

# Male appropriation and medicalization of childbirth: an historical analysis

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**Male appropriation and medicalization of childbirth: an historical analysis**

**Aims of the paper.** This paper aims to explore through historical analysis some of the means by which medicine successfully appropriated and medicalized pregnancy and childbirth and to consider the impact that this has had on women's experiences within maternity care.

**Background and rationale.** The appropriation and medicalization of pregnancy and childbirth by men are rooted in a patriarchal model that has been centuries in the making. A model that perceives women as essentially abnormal, as victims of their reproductive systems and hormones, it is also one that defines pregnancy as inherently pathological – a clinical crisis worthy of active intervention. In both law and medicine men have used their power to define reproduction as a biological defect (LeMoncheck L. 1996 *Journal of Clinical Ethics* 7, 160–176), requiring both legal regulation and medical intervention, whilst feminist writers have long argued that women's experiences within the health care system at least to some extent reflects their social position.

**Conclusions.** Male justifications of female inferiority have been developed and nurtured through professional discourses and socialization processes inherent within medical education and practice (Cahill H. 1999 MA Thesis, University of Keele). These assumptions are internalized and reproduced to shape quite profoundly, the nature of doctors' interactions with women in their care. Perhaps more fundamentally, such discursive explanations of women's bodies as inherently defective continue to shape women's position in society. Maternity care is a key area in which women's ability to exercise real choice and make informed decisions is limited and where doctor–patient interactions are themselves constructions of existing gender orders; women's autonomy continues to be violated through both quite subtle and overt discourse and practice.

**Keywords:** women, pregnancy and childbirth, medicalization, gender, obstetric intervention, occupational closure, birth cultures

## Background: Contemporary maternity care in the united kingdom

The last four decades have witnessed a largely consistent and persuasive argument from the obstetric establishment that the hospital is the best and safest place for babies to be born. Subscription to this overriding single policy led to an

estimated 97–99% hospital birth rate (Helman 1994) and considerable reductions in domiciliary midwifery services, as resources were centralized into large consultant units 'dedicated to the pathology of childbirth' (Flint 1986, p. 22). More importantly, the policy resulted in an almost complete medicalization of pregnancy (Stacey 1988); medical frames of reference and knowledge have been accepted and legitim-

ated within a system that has brought about not only a surge in engineering obstetrics but a steady erosion of maternal choice, control and satisfaction in relation to many aspects of pregnancy and labour. Although this trend continues to be justified in the name of safety, other factors are clearly at work in underpinning and sustaining the position.

Whilst the trend towards 100% hospital delivery unquestionably facilitated the increase in the development, purchase and use of a wide range of obstetric technologies (Jacobson *et al.* 1991), interestingly much of this occurred in the absence of any systematic evaluation of their efficiency or effectiveness (Schwarz 1990). Current caesarean section rates in the United Kingdom (UK) are around 12% (Francome & Savage 1993) – nearly double that warranted by established and agreed indications for operative delivery, which in turn suggests that nonmedical factors are continuing to influence clinical decisions.

The report *Changing Childbirth* (Department of Health [DoH] 1993) was significant in that it clearly placed the pregnant woman at the centre of maternity care, acknowledged the pivotal role of midwives in the management of normal labour and advocated a return to community based antenatal care. However, as Foster (1995) points out, the key problem remains that policy still casts the obstetrician in the lead role in the management of more complicated pregnancies. Whilst the definition of ‘complicated’ or ‘high-risk’ remains hugely subjective, importantly the decision to label individuals as such remains solely in the hands of this influential professional group. Back in 1981, Young argued that obstetricians consistently use the definitions of normal and abnormal to successfully strengthen their power base and she was probably right. So, not surprisingly, the number of pregnancies deemed ‘high-risk’, as Foster (1995) went on to suggest, continued to be high. The successful medicalization of reproduction and its prevention accounts for the majority of consultations between women and doctors (Clarke 1983) whilst the development of a specific medical speciality for dealing with women’s reproductive functions (i.e. gynaecology) and its association with obstetrics serves to further reinforce the pathological nature of pregnancy and illustrates the controlling influence of medicine over women’s lives. It is indeed significant that no such parallel speciality exists for men; just how medicine achieved its powers cannot be fully understood without recourse to some historical comparison.

### The basis of biomedicine

Medicine has become like a secular religion, a view reinforced by the knowledge that belief in its powers is based on myths about the past and faith in the present. (Hart 1985, p. 17)

From the times of the early Greek physicians, two fundamentally different approaches within medicine have existed (Dubos 1960). Firstly there is the *preservative* approach that focuses on the natural laws thought to influence and help maintain physical and mental health. Familiarly known as the social model of health, it is in the main concerned with the environment in general and populations at large. Secondly and more predominantly, there is the *restorative* approach that seeks to identify specific disease processes and treat them, this is the biomedical model that is primarily concerned with individuals. Despite changes in attitude, practice and a resurgence in interest in public health, current medical practice still largely rests on this restorative and importantly, mechanistic approach.

For medical practice, the 17th century represented a major turning point with the acceptance of Cartesian philosophy that drew a crucial distinction between the material and spiritual worlds – the so-called mind/body dualism. Descartes had conceived of the body as ‘a machine governed entirely by the laws of physics, which might be taken apart and reassembled if its structure and function were to be fully understood’ (McKeown 1979, p. 4). Whilst it seems that as a scientist, Descartes could accept a mechanical explanation for the body, as a religious man he was unable to accept such an explanation for the mind and so found it necessary to distinguish between the two. In taking this apparently innocent step, Descartes quite simply revolutionized medicine. Prior to this, the development of medicine had been limited by what Hart (1985, p. 14) describes as ‘a religious embargo’ on the study of human anatomy. Orthodox Christian doctrines had held that body and soul were one and it was therefore believed that the *body* had to be whole in order to allow the *soul* to enter heaven. Not surprisingly, the Cartesian revolution and the lifting of this religious embargo led to a far greater understanding of human anatomy and physiology.

Given this ever increasing body of knowledge of human structure and function that has developed over the last three centuries, it would be reasonable to assume that biomedical science has been responsible for the significant improvements in the health of the world’s population. Whilst there is little doubt that biomedicine has indeed been instrumental in saving many lives as a consequence of increasingly complex and technological approaches to the management of *disease*, popular assumptions about its role in improving *health* have been subjected to sustained challenge. Evidence suggests that the contribution of biomedical knowledge and expertise has in fact been overstated (Dubos 1960, McKeown 1979, Hart 1985); a pertinent illustration is provided by the considerable reduction in UK infant and maternal mortality rates during the first two decades of this century. If asked, it is probable

that most people (including many doctors) would explain this reduction largely as a welcome consequence of greater scientific knowledge and improved medical care. However, a notable conclusion of Winter's study (1982, cited Hart 1985) was that biomedicine made little direct contribution. Examination reveals that the rate fell most sharply during the First World War, when some 60% of available medical practitioners had been drafted and were in uniform. However, as any statistician would rightly argue, association need not necessarily mean causation. Standards of living for poorer sections of society increased substantially during the war years; if pregnant women were able to avail themselves of a better diet, clearly both they and their unborn infants would benefit, which is the most probable explanation for falling mortality rates. That said, the relationship between fewer doctors and fewer infant and maternal deaths could still in part be explained as causal; there would have been a significant reduction in surgical intervention and the use of forceps during delivery (Hart 1985), both of which were associated with increased morbidity and mortality.

Similarly, mortality rates associated with infectious diseases began to fall well in advance of the availability of any vaccination or effective treatment and are similarly explained by public health improvements, i.e. better diet and housing conditions (Hart 1985). The first drugs that were to have a major impact on mortality rates from infectious diseases did not begin to appear until the end of the 1930s (Fitzpatrick 1997).

So it is indeed possible that medicine's contribution towards overall standards of health and increasing life expectancy may be less than popularly assumed. But if this so, how has the profession created a culture that clearly assumes and readily accepts a far greater contribution? The weight of such biomedical ideology cannot be fully understood without recourse to historical analysis. Such an examination quickly reveals that the power invested in modern biomedicine stems from its success in gaining control over its own work (Hart 1985, Morgan *et al.* 1985) and achieving statutory legitimization as 'the official body to deal with matters of health and illness' (Morgan *et al.* 1985, p. 113). Analysis of these strategies clearly reveals the importance of class and gender in the development of healing practices in the public domain. That the group of practitioners deemed unacceptable by the medical men included large numbers of women (whatever their craft, but largely the midwives) is highly significant.

### The ascent of medical authority

The 17th and 18th centuries in this country witnessed the early beginnings of the medical market, a phenomenon

incisively described by Stacey (1988, p. 50) as 'creating the quacks to create the profession'. Such strategies necessarily required a sustained and determined attempt by orthodox medical groups (i.e. the physicians, surgeons and apothecaries) to smear and discredit the unlicensed. Whilst the orthodox groups were increasingly conscious of lower cost competition from the unlicensed, and regardless of the ready availability of 'antiquack' literature and rhetoric, the medical men were unsuccessful in demonstrating their espoused superiority for many years. Although they clearly perceived themselves as superior and indeed referred to themselves as professional (Stacey 1988), in reality there was probably very little to choose between the licensed and unlicensed groups, in terms of integrity or therapeutic effectiveness, but there continued to be in cost.

So medicine's legal monopoly over healing practice was secured in a largely fragmented fashion, through sustained pressure over time on a number of notable social institutions, such as the lay subscribers to the voluntary hospitals (Blane 1997). A significant factor in securing the monopoly was gaining control over admissions to these hospitals, as the physicians and surgeons could now select patients from those groups in society that most importantly had money, and further, provided good material for education.

However, it was the ability of the physicians, surgeons and apothecaries to organize themselves to form one occupational group called 'doctors' (Blane 1997) enshrined by the 1858 Medical Registration Act, that undeniably constituted their most notable achievement. As Nettleton (1995) points out, that the structure of the orthodox medical groups, in terms of class, gender and race most closely matched those in power at state level, undoubtedly assisted them in the professionalization process. However it would be wrong to assume that prior to the Act, the orthodox groups were really homogenous in terms of class or indeed, truly united.

The extent to which the unlicensed practitioners constituted a threat to each of the three groups was also quite varied. Although fewer in number than the surgeons, the physicians were undoubtedly the primary group, both hailing from and concerned with treating the wealthy middle classes. The surgeons, having split from the barber-surgeons to eventually create the Royal College of Surgeons of London in 1800 (Stacey 1988), were also relatively unaffected by the unlicensed groups. According to Morgan *et al.* (1985), it was the lower status apothecaries who were most at risk from the unlicensed competition and consequently those who had most to gain from unification.

The traditional tripartite system was further destabilized at the beginning of the 19th century by the growth of another group evolving from the apothecaries known as general

practitioners (GP), who were undertaking a more inclusive role that notably, included midwifery. Importantly, these GP were serving the needs of large rural populations (Witz 1992, Lupton 1994, Nettleton 1995), and according to Witz, were the key group responsible for leading the movement for medical reform. But however, important unification was, the time frame within which medicine achieved its healing monopoly remains a critical factor. Although Michel Foucault (1973) was primarily concerned with European social structure, his argument that biomedicine could only have been born from a sex and class divided society in which both women and the poor provided appropriate research and teaching material remains a powerful one.

Importantly, Blane (1997) notes that whilst all the steps in the professionalization process were accompanied by increases in both status and income for its members, medicine still did not possess any substantive means to alter the course of common diseases to any significant extent. However, as Ehrenreich and English (1974, p. 40) argue, professionalism should never be confused with expertise; 'expertise is something to work for and to share; professionalism is – by definition – elitist and exclusive, sexist, racist and classist'.

### The exclusion of women

But it wasn't just the 'quacks' that were under attack during the 17th and 18th centuries; some medical men were also actively vilifying the midwives (Stacey 1988). The decline of midwifery during this time and its dominance by medicine is probably best defined as instrumental in medicines' pursuit of professionalization rather than coincidental; medical control of the birthing business effectively transferred the art and craft of healing from the domestic arena to the public; 'from the hands of women to the control of men' (Nettleton 1995, p. 199).

For centuries, medicine and religion have systematically devalued assigned female roles and traits and excluded women from power in society through patriarchal ideology and misogynist preoccupations with women's reproductive power, a position clearly reflected in the Christian Church's obsession with witchcraft during the Middle Ages (Aggleton 1990). Ehrenreich and English (1974) identify three central accusations against witches that have remained consistent through history: their sexuality, their organization and paradoxically, their healing powers which included attendance at childbirth. These healing powers, men at the same time, envied, feared and most importantly, desired to *control*. It can be argued that medicine's pursuit of a health care monopoly with the purpose of excluding women from practice in the public domain is but part of a broader

strategy to control and subjugate women. The next section explores some of the key factors to be found in the complex project through which the traditional female practice of childbirth came to be dominated and managed by men.

Until the 17th century in this country, childbirth was firmly located within the domestic arena, an exclusively female domain. Prior to the invention of the forceps, men had only been involved in problematic deliveries, their instruments guaranteeing the death of the foetus and frequently that of the mother. But small numbers of *men-midwives*, now in possession of forceps that enabled them to deliver live babies, began to challenge the traditional position but largely as a result of cost, most labouring women continued to be attended by midwives. During the 18th century however, medical practitioners, armed with their greater 'scientific' knowledge of biology began to more systematically dispute and devalue midwives' knowledge, which Stacey (1988) describes as essentially a mix of their own experience as mothers and that which was handed down through generations of attending women. One way in which medical practitioners achieved this seems to have been through their opposition to abortion. Thomson (1998) suggests that in arguing against abortion beyond the stage of 'quickening', licensed practitioners were not only able to differentiate themselves from the unorthodox, but also with this 'superior' knowledge assert their intellectual and *moral* superiority over midwives and pregnant women. Importantly, Donnison (1977) contends that the general status and reputation of midwifery was already deteriorating, suffering from a continued lack of organization and regulation and with little or no support for training and development. Thus, the subordination of traditional, 'experiential' midwifery to more 'formal' knowledge and training, from which women, of course were excluded, was more easily facilitated. Even more importantly, this strategy challenged the existing gender order to leave women out in the cold and begin the ascendance of men in childbirth practice. So, not only do these events provide a lucid example of the hierarchy of knowledge in which academia assumes superiority over experience, but they also clearly indicate that scientific and factual knowledge is inherently 'male', and therefore claiming supremacy over 'female' intuitiveness, empathy and caring (Cahill 1999).

Witz (1992) explains this strategy as a model of occupational closure. Medicine, as the dominant group, operated both exclusionary and demarcatory strategies over the subordinate group, i.e. the midwives, through the downward exercise of power. The crux of Witz's argument is that the action of medicine to exclude midwives from the medical register indicates that the gender of occupational groups was

instrumental and essential in explaining both the nature and outcome of their strategies. Notably, the 1858 Medical Registration Act had utilized the term *persons*, not specifically men and women, in describing those who were fit to practise. But the exclusion of women from those very institutions that provided the necessary formal education required for entry into the medical profession, effectively barred them from that profession. Similarly, in ultimately limiting the midwives role to attendance only at *normal births* (eventually enshrined in the 1902 Midwives Act), medicine operated a successful demarcating strategy to define this 'subordinate' group's sphere of practice and competence.

### Exercising clinical freedom or social control?

But returning to the 18th century, it was clear that not all medical men accepted that childbirth represented appropriate work. Furthermore, those who did think it so were yet to convince the majority of women, who continued to call upon a midwife or their relatives to attend them during labour. As Arney (1982) suggests, medicine had to change both the meaning of pregnancy and its associated practices, technology alone (primarily the forceps) was not enough to affect the necessary cultural reform. Arney argues that such technology needs to be introduced into what he calls an 'ideologically fertile social field' (p. 27). The 'field' at the time was inhabited by the middle classes, growing in number and aspirations and therefore the reconceptualization of birth as a 'normal' and 'attended' life event to an 'abnormal' and 'managed' crisis was pivotal to the success of medicine. That this medicalization of pregnancy was achieved over time, more through ideological *claims* to greater medical expertise (Oakley 1980), than any demonstrable benefits to women, is of note. Donnison's (1977) argument that the medical men deliberately set out to frighten women into believing that male attendance was necessary by exaggerating the dangers of childbirth, still holds true in contemporary maternity care. Oakley (1980) presents compelling evidence that indicates the involvement of men in childbirth around the turn of this century brought new hazards to mothers and babies rather than greater safety; the increased transmission of fever and injuries associated with careless use of technology, especially the forceps are but two. There are still critics today who suggest that modern engineering obstetrics poses a considerable threat to women's health and well-being (Oakley 1984, Petitti 1985, Hillan 1992). It also threatens women's autonomy and rights to self-determination (Cahill 1999).

Freidson's (1970) assertion that medicine was and still is primarily concerned with serving its own interests is therefore a powerful one. Despite their enduring privileged position,

the extent to which accepted medical knowledge and expertise is actually effective, even within the profession's own terms of reference, is increasingly questioned, yet remains extraordinarily problematic to challenge empirically. For example, the strength of the medical argument in defining what constitutes a 'high risk' pregnancy and the power base of the consultant obstetrician in policy-making has resulted in limited choices in place of delivery. As it is difficult to separate hospital from technology, it is also impossible, as Hart (1985) rightly points out, to systematically evaluate the effectiveness of the ever-increasing application of technology *because* most births take place in hospital. But affecting the shift of childbirth into hospital was a significant factor in the obstetric establishment's pursuit of what Marsden Wagner (1994) has called the 'birth machine'. The consultant led unit in hospital, according to Wagner, clearly established medical control over childbirth, further restricted any competition from midwives and created boundless opportunities for teaching and inculcating the birth culture to future generations of medical practitioners.

Having identified the importance of gender and class in medicines' pursuit of a health care monopoly, the next section explores the ways in which it continues to provide a means of limiting women's political and social power in contemporary health care through the medicalization and male control of their reproductive function.

### Medicalization as social control

Through the application of biomedical science and technology largely within male dominated, hospital obstetrics, large numbers of healthy women are coming into frequent contact with doctors. Doyal (1979) argues that although this represents a covert mechanism of social control, it is frequently exerted under the guise of benevolent help. According to Zola (1977), modern medicine is:

...becoming a major institution of social control incorporating the more traditional institutions of religion and law. It is becoming the new repository for truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts ... an insidious and often undramatic phenomenon, accomplished by 'medicalising' much of daily living, by making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence. (Zola 1977, pp. 41-42)

Medicalization describes the expansion of medical jurisdiction into the realms of other previously nonmedically defined problems (Gabe & Calnan 1989), a process which clearly serves the interests of medicine with its increasing focus on the indicators of *disease* rather than the indi-

vidual's experience of *health* and *illness*. The process of medicalization has undoubtedly, according to Helman (1994), been assisted by successful and high profile advances in medical technology, which serve to further reinforce peoples' dependence on the medical profession for the solutions to their problems. Women's reproductive functions have clearly been subject to this process as normal cyclical events have been redefined as potentially hazardous and a major influence on women's psychological well-being. Thus, passivity and dependence upon the medical profession for both a safe outcome of pregnancy and conversely, safe prevention of the same, has been successfully nurtured (Cahill 1999). Two key contemporary examples of the medicalization of women's reproductive function, the Pre-Menstrual Syndrome (PMS) and the menopause provide clear examples of what Oakley (1980) describes as medicine's overuse of hormonal interpretation of psychological problems and unwelcome reinforcement of a mechanical model of women, the latter is especially relevant in the area of pregnancy and childbirth. It may be possible to defend biomedical definitions of PMS and menopause as endocrine disorders but the same surely cannot be said of pregnancy. Although it is difficult to appreciate how pregnancy can ever be defined as a disease, in contemporary medical discourse and practice, it clearly is:

Childbirth has been transformed into a 'clinical' crisis and hence is regarded as a legitimate and important area for medical intervention (Doyal 1979, p. 236)

Pathological perceptions of pregnancy are clearly related to hospital confinements, but according to Robinson (1990), the shift towards 100% hospital delivery took place in the absence of evidence of any perinatal or neonatal advantage or increase in maternal satisfaction. She rightly points out that it is midwives not doctors who have been trained to care for 'low risk' mothers, which represents a gross under-use of skill. The trend has also meant an increase in technological intervention but it is important to acknowledge that all interventions are not synonymous with unwanted interference. The provision of social support throughout pregnancy and labour has been shown to reduce not only maternal anxiety and analgesia consumption but also the risk of prolonged labour (Oakley 1984). However, little consensus regarding the efficacy of widespread use of obstetric interventions concerned with the active management of labour and which are custom and practice in the consultant units exists (Campbell & Mcfarlane 1987). Such interventions, incisively described by Murphy-Black (1995, p. 287) as 'toys for the boys' include routine episiotomy, induction/acceler-

ation of labour, epidural anaesthesia and foetal heart monitoring.

### The pathological nature of western childbirth

Further, it seems that problems occurring as a result of one intervention usually require other interventions for their treatment (Flint 1986). Failed induction or forceps usually requires caesarean section and routine use of foetal heart monitoring logically means that foetal distress is more likely to be diagnosed, but mistakes can and do occur. Francome (1986) identifies misreading of foetal monitors as a significant factor in explaining why the UK's caesarean section rate is twice as high as is medically necessary. Sharpe and Faden (1998) cite similar evidence to rationalize the fourfold increase in the caesarean section rate in the USA between 1970 and 1989. They believe that *only* the practice of defensive medicine can explain why foetal monitoring, a commonly used diagnostic procedure, has done so little to improve the outcome of 'high risk' deliveries, but is strongly associated with increased operative delivery rates. Concerns about the accuracy of the diagnosis of foetal distress are also raised in a study conducted by Barrett *et al.* (1990) which suggests that as many as a third of all caesarean sections carried out on the grounds of foetal distress may be unnecessary.

Davis-Floyd (1987) describes such interventions as examples of what she calls contemporary western 'birth culture' and levels a number of criticisms against the approach. In over-emphasizing the physiological (i.e. safety) aspects of pregnancy, it both underestimates and undervalues vital psychosocial changes occurring within the woman as she undergoes this important transition in her social status, i.e. from woman to mother. Findings from Oakley's (1980) study indicate that the routine use of 'high-tech' interventions such as epidural anaesthesia, forceps and caesarean section are closely associated with the incidence of postnatal mood disturbance. Oakley rightly challenges theories which at best, attempt to explain all postnatal mood variables as having a purely hormonal base or worse, as representing a 'rejection' of feminine role. She argues that many disturbances in mood are iatrogenic in nature and recommends an end to all unnecessary interventions in childbirth.

According to Clarke (1995), a midwife attends the whole of the perinatal period from antenatal care through to postpartum management and is the senior person at 75% of births, however, the obstetrician makes all essential management decisions within that care period. It is interesting to note however, that despite the fact that midwives

are generally looking after pregnant women, the obstetric establishment has successfully used demands for a better quality of service (i.e. greater maternal involvement and choice) to increase the number of consultant posts (Campbell & Mcfarlane 1987). This position indicates that a different alliance of factors is at work (Cahill 1999). Despite the apparently insatiable media preoccupation with women either having or not having babies, the public remains largely ignorant of the limited choices available to women in maternity care. Scientific medicine appears to offer safety and politicians need to be seen to be contributing something tangible towards the protection of future generations. So the obstetric establishment advocates the consultant unit with its on site 'high tech' interventions and the politicians gain kudos from providing more state of the art hospital facilities. Importantly, these facilities are highly 'visible' health care resources whilst the provision of primary maternity care by appropriately trained midwives is largely invisible to the public. And regardless of the strength of criticism levelled against this approach it is important to acknowledge that women largely assume that hospital means experts and that surely means a safer birth (Cahill 1999). They still believe that any difficulties they encounter in terms of limited choice, embarrassment and discomfort are, as Foster (1995, p. 47) puts it, 'a price worth paying for the increased safety offered by modern obstetrical practices'. But despite these popular beliefs it must be acknowledged that the 'hospital is best' policy took shape at a time when perinatal and maternal mortality was much higher than today and the enforced hospitalization of labouring women can no longer be justified on safety grounds.

### Some conclusions

It is clear that patients who are also women are doubly demeaned. Patient status plus female status makes one a very poor creature indeed. (Campbell 1974, p. 72)

For this the argument has been made that a necessary feature of orthodox medical groups claim to superiority and their eventual success in the management of disease seems likely to have been that they were *men*. Historical analysis reveals that the professionalization of medicine necessarily constructed male medical knowledge as scientific and therefore superior to female intuitiveness and experience. Oakley (1980) makes the important point that this hard fought, male medical knowledge of women's bodies is in many ways in conflict with women's own knowledge of their bodies. Thus the two 'experts' in the

doctor-patient relationship will have very different expectations of the interaction. As Oakley suggests, this remains the key area in which medical expertise is most vulnerable to challenge and brings into sharp relief some of the stereotypical assumptions about women; assumptions that underlie much of current medical practice and that may compromise or disempower women in other ways during their experience of pregnancy and labour. So despite the placement of the pregnant woman at the centre of maternity care by Changing Childbirth (DoH 1993), obstetricians concerns continue to lie more with what Doyal (1979, p. 148) terms as 'their newly discovered second patient'. In other words there seems to be a point at which the value of foetal life begins to outweigh, perhaps not so much the life of the mother, but perhaps her right to self determination, her plans and her choices. Medicine's construction of pregnancy as pathological seems so entrenched that an increasing gap between lay and professional birth cultures seems inevitable.

Growing concerns about the increasingly confrontational and interventionist nature of obstetric practice are crystallized in the succession of court ordered caesarean sections that occurred during the last decade (Cahill 1999). It seems that a small number of obstetricians clearly believe that to take such action is wholly warranted as the proposed intervention is manifestly in women's best interests and have resorted to the threat of court orders to obtain maternal compliance and consent (RCOG 1994). Although obviously an unusual extreme in obstetric practice, that they *have* happened at all highlights some stereotypical assumptions about women; assumptions that appear to underlie much of current medical practice. These are also assumptions that may compromise or disempower women in other ways during their experience of pregnancy and labour (Cahill 1999). Such intervention appears to be serving as a form of personal insurance for obstetricians, in that those doctors who interrupt normal pregnancy are absolved from blame, whereas those who do not intervene are censured if anything goes wrong (Oakley 1984). Surely this position reflects practices designed as much to enhance the position of the obstetric establishment within the wider sphere of medicine, as they are to protect individual infant and maternal health.

Medicines' continued dominance within obstetrics has meant that not only are doctors able to control the nature and scope of their own work but also that of the midwives. Midwifery practice had thus become even more defined and limited by obstetrics, and the midwife's role transformed into one more akin to a technical obstetric nurse (Stacey 1988, Clarke 1995). Only within the last 15 years have midwives begun to really campaign for recognition of their 'special' role

in childbirth, but realistically this is only because obstetricians have permitted them to do so. It is difficult to deny that obstetricians' continued right of access to patients protects their power base.

But the true scope of new midwife practitioner roles currently developing will only be realized when they *expand* midwifery practice, rather than *substitute* for doctoring. If the technology and approach utilized by medicine is unwanted, having a midwife to fulfil the role will offer no significant improvement. The extent to which such challenges to traditional medical boundaries will be accepted depends upon existing power relationships that Witz (1992) argues 'have been shaped as much by gendered patterns of dominance and subordination as they have been by bodies of medical or nursing knowledge' (p. 37). Given the nature of the professions history, it is somewhat ironic to now find obstetricians and gynaecologists such as Fawdry (1994), describing as 'unsustainable' the limitation of midwives to attendance at normal births. Arguing for expansion of the midwife role in order to meet women's needs more appropriately, he suggests this would also enable most consultant gynaecologists to stop pretending to be obstetricians. But such an expansion of midwifery would enhance partnerships between midwives and women to the extent that they would threaten the obstetricians' power base, and that is something I would argue, for which they are not yet ready.

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