncertainty and danger (opting for aggressive labor management including electronic monitoring, artificial augmentation of labor, and minor or major surgery).[8] Commonly accompanying these reports were stated convictions that the information offered by their chosen providers leading to the decisions to intervene, was soundly based on objective, scientifically proven or experientially substantiated clinical certainty (Irwin and Jordan 1987).[9] Only on very rare occasions, was the sequence of unforeseen events reported to have been influenced by subjective, perhaps uncertain information offered by a provider, hospital staff persons, or labor support persons.

In the telling of their birth stories the women in my classes most often claimed personal responsibility for the consequences of listening to professional advice, and the decisions they subsequently made. In fact, to the best of my knowledge, over the tenure of my teaching there were no lawsuits filed by my clients against doctors, hospitals, or midwives.[10] In summary, my clients continued to espouse the model of normal birth, but felt that "their" particular birth or "their" particular baby was anomalous; an exception to the model of normal birth. Moreover and importantly, largely as a consequence of their participation in informed decision making, they usually assumed personal responsibility for the outcome. Reports of a particular technological,

pharmacological, or surgical intervention were often accompanied by disclaimer phrases citing absolute certainty and conviction that the intervention was appropriate, was the "best" choice or the "only "choice to be made at the time. My clients used such verbal descriptors as "I was ready...I knew that it had to be this way...I wanted it..."

From my vantage point as a participant-observer, I most often did not interpret the reported events in the same way as my clients. On a personal level I began to suffer from cognitive dissonance; what I observed did not fit what I believed. If I was to keep my model of normal birth intact, what accounted for such a noticeable growing pool of pathology in my pregnant clients? I was drawn to critically explore this paradox.

Through a reading of current literature, and attendance at childbirth education teacher's conferences, I was aware that the pattern of increased intervention occurring with my clients mirrored a national trend. Intrigued, I began to explore a number of possible influences to account for my local microcosm's reflection of the national picture. Staunchly clinging to my firm belief that individuals can indeed exert control over the circumstances of their baby's births, I started with the two easiest and most obvious possibilities: perhaps I had modified my teaching style, or perhaps my clients had changed. Through careful review and evaluation of my teaching materials, my teaching style and my clients profiles, it did not appear that either of these alternatives could account for the observed change in the rate of intervention. Moreover, as reported by my clients, they did not feel to be the victims of coercion. They believed they were exercising their autonomous free will by making clear, informed, and uncoerced choices in birth situations totally unique to themselves and to their babies.

On occasion, I was invited to attend a client's birth in order to assist in labor support. From this participation and from the birth stories told at each class's final postpartum class meeting, I drew other conclusions. It was thus that the model of normal birth which I espoused became increasingly more vulnerable over time to a contradictory observed reality, further motivating me to try to effect changes in my client's birth experiences.

Consequently, I began to seriously question the accuracy and effectiveness of the liberal feminist consumer education model of informed choice in its attempt to help women avoid a medicalized birth experience. My childbirth education classes were predicated on the liberal feminist assumption that relevant education and knowledge could lead to increased control over the birth experience. Yet as I listened to the birth stories, I was compelled to confront my own failure. Equally, I felt a growing concern regarding my inadvertent collusion with a system that I opposed. I modified my teaching style regarding the issue of the patient/provider relationship, from one which encouraged women to "shop" for a provider who shared their values in order to establish a relationship of trust, to one which encouraged my clients to view their providers with what I regarded as a healthy dose of critical realism.

Certainly all parties involved sought a good outcome, a healthy mother and a healthy baby; but it was clear that there was a great conflicting disparity of opinion about how this goal was best achieved. Yet the language used in the birth reports belied this disparity. As the clients told their stories, they discussed consensual decision-making between themselves and their providers. Since I believed the level of routine intervention to be excessive, I no longer used role plays as I had in the past, to illustrate informed consent

scenarios. Instead I used them as opportunities to more accurately describe my interpretation of the dynamics, which was that of "informed disclosure."[11] I concluded that the term "informed disclosure" was more fully representational of the actual dynamics involved, which, from what I had observed first hand and from what I deduced listening to the birth stories was more like "Now, I'm going to tell you what I'm going to do to you."[12] Providers regularly supported informed disclosure information with further detailed and sometimes graphic information on what they perceived to be possible (read likely), worst case scenarios, if the proffered advice was not followed (Brody 1982). Further, the providers often used statistical information to support the menu of choices in light of perceived risks. Information framed by statistical data influenced my clients in two ways. One, they were certain that the information was surely grounded in scientific fact (Irwin and Jordan 1987); and two, the mention of risk usually persuaded them to comply with the suggested regimen or course of action. When the women told their birth stories, they often added emphatic phrases lifted from the interaction with their providers that they (the women) believed imbued indisputable validity to and corroborated the certainty of such information. Examples of corroborating phrases such as , "If I were you...," "If you were my wife...," "I'm concerned about the baby..." were related by the women as they told their birth stories.

Thus, in my classes, I discussed the realities of liability dictating practice and judgement; the seductive appeal of technology to both patients and providers and, moreover, its revered place in a courtroom, and the exigencies of imposing time limits on the stages of labor (LoCicero 1993). Yet, to my great surprise, my clients responded to these suggestions with a degree

of animosity and disbelief. They loyally defended their respective provider's various positions and actions, expressing their own certainty that what their respective provider offered was the best and most current information, reflecting sound judgement, firmly grounded in science buttressed by clinical experience. Moreover, to defend their stance, my clients would often cite what they viewed as a shared philosophy of normal birth between themselves and their provider. This conviction was particularly strong if the provider referred to my classes, in that the referral was viewed as evidence supporting a perceived collective shared philosophy which it was further believed must certainly translate into practice.

Stymied by my own failure to effectively assist women in obtaining a normal birth experience, I decided to stop teaching and to try to understand this puzzle of events from a different approach. To this end I entered the Interdisciplinary Program in Health and Humanities and chose as my areas of concentration the disciplines of Anthropology and Sociology. I did this so as to explore the social construction of childbirth within in the United States as it has occurred in the last half of the twentieth century.

CHAPTER 3

MEDICALIZED CHILDBIRTH: A BRIEF REVIEW OF ITS INCEPTION AND DEVELOPMENT

American women routinely labor within the institutional confines of a hospital, attended by nurses who are women, who are in turn assisted by all sort and shapes of machines of varying levels of technological complexity. The standard American birth presently occurs, with only rare exception, within these same institutional confines attended by clinically trained medical professionals, who are, most commonly, male physicians. Critical assessment of historical factors leading up to this current cultural construction reveals the influence and coercion of power, economics and politics in shaping the norms of social behavior and social policy in childbirth practices (LoCicero 1993). A review of the history of the medicalization of birth provides insightful clues into the development of current Western birth practices; practices which are intimately linked to the rise in dominance and authority of the medical profession.

> At a deeper level, a...theory is that the male acquisition of the domination of childbirth and society's acceptance of this situation represent a fundamental counter-attack on the female's strivings and achievements along the road towards political and economic equality. Cynics see this as a salutary demonstration that inroads into man's territory have been accompanied by the surrender of her own, woman's territory - a universal acknowledgement of her essential subservience (Tew 1990: 19).

The history of the transition of birth from home to the hospital and the transition in birth attendance from midwives to physicians while complex, has been extensively documented (Wertz and Wertz 1989; Waltzer Leavitt 1984; Donegan 1984; Schrom Dye 1984; Edwards and Waldorf 1984; Bogdan 1978; Donnison 1977; Barker-Benfield 1976; Ehrenreich and English 1973). For the purposes of this thesis, I will provide only a very brief and admittedly partial overview drawn from these histories. This overview will highlight issues of medical ideology and medical self-interest, and will also examine how these two aspects served to increasingly restrict women's birthing options to those available within the medical model.

In the United States, the medical model rose to prominence by replacing homebirth, a model whereby women gave birth in their homes, sometimes aided by family and friends, but most commonly aided by an experientially trained female midwife. While midwives typically were informally rewarded for their assistance through bartering and reciprocity, providing expertise in childbirth assistance was not part of a formal market economy (Wertz and Wertz 1989; Waltzer Leavitt 1984; Ehrenreich and English 1973). Childbirth was first of all a personal, and then a social event. Information on childbirth was part of an informal social exchange network.

As historians document, the end of the nineteenth century witnessed ever increasing restrictions being placed on the practice of midwifery as barber-surgeons strategically maneuvered their way into what has become, at the close of the twentieth century, nearly a complete monopoly of the birth market by the medical profession (Wertz and Wertz 1989; Waltzer Leavitt 1984; Donegan 1984; Schrom Dye 1984; Wertz and Wertz 1977; Ehrinreich and English 1973). A common popular assumption is that a decrease was realized in the

incidence of maternal and fetal mortality and morbidity in the late 1800's and happened as a consequence of physicians assuming control over the management of childbirth (Wertz and Wertz 1989; Donegan 1984; Schrom Dye 1984). Historical scholarship on the high rate of maternal mortality and morbidity associated with barber-surgeon's "meddlesome midwifery" disproves this assumption. Professionally trained midwives who offered home birth services, such as that which was available through the Frontier Nursing Service[13] had lower mortality rates than most hospitals of the time (Schrom Dye 1980). Real benefits in improved health status were not realized by pregnant women until the time of World War II. Again, as noted by Schrom Dye (1984) "early twentieth-century comparative investigation of physician- and midwife-managed births...found that midwives had fewer maternal deaths than general practitioners." Research in the 1840's by Hungarian physician, Ignaz Semmelweis on pathogen transmission by doctors from cadavers and ill persons to the laboring women causing a high rate of iatrogenic puerperal sepsis (childbed fever) did not influence physician practice in the United States until 1885 (Scully 1980: 31). It was also "the increasing practice of confining women to lying-in hospitals [that] heightened the probability of spreading infection" (Scully 1980: 31). In the 1920's 40 percent of all maternal deaths were due to puerperal sepsis (Schrom Dye 1984).

The end of century trend towards the increasing social power of doctors and the decreasing availability of midwives was followed by a post-Flexnerian increase in number of large teaching hospitals and the firm entrenchment of the power and authority of physicians. Women in their childbearing years were actively solicited as patients since they were viewed as the gatekeepers who provided access to the entire family as potential patients. Indigent

women were able to obtain medical care either for free or for a reduced cost in exchange for their use as teaching material for student physicians (Scully 1980: 34). A major population shift from rural to urban centers mandated both an increase in efficiency in order to address health care needs from a convenient central location, and a shift in reciprocity/barter relationships among those without access to an established social network to a market relationship (Starr 1982). Moving the primary location of birth from the home to the hospital had two major and far-reaching economic consequences. First, the choice of available trained birth attendants became increasingly restricted to recognized hospital providers who required a fee for their services. Second, as a consequence of this restriction, access to available sources of birth knowledge for pregnant women became part of this same market economy. Anxious to participate in modern technological society, women themselves supported the transition from midwifery attended homebirth to hospitalization for all childbirth (Edwards and Waldorf 1984: 153). In 1910, 50% of births occurred within the home but by the 1930's this number had dropped precipitously (Scully 1980: 31; Schrom Dye 1984: 328). Variations in this number occurred by ethnic group, by class, and by region (Edwards and Waldorf 1984: 153).

When physicians moved to hospitals as the preferred location for delivery of services, they brought with them the technological and pharmacological tools sought by women: anesthesia for the pain of labor and birth, and forceps for difficult births. Prior to World War II, half of American babies were born at home (Waltzer Leavitt 1984: 141).

It was at this period of time that,

> Obstetrician's abandoned the philosophy of restraint..[and] redefined normality in pregnancy and labour to justify the widespread practice of antenatal, intranatal and postnatal interventions, so that the need, as they perceived it, for most births to take place in hospital became inevitable. And since obstetricians, despite their vaunted skills, could never predict with accuracy when a complication would arise, the sensible precaution was to take every step to ensure that all births should take place in their kind of hospital. (Tew 1990: 9).

As one of the many "war efforts" during World War II the government placed a "cap" on wage increases. This cap opened the door for the addition of health insurance benefits as an alternative job incentive offered to the American worker (Starr 1982: 331). The influence of the market continued as mid-twentieth century, prolific post World War II mothers became the beneficiaries of third party payment for hospitalization, including maternity care coverage. Thus, the baby boom generation was most often welcomed into the world with forceps deliveries, a technique made necessary by the anesthetized state of the mother, within hospital delivery rooms. By this period, over 95 percent of births occurred within the hospital (Walzer Leavitt 1984). The sheer power of numbers served to feed and support the increase in popularity of the medical model. Concurrent with the expansion of post-World War II medical technology, birth rituals within the United States became intrinsically linked with the growing medicalization of birth (Davis-Floyd, 1991).

First in Great Britain and Russia, and then in France, new strategies arose for coping with the attendant pain of labor without relying on analgesia or anesthesia. (Dick-Read 1944; Lamaze 1956; Karmel 1959). Introduced to middle-class women in the United States through books and magazines, these

techniques attempted to teach women how to modify their response to labor pain in order to remain "awake and aware" (Karmel 1959). Conventional methods of childbirth preparation emphasized control, meaning control over socially visible and audible manifestations of the pain of labor. While the promise of diminished pain in labor was enticing, the suggested breathing gymnastics encouraged in childbirth preparation manuals failed to diminish the pain of labor. Instead, this form of labor control encouraged the laboring woman to be a better patient; teaching her to physically mask the pain and muffle her urge to respond to it vocally (Stoller Shaw, 1974). The legacy of control in childbirth was bequeathed to the next major group of women attempting to attempt to influence the medicalization of childbirth.

As second wave feminists entered into their own reproductive years, they became aware of the increasing medicalization of women's lives focused especially in the area of reproduction. The medical model's representation of birth as an inherently risky event authorized the social practice of aggressive medical management. Metaphorically, the cervix became a portal which provided access for societal commentary and the increased social control of women.

Review of Second Wave Liberal Feminist Responses to A Growing Awareness Of The Medicalization Of Women's Lives

A range of complex descriptions exists on the ethos of second wave feminism; what it was, what it is, and what it should be (Grant 1993). Proponents of different manifestations of feminist ideology passionately and fervently defend their wide-ranging agendas. In the 1960's, the early formation of feminist ideologies served to infuse energy, create solidarity, and

foster coalitions among the ranks, yet these same ideologies were simultaneously influencing and influenced by shifts in power relations serving to limit the types of feminist expression considered acceptable.

An important organizing principle in second wave feminism, was that the personal was political (Grant 1993). This slogan referred to the revelation experienced by women through participation in consciousness raising groups, that oppressions which women experienced within their individual lives were often a reflection of larger social inequities contributing to group oppression. While the recognition that individual oppression was reflective of group oppression was certainly true for many women, second wave feminist spokeswomen who rose to the fore were largely middle- and upper-middle-class white women. Given their relative race and class privilege, they focused on issues of oppression relevant to their lives and their social location; issues which were not necessarily reflective of the concerns of women from historically marginalized populations. The "default" consciousness of majority (White) middle- and upper-middle-class feminists (here on, referred to as majority feminists) allowed them to draw up a second wave liberal feminist agenda based on their concerns. These concerns commonly reflected their privileged social location.

Consequently, the agenda described was largely that articulated by majority feminists. Virtually every aspect of a woman's interface with institutionalized reproductive care was reexamined by majority feminists including sexuality, menarche, menstruation, menopause, routine well-woman care, birth control, sterilization, abortion, prenatal and obstetrical care. While this agenda certainly included specific areas of concern to minority women, the major profile of the agenda emphasized majority feminist concerns. In

particular, liberal second wave feminist correctives to problems of increased medicalization of women's lives were most often correctives believed to be within reach for those who could exert a certain amount of control over their own lives as a result of majority privilege.[14]

Careful inquiry into women's treatment within the institution of health care revealed that the medicalization of women's reproductive lives offered a vulnerable site for societal commentary on women's lives and social control of their behavior. Many feminist scholars undertook the task of deconstructing the medicalization of women's reproductive health care (Haire 1972; Boston Women's Health Book Collective 1973; Ehrenreich and English 1973; Stoller Shaw 1974; Arms 1975; Gordon 1976; Rich 1977; Corea 1979; Marieskind 1980; Scully 1980).

Predicated on the belief that knowledge translated into power, and that the transfer of knowledge about women's health to women would serve to equalize the asymmetrical and hierarchical power equation with health care providers and the institution of health care, majority feminists saw it as their responsibility to educate women about their bodies, their health, and their health care choices. The resultant exposure of the social construction of women's reproductive health encouraged women to resist in myriad ways. Spawned by gender consciousness-raising sessions, incipient self-help groups arose and advocated that women learn normal female anatomy and physiology (including use of the technique of self-taught vaginal self-examination). Women were also encouraged to learn about choices in health care such as access to safe and legal abortion, choices in safe and available birth control, choices in safe and normal childbirth and alternative healing modalities to Western biomedicine.

Alternative models of reproductive health care also arose, as evidenced by a variety of self-help health organizations which attempted to minimize professional domination over women's bodies by increasing lay knowledge of reproductive functioning through grass roots 'self-help" organizations. This groundswell of lay health activity was manifested by the organization of groups such as the Boston Women's Health Book Collective, the Women's Health Forum-Healthright, the National Women's Health Network, and the Feminist Women's Health Collective.

Closely linked to the mission of consumer education was another orienting concept in this menu of concerns and that was the theme of "choice." Liberal feminists stressed the notion that an important point of interaction missing in doctor-patient encounters was information sharing. The veracity of the "educate ourselves and wrest control" model went undisputed. Central to the second wave liberal feminist effort were two assumptions: first, that women need to assume the responsibility for educating themselves, and second, that such an education would in turn lead to greater control over their own health care. Majority second wave feminists were largely at this time in their own reproductive years. They focused efforts on acquiring information about reproduction. Have It Your Way by childbirth educator, Vicki Walton (1976) is an example of the simplistic "self-determination" style of book which supported the notion that women need only to educate themselves in order to be able to control the particulars of their health care. It was felt that increased awareness and education would yield greater control. But the lessons learned from the history of power struggles reveal that "the beneficiaries of hierarchical reward systems yield their privileges only when failing to yield is more costly than yielding"

(Reskin 1991: 155). The idea that women theoretically could, and indeed were, exerting control over the circumstances of their births continued to enjoy a high profile. Maintenance of such a high profile misled many women into concluding that when they failed to achieve their goals of a "normal" birth, this failure was due to deleterious individual anomalies and not to more pervasive and manipulative institutional influences. Since it superficially appeared that majority women were getting their health needs met, maintenance of this same high profile also served to distract policy makers from the attention needed by the health concerns and issues of women's everyday lives.

Thus it both was and is paradoxical that despite such feminist efforts, a review of birth statistics spanning the last two decades of the twentieth century reveals a zenith of technological, medical, and surgical intervention in normal healthy women's birth experiences.[15] The rate of intervention had increased so dramatically that by 1980 the United States government, through the Department of Health Education and Welfare (HEW), commissioned a study on the high rate of cesarean section. In this report, Dr. Marieskind documented that the cesarean rate had risen from 5.5 percent of all deliveries in 1970 to 20 percent in 1982 (Marieskind 1982). Through an analysis of selected feminist contributions on the medicalization of birth framed within their respective historical settings, and also through a retrospective analysis of selected birth experiences from women attending my childbirth preparation classes, this thesis next explores the way in which the hegemonic medical model of birth has influenced women's childbirth experiences.

CHAPTER 4

AN OVERVIEW OF FOUR ANALYSES OF THE MEDICALIZATION OF BIRTH BY SELECTED FEMINIST SOCIAL SCIENTISTS

Forced Labor: Maternity Care in the United States

Nancy Stoller Shaw

In 1967 and 1968 sociologist Nancy Stoller Shaw was a participant observer of obstetrical care delivery services at four diverse settings including a large public hospital, a university research hospital, a rural nursing homebirth service, and at a pre-paid health maintenance organization. In 1974, she published an ethnographic analysis describing this experience in which she critiques the extent of medicalized childbirth in the United States. Lamenting women's loss of control over the birth experience in all the settings with the exception of the rural home birth nursing service, she identified gender, race, class and institutional priorities as the contributing factors which led to the inhumane treatment she observed in the other three arenas (143).

Stoller Shaw paid careful attention to structure in her analysis. This included the structure of the institution of health care, the structure of the hospital, and the structure of the profession of medicine and medical training. From her study she concluded that patients are powerless in an institutional setting (129), and must submit to the legally and institutionally supported authority of a male physician as the director (85). She also explored gender

issues which were significant, since at the time of her study, virtually all the physicians were male, and certainly all the laboring women were female. As such, gendered issues of power and control within the various respective institutions occupied much of her analysis. She recognized the importance of laboring women having an opportunity to compare notes and share information, and as such, she lamented that hospital isolation discouraged such an opportunity (118). Since institutions require standardization for maximum performance, she concluded that hospital routines were determined by hospital staff for their own convenience and not for the benefit of the mother or her baby (109).

Stoller Shaw was particularly concerned about the dehumanizing treatment of the poor, especially since she observed what she determined to be kind, caring and fully adequate care and treatment offered to poor women through the rural homebirth service. She noted the intersection of sex/race/class/and language as barriers which prevented hospital staff from identifying and empathizing with their patients (115). Upon observing poor women's abusive treatment at the hands of the hospital staff, she concluded that Black women in particular were treated as if they were "outside the moral world of whites" (14). Poor Black women in particular were judged to be immoral as a result of what the staff nurses considered to be promiscuous extramarital sexual behavior. Stoller Shaw noted that the type of abusive treatment these poor Black women suffered in the hospital was really what was immoral, but to point this out would have challenged the nurses certain characterization of these women as "the other."

Since Stoller Shaw saw routine obstetrical care as gendered and hierarchical (54), she concluded that the use of power and status by male

physicians left patients but three choices: to submit, to resist, or to leave the system entirely (141). In particular, she concluded that the use of technology to control birth was a social metaphor for male physicians asserting power over women giving birth (133). Noting the occurrence of routine intervention, she observed that this particular strategy failed to teach residents when intervention was truly appropriate (100), and since the doctors did not see birth as a normal body process, they were trained to intervene routinely (70). Medical control through physical or chemical intervention occurred for nearly all "normal" births that she observed (101).

Her observations at the Pioneer Nursing Service served as a contrasting comparative model where laboring women in rural Kentucky utilized midwives to delivery their babies at home (124). She compared the differences in ideology and power relations in her observations between the hospital settings which she studied and the homebirth service. She reached dramatic, positive conclusions regarding the safety and efficacy of the homebirth service. This alternative model of care favorably impressed Stollar Shaw such that she lamented that it was only due to irrational fears about childbirth, that homebirth was not an option for a larger number of women (127). After drawing this conclusion, she did not aggressively pursue the origins or perpetuation of the "irrational" fears to which she alluded, except to say that women are socialized during their prenatal care to accept the hospital system. In her analysis, she fully recognized the hegemony of the medical control of childbirth. She cited a male physician's need to show power over women as the factor which encouraged them to technologically manage a birth.

In the few privileged patients using prepared childbirth strategies, Stoller Shaw saw hope for resistance (75), stating her belief that it was a lack

of knowledge about birth which prevented women from making informed decisions (57). She believed that mobilization for consumer-controlled care would be the corrective by which "mutual respect and power-sharing" between women and their physicians might be established (55). Knowledge was equated with power.

In her analysis, Nancy Stoller Shaw failed to look at the economic aspects of the medical model of birth. While she recognized the ways in which power, authority and control influenced the way the women were treated, she failed to explore the financial incentives which encouraged and supported this observed hegemony. On many an occasion, she cited an incident that she judged to be motivated by financial gain and not altruistic medicine. But while it appears that she was aware of these incentives, she failed to include such insights in guiding her correctives. Even if women went beyond their irrational fears regarding birth, most still would not have access to either a midwifery service or to a homebirth since the profession of medicine had done a very thorough job of eliminating this option with only very few exceptions.

The correctives she explored were limited to ones which would theoretically only be available to middle- and upper-middle-class women; women who mirrored her own social location. Thus, she also failed to explore options theoretically available to other groups of women. For example, if the rural homebirth service did such a noteworthy job of providing quality care which appropriately fit the diverse needs of the population it served, why did the author fail to see this same model of care as appropriate for the center city poor? While the author recognized the influence of race, class, gender, and social location, she addressed each if these variables individually, and in doing so, failed to look at the multiple influence of their intersection.

Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists

Diane Scully

Sociologist Diane Scully performed similar research in an "elite medical" training institution and at a general "mass medical" hospital in the early 1970's and published the results of her analysis in 1980. Using the same strategy of participant-observation, she focused on the surgical training of obstetrician-gynecologists noting especially "how the practice of medicine and physician's professional goals interact to influence the development of attitudes and skills that are at variance with the health care needs of women" (2). She expressed her hope that the then current "demystification of physicians will arm the consumer with a powerful tool--information"(2). Once again, knowledge was assessed to confer power on the possessor of such knowledge. As a result of her observations of the mistreatment of the poor in teaching hospitals, in particular their use as "training material", she was hopeful that illuminating such mistreatment would ultimately lead to positive change for the underserved.

Additional feminist scholarship exploring the medicalization of birth had emerged in the intervening years between the publication of Stollar Shaw's work and that of Diane Scully. Scully was thus able to draw significantly from insights gained through the contributions of these new works. She noted that the publication of Immaculate Deception by photo-journalist Suzanne Arms (1975) bridged a gap between feminist scholarship and childbirth education "how-to" manuals which proliferated with the natural childbirth movement efforts. With cross-cultural comparison and empirical data, Scully credited

Arms with illuminating the ways in which obstetricians had systematically "devised a set of interferences [to control childbirth] resulting in even greater, but more predictable risk" (Scully 1980: 35). Through the incorporation of interviews with mothers and alternative health care providers, lay and nurse midwives, Scully found that the research by Arms offered a new way of evaluating a normal birth experience.

Scully also highlighted criticism of other aspects of the childbirth experience, such as those documented by Doris B. Haire in her publication by the International Childbirth Education Association titled The Cultural Warping of Childbirth (1972). She pointed out that Haire's classic essay was one of the first comprehensive documents to expose the dangers to both women and their babies inherent in unnecessary obstetrical intervention. Again, citing cross-cultural research Haire drew attention to obstetrical practices rooted primarily in institutional self-justification and not necessarily in either "scientific research or in basic human physiology" (Scully 1980: 34). Along with these empirical studies Haire pointed out that United States health statistics for neonatal mortality placed it at that time fifteenth among developing nations (35). Countries with a lower socioeconomic status, and with lower levels of obstetrical intervention, had demonstrated better birth statistics. Haire's was also the first attempt to look at the institutional control exerted upon laboring women by the physical environment of birth, i.e., within hospitals, and she called on the existing foundation of feminist women's health groups to demand changes in invasive maternity care and also to encourage birthing alternatives through the support of both nurse and lay midwifery (Haire 1972, in Scully 1980: 35). Additionally, Scully gave support to the work by Gena Corea (1977) and Barbara Seaman (1972, 1977)

encouraging the expansion of the women's self-help movement as a way to provide women access to more knowledge in order to gain greater control over their reproductive lives (18).

In her examination of the asymmetrical power relationship inherent in obstetrics and gynecology, like Stoller Shaw, Scully paid particular attention to gender issues. In 1974, only 3.5% of the members of ACOG (American College of Obstetricians and Gynecologists), the profession's representative organization, were women (15). While she noted that there was inadequate evidence to suggest conclusively that "women [would be] better obstetrician-gynecologists than men" she mentioned data recognizing that "female residents were more empathic than males" (94) and she further suggested that an increase in female physicians and in non-physician health care workers could conceivably decrease the number of what she viewed as unnecessary surgeries (242).

While she was skeptical in her assessment that prepared childbirth classes only reinforced women's passivity and learned social behavior emphasizing control, she recognized that some women who utilized a "Lamaze" strategy were able to avoid a certain amount of medical intervention (96). Scully recognized that there were economic, personal and social barriers to institutional patients taking "Lamaze" childbirth classes (122). She also recognized that few institutional incentives existed to change this, since residents learned forceps deliveries and other obstetrical techniques on these same indigent patients (123). Recognizing the financial incentives as well as the incentive to increase one's experience from doing surgery, she observed obstetricians talking women into surgery using sales tactics (224) and related that from the perspective of an outsider looking in, the profession itself

appeared deviant (234). Unlike Stoller Shaw, Scully was cognizant of the discordant pressures within a "for-profit" health care system that required "teaching material" for the ongoing training of medical students (10).

She called for women to overcome both traditional passivity and learned reliance on men in order to reassert control over their bodies, stating that "informed consumers have a definite advantage in the marketplace" (21). Yet Scully's suggested correctives for changing the existing order are curiously paradoxical. The paradox is that her research both highlighted and challenged the macro level structure; the institutional and professional transgressions against the best health care interests of women, yet her correctives were two-tiered along lines of social stratification on the micro-level. She placed the onus of responsibility for changing the existing order at the micro level, on individual women. Despite her recognition of the plight of the poor at the hands of the health care system in general, particularly as a result of the certain power inequity between indigent patients and economically secure health care providers, she conceptually leapt to certain individualized solutions to what she had previously described as collective problems.

She suggested first, that women needed to assume the responsibility for closing the gap in their health care knowledge (252). Further, Scully recommended that women as patients should screen doctors to evaluate the type of care offered in advance of utilizing their services, and also that they seek second opinions on recommended surgeries (254); strategies, which given her description of the existing system, would be accessible largely to middle- and upper-middle-class women.

To address the abusive treatment of historically marginalized persons, she suggested recruiting working-class individuals into medicine and positions of power presumably, so that a projected "like-experience" identification would cause these individuals to be more sensitive and caring of their former peers (93). She also expressed her hope that highlighting the plight of indigent patients at the hands of obstetrician-gynecologists would encourage positive changes (3). Thus, like Stoller Shaw, Scully puts forth correctives based on attention to the individual variables of race, gender, class, and social location.

Indeed, a number of women privileged especially by social location actively sought to further educate themselves about female anatomy, physiology, and related health care issues. A minority of feminist health care activists vociferously demanded that the existing health care system respond to their stated needs. And indeed, in the area of obstetrical care, a limited number of hospitals and physicians attempting to respond to such consumer demands incorporated certain changes in the physical environment of the birthing arena such as the use of birthing rooms, "gentle-birth" baths, etc. Yet, following the period of Scully's research scrutiny of hospital routines by feminist scholars revealed that the majority of changes were limited to cosmetics.

The rate of technological, pharmacological, and surgical intervention continued to escalate. In particular, the rate of surgical cesarean section deliveries rose precipitously (Marieskind 1979; Wainer Cohen and Estner 1983). In advocating consumer demand for change, the liberal feminist perspective failed to look at the larger question of power relationships and social location in the hierarchy of the institutions which controlled

childbirth. Thus, the basic philosophy remained the same: normal birth was dangerous and required both a physician and a hospital to optimize the outcome.

In the 1980's, empty hospital beds fed a fierce competition among hospitals for available patients to fill them. Hospitals consequently relied on polished marketing strategies to increase profits (Arney and Bergen 1984). Building on the medical model of birth as inherently dangerous, advertising campaigns played on women's concerns over their own health or that of their babies. Augmenting their existing technology, hospital advertising highlighted the potential risks of childbirth and reassured the public that they (hospitals) certainly cared about the well being of a baby, and if the mother did so also, the way to insure a safe birth was to be in a hospital equipped with the latest in available technology. Hospitals further competed by augmenting existing services with even more and greater sophisticated technology.[16] It was into this competitive market climate that sociologist Barbara Katz Rothman introduced the results of her analysis of medicalized birth with suggestions for alternative choices.

In Labor: Women and Power in the Birthplace

Barbara Katz Rothman

Published first in 1982 in hardcover as In Labor: Women and Power in the Birthplace, and later as a paperback under the title Giving Birth: Alternatives in Childbirth,[17] Katz Rothman openly and directly compared the medical model with the midwifery model of childbirth care (23). Confronting the reality of the escalating technological and institutional control of birth, she took the medical model to task by holding it to the standards it publicly

embraced including the safety and health of women and their babies. She did so by uncovering institutional iatrogenic influences on the progress of normal birth. Through comparative analysis she illustrated how medical knowledge is both incomplete and often inaccurate (104). She gave a full endorsement to the option of home birth citing a study by Louis Mehl which matched homebirth with hospital birth and in this comparison found home birth to be a safer option for both the laboring women and their babies(43). Yet she realized that the real issues were not about safety, but about "autonomy and control" (95).

Using the example of the breastfeeding lay support group, La Leche League, she explored the strategic effectiveness of women talking to each other, and how this simple strategy led to shared information and recognition that expert knowledge was not always authoritative knowledge. Yet she did not see the efforts of childbirth preparation educators truly responding to the need for lay authoritative knowledge, since she viewed most childbirth classes as putting forth efforts to socialize women to accept the medical model (80). Katz Rothman portrayed the struggle over expert knowledge as a power struggle for control of childbirth; in her analysis, knowledge alone did not confer power. On one side was medical authority upholding the medical model of birth, and on the other was an uneasy alliance of feminists and family-first traditionalists who challenged the authority of the medical model (95). Like Stoller Shaw and Scully, she saw hope in the organization of diverse groups of women around a single issue (110) and called for the reconceptualization of birth for women of all social locations (246).

By focusing on the structure of the medical profession over gender issues, in particular on the specialty of obstetrics and gynecology, she

attributed the tendency to intervene, to the type of skills valued in this specialty i.e., surgical skills. She also pointed to the needs of the institution in shaping the management of birth (271), and illuminated the way in which the same institution relied on institutional correctives for misguided institutionally precipitated physiological management.

Katz Rothman's suggested correctives bridged those put forth by Stoller Shaw and Scully, whose correctives, (as noted earlier) were socially bifurcated according to a woman's social location. She was clearly willing to take the next step in reconceptualizing childbirth. While she first performed the same historical analysis of the medical model of birth as the other two scholars, and then followed with a similar sociological analysis of institutional and professional control over the representation of birth, she diverged from them in her formula for future change. Katz Rothman insightfully deconstructed the medical model of birth and boldly called for a collaborative effort led by women who were sympathetic to her cause, which was to attempt replacement of the medical model with the midwifery model, and included a reconsideration of the location of birth to include both out-of-hospital birth centers and the home (282-287). She proposed that the midwifery model of care should be the standard of care for all women. The work by Katz Rothman challenged feminists to carefully examine their rhetoric and their agenda. If, as feminists maintained, the medicalization of birth eroded what was essentially a normal, physiological event in a woman's life, then the way to demedicalize it was to move it both out of the hospital and out of the hands of physicians.

Birth as an American Rite of Passage

Robbie Davis-Floyd

Anthropologist Robbie Davis-Floyd was sympathetic to this proposal. Like Katz Rothman, Davis-Floyd drew energy from her own individual experience, an experience which catalyzed her in such a way that she was led to explore the medicalization of childbirth (248). While Katz Rothman had two reportedly safe and satisfying homebirth experiences, Davis-Floyd was transformed by her first negative experience of a planned and prepared for "normal" birth which, ultimately, ended in a cesarean delivery. Her subsequent second birth was a planned and prepared for homebirth that met her original expectations of a normal birth experience. As Davis-Floyd discussed in the introduction to her book Birth As An American Rite of Passage (1992), she continued to uphold a model of normal birth akin to that discussed by Katz Rothman. Yet her observations, much like those I made of the experiences of women in my childbirth classes, motivated her to confront the fact that a disproportionate number of women who anticipated and prepared for a "normal" birth ended up with a technocratic birth. She pursued possible explanations for such an observed disparity between the "the feminist critique of birth and the beliefs, desires, reactions, and behaviors of women" (5). Through her inquiry into this disparity she concluded that "the women's choices for birth technology [did not reflect] false consciousness, [but] choices...embedded in the hegemonic cultural model of reality...consistently presented to us through our most basic cultural rituals" (5).

The fact that she limited her sample of respondents to women who were privileged with private health insurance is noteworthy (4). She assumed that

such privilege allows one the opportunity to exercise individual will in their choice of options (4). As such, her analysis of cultural rituals appears to be a generalization of all women's behavior extrapolated from her limited sample of women privileged by social location. Much like the three other feminist scholars used in my analysis, in order to tease out the underlying assumptions and belief systems of each model Davis-Floyd found it useful to employ a strategy of comparative analysis between what she termed the "extreme forms" of the technocratic and the holistic model (158). The comparison of the two models is followed by a second analysis focused on the ways in which the laboring women received these underlying messages (187-240). It is this aspect of her research that I find most relevant to my analysis.

In an insightful exploration of how women conceptually resolved the disparity in prior expectations over the lived experience, Davis-Floyd made the connection between women's underlying belief systems and the way in which the choices they made in childbirth revealed those belief systems. Thus, if a woman chose to birth in a hospital and experienced a technocratic birth, Davis-Floyd sought clues which revealed the way in which that woman shared the underlying values inherent in a technocratic society. For women who managed to reject and/or avoid the technocratic model of birth, the author sought clues to the woman's real conceptual cognitive belief system.

Thus, Davis-Floyd's data suggested that the women she questioned were continuing to exert their individual will to achieve a "normal" birth, only they were in all likelihood unaware in advance what their (perhaps hidden) values were. The values remained hidden until, in a clutch, they were revealed through the experience of giving birth. So while she looked at the way in which the births progressed through the medical model as reflective of

the women's underlying belief systems, she failed to explore the way in which middle- and upper-middle class assumptions regarding control over individual life events might have influenced such cognitive belief systems. She also failed to examine the ways in which the women's choices were structured by the medical model to conform to institutional parameters.

This anthropological analysis is revealing of two points which I wish to explore further through analysis of the following two birth stories. The first is the way in which women exhibit agency in exerting their will and constructing their choices, the second is the way in which the institution structures the range of available choices, and in doing so covertly structures the experience to fit within institutional guidelines. In my exploration, I will evaluate the effectiveness of advice I provided to these women as their childbirth educator.

CHAPTER 5

TWO BIRTH STORIES

Susan's Story

Susan was at the time of the birth of her first child an academic professional who had done collaborative work with medical school faculty. As a result, she enjoyed both a personal and a collegial relationship with many medical school staff physicians. When she became pregnant, she sought the care of a physician who was her academic peer. Additionally, she contacted a nurse-midwife and myself to assist her husband in providing labor support.

Her labor began late one Monday evening with mild contractions. The nurse midwife checked Susan's cervical dilation and determined her to be in early labor. She suggested that Susan remain at home and that we all attempt to sleep through the night as much as possible. Additionally, Susan had contacted her physician, who concurred with the nurse midwife's assessment. The physician knew the midwife, and at this point was willing to trust her knowledge and judgement. The next morning the household was awakened by an early phone call from the physician who requested Susan to come to the office for assessment. The midwife got on the phone and questioned the necessity of this since she (the midwife) was present and able to provide information for phone assessment. The physician replied that she wanted to see for herself what was going on. Susan and her partner went to the office for the suggested exam, and I went off to work. The doctor agreed to allow Susan to go back home to continue her labor.

The midwife assisted in labor support and continued to encourage Susan to eat and drink lightly, since she was vomiting with the labor pains; a fairly common physiological response to labor. I arrived back at Susan's house late in the afternoon. Susan and her husband had just returned from a second requested visit to the physician's office. This visit was not as congenial as the one earlier in the morning. The doctor performed a pelvic exam and announced that although from all indications the baby appeared to be doing fine, the baby's presenting position was "asynclitic", a position which could make a vaginal birth difficult if not impossible. The midwife had given Susan this same information on the baby's position just before she left for the doctor's office. The doctor had expressed concern that the labor had gone on "too" long and she wanted to rupture Susan's amniotic membranes to speed up the labor. Additionally, she had concluded that Susan was dehydrated from vomiting, and suggested that the only remedy would be to start an intravenous drip. She stated that she wanted Susan to go to the hospital immediately. Susan politely declined, and said she wanted to go home for a couple of hours more, that she had been trying to "go with the flow" of the labor but would now try home remedies to "speed it up"if that was what the doctor wanted. She said that she would be willing to meet the doctor at the hospital around 7:00 that evening. A truce was called, and Susan went home feeling unproductive, tired and discouraged.

Meanwhile, the midwife consulted with one of her colleagues regarding available strategies to deal with the asynclitic diagnosis. The consulting midwife suggested a prolonged (1/2 hour) hands-knees position to be followed by aggressive walking (a minimum of 1 hour). When I arrived back at Susan's house that afternoon, Susan and her partner were taking a vigorous walk

around the yard. She continued with this regimen until she received yet another phone call from her physician who again asked Susan to go to the hospital. Susan repeated that she would be there at 7:00. Prior to the departure for the hospital, the midwife decided that given the conflicted interactions earlier it would probably be best for her to remain at the house. She felt that her presence might be more of a liability than an aid. Moreover, she had just done another check on the baby's presentation, and determined that the positional maneuvers were successful in changing its position. Before we left, I asked Susan to put on make-up and drink as many liquids as she possibly could. I felt that her appearance might affect the way in which the doctor related to her, and that an increase in her fluid intake might allay the doctor's concern over dehydration.

When we arrived at the hospital the first information the doctor requested was the whereabouts of the midwife. I informed her that the midwife had decided to go home. She then commented on Susan's appearance, noting that she looked better than she had earlier and also concluded that Susan must have finally stopped vomiting since her urinalysis indicated that she was no longer seriously dehydrated. She then announced her assessment of the baby's position. She allowed as it was probably a good idea that Susan had gone home, because in that time the baby had indeed changed positions. She asked the nurse to begin an I.V. and asked Susan to have a seat on the bed, as she felt they needed to clarify things before they continued. Susan's contractions had been coming every 2-3 minutes. They stopped for the next 15 minutes as the doctor lectured her on their "failure to communicate." The doctor reaffirmed that she (the doctor) had "done more for alternative birth than anyone else in town," that she would not use the available technology

unless it was indicated, that she "only wanted the best for both Susan and her baby." Susan reassured the doctor that she was not trying to undermine her authority, and the fact that she was at the hospital could be seen as testimony to that fact. She said at this time she "just wanted to have the baby" and followed with the comment that she would "be compliant."

The nurse began the I.V., strapped a fetal monitor on Susan, and attached an electrode lead to the baby's presenting part, the head. I lowered the lights and began to play a quiet tape of classical music on Susan's tape player. Susan labored for approximately two more hours and then commenced to push the baby out. The doctor performed an episiotomy during the final pushing. After the birth of the baby, she exhorted Susan to keep pushing to get the placenta out. In an attempt to assist in this endeavor the doctor grabbed the umbilical cord in her hand and pulled. The tension caused the cord to snap in the doctor's hand and blood poured from the severed end which spontaneously retracted into Susan's uterus. When this happened, the doctor appeared extremely distraught, and verbally expressed her concern over the possibility of excessive bleeding. She explained that she needed to prevent this from happening, and in saying this, reached into Susan's uterus with her hand and manually removed the placenta. She then further explained that this procedure would now allow the uterus to adequately contract to stop the excessive bleeding.

Later, as the doctor began the job of perineal repair, she showed to me and to Susan's partner the extensive repair work she had ahead and explained "See, her tissue is just like butter, that's why I needed to do the episiotomy and it is also why the cord snapped." Susan stayed in the hospital for another day and then went home feeling delighted with her baby yet defeated and

depressed about the birth. She suffered postpartum pain at the site of the episiotomy. The baby was pronounced healthy.

Jane's Story

Jane became pregnant in the month of October after trying to conceive for the prior twelve months. Twelve months was not an unusually long period for conception to take place, especially in light of Jane's age; she was forty years old at the time of conception. She chose to continue her medical care in pregnancy with her family practitioner with whom she had developed a long-standing friendship. Initially Jane planned to have her baby at home. Her plans changed when her doctor informed her that if she continued with this plan, she, the doctor, would be unable to attend the birth due to an inhospitable political climate relating to homebirth in the local community. Jane weighed the merits of her two choices: homebirth with a direct entry midwife or hospital birth with her chosen physician. Ultimately, she decided to continue seeking care with her family practitioner and thus to give birth in a hospital. She felt certain that her doctor's holistic attitude and philosophy regarding health care delivery would certainly translate into a similar attitude and philosophy in maternity care practice. She was seeking to have a "normal" childbirth experience and felt supremely confident that her own vigorously pursued physical health would allow her to facilitate this experience.

Throughout her pregnancy, Jane felt a strong sense of physical well being, and she enjoyed the transformations brought on by her much desired pregnancy. An instructor in the martial arts, she continued to practice the martial arts until she could no longer maintain her balance at the beginning

of the eighth month of pregnancy. Initially, the pregnancy was also much desired by Jane's partner. Yet as her pregnancy progressed, Jane felt him growing more distant and less interested. Six weeks before her due date, he told her that he was not sure how he felt about continuing their relationship, but that he would postpone a final decision until after the birth of their son.

This news, while not totally unexpected, left Jane in a state of anxiety for the remainder of her pregnancy. She decided that her marital relationship must be put on hold until the birth of their son. Her training in martial arts guided her to "act" when threatened. She translated this strategy to apply to the upcoming birth. She found it difficult to wait and psychologically difficult to allow the baby inside of her the time it needed to complete gestation.

An unassembled baby crib that needed attention stood in the corner of their room. While Jane anxiously waited for her partner to join her in the task of assembling the crib, the crib became a metaphor for their future relationship as parents. As time passed, and her partner showed no interest in taking on the task, Jane became convinced that she needed to challenge herself to do it alone. One night she closed herself off in the bedroom and over her large, pregnant belly, attacked the assembly job with a vengeance. Success at this small task metaphorically convinced her that she could indeed take on the anticipated task of single-parenting.

In order to prepare for the task of labor and delivery, Jane attended my prepared childbirth classes. Her partner accompanied her to the classes along with a friend she had chosen to provide additional labor support. Jane was an adept student and willingly practiced the strategies I taught her class such as variations on positions for labor and delivery. She also willingly participated in informed consent role playing. Other than the obviously distressing

uncertainty concerning the future of her relationship, she felt ready for the birth of her son.

During a vaginal exam at the time of her due date, Jane's doctor determined that Jane's cervix was fully effaced. At the onset of labor which was officially determined in an examination by the doctor, according to her doctor's calculations she was one week past her expected due date. Jane's interpretation of gestational length differed from that of her doctor; based on her knowledge of the date of conception, she believed she was three days past her date. When mild labor contractions started around 4:00 in the afternoon, Jane walked over to the doctor's office to be "checked" for progress. While there was no perceptible change from the effacement detected at the exam one week earlier, Jane did experience "bloody show" after the examination. She described her emotions after the exam as feeling as if the events of the day and the anticipated events to follow were a bit unreal. She was afraid of the expected pain of labor, and afraid of how her life and her relationship might change after the birth of her baby. Later that evening, her additional support person came over and Jane and her friend passed the time taking walks and sitting on her outdoor deck, and eating when she felt hunger. Meanwhile, her partner slept.

As Jane described her state of mind at this time, she explained that she felt disassociative with a split focus. She was acutely aware of her partner's profound ambivalence, and at the same time conscious of an aching rhythmic pain which felt much like menstrual cramps. She concentrated on relaxing and not resisting the pain.

The next day, her doctor came to her house every four hours and performed a vaginal exam in order to assess the progress of the labor. At 5:00

in the evening, when the doctor determined that Jane had not made any discernable progress, the doctor suggested that Jane take some Seconal in order to get some much needed rest. Jane followed her doctor's suggestion, hoping that the drug would ease her excitement and perhaps stop the labor long enough for her to get some sleep in order that she might then later wake, rested and refreshed, and continue with labor in a more vigorous manner.

The Seconal failed to have the desired affect. Instead, Jane's labor intensified, and Jane felt drawn into a vortex of pain combined with a disassociation presumably brought on by the drug. From 5:00 p.m. to 9:00 p.m. Jane described her labor as "stint from hell." While she experienced extreme pain, she at the same time, felt out of touch with her body. She chose to be alone at this time, as she felt that she needed the solitude to be able to deal with the disassociative pain. Both her husband and her other support person checked on her regularly to see how she was doing and to see if there was anything that they could do to help her. At 9:00 her partner entered the room and emphatically stated "This has to stop". By this statement he meant that he no longer wanted to have Jane continue this process on her own, and he felt it was time to go to the hospital. Jane felt grateful for this small demonstration of concern on his part, abdicated to his wishes, and called her doctor to meet her at the hospital at 10:00 p.m. Her doctor examined her and determined that Jane progress in labor had stalled at "a tight three" centimeters of cervical dilation. The doctor made a number of recommendations for correcting this inertia. Jane complied with her doctor's suggestions and thus entered into an extended contract of medical management of the birth.

The doctor ruptured her membranes and hooked up an internal electronic fetal monitor. She began a pitocin drip to augment the contractions

and concurrently had the anesthesiologist begin an epidural for the pain. Jane labored this way throughout the night, perceiving pressure with the contractions, but not pain. Her doctor described the contractions as powerful. At 6:00 the next morning, the doctor performed the last vaginal exam to check the progress of the labor. Jane was dilated to "a loose three". By all available measures the baby continued to do fine throughout. The doctor suggested that it was time to make a decision, and based on her medical judgement, recommended that the baby be delivered by cesarean section. As a family practitioner, Jane's doctor needed to check with the obstetrical consultant. The consultant offered that they could try "one more thing" but Jane declined the opportunity and said "let's do this". Jane felt an underlying of feeling of failure, yet an overriding sense of relief knowing that she would soon see her baby; this part of her felt like celebrating.

The anesthesiologist gave her "something to relax her" that made her disoriented and feeling "drunk." Jane desperately wanted to watch the birth; to be alert, but felt herself being pulled deeper into the drug-induced state of disembodiment. As she was prepared for surgery she became aware of her partner going through perfunctory motions and snapping pictures. Her other support person was asked to leave and did so which upset Jane even more. The ob/gyn who had assumed care, proceeded with the operation and removed the baby at 6:20 a.m. Jane heard her son's first cry and comforted him with " Baby guy, don't cry" and felt comforted herself when he responded. The doctor said "here's your son" bringing the baby closer. Jane fought the effects of the drug, desperately trying to lift her head and focus on her baby through a cloud of hazy reality. She tried to read the baby's expression, and interpreted what she saw to be "Here I am, are you ready for this..." and simultaneously

felt a sense of enormous responsibility and peace. Jane fell in love; utterly invested in her child.

While the doctor performed the repair on Jane's uterus and abdomen, the baby stayed with her for one hour. At this time her partner left and her baby was then taken for a mandatory two hour observation period in the nursery, accompanied by the other support person since Jane had expressed her wishes earlier that the baby not be left alone with strangers. Jane was grateful for the fact that her support person remembered this and honored her wishes, and angry at her partner for running home. While Jane slept in the recovery room, her friend brought the baby back to her. As soon as Jane was admitted to the regular hospital room where she would remain for the rest of her stay, she undressed her son and admired his absolute perfection. He was with her without interruption from that point on. When they went home two days later, her family and friends provided friendship, support and assistance. Her husband left the relationship three months later. A divorce followed shortly thereafter.

Birth Story Analysis

Informed by my analysis of the four texts which provided varying degrees of insight into the ways in which social structure and culture have influenced childbirth in the United States, I next attempt to unravel the threads woven into the fiber of these two births. At the beginning of this thesis, I maintained that there are certain variables by which one can evaluate a birth experience. These variables were safety, cost, access, and the quality of the experience. I then articulated the goals of the medical model and the second wave liberal feminist modifications of the medical model. I

now intend to examine these two births in light of both these four measures of birth and the second wave liberal feminist agenda to demedicalize childbirth.

Both Susan's and Jane's births surely met the goals of the medical model. The two women had access to, and used, both a physician and a technologically well-equipped hospital. Each woman also had third party payor insurance to cover the costs incurred and, as such, their access to the standard system was not impeded by financial constraints. Both babies were healthy at the end of the process. Both women eventually recovered from the process. Susan faced the challenge of recovering from both the episiotomy and the negative emotional sequelae suffered from the figurative battle in which she engaged with her health care provider. Jane faced the challenge of recovering from major abdominal surgery, and the negative emotional sequelae suffered from the disappointment realized when the sequence of events went other than the way she expected. In the telling of the two narratives, both women expressed moderate to extreme disappointment and dissatisfaction with the sequence of birth events.

In reviewing the events of the two births, one can posit the following questions: Did anything go wrong? If so, what went wrong, and how could the "errors" have been avoided? Both women had assiduously followed second wave liberal feminist dictates to avoid unnecessary medicalization of their birth experiences. They were attentive to preventive health measures throughout their pregnancies, and each enjoyed a state of physical health throughout the pregnancy period. They each selected a woman physician whom they believed to possess essentialized female qualities of caring and compassion. They each had established a conversation with their respective doctors about their desires to demedicalize their respective birth experiences

(Katz 1984). They sincerely believed that their doctors would attempt to actualize this desire for them. Both Susan and Jane attended childbirth classes, and were well-educated about the course of normal labor and delivery and were, moreover, highly motivated to avoid pharmacological, technological and surgical intervention, i.e., a medicalized childbirth experience. Yet, the information, the tools and the strategies offered in my childbirth classes failed them as soon as they entered the institutional environment of the hospital.

Each woman's birth experience was accomplished through the utilization of some form of expensive medical management and medical control of the experience. Was the medical management necessary to either facilitate or to insure the safety of the two births? What might have happened without the medical management? What were the physiological consequences of the management for the woman? What institutional incentives existed to avoid medical management? The experience of childbirth has a profound effect on women of all cultures, such that the significance of the experience is commonly recognized by various symbolic rituals noting the importance of the rite of passage for both the woman and the baby (Kay 1982). What was it about the rituals involved in the medicalized birth experience for these two women that the experiences served to demoralize them as they traveled through such a transformative experience?

The level of pharmacological, technological, and surgical intervention in Susan's birth was not unusual when compared with a standard hospital birth in the United States. It was, in fact, minimal compared to the average hospital birth in this particular city[18] and certainly fit within the standard of community care, both regionally and professionally.[19] But the outcome

experience was not what Susan wanted. Susan expressed a sense of personal dissatisfaction in the postpartum period with the course of events.

As seen from the physician's point of view, Susan caused herself unnecessary stress by her refusal to include the doctor in the customary manner of birth management. Since Susan and her doctor were previously academic peers who had enjoyed a friendly and warm collegial relationship, the contentious nature of their subsequent interaction at the time of the birth was unexpected. Perhaps Susan's expectations were unrealistic; maybe Susan should have realized that a doctor predictably relies on the social power base and on the tools and technology available in medicine. Maybe Susan should have anticipated that hiring two professionals who advocated different models of normal birth might potentially lead to a power struggle for professional authority. But she did not. She felt that she was acting wisely and covering all possible permutations on birth by hiring professionals with expertise in different arenas. Indeed, each had expressed admiration of the other's clinical experience when she discussed her plans with them early in her pregnancy.

The level of intervention in Jane's birth was fairly routine, especially considering that one in four to one in three (the numbers vary depending on the month) women are delivered of their babies by cesarean section in the tertiary care hospital where her doctor practiced.[20] The level of medical management also fit comfortably into the recognized and accepted standard of community care, both regionally and professionally.

Like Susan, Jane was also very disappointed at the level of medical management which occurred, but conversely, Jane concluded "all the intervention that I sought to avoid turned out to be necessary." Jane was convinced that she must have unconsciously attempted to postpone the

inevitable departure of her husband from their relationship by subconsciously stalling the labor and delivery of their baby. In fact, her family practitioner somewhat corroborated Jane's interpretation of the sequence of events, when she (the doctor) told Jane that she had submitted Jane's birth story to be discussed as "the case of the week." She told Jane that in the concluding comments of the medical staff they "chalked up [her] failure to progress as the mystery of the week." For Jane, the emotional baggage of self-doubt was additive to the emotional pain and concern that she experienced over her deteriorating relationship with her husband. Four years after the birth, Jane continued to express confusion about, and to agonize over her own perceived personal failure to attain her desired goal of a non-medicalized birth. Again, one can ask did anything go wrong, and if so what, and how might it have been avoided?

These two births reveal many subtle and overt dynamics involved in routine hospital births, the social construction of which reflects the values of the larger society as explicated by the four social scientists reviewed earlier in the thesis. The following critical interpretive analysis will continue to invoke a theoretical "yardstick" marked with the measures of safety, cost, access, and quality, and using this yardstick, explore the multiple and intersecting limitations of socialization, technology, power, authority, and control in these two births.

Chapter 6

SOCIALIZATION, TECHNOLOGY, POWER, AUTHORITY, AND CONTROL: THE INFLUENCE OF LIMITING VARIABLES IN MEDICALIZED BIRTH

> Through ritual, the belief system of a culture is enacted...thus, an analysis of ritual can lead directly to a profound understanding of that belief system....analysis of the rituals of hospital birth reveals their cognitive matrix to be the technological model of reality which forms the philosophical basis of both Western biomedicine and American society" (Davis-Floyd 1987: 156).
>
> ...All knowledge relating to the body is culturally constructed, negotiated, and renegotiated in a dynamic process through time and space (Lock and Scheper-Hughes 1990: 49).

The liberal feminist agenda suggested that an informed and healthy woman could make objective choices, and should do so in order to demedicalize her birth experience. But truly objective choices are nonexistent. "Objectivity" is socially constructed, and as such bears the mark of multiple subjective and most often invisible influences including socialization, technology, power, authority and control (Gordon 1988). Examination of the social construction of women's childbirth experiences reveals the way in which these factors limit women's available and socially acceptable choices to those within the medical model.

First, access to trained, competent health care providers has, with very few exceptions until recently, largely been limited to physicians. Thus the range of choices for birth attendants has been a limiting factor for childbearing women. The second limiting factor is that of the physical context in which birth is managed. The range of choice regarding the place of birth has, also with very few exceptions until recently, largely been limited to hospitals. Thus, the available options for the physical location of birth has

been a limiting factor. Third, within the same physical context of the hospital, both the range and the priority of available options for the management of birth has been a limiting factor. Fourth, birth managed by physicians is subject to physician's professional medical judgement, and as such, is limited by medical assumptions regarding childbirth. Fifth, both society and culture provide strict guidelines for what is considered to be acceptable health behavior. In part, such guidelines are delineated by and are responsive to the diverse needs of competing institutions in the professional-medical-industrial complex. Institutional constraints for acceptable social behavior are limiting factors in women's birth experiences and are revealing of the hegemonic priorities of institutional control in medicalized birth.

I will first illustrate my strategy for the analysis of the multiple and intersecting influences of socialization, technology, power, authority and control by deconstructing the dynamics involved in just one area of medicalized birth, that of pain in labor. I use a vignette from one local institution's recent response to managing childbirth pain. I will then use this same strategy to examine both Susan's and Jane's birth narratives.

An Example of Pain in Labor

Most women experience what they describe as moderate to extreme pain while in labor; and the way in which the institution at a policy level, and the staff individually, respond to a woman's labor pain will most certainly influence how she "chooses" to deal with such pain. In my childbirth classes, it was not unusual for a woman to be highly motivated at the beginning of her labor to avoid pharmaceutical pain relief due to concern over its inherent risks; yet, as Davis-Floyd also observed in her sample, many ultimately chose to

use it. As an instructor, I listened to their birth stories, and as I did so, contemplated on how the five variables listed above silently intersected in such a way that the woman fully believed that her choice in doing so was made objectively. Yet closer examination revealed that constraints imposed by the medical model served to guide the choices made towards conformity with that model.

The health care industry is a for-profit venture; even non-profit health care organizations operate under a profit incentive to cover expenditures (Kaye Abraham 1993). Within this industry, a hospital, as part of an institutional organization, holds the authority and the power to control many factors which serve to influence a woman's choice regarding pain relief while in labor. Such was the case when mid-way through my teaching tenure one of the local hospitals made the decision to have anesthesia readily available on a twenty-four hour basis in labor in delivery.[21] This decision meant that they had to adjust their current employment arrangement with their anesthesiologists. In order to accommodate around the clock availability, the hospital added new individuals to their staff of anesthetists. The labor and delivery unit then modified their policy such that all laboring women admitted to the unit were classified as pre-surgical patients.[22] With this reclassification, the unit adopted a subsequent policy whereby a staff anesthetist did a pre-surgical visit to each laboring woman. This pre-surgical visit was justified as part of normal pre-surgical protocol. Within this protocol it was viewed as optimal to have the anesthetist meet the patient prior to surgery in order to have the opportunity to discuss the risks and benefits of the various pharmaceutical options, and also to evaluate any risks especially in light of each patient's individual health history.

What followed was a dramatic increase in the rate of epidural administration within the labor and delivery unit. Within one year following the hospital's initial decision to have twenty-four hour anesthesia available in labor and delivery, I was contacted by a local pediatrician. He solicited my assistance in helping him in his efforts to attempt to lower the rate of epidural use during labor and delivery in this same hospital. He estimated the rate of epidural administration to laboring women had risen from 40-50% to between 90-95%. He expressed his surprise that so many women now asked for this type of pain relief. As a pediatrician, he was concerned about the increased potential for harm to the babies, realized through the increased interpartum use of pharmaceuticals (Doering 1982).[23] His suggested strategy was to educate women both about the attendant risks to their babies involved in the administration of interpartum pharmaceuticals and alternative choices for coping with the pain of labor. I politely refused his request for assistance.

Clearly, the above scenario can be subjected to different interpretations depending on one's vantage point. From the concerned pediatrician's point of view, women were naively taking unnecessary risks in asking for epidural administration to relieve their labor pain. From the hospital's point of view, a wise business decision was made. This decision allowed them to increase their profit margin through increasing their services to a laboring women for the length of their stay at the hospital. This strategy is noteworthy at a time when recent cost containment regulations mandate increasingly shorter hospital stays. From my point of view, the hospital created a situation which allowed it to increase profit through aggressive marketing of a service, and at the same time to "manufacture consent" for such a service from a captive audience of

laboring women (Herman and Chomsky 1988).[24] In support of my perspective, I offer the following insights.

The priority of available options serves as a limiting factor. The fact that pharmaceuticals are most commonly offered as a first choice for pain relief over many other less invasive available measures to ease discomfort and to minimize pain is revealing of values within the medical model, and also reveals the power and authority of hospital staff in controlling available choices. Equally, the manner in which the anesthesiologist presents the informed consent "risks/benefit" estimation of their pharmacopeia might sway a woman's decision. The menu of choices made available to the woman will certainly influence what she chooses.

Inexpensive, low-risk, low-tech options (touching, positional changes, warm water baths, etc.) are rarely available choices in this setting; the choice of such options are made obsolete by other hospital routines and conventions. Consequently, the physical context serves as a limiting factor. As an example, furniture options in a hospital labor and delivery room commonly include a bed for the woman and a chair for her support person. The potential for maneuvering positional changes with these two pieces of furniture in order to effect pain relief is negligible. Since a laboring woman is most often forbidden to eat (again a presurgical precaution)[25], the institutional substitute for sustenance is an I.V. solution of glucose. The I.V. equipment will limit her ability to change positions. Some hospitals do have a shower accessible to women in the labor and delivery unit, but most do not have a bath tub available. While the warm water of a shower can give some comfort, women in hard labor have a difficult time standing up by themselves for an extended

period and again, I.V. equipment and also fetal monitoring machines preclude either option.

Medical assumptions regarding childbirth most certainly will limit birth management for pain relief to fit within professional expectations. In this way, the attending physician most commonly relies on a long list of pharmaceuticals to manage the pain of labor. Many physicians have a standard protocol for pain management. Nurses are held responsible for remaining knowledgeable about the various protocols for the many physicians and for offering them to the patient as labor progresses. As mentioned earlier in this thesis, consumer-led interest in using breathing gymnastics to control one's response to labor pain met with an enthusiastic response from labor and delivery staff. Consequently, current institutional dictates for acceptable social behavior place a limitation on what are considered acceptable responses to pain. The institutional assumption regarding childbirth is that women will indeed control their vocal responses to labor pain such that women, who vocally respond to labor pain, will be judged to be "out of control" or conversely labeled "a screamer" and determined to be in need of the available pharmaceuticals.[26] This sequence of limiting factors illustrates the way in which the social construction of pain management within the medical model of birth constrains a woman's "choices" to meet institutional and professional expectations.

Women conform to self-imposed constraints guided by negative social sanctions. Consequently, the present social climate harbors social incentives encouraging conformity to medical model social dictates for giving birth. Thus, it is not surprising that most women follow them. Yet paradoxically, negative social sanctions for conformity are not about the outcome, they are

about conformity to social norms.[27] When an unexpected outcome occurs in birth, the focus centers on how closely all the individuals involved followed the socially recognized and socially acceptable "rules." When such outcomes are not serious or life-threatening, and can be remediated by a medical response, culpability is most often silently absorbed by institutional rationalization. For example, when a woman suffers an infection from an episiotomy, it is viewed as an unfortunate side effect from a procedure necessary to facilitate birth, since within the medical model, performing an episiotomy is an accepted way to manage birth. Most would agree that the woman was not at fault for allowing her doctor to perform this procedure, and most would also agree that the doctor was not at fault for doing so. Such is the case because this surgical procedure is accepted standard practice. The hegemony of the medical model obscures other possible management options that fall outside of the socially accepted rules. Societal acceptance for surgical insults to the mother become seamlessly woven into a social fabric of tacit acceptance for routine procedures designed to mitigate unacceptable circumstances.[28] Certain dynamics involved in Susan's birth exemplify this paradox.

A Critical Interpretation of Susan's Birth

As an academic who had worked closely with the medical school, particularly in the area of women's health care, Susan was highly cognizant and also critical of the growing medicalization of women's lives. Consequently, she was highly motivated to avoid the medicalization of the birth of her first child. She considered a homebirth, but felt that since this was her first experience, she would feel better (safer) in a hospital setting,

and felt that her chosen provider would facilitate a home birth experience in the hospital setting. Additionally, she felt that choosing a midwife and a childbirth educator for labor support would facilitate such an arrangement, assuming that this arrangement could somehow further mediate unnecessary medicalization. Susan's actions fell within acceptable social norms in choosing a hospital birth, yet the model of birth that Susan envisioned, that of a demedicalized experience, was really that of birth at home. There is a particular vulnerability experienced by a woman who is approaching the term of her pregnancy, and Susan was reluctant to make such a socially unorthodox choice. Many women in my childbirth classes considered the option of birthing at home, but chose not to. Commonly accompanying this decision in their conversation was the caveat, "I'd like to birth at home, but what if something happened?" implying that if something untoward occurred, they would have to assume responsibility for their decision, and it would be their fault for making a wrong choice. Curiously, when something <u>did</u> happen at a birth within the hospital (infection of the mother or baby, cesarean section, or other sorts of iatrogenic accidents), acceptance for the untoward event was silently woven into acceptable social behavior. Women are socialized to believe that both their own bodies and the process of birth are inherently dangerous, and as such they learn to place their trust in institutional and technological management to presumably make the birth safer. Yet in Susan's birth, birth management only made the sequence of birth events more predictable.

When the doctor first went against Susan's wishes to avoid an episiotomy, and then followed by exerting excessive traction on the umbilical cord causing it to snap from her efforts, she justified her actions by employing the

metaphor "her tissue is like butter," thus implying that it was Susan's friable tissue and not her own (the doctor's) actions which led to the need to intervene. Medical management and reliance on the use of "technology is embedded in social institutions, and individual choices are made within a social system that rewards some choices and punishes others" (Garner and Tessler 1989: 26). The standard of community care, a largely unwritten and often specious perception of what is considered good care as it is practiced in a given area, commonly guides medical practice. The standard of community care is responsive to institutional needs, including efficiency as well as to physiological medical management.

It is considered good "management" within the standard of community care to insure that the placenta is out of the uterus very shortly after delivery, usually within 1/2 hour at the most. The concern is that as long as the placenta remains within the uterus, the uterus cannot adequately contract. Uterine contraction is desirable because this process puts pressure on the major blood vessels within the uterus to stop them from bleeding excessively. Consequently, doctors are motivated to expedite this maneuver. When the attempt by Susan's doctor to assist in removing the placenta caused the cord to snap, the doctor panicked and followed with accepted medical protocol by manually removing the placenta, a procedure which Susan found extremely painful. While it is true that a doctor tempts serious negative professional sanctions if they practice outside of the net of "standard of community care" this apparently innocuous procedure deserves further examination.

By framing the occurrence as a medical crisis, the doctor was fully able to assert medical authority in remediating the crisis. Susan was not in a position to refuse, and as the doctor explained the immediacy of the situation to

Susan's husband, neither was he. Among the Bariba of Benin, the matrones who act as midwives recognize that "pulling on the cord...would kill the mother" (Sargent 1982: 207). This wisdom is shared fairly universally in most cultures (Kay 1982). But the concern is not for the same physiological rationale that the doctor provided to both Susan and her husband, since any blood from the snapped cord was placental blood and not the mother's, and as such was irrelevant to the mother's well-being. The placenta is not attached to the uterine wall, the bleeding over which the doctor expressed such concern would continue only until the placenta itself exsanguinated. Folk wisdom regarding traction on the cord has to do with concern over inadvertently causing premature or partial removal of the placenta, which does cause maternal hemorrhage.

After the birth of the baby, the uterine muscles continue to contract and shorten causing involution of the uterus, and in so doing, this same action disengages the placenta (which then slides out) and simultaneously causes uterine bleeding to subside through the concomitant pressure exerted on uterine blood vessels. Premature removal of the placenta could allow for excessive bleeding since it would not necessarily be followed by the pressure of full uterine involution. Excessive traction on the cord could also lead to only partial evacuation of the placenta, with similar consequences. Beyond the pain that Susan experienced when the doctor put her hand into Susan's uterus, this invasive procedure also increased the risk of a postpartum infection, and again, folk wisdom would caution against taking such a risk. As seen in Susan's experience, technological birth tolerates such an exception to folk wisdom since there are pharmacological and technological solutions to the problem created. One simply manually and/or instrumentally removes the

placenta, administers pitocin to effect the uterine contractions necessary to minimize bleeding, and then administers antibiotics to ward off any infection which might occur from such an invasion. When Susan discussed the birth with me at a later date, she stated that she was well aware of the fact that the doctor set "the crisis" described above in motion, because she (Susan) could feel the doctor pulling on the cord, but again, she (Susan) had just given birth, was holding her baby, and was not in a position to challenge the doctor's authority.

What she did not foresee was the resulting power struggle between the two authorities. Although Susan was a professional, she was not a medical doctor, and within this context Susan's behavior might be seen as rebellious or even naive. As Irwin and Jordan (1987: 319) note, medical knowledge has association with a stronger power base and "contempt for professionals is easier for those who live among them than it is for those who may have to submit to experts in a wider range of life experiences" (Nelson 1983: 295) as "doctors, in fact, appear to resist and reject aspects of each client model in favor of their own approach" (Nelson, 1983: 285). In Susan's case her doctor wanted Susan to believe in her (the doctor's) abilities, her skill and her beneficence. Susan wanted to use education and additional support as tools to control the circumstances surrounding her birth. This presented a direct threat to the doctor who viewed herself as the appropriate person to wield power and assume control. She wanted to be the primary authority and the decision maker. Irwin and Jordan note that medical power is often delivered with a "veiled threat of powerful sanction" (1987: 319) as was the case when the doctor lectured Susan when she first entered the hospital.

What Susan had attempted to negotiate was impossible due to the existing power structure in the institution of the hospital and the profession of medicine. When Susan became a non-compliant patient, her doctor asserted authority; verbally (the lecture) and physically (the I.V., episiotomy, and manual removal of the placenta manifesting the power of "the dark side of the force" within the medical profession (Brody 1992: 28).

A Critical Interpretation of Jane's Birth

Jane's birth illustrates a similar scenario of institutional control, medical management, and medical correction for problems created by the medical management. This scenario only becomes apparent by examining Jane's birth from an alternative stance. In the retrospective telling of her birth story, Jane pondered "I wonder if I was really in labor to begin with..." referring to the contractions which she experienced on the first day of what was certainly counted by her physician as the beginning of her labor. A retrospective analysis reveals that an alternative labor management strategy might have been to encourage Jane to maintain normal daily activities and to ignore the contractions until she could no longer do so. Instead, Jane's physician, in her role as a socially recognized authority in her capacity as a doctor, determined that the labor had indeed begun and encouraged Jane to move around in order to help the labor progress. Consequently Jane walked and talked through the night, going without sleep. The regular vaginal exams to assess dilation the next day were obviously well-intentioned on the part of Jane's physician, but such aggressive attention to cervical progress alerted all parties involved to fixate on cervical dilation as the goal for which they should strive. When the vaginal checks continued to affirm that cervical dilation was

euphemistically "stuck" at three centimeters, Jane was amenable to her doctor's suggestion that she use Seconal to bring on some much needed rest.

Jane attributes her subsequent disorientation and inability to cope with the pain as a consequence of the unanticipated side effects of the drug. When Jane's husband then responded to her manifestation of pain and disorientation with the statement "this can't go on," she was willing to accept his assumption of leadership. The subsequent institutional response to Jane's being "stuck" at three centimeters of dilation was her doctor's suggestion to give her an intravenous infusion of Pitocin to augment the effectiveness of the contractions along with an epidural for the associated pain of labor. Jane was then required to be recumbent and was allowed nothing to eat and only liquids to drink. For Jane, the next night was unending as she was hooked up to the I.V., confined to the bed, yet was unable to sleep through the resultant turmoil. Repeated vaginal checks served to reinforce her belief that "nothing was working" to progress the labor. When her doctor discussed "getting this over with" the next morning, Jane no longer believed in her own ability to give birth. Feeling defeated, she not only acquiesced, she welcomed the suggestion of surgery to remove the baby from her uterus.

Thus, it would appear that while Jane was initially an exemplar for liberal feminist dictates, like so many clients in my classes, she ended with a highly medicalized birth experience. The dynamics involved in Jane's birth are reflective of many related by my clients. What is not immediately apparent, is the way in which the choices Jane faced were restricted by the first choice that she made, which was to birth within the hospital.

> Choices in health care are structured by the opinions of family and friends, community values, and prior experience as well as the actual facilities and options available" (Michaelson and Alvin 1988: 147).

As institutions, hospitals have a need to standardize care and to implement routines. When these routines create problems and cause physiological disequilibrium, institutions incorporate ways to regain stability. Technological manipulation provides both the method and the technique to do so. Doctors follow through with such institutional directives by carrying them out in protocols within their practice.

I maintain that the only thing that was "wrong" with Jane's labor was that her certainly well-intentioned and caring physician began to pay attention to it much too soon. In my childbirth classes, I always attempted to alert women to the inevitable chain reaction of management events which I had witnessed occurring as soon as a doctor started counting labor signs as those of real (read imminent) labor. Many of the birth stories told by women who were delivered by cesarean section recounted a scenario similar to that which Jane experienced. In order to explain the reason for the surgical birth, the women were given a diagnosis describing their anomalous labor, "failure to progress," "dystocia or ineffective labor," and most commonly "CPD or cephalo-pelvic disproportion." I translated these diagnoses for my classes to mean "baby won't come out within the time we (supporters of the medical model) believe a baby should come out in." Using examples gleaned both from midwives stories and from my own experience in doing labor support, I described what I believed to be a long, but still normal labor as evidenced by a healthy postpartum mother and a healthy baby. While my clients gasped as I

described forty to sixty hour labors, they need not have, since this knowledge was irrelevant within the medical model.

Emily Martin (1989) describes the institutional metaphor for a woman giving birth as that of a machine which is intended to produce. The institution sets parameters for the amount of time it should ideally take for the woman's body to produce a baby. Within a medical institution, time translates into financial gain. Martin's work also revealed that the production aspect of birth it is not about mother and baby well-being, it is about time labor and money. What her work best illustrates is how the medical model, as conveyed through medical language, views women's bodies as mechanisms in need of control and repair. "Birth is seen as the control of laborers (women) and their machines (their uteruses) by managers (doctors), often using other machines to help" (Martin 1989: 146). In Jane's labor, her body was seen as one which needed ambulation (walking), sedation (Seconal), augmentation (Pitocin), hydration (I.V. glucose), anesthetization (epidural), observation (internal fetal monitor) and ultimately surgical intervention (cesarean section). Yet according to Jane's report, there was never an indication that her baby was in any kind of danger. Certainly Jane was tired and anxious, but why the sense of urgency, what was the hurry? And, finally in what light can the "cure" effected be considered more advantageous and desirable than the exhaustion and anxiety which she was experiencing? It was research by Emmanuel Friedman in 1955, that:

> mapped the instant-to-instant changes in cervical dilatation over time and plotted an 'ideal' labor progress curve, a mean labor progress curve, and statistical deviations around those curves...[he] developed technology to monitor cervical dilatation over

> time...including an ideal course with which the woman's labor could be aligned by various techniques (Arney and Bergen 1984: 100).

What has happened within the institutional setting is that these averages which in and of themselves are of questionable relevance since rarely do one's bodily functions conform to an average measure, and non-conformity is of questionable use for indicating pathology in what is a non-pathological event, are now used as the upper-most limit of what is considered safe for normal labor. Hence, a further limitation on labor options is that imposed by expectations that the labor fit within an artificially constructed picture of the range of normal labor. This is a spurious and self-serving use of statistics. Without this limitation, Jane could, instead, have been encouraged to ignore the early labor contractions, to have a nice dinner, to go to bed, and to distract herself the following day and from then until she no longer was able to. Clearly, not only was birth not imminent, the focus on cervical dilation was counterproductive to Jane's mental state.

The physiological consequence of such a directed focus on cervical dilation was the following domino-like chain of events: the subsequent sleep deprivation - Seconal as a corrective - the subsequent disorientation and panic - a Pitocin labor augmentation as the corrective - an epidural for the associated pain of labor augmentation - confinement to the bed - no food and no hope - a cesarean delivery as the corrective. Physiology was manipulated to meet institutional goals of production. The rituals of Jane's birth experience demoralized her because they conveyed to her that she was reproductively dysfunctional through her failure to give birth to her baby. Moreover, she was unable to see how her subsequent choices were limited by her first choice,

to birth in the hospital (Kozak 1984). Consequently, she searched her own behavior and psyche for both cause and culpability.

Powerful and persuasive social forces direct the perceived willingness and consent of women to participate in rituals which ultimately sabotage them by strengthening gender inequities enforced through the institutional social control of women. In particular, negative social sanctions serve to effectively influence and guide behavior. The ideology of the medical model of birth is that birth is inherently potentially dangerous, and that it cannot and will not proceed without medical/technological management. A corollary of this ideology is that the medical/technological management of birth is "safe." Since the practice of medicine is learned through apprenticeship, such medical practice, including the management of childbirth, is based on medical judgement grounded in a subjective and often conflicting combination of scientific data selected by a provider to support their own personal beliefs and clinical experience (Ehrenreich 1978). Conversely and ironically, my clients believed medical practice to be both grounded in fact and supported by objective, indisputable scientific inquiry. They were socialized to implicitly trust medical judgement. Such socialization served as a limiting factor to prevent them from questioning the authority and judgement of their physicians. The inherent power structure within the institution of birth rendered a consumer challenge ineffectual. Institutions confer on professionals who pass through their doors professional authority, so that historically "authority no longer depended on individual character and lay attitudes; instead, it was increasingly built into the structure of the institution" (Starr 1982: 20). Authority led the way to economic power and the monopoly which physicians have wielded ever since. While physicians have

claimed to be above the control of the market, closer observation of physician practice and profit belies the claim.

Ironically professional authority would have been impossible to establish in preindustrial America where individuals in rural communities relied on themselves and each other in a self-sufficient and independent manner. But urbanization brought the need for specialized skills, which often had to be purchased from strangers. Coupled with advances in science and technology, the public was willing to believe that not only did science have all the answers, it was better than trusting the old ways, or the whims of nature. Childbirth was seen to be within the jurisdiction of medical authority. In this milieu, childbirth preparation classes become a salve to soothe women's fears of the unknown and fears regarding a lack of control over the experience. As with other institutional birth methods, they "symbolically [met] the demands of parents-to-be while they maintain[ed] the control and prerogatives of the obstetrical community" (Matthews and Zadek 1991: 40).

Yet is only through the comparison of standard medical birth management in the United States with other available alternative models of care that the potentially harmful effects of technocratic birth management can be revealed (Chalmers 1978). It is clearly time to place the burden of proof regarding safety, cost, access, and quality of experience on the medical model of birth.

Insights Gained From A Critical Interpretation of Liberal Feminist Efforts

> ...when a theory is transformed into an ideology, it begins to destroy the self and self-knowledge. Originally born of feeling, it pretends to float above and around feeling. Above sensation. It organizes experience according to itself, without touching experience. By virtue of being itself, it is supposed to know. To invoke the name of this ideology is to confer truthfulness. No one can tell it anything new. Experience ceases to surprise it, inform it, transform it. It is annoyed by any detail which does not fit into its world view. Begun as a cry against the denial of truth, now it denies any truth which does not fit into its scheme. Begun as a way to restore one's sense of reality, now it attempts to discipline real people, to remake natural beings after its own image. All that it fails to explain it records as its enemy. Begun as a theory of liberation, it is threatened by new theories of liberation; it builds a prison for the mind (Griffin 1982: 648)).

The ideology underlying the medical model of birth has perpetuated a fictive model of expected normal birth events. The perception of normal behavior is itself a powerfully persuasive incentive for social conformity to group behavior. What is perceived as normal behavior feeds information into a self-perpetuating reinforcement loop, a homeostatic mechanism of social norms which then serves to exert control over potentially excessive or disruptive deviant behavior; a deviation dampening feedback strategy. Social reinforcement of behavior is both manifested and maintained through social institutions. Social institutions maintain social order by rewarding conformity and providing disincentives for those whose behavior deviates from accepted norms. The institution of medicine regulates their model of birth by restricting the standards used for assessment of efficacy and safety to those defined as important or meaningful with the medical model of birth, and selectively ignoring the consequences realized by the technocratic model of

birth in negatively influencing a woman's ability to give birth, a deviation amplifying feedback strategy.

A critical interpretive analysis of second wave liberal feminist efforts reveals that certain aspects of their approach were misguided while others were appropriately directed. Their concerns regarding the excessive medicalization of birth were then and continue to be well-founded. The technocratic medical model of birth has been reified.

> We also reproduce a political ideology in the guise of a science of (apparently) "real things"---biological and physical thinghood. In this way our objectivity as presented in medicine represents basic cultural axioms and modulates the contradictions inherent to our culture and view of objectivity. (Taussig 1992: 84)

The reification of technocratic birth combined with the comprehensively unrealistic picture of American reproduction as conveyed to women through media representation is directly counter to the sweat, blood, pain, exhaustion, tears, vomit and various other body fluids which are all part of normal birth. Within western societies, the health system is one of the most powerful existing institutions, and as such acts as an effective tool of social control. Pressures to operate within established guidelines of accepted normal behavior are pervasive within the institution and as such, these pressures serve to regulate the behavior of both providers and patients. As research by medical research statistician Marjorie Tew (1990) suggests, the assumption that the medical model of birth is superior to the model which it replaced (homebirth with midwives) is wrong. The story of the medicalization of birth in the second half of the twentieth century is "a record of the successful denial and concealment of extensive and unanimous evidence that obstetric intervention only rarely improves the natural process" (Tew 1990: vii).

Liberal feminists singled out the gender of health care providers as problematic. The mid-century predominance of men as obstetrical care providers was viewed as a causal factor in the increasing medicalization of birth. It was believed that women obstetrical care providers would participate in the childbirth arena differently than male doctors. Liberal feminists extrapolated from a belief in essentialized "feminine" qualities of caring and support, that women providers would bring such essentialized feminine qualities to the birth arena. Moreover, liberal feminists projected that women providers would be more amenable to a laboring women asserting her desires through a birth plan, and likewise would be more agreeable and willing to honor this plan, even when it included non-traditional strategies for birth management. Gender was seen to be determining variable in the way power was wielded. Control of this variable was assumed to be within reach of directed feminist effort as more women entered medical school. As women enter the profession of medicine in increasingly greater numbers however, it has become evident that liberal feminist assumptions regarding the influence exerted on the quality of patient care by the gender of a health care provider were uninformed. While their assessment of the impressive power of the health care institutions to shape behavior and norms was correct, it is this same power manifested in the profession of medicine which causes women as physicians to identify with the values and norms of the profession over those of gender. Consequently, it turns out that the type of care women offer as physicians does not significantly differ from that offered by men as physicians.

Consumer choice in a free market is upheld as a cherished classical liberal right within the United States. If current common practice by

childbearing women in the United States can be construed to indicate autonomous "choice", then it would appear that there is a clear consensus that the ideal model for normal childbirth is for it to be technologically, pharmacologically, and surgically managed within the confines of a hospital, attended by a physician. Over the past eighty years in the United States the medical model of birth has indeed replaced most other models to become the dominant model for normal birth. Yet a simplistic assessment that this is indeed the ideal (best/safest) way to give birth belies the influence and coercion of power, politics, and financial gain entrenched within social institutions that serves to shape social behavior and social policy. The frequency of technocratic physician-attended hospital birth reflects neither individual choice, a range of birth options, nor the best in scientific or clinical wisdom; it reflects the manufacturing of consent by the professional-medical-industrial complex (Mehl, et. al. 1980). Within this context, choice is illusory. Perpetuation of such an illusion satiates those who want to believe that a model of classical liberal choice insures that one will be able to influence and control their own care. The liberal feminist agenda was based on an erroneous assumption that women were free social agents who could act in their own best interests. Knowledge regarding alternative birth management is inconsequential when options are limited by the multiple influences of socialization, technology, power, authority and control evidenced within the medical model

Germane to the issue of "choice" of birth location and birth attendants are the political, social and economic contexts within which they occur; the political economy. As such, one must contextually frame the issues of current childbirth practices within their political and economic climate before

facilely assuming that the popularity of this current practice implies either ideal experience or individual choice. The same may be said about the assumption that individuals lacking health insurance prefer to choose lack of insurance as an option, since choice is shaped by the availability of options. Options in any arena are commonly delineated and limited by the powerful within a given system of control. The history of the medicalization of birth provides clues to the development of our current birth practices, which are intimately linked to the rise in dominance and authority of the medical profession. Critical assessment is required to uncover the influence and coercion of power, economics and politics in shaping the norms of social behavior and social policy in childbirth practices.

A major weakness in the liberal feminist approach was that it focused on individualized efforts. Individualized efforts proved to be ineffectual because they did not adequately address, nor challenge, the shifting power relations underlying medicalized childbirth in the United States. Power belongs to the institution (Jordanova 1989: 154). Issues of gender and knowledge are handmaidens to larger social, cultural, and economic constructs. The trajectory of institutional effort responds not to the concerns of individuals for reform but to institutional needs and interests; interests which represent the concerns of those in power which are currently buttressed by escalating economic pressures.

One of the aspects of the underlying assumption behind liberal feminist efforts, that increased knowledge would translate into increased power for women and that this power would then translate into improved maternal and child health proved not only to be naive, but also had several unforeseen social consequences. First, women who embraced the notion of childbirth

education and preparation as a tool of empowerment, and participated in childbirth classes as a way to participate in decision making at the time of their birth, were, as a result of their participation in decision making, likely to accept individual responsibility for a childbirth experience that went other than expected. They then failed to see that their experience was reflective of a larger pattern of social influence. Second, when liberal feminists articulated the health agenda they assumed to be most deserving of attention, they manifested a singular and somewhat exclusive identity agenda. Moving forward as if they were speaking with one voice, they univocally proclaimed a relatively narrow and self-interested agenda. Inattention to social location resulted in an agenda that was partial. Social location constrains the range of available choices for one's role in life. The assumption of univocality allowed them to believe that they were speaking with one voice, a voice that represented a women's health agenda most deserving of public attention, resources, and reform.

Attention to the highly visible middle- and upper-middle-class agenda served to divert attention from public health issues which, if given adequate resources, could much more significantly influence the health of mothers and their babies. Hence the liberal feminist agenda was inadvertently complicitous in focusing choice and responsibility at the individual and personal level, when the reality of this context was that personal choice and responsibility for such choice is institutionally controlled. Maintaining a focus on the individual level diverted attention from the public health concerns and health issues of everyday life. The consequences of defining women's "health" reality with a singular focus on reproduction proved to be reductionist, with far-reaching yet certainly unintentional results for

minority women. Careful scrutiny reveals that the "default" consciousness of majority feminists allowed them to refer to their own priorities to define the most pressing feminist issues needing attention. Problematically, the self-determination model paid inadequate attention to other factors such as race, class, and institutional power; factors which are potentially limiting within the social hierarchy due to gross systemic inequities.

Building on the conceptual contributions of Michel Foucault (1978) whose insightful scholarship provided the tools for analysis which revealed the body to be a locus of social control, philosopher Susan Bordo points out that,

> ...the discipline and normalization of the female body--perhaps the only gender oppression that exercises itself, although to different degrees and in different forms, across age, race, class, and sexual orientation--has to be acknowledged as an amazingly durable and flexible strategy of social control (Bordo 1992: 14).

Consequently, the illusion of consensual decision making is a construct both manufactured and perpetuated through the hegemonic social institution of medicine within the United States (Herman and Chomsky 1988). Further, I maintain that the final influence exerted by the economic gains at stake will result in the total institutionalization of power relations, subjugating biological birth to the expedient and legally reified dictates of a technologically driven medical model of childbirth management. The ultimate consequence is, perforce, the complete subjugation of physiological birth to a medical model where women are reduced to technologically manipulated vessels--where birth is scientifically and artificially accomplished through manipulation, management, and control to result in--the death of birth.

CHAPTER 6

CONCLUSIONS

Mid-twentieth century second-wave liberal feminists were largely ineffectual in their attempts to either decrease or even to slow the rate of technological, pharmacological, and surgical intervention in women's birth experiences. The initial second wave feminist focus on health care was solidly grounded on the twin American cornerstones of individual choice and individual control. Such a focus mistakenly assumed that if one could only substitute female control for male control and educated choices for blind trust, then available health care choices would be woman-centered and thus better; better for women exerting their individual and educated will in choosing sympathetic birth attendants while simultaneously eschewing a minimum of technological, surgical, and pharmacological intervention to effect a desired outcome.

Liberal feminists were aware of many of these issues, but they lacked the insights offered by more recent analytical tools which currently guide such analyses. In these current analyses, the significance of both the political economy of a system is revealed as well as that of the intersection of race, class, gender, and social location. Policies reflect the priority of the structure over values and principles. Within the present for-profit, institutionally-controlled and regulated system of care, the incentives are largely weighted towards making available those choices which further economic gain. As long as birth occurs within a for-profit institutional setting, institutions will

control and dictate the parameters of the experience to meet institutional ends. As long as women have doctors attending their births, their births will be managed along the lines of physician dictates. I propose that these are the most important variables to manipulate to influence both the experience and the outcome of childbirth for women. If as feminists maintain, birth is not a medical event, then it necessarily can and should be moved out of hospitals and away from physician management.

As we face the next century, it is certain that changes are coming within our current for-profit health care industry. Yet the shape of such change is as yet, unpredictable. Certainly such a climate of change offers a unique opportunity to incorporate an honest and fair evaluation of the merits of alternative models of birth. Health care reform efforts which reduce health care costs by decreasing technological dependency while improving outcome are surely a worthy goal. A review of international practices in the available literature suggests that a viable alternative model for normal birth has always coexisted; the midwifery model. The midwifery model is "highly beneficial in that it is primary care, is safe, enhances access, meets needs of virtually all childbearing women, involves judicious use of technology, is associated with a favorable liability record, is well-received by childbearing women, and is cost-effective" (Women's Institute for Childbearing Policy 1994).[29] A predicted future reliance on physician extenders, including nurse-midwives, will probably somewhat change the nature of the current birth experience (Annandale 1988). But if the profit incentive is allowed to remain within this future plan of care, there is little to suggest that midwives will take a path that differs significantly from that revealed by this examination of the medical model of childbirth in the United States.

END NOTES

1. See Burt Ruzek (1979) for a discussion of the political struggles involved in the convergence.

2. Anthropologist Robbie Davis-Floyd coined the term "technocratic birth" (Davis-Floyd 1992: 5) to describe this type of birth model. In this thesis, I use the term technocratic birth interchangeably with the more common term, the "medical model" of birth.

3. In Medicine and the Management of Living:Taming the Last Great Beast (1984: 166) sociologists William Arney and Bernard Bergen erroneously cite prepared childbirth as an example of the way in which medicine responds to challenges, "the rapidity with which medicine responds to such proposals is striking and is a distinguishing feature of medicine today.

4. Ludmilla Jordanova notes in Sexual Visions, "historians of women can list institutions...that exercise power over women...many would see medicine and natural knowledge as prime examples of such institutions" (Jordanova 1989: 154).

5. This book was originally published as In Labor: Women and Power in the Birthplace (Katz Rothman 1982)

6. The term normal contextually situates birth within the dominant medical model which controls the representation of birth. While these women talked about birth as a normal, non-pathological event, the overwhelming majority of women in my classes planned to birth in a hospital. During my teaching tenure, nurse-midwives were not available to my clients since they (nurse-midwives) had been unsuccessful in obtaining hospital privileges within any local hospitals. Thus my clients had the choice of homebirth with a lay midwife or a physician-attended hospital birth.

7. Sociologist Barbara Katz Rothman (Katz Rothman 1991) notes that the medical model represents all birth as risky, either high risk or low risk.

8. Certainly all of the technological, pharmacological and surgical interventions involved elements of pain, uncertainty and danger, but these risks were silently absorbed within the framework of the medical model as acceptable risks.

9. Howard Brody notes in The Healer's Power that physicians generally hold socially delegated authority to label what counts as medical truth. As a result of this socially delegated authority a physician can "make something be the case simply by saying it is so." (Brody 1992: 17).

10. Much has been written about the way in which the litigious social climate within the United States has served to influence physician behavior. It has been demonstrated that physicians practice defensive medicine by both ordering excessive testing and aggressively employing available technology

which are strategies which hold up a physician's defense in the courtroom. Many of my clients cited physician's fear of losing a malpractice lawsuit as a reason behind the escalating rate of cesarean deliveries. In a 1979 report requisitioned by the U.S. government's Department of Health, Education, and Welfare titled An Evaluation of Cesarean Section in the United States, public health consultant Helen Marieskind points out that the dramatic rise in the rate of cesarean sections predated the increase in malpractice suits, dispelling the speculative correlation between these two events.

11. In the classes, I used a role-playing strategy to teach my clients how to garner information necessary to make decision. In the role playing, I took the part of various physician figures who were some combination of authoritarian, compassionate, exhausted, etc. I had the women and their partners practice the following questions in order to gain information necessary for situational evaluation and decision making: "Who are you,what are you here for, what are you suggesting, why are you making this suggestion, what are the risks (to the woman--the baby), what are the alternatives to this suggestion--including doing nothing?"

12. I am indebted to Kip Kozlowski, CNM, for this insight.

13. This midwifery service will be explored in greater detail later in the thesis. A history of this service can be found in "Mary Breckenridge, The Frontier Nursing Service, and the Introduction of Nurse-Midwifery in the United States" by Nancy Schrom Dye in Women and Health in America ,Judith Waltzer Leavitt, ed. (1984).

14. Poet and feminist scholar Adrianne Rich recognized the limitations of the early feminist agenda: "conditions which affect the majority of women in labor - poverty, malnutrition, desertion by the father of the child, inadequate prenatal care...are not the issues being addressed" (Rich 1976: 169).

15. Information on recent birth statistics is available from the National Center for Health Statistics, "Advance Report of Maternal and Infant Health Data from the Birth Certificates, 1990."

16. The story of the very successful premature marketing of the electronic fetal monitor carefully researched and documented by Judith Kunisch in Healing Technology: Feminist Perspectives (Strother Ratcliff 1989), is a good example of this phenomena.

17. Citations given in this text refer to those the second publication Giving Birth: Alternatives in Childbirth (Katz Rothman 1984).

18. I make this judgement based on information obtained from a combination of three sources. First, from my client's birth stories as they were related in each final session of classes over my eleven years of teaching. Second, from information provided by labor and delivery nurses, physicians and medical residents who attended my classes. Third, through information provided by "inside "sources who were available to me as a result of my working with local hospitals in a consumer advocacy organization during this same time period.

19. Standard of community is terminology used to refer to accepted guidelines for what is considered good practice within a profession. For specialists, these guidelines are established within the specialty at a national level. For general practitioners, the guidelines are drawn from what is generally considered to be good practice within a given geographic region.

20. This data was provided by local hospital representatives at a meeting of the consumer group mentioned in endnote 18. This finding is in agreement with the rate of cesarean sections noted nationally.

21. Again, I was privileged with access to this information from the same sources noted in endnote 18. I also had the information corroborated by a local pediatrician which I mention later in this text.

22. This same hospital had a 25-30% cesarean section rate (personal communication). Given such a statistically high chance of obstetrical surgery for laboring women, within this framework, this reclassification can be viewed as entirely justified.

23. While I was certainly sympathetic to this physician's concern about the "other patient" i.e., the fetus/baby, I was also concerned about the increased risk to the mother. There is a curious prioritizing of interpartum risks whereby risks to the neonate frequently displace concerns about risks to the mother.

24. When I discussed the marketing of epidurals in my childbirth classes, a common response from nurses and physicians attending the class was to protest that this was not a marketing strategy, it was a response to consumer demand. This calls to mind an introductory quote by Milton in Manufacturing Consent (Herman and Chomsky 1988) "they who have put out the people's eyes, reproach them of their blindness."

25. The concern here is that there is a potentially mortal risk of aspirating if vomiting occurs while under general anesthesia.

26. In her evaluation of the women's varying class-specific responses to different models of childbirth, Nelson (1983: 296) describes one interaction in which a physician challenged a woman who was responding to labor pain by screaming, with a threat of making her "go natural."

27. As Kip Kozlowski, CNM observed when evaluating obstetrical outcomes "Punishment is about breaking the rules."

28. More serious outcomes in birth including death of the mother or baby are, in the current litigious climate, most often delegated to the judicial system to ascertain culpability; and fortunately, such occurrences are quite rare in a population of healthy women.

29. A collaborative position paper by the Women's Institute for Childbearing Policy, "Childbearing Policy Within a National Health Program: An Evolving

Consensus for New Directions" combines the insights of four major women's groups working on health care issues including the Boston Women's Health Book Collective, the National Black Women's Health Project, the National Women's Health Network, and the Women's Institute for Childbearing Policy. Their collective expertise provides the most comprehensive plan to date for implementation of such a program

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