

Childbirth practice and Feminist Theory.
Re-imagining birth in an Australian public hospital

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I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree at any other University or Institution.

(Signed) Albert Taylor

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CHILDBIRTH PRACTICE AND FEMINIST THEORY: RE-IMAGINING BIRTH IN AN AUSTRALIAN PUBLIC HOSPITAL

Abstract

The thesis involves a re-examination of feminist views of the childbearing body from a post-structuralist perspective and applies these theoretical ideas to an empirical investigation into contemporary childbirth and midwifery. Critiques of medicalised childbirth developed in Australia, Britain and the USA in the 1970s are related to debates within feminism about appropriate ways to theorise motherhood and the female body as well as to understand the role played by midwives and doctors in childbirth. It is argued these critiques were the product of three strands of feminism that differed in their analysis of gender politics, their philosophy of knowledge and their understanding of power. The three critiques are also related to differences between the USA, Britain and Australia in respect of their medical system, ways in which the history of childbirth practices are viewed and differences between the professional roles of midwives. It is argued that these critiques need to be modified by more recent post-structuralist feminist approaches, particularly the way in which bodies are shaped by language and power is related to the distribution of knowledge

The empirical study concentrates on a maternity unit in a regional town in New South Wales. The unit was studied through repeat interviews with mothers attending the hospital for the birth of their second or a later child, interviews with the midwives and doctors working in the unit and observations over several months. Childbirth is re-imagined as a drama and found to be an intense embodied experience shaped in turn by the practices of the hospital and the changing boundaries between medicine and midwifery, relationships of the women with the staff and the women's own diversity. This approach to the analysis of the interview data demonstrates the limitations of the liberal feminist critique that there is insufficient rational and 'scientific' evaluation of childbirth practices, the radical feminist critique that the key issue is men's domination of women's bodies and the materialist feminist critique of the lack of fairness and support given to childbearing women, while showing how these discourses continue to circulate in debates over the management of childbirth.

INTRODUCTION.

Childbirth and the social body.

A quarter of a million births take place in Australia every year, the overwhelming majority of them in hospitals (Nassar, Sullivan, Lancaster, & Day, 2000). Birth is both a powerful personal event and a fundamental and significant social event. Because childbirth and reproduction are essential to the continuation of any society, it is in many ways surprising that they are not more central to social theory. The explanation for this lack of attention seems to be because they have been assumed to be part of the natural, rather than the social world. Seccombe (1992:9) points out that even though Marx was critical of the naturalism of nineteenth century Malthusian theory, he nonetheless appears to have assumed that reproduction was part of the natural sphere and could be left to “the worker’s drives for self-preservation and propagation” (Seccombe, 1992:256). van Kreiken (1997) similarly notes that men and women in contemporary sociology are rarely understood as ‘reproductive beings’.

In an immediate sense the way in which birthing occurs shapes the population and age structure, which in turn affect the economic life of the community. These issues have been the focus of demography and the study of family formation (Seccombe, 1992:10), while the rates of maternal and infant mortality which have been within the domains of medicine and public health, are used as indicators of the prosperity and health of a society (Black, Townsend, Davidson, & Great Britain Working Group on Inequalities in Health., 1982). However, demography and public health approach birth as a biological event with cultural consequences, rather than seeing birth itself as culturally shaped.

This study of childbirth is focussed on the cultural and approaches it through three different types of understanding of the birth process. First the broad approach to a range of issues based on a scholarly understanding of childbirth in its social setting. Second, the understanding of those taking an active political role in fighting for policy changes in the childbirth field. And third, the understanding of the women who give birth and the staff who take care of them. This latter strand is based on my own empirical study of a regional hospital, focusing on routine practices in a mainstream institution. Hospital practices have often been set up as the despised “other” form of practice, which always falls short of the ideal childbirth, yet rarely is there a detailed examination of what actually happens.

Main issues

In the extensive debates about childbirth practices over the last thirty years, three main issues have been at stake. The first involves the individual subject and the significance of birth as a physical, psychological and cultural phenomenon. This involves theoretical questions about the understanding of the relationship between the mind and the body, the individual subject and the culture. Childbirth is both common

and exceptional as a physical experience and should be a fruitful site for theorising these issues, if it is not relegated to the realm of the 'natural'.

A second issue involves the significance of birth within feminist literature. Despite rumours of technological experimentation which would dispense with bodily birth or extend it to men, at present only women give birth, and so the significance of birth to female subjectivity and hence to feminism has been widely debated (Ruzek, 1978) (Oakley, 1981b) (Mortimer, 1985) (Adams, 1994) (Umansky, 1996). At the beginning of the 1970s there was a diversity of views about childbirth and feminism, though the issue was taken up most strongly by radical/cultural feminists in the USA. Since then a particular view of the 'natural body' has become associated with 'feminism', something that obscures the diversity of views amongst feminists and the wider community of women and elides the theoretical complexity of the issue into an opposition between male and female dominated childbirth (Annandale & Clark, 1996).

The third much debated issue relating to childbirth involves the context in which it occurs, the kind of assistance practitioners should provide and issues relating to their training, remuneration and the philosophical framework within which they should operate. Practices vary between countries and between different systems within countries (De Vries, Benoit, van Teijlingen, & Wrede, 2001; Oakley & Houd, 1990). But something observable in most countries is that the majority of obstetricians have been men and midwifery has been practiced almost exclusively by women. This raises the issue of the boundaries and power imbalances between different kinds of practice and professions in strongly gendered occupational structures (Ruzek, 1978) (Benoit, 1989; De Vries, 1985; Gross, 1984) (Butter, Carpenter, Kay, & Simmons, 1987; Schofield, 1995). The identification of midwifery as a feminist practice (Rothman, 1990) and with 'natural childbirth' should not divert attention from social and political differences in the practice of midwifery and the cultural shaping of childbirth (De Vries, Benoit, van Teijlingen et al., 2001).

The reason for my involvement in childbirth theory and practice.

My interest in these issues and my desire to understand them more fully are the result of my own experiences over the last thirty years during which I have been a witness to these developments and a participant in many of these debates. In the 1970s, I was interviewing women in the UK about antenatal care when I had my first experience of midwifery-managed childbirth. I was accompanying a community midwife who worked on a 'Domino' (Domiciliary in and out) scheme, meaning that she looked after her own patients at home before and after the birth. She did take advantage of the hospital facilities for the delivery, but behaved at the hospital exactly as she would have done if she had been in the woman's own home. This demonstrated to me that it is possible to have very personal individualised care in a public health system and that there is no contradiction between having high technology available and delivering safe low-tech care.

Later when I was living in the USA, the professional women I knew accepted without question the system of expensive private medicine. I observed that it seemed to be normal practise to have a Caesarean section, so that work schedules, leave and

childcare arrangements could be predictable. Working class women, on the other hand, especially African American women, had little access even to ante-natal care and there appeared to be very little public concern about the fact that a wealthy city like Boston was reported as having a rising perinatal mortality rate.

When I migrated to Australia, I maintained an interest in birthing issues and became involved with groups campaigning for increased recognition for alternative birth practices. After some time, I recognised that the campaigners had two different objectives. Some wanted mainstream policies to incorporate natural childbirth, including low risk homebirth, rather as midwifery was practiced in Britain. Others rejected mainstream practices and relied on a separate identity for midwives rather as alternative midwifery has developed in the USA. They were much more sceptical about medical concepts of risk and particularly emphasised the importance of all women having the choice to birth at home with any attendant they wanted.

As well as being immersed in the debates of the alternative birth movement, I was visiting mainstream hospital maternity units as a volunteer 'labour supporter'. Being present during several women's labours and births allowed me to observe the way institutions were or were not flexible in response to alternative demands. At the same time, I had many conversations with Australian women outside the alternative birth movement whose expectation was to have a private obstetrician if they could afford one, even for routine births. These quite extensive earlier experiences stimulated my interest to undertake this study and also sparked many of the questions that I have attempted to grapple with through the research.

Background

Childbirth issues were evident in academic and popular debates in the 1960s and 1970s because the medical profession was being heavily criticised for the excessive use of medical technology (Wajcman, 1991). It should be remembered that, although this development occurred widely across the English speaking world, the actual treatments and hospital systems were very different and this issue will be addressed in Chapter 2. It is the case that many women were dissatisfied with the experience of hospital care and felt that they had no choice over their childbirth nor control over their own body (Arms, 1975; Oakley, 1976, 1979) (Shaw, 1974). The ideas of 'choice' and 'control' suggested that hospital childbirth practices should be examined in terms of consumer satisfaction or lack of it, like other consumer issues such as more liberal visiting hours or access to elective surgery. The investigation of consumer satisfaction with medical care is fraught with difficulty. Most surveys do find that patients express satisfaction with medical care but this is often because they do not have a clear understanding of the alternatives to it or are deferential to the superior knowledge of the medical profession (Oakley, 1992a; Porter & MacIntyre, 1984). The issue of what women want in childbirth is extremely complex and the last thirty years have seen a proliferation of surveys and reports on the issue (Bramadat & Driedger, 1993; Brown, Lumley, Small, & Astbury, 1994; Cunningham, 1993; Gosden, 1990; Martin, 1990). The response from medical organisations involved pointing to surveys of satisfied patients in order to refute these criticisms. However, the issue was far more significant than simply one of consumer satisfaction, though as Crouch and Manderson (Crouch & Manderson, 1993b) argue, these changes in

childbirth practice were consonant with the change to an affluent consumer society in the post-war period.

Childbirth is not just a consumer issue, but touches on women's autonomy and control of their own bodies, issues which were central to second wave feminism. Although in some sections of the women's movement, issues of 'body politics' were controversial, the women's health movement argued strongly that they were an important aspect of the feminist agenda and not just a matter of middle class reformism (Ruzek, 1978). Childbirth appeared as a topic at feminist conferences in both Britain and the USA (Allen, Sanders, & Wallis, 1974) and women in the academy took up the subject. By 1977 there was sufficient literature for a review (MacIntyre, 1977) which categorised childbirth studies as "historical/professional, describing changes in the professional and lay management of childbirth; anthropological focussing on the relation between the management of childbirth and cultural beliefs; patient-oriented studies which examine the perspective of those using the maternity services and patient/service interaction which look at communication between users and providers".

MacIntyre cautioned against accepting 'natural childbirth' ideas uncritically and it does appear that one particular view of childbirth practices tended to be identified with the feminist movement. This suggested that hospital childbirth was a form of technological, patriarchal or capitalist domination which women should resist, "many feminists view obstetrics as forms of sexual politics, putting men's interests ahead of women's health" (Ruzek, 1978:12). Resistance to medicalised childbirth took various forms including the promotion of homebirth, midwifery care and 'natural childbirth'. Ruzek (1978:112) divided birth options into 'conventional feminist' care with registered practitioners and 'radical feminist care' which took place entirely outside the health care system. There is no reason to doubt that for many women the realisation that they could give birth without medical assistance was empowering (Gosden, 1990; Noble, 1997). However, as MacIntyre (1977) had suggested there was a tendency to idealise 'natural' birth and alternative midwifery.

In particular, the predominant theoretical position of the campaign to reform childbirth was to make a firm opposition between a 'medical model' of care by male doctors to an alternative 'woman centred' model practiced by female midwives (Lumley & Astbury, 1980). Hospital birth practice was seen as demeaning to women as mothers and as autonomous individuals. On the other hand, the midwifery model was seen as sensitive to women's concerns and based on a holistic understanding of the person leading to women's empowerment and to birth without intervention or pain relief (Cosminsky, 1976; Ehrenreich & English, 1973; Oakley, 1976). Setting these models up in opposition diminishes the differences which are found between countries or within occupational groups (Oakley & Houd, 1990). It also means that hospitals, where the vast majority of women have their children, are often compared unfavourably with the very small number of homebirths, instead of being understood on their own terms. This is, as Annandale and Clark (1996:30) point out, one of the disadvantages of a theory which assumes an opposition between male and female, technological and natural.

Similarly, the use of historical and cross cultural models led to a modern myth about a pre-industrial utopia in which women were at one with their bodies, gave birth naturally, controlled their sexuality with herbs, ate natural foods and gave birth

without any problems (Purkiss, 1996). Subscribing to this view implies both technophobia, which sees any interference with the body as a threat and a particular psychological understanding of a pre-existing natural body. If the 'oppressive' conditioning is removed the natural, healthy, non-violent, sexually liberated body will emerge.

This utopian view needs to be problematised for several reasons. First, it does not do justice to the theoretical complexity of the relationship between the mind and the body. Birth experiences are widely variable, with some people experiencing great pain and a high level of medical intervention. Others do not complain of pain and give birth with very little intervention (Arney & Neill, 1982; Green, Coupland, & Kitinger, 1990) (Sakala, 1988) (Sandelowski, 1984). Cultural constructions of the female body and social arrangements for pregnant and birthing women, as well as the practices of their carers play a major role in creating these differences. However, such beliefs and practices are more deeply rooted in both social life and the psyche of the individual than the 'myth' suggests. Such accounts abstract from idealised versions of history and from accounts of other cultures a literal understanding of how alternative birth practices can be introduced, rather than understanding them as saturated with complex relationships of knowledge and power. Studies based on actual examples of pre-industrial midwifery find that they are much less ideal than the myth suggests (Benoit, 1989; Leap & Hunter, 1993)

Second, this view associates 'feminism' with one particular kind of analysis of birth and the female body (Pringle, 1998:47). All strands of feminism aim to increase women's individual well being and social power, but many have reservations about promoting this on the basis of the ability to give birth and the qualities associated with motherhood, such as self-less commitment and non-aggression (Snitow, 1990). Many branches of feminism have reservations about the conservative political implications of promoting childbirth as empowering for women (Doyal, 1995) (Lupton, 1994).

Third, 'Natural childbirth' as a self-conscious entity (rather than as childbirth before the possibility of medical intervention) is far more problematic than was often recognised in the 1970s. The history of this self-conscious concept goes back to the 1930s in Britain and the USA and it was 'invented' by a male doctor (Sandelowski, 1984). Even in the 1970s natural childbirth practitioners were not necessarily feminists but also women whose political views and sexual politics were conservative, for example from the Mormon community (Sakala, 1988). It is mistaken therefore to suggest that there is something inherent in the nature of childbirth without medical intervention or midwifery care which is intrinsically feminist or liberating.

The question of whether women want natural childbirth is not a simple one. Margaret Nelson (1983) argued that fashionable ideas of natural childbirth which she had expected to elicit in her interviews with women were a middle class phenomenon and were not shared by her working class subjects who wanted to 'get the birth over with'. Emily Martin's (1987) research reached the opposite conclusion, that middle class women were more likely to adopt a "medicalised" vocabulary and frame of reference, while black and lower class women were not drawn in to the language of medicine and were at least as likely as middle class women to resist medicalisation (Martin, 1987:190,196). More recently, Ellen Lazarus (1994) has argued that there is a class dimension to women's desires but that it does not fall on a natural/technological

divide. She found that middle class lay women expect the doctor to be their advocate in the system to give them a sense of control, middle class health professionals use their knowledge of the system to get what they want, whether that is technology or not but poor women do not expect any control, but are more concerned with continuity of care.

Research in Britain, where midwifery care is more routinely available, does not appear to show a strongly marked pattern of class differences, but a wider acceptance of low intervention birth than reported in the USA (Green, Coupland, & Kitzinger, 1990; Martin, 1990). This variation in the research findings suggests that women's birth choices and hospital birth practices are highly conditioned by the cultural context. It is clear that there is a very complex relationship between women's desires and the organisation of maternity care (De Vries, Salveson, Wiegers, & Williams, 2001).

Activists who are immersed in the struggle to achieve choices for women, such as access to birth centre and homebirth options and increased recognition for midwives do not necessarily dwell on theory and continue to depend on a range of assumptions which mirror those of the '(cultural) feminist' position developed in the 1970s and 80s. Childbirth as 'natural', midwifery knowledge as 'innate' and women as essentially gentler are all commonplace concepts within campaigns for natural childbirth, as seen for example, the title of an Australian midwifery article, *Women have the innate knowledge and wisdom to birth* (Markus, 1997). Even mainstream sociology of health and illness often does not address the issue in terms of complexity but relies on a simplified version of the feminist critique of childbirth (Annandale & Clark, 1996:28).

On the other hand, contemporary feminist theorists tend to ignore childbirth in favour of more exotic terrain. Even though 'the body' is a central preoccupation in post-modern feminist theory, 'childbirth' almost never appears in the index of these works. Extreme bodily situations, such as torture, eating disorders and artificial reproduction seem more fruitful for theorising (Caddick, 1995; Komesaroff, 1995; Rothfield, 1995; Scarry, 1985). Some feminist writings on the body (see for instance Grosz, 1994) suggest that culture and language are not an overlay of the 'natural', but deeply intertwined in the construction and experience of the self. But birth appears to be abandoned as a topic to the advocacy of the natural, the authentic and the caring by childbirth advocates while other post structuralist feminist writers are concerned to work outside the 'reproductive metaphor' altogether (Butler, 1990; Haraway & Randolph, 1997). On the other hand, when post-structuralist concepts are suggested as useful for the study of reproduction within the sociology of health and illness (Annandale & Clark, 1996), they are met with vehement rejection (Campbell, 1997).

If the same theoretical concepts cannot be addressed to all areas of embodied experience, this reinforces the disjunction between maternity and sexuality as if, as Mortimer (1985) suggests, women were divided into 'reproductive and non-reproductive castes'. It is true that if present trends continue, almost 24% of women will remain childless in Australia (Australian Bureau of Statistics, 2001). However 76% of women will be expected to have children, so feminist thinking needs to address the issue rather than allowing a theoretical division of labour in which childbearing women are only mentioned by cultural feminist writing. It would be

strange if feminist theory split into different realms for women who give birth and women who do not. This is why it is important to question the taken for granted position, even if it still has currency in activist circles.

The absence of childbirth as a subject across the whole of feminist theory, as well as the issue of whether childbirth has or has not changed for the better in the past thirty years indicate that the taken for granted position is due for review. Good theory ought to allow the assessment of practice in the light of new theoretical models as well as to see how the theory performs in the realm of practical action (Fraser, 1989:2).

Childbirth and feminism in the twentieth century.

Lumley and Astbury (1980) trace two different understandings of the experience of childbirth – one that it should be pain free, the other that it is necessarily painful but that this may be a positive experience. Debates over this issue go back to nineteenth century controversies over women's education and political participation known as 'first wave feminism'. Laqueur's (1990) history of the scientific understanding of sex points out that the place of women in the public sphere and the claims of feminists and their opponents were highly contested and "the battleground of gender roles shifted to nature, to biological sex" (Laqueur, 1990:152). There was a rapid increase in writing about "the nature of women" and of scientific research about anatomy and physiology of reproduction and, in the early twentieth century, the role of hormones. But, Laqueur points out, claims made about sex were part of the political argument, "not susceptible to empirical testing" because the language and presuppositions of scientific enquiry were already saturated by gender (Laqueur, 1990:153). This nineteenth century scientific sexism underpins the idea that childbirth is women's destiny and that it is also a cause of her inferiority.

The question of whether middle class white women would want to continue having children was of great concern at the beginning of the twentieth century because of increasing education for women, the falling birth rate and the use of contraception (Davin, 1974; Reed, 1978; Willis, 1983:112). Many first wave feminists in the USA had experienced 'painless childbirth' developed at specialist clinics in Germany and they demanded anaesthesia in childbirth for all women as a feminist issue (Leavitt, 1980). Many doctors were reluctant to carry out this type of anaesthesia, because of side effects and because they did not like patients demanding particular treatments. The necessity for supervision of women who were heavily sedated expedited the move from home to hospital birth in the USA (Wertz & Wertz, 1977). However, even as changes were being made in childbirth practice, there was considerable debate about the meaning of birth and the best way to understand it. Psychoanalysis was one of the pervasive forms of cultural explanation in the twentieth century, both clinically, in popular culture and in the evolution of gender theory (Kaplan, 1992: chapter 2) and one of its best known formulations was Freud's argument that childbirth was the culmination of 'normal femininity', because, only by bearing a child, preferably a male child, could a woman be compensated for her 'penis envy'. This theoretical development was part of a heated debate over femininity within psychoanalysis in the 1920s and 1930s (Chodorow, 1989). Many women analysts argued against the idea of penis envy by asserting that little girls were equally proud of their ability to reproduce and had an intuitive knowledge of the value of their reproductive anatomy. This was "a model of women with positive primary feminine

qualities and self-valuation, against Freud's model of woman as defective and forever limited, and ... (a) recognition of a male-dominant society and culture" (Chodorow, 1989:3). Such an innate level of gender awareness places at least as much stress on biological destiny as the strictly Freudian view, but the debate lays the foundation for a division over the understanding of female subjectivity, one which promotes motherhood as a strength, the other as a source of weakness.

The idea that childbirth pain is productive became widely known through the work of Helene Deutsche (1945), a German trained psychoanalyst who moved to the USA to escape Nazism. Like Freud she argued that normal women are necessarily 'masochistic', in the technical psychoanalytic sense of deriving pleasure from pain, because otherwise they would not willingly submit themselves to the demands of reproduction. Even with this theoretical justification for the necessity of pain, Deutsche concluded that childbirth without anaesthesia was bound to disappear, not because the medical profession imposed it, but because the "new woman" of the 1930s and 1940s would not tolerate it.

A modern woman, asked to endure labor pains without recourse to the modern devices for easing childbirth, and thus to abide by the Bible's commandment, "In sorrow shalt thou bring forth children," would certainly reject the proposal with indignation. Obstetricians tell us that pregnant women often make them promise at the very first consultation that everything possible will be done to alleviate their labor pains... (Deutsche, 1945:241).

Margaret Mead and Simone de Beauvoir were writers of the generation before second wave feminism who became influential both as personalities and as theorists in the 1970s. These two writers can be taken to exemplify the gulf between two historical strands of feminism. de Beauvoir (1972) stressed the intellectual and social equality between men and women and Mead (Mead, 1962) emphasised the cultural differences between male and female emotions and embodied experience. In other words they represent the 'sameness' and 'difference' traditions referred to by Bacchi (Bacchi, 1990).

While Mead (1972) was known as an advocate of 'natural childbirth', de Beauvoir was a well known critic of motherhood because it confined women to the domestic and mundane (Appignanesi, 1988:3; de Beauvoir, 1972). Mead belonged to the Culture and Personality school of social anthropologists who assumed that psychoanalysis describes universals on which cultural differences, for instance birth customs and mothering practices, are overlaid (see for instance Mead, 1962). Her personal experience of other cultures served to relativise the practices of her own society and she saw no contradiction between motherhood and the professional career in anthropology that she herself enjoyed (Mead, 1972). de Beauvoir (1972) on the other hand portrays motherhood as one of the principle inhibiting factors in women attaining independent self-hood and cultural creativity. As an existentialist she saw psychoanalysis as biologically determinist and unhelpful to women. Her reading of anthropology showed women's lives enmeshed in the 'contingent' rather than the 'transcendent'.

The idea developed in the 1970s that medicine was oppressive to women did not feature in these earlier writers. Sandelowski's (1984) survey of medical, nursing and popular literature of the 1950s concludes that the Natural Childbirth movement of the

time was not marked by a political opposition between women and their doctors. When Margaret Mead, the third generation of a family of university educated women, argued for a 'natural birth' based on her experience of other cultures, she shared with her paediatrician and obstetrician an interest in psychoanalysis and cross-cultural medical and child-rearing practices. It was the nurses who were "too busy to manage any further alterations of the customary routine" (Mead, 1972:254). *Male and Female* (Mead, 1962:220-2) draws on the fieldwork Mead had done before her daughter's birth. She argues that the wide range of attitudes towards childbirth indicates that childbirth behaviour is learned rather than innate and suggests that it is men who are excluded from the event who elaborate fantasies about its fearsome and polluting nature. Anthropological views like Mead's were to become an important resource for childbirth theorists in the 1970s when they were looking for alternatives to medicalised childbirth (Jordan, 1980).

Simone de Beauvoir's monumental work on women, *The Second Sex* was published in 1949 and translated into English in 1953 (de Beauvoir, 1972). It was considered to be scandalous, especially in France because of its rejection of motherhood as a source of fulfilment for women (Okely, 1986:68). de Beauvoir is widely cited in the feminist literature as describing pregnancy as abhorrent. From an existentialist perspective "giving birth and lactating are not activities they are natural functions" (de Beauvoir, 1972:94). As such they have the quality of "immanence". They belong to the ceaseless round of material activities that endlessly repeat themselves in daily, annual and generational cycles and never progress. de Beauvoir wishes women to partake in activities that are transcendent, to adopt projects that will change human life by technical, political or intellectual means as men have always done, even if these are violent and destructive (de Beauvoir, 1972:29 and 95).

For it is not in giving life but in risking life that man is raised above the animal; that is why superiority is accorded in humanity not to the sex that brings forth but to that which kills (de Beauvoir, 1972:96).

Her reading of her anthropological sources is pessimistic and does not acknowledge cultural frameworks for ensuring that children would be appropriately spaced and nourished.

Pregnancy and childbirth and menstruation reduced (women's) capacity for work and made them at times wholly dependent upon the men for protection and food. As there was obviously no birth control, and as nature failed to provide women with sterile periods like other mammalian females, closely spaced maternities must have absorbed most of their strength and their time, so that they were incapable of providing for the children they brought into the world (de Beauvoir, 1972:94).

Unlike Mead who had first hand experience of non-medicalised birth and who sees it as an everyday matter, de Beauvoir finds that the practices of 'primitive peoples' confirm the dangerous uncleanness of birth, which is regarded with horror and she commends medical intervention as saving the lives of women and children (de Beauvoir, 1972:179). She comments that the role of anaesthesia is growing but its significance for women is not determined since their experience of childbirth is so varied:

There are some women who say that childbirth gives them a sense of creative power; they have really accomplished a voluntary and productive task. Many at the other

extreme have felt themselves passive, suffering and tortured instruments (de Beauvoir, 1972:521 2).

Mead on the other hand sees medical practice as 'male' even though increasing numbers of women become doctors. In her view they have to force themselves into a masculine model to compete in the field. She comments on the incongruity of men's determination to:

...indoctrinate women in 'natural childbirth', in fact to return to them the simple power of bearing their own children, which in the course of a most devoted but one-sided development of medicine has practically been taken away from them (Mead, 1962:338).

Mead's comments lay the groundwork for the idea to be taken up in the 1970s that medicine is inherently masculine and childbirth 'women's business', which is relatively straightforward if left without interference.

de Beauvoir's theoretical writing is less positive about motherhood, but her observations about women's experience is quite sensitive to their variety. Although she opposes psychoanalytic theories about women, she used many of Deutsche's (1945) case histories in the *Second Sex*. She describes childbirth as an area in which the conflicts of a woman's psychological history come to the fore, anything but a biologically ordained event. Birth is a unique combination of a bodily event which is automatic and without conscious control but in which the bodily process can be interrupted by unconscious emotional factors "...because of them a well initiated labor stops, contractions become too strong or too weak or they function in a paradoxical way" (Deutsche 1945:229). She argues that without medical intervention, childbirth has to be experienced as a combination of passivity, letting the process carry on and embodied activity, whilst it cannot be controlled, it can be actively participated in.

Direct observation of women in labour leaves no doubt that childbirth is experienced as a strenuous act of accomplishment and that it requires tremendous mastery over fear and suffering...Her activity is fully taxed, her accomplishment is connected with a tense "listening" to the innervation processes and everything else present, past and future seems to vanish (Deutsche 1944:228).

With active participation, the birth process produces a joyful catharsis (Deutsche 1944:244) which is lessened with anaesthesia or active management of childbirth because it reduces the woman's level of participation. Deutsche's description of an activity which is on the borders of the conscious and the unconscious, the social and the physical makes her observations relevant to contemporary considerations of embodiment, even though her psychoanalytic theories became the target for intense feminist criticism.

This was because psychoanalysis in the USA in the 1950s was a very medicalised therapy which prescribed a conventional understanding of femininity and women's roles as mothers. The medical monopoly on analysis in the USA led to the clinical practice of ego-psychology, which aimed to achieve 'adjustment' to the masculine or feminine role and the command of the rational ego over unruly impulses. It was thought normal that all women should become mothers. If they did not they risked

neurosis or a lack of fulfilment, which expressed itself as “masculine protest”, unfeminine behaviour such as lesbianism or seeking paid employment. This dovetailed nicely with the ideology of the housewife in the 1950s and underpinned the functionalist account of gender roles, with a psychic penalty of neurosis if they were not adhered to. The perception that psychoanalysis saw biology and motherhood as inescapable destiny explains the furious opposition of feminists like Millett (1972), and an aversion to the very idea of including the body and motherhood within feminist theory.

The medicalised psychoanalytic understanding of birth led to the practice of ‘psycho-obstetrics’ in which physical symptoms, like morning sickness and birth difficulties were attributed to a lack of adjustment to femininity and female role. Ann Oakley (1980) criticised this practice as oppressive because it enforced femininity and blamed women for psychological problems rather than seeing mothering work as necessary social labour which is insufficiently supported.

Overview of the thesis.

While birth is a cultural phenomenon, in contemporary western industrial society it is largely seen as a biological event to be handled by the medical profession. Even so, over the last thirty years there has been a ferment of debate about how birth should be arranged and managed, yet births in countries like Australia continue to take place in hospital, the level of technological intervention remains high and the place of midwives in health systems is equivocal. Three key areas of interest in explaining contemporary childbirth practice are; the significance of birth as a cultural phenomenon, its significance to women themselves and within feminist theories of gender and subjectivity, and the role of female practitioners associated with birth, especially midwives.

The starting point for the thesis is the complex way in which second wave feminists theorised childbirth and envisaged alternative practices, starting with debates about the significance of birth in the 1970s. The first chapter reviews liberal, radical and materialist feminist theory and examines their different positions on the significance of birth to women, their theoretical understanding of gender, the role of midwives as female practitioners and the politics of the organisation of childbirth services. Each position advocates a particular vision, a feminist utopia, of what a reformed childbirth practice would be like but these are not all compatible with each other.

The second chapter looks at the diversity of childbirth practice and provision in the UK, USA and Australia which accounts for some of the different prescriptions for change produced by the different kinds of feminism. Particular attention is given to the differences in the way female practitioners have been included or marginalized and the consequences for the kinds of alternative services which have been envisaged.

The third chapter examines the implications of theoretical changes in the 1980s and 1990s, which questioned the premises of the 1970s positions on childbirth in favour of a focus on language and the body. The chapter is concerned with a change from seeing power as domination to identifying it as surveillance and focussing on forms of power and knowledge. It considers post-structural feminist writing which questions

the idea of a 'natural body' in favour of a body and subjectivity formed and inscribed by language.

Chapter four describes the methods used in a study of a maternity hospital which is the source of the empirical material discussed in the second part of the thesis. Chapter five sets the scene for the study, describing the place and the circumstances of the women, doctors and midwives whose words appear in the following chapters. The hospital is described as a place which is intensely inscribed with emotion and meaning for the people who use it and work there. The ways processes of labour and work are structured by the building and the difficulties of accommodating difference and the possibilities of surveillance are shown to be significant issues.

Chapter six contains an account of the drama of birth as the women told it in the interviews, structured by the embodied experience of labour, birth and breastfeeding. The difficulty of speaking about issues on the boundary of the body and emotions and ways in which experiences of birth and relationships with carers are difficult and emotional are discussed. 'Natural' birth is shown to be itself a complex cultural phenomenon involving 'benign' technologies and intervention is found to be a desired choice for some women.

Chapter seven examines the hospital through the lenses of 'feminist utopias' discussed in Chapter one. In terms of the liberal critique, the hospital and its services are shown to be not as rational as they claim to be, choices are haphazardly made and heavily influenced by the emotional quality of relationships. In terms of the radical feminist critique, the accounts finds that 'natural' childbirth is an identity which is partially adopted by some people, but which is problematic to the staff because it interferes with the regime of surveillance of risk. However, most women do not adopt the identity consistently but only some elements of it. In terms of the materialist feminist critique, everyone at this hospital has access to 'good quality' free care, but there are distinctions made between those who have private insurance and those who are public patients, which contradict the assumptions of a universal health system.

Chapter Eight examines the boundaries between the medical profession and midwives. This is not only in terms of formal power but includes the culture of the professions, the use of language, the presentation of self and the emotional quality of work and relationships. The conclusion draws together reflections on the concerns of the feminists of the 1970s and the way they underpin this account of the maternity hospital in the 1990s. Given that none of the utopias has come to pass, the question of the future of maternity services in the post-modern era is raised.