

Pushing Choice: The Medicalisation of Childbirth

by

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B.A., University of Victoria, 2008

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## **Supervisory Committee**

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## Abstract

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Childbirth is an essential part of reproductive politics which have largely focused on expanding choice for women's reproductive lives. Childbirth in the west has been medicalised, which means that authoritative knowledge was moved into the hands of the patriarchal medical establishment through displacement of traditional midwives, casting women as 'hysterical' and inherently sick and seeing birth as a medical event and technology as the appropriate way to deal with birth and the body. In the United States, with surveillance and risk factors, each woman in labour is considered in medical danger and treated accordingly, curtailing women's ability to make decisions about their bodies and birth. The alternative or natural childbirth movement has resisted this form of medicalised birth, but within the movement, pressure can also be found on women to perform femininity and achieve a perfect birth. A focus on choice is therefore limited without also considering structural factors

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## Introduction

### Why birthing?

Women's reproductive rights and bodily autonomy have been a large component of the feminist struggle against sexism both historically and in the present. The idea that women should have control over their own bodies, both in terms of whether to become pregnant and whether to carry a pregnancy to term, is a key route in the path towards ending the oppression and marginalisation of women and people of other marginalised genders. Bodily autonomy in the area of childbirth is an important field in this struggle. Several scholars and activists have written on the importance of woman-led childbirth, significant reforms have been made in the area of hospital birth, and the midwifery and natural childbirth movements have worked to recast childbirth as an area where women should be making their own decisions, but otherwise decision-making and autonomy in childbirth has not been an important preoccupation of the pro-choice movement or mainstream feminism. Rather, childbirth appears to be an area where the ideas of bodily autonomy have been subsumed under the discourse of safety and the control of the medical establishment. Today, majority of births in the West take place in a hospital and involve many medical interventions, where consideration for women's bodily autonomy is frequently overridden.

Childbirth is an essential part of reproductive politics, which encompasses the question: "Who has power over matters of pregnancy and its consequences?"<sup>1</sup> This thesis engages in contemporary conversations about reproductive politics by examining some of the structures and rhetoric that surround birth, both how birth has become medicalised and the control that the medical system has over birth and over women's bodies. It also

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<sup>1</sup> Rickie Solinger, *Pregnancy and Power*, (New York: New York University Press, 2005): 3.

explores the politics of the alternative birth movement, as well as the pressures it imposes on women to perform appropriate femininity and motherhood and to ‘choose’ the right kind of birth.

Birth is not just a feminist issue because it happens to women.<sup>2</sup> It is also a feminist issue because the ideologies that guide how birth is practiced handled in the medical system are an extension of Western thought which is largely based on the mind/body and masculine/feminine dualisms, and thus has a long history of devaluing women, the body, and nature. bell hooks defines patriarchy as “a political-social system that insists that males are inherently dominating, superior to everything and everyone deemed weak, especially females, and endowed with the right to dominate and rule over the weak and to maintain that dominance through various forms of psychological terrorism and violence.”<sup>3</sup> The medical system has developed within and patriarchy along patriarchal lines, as such, it embodies these ideas to varying degrees. Examining how patriarchy operates in the medical system, and around childbirth, is essential in understanding how women are able to make choices about their own births. A society that tells women their bodies are defective and dangerous, that they must be controlled by a medical establishment, that pregnancy is an illness for which doctors hold the cure, is not feminist. Nor is a society that marginalises or outlaws midwives and alternative knowledge and approaches; under the guise of ‘safety’ the exercise of control, authority and dominance are hidden.

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<sup>2</sup> I want to acknowledge that not all those who engage in reproduction, such as pregnancy and birth, identify as women; for example some trans men and genderqueer people.

<sup>3</sup> bell hooks, *The Will to Change: Men, Masculinity and Love*, (New York: Atria Books, 2004): 18.

## Why choice?

The reproductive rights movement, especially the mainstream one, has focused on choice; that it is a woman's right to make choices about her body, including reproduction. This is evident in the title that has been used to describe a large part of the movement: the pro-choice movement. Even though the U.S.-based feminist and women's health movements of the 1960s and 1970s had various goals, including health care access for low-income women and women of colour, it became increasingly preoccupied with defending the recently-won right to abortion. There was less focus on general health care access, so health insurance became a class privilege.<sup>4</sup> Therefore, the 'right to choose' largely came to be the (legal) right to choose an abortion or not. The alternative birth movement, or the natural birth movement, along with the consumer choice movement, has also focused on choice. According to the rhetoric disseminated by these movements it is a woman's choice where and with whom she gives birth, and she should have access to a variety of facilities, including high-tech hospitals, low-tech birth centres, or supportive birth attendants in her own home. She should also have the ability to make an informed choice about various procedures that are available, such as pain relief, that fit her unique situation. However, a narrow focus on choice is a limited approach to women's health and reproductive rights. Choices are not made in a vacuum; economic conditions structure what choices are available, as do dominant ideas about women and reproduction, the values inherent in the system in which the choice is made, the power relations between individuals and their care providers, to name a few. For better or worse, choice became the issue, which raises a number of questions: how are women able to

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<sup>4</sup> Susan Faludi, introduction to *Complaints and Disorders: The Sexual Politics of Sickness* by Barbara Ehrenreich and Deirdre English, 2nd edition (New York: The Feminist Press at the City University of New York, 2011).

make choices about their births? What does choice mean in the context of birthing? Does choice lead to good outcomes for women giving birth, or does it actually limit and sometimes even harm those it means to help when it comes to reproductive rights?

In order to understand what the rhetoric of choice has meant in the context of birthing, it is necessary to consider how childbirth has been medicalised. Some important pillars in the structures that form the conditions in which women give birth are the assimilation of birth into a patriarchal medical system, the nature of the obstetrics profession, the economic and material structure of health care and cultural pressures on women to perform appropriate femininity and motherhood. In addition, the form that resistance to these conditions has taken and the pressures that exist within it. The focus on 'choice' in isolation is a limited approach. Women have different degrees of privilege according to their socioeconomic status and identity which influences how they are able to engage with the medical system and advocate for themselves. Ultimately, the choices that are available are largely predetermined by the system, and women are only able to manoeuvre within it; therefore it becomes crucial to examine the system that is available to women: "[T]he critical issue for feminists is not so much the content of women's choices, or even the 'right to choose,' as it is the social and material conditions under which choices are made. The 'right to choose' means little when women are powerless."<sup>5</sup>

Childbirth has been medicalised in the west and as such, has been subjected to the control of the medical establishment. That does not necessarily mean that women's empowerment will be achieved by removing birth from its current context; that would depend on what other contexts emerged. The medical system promises safety,

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<sup>5</sup> Rosalind Pollack Petchesky, "Beyond 'A Woman's Right to Choose' - Feminist Ideas about Reproductive Rights." *Signs* 5(4) (1980): 674.



professionalism, hygiene and modernity, and the majority of women in modern industrialised countries prefer hospital births for some of these reasons.<sup>6</sup> In the same way, organised resistance to the mainstream maternal care system has emerged in the last decades and in response, medicalised birth has changed. The overt control of the medical system has been reduced, but in its place more covert control mechanisms have emerged. The resistance to medicalised birth has also imposed additional pressures on women and their births. In particular, the rhetoric of the natural childbirth movement tends toward gender essentialism and put pressure on women to perform appropriate femininity and motherhood, which is not available to the same degree to all women, especially not low-income women and women of colour. The natural childbirth movement also tends to condone an individualistic achievement approach to birth that can induce feelings of failure for those who have a medicalised birth. The emphasis on choice pays insufficient attention to the structural conditions of women's lives.

### **The difficulty of writing about such a personal and political issue**

Some of the main problems with writing about this intensely personal aspect of women's lives is exactly that - it is intensely personal. It is difficult to write about choices available to women without placing judgment on which choices are better than others or to make generalised statements about birth management without homogenising the experience of the millions of women who give birth every year in different situations and conditions. Casting them as victims when many do not perceive themselves as such must also be avoided. It is also important not to make assumptions about their needs and preferences, or infer that they have a false consciousness and do not know what is best

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<sup>6</sup> Center for Disease Control and Prevention, Trends in Out-Of-Hospital Births in the United States, 1990-2012, <http://www.cdc.gov/nchs/data/databriefs/db144.htm>.

for themselves, their lives, their families and their bodies. An attempt is made here to focus on the pressures placed on women, not on how women deal with these pressures, which will be different depending on the person and on her situation. Also, it is important to iterate that most of the research discussed here focuses on women in the wealthy industrialised areas of the global north. When speaking about the medical system, I am referring to the system as a whole, not to individual care providers, many of whom may be caring and have their patients' best interests at heart.

### **Method and organisation**

This thesis is an attempt to shed light on the modern birthing system in the West, in particular in the United States and to a certain extent England. I use various historical examples to show how the ideas around birth and women's bodies have evolved within the medical system and how birth became defined as a medical issue, how the natural birth movement has developed, and what this means for women making choices about their birth. I do this using a feminist lens, which is defined thus by bell hooks: "Feminism is a movement to end sexism, sexist exploitation and oppression."<sup>7</sup> This thesis is not meant to be an exhaustive examination of all the areas surrounding birth, maternity care or women's bodies, but an investigation into the structures that surround birth in the areas specified.

The first chapter of this thesis is an overview of the history of medicalisation of childbirth, from developments in eighteenth century England to how hospital birth generally looked in the middle of the century in the United States. I argue that these foundations of medicalisation were in many ways harmful to women, and that their

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<sup>7</sup> bell hooks, *Feminism is for Everybody: Passionate Politics* (Pluto Press, 2000).

effects still inform medical practice today. The second chapter examines what modern birthing looks like, the consequences of medicalisation in practice, its overlap with surveillance medicine and the restrictions this places on women's autonomy in birth. The third and last chapter looks at some of the resistance to medicalisation of birth, mostly in terms of the alternative birth movement, or the natural birth movement. It also considers a critique of the alternative birth movement and the 'healthism' approach to bodies and birth in general, with an emphasis on choice where only some choices are considered 'right' ones. Both medicalised birth and the alternative birth movement claim to offer women more choice, but in the absence of taking into account structural factors, talking about choice becomes misleading if not meaningless.

## **Chapter 1: Early medicalisation of childbirth**

In order to understand the context of modern birthing and women's abilities to make choices about their births understanding how birth has been medicalised is crucial. Today, in most industrialised areas of the world, birth takes place in hospitals as a part of the medical system. This system has emerged out of specific historical and social conditions which can explain the form that the system takes today, its ideas about and approaches to birth and women's bodies. This chapter explores part of the history of the medicalisation of childbirth in the West in order to trace the development of four different but interdependent outcomes of this history: 1) the skills and knowledges of women and traditional birth attendants have been increasingly delegitimised; 2) women's bodies have become understood as weak, pathological and hysterical; 3) birth is increasingly understood to be a medical and biological event rather than one that involves social and emotional aspects of the whole human being giving birth; and 4) the body came to be understood as mechanical and technology was considered the appropriate method to deal with it. These changes effectively made childbirth the business of doctors, who were, until recently, overwhelmingly male, and meant that women had less say in how they conduct their own births. Authoritative knowledge was moved from mothers and midwives into the medical establishment which tried to assume almost complete control over women's bodies and the process of birth.

### **Medicalisation**

Western medicine, or the biomedical model, is the term that will be used for the dominant approach towards healing in North America and Europe. Its development is long and complex, but it is based on certain approaches to bodies, health and healing.

Western medicine is strongly linked with the scientific method. It is reductive and compartmentalising, operating within the Cartesian dualism, in which the body is considered a mechanical container for the mind/soul, and parts can be reorganised and exchanged. Its main focus is individuals, although aspects of it (such as public health) are more concerned with societies and social contexts. It has also been infused with significant power in Western society, holding an almost-monopoly on some areas of knowledge and knowledge production through the discourse of science and professionalism. In some ways, the biomedical model occupies the seat that religion has had in terms of providing frames of reference for how humans enter and leave this world, often having almost complete control over the processes of birth and end-of-life care.<sup>8</sup>

The main approach towards healing within Western medicine has been named the Restorative Approach which “seeks to identify specific disease processes and treat them.” This is contrasted with a Preservative Approach which “focuses on the natural laws thought to influence and help maintain physical and mental health” – also known as the social model of health. The Restorative Approach focuses on the individual as the locus of health and disease and fashions individual solutions, seeing the body as a machine of interchangeable parts and getting the individual back into their normal life or routine is considered the goal.<sup>9</sup> Technology is considered the appropriate tool to deal with these health challenges in a society where efficiency is valued.<sup>10</sup> Along with this comes the technological imperative: if something can be done with technology, it *must* be done with

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<sup>8</sup> Kevin White, *Introduction to the Sociology of Health and Illness* (London: Sage Publications, 2002): 12.

<sup>9</sup> Heather A. Cahill, “Male Appropriation and Medicalization of Childbirth: An Historical Analysis,” *Philosophical and Ethical Issues* (2001): 335.

<sup>10</sup> Barbara Katz Rothman, Wendy Simonds & Bari Meltzer Norman. *Laboring On: Birth in Transition in the United States* (New York Routledge: Taylor & Francis Group, 2007) 7.

technology. The mechanistic metaphor can be extended: “The Cartesian model of the body as a machine operates to make the physician a technician, or mechanic. The body breaks down and needs repair; it can be repaired in the hospital as a car is in the shop; once ‘fixed,’ a person can be returned to the community.”<sup>11</sup> This approach focuses on getting an individual ‘back’ to a ‘normal’ state and is often uncritical of greater structures and relations which may have caused the illness in the first place.

A debate exists on the effectiveness of the biomedical approach. Life chances have certainly improved greatly in most of industrial nations over the last century or two, but the relationship between such improvements and medicine, as opposed to improved hygienic conditions and alleviations of poverty, are unclear. This is not to make light of those who have seen their lives improved with the tools provided by medicine: “Whilst there is little doubt that biomedicine has indeed been instrumental in saving many lives as a consequences 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.”<sup>12</sup>

Medicalisation refers to the practices and discourses through which Western medicine has taken bodily functions and human conditions and categorised them as diseases and abnormalities, capturing them with the language and concepts of medicine; or according to Peter Conrad; “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders.”<sup>13</sup> Conrad points out that medicalisation is largely about definitions: who has the power to define

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<sup>11</sup> Rothman, 7.

<sup>12</sup> Cahill, 2001, 335.

<sup>13</sup> Peter Conrad, “Medicalization and Social Control.” *Annual Review of Sociology* 18 (1992): 209.

what, and in what way. “Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it.”<sup>14</sup> This process, especially in North America, has had an enormous impact on birth practices.

While medicalisation has been a strong force in Western medicine, affecting diverse aspects of society, its intersections with gender are specific and women’s bodies and behaviours have been medicalised to a greater degree.<sup>15</sup> With strong roots in science and Enlightenment thinking, the Western medical model emerged from an environment in which men and men’s bodies were considered the norm and women’s bodies deviant, but also in which women’s voices and agency were considered immaterial and unimportant. Medicine has played a strong role in perpetuating women’s oppression, by being a vehicle through which discourses about women being inherently weaker, hysterical, and non-intellectual (unless they damage their uterus), have been perpetuated and confirmed. In the late nineteenth century, doctors argued that “women were, by nature, weak, dependent, and diseased. ... the ‘scientific’ evidence [showed] that woman’s essential nature was ... to be a *patient*.”<sup>16</sup> At the same time, medicine can also be a tool that women have been able to use to justify and explain their experiences and making decisions about their own health within the biomedical system can be an empowering act for women and other people marginalised by sexism and heterosexism. Nonetheless, on the whole, Western medicine has colluded with and perpetuated patriarchy. Even though ever more female physicians and researchers exist, Western

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<sup>14</sup> Conrad, 1992, 211.

<sup>15</sup> Conrad, 2007, 10.

<sup>16</sup> Barbara Ehrenreich and Deirdre English, “The Sexual Politics of Sickness” in *The Reproductive Rights Reader*, ed. Nancy Ehrenreich. (New York: New York University Press, 2008), 25.

biomedicine has a long history of exercising power over women's bodies, more so than men's bodies. Women's reproduction, in particular, has been medicalised and considered pathological.<sup>17</sup> This can be seen in the invention of PMS and hormonal treatment for menopause, the scrutiny of pregnancy and childbirth, not to mention the 'hysteria' where almost everything that ailed women was blamed on the uterus and a hysterectomy was considered an excellent cure. Thus, medicine is not neutral but encompasses a value system. It has a strong hold on people's lives and behaviours, and as such, needs to be constantly scrutinised.

It is important to keep in mind that the focus here is on how childbirth is understood and defined. Like Ehrenreich and English, I am interested in the "medical *ideas* about women."<sup>18</sup> Peter Conrad states that "Medicalization researchers are much more interested in the etiology of definitions rather than the etiology of the behaviour or condition."<sup>19</sup> When it comes to medicine as social control, it is this definitional power which is salient: "the greatest social control power comes from having the authority to define certain behaviors, persons and things."<sup>20</sup> Many factors affect the context in which medicalisation takes place. Conrad suggests the following: "the diminution of religion, an abiding faith in science, rationality, and progress, the increased prestige and power of the medical profession, the American penchant for individual and technological solutions to problems, and a general humanitarian trend in western societies."<sup>21</sup> Medicalisation has

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<sup>17</sup> Cahill, 2001, 339.

<sup>18</sup> Barbara Ehrenreich and Deirdre English, *Complaint and Disorders: The Sexual Politics of Sickness*. 2nd edition. (New York: The Feminist Press at the City University of New York, 2011): 4.

<sup>19</sup> Conrad 1977, referenced in Conrad 1992, 212

<sup>20</sup> J. Schneider, as quoted in Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (Baltimore: Johns Hopkins University Press, 2007) 8.

<sup>21</sup> Conrad, 1992, 213.



both been applied to what could be considered social problems or issues (alcoholism, eating disorders, homosexuality) as well as “natural” processes (sexuality, birth).

Women’s reproduction can arguably be fitted into both categories.<sup>22</sup>

A few stages can be observed in the medicalisation of childbirth in the West. First, knowledge and skills about how birth had been managed and conceptualised were marginalised and delegitimised, and traditional birth attendants either pushed out or relegated to a different role. Second, women’s understanding of their own bodies was challenged and delegitimised. They were increasingly perceived as erratic, hysterical, irrational, and in need of outside interference, or at least guidance, in order to function properly. Third, birth was turned into a completely medical event, performed by another person, more akin to surgery than an act completed by the person giving birth, such as eating or having bowel movements, and removed from its context in an individual or a family’s life. Last, technology became increasingly seen as the appropriate path towards knowledge, and the language of science and outside observer “objective” knowledge was privileged over women’s embodied knowledge and experiences. Together, this meant that birth became subsumed under a patriarchal medical system.

### **Displacement of the midwife**

An important aspect of the medicalisation of childbirth was in the change of birth attendants and their approaches towards birth. It is useful to examine a few key transitions in birth management, such as when men started attending birth and when birth became a topic of science, overseen by men and physicians rather than community

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<sup>22</sup> Laura Purdy, “Medicalization, Medical Necessity, and Feminist Medicine.” *Bioethics* 15(3) (2001): 251.

midwives, because these illustrate the changes in approaches to women's bodies that underlie the current birth management system in the west.

Until the eighteenth century in England, births were the purview of women. A midwife was found in each parish, and when it was time for a birth she, along with a few other women, whether neighbours or relatives, would ensconce themselves in a bedroom or similar location for the duration of the birth, which is also where the new mother would rest for up to a month after the birth before resuming her duties in the household.<sup>23</sup> In some places the midwife was undoubtedly of low social standing, but it appears that in general they held a respected position; they not only assisted children into the world and baptised those who would not live, but also fulfilled a regulatory function by investigating and being an authority on issues such as infanticide and other sexual transgressions.<sup>24</sup> Earlier scholarship tended to associate midwifery and witchcraft, but that has largely been discredited.<sup>25</sup> The knowledge of women's health and sexuality rested with the midwife, which means 'with woman.' Her authority was largely based on her own experience as having given birth and as a character of good moral standing, in addition to perhaps apprenticing with a senior midwife.<sup>26</sup> Knowledge about bodies and birth was subjective; pregnancy was determined by the woman's experience, such as feeling the fetus "quicken."<sup>27</sup> In general, authoritative knowledge about birth rested with midwives and with the women giving birth.

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<sup>23</sup> For a more complete discussion of the history of midwifery, see Adrian Wilson, *The Rise of Man-Midwifery: Childbirth in England, 1660-1770* (Cambridge, Massachusetts: Harvard University Press, 1995)

<sup>24</sup> Wilson.

<sup>25</sup> Samuel S. Thomas. "Early Modern Midwifery: Splitting the Profession, Connecting the History." *Journal of Social History* 43 (2009): 115

<sup>26</sup> Thomas, 117.

<sup>27</sup> Thomas, 128.

Childbirth was a normal part of women's lives, took place in the home, and often was a ritual of women's camaraderie and support. Birth may actually have afforded women autonomy and power, beyond what experiences of bringing a new child into the world could offer. With the community of women that gathered together, strength could be found – by banishing men from either the house or the room or the part of the room, depending on the size of the mother's dwelling, it was often enforced that the mother have a month of lying-in time to herself, where she was exempt from the daily labour of the household, both giving her time to recuperate after the ordeal of birth, and establish a bond with her infant and get breastfeeding off to a good start. The other women who remained with her during this time, or checked in regularly, could ensure that the husband would leave off his advances towards her during this time, which could be a great reprieve for women whose husbands were overbearing or abusive.<sup>28</sup> This is not to gloss over the discomfort and physical and mental health challenges that can accompany childbirth, especially if the child or mother was of poor health. Rather, it is to point out the social role the rituals around childbirth played, and the challenges and opportunities it afforded women – including women giving birth, those around her (mother, sisters, cousins, aunts, neighbours, collectively known as god-sibs, or gossips), and the midwife.

Midwives who were women from the community with skill derived from personal experience and apprenticeship with another midwife, attended most births in pre-eighteenth century England; the male surgeon was only called as a last resort for those births that proved to be a true challenge. He was seen as fulfilling a different function than the midwife. The midwife was there to oversee normal births, and had various ways

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<sup>28</sup> For those who were married.

to give direction or intervene in births that were not going well. However, it was only when it was almost certain that the fetus was dead or dying, and that the mother's life was at risk, that the surgeon was called. He would then use a instrument resembling a crotchet hook to manoeuvre the fetus out, a move that almost invariably killed the fetus if it was not dead already. However, it could save the mother's life, often after days of obstructed labour.<sup>29</sup> Before the invention and dissemination of the forceps (a tool that is entered into the vagina and used to leverage an infant out), and certainly before the safe administration of a c-section, few tools were available to either prevent or deal with obstructed labour when it occurred.<sup>30</sup> Men had thus a small role to play in childbirth. I do not claim that women had full bodily autonomy or choice in childbirth in eighteenth century England. Childbirth was, however, a community event for the women of the neighbourhood with minimal outside intervention.

During the eighteenth century many societal changes were underway, including the emergence of the male midwife which quickly became the norm. A key factor in this transition were tools, in particular forceps. This tool, along with others called the fillet and the vectis, were most likely invented by the Chamberlens, a family that lived in London in the sixteenth and seventeenth century until 1732. However, they kept these tools, which could aid during obstructed labour, as a secret to increase demand for their services as doctors, even blindfolding the women that they used the tools on.<sup>31</sup> It was not until the end of their monopoly over the use of these tools that descriptions were

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<sup>29</sup> Wilson, 50.

<sup>30</sup> Notable exceptions are the Deventer manoeuvre, and various other attempts, like turning the child early in labour. See Wilson for a further discussion.

<sup>31</sup> Adrienne Rich, *Of Woman Born: Motherhood as experience and institution* 2nd ed. (New York: W. W. Norton & Company, 1986): 143.

published and made available to others.<sup>32</sup> These tools required considerable skill in order to be used successfully. However, rather than teaching practicing midwives how to use them, they were only made available to other men. After the Chamberlen monopoly came to an end, more surgeons gained access to these tools and began to establish themselves as skilled and capable men-midwives who charged considerably more than the local midwife. This is despite their sometimes limited knowledge of the processes of birth other than what to do in a specific kind of emergency – obstructed labour – as they did not have the training and experience that traditional midwives had. Nevertheless, they became popular and started attending entire births, rather than only the emergency calls.<sup>33</sup> Having a male-midwife became fashionable for wealthier women and by 1770 male midwives had taken over the practice of attending wealthy women in the country.<sup>34</sup>

The gendered dynamics around childbirth had been altered. While before authoritative knowledge about women's bodies had been considered to rest with the mothers and the traditional midwives, it had now been moved to the male-midwife who had a different background and training. The male-midwife's expertise and call to authority first and foremost rested with the possession of tools, such as the forceps. Using the forceps, as well as the fillet and the vectis, enabled the male-midwife to save mothers and babies during obstructed labour, which before had been all but impossible. However, rather than spreading these tools and the knowledge and training on how to use them among the traditional midwives that still attended majority of births, especially in rural and poorer communities, a new profession was created with different approaches to

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<sup>32</sup> Wilson, 71.

<sup>33</sup> Wilson, 164.

<sup>34</sup> Wilson, 169.

women's bodies and birth. Birth ceased to be a feminine mystery and became a mechanical topic; knowledge of birth and of women's bodies was slowly transferred from women to the discourse of science, which was dominated by men.<sup>35</sup> Birth changed from being a female ritual of camaraderie and started instead to be moved into lying-in hospitals where women were frequently used as teaching material for midwives-in-training. Men cast themselves as the keepers of authoritative knowledge on women's bodies and their births, justified by their access to technology, organised training, literacy and medical manuals, as well as the approach that said that the mechanical movement of the child down the birth canal and the subsequent expulsion was the most important part of the birth, and that that passage should be facilitated in order to achieve a successful birth, rather than considering it a complex event that involves both physical, social and emotional aspects. While some male birth attendants were without a doubt caring individuals, the focus went from being "with woman" to overseeing a procedure, like an operation, enabled by tools. The advent of new techniques and tools blurred the distinction between the spheres of the woman midwife and the male surgeon: "once a male practitioner could deliver a living child, the boundary was broken. ... The natural desire of the male practitioner, doubtless founded on both self-interest and compassion, was to hasten the transition, to eliminate the 'traditional' calls, to become pure man-midwife and no longer obstetric surgeon at all. Midwives were perceived as standing in the way of this development."<sup>36</sup> Slowly the midwives were replaced; the authority that they had enjoyed previously was slowly siphoned away, the knowledge that they

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<sup>35</sup> Lisa Forman Cody, *Birthing the Nation: Sex, Science, and the Conception of Eighteenth-Century Britons*, (Oxford, New York: Oxford University Press, 2005) 22.

<sup>36</sup> Wilson, 99.

accumulated became considered less valid than what was published in medical books; the skills they possessed became regarded as less valuable than the skills of those possessing tools that could be useful in certain situations. “Once physicians came to be *socially defined* as having expertise in the management of difficult or abnormal birth, midwifery effectively lost control over even normal birth.”<sup>37</sup>

Cahill draws our attention to the fact that the occupational groups that managed to establish themselves as professional were able to do so through specific historical actions — they organised and could cast themselves as a unified group, ‘doctors,’ as well as being in a position to do so because their status in terms of race, class and gender closely resembled those in power at the state level.<sup>38</sup> In the United Kingdom, the ascent of medical authority has been described 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.”<sup>39</sup> Midwives and other traditional healers were cast as ‘quacks’ and as non-professional, non-modern, and this enabled the category of ‘doctor’ to emerge and gain the status that it has. Midwives still practiced, but they suffered a loss of status and became the service of choice for those of the lower classes. Wilson discusses how changes in English society and the advent of industrialisation contributed to the changes in the rituals around birth. In the pre-industrialised society, time was more elastic. Women could change the timing of their housework and spend a few days attending a neighbour or relative in the lying-in bed. Once factory work became commonplace, this

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<sup>37</sup> Rothman 12.

<sup>38</sup> Cahill, 2001, 336.

<sup>39</sup> Stacey (1988), 50, quoted in Cahill, 2001, 336.

option was less easily available. No longer being able to count on neighbours and relatives to create and enforce this time and space needed for the rituals and habits surrounding childbirth, along with more crowded living conditions, women may have wanted to go into the hospital to have some privacy, as well as some peace of mind, although each woman's motives will be particular to her situation. Women could therefore use this medicalisation and institutionalisation of childbirth to their advantage, and some may have celebrated it. On the whole, the discrediting of the midwife and of accumulated knowledge and skill in favour of the crude use of tools and the disregarding of the social aspects of birth, impacted maternity care for the future.

The displacement of midwives also took place in the United States but in a different form. There, recently graduated medical men began to attend ever more births in the nineteenth century. A clear trend can be seen in the campaigns to discredit traditional midwives of male physicians trying to secure birth as an event under their jurisdiction. Economic incentives for aspiring physicians were strong, as childbirth was a common event and could be lucrative for those wishing to practice medicine. They also required access to pregnant women for practice and teaching. However, many communities were well staffed with traditional birth attendants. Racist, sexist, xenophobic and classed arguments and propaganda campaigns were employed to displace them, with good results in most cases:

Doctors used everything in their power to stop the midwives from practicing. They advertised, using racist pictures of 'drunken, dirty' Irish midwives and hooked-nose, witch-like Jewish midwives. They played on immigrant women's desire to 'become American,' linking the midwives with 'old country' ways of doing things. The displacement of the midwife can be better understood in terms of this competition than as an ideological struggle or as 'scientific advancement.'<sup>40</sup>

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<sup>40</sup> Rothman, 14.



These campaigns proceeded regardless of the skills of the physicians available, many of whom were underprepared and had perhaps not witnessed a birth before starting to practice. The doctors had the benefit of being able to organise and collude with their local government which helped them disseminate their information and control licensing. These developments started to curb midwives' ability to practice.<sup>41</sup> Quickly, "medicine gained virtually complete control of childbirth in the United States, beginning with the middle class and moving on to the poor and immigrant populations. And it did this without any indication that it was capable of doing it well."<sup>42</sup> With tools and frequent examinations in unhygienic conditions, the risks of infection were higher. The case of doctors refusing to wash their hands after dissecting cadavers, thus spreading puerperal fever infections and causing the deaths of countless women, is one that should not be forgotten.<sup>43</sup> By discrediting midwives and traditional birth attendants male doctors gained control over childbirth.

### **Hysterical women**

How women's bodies are viewed and understood will affect birth management and options in birth. Medicine and Western philosophy have a particular relationship to bodies, especially women's bodies. In addition to having been considered raw and animal-like, at whim to hungers and desires, that need to be overcome in order to reach true clarity, which usually was only considered available to men, the body has also been considered dirty, and a cage, something to be transcended. In addition, women's bodies

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<sup>41</sup> Rothman, 15.

<sup>42</sup> Rothman, 15.

<sup>43</sup> Erwin H. Ackerknecht, *A Short History of Medicine*, (Baltimore: Johns Hopkins University Press, 1982): 187.

have been considered even more so; that is, women have a harder time escaping their body-cage, and are more trapped by the whims, hungers and desires that reside in the body than men.<sup>44</sup> These ideas would also vary by race, sexuality, ability, and class. The female body is not any one thing. Women come in all shapes and sizes, with different histories and backgrounds.<sup>45</sup> The intersections of gender with race, ability, class, sexuality, and more, must not be overlooked, as homogenising discourses can erase and silence many women's lived realities.

Ehrenreich and English describe how illness and frailty was both associated with women, and how it became feminine to be ill and frail. Middle- and upper-class women in North America were expected to live lives of leisure, fashion, and childbearing. Frequent pregnancies in the absence of birth control, tightly laced corsets, and lack of exercise or physical labour, took their toll on their health, or at least their perceived health, as it became fashionable to be frail and sick. This frailty became a symbol of femininity and class, as only wealthy men were able to keep a wife of pure leisure.<sup>46</sup> Encouraging this idea of women as inherently frail served two important motives for the doctor profession. They could be called upon to dispense medicine to these women who were so frequently ill, and who had the means to pay. They became "highly qualified as patients;" and, perhaps even more importantly, it helped "disqualify women as healers."<sup>47</sup> In the late 1800s, the male medical profession needed to establish itself. They needed patients, they needed disorders to treat, and they needed to reduce or eliminate their

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<sup>44</sup> Peta Bowden and Jane Mummery, *Understanding Feminism: Difference*, (Stockfield Hall: Acumen, 2009), 49.

<sup>45</sup> Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth, *Body/Politics: Women and the Discourse of Science*. ed. by Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth. (New York: Routledge, 1989) 4.

<sup>46</sup> Ehrenreich and English, 2011, 16.

<sup>47</sup> Ehrenreich and English, 2011, 23.

competition, which at this time consisted partially of women, both midwives and lay healers. “The theory of innate female sickness, skewed so as to account for class differences in ability to pay for medical care, meshed conveniently with the doctors’ commercial self-interest.”<sup>48</sup> By casting women (especially upper and middle class women) as frail and sick, encouraging a life style that both seeks and reproduces those qualities as feminine, and thus disqualifying them from managing their own health or being capable of assisting others, male doctors managed all three.

Working-class women, poor women, and especially women of colour, who were frequently poor as well, did not receive the same attention from the medical establishment. Ehrenreich and English describe how they were considered fit for work or made for working, unlike the upper class women who were frail and delicate.<sup>49</sup> In this way the patriarchal medical establishment used medical and scientific language to justify and normalise the sexist, classist and racist societal organisation. In addition to the health tolls from inadequate housing and difficult working conditions, poor women and women of colour were used for medical experimentation.

[I]t should not be imagined that poor women were spared the gynecologist’s exotic catalog of tortures simply because they couldn’t pay. The pioneering work in gynaecological surgery had been performed by Marion Sims on black female slaves he kept as the sole purpose of surgical experimentation. He operated on one of them thirty times in four years, being foiled over and over by postoperative infections. After moving to New York, Sims continued his experimentation on indigent Irish women in the wards of New York Women’s hospital. So, though middle-class women suffered most from the doctors’ actual practice, it was poor and black women who had suffered through the brutal period of experimentation.<sup>50</sup>

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<sup>48</sup> Ehrenreich and English, 2008, 27.

<sup>49</sup> Ehrenreich and English, 2011, 14.

<sup>50</sup> Ehrenreich and English, 2008, 29.

In addition to ascribed weakness, various aspects of women's bodies were medicalised. The reproductive aspects of women's bodies, such as menstruation, pregnancy and menopause, became of particular interest to the medical establishment, possibly because these were only experienced by women and thus were different from the male body that was seen as the norm.<sup>51</sup> Female body parts, especially the uterus and the ovaries, were seen as inherently faulty and prone to malfunction, and some doctors believed that women would be better off without them, and recommended hysterectomies for various ills.<sup>52</sup> The catch-all diagnosis of 'hysteria' was used to depict as ill and weak all kinds of women and behaviours; everything "from irritability to insanity, could be traced to some ovarian disease."<sup>53</sup> In this way doctors, and the entire medical establishment, were instrumental in continuing and reinforcing women's role in society as the weaker sex by rephrasing the dominant ideas about women and women's 'appropriate' role in the language of biology and science, ideas that were classed and racialised as well.<sup>54</sup> Women were considered ill because they were women, but if they tried to avoid their womanly fate by choosing masculine occupations they would become ill as well. Medicine thus can function as a tool of the patriarchy to both depict women as inherently weak, by pathologising their bodies, but also to push them into conformity with the roles that they were allotted within patriarchy. This mindset towards women and women's bodies has fundamentally affected the way the medical system approaches childbirth.

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<sup>51</sup> While keeping in mind that the lines between "men" and "women" is blurry at best.

<sup>52</sup> Robbie Davis-Floyd, *Birth as an American Rite of Passage* (Berkeley: University of California Press, 2003), 53.

<sup>53</sup> Ehrenreich and English, 2008, 28.

<sup>54</sup> Ann Oakley, *Women Confined: Toward a sociology of childbirth* (Oxford: Martin Robertson, 1980) 13.

### **Birth transformed into a medical event**

The path towards birth becoming an almost mechanical procedure performed by a physician rather than an act by the mother is intricately connected with the rise of man-midwifery and the capture of birth within medical discourses. A crucial step in turning birth into a medical event was taken when it moved into the hospital. With that birth was moved from being an event that took place in the context of the woman's everyday life, into the world of doctors, nurses and medicine rather than family and home. Not all women will have had access to a comfortable home and a supportive family with which to give birth, but in the hospital most of the attention given to the woman was to her biological process, not her emotional or social needs.

During the time when man-midwifery was on the rise, birth started being viewed mechanically. William Smellie, one of the best known male midwives, set up lying-in hospitals, partially to train other man-midwives as well as traditional midwives. For that he found he lacked teaching material, so he fashioned a model of the pelvis: "I endeavoured to reduce the art of midwifery to the principles of mechanism, ascertained the make, shape, and situation of the pelvis, together with the form and dimension of the child's head, and explained the method of extracting, from the rules of moving bodies, in different directions."<sup>55</sup> This approach was different from the one that was dominant before this transition. Here it is the language of physics, of the movement of the fetus down the birth canal, that is privileged, rather than the experience and agency of the mother and the midwife. Ann Oakley quotes an obstetrician from 1871 as writing: "The operation [of inducing labour] may be brought entirely within the control of the operator. Instead of being the slave of circumstances, waiting anxiously for the response of nature

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<sup>55</sup> William Smellie, quoted in Wilson, 125-126.

to his provocations, he should be master of the position”.<sup>56</sup> What is striking here is that the woman is not mentioned; she is extraneous. The ‘operator’ is the subject of the situation, the ‘slave of circumstances’ that suffers the wait during a long labour. The birth, the emergence of the child, is the event, which the ‘operator,’ controls and guides.

In the United States during the 1920s and 1930s, births were quickly moving into the hospital. A routine was established by obstetricians that remained in place until the 1970s where the woman was sedated through labour and the fetus removed with forceps from the unconscious mother with the help of an episiotomy, which is a cut in the perineum.<sup>57</sup> During the early part of this time period a drug known as Twilight Sleep, or a mixture of morphine for early labour and scopolamine for the delivery, was used to sedate women. Ostensibly, it was supposed to relieve pain, and many women did indeed wake up not remembering any pain. However, many did not remember anything at all, and it is questionable how much pain was indeed relieved. Women were routinely strapped down, given enemas, shaved, separated from their partners, and drugged. Some women lost control of their actions and behaviour under the effects of this drug and were tied down to their beds, sometimes for days, until an obstetrician arrived to manually extract the infant from them with tools, applying fundal pressure. The baby was born drugged and lethargic and needed careful observation. The women took a while to recover from the anesthesia and were in most cases unequipped with caring for their

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<sup>56</sup> Cited in Fields, et al., 1965, pp. 11-12, as cited in Ann Oakley, *The Captured Womb: A history of the medical care of pregnant women* (Oxford: Basil Blackwell, 1984) 207.

<sup>57</sup> Rothman, 16.

children in the first hours or even days after birth; many did not see their children until then.<sup>58</sup>

The dualist, Cartesian view of bodies was essential for this development to be able to take place. The body and the mind were seen as separate. The body was conceived of like a machine that, once certain buttons were pushed, would perform certain actions with a measurable outcome. Aberrations from this pattern would then be treated to make it conform to expectations. In particular, the uterus was considered as an involuntary muscle, like the heart. Therefore, it did not matter what the person possessing the uterus was otherwise doing, thinking or feeling, or whether she was even conscious; the uterus would continue its contractions regardless. If the contractions stalled, medication would be administered to speed it up. This led to the idea that labour and birth are events that happen involuntarily rather than acts completed by the person in question.<sup>59</sup>

In the early twentieth century maternal mortality rates were high. An obstetrician, Joseph DeLee, was horrified at these rates, and also at the attitudes of both government and doctors, that suffering during childbirth was considered a part of woman's natural role. He set out to argue for more health care for pregnant women by emphasising its dangers. With this he was able to argue for birth's "proper" place as being in the hospital.<sup>60</sup> He wrote an article where he laid out this idea for the management of birth as described above. He was successful in convincing politicians and doctors that suffering in childbirth was not woman's lot, but should be dealt with by the medical establishment.

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<sup>58</sup> Rothman 16-17.

<sup>59</sup> Emily Martin, *The Woman in the Body: A cultural analysis of reproduction* (Boston, Massachusetts: Beacon Press, 1987), 10.

<sup>60</sup> Caroline H. Bledsoe and Rachel F. Scherrer, "The Dialectics of Disruption: Paradoxes of Nature and Professionalism in Contemporary American Childbearing," in *Reproductive disruptions: Gender, Technology, and Biopolitics in the New Millennium*, ed. Marcia Claire Inhorn (Great Britain: Berghahn Books, 2007), 54.

The welfare of the fetus was the priority for him; vaginal birth put pressure on the head of the fetus which, he believed, could be likened to being crushed in a door. To avoid that, the forceps should be used. However, when forceps are used, the perineum almost always tears. Therefore, it was best to avoid that tear occurring by itself by pre-empting it with a cut into the perineum. Those clean, straight cuts were easier to sow than the jagged ones that occurred without the knife and thus, the assumption was, must have healed quicker and easier.<sup>61</sup> It was not until decades later that any systematic studies were done on the effectiveness of the episiotomy. These studies showed that the ‘clean cut’ was more at risk of tearing further, into a 3rd or 4th degree tear, while a tear that occurred on its own tended to be smaller.<sup>62</sup>

In addition to the effects of vaginal birth being compared to a baby’s head being crushed in a door, DeLee argued that the effects of birth on the mother could be compared to falling on a pitchfork. Tears on the perineum can be serious and cause long term injuries. It must be asked, though, which conditions lead to the perineum tearing and in what conditions it remains intact. One reason for the frequency of perineal tears in women giving birth in hospitals during the first and middle part of the twentieth century may have been the position in which they gave birth. Lying on their back with their legs in stirrups, the so-called lithotomy position, which gives a birth attendant excellent view of a woman’s vagina, has been associated with an increase in tears.<sup>63</sup> Therefore, DeLee’s argument that the best practice is to cut the woman’s perineum while she lies flat on her back and then remove the baby with forceps, is most suspect. “Most intriguingly,

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<sup>61</sup> Rothman, 17.

<sup>62</sup> Margaret Macdonald, “Gender Expectations: Natural Bodies and Natural Births In The New Midwifery in Canada.” *Medical Anthropology Quarterly* 20(2) (2006): 249.

<sup>63</sup> Rothman, 17.



perhaps, DeLee claimed that the episiotomy and the subsequent repairs by the physician, would restore ‘virginal conditions,’ making the mother ‘better than new.’ All through the 1970s obstetricians were heard to assure husbands, who were just then starting to attend births routinely, that they were sewing the woman up ‘good and tight.’<sup>64</sup> With these analogies, DeLee was able to argue that labour and birth were abnormal conditions that should not be left to their own devices; they were illnesses that needed medical treatment. This bolstered the arguments for aggressively medically managed birth. However, these methods remained in place even when the health of the general population increased and better health care facilities had been built and policies put in place; the conditions that DeLee was fighting against. His ideas informed American hospital birth practices for half a century, until the 1970s. Birth came to be seen as something that the *doctor* does – hence the popularity of the phrase ‘deliver’ – as in, ‘the doctor delivered the baby’ or ‘the woman was delivered’ rather than ‘the woman gave birth’ or ‘the woman birthed a baby’: “the role of the mother has been written out of a birth process which is now projected as an interaction between doctor and fetus.”<sup>65</sup>

Mainstream birth practices have changed since DeLee’s ideas held sway. Nevertheless, traces of them can still easily be found. Emily Martin examined several obstetrics textbooks and found examples where birth is described as a mechanical operation, with how many centimetres per hour dilation should reach during each stage of labour, and how the obstetrician should manage labours that deviated from these statistics.<sup>66</sup> The woman giving birth is almost absent from these descriptions. Rather, her

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<sup>64</sup> Rothman, 17.

<sup>65</sup> Jacobus, 5-6.

<sup>66</sup> Emily Martin, 1987, 59.

body, in particular her uterus, functions as a machine within tightly controlled statistical measurements, that must be “managed” by the doctor/operator. Even though birth is described as a ‘natural’ event, these mechanistic approaches are close to the surface. With this transition into a medical, or mechanical, approach towards birth, the ownership of birth was moved from the woman giving it to the doctor attending it, justified by the discourses of medicine, the inherent danger and abnormality of childbirth, that women’s bodies were defective, and that birth would proceed on its own, at least with guidance from qualified professionals, so that the mother’s active participation was unnecessary and could even be a hindrance.

### **Technology and shifting epistemology**

Science is a privileged discourse in modern Western societies, and one that has been used to justify and explain many social phenomena, especially when it comes to issues like gender. Robbie Davis-Floyd describes American society as deeply technocratic by which she means that the basic fundamental understandings of the world is that it functions like a machine. This approach bolstered the validity of the sciences as a valuable approach to truth and with it came increased power in the hands of medical practitioners.<sup>67</sup> This transformation from viewing both nature and the body as a whole organism into a machine had a significant impact on birth practices. “As a result of this switch in base metaphors, nature, society, and the human body soon came to be viewed as composed of ‘interchangeable atomized parts’ that could be repaired or replaced from the outside.”<sup>68</sup> This enabled the view that the uterus would contract no matter what else was going on for the person the uterus belonged to, and consequently that the feelings and

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<sup>67</sup> Davis-Floyd, 45.

<sup>68</sup> Davis-Floyd, 44.

emotions of the ‘rest of the person’ were insignificant as long as the fetus was expelled properly.

Davis-Floyd puts forth an argument that attempts to explain how birth became so technologically managed. From the point of view of anthropology, she argues that the “standard procedures for a normal birth” are not influenced by a physiological reality, but are rather an intricate ritual around this event, the childbirth: “these obstetrical procedures are in fact rational ritual responses to our technocratic society’s extreme fear of the natural processes on which it still depends for its continued existence.”<sup>69</sup> She continues: “routine obstetrical procedures ... are felt by those who perform them to transform the unpredictable and uncontrollable natural process of birth into a relatively predictable and controllable technological phenomenon that reinforces American society’s most fundamental beliefs about the superiority of technology over nature.”<sup>70</sup> The worldview of Westerners changed during the seventeenth century into seeing the world as largely mechanistic. For Davis-Floyd, this mechanistic worldview can help explain the transition from birth as a woman-led community event into something that took place in hospitals under complete control of doctors and other professionals with an unconscious mother. These routines are a system through which experiences are mediated and made sense of. What has emerged is a logical and a coherent system that has predictable inputs and outputs that fits with the technocratic society Davis-Floyd has described. This technocratic approach to bodies, and to birth, enables the medical system to treat women like their bodies are machines that need to be managed by an operator, and that their preferences, desires and bodily autonomy are irrelevant.

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<sup>69</sup> Davis-Floyd, 1-2.

<sup>70</sup> Davis-Floyd, 2.

**Conclusion**

In the course of the last 300 years, childbirth has been medicalised in the West. By displacing traditional birth attendants and the knowledge that they possessed, coding women's bodies as inherently sick and malfunctioning easily, conceiving of birth as a medical event that is performed by a doctor rather than the person who is pregnant and/or in labour, and by privileging the discourses of technology and science, authoritative knowledge about birth has moved from women giving birth and the midwives that attended them. A patriarchal medical establishment has increasingly assumed power over women's bodies and their births and significantly impacts how women are able to make choices on what they want their births to be like, both in terms of what services are available in their communities, and how the women themselves are able to imagine birth. Understanding these patriarchal roots of the medical system and its approach to birth is necessary in order to understand the modern maternity care system. The frequency and acceptability of various interventions in the process of birth, the treatment of the body as separate from the mind and the uterus from the whole person, the casual approach towards informed consent and bodily autonomy in birth and the idea that the obstetrician is the one who makes decisions, are in direct continuation of the patterns that were established in the early medicalisation of birth.

## Chapter 2: Surveillance medicine and modern birthing

Through patriarchal medicine, women have been systematically divested of authoritative knowledge of their own bodies and of autonomy in childbirth. With the marginalisation of midwives and traditional birth attendants, understanding women's bodies as inherently sick, casting birth as a medical event performed by someone other than the mother and through seeing technology as the appropriate tool to deal with birth, medicalisation of birth reached its apex from 1930s-1970s in the United States. In these highly medicalised births women were drugged, separated from their partners and other supporters, and the fetus removed from them with forceps while they were lying on their backs with their legs in stirrups, in some cases with their hands tied. Nancy Stoller Shaw, who later was one of the founders of the Boston Women's Health Collective that produced *Our Bodies, Ourselves*, described the hospital deliveries she witnessed in the 1970s as all following the same track: "The patient was placed on a delivery table similar in appearance to an operating table. The majority of patients had spinal anesthesia or an epidural. The woman was placed in the lithotomy position and draped; her hands were sometimes strapped to prevent her from 'contaminating the sterile field.' She could not move her body below the chest, and her 'active participation' in the birth was effectively over."<sup>71</sup>

Birth is rarely like that any longer. Routine shavings and enemas are a thing of the past. Fathers and partners are welcome in the delivery room. Women have a range of options for anesthesia, the epidural allows the woman to get pain relief but retain consciousness and control of her movement, unmedicated births take place in the hospital

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<sup>71</sup> Nancy Stoller Shaw, 1974: 84, quoted in Rothman, 56.

as do elective cesarean sections. Birthing rooms have been installed in hospitals with flowered curtains, jacuzzis and a food menu with a variety of options.<sup>72</sup> However, it can be argued that instead of the overt medical control of the 1950s, a more covert form has taken its place. Women are told they have choice, but through constant pathologisation of their body and birth, surveillance and the expanding category of risk, as well as the institutional aspects of hospitals, the cascade of intervention, an atmosphere of litigation and defensive medicine, that choice is hard to realise.

### **What does medicalised birth look like?**

In the Listening to Mothers III survey, where women who had given birth in 2011 and 2012 in American hospitals were asked about their experience, it was found that rates of interventions were high. Forty percent of the women reported that their provider had attempted to induce their labour, 83% used one or more type of pain medication at some point during their labour and birth, with epidural or spinal analgesia used for 67% of all the women. One third of the women gave birth via cesarean section, with half of those being their first section, and the other half a repeat cesarean. Eighty six percent of the women who had a previous cesarean section had a repeat c-section, even though 46% of the women with a previous cesarean had been interested in a VBAC (vaginal birth after cesarean). Only 1% of the women surveyed reported having requested a cesarean prior to labour without a medical indication.<sup>73</sup> Jennifer Block offers the following description:

Walk into any freshly occupied U.S. hospital ‘LDRP’ room – it stands for labour, delivery, recovery, and postpartum – and you will find the expectant

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<sup>72</sup> Rothman, 285.

<sup>73</sup> Eugene R. Declercq, Sakala C, Corry MP, Applebaum S, Herrlich A. “Listening to Mothers III: Pregnancy and Birth.” (New York: Childbirth Connection, May 2013).

patient lying in a recumbent position on an obstetric bed. One of her arms is connected, by thin tubing that extends from a vein on the back of her hand, to a plastic IV bag suspended above her head; the other is probably wrapped at the bicep with a nylon and Velcro blood pressure cuff that automatically contracts every ten minutes or so. A finger might be ensconced in similar material, measuring her pulse and blood oxygen levels. An elastic band tethers her belly to an electronic fetal monitor, a machine that rhythmically prints out a paper trail of fetal heartbeats like an accountant's register and displays the reading on a flat-screen monitor mounted at the bedside. She's likely to have several other appendages as well: an epidural catheter extending into the space between her vertebrae and spinal cord, a Foley catheter threaded into her urinary tract, an intrauterine catheter inserted through her cervix and into the uterus, and circulation stockings on her legs. At any one time, she might have five or more drugs pulsing through the IV line. Altogether, she may have up to 15 different tubes, drugs, or attachments.<sup>74</sup>

I do not put forth these mechanistic descriptions of childbirth to contrast them with an alternative that has not been 'tainted' by the technocratic gaze, and only needs to be 'liberated' from the linguistic and material captivity of the medical approach. There is no 'pure' birth to return to once medicalisation is stripped away. I also do not suggest that technological devices alone make for a negative birth experience, or that they are inherently bad. I make the words of Peter Conrad my own: "I am not interested in adjudicating whether any particular problem is *really* a medical problem. ... I am interested in the social underpinnings of this expansion of medical jurisdiction and the social implications of this development."<sup>75</sup> Therefore, I do not take a stance on whether health care or medicalisation is appropriate for any condition, such as pregnancy and birth, but rather wish to look at the causes of this medicalisation and some of its consequences. Whether these women chose these interventions or not is hard to judge; some most certainly did, or were grateful for the effects they had on their birth. What is

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<sup>74</sup> Jennifer Block, *Pushed: The Painful Truth about Childbirth and Modern Maternity Care* (Cambridge, Massachusetts: Da Capo, 2007), xix.

<sup>75</sup> Conrad, 2007, 3-4.

clear is that it is much easier to ‘choose’ a medicalised, intervention-filled birth in the current medical system, rather than an alternative.

### **Birth is normal only in retrospect: Surveillance childbirth**

The “prevailing wisdom of obstetrics” is that “birth is normal only in retrospect.”<sup>76</sup> Birth has been defined as a dangerous and pathological event. Within medical thought, it is considered an exception for it to progress without complications, rather for that to be considered the norm. It is only after a birth has taken place without complications that it can be called a “normal birth” or to have proceeded normally. Complications are expected until the moment for them to occur has passed, even when these complications are rare. Some argue that it is safer to be prepared for these possibilities to occur and this constant vigilance is the best way to ensure the health of mothers and infants. The other side of this coin is that each woman, each birth, is considered pathological until it has been proved otherwise, which means that each birth will be treated as a medical event and an illness, which may impact how the birth will progress — it may take a birth that might proceed without complications and turn it *into* a medical illness, even an emergency. A key aspect of this philosophy is surveillance.

David Armstrong describes the development of medicine as passing from Bedside Medicine, to Hospital Medicine, to Laboratory Medicine, to what he terms Surveillance Medicine. Surveillance Medicine is a model of medicine that centres on the “the observation of seemingly healthy populations.”<sup>77</sup> These different epochs in approaches towards sickness and healing can be discussed in terms of what Foucault calls the

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<sup>76</sup> Raymond G. DeVries, “The Warp of Evidence-Based Medicine: Lessons from Dutch Maternity Care,” *International Journal of Health Services* 34(4) (2004), 607.

<sup>77</sup> David Armstrong, “The rise of surveillance medicine,” *Sociology of Health and Illness* 17(3) (1995): 393.



spatialisation of illness.<sup>78</sup> According to Armstrong, illness used to be understood as “coterminous with the symptoms that patients experienced and reported” in the era of Bedside Medicine, but with the move into Hospital Medicine in the late eighteenth century, symptoms and illness took on a new relationship “involving symptom, sign and pathology.”<sup>79</sup> Both through the explanations of the patient and of the examination of the physician, the “underlying lesion” could be inferred, which was the ‘actual’ disease. That is, pain in a certain part of the body, coupled with a “sign” that a physician observed through examination, together pointed to an illness, as opposed to during the era of Bedside Medicine when pain in a part of the body, such as a headache, *was* an illness. This organisation of symptom, sign and lesion is what Foucault refers to as the secondary spatialisation of disease and meant that the human body became a focus of medicine in a different way.<sup>80</sup> The tertiary spatialisation of disease refers to the organisation of disease and bodies in their social and physical context. This refers to the ‘appropriate’ location of ill bodies and treatments, whether they are considered to be best placed in the home of the patient or transposed to certain buildings, such as hospitals where the disease can be examined and understood better without interference by other aspects of the patient’s life.<sup>81</sup> This coincided with the rapid growth of hospitals throughout Europe.

Armstrong claims that the philosophy and practice of Hospital Medicine has dominated for the last two centuries but a new form of medicine has gained ascendancy in the last decades of the 20th century. This new trend involves a “fundamental

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<sup>78</sup> Michel Foucault, *Birth of the clinic: An archaeology of medical perception*, New York: Random House, (1994): 3.

<sup>79</sup> Armstrong, 394.

<sup>80</sup> Foucault, 9.

<sup>81</sup> Armstrong, 395.

remapping of the space of illness,” where illness starts to “inhabit a novel extracorporeal space.”<sup>82</sup> That is, the normal, the “healthy,” started being problematised, with the “targeting of everyone”; “Surveillance Medicine requires the dissolution of the distinct clinical categories of healthy and ill as it attempts to bring everyone within its network of visibility.”<sup>83</sup> With Hospital Medicine, individuals only became patients when they became ill, but with Surveillance Medicine, illness is always around the corner. Health was no longer an either-or: “Surveillance Medicine fixed on these gaps between people to establish that everyone was normal yet no-one was truly healthy.”<sup>84</sup> Because medicine was no longer only concerned with ill bodies that were in the hospital, its net was cast wider. Primary health care facilities and screening programs were developed, first in response to social diseases such as tuberculosis, then expanded.<sup>85</sup> However, compliance was an issue. Not everyone could be reached with these methods and not everyone was a willing participant in these various health screening programs. Therefore, a strategy of health promotion was developed that “involved giving responsibility for surveillance to patients themselves.”<sup>86</sup> The vision was that eventually, through proper thoughts and behaviours, Surveillance Medicine would be internalised by the entire population.

According to Armstrong, the tactics of Surveillance Medicine are pathologisation and vigilance. Health and illness no longer exist in a binary, but on a continuum: “the healthy can become healthier, and health can coexist with illness. ... a world in which everything is normal and at the same time precariously abnormal, and in which a future

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<sup>82</sup> Armstrong, 395.

<sup>83</sup> Armstrong, 395.

<sup>84</sup> Armstrong, 397.

<sup>85</sup> Armstrong, 398.

<sup>86</sup> Armstrong, 399.

that can be transformed remains a constant possibility.”<sup>87</sup> There is now a temporal axis for health. Another significant shift that took place with the advent of surveillance medicine, according to Armstrong, is the reconfigured spatialisation of symptom, sign and illness into predictive factors. Rather than an underlying lesion causing certain signs and symptoms, these categories were now all merged into the concepts of ‘factor’ and ‘risk.’ A symptom was a risk factor for a certain disease, which was again a risk factor for another illness: “It is no longer the symptom or sign pointing tantalisingly at the hidden pathological truth of disease, but the risk factor opening up a space of future illness potential.”<sup>88</sup> The ‘lesion’ is no longer the end point of the understanding of the disease — rather, it opens up the understanding of a risk factor for a whole host of possible future illnesses and conditions. This means that an extracorporal space becomes ever more important, which can be understood as ‘lifestyle’ and used as a further risk factor for future illness. “In Surveillance Medicine each illness is simply a nodal point in a network of health status monitoring. The problem is less illness per se but the semi-pathological pre-illness at-risk state.”<sup>89</sup>

Clear parallels with this approach can be seen in mainstream birth management. In fact, according to Armstrong, the child was the first target focus for Surveillance Medicine.<sup>90</sup> Now everyone, especially children who were on a path of development that could go wrong, were monitored constantly, not only after a complaint or a noticed symptom of ill health. Charts for appropriate size for age, developmental milestones, both inside and outside the womb, were developed, as this information became not only

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<sup>87</sup> Armstrong, 400.

<sup>88</sup> Armstrong, 400.

<sup>89</sup> Armstrong, 401.

<sup>90</sup> Armstrong, 396.

statistically observable but those statistics became an imperative. Being outside the ‘norm’ was not only an interesting case, unless it proved to be unhealthy or problematic in some way – being outside the norm became inherently problematic, and might require treatment. In addition, signs that were considered on the fringes of what was accepted and expected were considered clues for future complications and diseases. “Risk factors, above all else, are pointers to a potential, yet unformed, eventuality. ... The techniques of Surveillance Medicine – screening, surveys, and public health campaigns – would all address this problem in terms of searching for temporal regularities, offering anticipatory care, and attempting to transform the future by changing the health attitudes and health behaviours of the present.”<sup>91</sup>

A trend can be observed in the history of management of labor. Observations of what is common or normal in labour, or what has been associated with good outcomes, became a measurement of what labour *should be* like. An example of this are observations on the length of labour, various biometrics that can be observed in the mother (such as blood sugar or hemoglobins), weight gain in the mother, and more. Actions are then taken to move either labor or the mother within these metrics, as that is assumed to be associated with good outcomes, which leads to screening and surveillance when it comes to both pregnancy, labor and birth. Many obstetrical prenatal care visits are essentially screening, with little time devoted to conversation and reassurance of fears or dealing with emotional problems, and as well during the labor much surveillance takes place: of the fetal heartbeat, cervical dilation, the length of gestation and frequency of

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<sup>91</sup> Armstrong, 402.

contractions.<sup>92</sup> These variables are allowed to proceed at their own pace as long as they follow a predetermined script in terms of length, timing, frequency and intensity. If they stray outside, measures are taken to push them back inside. Labour is induced for those who carry too long, contractions are sped up when dilation is not quick enough, cesarean section is recommended when labour has taken too long. Barbara Katz Rothman points out that “statistically abnormal labors are medically treated”<sup>93</sup> regardless of physiological reality — whether a problem has been indicated other than rarity. She compares this approach to treating an unusually tall woman for her “height condition.”<sup>94</sup>

The obstetrician Emanuel A. Friedman measured the length of births and from his data split labour into several phases, the latent and active phase, and assigned an appropriate amount of time for each, known as Friedman’s Curve, which he published in a major American obstetrical journal between 1954 and 1959.<sup>95</sup> This curve was considered standard by the American College of Obstetricians until in early 2014, when ACOG released new guidelines where active birth was to be considered to start at 6cm dilation rather than 4, as per Friedman’s curve, reflecting their experience that some labours simply took longer without that being a problem in itself.<sup>96</sup> According to the thinking inherent in the Friedman’s Curve, like a machine, labour could only move forward. If it stopped, there was a problem and that was an indication for a cesarean section. According to the midwifery model of care, however, these phases are not

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<sup>92</sup> Rothman, 53.

<sup>93</sup> Rothman, 63.

<sup>94</sup> Rothman, 63.

<sup>95</sup> Rothman, 63.

<sup>96</sup> The American Congress of Obstetricians and Gynecologists, “Nations’ Ob-Gyns Take Aim at Preventing Cesareans,” February 19, 2014.

[http://www.acog.org/About\\_ACOG/News\\_Room/News\\_Releases/2014/Nations\\_Ob-Gyns\\_Take\\_Aim\\_at\\_Preventing\\_Cesareans](http://www.acog.org/About_ACOG/News_Room/News_Releases/2014/Nations_Ob-Gyns_Take_Aim_at_Preventing_Cesareans) Accessed July 4th, 2014.

important and there is less emphasis on how labour is like a train that moves forward unless it is derailed. In fact, midwives consider labour to be able to start and stop, and sometimes go backwards, depending on the condition of the mother, who after a rest might return to her full forces and give birth.<sup>97</sup>

In addition to these strict pre-determined barometers of normal labour, women must also navigate the language of risk in order to make choices about their birth. “Since the development of modern obstetrics, there has never been more talk of birth as a ‘healthy natural event,’ yet each individual birthing woman is now acquainted with her personal ‘risk factors,’ which doctors tell her make *her* birth less than healthy and far less than ‘natural.’”<sup>98</sup> As a significant aspect of surveillance birthing, risk has become a governing category. Only those who are deemed “low-risk” are “allowed” to birth with a midwife, or at home. Those who are deemed “high-risk” are monitored even more and given more interventions. As previously stated, I am not interested in discussing what kind of risk factor ‘really’ necessitates a medical intervention; that is beyond my level of expertise. What is of interest here is who gets to decide where the line of risk lies, and what consequences that has.

Everybody, it sometimes seems, is ‘high-risk.’ ... the pregnancies of U.S. women all seem to be of above-average risk. Not everybody who gets pregnant can be a tall, well-nourished, Rh positive 24-year-old who has never miscarried or had a stillborn, has never been sick except for rubella and toxoplasmosis many years before, and has given birth vaginally three years earlier to a healthy baby weighing between seven and nine and a half pounds. Yet virtually any deviation from this ideal makes a woman “high-risk.” Even though she and her doctor may accept in principle the idea that pregnancy is a normal and healthy condition, the many tests, the careful watching, and the constant screening will help her think of her own particular pregnancy as being precarious, even dangerous. ... In fact, even if a woman does have all the healthy characteristics

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<sup>97</sup> Rothman, 64.

<sup>98</sup> Rothman, 3.

medicine can ask for, she still won't be called healthy, or even normal. She will be classified as "low-risk." In that sense, all of us are at some risk for developing virtually any disease and even dying of it in the next year. But what if you went for an annual check-up, and instead of being told you were healthy, you were told that you were at low risk of dying of leukemia, lung cancer, or heart disease this year?<sup>99</sup>

What determines a person as being "high-risk" changes frequently. All those expecting their first child can be described as high-risk, while on the other end of the spectrum, those who have had many previous children are also considered high-risk. Interestingly, the amount of previous children was changed a few years ago, from five previous children to three.<sup>100</sup>

This approach towards birth, where labours are constantly measured and surveilled, and expected to fit a normal pattern and are pushed within it if they stray outside, and where few labours are considered normal due to the proliferation of risk factors, is a reflection of the mindset inherent in the medicalisation of birth. The mother is all but absent; what matters are the measurements of cervical dilation, the timing of contractions and other metrics that can be measured. The physician is the one who performs birth, measurements and technology are considered the appropriate way to 'manage' labours, and birth is considered a biological or medical event, not one that involves the whole person giving birth, including her psychological and social needs as well as her biological ones. It does not leave space for a variety of labours and births, unique to each woman. While it will vary how closely care providers adhere to this mindset, it is embedded in the obstetric profession, meaning that women who wish to avoid it face an uphill battle.

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<sup>99</sup> Rothman, 30.

<sup>100</sup> Rothman, 31.

### **Safety and iatrogenic disease**

It is important to reiterate that the population that is up for discussion here is the generally healthy population of the global North, in particular in Western Europe and North America, in particular in the United State. The criticism of medicalisation of childbirth also has its place, but must necessarily be approached differently in areas where large numbers of women suffer from ill health from poverty, displacement, malnutrition and war, and where basic health care infrastructure is in a different state than in the richer countries of the North, and as a consequence, maternal and infant mortality and morbidity rates are much higher.

Both health professionals and others argue that obstetrics has been successful in making childbirth healthy and safe for the vast majority of women who give birth each year. Others credit the general good health of the population instead due to improved housing, sanitation and health care, rather than obstetric care in particular.<sup>101</sup> It has also been suggested that overuse of medical interventions increase poor outcomes, such as a recent study which found that babies born in private hospitals in Australia were likelier to have health problems, and surgical deliveries were 20% more likely, despite the women attending the private hospitals generally being healthy and well-off.<sup>102</sup> This and other things has led some to say that “obstetrics has been successful — not in creating safe childbirth but in creating a monopoly.”<sup>103</sup> Indeed, few alternatives to hospital birth are available, and especially not to those women who do not have the class or educational

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<sup>101</sup> Michele L. Crossley, “Childbirth, Complications and the Illusion of ‘Choice’: A Case Study.” *Feminism & Psychology* (17)(2007): 544.

<sup>102</sup> Michael Safi, “Babies born in private hospitals ‘more likely’ to have health problems,” *The Guardian*, 21 May 2014, <http://www.theguardian.com/world/2014/may/21/babies-born-in-private-hospitals-more-likely-to-have-health-problems>.

<sup>103</sup> Paula A. Treichler, “Feminism, Medicine, and the Meaning of Childbirth” in *Body/Politics: Women and the Discourse of Science*. ed. Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth (New York: Routledge, 1989), 114.



privilege to be able to organise their own birth experience, such as finding a care provider that shares the woman's views on birth or has insurance that covers midwives and home birth.

Scientifically examining different childbirth techniques is difficult. Using the scientific method in medicine and human healing is difficult in the first place, due to human beings and bodies being complex and always embedded in various contexts and power relations that differ from individual to individual; nevertheless, certain statistical approaches have been used and are afforded some legitimacy. However, it is ethically problematic, and functionally almost impossible, to perform randomised controlled studies on different birth practices, as randomly assigning a group of women to have cesarean sections and others to have vaginal births is not a feasible option. In those cases where statistics might be used to assess patterns, the mortality rates are so low that a large sample would be needed for it to become statistically significant.<sup>104</sup> This, and more, leads to the situation of different opinions on the relative safety and effectiveness of the various birth management techniques existing simultaneously, each supported by a body of scientific data, even when they are mutually exclusive.<sup>105</sup> Therefore, and for other reasons, it is important to look to more factors than statistics about various medical interventions and their statistical outcomes, to have a conversation about childbirth.

The numbers of maternal and infant mortality rates have plummeted in most modern industrialised societies.<sup>106</sup> However, a closer look reveals a more complicated picture than that. Maternal and infant mortality rates are indeed much lower in these

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<sup>104</sup> DeVries, 602.

<sup>105</sup> DeVries, 600.

<sup>106</sup> World Health Organization, Global Health Observatory, Maternal Mortality Country profiles. [http://www.who.int/gho/maternal\\_health/countries/en/](http://www.who.int/gho/maternal_health/countries/en/)

societies than they are in the impoverished areas of the global South, and in the not-so-distant past. Ninety nine percent of maternal deaths occur in developing countries, thereof half in sub-saharan Africa and a third in south Asia.<sup>107</sup> However, not only are these rates still different between the wealthier countries, they also differ between regions, between women of different socio-economic standing within the same region, and in some cases they are rising. The United States has experienced an increase in maternal deaths in the last several years, where now 18.5 mothers die for every 100.000 births, or 800 in a year, but in 1987 the rate was 7.2 for every 100.000 births, although this increase has been partially attributed to changes in classification.<sup>108</sup> In 1915, for every 100.000 live births, however, 607.9 women died of pregnancy and childbirth related causes in the United States.<sup>109</sup> The risk of maternal death is approximately four times higher for black women than it is for white women.<sup>110</sup> These discrepancies remained after controlling for poverty.

There does not seem to be a direct correlation between amount the expenses of a health care system and outcomes, as the American health care system is the most expensive one in the world, with healthcare costs 2.5 times higher than the OECD average,<sup>111</sup> yet is in the 65th place for maternal mortality rates in the world.<sup>112</sup> The

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<sup>107</sup> World Health Organization, Fact sheet no 348, updated May 2014, <http://www.who.int/mediacentre/factsheets/fs348/en/>

<sup>108</sup> Carol Morello, "Maternal deaths in childbirth rise in the U.S.," *The Washington Post*, 2 May, [http://www.washingtonpost.com/local/maternal-deaths-in-childbirth-rise-in-the-us/2014/05/02/abf7df96-d229-11e3-9e25-188ebeb1fa93b\\_story.html](http://www.washingtonpost.com/local/maternal-deaths-in-childbirth-rise-in-the-us/2014/05/02/abf7df96-d229-11e3-9e25-188ebeb1fa93b_story.html)

<sup>109</sup> Gopal K. Singh, United States Department of Health and Human Services, Maternal Mortality in the United States, 1937-2007: Substantial racial/ethnic, socioeconomic, and geographical disparities persist. <http://www.hrsa.gov/ourstories/mchb75th/mchb75maternalmortality.pdf>

<sup>110</sup> Singh.

<sup>111</sup> OECD (2013), "Total expenditure on health", *Health: Key Tables from OECD*, No. 1. doi: 10.1787/hlthxp-total-table-2013-2-en

picture is also not simple when different birth modes and interventions are examined. The rates of cesarean sections differ widely from region to region, both from country to country, region to region, and hospital to hospital; in 2013 the cesarean section rate was 22.4% in Utah but 38.9% in Louisiana.<sup>113</sup> The World Health Organisation recommends a cesarean section rate no higher than 10-15%, after that they caution the side effects of that major surgery will start to outpace the benefits of the surgery where situations warrant it.<sup>114</sup> Nevertheless, current cesarean section rates in the United States are around 32% and have risen sharply in the last several decades.<sup>115</sup> As a contrast, the c-section rate in the Netherlands was 15.6% in 2013%, where 30% of all births took place outside the hospital, either at home or in a birth centre.<sup>116</sup> The question must be asked whether the high use of interventions and surgeries in maternal care in the United States is fighting against or contributing to these rising maternal mortality rates.

### **Institutional aspect of hospitals and convenience of staff**

The institutional rhythms of the hospital are one of the aspects of medicalised birth that its critics point out. Scarcity of resources, and the for-profit nature of some hospitals, means that it is in the institution's interest to fill and empty the beds quickly. Robbie Davis-Floyd claims that there is a "vast qualitative difference between births in which the woman's own rhythms hold sway and births on which institutional rhythms are

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<sup>112</sup> The World Bank, Maternal mortality ratio (modeled estimate, per 100,000 live births), <http://data.worldbank.org/indicator/SH.STA.MMRT> accessed 20 June 2014.

<sup>113</sup> Cesarean rates by state, *cesareanrates.com*, <http://www.cesareanrates.com/csection-rates-by-state/>

<sup>114</sup> World Health Organization. Appropriate technology for birth. *Lancet* 1985; 2: 436-7.

<sup>115</sup> Centers for Disease Control and Prevention, Births - Methods of Delivery, <http://www.cdc.gov/nchs/fastats/delivery.htm> accessed June 20th 2014.

<sup>116</sup> OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing. [http://dx.doi.org/10.1787/health\\_glance-2013-en](http://dx.doi.org/10.1787/health_glance-2013-en)

constantly superimposed.”<sup>117</sup> Institutional pressure for labour to progress, not due to any ill signs from mother or fetus but because other women are waiting or staff is rushed, may increase the chances of various medications or other interventions being used to speed up the labour.

Various aspects of the institutionalisation of birth can affect its treatment. For example, a woman who finds herself in labour may go to the hospital, be told she has not started dilating and sent back home, only to show up again the day after with labour in full progress and give birth a few hours later. Another woman may show up with the same signs, but for whatever reason be admitted. The day after she has dilated to the same extent as the first woman, but since her labor has been going on for so long, according to the staff that has been observing her for this time, she may be diagnosed with “dystocia” (i.e. prolonged labour)<sup>118</sup> and given a c-section.<sup>119</sup>

It is unclear to what extent inductions and cesarean sections are scheduled around the availability of care providers. Cesarean sections are certainly more convenient for the provider, as they generally take less than one hour and can be scheduled, while spontaneous labour can start at any time of the day or night and be of indeterminate length. Most c-sections take place around 4pm and 10pm, which may coincide with shift changes and the desire of obstetricians to complete their work day.<sup>120</sup> Cesarean sections may also be more lucrative for care providers. Even where the reimbursement scheme has been changed to make sure that c-sections are not higher paid than vaginal deliveries,

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<sup>117</sup> Davis-Floyd, xv.

<sup>118</sup> Katherine Beckett, “Choosing Cesarean: Feminism and the Politics of Childbirth in the United States,” *Feminist Theory* 6(3) (2005), 265.

<sup>119</sup> Rothman, 58.

<sup>120</sup> Abby Epstein and Ricki Lake, 2008. *The Business of Being Born*. New York: New York, Barranca Productions.

they allow the obstetrician to attend more births as they are much quicker. This is considered one of the factors that contribute to the high cesarean rate in Brazil, where doctors take on many clients for financial reasons.<sup>121</sup> In the same way, when there are less institutional pressures, such as during the night time, there tend to be fewer interventions.<sup>122</sup> These institutional pressures may make it harder for women to give birth on their own terms.

### **Cascade of interventions**

Although the discourse surrounding medicalised birth is one of safety, it has been suggested that some of the complications that are treated with technology and drugs are actually caused by technology and drugs. The use of medical interventions, both ones that aim to alter the course of labour (such as inductions), those meant to monitor labour (such as electronic fetal monitors), and those in place to be prepared for a possible risk (restricting eating in case the woman needs emergency surgery and might aspirate vomit), can derail physiological birth. A woman unable to move around at will due to IVs and EFM's might be so uncomfortable that an epidural will be called for. The epidural might slow down labour, which will call for labour augmentation with synthetic oxytocin. This has been termed the "cascade of interventions."<sup>123</sup> Individuals will differ greatly on the costs, risks and benefits of various interventions and in what case they are justified or desirable.

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<sup>121</sup> Cecilia McCallum, "Explaining Caesarean Section in Salvador Da Bahia, Brazil." *Sociology of Health & Illness* 27(2) (2005), 232.

<sup>122</sup> Rothman, 67.

<sup>123</sup> World Health Organization, *Care in Normal Birth: A Practical Guide*. Geneva: Department of Reproductive Health and Research, World Health Organization, 1996.

A common intervention is rupturing the membranes. Breaking the sac that contains the fetus is considered to speed up labour. However, once the membranes have been ruptured, there is a greater risk of infection as there is no longer a barrier between the fetus and the outside, especially if frequent vaginal examinations are performed. Therefore, it is important that the labour proceed quickly, and it may call for other interventions to speed it up.<sup>124</sup> The intervention therefore calls for another. The same can be said for c-sections. Cesarean sections are major surgeries that take weeks or months to recover from, and some have effects that will last throughout the woman's life. The convenience of a scheduled c-section can be appealing, and by-passing labour altogether can be tempting for many women. Sometimes they are necessary, and can absolutely be life-saving devices in such cases, but how many is enough is disputed. Perhaps one of the most significant side effects of cesarean sections is that although the first may be relatively easy and free of complication, the risks increase with each subsequent section. For example, the placenta may attach to the uterine scar. Vaginal birth after cesarean (VBAC) has been demonstrated to be safer than a repeated elective cesarean (that is, a non-emergency one), but institutional restrictions and the general mindset of "once a cesarean, always a cesarean" has caused that to be true in more than three quarters of all cases.<sup>125</sup>

Another tool that is frequently used in childbirth is the electronic fetal monitor (EFM). Able to measure the fetal heart rate during labour and birth, its development brought hopes of being able to accurately depict when the fetus was in distress, necessitating a cesarean section or another method of completing the birth quickly.

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<sup>124</sup> Rothman, 66.

<sup>125</sup> Declercq et al, 21.

However, there are two main drawbacks to the EFM. The first is that it is subject to individual's subjective readings making it difficult to rely on for accurate information. Avoiding injuries to the infant resulting from oxygen deprivation during birth are one of the main goals of using EFMs, but "the false-positive rate for fetal hypoxia leading to cerebral palsy exceeds 99%."<sup>126</sup> The other main drawback of the EFM is that it necessitates the woman to remain still, usually lying on a bed, rather than able to move around at will which for many can be a great pain relief and source of comfort in labour. Again, the benefits of being able to (frequently inaccurately) monitor the fetus must be weighed against the costs of a more restrictive labour for the mother, but what may be of most interest is that whether or not to use a fetal monitor is rarely the woman's choice, but is rather hospital policy.<sup>127</sup>

### **Litigation and defensive medicine**

The rates of law suits against hospitals and staff for births that did not result in optimal outcome, whether that be illness, disability or death of an infant, or of the mother, as well as other factors, have both raised insurance costs as well as contributed to an atmosphere where more intervention and management is favoured over less. In 2010, just before taking office as the president of the American College of Obstetrics and Gynecology, Richard Waldman said: "Unfortunately we don't get sued for doing C-sections. We get sued for not doing C-sections soon enough. ... That has really increased, I think, our C-section rate."<sup>128</sup> This outlook has been termed defensive medicine.

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<sup>126</sup> Clark, Steven L, Michael a Belfort, Gary D V Hankins, Janet a Meyers, and Frank M Houser. 2007. "Variation in the Rates of Operative Delivery in the United States." *American Journal of Obstetrics and Gynecology* 196(6): 526

<sup>127</sup> See for example, Davis-Floyd.

<sup>128</sup> quoted in Jill Arnold, "Defending Ourselves against defensive medicine," *The Unnecesarean*, <http://theunnecesarean.com/blog/2011/1/10/defending-ourselves-against-defensive-medicine.html>

Defensive medicine occurs when doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily (but not necessarily or solely) to reduce their exposure to malpractice liability. When physicians do extra tests or procedures primarily to reduce malpractice liability, they are practicing positive defensive medicine. When they avoid certain patients or procedures, they are practicing negative defensive medicine.<sup>129</sup>

It is added that this bias need not be conscious, and also that it may not always lead to adverse outcomes for patients — defensive medicine may improve patient care in the sense that doctors go to great lengths to avoid being wrong. However, the discussion around defensive medicine usually centres on the high costs of many unnecessary diagnostic tests and clinical procedures and the discomfort and risk of multiplying medical interventions on the patient’s body. One study which asked obstetricians how many of their c-sections were performed to avoid litigation estimated 38%.<sup>130</sup> Jill Arnolds, a birth advocate, terms defensive medicine “the aggressive use of an unsuspecting patient’s body to provide a feeling of security and self-preservation to the physician.”<sup>131</sup> Defensive medicine may, therefore, be practiced in the interest of the care provider and not the woman giving birth, and may skew the information she is given about the necessity and safety of the interventions she is offered.

### **Power differences between patient and provider**

During pregnancy a woman will be lectured monthly, then bi-monthly, then weekly about the requirements and expectations she must meet. How much weight she may gain, which tests she’s obligated to take, how long she will be “allowed” to remain pregnant, and which items on her birth plan are frivolous fantasies, and ‘we’ll see dear; it’s important to have an open mind; I need you to trust me when I say it’s time for an epidural / c-section / episiotomy / pitocin.’

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<sup>129</sup> U.S. Congress, Office of Technology Assessment, *Perspectives on the Role of Science and Technology in Sustainable Development*, OTA-ENV-609 (Washington, DC: U.S. Government Printing Office, September 1994. Congressional Office of Technology Assessment, 1994) 13

<sup>130</sup> Jackson Health Care. “A costly defence: Physicians sound off on the high price of defensive medicine.” [http://www.jacksonhealthcare.com/media/8968/defensivemedicine\\_ebook\\_final.pdf](http://www.jacksonhealthcare.com/media/8968/defensivemedicine_ebook_final.pdf) 2011.

<sup>131</sup> Arnold.



At the time of birth, women will have their express wishes ignored, endure forced penetration, verbal bitch slaps, and condescending, ‘you need to let me do my job’ comments. They will be coerced into procedures and surgery, treated as a sideline participants in their own birthing process. When offered a routine intervention a woman may muster through contractions, ‘can ... we .... just.... wait .. a little ... longer?’ and she’ll receive combative eye rolls or ‘No, your doctor said....’ as though she is an incompetent child existing as a mere pupil under the dictative tutelage of the staff around her.<sup>132</sup>

One of the problems that has been highlighted by the critics of medicalised birth is the control the medical system and/or the state have over the bodies of pregnant women. This can be seen clearly in the language of ‘allowing’ that is pervasive in obstetric care — doctors ‘allow’ the woman to have a trial of labour (to see if she will be able to give birth spontaneously or whether a c-section will be administered), or ‘allow’ her to move around at will. “Women with low-risk pregnancies should be *allowed* to spend more time in labor, to reduce the risk of having an unnecessary C-section, the nation's obstetricians say.”<sup>133</sup> “That may mean that we *allow* a patient to labor longer, to push for a longer amount of time, and to allow patients to take more time through the natural process,” says assistant vice president of Women’s and Children’s Services at Virtua Hospitals in Philadelphia, Pennsylvania.<sup>134</sup> This is an excerpt from the 2014 guidelines published by the American Congress of Obstetricians and Gynecologists aimed at reducing cesarean sections:

- *Allowing* prolonged latent (early) phase labor.

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<sup>132</sup> Kathi Valeii, “My uterus doesn’t make me a child; I don’t need your permission,” *Birth Anarchy*, <http://birthanarchy.com/uterus-child-permission>, accessed 2 July 2014

<sup>133</sup> Nancy Shute, “Doctors urge patience, and longer labor, to reduce c-sections,” *NPR*, 20 February 2014, (emphasis added) <http://www.npr.org/blogs/health/2014/02/20/280199498/doctors-urge-patience-and-longer-labor-to-reduce-c-sections>

<sup>134</sup> Ian Bush, “Under The Knife Too Often: Study Finds Local Hospitals Perform Many Unnecessary C-Sections,” *CBS Philadelphia*, 9 May 2014 (emphasis added), <http://philadelphia.cbslocal.com/2014/05/09/under-the-knife-too-often-study-finds-local-hospitals-perform-many-unnecessary-c-sections/>

- Considering cervical dilation of 6 cm (instead of 4 cm) as the start of active phase labor.
- *Allowing* more time for labor to progress in the active phase.
- *Allowing* women to push for at least two hours if they have delivered before, three hours if it's their first delivery, and even longer in some situations, for example, with an epidural.
- Using techniques to assist with vaginal delivery, which is the preferred method when possible. This may include the use of forceps, for example.
- Encouraging patients to avoid excessive weight gain during pregnancy<sup>135</sup>

Birth activist Cristen Pascucci writes: “What woman, who has experienced nine months of language like ‘we can’t let you’ and ‘you’re not allowed’ is going to suddenly have the wherewithal to refuse an unnecessary surgery—or to even know she has the right to do so?”<sup>136</sup> This is in addition to many women being socialised into not being ‘difficult’ — a trait that is also beneficial in a compliant patient,<sup>137</sup> even though deferring to medical authority and fearing being labeled ‘difficult’ is not solely a feminine trait.<sup>138</sup> Therefore, even if women are told they have choices in their labour and birth, the uneven status between the patient and the provider makes that choice hard to realise.

Michele Crossley describes how an intervention was performed on her without her informed consent: “As she gave me a vaginal examination, I was unsure what was happening. I felt a slight brush against the tip of my uterus and surmised that this might be a ‘vaginal sweep’ to try and induce me. As she took off her gloves and gestured for me to get up, I asked her ‘Was that a sweep?’ She said yes. Then, she left the room and went

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<sup>135</sup> The American Congress of Obstetricians and Gynecologists, “Nations’ Ob-Gyns Take Aim at Preventing Cesareans,” February 19, 2014. [http://www.acog.org/About\\_ACOG/News\\_Room/News\\_Releases/2014/Nations\\_Ob-Gyns\\_Take\\_Aim\\_at\\_Preventing\\_Cesareans](http://www.acog.org/About_ACOG/News_Room/News_Releases/2014/Nations_Ob-Gyns_Take_Aim_at_Preventing_Cesareans) Accessed July 4th, 2014, emphasis added.

<sup>136</sup> Cristen Pascucci, “You’re not allowed to not allow me,” *Birth Monopoly*, accessed 27 June, 2014, <http://birthmonopoly.com/allowed/>

<sup>137</sup> Davis-Floyd, 30.

<sup>138</sup> Dominick L, Frosch, Suepattra G May, Katharine a S Rendle, Caroline Tietbohl, and Glyn Elwyn. 2012. “Authoritarian Physicians and Patients’ Fear of Being Labeled ‘Difficult’ among Key Obstacles to Shared Decision Making.” *Health Affairs (Project Hope)* 31 (5): 1030–38.

to get the midwife.”<sup>139</sup> It is in this way, she describes, that women’s choices are not respected on the ‘quotidian level’, that is, in the everyday interactions between women and their health care providers. Following McCallum, choice in childbirth is complex, and rather than a straight-forward result of the philosophy or approach of either the mother or her health care providers, it is based on “routine, everyday interactions between the birthing woman, the obstetrician, hospital routines and her family.”<sup>140</sup>

More grave are the situations where women’s bodily autonomy is completely overridden and they are subject to unwanted interventions or surgery. Several cases of women given c-sections against their will have been documented.<sup>141</sup> In a case in 2011 the notes from the doctor read: “The woman has decisional capacity. I have decided to override her refusal to have a C-section. Her physician ... and hospital attorney ... are in agreement.”<sup>142</sup> This is despite the clear right that all patients have to deny treatment, regardless of whether or not they are carrying a fetus. The (perceived) rights and wellbeing of the fetus are privileged over the mother’s, in what has been termed foetucentric discourse.<sup>143</sup> This foetucentric discourse means that almost any intervention is considered justifiable if it is considered being for the benefit of the fetus, regardless of the effects on the mother: “a healthy baby trumps all previous violations and the end

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<sup>139</sup> Crossley, 553.

<sup>140</sup> Crossley, 546.

<sup>141</sup> Heather Cahill, “An Orwellian Scenario: Court Ordered Caesarean Section and Women’s Autonomy.” *Nursing Ethics* 1999 6(6): 494–505.

<sup>142</sup> Emily Shire, “The Mom Forced to have a C-Section,” *The Daily Beast*, 6 June 2014, <http://www.thedailybeast.com/articles/2014/06/05/rinat-dray-s-forced-c-section-how-doctors-forget-pregnant-women-have-rights-too.html>

<sup>143</sup> Austyn Snowden, Colin Martin, Julie Jomeen, and Caroline Hollins Martin. 2011. “Concurrent Analysis of Choice and Control in Childbirth.” *BMC Pregnancy and Childbirth* 11 (1). BioMed Central Ltd: 40. doi:10.1186/1471-2393-11-40. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3123250&tool=pmcentrez&rendertype=abstract>. 8.

justifies the means.”<sup>144</sup> The mindset that allows for physicians to override women’s bodily autonomy like this is patriarchal and built on ideas of women as weak, of their bodies as defective, and of technology as the preferred method for the doctor to ‘save’ the baby from the mother, and the mother from herself.

The health care provider, especially the obstetrician in the hospital, has both authoritative knowledge as well as the backing of an entire institution built around the authority and position of the doctor. Crossley examined her own birth experience in the context of the rhetoric of choice. She found that she was unable to advocate effectively for herself within the delivery room, due to, among other factors, the significant power differential that existed between her and her care providers, even though she was well informed on different birth practices and had a strong desire for a low-intervention birth. “[A]s events unfolded, I had ‘little power to resist the doctor’s claims to authoritative knowledge’ ... or to exercise any kind of ‘choice’ over the birthing process. I could not argue against the medical professionals with regard to the risks posed because I had no knowledge or practice base from which to do so.”<sup>145</sup> She continues: “This really begs the whole question. On what basis can lay people, in the context of the birthing encounter, claim the knowledge, authority and confidence to challenge the decisions of medical professionals?”<sup>146</sup> Informed consent is, therefore, not always present in birth management. Not only do the power differences make full consent difficult, but the informed aspect of it is also frequently lacking, as it is not clear women are always fully

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<sup>144</sup> Snowden et al, 9.

<sup>145</sup> Crossley, 559.

<sup>146</sup> Crossley, 559.

informed of the possible consequences of various interventions.<sup>147</sup> The identity and background of the woman giving birth will also affect how she is treated. Martin describes how white women, during labour, would get away with much more hostile behaviour than women of colour, such as kicking and biting, but still receive care, while young women of colour would not have the procedures explained to them and sometimes be denied pain medication.<sup>148</sup> This again becomes a part of (popular) culture, where women start expecting managed births, interventions are normalised and conceptualised as necessary, and the medical model's hold on birth becomes even stronger. In a study done on reality television featuring births in the United States in 2007, the researchers found that complications were presented as expected in almost every birth, women's bodies were depicted as faulty and prone to malfunction and that doctors were shown as having the means to 'fix' and 'save' these women and their babies through the use of technology, as interventions were described as normal and expected.<sup>149</sup>

The conceptualisation of maternity care through risk has changed the approach towards birth and also the birth attendants. "Birthing is no longer a purely 'natural' process in which the outcomes are the product of chance and adverse outcomes are unpreventable 'accidents'. It is increasingly viewed as 'man-made', and therefore adverse outcomes cannot be accidental."<sup>150</sup> This mode of thinking indicates that someone must always be responsible for adverse outcomes, as they could have been prevented. This

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<sup>147</sup> Beckett, 265.

<sup>148</sup> Martin, 1987, 137.

<sup>149</sup> Theresa Morris and Katherine McInerney, "Media Representations of Pregnancy and Childbirth: An Analysis of Reality Television Programs in the United States." *Birth* (Berkeley, Calif.) 37 (2) (2010):

<sup>150</sup> Scamell, Mandie, and Andy Alaszewski.. "Fateful Moments and the Categorisation of Risk : Midwifery Practice and the Ever-Narrowing Window of Normality during Childbirth." *Health, Risk & Society* 14(2) (2012): 207–21.

interacts with surveillance medicine and defensive medicine and means that ‘doing something’ becomes the preferred mode of dealing with births, rather than waiting and seeing how it turns out, which again interacts with the cascade of interventions and further pushes births into medicalised and managed territory. It also intersects with the pressures of appropriate motherhood, whether mothers are expected to sacrifice for their children. Women are expected to perceive risk to their own bodies differently than risk to their children’s: “good mothers make sacrifices for their children, and surgical birth may be one of those sacrifices.”<sup>151</sup>

The consequences of this surveillance and medicalisation are frequently gendered. “Women feel pressure, exerted by medical professionals, agencies of the state, women’s magazines and pharmaceutical marketers to monitor their diets, weight, appearance, activities, behaviours and thoughts for any signs of abnormality or illness. During pregnancy this surveillance effort is increased, as medical doctors and nurses conduct tests to ensure that mothers are complying with best medical practices and fetuses are developing normally.”<sup>152</sup> This turns the body into a project and ensures that one can never understand oneself as in a state of health, but always in that ambiguous space between good and bad health with risk factors leading the way. This insecurity about the body that is instilled in women, particularly around their reproductive capacities, is an important aspect of patriarchal body politics that needs to be examined. It is in addition to the pressures and gendered surveillance that many women experience in a patriarchal society, where they are pressured to perform appropriate femininity by, for

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<sup>151</sup> Beckett, 267.

<sup>152</sup> Candace Johnson, “The Political ‘Nature’ of Pregnancy and Childbirth.” *Canadian Journal of Political Science* 41(4) (2008), 894.

example, attaining a certain body size and shape, move in space in a prescribed way and turn their body into an ornament.<sup>153</sup> This all influences how a woman may interact with her health care providers and how she may perceive her ‘right’ to have a statistically abnormal labour, or whether it is her ‘job’ to ‘perform’ her labour in accordance with the standards set for her, and thus submit to whatever interventions she is offered to normalise her labour and birth.

### **Conclusion**

It is not my intention to evaluate the benefits of Surveillance Medicine on the overall health of populations and whether they are worth the costs. What I suggest is that with the application of surveillance medicine to birthing, the medicine system has assumed control over pregnant women and their births. Everything is measured and used as a prediction ‘factor’ to determine ‘risk’ of adverse outcomes. This system encourages the birthing woman to internalise her own surveillance and compliance. The intensity of these surveillance mechanisms — the blood tests, the weigh-ins, the fetal heartbeat monitors — have their own effects, aside from giving information that can be used to determine whether services are required according to the parameters inherent in this philosophy. The surveillance itself has effects, such as having monitors strapped to one’s belly while labouring and giving birth, as they significantly restrict movement. Prioritising access to the fetus at all times over the comfort of the mother, disregards the idea that the wellbeing of the mother will affect the process of labour. Actively managed birth and surveillance childbirth together make for an environment that has already pathologised a woman’s birth, and as such she is always already in a state of danger and

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<sup>153</sup> Sandra Lee Bartky, “Foucault, Femininity, and the Modernization of Patriarchal Power.” in *The Politics of Women’s Bodies: Sexuality, Appearance, and Behavior*, ed. by Rose Weitz. New York: New York University Press, (1998), 27.

abnormality, which means that making her own decisions about her body and her birth and/or having it take place on her own terms is challenging. Women may internalise this approach towards their bodies and their birth, expecting danger and medical intervention, even calling for it. This atmosphere means that “all births were potentially hazardous, and normality could only be recognised in hindsight, after a woman had given birth to her baby and was no longer in the crisis of labour.”<sup>154</sup>

In the context of the pathologisation of women’s bodies, medicalisation of childbirth restricts women’s choices in birth in several ways. The limits between appropriate health care and overuse of various interventions can be hard to determine, but various factors limit women’s abilities to make their own decisions about their bodies and birth. The structure of hospitals means that there is frequently limited time allotted to each woman’s labour, the institutionalisation of the active management of birth means that births are expected to follow a certain time line and those that stray outside of the prescribed path are pushed back on with various interventions. The interventions can form a cascade, where one calls for the next one, often without the woman giving birth being appropriately informed or able to make a decision on what path she wishes her birth management to take. Litigations, high insurance costs and defensive medicine may encourage physicians to intervene more, rather than less, in births, and the effects of surveillance and the philosophy that no birth is normal until it is over, mean that all births are treated as if they are dangerous. The rhetoric of risk plays a large part in treating all births as being at various levels of risk of pathology taking place and anticipating it,

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<sup>154</sup> Scamell and Alaszewski, 213.



which means that “normal” births are hard to attain and women have restricted ability to make their own choices about their own births.

### Chapter 3: The politics of choosing birth

Women's choice and control over their births is limited under medicalised birth, at least the kind of medicalised birth that was practiced in the United States from the 1920s to the 1970s. While some women may have preferred the medically managed births that were on offer, it is difficult to call it choice if that was the only option available. Significant resistance has been mobilised to medicalised birth, mostly by what can be called the natural childbirth movement. This movement has enabled women to have a wider range of choices about their birth, and in response to this movement medicalised birth has changed.<sup>155</sup> While many women have been able to use the tools of this movement to have births that align closer with their interests and desires, the natural childbirth movement and the rhetoric of choice also constrain women's abilities to make their own choices about their births. Some of this resistance falls into either a nostalgic and conservative "back to nature" camp, which valorises a connection between femininity and nature in a way that may put expectations on women to uphold conservative and limiting forms of femininity and motherhood, or it falls into the neoliberal camp of positioning mothers as individual consumers, exhorting them to take responsibility for their own birth and experiences, while paying insufficient attention to the structural barriers that shape women's experiences, both outside the delivery room and within it. This places too much responsibility on individual women to choose the 'right' birth experience, and thus the blame is theirs if they 'fail.' This individualistic approach is revealed when women are applauded for organising and achieving birth in a particular way, in line with what has been termed healthism. In this way, choice is a

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<sup>155</sup> Rothman, 56.

limited concept when it comes to reproductive politics. A more fruitful approach is to look at a birth in the context of a woman's life rather than as an isolated event. It will be argued that while all of these approaches to the resistance of medicalised childbirth have made certain gains, full freedom in how to give birth will not be reached without a reproductive justice approach, where a woman's entire physical, social, emotional and economic wellbeing is centred.

### **The natural childbirth movement**

The natural childbirth movement has arisen largely in response to the medicalised birth system and claims to offer women choice in how to birth. This disparate movement, amalgamated from various backgrounds, is not unified, and has campaigned for various goals such as licensing of midwifery, access to vaginal births after cesarean sections, support for women who have had cesarean sections, decriminalisation of home births and unassisted births, changes in hospital birth, doula training, the right to retain the placenta after birth and more. There are overlaps between the natural childbirth movement and movements against vaccination and those for more alternative health approaches such as homeopathy, but there are also staunch supporters of science within the natural childbirth movement, calling for more evidence-based care. What unifies this movement is a commitment to expanded choice in childbirth and an alternative to medicalised birth.

The start of a movement for natural childbirth, or childbirth alternative, can be traced to a book titled *Natural Childbirth* by Grantley Dick-Read, published in 1933 in England and 1944 in the U.S.<sup>156</sup> Dick-Read, an English obstetrician, is supposed to have attended a woman in labour and birth in a quiet, calm environment and, during the

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<sup>156</sup> Rothman, 21.

pushing stage, offered her pain relief which she refused. When asked why, after the birth, she responded: “It didn’t hurt. It wasn’t meant to, was it, doctor?”<sup>157</sup> This experience led Dick-Read to form a theory about the connection between fear and pain. Fear inhibits the ability to relax, which causes muscles to contract, which makes childbirth painful:

fear, pain and tension are the three evils which are not normal to the natural design, but which have been introduced in the course of civilization by the ignorance of those who have been concerned with attendance at childbirth. If pain, fear and tension go hand in hand, then it must be necessary to relieve tension and to overcome fear in order to eliminate pain.<sup>158</sup>

Dick-Read’s book was published in the United States in 1944 as *Childbirth without Fear: The Principles and Practices of Natural Childbirth*. In it Dick-Read wrote of the importance of relaxation techniques but most significantly, of the importance of continuous emotional support: “No greater curse can fall upon a young woman whose first labor has commenced than the crime of enforced loneliness.”<sup>159</sup>

Many women attempted to use Dick-Read’s methods in their births in the United States around the middle of the century. They refused the pain medication offered by the hospital staff, attempting to use the relaxation techniques instead, but the environment was adverse. The continual support that Dick-Read determined as so important was not available. “They were confined to labor beds, they shared labor rooms with women who were under scopolamine, and their screams, combined with the repeated offering of pain-relief medication by the hospital staff, reinforced the fear of birth that Dick-Read set out

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<sup>157</sup> Dick-Read 1944: 2, as cited in Rothman, 22.

<sup>158</sup> Dick-Read, 1944, 5-6, as cited in Rothman, 22.

<sup>159</sup> Dick-Read, 1944, 155, as cited in Rothman, 23.

to remove. The results were generally perceived as failures of the method or failures of the individual woman.”<sup>160</sup>

A different method that combined relaxation techniques with the realities of hospital births in the United States in the twentieth century had more success. Lamaze, or the psychoprophylactic method, was developed in the Soviet Union and was implemented there as the official approach to childbirth in 1951. It was based on a similar insight as Dick-Read’s childbirth without fear, that women had learned to associate fear and pain with the uterine contractions, and with training could unlearn this, or retrain themselves to associate differently with techniques such as breathing exercises.<sup>161</sup> A French obstetrician, Ferdinand Lamaze along with Pierre Vellay, observed these techniques in Russia and introduced them in Paris with minor changes, then published a book titled *Painless Childbirth* in 1956. A woman who gave birth with Dr. Lamaze then wrote a book about her experiences and published it in the United States in 1959, following which she and others founded ASPO, the American Society for Psychoprophylaxis in Obstetrics.<sup>162</sup>

Rothman writes that the Lamaze approach did not challenge the authority of obstetricians as it only replaced pharmacological control of pain with psychological tools. Women were still encouraged to heed the words of their doctors. “It is most important to stress that her job and his [sic] are completely separate. He is responsible for her physical well-being and that of her baby. She is responsible for controlling herself and her

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<sup>160</sup> Rothman, 23-24.

<sup>161</sup> Rothman, 24-25.

<sup>162</sup> Rothman, 25.

behaviour.”<sup>163</sup> Other routine aspects of hospital birth at the time were included in the original Lamaze instructional method; shaves, enemas, restraints, and no mention was made of other aspects of the hospital birth environment that were critiqued, such as lack of support for breastfeeding and separation of mother and baby following the birth. Lamaze became popular, however, and partially through its popularisation husbands and partners started becoming a regular presence in delivery rooms. Women who employed the Lamaze techniques were able to stay conscious throughout the birth, and control their pain to a certain degree, which is a far cry from the unconscious, sedated, alienated birth experiences that many women previously had endured. However, this does not mean that women had power and control over their entire situation. Rothman argues that Lamaze succeeded while Dick-Read’s approach failed because it took into account the realities of hospital birth and worked with it, rather than challenging or ignoring it, but this also meant that the ability of Lamaze to change the hospital birth environment was limited.<sup>164</sup>

In the early 1970s various movements took place that started pushing for a different kind of birth experience than what was available in hospitals. Ina May Gaskin, along with her husband Stephen Gaskin and others, founded The Farm, a spiritual community in Tennessee, where she and others fashioned their own maternal health care system and developed midwifery skills.<sup>165</sup> Other similar communities were founded elsewhere in the United States, partially inspired by the civil rights movement and the women’s health movement. In many states where the alternative childbirth movement started gaining hold, physicians perceived it as a threat to their profession and both

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<sup>163</sup> Bing and Karmel, 1961, ASPO training course, p. 33, as cited in Rothman, 50.

<sup>164</sup> Rothman, 26.

<sup>165</sup> Katherine Beckett and Bruce Hoffman, “Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth” *Law & Society Review* 39(1) (2005), 131.

refused to serve the women that participated, but also pushed to criminalise midwifery. While licensure and institutionalisation was not the initial goal of many of these alternative communities and movements, after midwives were prosecuted, a movement to create a midwifery profession was started and was ultimately successful.<sup>166</sup>

## **Midwifery**

Today, while there are certainly many different ideas about what natural birth consists of, some of them can be crystallised in the midwifery model of care. This term, coined by Barbara Katz Rothman, has now been trademarked by the Midwifery Task Force, and is used and endorsed by various midwifery organisation, such as the Midwives' Alliance of North America (MANA). The midwifery model of birth is “woman-centered” and “based on the fact that pregnancy and birth are normal life events.”<sup>167</sup> The model has further been described: “[m]idwifery is a woman-centred, political, primary health care discipline founded on the relationships between women and their midwives.”<sup>168</sup> Midwifery rhetoric tends to centre around the concepts of ‘normal’ and ‘natural.’ According to Rothman, both the medical model and the midwifery model emerged out of specific contexts and had to justify the existence and legitimacy of their respective professions: “Medicine had to emphasize the disease-like nature of pregnancy, its ‘riskiness,’ in order to justify medical management. Midwifery, in contrast, had to emphasize the normal nature of pregnancy in order to justify nonmedical control in a

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<sup>166</sup> Beckett & Hoffman, 134.

<sup>167</sup> Midwives Alliance of North America, “Midwifery Model,” <http://www.mana.org/about-midwives/midwifery-model> accessed July 1 2014.

<sup>168</sup> Kathleen Fahy, “What Is Woman-Centred Care and Why Does It Matter?” *Women and Birth : Journal of the Australian College of Midwives* 25(4) (2012): 150.

society in which medicine has a monopoly on illness management.”<sup>169</sup> The midwifery model can be summed up as follows:<sup>170</sup>

<b>The midwifery model</b>	<b>The medical model</b>
The woman maintains power and authority over herself.	Power and authority are handed over to the physician and institution.
Responsibility is in the hands of the woman herself, shared with her midwife.	Responsibility is assumed by the physician.
The goal is to assist the woman toward self-care as a healthy person in a state of normalcy.	The woman is encouraged to be dependent and is treated as potentially ill and in an abnormal state.
The mother and baby are a unit whose medical and emotional needs are complementary; what meets the needs of one meets the needs of both.	The mother and baby are separate patients whose medical and emotional needs may conflict; the mother's emotional needs may jeopardize the baby's health.
The woman's body is a well-functioning home for herself and her baby. Its needs and workings are best known by the woman herself.	The woman's body is a mechanical organism that needs fixing. Its needs and workings are best known by the physician.
The emphasis is on pregnancy and birth as times of physical/ psychological/ emotional growth for the mother and fetus.	The emphasis is on pregnancy and birth as times of stress and danger.
Childbirth is seen as an activity that the healthy woman engages in.	Childbirth is seen as an occasion for the provision of medical services.
The midwife guides and educates the woman during her experience.	The physician manages the care of the woman.
Childbirth is seen as an event in the lives of the woman and her family. The woman's active birth-giving is enhanced by education, support, and skilled care.	Childbirth is seen as a surgical procedure (obstetrics is a surgical specialty) performed on the pelvic region of a woman, involving the removal of a fetus and placenta.

<sup>169</sup> Rothman, 52.

<sup>170</sup> Reproduced from *Midwifery, Pregnancy and Birth: The Midwifery Model*. Adapted from *In Labor: Women and Power in the Birthplace* by Barbara Katz Rothman, 1991. *Midwife and doula services*. <http://www.midwifeanddoula.com/midwiferymodel.htm>



With care that follows the midwifery model, women's agency is respected.

“Choices are expanded for location and type of care, and women are included, recognized and respected as ‘subjects’ in the experiences of pregnancy and childbirth, rather than treated as passive patients receiving care from medical personnel.”<sup>171</sup> There is no guarantee that all midwives practice within this model. Some midwives, especially those who are closely aligned with the medical system, may be risk-averse and interventionist: “Midwifery practice [in the UK] coalesced around an apparently irresistible desire to anticipate and avoid even the smallest possibility of an adverse outcome, even when this might involve abandoning any commitment to the notion of normality.”<sup>172</sup> It is also important to note that in many places, especially in the US, midwives are only allowed to practice with either the supervision of a physician or an OB/GYN, or are dependent on the back-up services of a doctor, and frequently the physicians decide where the limits of ‘low-risk’ are, which midwives are obligated to follow, either due to the supervisory relationship or in order to keep their backup doctor on good terms. The independence of the profession is therefore limited.<sup>173</sup>

### **Slippery natural slope**

The term ‘natural’, in the context of natural birth, is ambiguous, and what exactly it means in this context is debated. Bledsoe and Scherrer analysed various magazines, websites and chatrooms aimed at mothers and mothers-to-be, and claim that in a popular

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<sup>171</sup> Johnson, 892.

<sup>172</sup> Scamell & Alaszewski, 213.

<sup>173</sup> Beckett & Hoffman.

US usage ‘natural’ refers to delivery and ‘normal’ to outcome (health of mother and baby).

If the outcome was normal, then the process must have been natural — or at least it should have been. If the woman was on good terms with the doctor, and both agreed on the types of actions that were appropriate and when they ought to take place, then the process must have been natural. ... If, on the other hand, the woman disagrees with the actions undertaken by her doctor, she is more likely to label them as interventions and the process as not having been natural.<sup>174</sup>

Natural birth can, therefore, mean everything from a completely non-medical birth where the mother gives birth outside the hospital, either unassisted or with a midwife, ideally a direct-entry midwife rather than a nurse-midwife, completely on her own turf and terms, to a hospital birth with minimal intervention, to a medicated vaginal birth, or even more, depending on the ‘nature’ of the relationship with the care provider.

For me a birth is natural when I can keep the child close to me and do what I feel right in the process, whether I will use technologies or I won't. First and foremost the natural in birth means my choice and my decisions. If I feel that an intervention is necessary it is not against the idea of a natural birth, nor is the use of medicine<sup>175</sup>

said a woman who had a home birth in Finland. The concept of natural, or normal, is also elastic within midwifery. A study on midwives in the UK found that since they were so committed to normal birth, everything that midwives did was, therefore, part of normal birth: “Midwifery activity, even when it is directed towards interfering with the physiological birth process or introducing pharmaceutical agents to disrupt the woman’s experience of birth, coincided with normality to such an extent that they become virtually one in the same thing – a normal birth was a midwife-managed birth.”<sup>176</sup> Despite the

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<sup>174</sup> Bledsoe & Scherrer, 58.

<sup>175</sup> Kirsi Viisainen, “Negotiating Control and Meaning: Home Birth as a Self-Constructed Choice in Finland,” *Social Science & Medicine* 52(7) (2001), 1116.

<sup>176</sup> Scamell & Alaszewski, 214.

professed intentions of the natural birth movement to expand alternatives to medicalised birth, it can still constrain women's choices in childbirth. Either by conflating medicalisation and health care and rejecting both in a search for empowerment, or by uncritically valuing 'the natural,' which can fall into gender essentialism.

Even though medicalisation as a whole has pathologised women's bodies and the medical dominance that exists within current Western medical culture, and its intersections with state power that can regulate women's bodies to the extent that they can be given court-ordered cesarean sections against their will, medicine and various technological interventions in the body and in birth can be used for women's comfort, desire, empowerment and health care. An obvious example here is abortion, but voices for the demedicalisation of abortion are few and far between. On the contrary, pro-choice voices frequently position abortion access as an integral aspect of women's health, and a private matter between her and her doctor.<sup>177</sup> Though more 'natural' abortifacents certainly exist, such as various herbs, there is little movement towards championing them as the path to women's empowerment. Rather, safe abortions provided by trained health care professionals are called for, especially in those areas where access to abortions is restricted or criminalised. The push for a natural approach to childbirth can seem peculiar in this context. The difference is that birth can follow a physiological path that can get derailed if interfered with, nevertheless this brings up questions about where the line lies between creating the kind of optimal conditions for physiological birth and urging women to associate themselves with what has historically been used to subordinate women: domesticity and 'nature.'

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<sup>177</sup> Ehrenreich and English, 2011, 3.

While there are clear parallels between the natural childbirth movement and feminism, that link is not absolute.<sup>178</sup> There is a strong current within the movement that wants to revalue the feminine. That is not incompatible with feminism. Cultural feminists, in particular, have tried to focus on the positive aspects of a women's culture, although there is no clear consensus on whether or how to reconcile valuing femininity in a patriarchal society without reinforcing sexist attitudes towards women and femininity.<sup>179</sup> Phipps suggests that the natural childbirth movement falls into "gender essentialisms in its appeals to women's innate abilities and desires to birth and nurture."<sup>180</sup> She continues: "Within this discourse, 'normal' or 'natural' birth is positioned as a defining moment of womanhood, a positive life-changing and even spiritual experience. ... Achieving 'normal birth' is equated with women's empowerment."<sup>181</sup> In the U.K., birth activists and the midwifery movement were successful in their advocacy for natural and 'normal' birth on a policy level in a way that did not happen in the U.S.<sup>182</sup> 'Normal' birth (defined as a birth that started and ended spontaneously, without intervention) became a goal to be achieved, with the implication that "almost every woman was able to birth 'normally,' so the focus should be on proactively attempting to reduce levels of intervention rather than merely ensuring that low-risk women were not interfered with."<sup>183</sup> This meant that 'normal' birth was

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<sup>178</sup> Beckett and Hoffman.

<sup>179</sup> Bowden and Mummery, 20.

<sup>180</sup> Alison Phipps, *The Politics of the Body: Gender in a Neoliberal and Neoconservative Age* (Cambridge, UK: Polity Press, 2014) 114.

<sup>181</sup> Phipps, 114.

<sup>182</sup> Phipps, 106.

<sup>183</sup> Phipps, 107.

promoted and statistics about ‘normal’ birth were used to measure the quality of care, and became normalised to such an extent that it has been called hegemonic.<sup>184</sup>

This rhetoric aligns closely with conservative ideas about women and motherhood. Parallels can also be seen here with the pressure to withstand difficult births in order to give the baby the best possible start in life. In this discourse the woman is expected to sacrifice herself and her body for her child, but while within medicalised discourse that may be through surgery or various other interventions on the woman’s body, here it is by avoiding these interventions and withstanding the pain, casting “motherhood as an experience which allows women to find and fulfil themselves through self-sacrifice. In this narrative, withstanding the ordeal of childbirth is the route to authentic motherhood.”<sup>185</sup> Again, stereotypes and gender expectations of the sacrificing mother impact what choices are available to women and the different values of these choices. This discourse also leaves out those whose home may not be a safe haven, such as women in abusive relationships, those living in poverty, or otherwise wishing to escape or change their home situations, and for those on whom domesticity may have been forced, and not something they wish to reclaim.

## **Choice**

Chapter 2 examined how choice within the medical system can be limited, with the power differences that exist between care provider and patient, with the cascade of interventions where one intervention calls for another, and with the institutional constraints of the hospital. Technological advances have certainly multiplied the options available when it comes to reproduction, both in terms of conception, how to manage and

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<sup>184</sup> Phipps, 130.

<sup>185</sup> Phipps, 115.

treat pregnancies, as well as different options for birth. This is easily conceived of as a good thing. “This moment [of greater technological possibilities in reproduction] provides unparalleled reproductive choices for women in navigating their reproductive lives. For many feminists, choice has been the goal of their political and scholarly activities and, so for them, this current moment should constitute a major victory.”<sup>186</sup> It is therefore easy to understand that focusing on choice in birth is an appropriate and pursued goal, both because women are persons and as such have the right to determine their actions and fate as much as they are able, but also because choosing the mode and location of delivery may be one of the ways to make a woman feel like she has control over the birth process and as such, improve her wellbeing and the likelihood of the birth going well. However, what exactly choice means in this context is complex.

Many champion choice when it comes to birthing. Physicians and representatives of the American College of Obstetricians and Gynecologists argued that women should be allowed to choose the mode of birth, even if this was more frequently heard when their decision to choose a cesarean section was being discussed, rather than their decision to choose to birth at home or in a birth centre.<sup>187</sup> Proponents of the natural childbirth movement and those who fought for licensing of midwifery argued that women should be able to choose the location and provider for their birth.<sup>188</sup> They should be able to choose what kind of interventions they want, choose their doctor or midwife, choose the location for their birth, and enshrine this all in a birth plan. However, one cannot just “choose” their way out of difficult situations. McCallum, in researching the high cesarean rate in

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<sup>186</sup> Johnson, 890.

<sup>187</sup> Beckett, 261.

<sup>188</sup> Beckett and Hoffman, 148.

Brazil, argues that “it is not enough to focus on the choices made by the subjects who participate in the events surrounding childbirth. Rather, subjects’ understandings and actions only make sense when seen in relation to the context that conditions their actions.”<sup>189</sup> When it comes to the actual interactions in the examining or delivery room, “women have little power to resist the doctor’s claims to authoritative knowledge. Thus, women’s capacity to choose is severely compromised from the start.”<sup>190</sup>

Alison Phipps critiques “the notion of ‘informed choice’” as a “coercive device which can produce shame and feelings of failure in women unable to make the ‘right’ choice for structural reasons.”<sup>191</sup> The natural childbirth movement’s celebration of choice sometimes does not extend to non-natural choices and can veer into shaming of those mothers who choose medical interventions for their births. This can be seen, for example, in the negative attention that Victoria Beckham received for scheduling cesarean sections for her sons, dubbed “too posh to push,” as well as calls to put warnings, like those found on tobacco products, on formula packages.<sup>192</sup> According to this thinking, choice is great, as long as you choose the right thing.

This can lead to women to internalise the fault for their birth experiences, if they did not go according to plan. Crossley, in her discussion of her own birth experience, writes: “I truly believed, by preparing and acting in the appropriate manner, that it would be possible to transcend above and beyond the pain and to bring the child forth through ‘natural’ physical and psychological processes.”<sup>193</sup> Phipps writes that “within this

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<sup>189</sup> McCallum, 216.

<sup>190</sup> McCallum, 230.

<sup>191</sup> Phipps, 134.

<sup>192</sup> Phipps, 127.

<sup>193</sup> Crossley, 557.

framework of compulsory empowerment through ‘informed choice’, deviant behaviours are positioned as being a product of ignorance or weak-mindedness, rather than affirmative choices in favour of an alternative.”<sup>194</sup>

These debates yield interesting results in areas with high intervention rates. Béhague has researched birthing in Brazil, which has one of the highest cesarean section rates in the world, with a country-wide average of 52% in 2010,<sup>195</sup> and up to 70% in some private hospitals.<sup>196</sup> In Brazil, a cesarean section may be a response to a medicalised birth. According to a researcher at the National Public Health School at the Oswaldo Cruz Foundation in Brazil, “Here, when a woman is going to give birth, even natural birth, the first thing many hospitals do is tie her to the bed by putting an IV in her arm, so she can’t walk, can’t take a bath, can’t hug her husband. The use of drugs to accelerate contractions is very common, as are episiotomies. ... What you get is a lot of pain, and a horror of childbirth. This makes a cesarean a dream for many women.”<sup>197</sup> Augmented labours without pain medication may make the cesarean section an appealing alternative. Race and class also play a significant role. According to Dr. Simone Diniz, an associate professor in the department of Maternal and Child Health at the University of Sao Paulo, “In our culture, childbirth is something that is primitive, ugly, nasty, inconvenient. ... It is something poor women are supposed to endure.” In this context, wealthier women with access to private health care system seek and use c-sections as a

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<sup>194</sup> Phipps, 128.

<sup>195</sup> World Health Organization, Global Health Observatory Data Repository, Region of the Americas: Brazil statistics summary (2002 - present) <http://apps.who.int/gho/data/?theme=country&vid=5200442>

<sup>196</sup> Dominique P. Béhague, “Beyond the Simple Economics of Cesarean Section Birthing: Women’s Resistance to Social Inequality.” *Culture, Medicine and Psychiatry* 26 (2002): 477.

<sup>197</sup> Juliana Barbassa, “Brazil’s Women Rebel Against C-Section,” *Huffington Post*, 8 November, 2012, [http://www.huffingtonpost.com/2012/08/11/brazils-women-rebel-again\\_n\\_1767972.html](http://www.huffingtonpost.com/2012/08/11/brazils-women-rebel-again_n_1767972.html)



status symbol, as they are considered “modern and elegant.”<sup>198</sup> In the context of economic inequality and citizens’ lack of faith in the government’s ability to provide adequate care, more health care in the sense of more technological care, such as c-sections, was both something that women sought to avoid the pain and discomfort and perceived risk of vaginal birth, but also a way to access more care for themselves from a perceived sub-par public health care system.

Béhague points out that:

A naive interpretation of these [high caesarean rates] may focus on the use of technology as a politically unjust process that alienates self from body, reducing the amount of control women can have over their bodies. In this way, a more natural birth would theoretically reinstate lost power back into the hands of women. Given this logic, it would be easy to state that Brazilian women’s practices have resulted from ‘mystification’: from a set of technological needs made to appear essential by the system. This sort of analysis homogeneously equates biomedicine with negative control.<sup>199</sup>

She describes how many of the women she interviewed skilfully manoeuvred their physicians into agreeing on a cesarean section which they perceived as being better care.

That is clearly at odds with the arguments from many other feminist scholars and activists who have pointed to the medicalisation and technologification of health care and birth as a sign of alienation from the body, and thus a disempowered birth experience. In this context, criticising women for ‘choosing’ a medicalised birth, without adequate attention to the structures of both the medical system and society in general, misses crucial aspects of the way women’s choices are enabled and constrained.

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<sup>198</sup> Jill Filipovic, “Inside a war on natural birth: C-sections as status symbol and ‘choice’ as a myth,” *The Guardian*, 10 April 2014, <http://www.theguardian.com/commentisfree/2014/apr/10/natural-birth-c-section-choice-brazil-forced-pregnancy>

<sup>199</sup> Béhague, 498.

Similarly, Veronique Bergeron, when discussing cesarean delivery on maternal request which the American College of Obstetricians and Gynecologists recommended be adopted as an option, questions the choice approach. ACOG argued that being able to request a cesarean section at will is an important part of bodily autonomy and reproductive freedom. Bergeron, on the other hand, argues that in the light of medicalisation of childbirth, there are other pressures which influence women's desire for a cesarean section. These are the sexist underpinnings of the medical system and its attempts to normalise birth and the body through various medical interventions. Only when this is fully understood, and alternatives are available, will she recommend cesarean request on maternal demand as an ethical opinion.<sup>200</sup>

### **Healthism and the body project**

The alternative health movement has resisted the medicalisation of birth and attempted to expand options in childbirth for women. There is another layer to some of these ideas and actions that go beyond enabling women to have the best possible birth experience in a manner that they define for themselves. This layer consists of putting value onto different kinds of birth experiences, that some kinds of births, and following some kinds of bodies, are more valuable, more inspiring, more morally worthy. Being able to say "I went all natural" may, to some, be a sign that they gave their own bodies and babies the best possible start in life with the quickest recovery period, and value the pleasure that can be found in fully experiencing a birth even when it is challenging. To others, it may also represent a status either to seek or maintain.

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<sup>200</sup> Veronique Bergeron, "The Ethics of Cesarean Section on Maternal Request: A Feminist Critique of the American College of Obstetricians and Gynecologists's Position on Patient-Choice Surgery," *Bioethics* 21(9) (2007).

Healthism, or making the body perform in certain ways, often using the rhetoric of health, can be seen in debates about birthing. Robert Crawford defined healthism as a “particular way of viewing the health problem ... characteristic of the new health consciousness and movements” such as holistic care.<sup>201</sup> Healthism considers health, both in terms of the problem of health and solutions to it, at the level of the individual. Health has also been elevated “to a super value, a metaphor for all that is good in life.”<sup>202</sup> Individuals become judged not only by their work ethic and personal aesthetics, but also on their health and health practices. It becomes a moral good to be healthy, or to employ practices that are considered leading to health. Of course, health is a precarious concept in this discussion. A person who engages in calorie counting and exercising may appear to be participating in behaviours that are considered leading to health, but may actually have an unhealthy relationship with themselves and with their body, perhaps suffering from an eating disorder. Nevertheless, they get praised for their actions by those who see from the outside; health has become performative. “The individual is now deemed accountable for his or her body and judged by it. ‘Looking after oneself’ is a moral value. The body is becoming akin to a worthy personal project.”<sup>203</sup> Susie Orbach argues:

Late capitalism has catapulted us out of centuries-old bodily practices which were centred on survival, procreation, the provision of shelter and the satisfaction of hunger. Now, birthing, illness and ageing, while part of the ordinary cycles of life, are also events that can be interrupted or altered by personal endeavour in which one harnesses the medical advances and surgical restructurings on offer. Our body is judged as our individual production. We can fashion it through artifice, through the naturalistic routes of bio-organic products or through a combination of these, but whatever the means, our body is our

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<sup>201</sup> Robert Crawford, “Healthism and the medicalization of everyday life,” *International Journal of Health Services* 10(3), (1980): 365.

<sup>202</sup> Crawford, 365.

<sup>203</sup> Susie Orbach, *Bodies* (New York: Picador, 2009) 12-13.

calling card, vested with showing the results of our hard work and watchfulness or, alternatively, our failure and sloth.<sup>204</sup>

The body has become a project and we can showcase it to others and attain status through it. Orbach connects it with capitalism and consumerism: “The numerous industries — diet, food, style, cosmetic surgery, pharmaceutical and media — that represent bodies as being about performance, fabrication and display make us think that our bodies are sites for (re) construction and improvement. Collectively, they leave us with a sense that our bodies’ capacities are limited only by our purse and determination.”<sup>205</sup>

In relation to birthing, Orbach does not distinguish between using the language of science or medicine, or of using “nature”, to alter bodies; both discourses can be used to normalise it and its performance. Phipps is in line here with Orbach, and argues that

[a]chieving ‘normal birth’ and successful breastfeeding can also be conceptualized as a ‘body project’, reflecting the emphasis on bodily maintenance, modification and performance which characterises contemporary neoliberal societies due to the decline of religious formations of identity, the growth of consumer culture, the performative nature of postmodern identities and the emphasis on individual responsibility. ... The new reproductive politics resonates with this model in its individualism, focus on achievement and increasing commodification.<sup>206</sup>

It is in this way that the discourse of the natural childbirth movement can start to ‘empower’ the individual through obligatory achievement, and thus install a sense of failure if that achievement is not reached, in essence adding yet another pressure onto women and their bodies on how they must look and perform in a patriarchal society, going so far as to decree some birthing methods more feminist than others.<sup>207</sup>

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<sup>204</sup> Orbach, 5.

<sup>205</sup> Orbach, 97.

<sup>206</sup> Phipps, 120.

<sup>207</sup> Glosswitch, “The myth of choice: some ways of giving birth aren’t ‘more feminist’ than others,” *The New Statesman*, 2 April 2014. <http://www.newstatesman.com/culture/2014/04/myth-choice-some-ways-giving-birth-aren-t-more-feminist-others>

### **Conflating health care and medicalisation**

It is clear that many women choose and prefer obstetric care and intervention in their births. That choice is made within a context of childbirth being defined as dangerous and risky and the medical system offering safety, but women seek it out nevertheless.<sup>208</sup> “Historically, women have utilized medical practices as a way of achieving freedom from the pain, exhaustion and lingering incapacity of childbirth. Both historically and cross-culturally, women have assented to technological intervention in order to prevent their own and/or their child’s death.”<sup>209</sup> As well, women have sought medicine and technology as a “‘liberation from the tyranny of biology’ and as empowering them to stay in control of an out-of-control biological experience.”<sup>210</sup>

The natural childbirth movement has been criticised for its uncritical denouncement of health care, both from those who are grateful for the medical interventions available, and those that see it as disingenuous, hypocritical or dangerous to criticise health care for pregnant women, especially in light of the high rates of maternal mortality in developing nations. These fall under what Beckett refers to as the “third wave” of feminist medicalisation critics, those that critique the anti-medicine stance that can be found in the second wave of feminist medicalisation criticism.<sup>211</sup> Many of the authors that are critical of the resistance to medicalised birth tend to conflate interventions and health care. Most certainly, the line between these is blurred, and what can be an unnecessary and possibly harmful intervention in one instance can be greatly beneficial in another. However, that does not mean that all medical interventions are, by

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<sup>208</sup> Davis-Floyd, 2004,

<sup>209</sup> Crossley, 545.

<sup>210</sup> Crossley, 546.

<sup>211</sup> Beckett, 258.

definition, health-promoting, or that their usage comes without risk and/or consequences. Bledsoe and Scherrer describe the current shift towards natural birth as the desire for control and to experience the birth, and “the interventions that can save lives ... tucked into the invisible front end of pregnancy or behind wood-paneled walls,”<sup>212</sup> without acknowledging how in some cases the life-saving may become necessary because of interventions in the first place. Similarly, Fox and Worts who astutely analyse the reasons why women might engage in patient behaviour and seek medicalisation, in order to get all the support they can in the context of privatised care for children, do not make a distinction between the services and support that the health care system can offer and the interventions that the hospital rhythm superimposes on women, or the way that starting interventions may lead to the next one.<sup>213</sup>

Candace Johnson points out the inconsistencies in privileged Western women wishing for less medical intervention in their birth at the same time as more medical intervention is called for in poorer areas of the world: “there are no feminist complaints about inappropriateness of (scarce) medical care for pregnant and parturient women in countries with high rates of maternal mortality.”<sup>214</sup> Similarly, Purdy points out that “When we learn that African-American women in the United States die more often in childbirth than white women, and that horrifying numbers of Third World [sic] women are dying as we speak, nobody concludes that preventive action would be morally intrusive. Yet we tend to be bewitched by the claim that menstruation and pregnancy are

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<sup>212</sup> Bledsoe & Scherrer, 63.

<sup>213</sup> Bonnie Fox and Diana Worts, “Revisiting the Critique of Medicalized Childbirth: A Contribution to the Sociology of Birth.” *Gender & Society* 13(3) (1999): 326–346.

<sup>214</sup> Johnson, 897.

natural processes and thus inappropriately dealt with in the medical realm.”<sup>215</sup> This debate might benefit from a better clarification of terms.

Conrad’s definition of medicalisation is neutral in the sense that he does not define it as negative or positive, but rather the process of using medical language, frameworks or interventions to assess or treat a problem.<sup>216</sup> However, as was argued in the first chapter, Western biomedicine is not neutral but rather encompasses a value system, one that sees women’s bodies as dysfunctional and ripe for management and intervention. In this light, health care is not a neutral good that can be consumed to a greater or lesser degree without any ulterior consequences. Therefore, just as it can rightly be criticised when the natural, and especially ‘primitive’ approaches towards childbirth are championed and coopted, without the acknowledgment of just how dangerous childbirth can be in unsafe conditions, it should also be criticised when Western medicine is considered the ultimate solution to maternal health problems in poor areas of the world. That is not to say that access to health care should be restricted – absolutely not – but that *what kind* of health care is offered needs to be scrutinised. This conflation of medicalisation and health care can make it harder for women to exercise their own informed choice about their birth practices, as it may provide them with only two options: ‘natural’ childbirth or medical childbirth. Many may wish to employ the best of both approaches, but when the discourse of natural birth assumes that vaccinations are harmful and that hospitals are terrible places, it may push women who wish to employ health care away.

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<sup>215</sup> Purdy, 254.

<sup>216</sup> Conrad, 1992, 211.

### **The context of women's lives**

“Choice is ... inextricably linked to privilege,”<sup>217</sup> writes Phipps. The mothers that are able to, for example, breastfeed for extensive periods of time either are able to stay at home with their children or have enough autonomy in their workplace to be able to arrange their schedule around breastfeeding. Similarly, home birth takes research and a time and energy investment. Being able to converse or debate with health care providers about the benefits of various birth interventions requires a certain level of literacy and knowledge of science, as well as assertiveness skills that are closely linked with class and race. This also goes for “doctor-shopping” which takes time, good insurance, energy and money. Without sufficient attention to structural conditions of women's lives, discussion of choice can become a distraction and a normalising and disciplining discourse.

Fox and Worts point out that many of the early and influential texts exploring and critiquing the medicalisation of childbirth were written during the time in the women's movement that was dedicated to documenting and showing women's oppression. Therefore, the texts were disproportionately aimed towards showcasing the lack and loss of control women experienced during childbirth. However, this may have overlooked women's agency: “many researchers fail to explore how women might be using medical intervention and what they might accomplish in becoming patients.”<sup>218</sup> In a study conducted in Toronto in the late 1990s, they found a great variance in the factors that influenced how women felt about their own birth. Some of it was in line with the critique of medicalised birth, that the amount of technical and pharmaceutical interventions and the ensuing loss of control made them feel disempowered and alienated from their bodies

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<sup>217</sup> Phipps, 129.

<sup>218</sup> Fox and Worts, 329.



and the process of birthing, but that was not the case for the majority of the women interviewed. Factors like the attentiveness of the hospital staff, length of labour, access to pain relief, and more, seemed also significant, and their experiences to their births, which went from cesarean sections to ‘natural’ childbirths, varied greatly.<sup>219</sup> More important was how each woman felt her needs were being met, regardless of whether the original intent was to go ‘natural’ or not.<sup>220</sup>

Fox and Worts also put the birth in the context of women’s lives. Those that had a strong support network present at and after the birth, in the form of supportive partners and also perhaps extended family, were able to deal with the pain and anxiety without drugs and technology, and also had more favourable birth outcomes in their own assessment. They were also less likely to experience “baby blues,” or post-partum depression. An important insight is that the women who play the role of the patient, perhaps because they have additional health challenges than an uncomplicated pregnancy and birth, and those that sought out more intervention in their birth, such as pain relief, experienced more and better care in the hospital. They were also the ones that could rely on less support outside the hospital. Therefore, the conclusion can be drawn, that in order to seek support and prepare themselves for the hardship of privatised motherhood, they place themselves (both through choice and force) in the “patient” role, suggesting that the “patient” role is the only discourse they had access to where it is acceptable to admit weakness and inability, and need of support.<sup>221</sup> The aspect of the natural childbirth movement that emphasises natural birth as an individual achievement may not leave

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<sup>219</sup> Fox and Worts, 335.

<sup>220</sup> Fox and Worts, 340.

<sup>221</sup> Fox and Worts, 342-343.

space for those vulnerabilities that can come along with both the difficulties of labour and birth, as well as entrance into motherhood in a society where childcare is considered a private responsibility. The women who have the privilege and social capital to have a solid support network are the ones that have the ability to pursue the individualised achievement birth.

### **Reproductive Justice**

When the greater context of women's lives is examined it becomes clear that what women seek in their birth is intimately linked with what else is going on in their lives. The privatised care for newborns may drive some mothers of them to seek as much support as they can in the hospital system, some of which they may receive through being patients. Other women may see interventions in their births as a way to escape the painful and disempowering birth experience. Not all women have access to a safe environment and a supportive partner in order to plan a home birth, nor the insurance coverage or funds available to seek midwifery care or otherwise an alternative to what is offered to them in their local hospital. In addition, even when women are educated and have a clear preference for a type of birth, the social relations and dynamics of the medical setting and the birth itself frequently leads to those choices not being actualised, but with the focus on individual achievement rather than structures, the blame is put on the individual woman for "failing." Therefore, true choice in childbirth will not be achieved until reproductive justice has been achieved; that is, the full emancipation of women in all areas of their lives.

Frustrated by the mainstream "pro-choice" movement, which has focused on abortion rights and the rhetoric of choice, various women of colour associations have

instead turned to reproductive justice. “Reproductive Justice is the complete physical, mental, spiritual, political, social and economic well-being of women and girls, based on the full achievement and protection of women's human rights.”<sup>222</sup> This will be achieved “when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives,”<sup>223</sup> according to the activist group Asian Communities for Reproductive Justice. This approach, rather than the call for choice in birthing, may be more fruitful in both working against the disempowerment that many women experience within the medical system, whether it is because they are forced to have technologically involved births or experience a lack of support from their providers, as well as working against the pressures that can be found within the natural childbirth movement, to have the perfect birth and simply to “choose” their way to a more preferred birth outcome without regard for the structures that enable those kinds of choices.

## **Conclusion**

The natural childbirth movement emerged in response to medicalised birth and the lack of power and choice that women experienced within the hospital birthing system. The licensing of midwifery and normalisation of various approaches towards birth, such as Lamaze, have changed the face of hospital birth and opened up more avenues for women to pursue their birth experiences. However, there are also disciplining discourses to be found within the natural childbirth movement. In particular, there can be an overemphasis

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<sup>222</sup> Loretta Ross, “Understanding Reproductive Justice: Transforming the Pro-Choice Movement,” *Off our backs*, 36(4) (2007): 14.

<sup>223</sup> Kimala Price. “What Is Reproductive Justice? How Women of Color Activists Are Redefining the Pro-Choice Paradigm.” *Meridians: Feminism, Race, Transnationalism* 10(2) (2010): 43.

found on choice without attention to the structures that surround the choices being made. Conservative ideas about women, motherhood and nature can also find a fertile ground in the natural childbirth movement, and it is difficult to reclaim the feminine in a patriarchal society. Pressuring women to have the perfect birth, and casting natural birth as an achievement, worthy of moral praise, can yet again add even more pressure onto women and their bodies, and how to perform appropriate femininity, and can also induce feelings of 'failure' when this achievement is not reached. Therefore, despite the initial intentions of helping women achieve better births, the natural childbirth movement can add to the pressures and the disempowerment that can be found in childbirth.

## Conclusion

In this thesis I have looked at the way childbirth has been medicalised and what the resistance to that medicalisation has looked like, as well as how women's choices are constrained when it comes to childbirth, both within the medical system and the resistance to it. How women are treated during this part of their lives is important, and can have long-ranging influence on their bodies, their parenting, their children and their lives. Therefore, it is important to examine the roots of the current maternity care system and how it functions today in order to understand how it can be improved, how women can better exercise their own bodily autonomy and make their own choices for their own selves and children, and how we can reach reproductive justice in these respects.

Birth has become medicalised in the West through several factors; the displacement of the midwife, a discourse that defined women and women's bodies as inherently sick and prone to malfunction, through casting birth as a medical event that does not involve the whole person and is performed by someone other than the mother, and by considering technology and science as the appropriate ways to view bodies and birth. The Western biomedical system has evolved with and through patriarchy and has assumed control of the birthing process, including its location and what it should look like. Even though maternity care in today's United States does not look the same way as it did fifty years ago, control is still in the hands of the medical establishment. Through surveillance and risk each birth is considered on a temporal axis heading towards complications, which are pre-emptively treated, until the birth is over at which point it may be considered 'normal.' The vast majority of women in the United States receive interventions in their births, with one third of births taking place via cesarean section.

These interventions, along with the defensive and litigious atmosphere of hospitals, the restraints of the institution, as well as the power differences between patient and provider, mean that it is hard to advocate for a different birth experience than what the system offers.

The natural childbirth movement emerged in response to medicalised birth. It has provided options for those who seek alternatives to hospital birth, and in response hospital birth changed as well. However, there are also constraints on women's choices to be found within the alternative birth movement. Its association with the natural can fall into gender essentialism, where women are supposed to find personal fulfilment through authentic motherhood. The discourse found within the alternative birth movement can be anti-science and anti-technology which may drive away those who wish to avail themselves of the benefits of technology. The pressures of healthism, or of having the perfect birth, in addition to the perfect body and the perfect baby, may further add to the gendered expectations of women and their bodies, as well as the pressures to sacrifice themselves for their child by enduring a medication-free labour. The discourse of choice found within the alternative birth movement can also focus too much on the individual, claiming that with sufficient preparation all women should be able to have their perfect birth, without adequate attention paid to structural factors that enable some women to have an easier access to the conditions in which to achieve their ideal birth, and places blame on those who do not reach this goal.

Choice can become an illusion and a distraction. Bodily autonomy and reproductive choice are worthy goals, but making choices in an unequal and patriarchal society is difficult. Women have agency but their options as well as their desires are

influenced by the society they live in. In the context of medicalised birth it can become hard to imagine an alternative. At the same time, the patriarchal power that is embedded in the medical system can make it hard to take advantage of the possibilities offered by medicine and technology without submitting to the power of the medical establishment. Technology is not inherently controlling and neither is medicine, nor is nature inherently empowering; both can be used by women to their own ends. What is needed is reproductive justice, where women and girls are fully empowered in all aspects of their lives, and feminist medicine, which women can access and use on their own terms as equal partners in their own care.

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